Mental Health and Elite Women Footballers in England: Tensions and Challenges in a Time of Transition

By

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Declaration

For the award of **Doctor of Philosophy (PhD)**, School of Health, Social Work and Sport, University of Central Lancashire.

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.

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Carly Young Perry

Abstract

Change in the English women's professional game has accelerated significantly over the past several years. Developments include the introduction of the first fully-professional women's league, increased financial and commercial investment, and heightened media interest in both the game and its players (Culvin, 2019). Despite the positive conversation that surrounds these shifts, Culvin (2019) identified that elite women footballers encounter financial instability, limited post-career playing options, lack of women-specific workplace policies, and inconsistent physical and mental health support. In turn, Culvin (2019) called for further research specifically focused on the mental health of this population. Similar calls have since been echoed by players, academics, the UK government and wider sporting stakeholders. In response, this thesis—a first-of-its-kind—explores mental health and elite women footballers in the top two tiers of women's football in England, the Women's Super League (WSL) and the Women's Championship (WC).

Using four studies, this project sought to advance understandings of mental health challenges concerning elite women footballers in England and explore the support available to players, providing empirically driven recommendations for practice and policy. Study One—a scoping review—investigated research concerning elite women athletes and mental health and mental illness. Findings from this review provided critical insight into the methods, theories, and focuses of research with this population, and informed subsequent studies in the thesis. Study Two attained prevalence rates of mental ill-health symptoms and help-seeking intentions in elite women footballers in England (WSL=63; WC=52). Study Three involved 21 interviews with elite women footballers (WSL= 8, WC=13) and explored their lived experiences with mental health, specifically in relation to their football context. The final study in this thesis—Study Four—included interviews with players and support staff working in WSL and WC

clubs. This study explored the tensions and barriers footballers face when accessing mental health support at their club.

Key findings from this thesis highlighted that elite women footballers experience mental ill-health and face unique challenges—largely linked to aspects of their professionalising football environments—which negatively impact mental health. Notably, in contrast to previous sporting literature in this area, the footballers expressed a strong appetite for mental health support, though encountered challenges to using such support. Collectively, this thesis demonstrates that mental health support and provision across elite women's football has not kept pace with professionalisation, despite its importance to players.

Research dissemination

Journal articles

Perry, C., Chauntry, A. J., & Champ, F. M. (2022). Elite Female Footballers in England: an Exploration of Mental Ill-health and Help-seeking Intentions. *Science and Medicine in Football, 6*(5), 650-659. DOI: 10.1080/24733938.2022.2084149

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Conference presentations and awards*

*Perry, C. (2023). Mental Health and Professional Female Footballers. Oral presentation delivered at the World Congress on Science and Football, Groningen, Netherlands.

Invited speaker

Perry, C., Chauntry, A. J., Macbeth, J. Spandler, H. (2023). Player and Staff Perceptions of Mental Health Support Within Elite Women's Football in England. Poster

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Perry, C., Chauntry, A. J, Champ, F.M. (2022). Elite Female Footballers in England: An Exploration of Mental Ill-Health and Help-Seeking Intentions. Poster presentation delivered at Association for Applied Sport Psychology Annual Conference (AASP) Fort Worth, Texas, USA.

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*Perry, C., Champ, F. M., Macbeth, J., Spandler, H. (2021). Mental health and Elite Female Athletes: A Scoping Review. Oral presentation delivered at Association for Applied Sport Psychology Annual Conference, Virtual. **Abstract award**

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Involvements

FIFPRO Women's Mental Health Taskforce, 2022

Mental performance coach Loughborough University's men's football 1st team, 2020 to 2022

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List of Tables and Figures

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Abbreviations

ACL	Anterior cruciate ligament
APA	American Psychological Society
BEDA-Q	Brief Eating Disorder for Athletes Questionnaire
DCMS	Department for Culture, Media & Sport (UK Government)
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
FA	Football Association—England
FIFA	Fédération Internationale de Football Association
FIFPRO	International Federation of Professional Footballers
GAD-7	General Anxiety Disorder, 7-item
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
IOC	International Olympic Committee
NCAA	National Collegiate Athletics Association
NL	National league
PFA	Professional Footballers' Association (England)
PHQ-9	Patient Health Questionnaire, 9-item
UEFA	Union of European Football Associations
WC	Women's Championship
WSL	Women's Super League

Chapter One

Introduction

1.0. Overview

This thesis sits at the intersection between elite women's football in England and mental health in elite sport; two rapidly evolving subjects which have each been the focus of calls for further research attention. This introductory chapter situates this research—and its relevance—within its cultural and academic context. It outlines significant developments that have taken place within elite women's football in England and provides an overview of mental health and elite sport research to date. The thesis' objectives are then presented, as well as the structure of the forthcoming chapters. Finally, discussion surrounding the language used throughout this thesis is offered.

1.1. Elite women's football in England

To understand the timeliness and relevance of this thesis, it is important to provide context on the recent trajectory of women's football in England. This section offers an overview of some of the key milestones in the development of elite women's football, mainly over the past several years. It will focus on the changes that have taken place to England's professional and semi-professional leagues within which this thesis' population competes. It is worth noting that the data for this thesis was collected between 2020 and 2022, after the restructuring of the leagues in 2018/2019 and the launch of the first completely full-time professional women's league in England, yet before England women's national team (known as 'the Lionesses') historic EURO 2022 win. Therefore, the events mentioned in this introduction that occurred after the research was conducted are provided to highlight the continued relevance of conducting mental health research within this population.

1.1.1. Professionalisation and growth of the elite women's game in England

Women's football in England has undergone a period of transformational change over the last decade, specifically at the elite level ('elite' referring to the top two tiers of women's football in England.) Driven by the sport's professionalisation—and further accelerated by unprecedented on-pitch success by the Lionesses—women's football in England is being somewhat 'reborn' following decades in the shadows of the men's game; underfunded, deprioritised, and culturally sidelined (Culvin, 2019; Fielding-Lloyd & Woodhouse, 2023). To appreciate and understand the significance of the last decade, it is important to note some of its history and the journey towards professionalisation.

This historic neglect of women's football is perhaps best demonstrated by the 50-year pitch ban of women's football in England from 1921 to 1971 implemented by the Football Association (FA)—the governing body of football in England (Williams, 2003). In 1921, the FA stated that "the game of football is quite unsuitable for females and should not be encouraged" (from FA heritage "The Story of Women's Football in England" n.d. [FA heritage, n.d.]). This neglect was not confined to England. Notably, two-thirds of football associations—both in Europe and across the world—banned women from playing football in the twentieth century (Culvin & Bowes, 2023). For example, the German Football Association rejected women's football participation for physiological reasons, arguing that football would hinder a woman's ability to bear children (Pfister, 2003). While the FA used similar physiological explanations to justify their pitch ban in England, researchers suggest the impetus for this ruling was more likely due to the unprecedented popularity of the women's game during this period, with large crowds of approximately 45,000 at women's matches before 1921 (Culvin & Bowes, 2023; FA heritage, n.d.; Williams, 2003). The women's game was seen as threat, and thus the

exclusion of women's football was an attempt to "safeguard" the men's game (Culvin & Bowes, 2023, p. 4).

These exclusionary practices had consequences in effectively establishing football as a sport for men (Williams, 2003). As noted by Culvin & Bowes (2023, p. 4) these early practices, "marginalised the sport socially, culturally, and economically" for women for decades. This characterisation of football as a sport for men therefore socially and culturally impacted those women who did play football during and after the ban. One example being girls and women who played football were perceived as deviant and masculine (Caudwell, 2011). Caudwell (1999) notes that women's football has historically been stereotyped as played by "butch lesbians" which, in the context of prevailing sexism and homophobia, marginalised those who did play the sport (regardless of their sexuality) and might have impacted wider participation. Perhaps, more importantly, it most likely negatively impacted the reception and coverage of the game. Even up until the late 2000s, perceptions associated with women's football have been cited as major barriers for girls and teens in terms of participation (Welford & Kay, 2007). The ban on women's football was eventually lifted in 1971 and coincided with the formation of the Women's Football Association (WFA) who drove progress and grew the game over the coming decades until the FA eventually assumed control of the women's game in the mid-1990s (Dunn & Welford, 2015; Williams, 2003).

The seeds for the contemporary professionalisation movement were, however, sewn just over a decade ago with the launch of the FA Women's Super League (WSL) in 2011, the first women's semi-professional football league in England (Culvin, 2019). This was later followed by the introduction of the WSL 2 in 2014—now the Women's Championship (WC)—the second division of women's football in England. A major re-structuring of women's football by the FA in 2018 would see the WSL become England's first fully professional

women's league. At the licensing level, this required clubs to offer their players minimum 16-hour per week contracts (rising to 20 hours per week by 2020/2021) (FA, 2017). It also required clubs to provide a minimum level of financial investment into their women's teams and enforced clubs to abide by a squad cap (FA, 2017).

The licensing requirements also had a significant impact on the ability of certain women's teams to remain in or enter the top two divisions for the 2018/2019 season. Independently-run clubs who could not financially afford to stay in the top divisions were essentially lost in the restructure and replaced by women's teams often associated with Premier League men's clubs, such as Manchester United (Clarkson et al., 2023). Notably, prior to the restructure, many of these top clubs—such as Manchester United—had placed minimal investment into their women's team (Clarkson et al., 2023). The financial investment from the men's side of the game was vital for the immediate progress of the game—and will likely contribute to the long-term financial sustainability of the women's game—however, it also meant that many of these women's teams were now further assimilated into structure, practices, and cultures designed for the men's players (Clarkson et al., 2023; Fielding-Lloyd & Woodhouse, 2023).

Since then, the WSL and WC has grown year-over-year. Rocketing match attendances, as well as increasing cultural relevance and growing commercial value has come to define the game's recent history. Viewership and attendance rates at the WSL level have rapidly increased with Sky's WSL coverage averaging 125,000 viewers per game in the 2021/2022 season, a 170% increase compared to the 2020/2021 season (Carp, 2022). Attendance rates have also substantially increased, with Arsenal breaking the WSL attendance record with 60,160 fans at the Emirates versus Manchester United in February of the 2023/2024 season (BBC, 2024). In

terms of commercial value and revenue, the WSL is believed to soon become the first billion-pound ($1.24 billion) women's football league in the world (FA, 2023).

Much of this growth was turbocharged by the England women's national team victory at EURO 2022. As reported by UEFA (2022), the victory had a "transformative" effect on women's football. For example, UEFA reported that the total attendance during the 2022/2023 WSL season was 172% higher than the previous season, and 2.3 million more women and girls played football post-tournament compared with the season prior (UEFA, 2022).

Following England's historic EURO 2022 win, the UK Government's Department of Culture, Media and Sport (DCMS) launched an independent review into women's football, with former Chelsea and England player Karen Carney MBE selected to lead the year-long project. The purpose of this review was to examine the state of the women's game in England, specifically at the elite level—the WSL and WC. Recommendations from the review were published in 2023 and a significant focus was placed on the ongoing professionalisation of the top two tiers; as Carney (2023) expressed, the elite women's game is "essentially still in start-up mode" (p. 8). With this, Carney (2023) called for clubs to ensure they are supporting players—mentally and physically—especially with a major change in the organisation of professional women's football in England on the horizon (i.e., 'NewCo').

In November 2023, the FA announced it would hand over the running of the women's game to a new, independent organisation—i.e., 'Newco' (FA, 2023). All 24 clubs involved in the top two divisions voted in favour of the takeover which will take hold from the start of the 2024/2025 season (Carney, 2023). The FA (2023) called the move a "historical moment for the women's professional game in this country" and said that NewCo would allow clubs and players to "make even bigger strides both on and off the pitch" (para. 13).

That said, the picture of professionalisation has been uneven and not positive for all players – as found by Dr. Alex Culvin in her 2019 doctoral thesis titled, 'Football as Work: The New Realities of Professional Women Footballers in England.' She notes that the very nature of women's football as a career for women is a new concept and explored the lived realities of football as work for players competing in the WSL.

1.1.2. Player welfare concerns and mental health research calls

Despite the positive changes to the game mentioned above, numerous concerns have been raised across academic literature and by themselves regarding player welfare and mental health. For example, Culvin's 2019 work drew attention to the precarious working conditions in professional women's football as it is often considered of little importance for clubs and organisations compared to the men's side. She highlighted that football as an occupation is linked historically to a highly masculinist, and often gender-exclusive, culture which has impacted women footballers' experiences in their new career. This has resulted in elite women footballers in England mixing into an existing system of professional football with limited policy consideration of their needs as women. For example, a key finding from Culvin's work was the neglect of essential employment and workplace policies such as education, maternity leave, and post-career options, as well as inconsistent workplaces and financial instability (Culvin, 2019; Culvin & Bowes, 2021). Unfavourable injury policies for example, meant clubs only had to pay players for three months during injury (Taylor, 2018).

Recent figures from 2023 estimated that the average salary in the WSL is around £25,000 to £27,000 a year, and salaries in the WC are as low as £4,000 a year (Carney, 2023). This is well under the national average in the UK which is estimated to be £34,000 a year (Office for National Statistics, 2023). In comparison, the average player's salary in the Premier League—the top men's league in England—is over £3 million per year (Carney, 2023). As a

result of low salaries, players reported being forced to engage in alternative paid employment alongside their football career (Culvin, 2019).

Culvin's doctoral thesis also highlighted that elite women footballers often work in unsatisfactory conditions, and yet felt required to 'make it work' to demonstrate they were 'cut out' for professional football (Culvin, 2019). She highlighted that resource-related factors, paired with limited support and policies not designed for women, can negatively impact players' mental health, and her work made further calls for mental health-specific research into this population (Culvin 2019, p. 307). Culvin (2019) concluded the following:

> As the women's game continues on an upward trajectory, further consideration must be given to the mental health of professional women footballers. Mental health is neglected both within research, by the clubs and, at times, by the players themselves. Participants noted an uncertainty of whose responsibility it was to offer support, and in the rare occasion participants sought help, players felt that their club was reluctant, or had spent their budget elsewhere. (p. 307)

More recently, similar research calls were echoed by Culvin and Bowes (2023), "when we consider the pathway for future research, one pertinent area to consider is the welfare and mental health of professional women footballers, which has not been covered within this book or adequately elsewhere to date" (p. 250).

Since Culvin's 2019 research, mental health in elite women's football has been an area of increasing concern and interest for those involved in the game. The players themselves have also made this clear. By way of example, in 2020 the then West Ham captain Gilly Flaherty spoke about the different mental health challenges she had experienced throughout her career (Sky Sports, 2020). Fara Williams, Fran Kirby, Molly Bartrip, Clare Rafferty, Demi Stokes, Aoife Manion, and Lucy Bronze are among other professionals to have spoken publicly about

their experiences and the importance of supporting mental health. For example, Molly Bartrip—currently playing for Tottenham Hotspur—wrote about her experience with mental health challenges and called for more to be done in the women's game (The Players' Tribune, 2022, see "Ana"):

> We're at a moment now where we're really trying to push women's football for the next generation. We see it as part of the job, to keep promoting it and to keep doing what we can to make sure that women's football gets to parity with the men's game. And getting there means acknowledging the elephant in the room when we need to and making mental health a big deal — not just a side project. I think, just from my own experience, it's almost as if people need to see it to respond. Help is always reactionary. People aren't trained to notice certain behaviours and be proactive. We need more awareness about triggers.

The UK government (i.e., DCMS) and nationally-recognised mental health charities (i.e., Mind)—have also recognised the need for more mental health understanding in this population. For example, Carney's review of women's football focused heavily on mental health and player welfare, making a series of recommendations aimed at ensuring the game provides a "gold standard" of mental health support to its players (Carney, 2023, p. 104). Additionally, MIND—one of the England's largest mental health charities—also voiced the need for more research within this population in their elite sport review published in 2022, stating the following:

> Women's team sports – such as cricket, football and rugby – are becoming more professionalised. And athletes told us they want help facing the extra pressure. In 2020, the FA started supporting England's women footballers [England's national team] with their mental health. The Professional Football Association also has help for

> members. But for most women, there isn't much support directly from their sports. We need more research about mental health in women's sport – and more support. (Mind, 2022, p. 15).

The most recent call for greater attention to mental health came following the suicide of Maddy Cusack in 2023, a midfielder for WC side Sheffield United. Maddy's death sent shockwaves through the sport and further amplified calls for more support, especially from players (Taylor, 2024). Following her death, her parents spoke about some of the pressures she faced as a footballer which they say had contributed to her mental health challenges (Lowbridge & Satchell, 2023). This tragedy happened after data collection for this thesis, yet it is mentioned here as it reinforces the importance of this project and for mental health to be a priority during the game's transition to its independent ownership under NewCo.

1.2. Mental health and elite women's football research

Despite vast growth in the women's game within the last decade, mental health research with this population remains underexplored. This is despite numerous calls from players and researchers (e.g., Bennet, 2020; Culvin, 2019; Culvin & Bowes, 2023; Wood et al., 2017). This section will provide a short overview of research that has been conducted to date on women footballers, before providing a summary of the status of mental health research in elite sport more broadly.

To date, only two published studies—by Abbott et al. (2021) and Bramley et al. (2024)—have focused on mental health and women footballers competing in England, though neither have exclusively focused on players in the top two tiers. Abbott et al. (2021) explored disordered eating and perfectionism among men (n=137) and women (n=70) players in the top four tiers of football in England and Scotland—notably, women made up just one-third of the

total participants in this study. The study found disordered eating prevalence rates were higher in non-football women (25%) than women footballers (11%) and observed strong associations between perfectionism and disordered eating risks in both men and women footballers. As noted by Abbott et al. (2021), these findings sit in contrast to previous literature which has identified women athletes are at a higher risk for disordered eating than the general population. They noted that this discrepancy was potentially due to 'sport-type' and, in turn, suggested women footballers might be less likely to experience disordered eating than lean-physique athletes. However, no further insight was provided. This study did not explore how many players were in each individual league, nor present the results from each league, which makes drawing out further understandings extremely difficult, such as variations between amateur, semi-professional, and professional women players.

Bramley et al. (2024) conducted a mixed-methods study on women footballers from tier 3 of the English game (the FA National league); hereafter considered 'semi-elite.' It found that 44.7% of the players displayed depression symptoms, 20.4% anxiety symptoms, and 22.3% eating disorder symptoms. Following the survey, six interviews were conducted with players who demonstrated mental ill-health symptoms according to the questionnaire. Interviews allowed for more contextual insight; for example, players suggested that balancing work and football and the rapidly increasing demands of the women's game due to professionalisation at the higher levels was difficult to navigate and took a toll on their mental health. Findings from their study go some way towards providing insight into the lived experiences of players yet highlight the need for significantly more research concerning elite women footballers and mental health in tier 3 and other levels of the game.

Globally, research concerning semi-elite and elite women footballers is similarly scarce. For example, women make up only 7.7% of the total participants in mental health and

elite football research (Woods et al., 2022). Further, just eight studies included active, semi-elite or elite women footballers where data relating to the women is available separate to the men (Appendix A mental health and elite women's football studies). Of the eight studies, three exclusively focused on women, and two included a focus on elite (professional or top two tiers in the respective country) women footballers.

Two studies—Junge and Prinz (2019) and Prather et al. (2016)—explored elite women footballers and mental health in countries outside of England. Junge and Prinz (2019) explored depression and anxiety symptoms in elite women footballers competing in Germany, as well as the potential influence of personal and sporting risk factors (e.g., injury, frequency of starting for their team, competition level) on mental ill-health. This study found that several factors increased the risk for depression and anxiety symptoms, including playing in the second professional division instead of the first division, rarely or never starting for their team, and reporting a need for psychotherapeutic support. Meanwhile, Prather et al. (2016) explored eating disorder symptoms in footballers in the United States (US) in relation to stress fractures and menstrual dysfunction (i.e., menstrual irregularities). Findings indicated that players with higher scores on the Eating Attitudes Test (EAT-26) had a higher prevalence of menstrual dysfunction in the past year compared to athletes with an EAT-26 score of less than 10. No elite players reported scores above 20 on the EAT-26 which was the cut-off score used by the authors to demonstrate severe eating disorder symptoms.

Collectively, literature concerning mental health and women footballers is limited in terms of both their quantity and quality. For example, all but one study involved self-report questionnaires which are helpful to indicate the prevalence of mental ill-health symptoms, yet are rarely able to provide insight into players' lived experiences and their sociocultural context which can negatively impact their mental health. Gathering prevalence data as well as insight

into players' lived experiences of their mental health is vital when looking to design and provide tailored mental health support to specific populations.

This lack of research specific to women footballers sits somewhat in contrast to the global state of mental health research in elite sport, which has in fact has increased significantly in recent times. Over 80% of mental health and elite sport research was published between the years 2013 and 2018 (Kuettel & Larsen, 2020).

1.3. Mental health and elite athletes

Prior to the last decade, mental health has historically been a topic rarely discussed in elite sporting literature and was very much considered a 'taboo topic' amongst elite sporting populations (Lundqvist & Andersson, 2021). Researchers have suggested that the previous lack of attention on mental health with athlete populations was largely due to a narrow focus on physical health and performance (Rice et al., 2016). It has also been suggested that narratives surronding mental toughness and 'what it means to be an athlete' have also prevented athletes from speaking about mental health problems as doing so has historically been seen as a 'weakness' within sporting cultures (Bauman, 2016; Castaldelli-Maia et al., 2019; Lundqvist & Andersson, 2021).

To date, research into elite athletes and mental health has primarily focused on identifying prevalence rates of mental ill-health (Kuettel & Larsen, 2020; Rice et al., 2016). In turn, it is now well-documented that athletes experience mental health challenges as well as clinically diagnosed mental illnesses at rates between 5 to 35% annually, which is comparable to that of the general adult population (Castaldelli-Maia et al., 2019; Gorczynkski et al., 2017). Elite women athletes are believed to have higher rates of poor mental health compared to their male counterparts and compared to the general population (Gorczynski et al., 2017; Gouttebarge et al., 2019; Kuettel & Larsen, 2020). And yet, despite women consistently

reporting higher prevalence rates, less than one-third of mental health and elite sport research has focused on elite women athletes (Kuettel & Larsen, 2020). This gap has been subject to numerous calls for heightened research focus on women athletes (e.g., Gouttebarge et al., 2019; Poucher et al., 2019; Tahtinen et al., 2021).

In addition to prevalence studies, significant focus has been placed on establishing or exploring risk factors in relation to mental ill-health (see Rice et al., 2016; Kuettel & Larsen, 2020). Researchers have established that elite athletes exist in unique contexts and therefore face unique stressors during their short-lived career, including intense performance demands, rigorous training schedules, injury, identity challenges, contract instability, limited social support, media scrutiny, and toxic sporting cultures (Kuettel & Larsen, 2020; Ogden et al., 2022; Rice et al., 2016). For example, the 'win-at-all-costs approach' which is present across many elite sporting organisations and is demonstrated by a focus on winning over individual well-being (Hughes & Coakley, 1991). In such cultures, athletes are more likely to feel dehumanised, experience unhealthy power dynamics with staff, and potentially encounter higher rates of mistreatment—all of which can negatively impact mental health (Carless & Douglas, 2013; Douglas & Carless, 2017; Kavanagh, 2014; Wood et al., 2017).

Importantly, in the context of this thesis, researchers have also highlighted transitions (e.g., injury, changes in sporting level and environment) and gender (i.e., being a woman) as risk factors for poor mental health (Castaldelli-Maia et al., 2019; Kuettel & Larsen, 2020; Pilkington et al., 2024). As noted by Schlossberg (2011), transitions—irrespective of gender or occupation—are difficult because of "how much it alters one's roles, relationships, routines, and assumptions. This explains why even desired transitions are upsetting" (p. 159). While transitions impact all athletes differently, research has highlighted that for elite athletes in-career transitions—such as moving to a new team, moving to a new country, academy to first

team, injury, de-selection—can substantially impact mental health specifically when an athletes' social support is limited (Brown et al., 2018; Pilkington et al., 2024). Further, out-of-career transitions (i.e., retirement)—which is where the majority of transition research has been placed—is well-documented to negatively impact elite athletes' mental health (Kuettel & Larsen, 2020; Voorheis et al., 2023).

Elite women athletes are believed to be at a higher risk for poor mental health as they encounter additional, unique stressors. As noted by Pascoe et al. (2022), women athletes experience a combination of interpersonal, organisational/structural, and sociocultural factors which can negatively impact their mental health. For example, women athletes can experience a lack of acceptance of women athletes in certain cultures, unequal training opportunities, limited financial support, lack of women-specific policies (e.g., maternity leave), sexualisation in the media, social media gender violence, increased homophobia, and societal and personal expectations around traditional gender roles (Castaldelli-Maia et al., 2019; Kavanagh et al., 2019a; Pascoe et al., 2022; Walton et al., 2021). This somewhat mirrors research concerning women in the general population; studies have found women report higher rates of poor mental health due to individual, environmental, and systematic factors such as power imbalances in the workplace, differences in pay, gender norms, and sexualisation (Sojo et al., 2016).

So far, this chapter has outlined the rapid growth of women's football in England and highlighted the gap in academic literature focused on mental health and elite women footballers, despite ongoing calls for research from players and researchers over the last several years. Therefore, this thesis is an attempt to address this significant research gap, offering insight into the mental health of elite women footballers in England during a unique time for the women's game.

1.4. Thesis objectives

The overarching aim of this doctoral thesis is to advance understandings of mental health challenges concerning elite women footballers in England, explore the support available to players, and provide empirically driven recommendations for practice and policy. To do this, four objectives were established: (a) conduct a scoping review to explore research concerning mental health and elite women athletes; (b) attain prevalence rates and risk factors of anxiety, depression, and eating disorder symptoms, as well as help-seeking intentions, among elite women footballers in the WSL and WC; (c) explore women footballers' lived experiences of their mental health and associated challenges within their sporting context; (d) explore player and staff experiences of the provision and accessibility of mental health support from clubs.

1.4.1. Thesis structure

This thesis includes a methodology chapter (Chapter Two), four empirical studies (Chapter Three, Four, Five, and Six), and a discussion and concluding chapter (Chapter Seven). To answer the above research aims, four studies were conducted. The first study is a scoping review into research concerning elite women athletes and mental health and mental illness (Chapter Three). Findings from this review provide critical insight into the methods, theories, and focuses of research with this population to date, ultimately helping to inform the subsequent studies in this thesis. The second study is focused on identifying the prevalence rates of mental ill-health symptoms and help-seeking intentions in elite women footballers in England (Chapter Four). Study Three explores elite women footballers' experiences with mental health, specifically in relation to challenges to their mental health in their current context (Chapter Five). Study Four, the final study in this thesis, involves interviews with players and support staff to better understand the barriers and challenges footballers face to using mental health support at their club (Chapter Six).

Recommendations for practice and policy are presented in the final chapter of this work, driven by this thesis' empirical findings (Chapter Seven). Notably, each study (Chapter Three through Six) is written and presented in article publication format—meaning, each study chapter includes an abstract, introduction, methods and results section, and a discussion. Additionally, individual chapters include a summary of the studies limitations and recommendations for future research. The final discussion chapter synthesises these significant aspects across the whole thesis and offers suggestions for future research.

1.4.2. Language

It is important to highlight how certain terms are used throughout this thesis; specifically, 'mental health,' 'eating disorders,' 'elite,' and 'woman/women.' Mental health is used across sporting and mainstream research in a variety of ways and is often used interchangeably with terms such as mental well-being, and also, confusingly, terms that seem to indicate the opposite such as poor mental health, mental disorders, mental illness, and mental health conditions. Efforts to establish a global consensus surrounding a definition of 'mental health' (or indeed mental ill-health) have been challenged by numerous factors, including cross-cultural differences and competing theoretical orientations and understandings. As noted by Lundqvist and Andersson (2021), "Mental health is a highly complex construct and, based on the history from other research areas, it seems unlikely that consensus will be reached on a uniform definition to be used in elite sporting contexts" (p. 7).

For this thesis, the term 'mental ill-health' is used for Study Two, where the aim is to gather prevalence rates for symptoms of recognised mental illnesses using validated questionnaires. The reason for the use of this term is that individuals can significantly struggle with their mental health, yet still not meet the criteria for a mental health diagnosis. For Study Three and Study Four—where lived experiences of challenges to mental health and help-

seeking are the focus—language such as ‘poor mental health’ and ‘mental health challenges’ are used to incorporate a broad range of experiences; from mild struggles with mental health, to more severe struggles, including clinically diagnosed mental illness (Poucher et al., 2023).

Given the frequency with which eating disorders and related terms such as disordered eating are discussed in this thesis, it is important to provide some explanation surrounding how these terms are used throughout the following chapters. In mental health literature, ‘eating disorder(s)’ most often refers to clinical mental illness such as such as anorexia nervosa and bulimia nervosa; both of which are characterised by severe and ongoing disturbances in eating behaviours and distressing thoughts and emotions (American Psychiatric Association [APA], 2016).

Disordered eating is another team used in the literature, particularly in sport research (Sundgot-Borgen & Torstveit, 2010). This term is commonly reserved for those who experience eating psychopathology and maladaptive thoughts, attitudes, and behaviours towards food but do not have a clinical diagnosis from a licensed practitioner; or do not meet the clinical eating disorder criterion set by The American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM); or WHO’s International Classification of Diseases (ICD-10) (Howard et al., 2020; Wells et al., 2020). As noted by Wells et al. (2020), disordered eating can include a spectrum of experiences, from significant eating distress (e.g., binging, purging) to more mild patterns of atypical eating and body attitudes (e.g., calorie restriction, excessive energy expenditure, obsessive self-weighing). In sporting literature, researchers often use both terms interchangeably. This is partly due to the difficulty in identifying ‘clinical’ eating disorders with athletes due to normalisation of eating behaviours that accompany being an elite athlete—such as hyper fixation of body and excessive

focus on weight or nutrition. In turn, the term disordered eating is often used to cover the range of experiences (Sundgot-Borgen & Torstveit, 2010; Wells et al., 2020).

In this thesis, I use the term eating disorder when discussing literature, media reports, or findings where a clinical diagnosis is discussed or where eating disorder symptoms are explored using a validated eating disorder questionnaire. For example, in Study Two where the Brief Eating Disorder in Athletes Questionnaire (BEDA-Q) is used, findings are reported and discussed using the language such as 'eating disorder symptoms.' In using this language, consistency is maintained between the measure employed and how the finding is reported. For Study Three and Four, the term eating disorder is only used if a player has shared they have a diagnosis or if they used this term describe their experience. The term disordered eating is reserved for studies where authors have suggested this to be their focus.

Researchers have called for transparency when using the word 'elite' in sporting literature (McAuley et al., 2022). For purposes of consistency and inclusion, in this research, footballers in the top two tiers of women's football are referred to as 'elite' women footballers, which aligns with the terminology used in the Carney review (Carney, 2023). Notably, while the WSL is fully professional, the WC is not yet considered an entirely professional league as minimum contact time is lower for this league and many players still must work alongside their football career to afford their expenses (Carney, 2023). Culvin & Bowes (2023) note that for women footballers to be considered 'professional' they should earn enough to commit full-time to football, which is not yet the reality across the WC.

For Study One—the scoping review—the term 'elite' is used more broadly. 'Elite' is used to describe research conducted with both semi-elite or elite women athletes—i.e., research including women competing in the United States (US) National Collegiate Athletic association division one (NCAA D1) level and at the professional level athletes. This decision was made

due to the focus of the review and due to many authors referring to women at these various levels as 'elite'; for example, the majority of authors referred to athletes at the NCAA D1 level and semi-professional level as 'elite' in their studies.

Throughout this thesis 'women' or 'woman' is used instead of 'female.' For example, the footballers are referred to as 'women footballers' instead of female footballers. When referring to previous research where authors have used female or both terms throughout their research, 'women' will mainly be used to describe the study. While both terms are accepted in the literature, 'women' is currently considered more inclusive when compared to 'female' (Cowan et al., 2023; Culvin & Bowes, 2023). Further, 'women' aligns with the title of both leagues that this thesis is focused on—i.e., *Women's* Super League and *Women's* Championship. Importantly, while 'women' or 'woman' is used throughout this thesis, inclusion criteria was not based on gender identity or biological sex but whether participants competed in the top two tiers of women's football in England.

1.5. Conclusion

Contextualising this research project, this chapter offers critical insight into the elite women's football landscape in England and provides a brief overview of the mental health and elite sport literature. This chapter sheds light on the developments in the women's game which—while positive in many ways—have resulted in concerns about this population as they are tasked with navigating numerous changes, heightened performance expectations, low wages, and often exist within a male-centric football environment. The expectations and pressures placed on this population have resulted in calls for more research and better mental health support, from academics, practitioners, and players themselves, which this thesis aims to highlight and explore. This section has outlined the specific aims of this thesis, introduced

the structure of the remaining chapters, and provided explanations for terminology used throughout this project.

Chapter Two

Methodology

2.1. Introduction

My approach to this thesis was shaped by the literature review outlined in Chapter One, my own direct lived experience in football and research, as well as the scoping review detailed in Chapter Three concerning mental health and elite women athletes. This chapter offers insight into how this thesis was approached—philosophically, methodologically, and ethically—starting with an acknowledgment of my own experiences and assumptions. As stated by Sparkes and Smith (2013, p. 19):

> The connections between the self and study are often powerful forces in shaping many aspects of the research process, from the topic selection to the way data are reported and how these are interpreted.

2.2. Researcher background and positioning

My life-long involvement in football – as a player, fan, and trainee mental performance coach both in the US and England – has influenced the philosophical approach I have taken for this project and shaped the chosen focus areas, research methods, and data analysis. Several phases of this research have been aided by my background and position as somewhat of an 'insider'—not necessarily to the population, but to the context in which they operate. One is considered an 'insider' when engaging in research with participants from a group or population that the researcher belongs to (Dwyer & Buckle, 2009). However, as DeLyser (2001) asserted, being an 'insider' or an 'outsider' is not 'black or white' and therefore, "[i]n every research project we navigate complex and multi-faceted insider-outsider issues" (p. 442).

For this project, I maintained a unique and dual insider-outsider status across all studies thus making me a 'semi-insider.' For example, my own personal experience as a women's footballer spanned 20 years and included competing in the US at the NCAA D1 level and semi-

professionally for four years. My football career was interrupted by several severe injuries, including two anterior cruciate ligaments (ACL) ruptures at ages 13 and 14, and a further tear aged 22. I have had five major knee operations, with my most recent knee surgery in 2023 following a failed ACL procedure in 2019 after competing in England at Loughborough University and in tier 3 before rupturing my ACL in for the third time in November 2018. I have experienced many 'high and lows' that come with competing at a high level and alongside experiencing severe injury—I experienced severe anxiety, as well as a period of depression and disordered eating following a knee operation at age 19. My experiences with injury, and subsequent mental health struggles led me to eventually see a psychologist which prompted an appreciation and interest towards the relationship between elite sport and mental health.

These experiences then led me to pursue related academic endeavours, including an undergraduate BA in psychology at American University in Washington D.C., and a further MSc in sport and exercise psychology at Loughborough University where I conducted research on disordered eating during ACL injury recovery in elite women footballers. Throughout my MSc project I was supervised by a leading expert in mental health research in sport, and away from my studies I worked regularly with the university men's performance team as a voluntary mental performance coach. These experiences have enhanced both my academic research abilities—e.g., conducting in-depth interviews on mental health and applying narrative theory and analysis—and embedded me within the football community; in particular in the UK where I have developed a strong network across the sport.

Not only did this 'insider' position give me a strong knowledge base about the topic, it helped inform the design of the thesis at all stages—from participant recruitment and interviewing to analysis and recommendations. Embarking on this project having already operated within this 'ecosystem'—as a player, fan, researcher and practitioner—helped me

lean on my own understandings of the sport, the players, and its associated challenges. Also, it allowed me to utilise my networks across football to reach relevant populations who are considered increasingly hard to reach due to their growing profiles (Culvin, 2019).

My own lived experiences within women's football—on and off the pitch—helped catalyse my interest in pursuing this work. More importantly, it was my own experiences with mental health and watching my teammates navigate various challenges with theirs, which highlighted the need for research in this area. In turn, this work is primarily anchored in foregrounding players' voice, and its methodology is shaped deliberately to capture their experiences and to make a practical real-world difference.

Due to my positionality, it has been important to engage in an active process of self-reflection throughout this project and critical analysis of personal biases during this research. As advocated by Jamieson et al. (2022), measures have been taken to help me reflect on any personal prejudices, mitigate bias, and enhance the overall rigour and quality of the research. These reflective processes will be explored later in this chapter (see 2.4.3.1.)

2.3. Philosophical underpinning: a pragmatic approach

Paradigmatic assumptions and beliefs can influence the way research is approached, conducted, analysed, and interpreted (Sparkes & Smith, 2013). Therefore, at the beginning of any research project, it is important for researchers to reflect on their assumptions and explore the paradigm in which their research is situated. Simply put, a paradigm is a set of beliefs which represents how a researcher views the world and how they believe it should be studied (Guba & Lincoln, 1994, p. 107; Sparkes, 1992). These beliefs are made up of ontological and epistemological assumptions: ontology refers to the nature of reality (i.e., 'what is reality?' and 'what do we see as real?') and epistemology is concerned with the nature of knowledge and

how reality is learnt and understood (i.e., 'how can I know reality?' and 'how do we know what we know?') (Poucher et al., 2020; Sparkes, 1992). Together, ontology and epistemology influence methodology which refers to the philosophical underpinnings of the selection of research methods or techniques used to collect and interpret data.

For this research project I took a pragmatic approach overall. Pragmatism–both a philosophy and a paradigm–emphasises the practical application of ideas and theories and is not committed to any one system or reality (Cherryholmes, 1992; Morgan, 2007). Instead, it maintains that the research question for each study—rooted in moral, ethical, and social concerns—drives the methods and assumptions by which each study is conducted through and situated in (Morgan, 2007). This significantly differs from other approaches and paradigms (e.g., post-positivism, constructivism) whereby epistemological and ontological beliefs guide research inquiry and methods (Morgan, 2014). This difference stems from pragmatists' belief that the starting point for research should be based on its applicability to "real life" situations rather than metaphysical discussions about the nature of reality or truth (Dewey, 2008; Morgan, 2007; Morgan, 2014). This felt more congruent with my lived experience, the calls for this kind of research by players and academics (see Chapter One), and my ambition for this project; to make real-world, practical changes to sport.

According to the pragmatic philosopher John Dewey, research inquiry is driven by human experience, which is always social in nature (Dewey, 2008; Morgan, 2014). For Dewey, inquiry is a type of human experience and an active process which begins with the researcher's recognition that certain situations are in need of attention or change. Therefore, the main purpose of inquiry is to generate knowledge and produce tangible recommendations that respond to moral, ethical, and social concerns (Morgan, 2007; Morgan, 2014). This is applicable to this thesis because my ultimate aim is to understand players' experiences of

mental health in order to provide practical recommendations for practitioners and stakeholders to develop more appropriate support for this population.

Central to Dewey's pragmatic approach is the understanding that inquiry is a self-conscious decision-making process, which involves careful consideration of different research approaches (Kaushik & Walsh, 2019). Dewey used the term 'habit' to refer to human actions and beliefs whereby thoughtful reflection is not required. He contrasts this with 'inquiry,' which requires careful engagement with the consequences of different actions (e.g., methods) and the potential benefits of one action over another when designing research projects (Morgan, 2014). Applying this in my thesis, I conducted a scoping review as my first study to better understand the methods and theories used in research concerning mental health and elite women athletes to inform my decisions about the design of the subsequent studies. In this way, pragmatism is not just a paradigm, but a philosophical tool for addressing real-life concerns (Kaushik & Walsh, 2019).

Using a pragmatic approach allows for flexibility in research design and encourages the combination of different types of research when they can contribute to the overall aim of the research (Morgan, 2014). Essentially, where other paradigms might reject the mixing of different methods, pragmatists recognise the value of different methodological approaches and philosophical assumptions which guide choices about how to conduct inquiry (Kaushik & Walsh, 2019; Morgan, 2014). In practice, this means pragmatist researchers can make methodological and philosophical choices, from one study to the next, dependent on the research question. For example, I used both quantitative and qualitative methods because exclusively quantitative or qualitative methods would not have been able address the research questions as effectively. Instead, the combination and analysis of both quantitative and qualitative data in this thesis generated findings that help extend understandings of mental

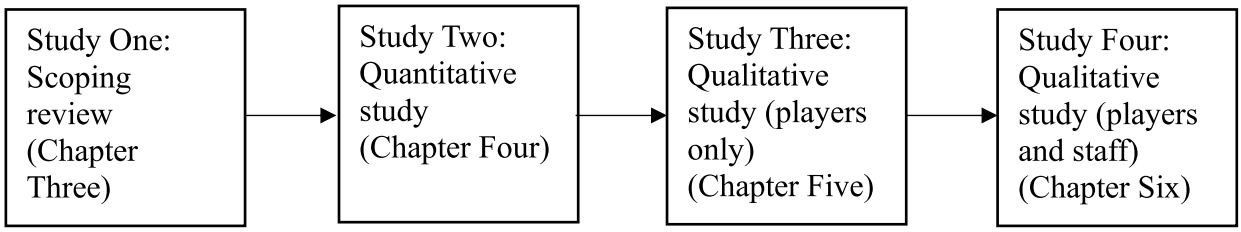
health in this population through prevalence rates, players' lived experiences, and the challenges they faced seeking support for their mental health from within their clubs.

The use of a pragmatic approach for this thesis allowed for the creation and development of four distinct, but interrelated, studies which vary methodologically and philosophically. The first study—a scoping review—was conducted to gather insight into the methods and theories used in mental health research with elite women athletes and to inform subsequent studies in the thesis. The second study uses a quantitative approach to identify prevalence rates among the participating population of depression, anxiety, and eating disorder symptoms and risk factors including help-seeking intentions. Then, to elaborate on these statistical findings, the third study utilised a qualitative approach to explore players' views in more depth and to understand the challenges faced with regards to their mental health. Drawing on the interviews from Study Three, the fourth study explored player and staff perceptions of the challenges players face in relation to using support for their mental health at their club. Importantly, these studies provided recommendations for research and practice which I identify in the final chapter of this thesis. Ultimately—and similar to several recent doctoral theses focused on mental health and elite sport (e.g., Buck, 2022; King, 2019; Lebrun, 2019)—using a pragmatic approach enabled methodological and philosophical flexibility to approach this new and complex research area, while placing human experience and real-life applicable recommendations at its core.

2.4. Study by study: paradigms, methods, and analysis in this thesis

In this section, an overview of the paradigmatic assumptions, methods, and analytical technique used for studies one, two, three, and four are presented. More details (e.g., pilot study information) are provided in each chapter, respectively.

Figure 2.1 Study by study display



2.4.1. Study One: Scoping review

In Chapter One I identified a lack of research concerning mental health and elite women footballers and highlighted the complexity of researching mental health in terms of study focus, design, methods, and theory. Thus, before conducting research specific to elite women footballers, I opted to conduct a scoping review to explore how research concerning mental health and elite women athletes has been conducted. I chose to conduct a scoping review due to its focuses aligned with the aims of Study One—that is, summarising existing research findings, mapping implications for practice, and identifying research gaps (Arksey & O'Malley, 2005). I followed the methodological framework suggested by Arksey and O'Malley (2005), which involves five steps: identifying the research question, identifying relevant studies, selecting studies, charting the data, and summarising and collating the data along with reporting the results. Further information on how I approached each step is presented Study One (Chapter Three).

2.4.2. Study Two: Quantitative research

Literature presented in Chapter One, paired with the findings from the scoping review, helped to develop the survey used for Study Two. In this study, general understandings of players' mental health prevalence rates, help-seeking behaviours, and demographic information were gathered. More specifically, this study sought to explore the prevalence of anxiety,

depression, and eating disorder symptoms of elite women footballers using validated questionnaires and cut-off points as recommended by the International Olympic Committee (IOC) (Gouttebarge et al., 2021). Further, this study aimed to examine potential associations between possible risk factors established in previous research and symptoms of depression, anxiety, and eating disorders.

Methods and analytical techniques which best aligned with the research aim above were used. I designed an online survey detailed in Chapter Four and available in Appendix G which included demographic questions, questions regarding support availability at clubs, three validated mental health questionnaires, and a help-seeking questionnaire. A significant focus was placed on using reliable and valid measures to obtain findings which was ultimately achieved through a rigorous exploration of valid measurement options evidenced in the scoping review study.

To analyse the data, cut-off scores to determine prevalence rates were used in alignment with recommendations from the IOC's Mental Health in Elite Athletes Toolkit (see Gouttebarge et al., 2021); this toolkit was designed and published by over a dozen leading specialists in mental health and elite sport globally. It was deemed appropriate to use their recommended tools and cut-off scores due to the measures being validated and recommended by leading researchers. Notably, there are dozens of mental health scales used across mental health and elite sport research and often the cut-off scores vary across studies even when the same scale is used (see Table 3.4 for an example of scales used in mental health and elite women athlete research to date). Thus, part of the rationale for using the IOC's recommended scales was in response to research calls for more consistent use of measures to allow findings across studies to be compared going forward (Poucher et al., 2019; Tahtinen et al., 2021).

To analyse the data, multiple statistical analyses were run; for example, linear regressions with categorical dummy variable (0,1) predictors were used to examine the association between mental ill-health symptoms (e.g., depression, anxiety, and eating disorder) and factors such as playing level, age, injury status, match-starting status, current self-reported need for psychological support, full-time status, paid-contract status, and help-seeking intentions scores. Further details on the specific questionnaires used and analyses run are offered in Chapter Four.

The decision to begin with a quantitative study was critical to providing demographic and player information, numeric insight into prevalence rates, and help-seeking intention scores which ultimately warranted further exploration. It also helped recruitment for the following qualitative study(s) as players were able to leave their email if they were interested in taking part in the upcoming interview study. The following two studies in this thesis were approached qualitatively and were guided by a social constructionist paradigm which helped to explain and elaborate on some of the preliminary quantitative findings.

2.4.3. Studies Three Four: Qualitative research

The quantitative study highlighted the need for further exploration into the players' lived mental health experiences through qualitative research. Specifically, there was need to understand their experiences in relation to the challenges they face within their specific context and the ongoing professionalisation of women's football. Therefore, Study Three qualitatively explored 21 elite women footballers' experience of mental health in relation to challenges they have faced, specifically since the league became professional in 2018/2019. Findings from Study Two and Three highlighted the need to better understand the challenges players encounter when seeking support for mental health from their club, which was the focus of Study Four. Study Four, explored player and staff experiences of mental health support within

women's football and the challenges of its utilisation for players. This final study involved interviews with ten staff members and included relevant data generated from the 21 player interviews in Study Three.

After establishing the research questions, I decided to approach both qualitative studies through social constructionism. This approach is made up of a relativist ontology and constructionist epistemology: ontological relativism maintains that reality is fluid, multiple, and dependent on the meanings given to objects, events, and practices and epistemological constructionism suggests that knowledge is constructed through transactions between the researcher and participant subject to different interpretations and mediated by values (Poucher et al., 2020). This approach places emphasis on personal experiences and understandings within a specific cultural context; for example, the changing context of elite women's football in England. As explained by Poucher et al. (2020), constructionism provides a lens by which a focus is placed on how society, culture, and power relations impact and shape individual experiences and understandings, and was therefore deemed particularly relevant for these studies.

2.4.3.1. Interviews and semi-insider status

Semi-structured interviews were deemed most appropriate for both studies. This interview style was selected as it allows for more natural and dynamic conversations to take place between the interviewee and interviewer and affords participants the opportunity to share stories, perspectives, and experiences (Brinkmann, 2014; Smith & Sparkes, 2016). In turn, knowledge can be co-constructed between the interviewer and interviewee, which is a key feature of social constructionism.

My ‘semi-insider’ positionality was important to the interview process in numerous ways, including building rapport and exploring focus areas. As mentioned at the beginning of this chapter, I played at a high level in the US, played at the semi-elite level in the UK, experienced severe football-related injuries (e.g., three ACL ruptures), and had mental health struggles throughout my football career. Such experiences allowed me to share carefully-selected stories from my own experience which I found enhanced reciprocity, reduced power differentials, and encouraged dialogue (Hayman et al., 2012).

Additionally, due to my past experiences, I was able to ask questions pointedly but empathetically from a more obviously-informed position, which would be more challenging for an ‘outsider’ to elite sport. For example, I was aware of the devastating physical and mental impacts of injury from my own, and teammates’, experiences; when this was raised, I was able to ask appropriate questions which might be harder for someone who had not had such experiences. Ultimately, my personal experiences as well as my familiarity with their football context gave me additional credibility in the eyes of players and this helped me to connect and build trust with them—which is vital to conducting in-depth interviews where participants felt comfortable sharing their stories, resulting in rich data generation (Dwyer & Buckle, 2009).

At the beginning of each interview, I introduced myself and shared my interest in this research area. In doing so, I briefly—and casually—shared some of my experiences which led me to undertake this project; for example, my experience playing in the US and my knee injuries. This brief introduction allowed those who were not familiar with me to have some understanding of why I was interested in this research. Importantly, I was friends with a few participants—one player and three staff members—who took part in the interview which meant I did not need to introduce myself or situate my interests in this area. It is important to note that while there are many advantages of interviewing friends for research purposes (e.g.,

participants might be quicker to disclose stories) there are also potential drawbacks, such as participants withholding stories due to pre-existing dynamics between the interviewer and interviewee (Tillmann-Healy, 2003; Papathomas & Lavallee, 2006). Thus, prior to these four interviews, I reflected on potential scenarios and decided on steps to take if—for example—the participant voiced feeling uncomfortable that they had shared certain stories after the interview due to our friendship status. As far as I am aware, no such scenarios arose, and all four interviews were filled with rich dialogue.

There are other potential limitations and drawbacks of maintaining a semi-insider position. For example, there is the potential for insider-researchers to project their own experiences onto participants or brush over certain experiences which seem more mundane and taken-for-granted. Therefore, I engaged in ongoing reflexivity throughout the interview process to ensure I was not projecting my own experiences onto participants. Importantly, throughout the interviews I continuously engaged in reflexivity to ensure I was using language that reflected the participants' understandings and interpretations of mental health; for example, instead of using terminology I found helpful, I used words and sayings that participants used in their interviews. This required reflexivity through the use of reflexive diaries and critical friends—mainly my two primary supervisors—where I took note of my own language-use and understandings of mental health and elite sport in relation to my experience. Notably, one supervisor had no personal connection with the game which was important at various stages of the project as they were able to provide feedback from a somewhat more objective stance. More specific examples are offered throughout the following chapters, for example see 5.2.6.

2.4.3.2. Reflexive thematic analysis

Reflexive thematic analysis (RTA) (Braun & Clarke, 2019) was employed for the two empirical studies presented within chapters three and four on players' mental health

experiences and staff and players' understandings of help-seeking challenges. This analytical method was carefully selected in line with the research aims for each respective study and the philosophical lens used for both chapters—i.e., ontological relativism and epistemological constructionism. Further, RTA affords analytical and theoretical flexibility which is important when investigating topics such as mental health and help-seeking where there is unlikely to be an all-encompassing explanatory theory (Braun et al., 2021; Braun et al., 2023). Instead, relevant literature and analytical links were made throughout the analytical process.

The six phases for RTA presented by Braun & Clarke (2006, 2019) were used as a tool to guide the analysis process. These phases include, familiarisation, coding, generating initial themes, reviewing, and developing themes, refining, defining and naming themes, and writing up (Braun & Clarke, 2021). Importantly, RTA places emphasis on the importance of the researcher's subjectivity as analytic resource, and their reflexive engagement with data and interpretation (Braun & Clarke, 2021). Specific details on how I utilised and approached these phases throughout the analysis are provided in Chapter Five and Six.

2.5. Participants and sampling

In total, 146 participants took part in studies Two, Three, and Four – Study One was a scoping review, meaning participants were not recruited. Driven by the research aims, the sample was criterion-based, and participants were able to take part if they fit the criteria I established at the outset (Patton, 1990). For example, the predetermined criteria for the quantitative study were that players must have competed in the WSL or WC for the 2020/2021 season to take part. For the qualitative studies, the same criteria applied except for two players who competed in the WSL or WC in the 2019/2020 season and then changed levels for reasons of looking after their mental health or for financial reasons.

To ensure all who met the criteria were provided an opportunity to take part, an introductory email was sent to each club in WSL and WC in the 2020/2021 season detailing the studies and inviting players to participate and follow up emails were sent. Additionally, I used social media, personal connections, and snowball sampling, whereby participants were asked to pass on the study information to teammates and staff. Serious consideration was given to how to recruit participants due to the potentially sensitive nature of the research, the high-profile population, and the power dynamics that can exist in elite sport. For example, I did not want anyone to feel pressured to take part therefore I stressed in the email to clubs that the study was voluntary and I highlighted to players that the questionnaire was anonymous. Specific recruitment details for each study are provided in each respective chapter.

2.6. Research quality and rigour

For studies three and four, I used a relativist approach to judging qualitative research; this is often referred to as a 'non-foundational' approach (Smith & McGannon, 2018). This approach means judgement criteria are tailored to each study, as opposed to adopting a universal qualitative judgement criterion such as the "Big-Tent" criteria by Tracy (2010) (Smith & McGannon, 2018; Tracy, 2010). In this way, I had the flexibility to select the most meaningful characteristics to judge each study on. Below, an overview of the characteristics selected for both studies are provided. Examples of how each criterion were achieved for Study Three and Four are provided in the respective chapters (i.e., Chapter Five and Six).

For these two qualitative studies, the reader is asked to judge the quality of the research based on the list of characteristics provided. For Study Three (Chapter Five), three characteristics were selected: credibility, meaningful coherence, and significant contribution. Credibility broadly refers to the trustworthiness of the research findings and meaningful coherence assesses if the study explores what it sets out to do. Tracy (2010) provided a set of

questions researchers should ask when assessing if their study is meaningfully coherent, two of which can be summarised as allows: ‘does the study use methods and procedures that fit its stated goals?’ and ‘is there meaningful interconnectedness between the literature, research questions, findings, and interpretations?’ (Smith & McGannon, 2018; Tracy, 2010,). Finally, significant contribution refers to the extent to which the study produces new knowledge theoretically, heuristically, or practically. For Study Four (Chapter Six), judgment criteria include credibility, significant contribution, and resonance. Resonance is the potential for research to connect with people—even those who have no direct experience with the topic discussed. As Dadds (2008) suggested, the aim of resonance is to “promote mutual regard”, or as he referred to it “empathic validity” (Dadds, 2008; Tracy, 2010).

Each of the above criteria were carefully selected in line with the aims of the specific research study and the broader aims of this thesis. For example, resonance was chosen to evaluate Study Four due to the importance of evoking emotions or recognition in readers, specifically football stakeholders (e.g., club managers, board members, coaches), so that action can be taken to better support this population. Given the power stakeholders have over players’ mental health in terms of who they hire (e.g., managers, coaches), and the provision of mental health support players receive, I focused on writing this chapter evocatively (e.g., using players’ quotes as the theme titles) and also in a way that others outside the sport could relate to; I did this by including workplace literature concerning the general population throughout the findings. Like resonance, all criteria were chosen in accordance with each study, and they were achieved in various ways as outlined in each respective chapter.

2.7. Ethics

Ethical considerations are central to any research process. Institutional ethics approval was gained for all research where empirical data was gathered—within chapters four, five, and

six. Ethical approval was gained via the demonstration of ethical data collection methods which included, for example, informed consent, participant confidentiality, anonymity, and protection from harm. Additionally, as part of my ethics application, I completed a safeguarding course and mental health first aid training through Mental Health First Aid England. Further specific procedural ethics information is provided in each chapter.

Beyond institutional ethical approval, I engaged with the ethical implications of the studies I conducted. As described by Lahman et al. (2011), there are many ethical dilemmas that arise throughout the research process—beyond institutional ethics—which should be considered. Such situational ethics are referred to as "ethics in practice" and "ethically important moments" (Guillemin & Gilliam, 2004). Through reflexivity (see examples below), I tended to these situations and moments throughout the research project. In doing so, I strove to achieve "aspirational ethics" which is defined as, "the highest stance researchers can try to attain in ethics above and beyond minimum requirements" (Lahman et al., 2011, p. 1400; Southern et al., 2005). Specifically, I sought to achieve aspirational ethics through a 'culturally responsive, relational, and reflexive ethical stance' (CRRRE) (Lahman et al., 2011). This form of ethics requires balancing the objectives of the research with the care of the participants.

To navigate ethical situations and moments outside of institutional ethics, I engaged in reflexivity throughout the entirety of the research process. For example, at the beginning of the project, I considered the specific population that I was collecting data from. Participants in this research are considered a high-profile group and were being asked about a topic that is considered sensitive and even taboo (i.e., mental health) especially within a conventionally 'masculine' or male dominated sport such as football (Roderick, 2006; Roderick & Gibbons 2014). Therefore, I reserved the first part of the interview to check-in with interviewees prior to asking them the pre-prepared interview questions, and I reserved the last part of the interview

to speak with each participant about their interview experience. This provided them the opportunity to ask any follow-up questions about the study.

Additionally, trust is built from being caring and responsive to participants' needs before, during, and after data collection. Thus, prior to the interviews I sensitised myself to some of the potential reactions that might occur as I was very aware that conversations around mental health and elite sport can evoke strong emotions. I spent time considering how I might best respond to such instances and established some steps to take. For example, occasionally when participants did become visibly upset while sharing stories about football or an experience in relation to mental health, I tried to respond empathetically by offering to pause the interview or stop the interview entirely. Also, during such moments I reassured players that I would not use any stories they were not comfortable with me using. This allowed participants to continue with their story if they wanted to, while providing them the opportunity to remove any contributions they wanted after the interview. By offering this to participants I demonstrated care beyond my own research objectives and helped to establish trust. If participants became emotional during their interviews, I followed up with them afterwards and gave them information about support options which were also provided to them in an information sheet.

Ethical considerations carried on throughout the write up of the studies, until the final submission of the thesis. While all institutional ethics were followed (e.g., consent, anonymization), the interconnectedness of the small and tight-knit women's football community meant that I had to put extensive time and effort into protecting participants in this research. For example, during the write up of the qualitative studies, I reached out to five participants whose quotes referenced an interaction between them and a staff member and could have made them identifiable. All five players replied and two subsequently asked for

edits to be made. Specifically, one entire quote was removed, and one quote was edited to include only part of the interaction in order to lessen the possibility of the conversation being identifiable to that member of staff.

Other ongoing ethical questions and considerations were made frequently, and I had regular conversations both with participants and my supervision team to help me navigate these different and difficult decisions which, while extremely time consuming, allowed me to achieve aspirational ethics. Ultimately, these processes aligned with my ethical stance to this entire research project.

2.8. Conclusion

This chapter provides insight into the philosophical and methodological approaches taken in the thesis. Starting with my own positionality as a footballer turned researcher, insight is provided into how my experiences shaped many aspects of this thesis, including the use of pragmatism as the overarching approach to this thesis. From this approach, empirical studies in this thesis were philosophically and methodologically shaped by the research questions and the research questions were driven by real-world concerns established from my own lived experience, calls for such research from players and academics discussed in Chapter One, and the scoping review offered in the following chapter.

Chapter Three

Mental Health and Elite Women Athletes: A Scoping Review

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3.0. Abstract

This scoping review examines the current state of literature focusing exclusively on mental health and mental illness of elite women athletes. The scoping review aimed to (1) identify the methodology used in this research, (2) explore the use of theory in these studies, and (3) provide an overview of the purpose of the studies in order to identify gaps in the literature and provide recommendations for future research. Following the methodological framework by Arksey and O'Malley (2005), four databases were searched for studies that fulfilled the inclusion criteria. Following the identification of studies using broad search criteria, specific exclusion criteria were applied. Twenty-four studies met the review criteria, of which 20 studies (83.3%) used quantitative methods and a cross-sectional research design. Of these 20 studies, 95% focused on eating disorders and disordered eating with the majority of these studies focused on identifying prevalence rates in elite women athletes who compete in 'lean-physique' or endurance sports (e.g., gymnastics, running). The restricted sample population of United States collegiate athletes, overreliance on quantitative methods, and heavy focus on eating disorder prevalence rates demonstrates an ongoing need for sport scholars to expand their research samples, methods, and aims. Findings highlight the need for greater methodological diversity to advance conceptual and theoretical understandings of elite women athletes' experiences of mental health and mental illness. Future research is needed to explore mental health in elite women athlete populations beyond lean-physique athletes.

3.1. Introduction

Research into mental health and mental illness has received increased attention in elite sport over the last decade (Kuettel & Larsen, 2020; Poucher et al., 2021; Prior et al., 2022; Rice et al., 2016). In turn, it is well-documented that elite athlete population experience mental illness at rates of five to 35% annually which is comparable to that of the general adult population (Castaldelli-Maia et al., 2019; Gorczynkski et al., 2017). However, prevalence rates are higher amongst women athletes when compared to men athletes and the general population (Kuettel & Larsen, 2020).

Despite the above suggestions, prevalence rates are difficult to establish and have been subject to debate among researchers due to limited research, definitional issues, a lack of awareness and stigma, and use of inconsistent measures (Kuettel & Larsen, 2020; Poucher et al., 2021). Nonetheless, sport scholars agree that athletes who compete at the elite level are exposed to unique risk factors such as intense performance demands, rigorous training schedules, media attention, injury, and de-selection (Kuettel & Larsen, 2020; Rice et al., 2016). Moreover, improving the mental health of elite athletes is now a priority for many sporting organisations and governing bodies, and is an area that warrants further study (Henriksen et al., 2020a; Prior et al., 2022).

While ‘mental health’ and ‘mental illness’ have been defined and conceptualised in various ways, this review uses definitions often used in the recent elite sport literature (see Henrikesen et al., 2020; Lundqvist & Andersson, 2021). This review will refer to ‘mental health’ and ‘mental illness’ as two distinct concepts (Henriksen et al., 2020a). Mental health is defined as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (The World Health Organisation [WHO], 2014,

para 2.). Different to mental health, mental illness is usually perceived to be a diagnosable 'condition' or 'disorder' related to experiences (such as depression or anxiety) which impacts an individual's thinking, feeling, mood, and behaviours (Centers for Disease Control and Preventions [CDC], 2020). In contrast, mental health is viewed more broadly as one component of a person's overall wellbeing (CDC, 2020). Through these definitions—for example—an elite athlete may suffer from poor mental health during injury, but this does not necessarily mean that they would meet the criteria for diagnosable mental illness. Importantly, I acknowledge that distinguishing between the two—i.e., mental health and mental illness—is extremely difficult and also that this understanding perpetuates an idea that people are either mentally ill or mentally healthy which is not the reality. However, for the purpose of this review it is important to utilise the most readily drawn-upon terminology.

Identified by several systematic reviews in this area, much of the current research has narrowly focused on identifying prevalence rates of mental illness amongst elite (male) athletes (Kuettel & Larsen, 2020; Rice et al., 2016). However, two reviews have explored both mental illness and mental health; for example, Rice et al. (2016) conducted a narrative review to synthesise literature on both mental illness and mental health amongst elite athletes, and Kuettel and Larsen (2020) published a scoping review which explored various risk and protective factors of mental health in elite athletes. In focusing on both mental health and mental illness in their reviews, further insight into more sport-specific challenges that might impact different athlete populations' mental health were provided. For example, studies included in both reviews highlighted elite women athletes are at an increased risk for anxiety, depression, and eating disorders when compared to elite men athletes. In Kuettel & Larsen's (2020) review, gender (women or female) emerged as a risk factor for poor mental health more broadly amongst elite athletes.

Kuettel and Larsen (2020) speculated that the increased rates amongst women were due to biological differences between the sexes—however, no evidence was provided for this, and it was not discussed in any further detail in their review. The lack of knowledge concerning elite women athletes and mental health is likely in part due to existing research overlooking elite women athletes. Subsequently, sports scholars are left to make assumptions regarding the many possible risk factors contributing to mental health difficulties. For example, Castaldelli-Maia et al. (2019) suggested that the lack of acceptance of women athletes in certain cultures, unequal training opportunities, limited financial support, sexualisation, sexuality stereotypes, and societal and personal expectations around traditional gender roles will likely negatively impact the mental health of this population. While these psychosocial and contextual demands are extremely plausible, it is critical that future research is conducted with elite women athletes so further insight can be provided.

Across numerous mental health and elite sport reviews, researchers have called for more research with mental health and elite women athletes (Gouttebarge et al., 2019; Kuettel et al., 2020; Poucher et al., 2021; Tahtinen et al., 2021). Such calls are driven by the aforementioned higher rates of mental ill-health experienced by elite women athletes and lack of insight into this population, as well as a practical need for better support for this population. Noted by numerous scholars, conducting research with elite women athletes is essential for creating effective mental health programmes and interventions (Castaldelli-Maia et al., 2019; Foskett & Longstaff, 2018). As Breslin et al. (2017) argued, gender-specific and sport-specific data should be used to inform support provided to athletes for mental health. They noted that that neglecting contextual factors will substantially reduce the quality and effectiveness of mental health support and interventions. Therefore, it is critical that research into mental health and elite women athletes is conducted before support programmes and interventions are designed. Prior to conducting the much-needed mental health research with elite women

athletes, it is important researchers consider the study design, methods, research aims, and use of theory (Poucher et al., 2021).

This review offers a systematic approach to the literature and focuses on the methods and theories used in research conducted exclusively with elite women athletes. This current review differs from other reviews conducted in this area due to the focus on methods, the consideration of how theory has been used, and the exclusive focus on elite women athletes. While there are numerous 'types' of reviews that can be conducted, a scoping review was deemed the most appropriate approach to answer the research aims of this review (see section 3.2.1. for aims). More specifically, the purpose of a scoping review is to summarise existing research with the aim of systematically mapping implications for practice and identifying research gaps (Arksey & O'Malley, 2005). Like this current review, scoping reviews are primarily used in the field of sport and exercise psychology when addressing unexplored topics such as mental health and sport where limited research is available (see Kuettel & Larsen, 2020). For topics where more research is available, systematic reviews or meta-analysis are often used as they allow researchers to examine study quality more rigorously (Grant & Booth, 2009; Munn et al., 2018). Importantly, while narrative reviews are increasingly popular in sport and mental health research—for example, see Rice et al. (2016) and Souter et al. (2018)—and provide helpful insights into the topic under investigation, they do not follow a strict research criteria and risk missing studies.

This is the first published review, to the best of my knowledge, to have mapped literature exclusively focused on mental health and mental illness with elite women athletes. Specifically, this review focused on (1) identifying the methodology used in research concerning mental health or mental illness and elite women athletes, (2) exploring the use of theory in these studies, and (3) providing an overview of the research purposes. In turn, the aim

of this review was to map the research that has been conducted with this population, identifying potential gaps in the literature, and informing my research study design and focus.

3.2. Methodology

In this review, the methodological framework suggested by Arksey and O'Malley (2005) was followed; (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, and (5) summarising and collating the data and reporting the results. Additionally, all items on the recently developed PRISMA checklist for scoping reviews were adhered to (Tricco et al., 2018) (Appendix B PRISMA checklist).

3.2.1. Identifying the research question

The overriding research question guiding this review was 'how has mental health and mental illness concerning elite women athletes been researched?' This review therefore centred on three underlying aims: (1) identify the methodology used in research concerning mental health or mental illness and elite women athletes, (2) explore the use of theory in these studies, and (3) provide an overview of the research purposes with the goal of identifying gaps in the literature and making recommendations for future research.

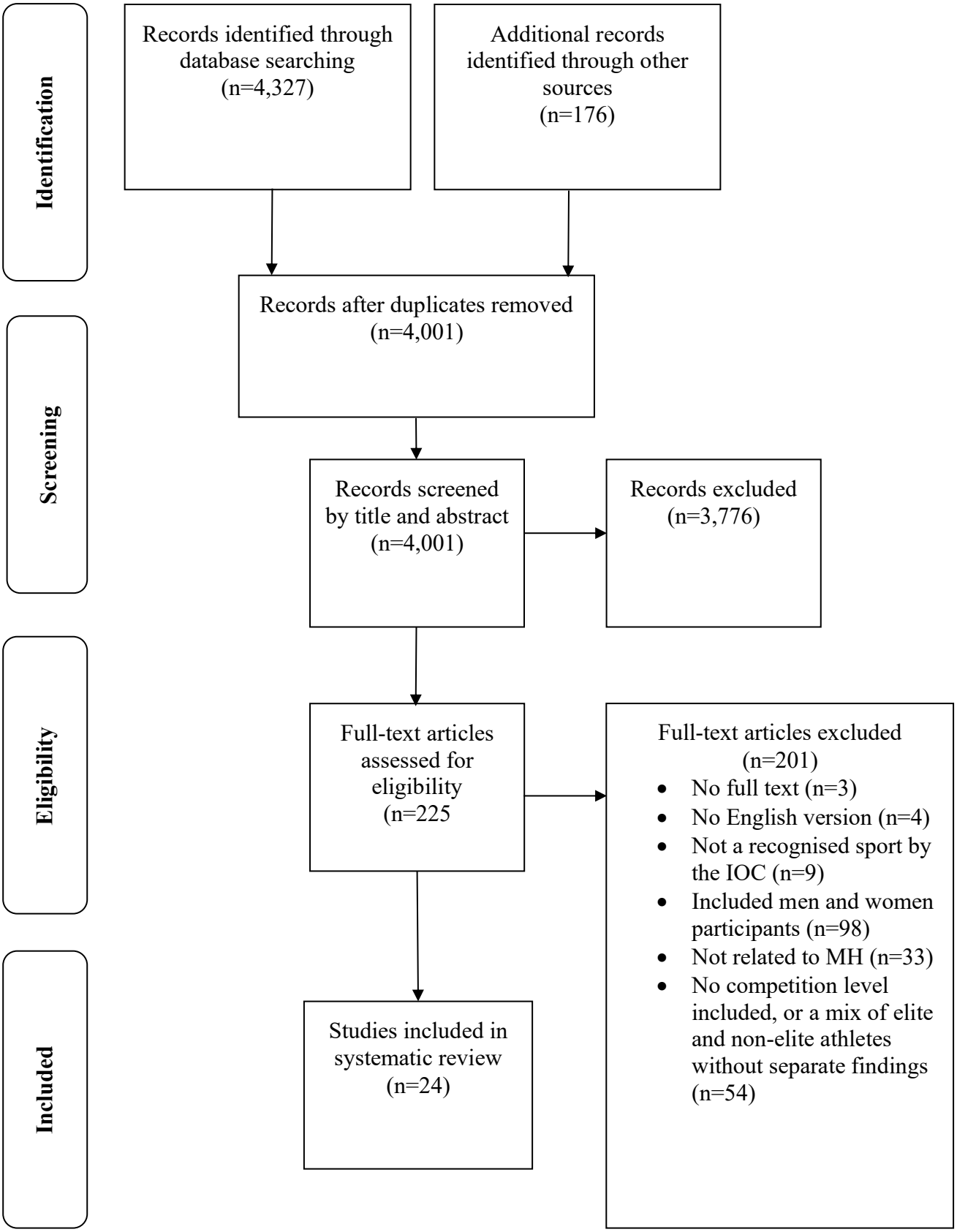
3.2.2. Identifying relevant studies

In this review, studies were included that met the following criteria: (a) exclusively sampled 'women athletes' or 'female athletes' according to the author(s) of each study. In contrast to previous reviews concerning mental health and elite athletes, studies involving both male and female athletes were excluded. It is important to note here that sport researchers often take a 'binary' approach to research (e.g., male or female) due to the elite sporting environment being predominantly structured with reliance on gender binaries (Phipps, 2021); thus, I am aware that some athletes do not identify with the terminology 'female' or 'woman' and

therefore might be missed in this review. While there is a need for more inclusive research in the future, this scoping review involved studies where 'women athletes' or 'female athletes' were the identified population in order to report on the current state of knowledge; (b) 'involved athletes competing at the elite sporting level.' In this review, 'elite athletes' are defined as high-performance, elite, or professional athletes, and US National Collegiate Athletic Association Division One (NCAA D1) student athletes (Rice et al., 2018; Swann, Moran, & Piggott, 2015). US collegiate athletes often compete and train at hours similar to those at the highest levels in other countries thus they were included; this is an approach used in other reviews with elite athletes (see Knights et al., 2016). Studies that included athletes competing at the provincial, regional, or county level were included if they were defined by the author as 'elite'. Additionally, studies comprising both 'elite and non-elite athletes' or 'senior and junior elite athletes' were only included if the findings between groups were distinguishable; (c) 'involved current athletes.' Retired athletes were excluded unless findings were distinguishable between athletes who were retired at the time of the study and those still competing; (d) involved a focus on mental illness, mental health, or mental wellbeing as defined by the authors of each individual study in their research aims. Studies that indicated the research purpose was to explore 'mental illness,' 'mental health,' or 'mental wellbeing' were included. Additionally, studies that aimed to explore a specific mental illness (e.g., anxiety or depression) from an established criteria were included—i.e., The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) or WHO's International Classification of Diseases (ICD-10); (e) 'were published between 1996 and 2020'. In the development of women's sport, 1996 was a pivotal year as women were allowed to participate in football and softball at the summer Olympics for the first time, and the first International Olympic Committee (IOC) world conference on 'Women and Sport' took place in Lausanne, Switzerland; (f) 'were qualitative, quantitative, or mixed method studies.' Systematic and

scoping reviews, meta-analyses, commentaries, grey literature, and dissertations were excluded from data analysis.

Figure 3.1 Prisma flow diagram



3.2.3. Study selection

The search was initiated in March 2020 and ended in June 2020. The following databases were searched: SPORTDiscus, PsychINFO, CINAHL, and MEDLINE. These databases were chosen because their scopes were most closely aligned with the research question and aims of this review. Additionally, these databases have been used in recent reviews of a similar nature (e.g., Kuettel & Larsen, 2020, Rice et al., 2016). In addition to the identified databases, academic journals, reference lists, and previous reviews were manually searched to ensure studies were not missed.

The search terms spanned four core categories: (1) gender (e.g., female or women/woman), (2) mental health (e.g., mental health or mental illness or mental wellbeing), (3) competition level (e.g., elite or international), and (4) sport (e.g., sport or athlete). Four specific 'types' of mental illness were included as search terms—i.e., depression, anxiety, eating disorders and disordered eating, and substance abuse. These four were selected given the incidence of these specific challenges in elite athlete populations and the focus on these disorders in past reviews (Gouttebarge et al., 2019; Rice et al., 2016). Due to the ambiguous conceptualisations of mental health and mental illness in sport research, 'mental wellbeing' was included as a search term as it is sometimes used interchangeably with 'mental health' in the sport literature (Lundqvist & Andersson, 2021). See Appendix C for example of search terms.

Screenings of the databases were performed in three phases (Levac et al., 2010). First, I screened the titles and abstracts of identified articles with the aim of eliminating studies that did not meet the predefined eligibility criteria. Following this, full texts of the potential studies for inclusion were screened for eligibility by the myself and one of my supervisors, independently. Following the completion of article screening, we both came together to

critically discuss findings. Finally, another member of my supervision team completed a full-text screening of the articles we deemed eligible. Following study selection, I mapped the key findings, identified gaps in existing literature, and charted the data which was then checked by the research team. Data charting involved recommendations from Arksey and O'Malley (2005) and included: year of publication, study aim and purpose, characteristics of study populations (e.g., sporting level, type of sport), study design, measurements used, identification of theory, and key findings.

3.3. Results

The search yielded a total of 4,327 records. After removing the duplicates, 4,001 articles were screened for eligibility by title and abstract. Then, 3,776 were excluded and the remaining 225 articles were assessed for eligibility. Following the full text review, 201 articles were excluded leaving 24 to be included in this review (Figure 3.1).

Table 3.1 Mental health and elite women athletes included articles study characteristics

Author; year[1]	Aim[2]	Participants (total, mean age[3], sport, competition level, country)	Methods (Study design, data collection, measurements[4])	Use of theory[5]	Key findings
1. Anderson, Petrie, & Neumann (2011)	Examine and test Petrie and Greenleaf's model of bulimic symptoms in two samples of female collegiate gymnasts and swimmers/divers	414 *Mage* =19.14 Gymnastics, swimming/ diving NCAA D1 United States	Quantitative Cross-sectional Weight and sport pressures (WPS), sociocultural pressures (PSPS, SATAQ-3), body dissatisfaction (BPSS-RR, BSQ-10), dietary restraint (DIS), negative affect (PANAS-X), disordered eating (BULIT-R) & social desirability (MCSD), demographics (age, race, height, weight, ideal weight, year in school, current/past ED & menstrual history)	Petrie and Greenleaf's (2007) model of bulimic symptoms	Model showed sport pressures were directly related to body dissatisfaction and dietary restraint in female athletes. Negative affect, body dissatisfaction, and restrained eating explained 55–58% of the variance in the athlete's bulimic symptoms.
2. Anderson, Petrie, & Neumann (2012)	Explore the pathways between (1) sport environment pressures about appearance, (2) body and weight in female athletes' body satisfaction, and (3) self- reported intentions	325 *Mage*=19.24 Gymnastics, swimming/ diving NCAA D1 United States	Quantitative Longitudinal Sport pressures (WPS), body satisfaction (BPSS-R) dietary restraint (DIS & 10-item DRES)	Petrie & Greenleaf's theoretical model of sociocultural factors and disordered eating	All variables were stable across the five-month season; dietary restraint and body satisfaction are the best predictors of future. The stability across the season suggests female athletes train and compete in an environment where they are constantly forced to focus on their bodies, eating, and weight. Findings highlight the need for interventions that target

					messages, ideals, and behaviours that currently exist in elite sport for women.
3. Brannan et al. (2009)	Examine perfectionism, optimism, self-esteem, and reason-for-exercise as moderators of the body dissatisfaction-bulimic symptoms relationship among female collegiate athletes	204 *Mage*=20.16, *SD*=1.31 Various Sports NCAA D1 United States	Quantitative Cross-sectional Disordered eating (BULIT-R), body dissatisfaction (BPSS- R), perfectionism (MPS), optimism (LOT- R), self-esteem (RSE), reasons for Exercise (REI), social desirability (12-item Marlow-Crowe), demographics (age, race/ethnicity, class rank, height weight, BMI)	No theory	Body dissatisfaction was related to the measure of bulimic symptoms. Females that reported more concern over mistakes – and who reported being motivated to exercise to improve appearance and attractiveness or to socialize and improve mood – increased the strength of the relationship between body dissatisfaction and bulimic symptoms.
4. de Bruin & Oudejans (2018)	Explore the role of contextual body image in the development of ED in female athletes who participate in 'at-risk sports' –i.e., aesthetic, endurance, and weight-class sports)	8; active athletes= 4, former athletes=4 Age range=18-33 Various Sports (inter)national level Country not specified	Qualitative Phenomenological interviews	Contextual body image framework (Loland, 1999)	Relationship between ED symptomology and sports environment was recognised by all elite athletes, and all saw sport as a "high risk" culture. Contextual body image appeared to influence development EDs suggesting that environment of elite sport is likely to influence the development and maintenance of EDs.
5. Greenleaf et al. (2009)	Explore the prevalence of clinical and subclinical levels of EDs among female college athletes and examine the	204 *Mage*=20.16, *SD*=1.31 Various Sports NCAA D1 United Sates	Quantitative Cross-sectional Disordered eating (QEDD, BULIT- R) and demographics (height, BMI,	No theory	Findings indicated 54.4% reported being dissatisfied with their bodies, 88.2% believed they were overweight, 15% reported binge eating and 25.5%, reported they exercises for 2 h specifically to burn calories.

	prevalence of pathogenic eating and weight control behaviours		grade level, sport, and years participating in sport).		
6. Haase (2009)	Examine social physique anxiety (SPA) and disordered eating correlates in two sport types	137 *Mage*=19.50, *SD*=3.69 Various sports (inter)national level Australia	Quantitative Cross-sectional Social physique anxiety (SPAS), disordered eating (EAT-26), and weight (self-report weight and height measures)	No theory	Females in individual sports reported higher SPA, dieting, and bulimic behaviours than in team sports.
7. Hausenblas Mack (1999)	Examine elite female athletes' concerns related to physique (i.e., social physique anxiety) and eating disorder correlates	114; elite =36, athletic control group=39, nonathletic control group = 39 *Mage* =16.33, *SD*=2.44 Various sports National or Provincial level Country not specified	Quantitative Cross-sectional Eating disorder symptoms (EDI-2), social physique anxiety (SPAS), body mass (BMI), and demographic information	No theory	Female divers reported significantly less SPA than the athletic control group and nonathletic control group. No differences were found between the divers, athletic control group, and nonathletic control group regarding correlates associated with eating disorders. Results showed dissatisfaction with body and extreme concern with dieting and thinness were strong predictors of SPA.
8. Hinton & Kubas (2005)	Develop athletics-oriented measure of psychological predictors of DE and test its reliability and validity	167 Age=18-22 Various sports NCAA D1 United States	Quantitative Cross-sectional Disordered eating (ATHLETE subscale against external criteria derived from the Q-EDD)	No theory	16% of female athletes displayed symptoms of disordered eating. The ATHLETE-scale was found to be a reliable and valid measure of the psychological factors associated with disordered eating in athletes.
9. Hulley & Hill (2001)	Explore ED symptoms in elite women distance runners in the United Kingdom	181 *Mage*=28.5 Running	Quantitative Cross-sectional Eating, weight and diet concerns (EDE-Q), body	No theory	16% displayed clinical ED symptoms. Over 50% of total participants were dieting when they completed the questionnaire or had dieted recently.

		'Elite' as defined by the authors United Kingdom	cathexis (BCS), self-esteem, mental health (MHI), and demographics (e.g., age, weight, training time, illness, injury)		Dieting was significant more present in eating disorder group.
10. Junge & Prinz (2019)	Determine prevalence and risk factors of depression and anxiety symptoms in across 17 elite teams of female footballers in Germany	290; first league=184, lower league=106 *Mage*=21.5, *SD*=4.2 Football (Semi)professional Germany	Quantitative Cross-sectional Depression (CES-D), anxiety (GAD- 7), support availability (e.g., current need and use of psychotherapeutic support), and personal and player characteristics (e.g., match experience, level of play, starting status, injury status)	No theory	First league footballers had similar depression prevalence rates to general population. Second league players had higher depression prevalence rates than first league players and then a female general population of similar age. Across both leagues, 45 players reported currently wanting or needing psychotherapeutic support yet only 16% of them who reported this received it.
11. Klinkowski et al. (2008)	Explore psychopathology amongst elite rhythmic gymnasts and anorexia nervosa patients	159 *Mage*=15.2 Gymnastics (Inter)national level Germany	Quantitative Cross-sectional Psychopathology (SCL-90-R), body mass index (BMI), and demographics and personal characteristics (e.g., body height, weight, the presence of amenorrhea)	No theory	Rhythmic gymnasts showed different profiles in psychopathology from those diagnosed with anorexia nervosa. Findings indicated that need to maintain a specific weight in rhythmic gymnastics may lead to females engaging in weight regulating behaviour and increase their likelihood of developing an ED.
12. Kong & Harris (2015)	Explore the role of body image in sport and non-sport contexts, pressures from coaches, influences from sport	320; elite level=128, recreational level=12, non-competitive level=80 *M*age=21.7 Various sports	Quantitative Cross-sectional Eating attitudes test (EAT-26), Figure Rating Scale (FRS), and demographic	No theory	Findings showed 23% of elite athletes were at risk for clinical EDs. The elite athlete group reported the highest scores for pressures from coaches to maintain a low body weight and lean physique.

	that emphasise learner body shapes and the role of competition in motivating efforts to maintain specific body weights or shapes	Australia	and personal characteristics (e.g., age, weight)		
13. Kroshus et al. (2014)	Explore strategies used by two similarly competitive female collegiate cross-country running teams to address teammate eating behaviours perceived to be unhealthy and problematic	35 *Mage*=19.37; team 1 *Mage*=20.19; team 2 Cross-country NCAA D1 United States	Qualitative Cross-sectional Semi-structured interviews	Used Bronfenbrenner's (1979) ecological model to explain the study's focus on team-specific contextual factors that help explain problematic team communication around food and weight. It was also drawn up during analysis	Notable between-team differences in communication about eating behaviours considered to be problematic and unhealthy among team members. Differences emerged in role of the teammates and coaches in communication around this topic. Bronfenbrenner's (1979) ecological model can help guide analysis and can help suggest areas to target for intervention amongst athletes.
14. Kroshus et al. (2015)	Explore how anti-dieting advice from teammates impacts eating disorder symptomology amongst elite female athletes	89 *M*age=19.76 Cross-country NCAA D1 United States	Quantitative Cross-sectional Disordered eating (EAT-26), perceived anti- dieting advice, body mass (BMI), and demographic and personal characteristics (e.g. height, weight, age, race)	No theory	Significant between-team differences in the frequency of anti- dieting advice emerged. Eating pathology and BMI were positively associated with anti-dieting advice received.
15. Papathomas & Lavallee (2014)	Explore and provide an alternative to medical understanding of DE in sport through an emphasis on personal perspectives	1 Age=20 Basketball Elite level United Kingdom	Qualitative Unstructured interviews: seven hours of life history data gathered over a period of eight months	Narrative theory	Through life history interviews, they found Holly struggled to align her life experiences with a culturally specified performance narrative – based on achievement in sport. In attempt to align with her achievement narrative,

					she used self-starvation as a means to fulfil this. Their study showed the benefits of using narrative as a method and theory to explore how athletes make sense of, and live with, DE.
16. Prather et al. (2016)	Explore the prevalence of stress fractures, menstrual dysfunction, and DE attitudes in female elite soccer players	220 *Mage*=16.4, *SD*=4 Soccer NCAA D1 and Professional United States	Quantitative Cross-sectional Disordered eating (EAT-26), body mass (BMI), menstrual history, stress fracture history confirmed by a physician, and demographic and personal characteristics (e.g., age, height, injuries)	Rationale for study was supported by the 'Female Athlete Triad'	Findings indicated 17.9–19.4% professional players and NCAA D1 athletes had menstrual dysfunction. Of this population, 8.3–17.8% had scores on EAT-26 suggesting they were at risk for ED.
17. Reel et al. (2010)	Develop a reliable and valid measure to explore sport-related body image pressures across a variety of sports rather than a single sport	204 *Mage*=20.16 Various sports (17+ types) NCAA D1 United States	Quantitative Weight pressures (WPS–F) and demographic and personal characteristics (e.g. weight, height)	No theory	They developed a 16- item measure with four factors and found weight pressures from coaches/team/sport explained 37.5% of variance; the second factors, self-consciousness of weight and appearance explained 8.7%. The remaining two factors were weak in explaining variance.
18. Shriver, Wollnbereg, & Gates (2016)	Explore the prevalence of DE among female college athletes and examine potential difference between athlete in weight-sensitive and less-weight-sensitive sports	151 *M*age=19.5, *SD*=1.2 Various sports NCAA D1 United States	Quantitative Cross-sectional Disordered eating (EAT-26 & MEBS), emotional regulation (DERS), and demographic and personal characteristics (e.g., weight, height)	No theory	Over 70% of athletes indicated a desire for a lower weight, with the highest desire in soccer players (81%) and lowest desire among cross-country runners (40%); this directly contrasts what the literature has said to date about weight-sensitive sports (e.g., cross-country) versus less-weight sensitive sports (e.g., soccer). DE

					scores did not differ significantly between weight-sensitive and less-weight-sensitive-sports. Further, findings indicated DE scores were positively associated with difficulties with emotional regulation.
19. Smith & Petrie (2008)	Test a cognitive dissonance program with female athletes for DE, ED, and body image	29 *Mage*=19.32, *SD*=.94 Various sports NCAA D1 United States	Quantitative Cross-sectional Thin-ideal internalisation (BAA- R), body image concerns (BPSS-R & BSQ-10-R), negative affect (PANAS-X), disordered eating (BULIT-R & DRES), and demographic and personal characteristics (e.g., weight, height)	The intervention is grounded within dissonance theory	No treatment effects were significant however, post-hoc analyses suggested that the cognitive- dissonance intervention provided some effects in reducing sadness and depression. The cognitive dissonance-based intervention should address factors unique to female athletes and the sporting environment.
20. Stirling & Kerr (2012)	Examine female athletes perceived vulnerabilities to the development of DE	17 Age=18-25 Various sports Provincial, national, or collegiate Country not specified	Qualitative Cross sectional Semi-structured interview	No theory	Athletes from aesthetic and non-aesthetic sports perceived their DE vulnerabilities mainly stem from their sport environment, including sports' focus on the body, appearance, weight monitoring, and media influences. Personal and internal characteristics mentioned by athletes that they perceived might impact DE were self-absorption, achievement- orientation, perfection-ism and hyper-competitiveness.
21.Sundgot-Borgen, et al. (2003)	Explore the prevalence of ED in female elite athletes	1069; athletes=553, controls=516 Age=15–39	Quantitative Cross-sectional	No theory	A significantly higher percentage of athletes (20%) compared with controls (9%) met the DSM-5 criteria for ED.

	and controls reporting sexual harassment and abuse (SHAB) and explore this relationship	Various Sports Junior and senior Olympic level Norway	Eating disorder prevalence (EDI), sexual harassment, pathogenic weight behaviours, clinical interviews with diagnosis based on symptoms according to DSM-5 criteria, and demographic and personal characteristics (e.g., weight, height)		A higher percentage of ED athletes (66%) compared to non-ED athletes (48%) met reported experience of SHAB both inside and outside the sporting community.
22.Torstveit, Rosenvingee, & Sundgot-borgen (2008)	Explore the prevalence of female elite athletes and controls with DE and clinical EDs	1838; active athletes= 938, non-athletes=900 Age=13-39 Various Sports Junior and senior Olympic level Norway	Quantitative Cross-sectional Two-part questionnaire: part 1= menstrual cycle, self-reported ED, body dissatisfaction (BD), drive for thinness subscales (DT) from EDI, part 2= random selection from part 1 invited to clinical interview (EDE interview guide was used).	No theory	A high percentage of both athletes and controls met the criteria for DE and clinical ED. Specifically, 46.2% of the athletes and 51.7% of the controls reported one or more of the five indicators of DE. Higher prevalence of EDs was found among athletes competing in leanness sport compared with athletes competing in non-leanness and controls, which aligns with previous literature.
23. Torres-McGhee et al. (2011)	Explore the prevalence of ED amongst equestrian female athletes and associations between academic status and riding discipline	211 *M*age=19.8 English & Western Equestrian NCAA D1 United States	Quantitative Cross-sectional Eating attitudes (EAT-26), sex-specific BMI figural stimuli silhouette (The figural Stimuli Survey), academic status, and demographic and personal characteristics (e.g., weight, height)	No theory	Findings indicated 38.5% of English riders scored in clinical range for ED & 48.9% among western riders. No BMI or silhouette differences were found across academic status or DE risk.

24. Wilinski (2012)	Explore the relationship between gender-identity, the perception of the body, depressiveness, and aggression in female football players who represent different competition levels	94 *Mage*=20.77 Football Premier league and second league Poland	Quantitative Cross-sectional Sex role inventory (BSRI), body image questionnaire, depression inventory, hostility (BDI), and demographic and personal characteristics (e.g., weight, height)	Rationale for study included gender schema theory & Franzoi's theory	This study found that football does not take-away female players femineity however, it does protect a high level of femineity with masculinity. Further, findings indicated that female footballers have androgynous gender identities, a higher level of masculinity than among non-training women, a more favourable perception of body-as-process, a higher evaluation of body-as-object. And, along with an increase of masculinity and a decrease in indirect aggression at higher competition levels

Notes: [1] Reference numbers for the following tables; 1 = Anderson, Petrie, & Neumann (2011); 2 = Anderson Petrie, & Neumann (2012), 3 = Brannan et al. (2009); 4 = de Bruin & Oudejans (2018), 5 = Greenleaf et al. (2009), 6 = Haase (2009), 7 = Hausenblas & Mack (1999), 8 = Hinton & Kubas (2005), 9 = Hulley & Hill (2001), 10 = Junge & Prinz (2019); 11 = Klinkowski et al. (2008); 12 = Kong & Harris (2015), 13 = Kroshus, Goldman, Zubzanksy & Austin (2014), 14 = Kroshus, Kubzansky, Goldman, & Austin (2014), 15 = Papathomas & Lavallee (2014), 16 = Prather et al. (2016), 17 = Reel et al.(2010), 18 = Shriver, Wollnbereg & Gates (2016), 19 = Smith & Petrie (2008), 20 = Stirling & Kerr (2012), 21 = Sundgot-Borgen et al. (2003); 22 = Torstveit, Rosenvingee, & Sundgot-borgen (2008); 23 = Torres-McGhee et al. (2011); 24 = Wilinski (2012)

[2] Terminology in this table mirrors that which is used in each study – i.e., 'female'

[3] In studies where mean age is not provided, age range is offered.

[4] Measurement names are located in Table 3.4.

[5] Theory is only marked if the authors overtly used it.

3.3.1. Study characteristics

Of the 24 studies included, 11 were conducted in the US (45.8%), three in the UK (12.5%), two in Australia (8.3%), two in Norway (8.3%), two in Germany (8.3%), and one in Poland (4.2%). The remaining three studies did not indicate a country (12.5%). The participants ranged from thirteen to 30 years of age, with 22 of the studies including participants between the ages of 16 and 26 (92%). Sample size varied from one participant to 938 participants.

Regarding competition level, 11 studies (45.8%) included NCAA D1 student athletes, and 11 studies (45.8%) included professional, national, international, and provincial athletes. Only one study (4.2%) included 'elite athletes' defined through ambiguous terminology. Between one and 58 different sports were explored across the studies. More specifically, 10 studies included only one sport, nine studies included two to 10 sports, and four studies included 10 or more sports. The most commonly included sports were football (or 'soccer' if referring to studies in the US) (*n*=11), swimming/diving (*n*=10), track and field (*n*=8), volleyball (*n*=8), basketball (*n*=8), gymnastics (*n*=9), and running (*n*=8).

Table 3.2 Sample characteristics

Study characteristics	Reference number	*n*	%
Country of study			
Australia	6, 12	2	8.3
Germany	10, 11	2	8.3
Norway	21, 22	2	8.3
Poland	24	1	4.2
UK	9, 14, 15	3	12.5
US	1, 2, 3, 5, 8, 13, 16, 17, 18, 19, 20	11	45.8
Country not specified 12.5%	4, 7, 20	3	12.5
Number of sports included			
1 sport	9, 10, 11, 13, 14, 15, 16, 23, 24	9	37.5
2-9 sports	1, 2, 4, 6, 7, 8, 18, 19, 20	9	37.5

10+ sports	3, 5, 12, 17, 21, 22	6	25
Study design			
Quantitative	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 21, 22, 23, 24	20	83.3
Qualitative	4, 13, 15, 20	4	16.6
Mixed-method	0		
Cross-sectional	1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24	21	
Longitudinal	2	1	4.2
Sample size			
1	15	1	4.2
1≤10	4	1	4.2
11–50	13, 19, 20	3	12.5
51–100	14, 24	2	8.3
101–300	3, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 23	12	50
>300	1, 2, 12, 21, 22	5	20.8
Sporting level			
NCAA D1	1, 2, 3, 5, 8, 13, 14, 17, 18, 19, 23	11	45.8
Professional	10, 12, 16, 24	4	16.6
(Inter)national	4, 6, 7, 15, 11, 12, 20, 21, 22	9	37.5
Elite as defined by author	9	1	4.1
Mixed samples			
Elite and non-elite or general population	7, 11, 12, 16, 21	5	20.8
Athletic status			
Active	1, 2, 3, 5, 6, 7, 8, 9, 11, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24	23	95.8
Active & Retired	4	1	4.2
Mean age			
<16	11	1	4.2
16–26	1,2,3,4,5,6,7,8,10,12,13,14,15, 16,17,18,19,20,21,22,23,24	22	92
27–40	9	1	4.2
Use of theory			
Yes	1, 2, 4, 13, 15, 19, 24	7	29
No	3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 20, 21, 22, 23	17	70.8
NCAA D1: Number of universities included per study			
1	18, 19	2	8.3
1≤3	3, 5, 13, 17	4	16.6
4 ≤	1, 2, 23, 14	4	16.6

Table 3.3 Sport-types across included studies

Sport	Reference number
Alpine Skiing	3, 5, 17
Basketball	3, 5, 15, 17, 18, 19, 20
Cheer	10, 17
Cross country running	3, 5, 13, 14, 17, 19
Running	9
Cycling	4
Dance	4, 20
Diving only	3, 5, 7, 6, 17
Divers and Swimmers	1, 2
Equestrian	23, 18
Field hockey	5
Figure skating	20
Golf	3, 5, 17, 18, 19
Gymnastics	1, 2, 3, 4, 5, 11, 17, 20
Ice Hockey	3, 17
Judo	4
Lacrosse	3, 5, 7, 17
Netball	6
No-sport clarified	21, 22
Soccer/football	3, 5, 7, 11, 16, 17, 18, 19, 20, 24
Softball	3, 5, 17, 18, 19
Swimming	3, 5, 17, 19, 20
Synchronized swimming	3, 5, 17
Rowing	3, 5, 17
Tennis	3, 5, 16, 17, 18
Track & Field	3, 4, 5, 17, 18, 19, 20
Volleyball	3, 5, 17, 18, 19, 20

3.3.2. Study design and instrument

In this review, 20 out of the 24 studies used quantitative methods (83.3%), all of which involved self-report measures. Of the quantitative studies, 19 involved a singular cross-sectional design (95.8%) and one study used a longitudinal design (4.2%) (Anderson et al., 2012). In using a longitudinal research design, the researchers were able to examine the influence of sport pressures, body dissatisfaction, and dietary restraint across a five-month competitive season. A total of four studies employed qualitative research methods (16.6%). Of

these studies, two used semi-structured interviews (Kroshus et al., 2014a; Stirling & Kerr, 2012), one used a life history approach (Papathomas & Lavallee, 2014), and one used a mix of phenomenological interviews and ethnographic research methods (de Bruin & Oudejans, 2018).

A total of 34 validated scales were used in the 20 quantitative studies (Table 3.4 for list scales used across included studies). Eighteen studies utilised scales to explore eating disorders and disordered eating (75%), with three scales appearing frequently: the Bulimia Test Revised (BULIT-R; Thelen et al., 1984) (included in four studies), the Eating Disorder Inventory (EDI; Garner, 1982) (included in four studies), and the Eating Attitudes Test (EAT-26; Garner, 1982) (included in six). Additionally, three studies used the Body Parts Satisfaction Scale–Revised (BPSS-R; Petrie & Austin, 1997) and the Weight Pressures in Sport for Females (WPS–F; Reel et al., 2010). Notably, the WPS-F was the only athlete-specific measure used in the studies included in this scoping review. In addition to eating disorders, disordered eating, and body satisfaction measures, three studies used the Social Physique Anxiety Scale (SPAS; Hart, Leary, & Rejeski, 1989). Two studies explored depression and anxiety using the Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 19377), the General Anxiety Disorder scale (GAD-7; Spitzer, 2006), or the Beck Depression Inventory (BDI; Beck et al., 1961).

Table 3.4 Screening tools and measurements across studies

Screening tool purpose	Name*	Reference number	*n*	%
Demographic and general information				
	Menstrual history or amenorrhea	1, 11, 16, 17, 18, 21, 22	7	29.2
	Use of pathogenic weight control measures	21, 22	2	8.3

	Past and current eating disorders	1, 3, 11, 16, 17, 18, 22	7	29.7
	Family eating disorder history	18	1	4.2
	Participants reported weight satisfaction – i.e., changes in weight experienced in season and out of season	5, 17	2	8.3
	Injury Stress fractures	9, 10, 21, 22 16	5	20.8
	Contraception use, pregnancy, breastfeeding status	11, 22 12	3	12.5
	Illness (physical)	9, 16	2	8.3
	Wellbeing	9	1	4.2
	Personal and player characteristics	10	1	4.2
	Current general health	10	1	4.2
	Need and use of psychotherapeutic support	10	1	4.2
	Match experience	10	1	4.2
	Starting status	10, 17	2	8.3
	Ideal weight	12, 18, 23	3	12.5
	Coach required monitoring of weight	12	1	4.2
	Academic status	23	1	4.2
Mental health				
	Mental health inventory (MHI; Berwick et al., 1991)	9	1	4.2
Anxiety				
	Generalized Anxiety Disorder Scale-7 (GAD-7; Spitzer et al., 2007)	10	1	4.2
Depression				
	Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977)	10	1	4.2
	Beck depression inventory	24	1	4.2
Psychopathology				
	The Symptom Checklist-90-Revised (SCL-90-R; Derogatis et al., 1973)	11	1	4.2
Sport weight pressures				

	Weight Pressures in Sport (WPS; Reel & Gill, 1996)	1, 2, 17	3	12.5
Body satisfaction & dissatisfaction, body image, thin-ideal interalisation, and figure				
	The 7-item Body factor from the Body Parts Satisfaction Scale-Revised (BPSS-R; Petrie, Tripp, & Harvey, 2002)	1, 2, 3, 19	4	16.6
	Single item about body satisfaction	2	1	4.2
	Body Image Evaluation Questionnaire – based off of Franzoi's concepts	24	1	4.2
	The Body Cathexis Scale (BCS; Mintz & Betz, 1986)	9	1	4.2
	Figure Rating Scale (FRS; Stunkard et al., 1983)	12	1	4.2
	The 10-item Body Shape Questionnaire-Revised (BSQ-10-R; Mazzeo, 1999)	19	1	4.2
	The 19-item Beliefs About Attractiveness Scale-Revised (BAA-R; Petrie, et al., 1996)	19	1	4.2
Eating disorder (ED) & disordered eating (DE)				
	The Bulimia Test Revised (BULIT-R; Thelen et al., 1991)	1, 3, 5, 19	4	16.67
	Questionnaires for Eating Disorder Diagnoses (Q-EED; Mintz & O'Halloran, 1997)	5, 8	2	8.3
	Eating Attitudes Test (EAT-26; Garner, 1982)	6, 12, 14, 16, 18, 21	6	25
	Eating Disorder Inventory-2 (EDI-2; Garner, 1991)	7, 8, 21, 22	4	16.6
	SCANS, SPA-subscales only (Slade et al., 1986)	8	1	4.2
	Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994)	9	1	4.2
	Minnesota Eating Behaviors Survey (MEBS; Klump et al., 2000)	18	1	4.2

	The 9-item Dietary Intent Scale (DIS; Stice, 1998)	1, 2	2	8.3
	Dutch Eating Behavior Questionnaire (DRES; Van Strien et al., 1986)	2, 19	2	8.3
Social physique anxiety				
	The Measurement of Social Physique Anxiety (SPAS; Hart et al.,1989)	6, 7	2	8.3
Negative and negative affect				
	Positive Affect (PA) and Negative Affect (NA) (PANAS-X; Watson & Clark, 1992)	1, 19	2	8.3
General sociocultural pressures and social Desirability				
	The Perceived Sociocultural Pressure Scale (PSPS; Stice & Agras, 1998)	1	1	4.2
	The sociocultural attitudes towards appearance scale-3 (SATAQ-3; Thompson et al., 2004)	1	1	4.2
	Marlowe-Crowne Social Desirability Scale (MCSD; Reynolds, 1982)	1, 3	2	8.3
Modeled behavior				
	Modeled behavior survey designed for this study to explore the influence of seeing disordered eating behaviours on individual behaviours	1	1	4.2
Perfectionism				
	Multidimensional Perfectionism Scale (MPS; Frost et al., 1990)	3	1	4.2
Optimism				
	Revised Life Orientation Test (LOT-R; Scheier, Carver, & Bridges, 1994)	3	1	4.2
Self-Esteem				
	Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965)	3, 9	2	8.3
Reasons for Exercise				

	Reasons for Exercise Inventory (REI; Silberstein et al., 1988)	3	1	4.2
Perceived anti-dieting advice				
	Anti-dieting advice scale (Thompson et al., 2007)	14	1	4.2
Emotional regulation				
	Multidimensional Assessment of Emotion Regulation and Dysregulation: (DERS; Gratz & Roemer, 2004)	18	1	4.2
	The Buss-Durkee Hostility Inventory (BDHI; Buss & Durkee, 1957)	24	1	4.2
Sexual harassment				
	Sexual Harassment and Abuse (SHAB; Brackenridge 1997)	21	1	4.2
Other				
	Bem Sex Role Inventory (BSRI; Bem, 1974)	24	1	4.2
	Clinical Interview	21, 22	2	8.3

*Note: references for each individual scale (e.g., 'Bem, 1974') are not provided in the reference list of this thesis. Please see the associated study to access further information for each scale.

3.3.3. Use of theory

The majority of studies did not specify whether a theoretical framework informed the study objectives or the design, implementation or evaluation of programs or interventions. One intervention study in this review was grounded in dissonance theory and aimed to reduce eating disorder symptomology (Smith & Petrie, 2008). Of the few studies that did specify theory in their rationale, two employed and tested the Petrie and Greenleaf (2007) Sociocultural Model (Anderson et al., 2011; Anderson et al., 2012). The Sociocultural Model was created by Petrie and Greenleaf (2007) to identify potential mediators and moderators that shape an athlete's experiences of sport and non-sport specific pressures regarding weight, body, appearance and eating, and the development of disordered eating symptoms.

One study utilised two theories, the Gender Schema Theory (Bem, 1981) and the Body Conceptualisation Theory (Franzoi, 1995) to explore the relationship between gender identity and depression in female footballers (Wilinski, 2012). Prather et al. (2016) rationalised their study objectives in relation to the 'female athlete triad' to explore stress fractures and eating disorder symptoms in soccer players which allowed the researchers to show that female footballers were at more of a risk for stress fractures than previously believed. Additionally, Papathomas and Lavallee (2014) used narrative theory to analyse and understand the life experiences of an elite female athlete engaging in self-starvation.

One study used the Contextual Body Image Framework to inform their rationale (de Bruin & Oudejans, 2018); the contextual framework perceives body image as a multifaceted reactive concept (Loland, 1999). In this study they found that, for some athletes, negative body evaluations were present in both their daily life and sport whereas for other athletes, negative body evaluations were only present in the sport context. In turn, the researcher concluded that elite sport represented a "high-risk culture" that overemphasised body and weight (de Bruin & Oudejans, 2018).

3.3.4. Research purpose

The aim of each individual study is stated in Table 3.1 The studies in this scoping review primarily focused on the four following areas: (1) mental illness prevalence rates and risk factors, (2) elite women athletes competing in 'lean-physique' sports, (3) the elite sporting environment and mental illness, and (4) design of interventions or measures for women athletes and mental health.

3.3.4.1. Mental illness prevalence rates

The majority of studies in this review were quantitative focused on the presence or absence of mental illness amongst elite female athletes. The qualitative publications focused on female athletes' subjective experiences of mental illness, specifically, eating disorders and disordered eating at a personal, social, and cultural level. There was a heavy focus on the prevalence of eating disorders and disordered eating across the studies included in this review. Eighteen of the 20 quantitative studies (90%) focused on eating disorders or disordered eating whereas only two of the 20 quantitative studies (10%) explored the prevalence of depression and anxiety.

The majority of the quantitative studies also explored one of, or a combination of the following factors: physique or social physique anxiety (Hasse, 2009; Hausenblas & Mack, 1999), pathogenic weight behaviours (Greenleaf et al., 2009; Torres-McGehee et al., 2011), body image (Anderson et al., 2012; Hulley & Hill, 2001; Torres-McGehee et al., 2011), body (dis)satisfaction (Anderson et al., 2011; Anderson et al., 2012; Brannan et al., 2009; Kong & Harris, 2015; Smith & Petrie, 2008), thin-internalisation (Smith & Petrie, 2008), sexual harassment (Sundgot-Borgen et al., 2003), academic status (Torres-McGehee et al., 2011), personality traits/qualities (e.g., perfectionism) (Brannan et al., 2009), psychosocial skills (e.g., emotional regulation) (Shriver, et al., 2016), stress fractures and menstrual dysfunction (Prather et al., 2016), societal ideals (Anderson et al., 2011; Anderson et al., 2012; Kong & Harris, 2015), and gender identity (Wilinski, 2012).

3.3.4.2. Elite women athletes competing in 'lean-physique' sports

Eleven studies (45.8%) specifically explored eating disorders in elite women athletes competing in 'at-risk' sports such as those that are 'appearance-based' or where require 'lean-physique' is perceived as advantageous for athletic performance (e.g., gymnastics and running)

(Anderson et al., 2011; Anderson et al., 2012; de Bruin & Oudejans, 2018; Hulley & Hill, 2001; Kroshus et al., 2014a; Kroshus et al., 2014b; Klinkowski et al., 2008; Kong & Harris, 2015; Shriver et al., 2016; Torres-McGehee et al., 2011; Torstveit et al., 2008). Three of the 12 studies (25%) explored and compared the presence of eating disorder symptomology in athletes who compete in 'leanness' and 'non-leanness' sports (Kong & Harris, 2015; Shriver et al., 2016; Torstveit et al., 2008). A further study explored the prevalence of eating disorders symptoms in elite female athletes competing in individual sports versus team sports (Hasse, 2009).

3.3.4.3. The elite sporting environment and mental illness

Three studies focused on comparing the prevalence rates of mental ill-health symptoms between elite women athletes and various other populations (e.g., recreational athletes or the general female population) to gain insight into the elite sporting environment and culture (Hausenblas & Mack, 1999; Kong & Harris, 2015; Sundgot-Borgen et al., 2003). For example, Kong and Harris (2015) investigated body image perceptions of women in sporting and non-sporting contexts to explore how the sporting environment might positively or negatively influence body image and mental health. In relation to this, three studies explored the influence of the elite sport environment in shaping eating disorder experiences through personal accounts (de Bruin & Oudejans, 2018; Papathomas & Lavallee, 2014; Stirling & Kerr, 2012).

3.3.4.4. Intervention, theory, measures, and methods

One study extended the work of Stice et al. (2000) and tested their three-session cognitive dissonance program among elite women athletes to reduce the risk of disordered eating (Smith & Petrie, 2008). Another study aimed to test and further develop the appropriateness of the Sociocultural Model of Disordered Eating by Petrie and Greenleaf (2007) (Anderson et al., 2011). A further study developed, proposed, and evaluated the reliability and validity of an athletics-oriented measure of psychological predictors of (Hinton

& Kubas, 2005). Two studies aimed to highlight the importance of using qualitative methods to gain insight into elite women athletes' subjective experiences of mental health challenges in elite sport (de Bruin & Oudejans, 2018; Papathomas & Lavallee, 2014). For example, Papathomas and Lavallee (2014) used life history interviews to attain an in-depth understanding of how the 'performance narrative' shaped a woman athlete's personal experiences of a clinical eating disorder.

3.4. Discussion

This review provides an overview of research aims, methods, and theories used in studies focused exclusively focused on elite women athletes and mental health or mental illness. In this section the study characteristics, research purpose(s), study design, methods, measurements, and use of theory are critically discussed. Recommendations for future research are offered throughout the following sections where appropriate. To guide this discussion and to further interpret the aims, approaches, and findings of the included studies, a gender lens was used to highlight specific gender-related issues.

3.4.1. Study characteristics

3.4.1.1. Variety of sports

The majority of the studies in this review included a variety of sports (e.g., swimming, gymnastics, and running) as opposed to one sport-type (e.g., football) (Table 3.3). For example, 65% of the studies included in this review involved more than two sports in their sample, yet rarely did the authors present or provide findings in relation to each individual sport. Depending on the aim of the study, the breadth of sports explored in a number of the studies can be seen as a strength or a methodological weakness due to the limited sport-specific insight provided. It is increasingly understood that each sport contains its own unique risk factors that can negatively impact mental health (Castaldelli-Maia et al., 2019); however, the vast majority

of the studies in this review overlooked sport-specific risk factors both in their rationale (introduction) and research focus. Since mental health interventions and awareness/education programs should be tailored to sport-specific demands (Breslin et al., 2017), future research is needed to explore the risk factors related to each individual sport. One positive example in this review was in the study by Anderson et al. (2012) who focused specifically on women gymnasts and found that sport-specific uniforms heighten their susceptibility for body image concerns. Beyond this, the included studies did not provide insight into risk factors specific to any one sport.

3.4.1.2. Competition level

The study samples varied in competition level due to inconsistencies in the definition of 'elite' athletes. For example, Prather et al. (2016) identified both professional women athletes and NCAA D1 women student athletes as 'elite participants.' Findings suggested that NCAA D1 women soccer players were at a significantly higher risk for an eating disorder (17.4%) when compared with professional players in the US (6.1%), however, no further insight was provided as to why there is a significant statistical difference between these two sub-categories of elite athletes. This example demonstrates the need for more targeted research to better understand an individual's experiences of mental health and mental illness across various competition levels and the elite athlete spectrum.

The definitional inconsistencies of 'elite athlete' made comparison between findings difficult. If researchers could refer to a universal definition of 'elite', that accurately covers all gender and sport types across the world, comparing findings would be made easier. This is supported by Swann et al. (2015), however, significant economical, societal, sociocultural, and environmental differences in sport across different continents present barrier to adopting such a universal definition. Thus, it is important that future researchers provide a clear rationale and

description of the competition level of their research subjects in the context of their studied sport(s) to allow for findings to be more easily compared and understood for the reader. This importance is further critical in research concerning elite women athletes as the spectrum of what 'elite' means is further varied due to fragmented development in 'elite' women's sport around the world (Culvin & Bowes, 2023; Schell & Rodriguez, 2000).

3.4.1.3. Country

The largest proportion of studies were conducted in the US (45.8%), which provided insight into elite women athletes in the US and particularly those competing at the NCAA D1 level. However, more research is needed to explore this area amongst elite women athletes in countries and cultures outside of the US. As noted by Castaldelli-Maia et al. (2019), elite women athletes living and competing in 'non-western societies' might face different risk factors, for example less acceptance of women's sport and more discrimination. Further, they might have different experiences of what impacts mental health. For example, Tshube et al. (2021, p. 36) shared an example of an athlete in Sub-Saharan Africa who believed their mental health distress stemmed from a teammate 'bewitching' them.

Differences in levels of professionalisation between countries will also likely result in athletes having vastly different experiences of mental health (Castaldelli-Maia et al., 2019). For instance, women competing in countries and sports with lower levels of professionalisation are more likely to experience financial strain and encounter poorer injury management, which may in turn negatively impact their mental health and increase risk of severe mental health challenges or mental illness (Castaldelli-Maia et al., 2019; Moesch et al., 2012). Even in countries where elite women athletes seem relatively well-supported (e.g., in the US), elite women athletes still receive substantially poorer quality training resources, lower pay, less mainstream mass media attention, and fewer sponsorship opportunities in comparison to elite

male athletes (Allison, 2020). For example, in the US, 5–8% of sport media coverage is focused on women's sports even though women account for 40% of sports participation (Hardin & Greer, 2009). The lack of media attention and subsequent sponsorship deals only furthers the financial strain and disparity in pay that often accompanies being a professional woman athlete. This often forces these athletes to engage in some form of alternative paid employment in addition to their elite sporting career and training (Allison, 2020; Culvin, 2019). These resource related factors may negatively impact mental health and warrant consideration for future research (Castaldelli-Maia et al., 2019; Culvin, 2019). Taken together, it is important for future research to explore the mental health experiences of athletes in a range of cultural contexts to develop a more nuanced understanding and deliver culturally informed mental health support services.

3.4.2. Research purpose(s)

3.4.2.1. A narrow focus on eating disorders

Twenty studies (83.3%) utilising quantitative methods explored the presence or absence of mental illness. More specifically, of the twenty quantitative studies 18 studies (90%) focused on gathering eating disorder or disordered eating prevalence rates. In the qualitative studies, the focus was centred upon better understanding how contextual and cultural influences shape elite female athletes' experiences of eating disorders or disordered eating. The narrow focus on eating disorders is surprising considering researchers have evidenced women athletes are at a heightened risk compared to men for numerous 'types' of mental illness, not only eating disorders (Kuettel & Larsen, 2020; Rice et al., 2016). Future research could look to expand focus outside of eating disorders and look to include measures of other types of mental illness – such as depression and anxiety.

3.4.2.2. Limited risk factors explored

In relation to the studies exploring eating disorder symptoms or disordered eating, the most commonly explored risk factor was 'sport-type.' More specifically, 12 studies (50%) focused on elite women athletes competing in 'aesthetic/appearance-based' or 'lean-physique' sports (e.g., dance, figure skating, long-distance running). This sub-population of elite women athletes is considered vulnerable for eating disorders and disordered eating given the pressures they face around body, weight, eating, and performance from coaches, teammates, judges, and the media (Anderson et al., 2011; Anderson et al., 2012; Kong & Harris, 2015). Additionally, researchers in the included studies claimed 'lean-physique' athletes are at a far greater risk for eating disorders than elite women athletes who compete in power-based sports where the focus tends to be on more masculine qualities such as strength and muscularity (e.g., football, field hockey, rugby). However, only one study showed 'lean-physique' athletes to be at an increased risk for eating disorders or disordered eating when compared with elite female athletes who compete in power-based sports (Kong & Harris, 2015).

Despite the claim that lean-physique athletes are more likely to encounter eating disorders or disordered eating, only one study showed lean-physique athletes are at an increased risk for eating disorders compared with those who compete in power-based sports (Kong & Harris, 2015). Assumptions that elite women athletes competing in power-based sports are less objectified or impacted by ideals of emphasised femininity are misguided and hinder understandings of women competing in other sports (Connell & Messerschmidt, 2005). In support of this, two studies in this review found that women who compete in non-traditionally gendered sports (power-based and/or contact sports) will face unique challenges in relation to their body image and gender identity (de Bruin & Oudejans, 2018; Shriver et al., 2016).

Individuals who compete in power-based sports are likely required to develop muscular bodies in pursuit of sporting success which may result in a body-type that clashes with societal determinations of the 'feminine ideal.' In turn, researchers have suggested these women may face related insecurities which can potentially influence the onset of eating disorders (de Bruin & Oudejans, 2018; Krane, 2001). One recent example is that elite women footballers in England have reported feeling that their bodies are under constant scrutiny as they are frequently tasked with the responsibility of promoting and conforming to a brand image that emphasises femininity (Culvin, 2019). Thus, researchers should expand their samples to explore elite women athletes in power-based sports and strength-based sports as challenges with body image, food, and weight are not exclusive to athletes in lean-physique sports.

In addition to exploring lean-physique sports as a risk factor, several studies explored personality characteristics and social physique anxiety (SPA) as risk factors for eating disorders or disordered eating (Brannan et al., 2009; Haase, 2009; Hausenblas & Mack, 1999; Klinkowski et al., 2008). Researchers have found that certain personality characteristics (e.g., perfectionism) might lead to an obsessive focus on improving personal eating habits which in turn might result in the onset of an eating disorder or disordered eating (Klinkowski, et al., 2008). However, studies which focus on personality traits and their association with eating disorders or disordered eating often neglect other probable influences such as social, cultural, and environmental factors which are likely to contribute to an athlete's experiences of eating distress. Without any attention placed on sociocultural or contextual factors, this can unhelpfully pathologise or place blame on the individual athlete (Busanich et al., 2014; Papathomas & Lavallee, 2012).

As demonstrated in this review, the literature concerning eating disorders and disordered eating and elite women athletes is almost entirely made up of prevalence studies

and focused on person-specific risk factors and those in lean-physique sports which is extremely limiting (Papathomas & Lavallee, 2012). Research exploring eating disorders could add to the literature by exploring populations in power-based sports (e.g., football) or by exploring athletes lived experiences to obtain a deeper insight into how they make sense of their eating distress (Papathomas & Lavallee, 2012).

Additionally, future studies should look to explore eating disorders or disordered eating as well as other mental health challenges with elite women athletes in relation to a variety of psychosocial risk factors and transition periods (e.g., injury, financial strain, de-selection) and utilise different methodological approaches to gather insight into elite women athletes' personal experiences. Further research should also consider race or sexuality in relation to mental health experiences. For example, individuals in the general population identifying as lesbian or bisexual can experience higher rates of poor mental health and mental illness, however such research has rarely been considered with elite women athletes (Herek & Garnets, 2007; Meyer, 2003). Such limited attention on this area is somewhat surprising given the high rates of 'out' women who compete in elite sport.

3.4.3. Study design, methods & measurements

3.4.3.1. Study design

Twenty-three studies (95.8%) used a cross-sectional research design and twenty studies (83.3%) used self-report data collection. A cross-sectional research design is valuable for gathering insights into athletes' mental health at one moment in time. Several studies have suggested a longitudinal research design would be advantageous for future research as it would allow for a deeper understanding of existing patterns and insight into sociocultural and contextual factors that influence elite women athletes' experience with mental health and mental illness (Anderson et al., 2011; Brannan et al., 2009; Haase, 2009; Torstveit et al., 2008).

Notably, only one study used a longitudinal research design (Anderson et al., 2012). Anderson et al. (2012) assessed the stability and influence of sport pressures, body satisfaction, and dietary restraint over a 5-month season, finding that athletes' body satisfaction stayed stable over the entire season.

3.4.3.2. Methods

Twenty studies (83.3%) utilised quantitative methods and just four studies (16.6%) utilised qualitative methods. The studies that employed qualitative methods allowed for insight into the sociocultural and environmental factors of the sporting environment that impacted the elite women athletes' experience of mental health or mental illness (e.g., de Bruin & Oudejans, 2018, Papathomas & Lavallee, 2014). For example, participants in the qualitative study conducted by de Bruin and Oudejans (2018) believed the sporting environment was a 'high risk' culture and it influenced their susceptibility to poor mental health. Peer influence was noted as a factor influencing many athletes' experiences of body dissatisfaction and disordered eating behaviours (de Bruin & Oudejans, 2018). These insights illuminated the importance of conducting future research that aims to better understand the role of teammates and stakeholders in shaping athletes' experiences of mental health and mental illness. Such understandings can enable applied practitioners to create mental health programs and interventions that target influential others (e.g., teammates and coaches).

Depending on the research aim, researchers should consider exploring highly personal topics such as mental health and eating disorders through qualitative methods such as unstructured interviews, or a combination of both quantitative and qualitative (Papathomas & Lavallee, 2014). Qualitative methods—such as interviews—can provide athletes with the opportunity to talk freely about their unique and deeply personal mental health experiences which can provide insight not possible through Likert scale type questions (Eklund et al., 2011;

Papathomas & Lavelle, 2012). Importantly, quantitative methods and qualitative methods can work together. As noted by Pereira Vargas et al. (2021), the medical and quantitative approach and interpretive and qualitative approach can work together to increase knowledge and provide insight to better support athletes' mental health.

In addition to using both methods, taking a more pragmatic philosophical approach to research would be extremely useful at this juncture due the lack of knowledge in certain populations and the need for more 'real-world' practically focused research in this area (Kuettel & Larsen, 2020; Lundqvist & Andersson, 2021; Pereira Vargas et al., 2021; Prior et al., 2022). Pragmatism, both as a philosophical tool and paradigm, can provide the needed methodological flexibility to advance research in this area while placing elite women athletes' voice at the centre of the research area (Prior et al., 2022).

3.4.3.3. Measurements and screening tools

There is general uncertainty around the most appropriate measures to use when exploring mental health and mental illness within the elite women athlete population. We found thirty-four validated measures employed in this review alone (Table 3.4). Researchers often used different measures to identify the prevalence of the same disorders. For example, eight different measures were used to explore eating disorder or disordered eating prevalence. The use of different measures to study the same phenomenon can make accurate comparisons across different research studies difficult (Poucher et al., 2021). The most commonly used measure was EAT-26 (Garner, 1982) which was used in five studies. Overall, the large variety of screening tools found in this review and the lack of consistent measures highlights the difficulties in choosing appropriate mental health screening instruments to use with elite women athletes (Pope et al., 2015). Due to the unique psychological, social, and biological demands placed on athletes, it may be more appropriate to utilise questionnaires that are

tailored towards athletes and validated for different competition levels (e.g. grassroots, recreational, sub-elite, elite) or age groups (e.g., high school age) (Knapp et al., 2014).

For example, the Weight Pressures in Sport Questionnaire (WPS-F)—a validated athlete-specific questionnaire—was used in three of the studies in this review. The use of the WPS-F allowed for links between quantitative and the qualitative findings to be drawn, whereas the other screening tools did not allow for the same level of insight. For example, Reel et al. (2010) used the WPS-F and indicated elite women athletes experienced significant pressures surrounding weight from teammates (36.8%), uniforms (34.3%), and coaches (33.8%). These findings are similar to the qualitative findings in the study by de Bruin and Oudejans (2018) where participants indicated that weight-pressures were most heavily influenced by their coach, teammates, and other sport-specific environmental factors (e.g., sports attire). Notably, several studies in this review highlighted that coaches have a significant impact on athletes' experiences with food, weight, and body image. For example, Kroshus et al. (2014a, b) revealed how coaches verbally communicate about food impacts how team members communicate about the same topics amongst one another. Further, it found that the way topics surrounding, food, weight, body image, and eating behaviours are communicated within a team can contribute to the onset of eating disorders or disordered eating. Given the impact coaches have on athletes' experiences with eating disorder and disordered eating, there is a need for future research to design and evaluate mental health education programs for coaches and teammates.

Measurements suggested by the International Olympic Committee (IOC) in their Sport Mental Health Assessment Tool 1 (SMHAT-1) and Sport Mental Health Recognition Tool 1 (SMHRT-1) (Gouttebarge et al., 2021) could be considered in future research. Several of the measurements provided in these tools are specifically designed for the athlete population, for

example, the Brief Eating Disorder in Athletes Questionnaire (BEDA-Q; Martinsen et al., 2014). This has the potential to elicit valuable insight that could not be discovered in questionnaires designed for the general population. Another questionnaire that might be considered in future research is the Athlete Psychological Strain Questionnaire (APSQ) designed by Rice et al. (2020) to measure psychological stress amongst elite athletes. This has been validated amongst 1093 elite athletes, however just 84 were female (Rice et al., 2020).

3.4.5. Theory

Theory was charted where authors used it to rationalise and inform study objectives, and in designing, implementing, and evaluating programs or interventions. Studies in this review rarely mentioned theory in their rationale, which aligns with similar reviews in meant health and elite sport which have highlighted that much of the research in sport is atheoretical (Sabiston et al., 2019). Theory was used primarily for informing mental health interventions compared to prevalence studies. The intervention by Smith and Petrie (2008) showed that cognitive-based interventions may be useful in reducing disordered eating symptomology, however, such interventions would need to be redesigned to address important issues and factors that are unique to women athletes and the elite sport environment.

3.4.6. Future directions

Expanding on the recommendations made in the aforementioned sub-sections, there are several considerations for future research concerning mental health in elite women athletes. These considerations emerged as a direct consequence of the results in this scoping review and focus primarily on research aims which warrant further exploration. Firstly, mental health research concerning elite women athletes in power-based sports is needed given the majority of research has focused on lean-physique athletes and given the potential differences in mental experiences. Additionally, research exploring athletes outside of the NCAA D1 level is

warranted as there are different stressors which are likely to impact on women athletes' mental health at different levels and in different countries. Methodologically, there is a need for research to expand beyond just quantitative research, meaning a combination of quantitative and qualitative research could allow for both numeric interpretations as well as insight into athletes lived experiences through qualitative research.

3.4.7. Limitations

The following limitations are appropriate given the objectives of this scoping review. Firstly, the broad nature of the research question resulted in a wide scope of studies incorporating elite women athletes to be included. Secondly, although all participants fell within the blanket term 'elite', their level of competition varied due to definitional inconsistences. There are different risk factors across the spectrum of 'elite' competitors which can negatively impact mental health. Thirdly, this review did not include studies that involved men and women in their sample due to the exclusive focus on elite women athletes for this review. Inclusion of studies with both men and women may have allowed for a more rounded view and for insight possibly missed by not including such studies. This decision was made however to not include such studies as research that includes men and women respondents tend not to draw out the specificities of women's experiences and women-specific data can get subsumed under men's which further limits the already scarce insight that is available. Further, because sport tends to be organised separately, along binary lines (male or female), where men's sport is privileged, women athletes will likely have specific issues and difficulties that may differ from those of men athletes. Thus, the focus solely on women athletes enabled the opportunity to provide a more gender sensitive analysis. Finally, while not a limitation per se, it is important to note that the quality of study design was not assessed in this review as that is not the purpose of a scoping review.

3.5. Conclusion

This scoping review mapped out the currently available research concerning mental health and elite women athletes. The main findings from this scoping review highlight the need for greater methodological diversity to advance our conceptual and theoretical understanding of elite women athletes' experiences of mental health and mental illness. The restricted sample population of US collegiate athletes, overreliance on quantitative methods, and heavy focus on eating disorder prevalence demonstrates an ongoing need for researchers to expand their study samples, methods, and aims. More specifically, this scoping review highlights the narrow focus on aesthetics, body satisfaction, and personal-risk factors used in determining the nature of the research questions explored in elite women athlete populations.

For future quantitative research, this review demonstrated the need for researchers to focus on one specific elite women athlete population and include potential risk factors that the population studied might face within their sporting context—instead of just personality characteristics. Further, it is important that measures beyond just eating disorder questionnaires are included. Additionally, this review highlighted the need for qualitative research. The almost exclusive use of quantitative methods and eating disorder and disordered eating screening tools identified in this review has reduced insight into the complexities of mental health struggles in elite women athletes. In turn, there is a significant gap in the research in terms of understanding the broader mental health changes women face in the game, outside of diagnosed mental illnesses. Understanding challenges elite women athletes encounter—which impact on their mental health—is critical to ensuring they receive appropriate support.

Tending to these gaps, the following studies in this thesis have been designed. For example, the next study in this thesis (Study Two), uses quantitative methods and was designed and informed by this review—i.e., it focuses on one specific elite athlete population, includes

questionnaires for help-seeking intentions, depression, anxiety, and eating disorders symptoms, and involves questions surrounding risk factors beyond just personality characteristics. Then, two qualitative studies are conducted to (a) better understand players' lived experiences with challenges to their mental health within the context of their sporting environment and (b) understand player and staff experiences of barriers to the footballers' face to seeking mental health support from their club.

Chapter Four

Mental Ill-Health, Help-Seeking Intentions, and Elite Women Footballers in England

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4.0. Abstract

Mental health research in sport is almost entirely focused on men. However, research suggests that women athletes—particularly those at the elite level—are at higher risk of mental ill-health when compared to men athletes. Given the recent growth of women's football in England and lack of research surrounding mental health in this population, this study sought to explore the prevalence of, and factors associated with, depression, anxiety, and eating disorder symptoms in women competing in the top two tiers of English football. An anonymous online questionnaire pack, which measured personal and player characteristics and included the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder scale (GAD-7), Brief Eating Disorder Questionnaire (BEDA-Q), and General Help-Seeking Questionnaire (GHSQ), was completed between November 2020 and March 2021 by elite women footballers competing in the Women's Super League (WSL) and Women's Championship (WC). A total of 115 players completed the questionnaire (WSL = 63; WC = 52). Thirty-six percent displayed eating disorder symptoms (BEDAQ), 11% displayed moderate to severe anxiety symptoms (GAD-7), and 11% displayed moderate to severe depression symptoms (PHQ-9). Significant associations emerged between starting status, want for psychological support, student-athlete status, help-seeking intentions score, and mental ill-health symptoms. In summary, elite women footballers in England reported significant mental health symptoms, particularly eating disorder symptoms. Further research should explore the experiences of mental ill-health in this population, focusing on the factors that were important in this study.

4.1. Introduction

The increased focus on elite athletes and mental health over the past ten years has provided researchers and practitioners with novel insight into this unique population. It is now well-established that elite athletes experience mental ill-health at similar rates to the general population (e.g., 5–35% annually) (Gorczynski et al., 2017; Gouttebarge et al., 2019). Yet, unlike the general population, athletes encounter a variety of personal (e.g., living away from home, financial instability), competitive (e.g., intense performance demands, rigorous training schedules, contract renewal, social media abuse, injury, and de-selection), and organisational (e.g., coach conflict) (Kuettel & Larsen, 2020; Sarkar & Fletcher, 2014) stressors, as well as stigma surrounding help-seeking behaviours for mental health (Gulliver et al., 2012; Kola-Palmer et al., 2020).

Researchers and applied practitioners have called for further investigation into mental health and elite sport and have provided numerous recommendations for future studies (see Castaldelli-Maia et al., 2019; Kuettel et al., 2020; Vella et al., 2021; Walton et al., 2021). One recommendation that has emerged across recent reviews is for more research into mental health and elite women athletes (Gouttebarge et al., 2019; Kuettel & Larsen, 2020; Poucher et al., 2021; Tahtinen et al., 2021). To date, mental health research concerning elite athletes has focused mostly on elite male athletes (Gorczynski et al., 2017; Gouttebarge et al., 2019; Kuettel et al., 2020). Of the limited research available that does involve women athletes, findings have indicated that women experience higher rates of mental ill-health compared to elite male athletes (Gorczynski et al., 2017; Gouttebarge et al., 2019) and likely encounter gender specific stressors which can negatively impact mental health—i.e., sexualisation and limited resources (Castaldelli-Maia et al., 2019; Pascoe et al., 2022; Walton et al., 2021).

To date, most research concerning elite women athletes has focused on collegiate-level student-athletes in the US who compete in individual sports and lean-physique sports (e.g., running) (see Study One; Golding et al., 2020). As a result of past research focuses, there is currently limited insight into the mental health experiences of women athletes who compete at the elite level and in team and/or power-based sports (e.g., football) where the stressors and pressures may be very different (e.g., contractual issues, teammate conflict) than women competing in individual sports. Additionally, limited insight into elite women athletes' experiences with mental health competing outside of the US is currently available (see Study One; Tahtinen et al., 2021). Recently researchers have called for a focus on elite women athlete populations competing in countries outside of the USA as they may encounter different barriers, stressors, and support depending on the sociocultural context in which they exist in (Castaldelli-Maia et al., 2019; Tahtinen et al., 2021).

For example, researchers have suggested that women athletes who compete in certain countries or sports with lower levels of professionalisation are likely to experience financial strain and encounter poorer injury management which could heighten their risk for mental ill-health (Castaldelli-Maia et al., 2019; Moesch et al., 2012). In direct contrast, researchers in women's football have found that higher levels of professionalisation can also negatively impact professional women athletes' mental health if expectations placed upon footballers are not balanced with appropriate financial, mental, and physical support (Allison, 2020; Culvin, 2019).

More specifically, Culvin (2019) found that the rapid professionalisation of women's football in England over the last decade (e.g., first fully professional women's division, full-time contracts) has resulted in players experiencing inconsistent workplaces, financial instability, a lack of support, and limited post-career playing options which has negatively

influenced mental health. Further, women footballers in England reported feeling that their bodies were under constant scrutiny as they are constantly tasked with the responsibility of promoting and conforming to a brand image that emphasises femininity which they reported to impact their body image and eating behaviours.

To date, only two studies have exclusively focused on mental health and elite women footballers. One study by Junge and Prinz (2019) explored depression and anxiety symptoms in professional women footballers in Germany, as well as the potential influence of personal and sporting risk factors (e.g., injury, frequency of starting for their team, competition level) on mental ill-health symptoms. They found that several factors increased the risk for depression and anxiety symptoms, including playing in the second professional division instead of the first division, rarely or never starting for their team, and reporting a need for psychotherapeutic support. In the only other study specifically focused on elite women footballers, Prather et al. (2016) explored eating disorder symptoms in footballers the USA and found that no professional footballers met the cut-off for an eating disorder. Only one study has explored mental ill-health in women footballers in England (Abbott et al., 2021), however this was not at the professional level. Abbott et al. (2021) focused on male and female footballers in the UK (tier 4 and above) and found that 13% of female footballers displayed eating disorder symptoms when using the EAT-26. Their study only measured eating disorder symptoms.

The aim of this particular study is to (1) attain the prevalence of anxiety, depression, and eating disorder symptoms of elite women footballers using validated questionnaires and cut-off points as recommended by the International Olympic Committee (Gouttebarge et al., 2021) and (2) examine potential associations between possible risk factors for mental ill-health and symptoms of depression, anxiety, and eating disorders.

4.2. Methodology

4.2.1. Study design and participants

Inclusion criteria was any contracted footballer in the top two tiers of women's football in England, the WSL or WC, during the 2020/2021 football season. During this season, there were 12 teams in the WSL and 11 teams in the WC, with a range of 19 to 24 players per team. In total, there were approximately 500 footballers registered in the WSL (n=264) or WC (n=240) during 2020/2021 season. The number of players across both leagues was approximated using squad lists from each club's official website.

4.2.2. Procedure

Following institutional ethical approval, data was collected between November 2020 and March 2021 via Qualtrics (Version 28, Qualtrics, Provo, US). I emailed all 23 clubs that made up the WSL (n=12 clubs) and WC (n=11 clubs) in 2020/2021 regarding the study by using the email address(es) provided on the club websites (see Appendix D for introductory email). Where possible, the email was sent directly to the first team via general managers, welfare officers, sport psychologists, and other support staff members asking them to act as mediators for accessing potential participants. It was emphasised in the email to clubs that their role was merely to distribute to the link to the players, not force players to take part. Not all club websites provided individual staff member's email addresses online therefore the general email address(es) provided online were used. The introductory email contained the following: (1) a welcome letter introducing the study, (2) an information sheet, and (3) a link to the questionnaire for the players (see Appendix D). Every club in the WSL and WC was sent an email and offered the opportunity to participate, however there is no guarantee that every club distributed the link to the players as was requested in the email sent to them.

Additionally, the social media platform 'Twitter' (now 'X') was used to recruit participants and snowball sampling was used to generate further study interest (Leighton et al., 2021) (Appendix E recruitment advert). Research concerning elite athletes is notoriously challenging due to limited access to this population and time constraints of elite athletes, thus research into the elite athlete population is often not possible without personal connections (Culvin, 2019; Ogden et al., 2022). Therefore, it is important to note that many of my personal connections from my football background competed in the WSL and WC shared the study link with their teammates (see researcher background in Chapter Two section 2.2). It is very likely that this led to greater survey distribution and likely higher participation.

4.2.3. Pilot study

Due to mental health research in this high-profile population being underresearched, or uncharted territory, a pilot study was conducted, and feedback was attained at the end of the survey. The pilot study included 50 players from tier 3 (Women's National League) and tier 4 (Women's National League Division 1) of women's football in England. This population was selected due to my own personal connections in tier 3 and 4, and this population being much more accessible at the time of recruitment due to both leagues being less professionalised. Additionally, there are more teams competing in tier 3 and 4, meaning, there are more players to take part than in the top two tiers. The pilot study footballers ranged from 18 to 36 years old and included players from 10 – this allowed feedback to be gathered from a demographically diverse sample. The primary objectives of the pilot study were to (1) attain insight and feedback on the average time of completion and check mobile accessibility, (2) gather feedback surrounding the ease of the survey in terms of understanding and answering questions, and (3) ensure the players would not be identifiable from the questions asked in the survey. Data from the pilot study was only used to answer these objectives, and not for empirical findings anywhere in this study or thesis. See Appendix F for feedback from the pilot study.

Feedback was provided from players regarding the questionnaire and changes were made where possible. Players suggested the length of the questionnaire was good as it usually only took 5 to 15 minutes to complete. Understanding the time restraints reported by professional athletes, it was important that the questionnaire was not redundant or too time consuming (Culvin, 2019; Tonge, 2021). Mental health is highly personal and is often considered a sensitive topic particularly among elite athlete populations—specifically, elite footballers (Roderick & Gibbons, 2010)—thus it was particularly important to engage with the feedback surrounding the language used in the questions asked. Several players provided comments on some of the wording which was helpful in the final design of the survey. For example, one of the questions asked in the survey was "what are the most important factors responsible for any performance lows during your professional football career? Please tick a maximum of 4 answers." Two players suggested that instead of the response option reading 'lack of inner drive' it should say 'lack of motivation.' Finally, the pilot study indicated that players could be identifiable if they said which club they played for, thus this question was removed. Instead, the question "which league do you currently compete in (WSL or WC)?" was added to the final version.

4.2.4. Measurements

The first part of the survey incorporated questions surrounding personal and player characteristics, important factors responsible for any performance lows, coping mechanisms, and access to psychological support adopted from Junge and Prinz (2019) (Appendix G Qualtrics survey).

The second part of the survey included three validated questionnaires to explore mental ill-health symptoms (depression, anxiety, and eating disorders) as well as a help-seeking intentions questionnaire. Importantly, I emphasise that the questionnaires in this study are used

to provide a snapshot of mental ill-health symptoms amongst the population not to diagnose disorders.

First, the Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001) was used to assess the prevalence of depressive symptoms during the two weeks prior to questionnaire completion. This nine-item self-report questionnaire is based on an established criterion (DSM-5) and uses a 4-point Likert scale ranging from '0' (not at all) to '3' (nearly every day) (Kroenke et al., 2001). The PHQ-9 has been used in elite athlete populations (e.g., Gouttebarge et al., 2021) and has a sensitivity of 88% and a specificity of 88% for detecting major depression (Kroenke et al., 2001).

The General Anxiety Disorder-7 (GAD-7) (Spitzer et al., 2006) assessed the prevalence of anxiety symptoms in the preceding two weeks. This seven-item questionnaire is also underpinned by the DSM-5′s established criteria and uses a four-point Likert scale from '0' (not at all) to '3' (nearly every day). The GAD-7 has a sensitivity of 89% and a specificity of 82% for detecting anxiety disorder symptoms (Spitzer et al., 2006). The GAD-7 has been used in numerous studies involving elite athletes as well as a study specifically focused on mental health and professional footballers (Junge & Feddermann-Demont, 2016).

The Brief Eating Disorder in Athletes Questionnaire (BEDA-Q) (Martinsen et al., 2014) was used to measure the prevalence of eating disorder symptoms over the previous four weeks. This nine-item self-report questionnaire was designed for female athletes and has a sensitivity of 82.1% and specificity of 84.6% (Martinsen et al., 2014). Questions 1–6 use a six-point scale: from '1' (always) to '7' (never). Question seven asks 'are you currently trying to lose weight?' with the option of 'yes'/'no', Question eight asks 'have you tried lose weight over the last four weeks?' with the option of 'yes'/'no.' Question nine asks if 'yes to Question 8, how many times have you tried to lose weight (over the last 4 weeks)?' with the options of

‘1 − 2 times’/ ‘3–5 times’/‘over 5 times.’ This questionnaire was recently used with elite female footballers in Australia (Kilic et al., 2021).

The General Help-Seeking Questionnaire (GHSQ) (Wilson et al., 2005) was included to assess individual’s intention to seek help from different sources for two problem types: (1) personal or emotional problems and (2) suicidal thoughts. The two questions on the questionnaire include: (1) ‘If you were having a personal or emotional problem, how likely is it that you would seek help from the following people . . .?’ and (2) ‘If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people . . .?’ Following each question, the participant rated several potential sources of informal help (e.g., ‘friend’) and formal help (e.g., ‘Doctor/GP’). Each source of help was rated on a seven-point Likert-type scale ranging from one (extremely unlikely) to seven (extremely likely). Similar to the other questionnaires included in this study, the GHSQ has been used in research concerning elite athletes (see Confectioner et al., 2021).

4.2.5. Data analysis

Data were processed using Excel and SPSS v25 (IBM, Chicago, USA), with significance set a at $p< 0.05$. Firstly, prevalence rates of mental health symptoms were explored using recognised thresholds. For depression symptoms (PHQ-9) a global score of >9 was used to indicate moderate depression symptoms and >14 severe symptoms (Kroenke et al., 2001). For anxiety symptoms (GAD-7) a global score of >9 reflected moderate anxiety symptoms and >14 severe symptoms (Spitzer et al., 2006).

For eating disorder symptoms (BEDA-Q), we followed the recommendations and instructions provided by the International Olympic Committee Sport Mental Health Assessment Tool 1 (SMHAT-1) and calculated the total score by summing up the answers on the first six items, thus responses to question seven and eight are not included in the equation.

A cut-off score of ≥4 was used to detect 'above threshold' eating disorder symptoms, which is the exact criteria proposed by IOC (Gouttebarge et al., 2021) and has been used by previous research (Kilic et al., 2021). It is important to note that the BEDA-Q has no established cut-off criteria (Martinsen et al., 2014), and therefore the IOC proposed a cut-off score of ≥4 based on the data presented in their recent study (see Gouttebarge et al., 2021). Importantly, using the cut-off score of ≥4, they found only a small proportion of cases were misclassified for the BEDA-Q (11%) and internal consistency was acceptable for the BEDA-Q (men: Cronbach's α = 0.59; women: Cronbach's α = 0.66) (Gouttebarge et al., 2021).

Secondly, linear regressions with categorical dummy variable (0,1) predictors were used to examine the association between mental ill-health symptoms (e.g., depression, anxiety, and eating disorder) and factors such as playing level, born in the UK (anything more specific would make the players identifiable), age, injury status, match-starting status, current self-reported need for psychological support, full-time status, paid-contract status, and help-seeking intentions scores. The factors were selected based on known links to mental ill-health symptoms in similar populations (Junge & Feddermann-Demont, 2016; Junge & Prinz, 2019; Kilic et al., 2021; Kuettel & Larsen, 2020). Unstandardized betas (reflecting effect size) are presented alongside 95% confidence intervals.

Finally, linear regressions examined the relationship between continuous factors: (1) age and (2) help-seeking intention scores, in relation to depression, anxiety, and eating disorder scores. Again, unstandardized betas are presented. The regression models above were statistically adjusted for a priori covariates, selected based on existing literature: age, level of competition, injury, need for psychological support and starting status (Gulliver et al., 2015; Junge & Feddermann-Demont 2016; Junge & Prinz 2019). When variables were the main predictor of interest, they were not included as a covariate in the same model. Finally, if

participants had missing data from any of the validated questionnaires in this study, then that participant was not included in subsequent analyses focusing on that specific questionnaire. As evidenced in Table 4.1, 4.2, and 4.3 most of the questionnaires had complete data. Additionally, prior to analysis, a priori G*Power calculation suggested that a minimum sample size of 90 would be needed thus our sample of 115 surpassed this recommendation.

4.3. Results

4.3.1. Participant characteristics

Table 4.1 summarises participant characteristics. A total of 115 players completed the survey meaning this study represented approximately 23% of the elite female football population in England.

Table 4.1 Player Characteristics

Characteristic	Sample size	Responses	*n* (%)
Age (years)	99		
		<20	9 (9)
		20-25	45 (46)
		26-29	29(29)
		30-34	16 (16)
Playing league (currently)	115		
		Women's Super League	63 (55)
		Women's Championship	52 (45)
Competed at international level	113		
		No	28 (35)
		Yes, under senior level	56 (50)
		Yes, at senior level	29 (25)
Born in the UK	115		
		No	22 (19)
		Yes	93 (81)
Currently injured	112		
		No	90 (80)
		Yes	22 (20)
Some form of paid contract from club	110		

		No	21 (19)
		Yes	85 (77)
		Other	4 (4)
Student-athlete (current)	108		
		No	75 (69)
		Yes, college	3 (3)
		Yes, university (part-time)	7 (6)
		Yes, university (full-time)	17 (16)
		Other	6 (6)
Diagnosed with mental illness	110		
		No	90 (81)
		Yes	15 (14)
		Other	5 (5)
If 'yes' diagnosed with mental illness and are comfortable sharing your diagnosis Mental health diagnosis (if comfortable reporting)?	15		
		Did not disclose	4 (26)
		Depression & Anxiety	4 (26)
		Anxiety	3 (20)
		Depression	1 (4)
		ADHD	2 (20)
		Eating disorder	1 (4)
Starting Status	113		
		No games	14 (12)
		Few games	11 (10)
		Some games	21 (18)
		Most games	39 (35)
		Every game	28 (25)
Occupation	110		
		Full-time footballer	66 (60)
		Not a full-time footballer	44 (40)
If football is not your full-time occupation, why is it not?	26	Check all that apply	
		My club has not offered me a full-time contract	23
		My contract does not cover my living expenses	17
		I do not want football as my sole occupation	5
		Other, please explain	5
Availability of psychological support through their club	102		
		No	35 (34)
		Yes	51 (50)
		Unsure	14 (14)
		Other	2 (2)

Want or need for psychological support during football career	102		
		No Yes, currently I want support Yes, at different times I wanted/needed support	14 (14) 16 (16) 72 (70)
Belief you would have benefited from seeing a psychology professional at some point during your football career	101		
		No Yes	10 (9) 91 (90)
Received counselling or treatment from a psychologist (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) inside your club?	102		
		No Yes	74 (73) 28 (27)
Received counselling or treatment from a psychologist (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) outside your club?	102		
		No Yes	64 (63) 38 (37)
Have you ever engaged in any of the following coping strategies to deal with low mood or psychological challenges?		(Check all that apply)	
		Excessive exercise Excessive focus on health/eating habits Self-harm Substance abuse and misuse Gambling Overeating None Other	39 36 4 5 1 22 42 2

What are the most important factors responsible for any performance lows during your professional football career?	(Check up to four)	
	Injury	66
	Overtraining	23
	Psychological problems	57
	Fatigue	47
	Lack of confidence	85
	Overloaded by the combination of work/school, football training/matches	28
	Lack of inner drive or motivation	30
	Other	4
	Unsure	3
What are the most important factors responsible for any low moods during your elite football career?	(Check up to four)	
	Conflicts with partner	12
	Conflicts with the coach	32
	Conflicts with the club management	22
	Conflicts within the team	27
	Low performance	60
	Injury	66
	Financial problems	12
	Too little support/recognition by the coach	48
	Too little support from friends	2
	Difficulties/pressures in your relationship/family	10
	The Press, media, public pressure	9
	Leadership pressure (e.g. being captain or having multiple roles on the team)	4
	Worry about contract extension	15
	Separation/divorce, illness, or death of someone close to you	15
	Other	5
What helped you to cope with any low moods during difficult times during your professional football career?	(Check up to four)	
	My family	83
	My teammates	48
	My partner	49
	My coach or someone on the coaching staff	23
	My friends	54
	Distraction	27

	Training/physical activity	48
	Medication	5
	Professional help from a psychologist/doctor/psychotherapist	23
	A hobby	16
	Relaxation/rest/retreat	27
	My belief in God/religion	2
	Other	1

For certain questionnaires there were some missing data due to participants choosing not to answer. The mean (SD) age of the sample was 25.1 (4.5) years. Of the footballers who took part in this study, 65% had competed at the international level (at any age group) and 25% competed internationally at the senior level. Sixty percent of the footballers identified football as their full-time occupation and the remaining 40% indicated football as a part-time job. This means a significant number of footballers who compete at the international level and the elite level do so while working another job—notably, most who were working alongside football were in the WC. Additionally, approximately 20% of the footballers who took part in this survey indicated they were on no form of a paid contract, all of which were in the WC.

Nearly one-quarter identified having an injury that currently kept them from regular training. Of this group, 50% provided their 'injury diagnosis' in the blank space provided. The most common injury was 'ACL injury' (*n*=4). Most participants stated they had not been clinically diagnosed with a mental illness (*n*=81, 81%). The remaining one-fifth checked 'yes' (*n*=14, 14%) or 'other, please explain' (*n*=5, 5%). A place was provided on the questionnaire for participants to disclose their diagnosis. Of the 14 footballers that responded 'yes' to having received a clinical mental health diagnosis, 12 participants provided their diagnosis which included the following: depression and anxiety (*n*=4), anxiety (*n*=4), depression (*n*=3), and ADHD (*n*=1). Of the five that checked 'other, please explain' none left anything in the space provided.

In relation to performance lows, footballers were asked to tick the four most important reasons for *performance lows* during their elite football career, they ticked 'too little support/recognition by the coach' *(n*=46, 46%) 'injury' (*n*=64, 64%) 'overtraining' (*n*=22, 22%) 'psychological problems' (*n*=52, 52%) 'fatigue' (*n*=43, 43%) 'lack of confidence' (*n*=80, 80%) 'overloaded by the combination of work/school/football training/matches' (*n*=27, 27%) 'lack of inner drive or motivation' (*n*=28, 28%) 'other' (*n*=2, 2%) and 'unsure'(*n*=3, 3%). In relation to low moods during their football career, participants were asked what factors were most responsible for any *low moods during their elite football career* and were able to check up to four responses that applied. They most frequently checked: 'injury' (*n*=64), 'low performance' (*n*=59), 'too little support/recognition by the coach' (*n*=45) and 'conflicts with the coach' (*n*=30).

In terms of coping, footballers were asked to tick the four most important factors that helped them *to cope with any low moods* during difficult times during their professional football career, they checked 'my family' (*n*=80, 80%), 'my friends' (*n*=53, 53%), 'my partner' (*n*=49, 49%), 'training physical activity' (*n*=47, 47%), 'my teammates' (*n*=46, 46%), 'relaxation/rest/retreat' (*n*=27, 27%), 'distraction' (*n*=27, 27%), 'my coach' (*n*=23, 23%), 'professional help from a psychologist/doctor/psychotherapist' (*n*=22, 22%), 'a hobby' (*n*=16, 16%), and 'medication' (*n*=5, 5%). Asked to tick all options that applied, the players were asked if they had engaged in any of the following *coping strategies* to deal with *low mood* or *psychological challenges,* they most often ticked 'excessive exercise' (*n*=37, 37%), 'excessive focus on healthy eating habits' (*n*=35, 35%), 'none' (*n*=41, 41%), and 'overeating' (*n*=24, 24%). They least often ticked the following options: 'substance abuse and misuse' (*n*=5, 5%), 'self-harm' (*n*=4, 4%), 'other please explain' (*n*=2, 2%), and 'gambling' (*n*=1, 1%).

4.3.2. Prevalence of depression, anxiety, and eating disorder symptoms

Ninety-eight participants completed the PHQ-9 in full. The mean (SD) score was 4.7 (3.5). When using cut-off scores recommended by the IOC's SMHAT-1 (Gouttebarge et al., 2021), 26.5% of players reported mild to moderate depressive symptoms, 10.2% showed moderate to severe symptoms, and 1.0% displayed severe depressive symptoms.

One-hundred participants fully completed the GAD-7 questionnaire. The mean (SD) score was 4.5 (3.6). Using recognised cut-off scores (see SMHAT-1, Gouttebarge et al., 2021), 28% had scores indicating mild anxiety symptoms, 11% showed scores for moderate anxiety, and no participants met the cut-off for severe anxiety symptoms.

One-hundred participants fully completed the BEDA-Q questionnaire. The responses revealed a mean (SD) score of 3.6 (3.0) with 36% of players meeting the IOC's criteria for eating disorder symptoms. Additionally, 35% of the total participants selected 'yes' that they were currently trying to lose weight and 45% selected 'yes' to trying to lose weight in the last four weeks. Of that 45% who indicated they had tried to lose weight over the past four weeks, 74% reported attempting to lose weight '1–2 times,' 19% responded '3–5 times,' and 7% indicated 'over 5 times.'

Table 4.2 Prevalence of depression, anxiety, and eating disorder symptoms

	Total responses	**Response choices**	***n* (%)**
Depression Symptoms (PHQ-9)	*n*=98		
		Mild (5-9)	29 (26.5)
		Moderate (10-14)	10 (10.2)
		Severe (15-19)	1 (1.0)
Anxiety Disorder Symptoms (GAD-7)	*n*=100		

		Mild (5-9)	28 (28)
		Moderate (10-14)	11 (11)
		Severe (>15)	0 (0)
Eating Disorder Symptoms (BEDA-Q)	*n*=100		
		>4	36 (36)
		Q1. Currently trying to lose weight? ‘Yes’	35 (35)

4.3.3. Associations between factors and mental ill-health symptoms

4.3.3.1. Depression

The associations between factors for mental ill-health and depressive symptoms are summarised in Table 4.3. After adjusting for covariates, compared to those who indicated ‘no’ they do not currently need psychological support, those who responded ‘currently’ needing psychological support had elevated risk of reporting depressive symptomology (B = 3.029, 95% CI = .580– 5.478, p= .016). No such risk was observed for those in the ‘yes, at different times’ category (B = 0.294, 95% CI = −1.562–2.150, p= .754). Starting status was significantly associated with depression scores; with ‘no’ to starting games as the reference category, those who reported starting ‘every game’ had lower risk of reporting depressive symptomology (B = −3.466, 95% CI = −6.114 – −.819, p= .011). Further, ‘most games’ was significantly associated with lower depressive risk (B = −2.385, 95% CI = −4.735 – −.034, p= .047). No other factors were associated with risk of depression (p’s >0.05; Table 4.3).

4.3.3.2. Anxiety

As shown in Table 4.3, compared to those who indicated ‘no’ they do not need currently need psychological support, those categorised as ‘currently’ needing psychological support had elevated risk of reporting anxiety symptoms (B = 4.739, 95% CI = 2.132– 7.346, p= .05; Table 4.3).

4.3.3.3. Eating disorder

Compared to ‘not student-athletes’, ‘part-time’ student-athletes had elevated risk for eating disorder symptomology (B = 2.560, 95% CI = .189–4.931, p= .035). No other factors were significantly associated (p’s >0.05; Table 4.3).

Table 4.3 Associations between mental ill-health factors (as dummy variables) and symptoms of depression, anxiety, and eating disorders

	Depression (PHQ-9)					**Anxiety (GAD-7)**					**Eating disorder (BEDA-Q)**				
	B	SE	Lower CI	Upper CI	*p*	B	SE	Lower CI	Upper CI	*p*	B	SE	Lower CI	Upper CI	*p*
Playing level	*n*=97					*n*=99					*n*=99				
Women's Championship (reference)															
WSL	-1.044	.673	-2.381	.292	.124	-.390	.716	-1.811	1.032	.587	-1.081	.626	-2.325	9.657	.088
Born in UK	*n*=96					*n*=98					*n*=98				
No (reference)															
Yes	.415	.853	-1.281	2.110	.628	.464	.902	-1.328	2.256	.608	.278	.791	-1.292	1.849	.726
Paid contract	*n*=97					*n*=99					*n*=99				
No (reference)															
Yes	-.561	.908	-2.366	1.244	.539	-.669	.977	-2.609	1.2711	.495	-1.088	.850	-2.776	.600	.204
Other	-2.317	2.070	-6.429	1.795	.266	-1.380	2.226	-5.802	3.042	.537	-.567	1.937	-4.415	3.281	.770
Want for psych support	*n*=97					*n*=99					*n*=99				
No (reference)															
Yes, at different times	.294	.934	-1.562	2.150	.754	1.980	1.016	-.038	3.998	.054	.468	.890	-1.299	2.235	.600
Yes Currently	**3.029**	1.233	.580	5.478	**.016***	**4.739**	1.312	2.132	7.346	**<.001***	.410	1.149	-1.872	2.692	.722

Starting status	*n*=97					*n*=99					*n*=99				
No games (reference)															
Few games	-2.190	1.360	-4.893	.513	.111	-1.721	1.451	-4.604	1.161	.239	.239	1.272	-2.288	2.765	.852
Some games	-1.771	1.232	-4.220	.678	.154	-1.033	1.313	-3.642	1.576	.434	.811	1.151	-1.476	3.098	.483
Most games	**-2.385**	1.183	-4.735	-.034	**.047***	-1.167	1.244	-3.639	1.304	.351	.915	1.090	-1.251	3.081	.404
Every game	**-3.466**	1.332	-6.114	-.819	**.011***	-2.359	1.395	-5.130	.413	.094	.143	1.223	-2.286	2.572	.907
Injury status	*n*=97					*n*=99					*n*=99				
No (reference)															
Yes	.782	.819	-.845	2.409	.342	.293	.868	-1.431	2.017	.736	.662	.760	-.846	2.171	.386
Student-athlete status	*n*=97					*n*=99					*n*=99				
No (reference)															
Other student athlete	.364	1.628	-2.871	3.599	.823	.412	1.575	-2.717	3.540	.794	.389	1.362	-2.316	3.095	.776
College student athlete	-2.476	2.560	-7.565	2.613	.336	1.311	2.720	-4.094	6.716	.631	.681	2.352	-3.993	5.354	.773
Part time student athlete	-.811	1.296	-3.387	1.764	.533	-.863	1.380	-3.605	1.879	.533	**2.560**	1.193	.189	4.931	**.035***
Full time student athlete	-.533	1.018	-2.557	1.490	.602	-1.331	1.068	-3.454	.791	.216	.565	.924	-1.271	2.400	.543

Football as FT occupation	*n*=96					*n*=98					*n*=98				
No (reference)															
Yes	.174	.938	-1.690	2.038	.853	.089	1.001	-1.900	2.078	.929	-.174	.877	-1.917	1.568	.843

Note. B=unstandardized beta, SE=standard error, lower CI = lower confidence interval (95%), upper CI= upper confidence interval (95%). Bold type indicates significance at the p<.05 level. All models above are adjusted for the following covariates; age, level of competition, injury, need for psychological support, and starting status. FT= full-time

4.3.4. Associations between age and help-seeking intention (as continuous scores) and mental ill-health symptoms

The mean (SD) GHSQ score for 'personal or emotional problems' (question one) was 40.75 (8.51) and for 'suicidal emotion' (question two) was 38.9 (11.86). The average score for help-seeking intentions for question one was 3.39 (1.40) and for question two was 3.43 (1.09). For both problem types, the highest help-seeking intention score was for 'intimate partner' (e.g., girlfriend, boyfriend, partner). For question one, scores indicated the footballers are least likely to seek help from a 'phone helpline' and for question two this was 'current manager or staff'.

As shown in Table 4.4, a higher help-seeking intention score for question one was significantly associated with lower depression symptoms (B = −.098, 95% CI = −.186 – −.010, p= .029), such that those more likely to seek help were less likely to report symptoms of depression. Similar finding also emerged for question two (B = −.083, 95% CI = −.157 – −.009, p= .028), indicating that lower depression scores were significantly associated with higher help-seeking intention scores.

Table 4.4 Associations between age and help-seeking intentions, and depression, anxiety, and eating disorder symptoms

	Depression (PHQ-9)					Anxiety (GAD-7)					Eating disorder (BEDA-Q)				
	B	SE	Lower CI	Upper CI	*p*	B	SE	Lower CI	Upper CI	*p*	B	SE	Lower CI	Upper CI	*p*
Age	*n*=97					*n*=99					*n*=99				
	-.023	.092	-.205	.159	.799	.120	.092	-.062	.303	.193	-.121	.080	-.280	.039	.137
Help-seeking intentions (Q1: personal or emotional problems)	*n*=67					*n*=68					*n*=68				
	-.098	.044	-.186	-.010	**.029***	-.031	.045	-.122	.059	.488	-.042	.048	.377	-.138	.377
Help-seeking intentions (Q2: suicidal emotion)	*n*=55					*n*=55					*n*=55				
	-.083	.037	-.157	.009	**.028***	-.051	.040	-.131	.029	.205	-.031	.036	-.104	.041	.391

Note. B= is under unstandardised beta, SE=standard error, lower CI = lower confidence interval (95%), upper CI= upper confidence interval (95%). Bold type indicates Significance at the $p<.05$ level. All models above are adjusted for the following covariates: age, level of competition, injury, need for psychological support, and starting status.

4.4. Discussion

In this section the findings and implications from this study are critically discussed and strengths and limitations are offered. Future research directions are interwoven throughout these sections, meaning a separate section is not presented in this study.

This is the first study to explore the prevalence of, and possible contributing factors to, mental ill-health symptoms in elite women footballers in England which allowed for critical insight into this population, including prevalence rates for depression, anxiety, and eating disorder symptoms. The prevalence of moderate and severe depression symptoms (combined) in this population was 11.2%, which is similar to elite women footballers in Australia (10.5%) and slightly less than first team players competing in Switzerland (13%) when using the same questionnaire and cut-off scores (Junge & Feddermann-Demont 2016; Kilic et al., 2021). The depression prevalence rates were significantly lower than professional footballers competing in Germany (37.1%) (Junge & Prinz, 2019). Notably, data collected with players competing in Germany was done so several years ago (i.e., 2014-2016) during a time where players in the national team were likely faced with increased psychological pressures—due to their position as a top-ranked country for women's football—as well as a general lack of mental health support, which could have influenced depression scores (Junge & Prinz, 2019; Prinz et al., 2016).

The prevalence of moderate and severe anxiety symptoms among the population combined in this study was 11%, which is marginally higher than players in Germany (8.3%) and players in Australia (8.3%), and significantly higher than women footballers competing in the Swiss first league (1.1%) (Junge & Feddermann-Demont, 2016; Junge & Prinz, 2019; Kilic et al., 2021). There are multiple potential explanations as to why footballers in England had higher anxiety symptoms. Firstly, this study took place during the COVID-19 pandemic which

might have impacted anxiety symptoms due to the increased stress that elite athletes faced during this period (Haan et al., 2021). It is well-documented that lockdown had a negative impact on mental health of the general population in the UK (Kwong et al., 2021) as well as athletes' mental health globally which could have impacted anxiety symptoms (Carnevale Pellino et al., 2022; Perry et al., 2022; Reardon et al., 2021).

Additionally, the new demands placed upon elite women footballers (e.g., media expectations, fan engagement, sponsorship, and commercial partnerships)—resulting from the rapid professionalisation of women's football in England—may have increased anxiety symptoms (Culvin, 2019). Therefore, further qualitative research is needed to better explore their lived experiences. Additionally, further research into elite women footballers in other countries and cultures is warranted given the substantially lower rate of anxiety symptoms reported in Switzerland compared with footballers in England, Australia, and Germany. Research into the sociocultural context in which footballers exist might provide important insight for practitioners working with elite women footballers.

Rates for eating disorder symptoms in this present study (36%) were higher than those identified with women footballers in the UK in tier 4 and above (11%) and professional female footballers in the USA (0%) (Abbott et al., 2021; Prather et al., 2016), yet were lower than footballers competing in Australia (44%) (Kilic et al., 2021). Again, numerous factors may have influenced such differences, including the use of distinct instruments, varying cut-off scores, heightened performance pressures, increased media attention and subsequent body image concerns, and COVID-19.

Further, the findings from the BEDA-Q demonstrated that 35% of footballers were 'currently trying to lose weight', and 45% reported attempting to lose weight in the previous four weeks. Of that 45%, 74% indicated they had attempted to lose weight '1–2 times,' 19%

responded ‘3–5 times’, and 7% indicated ‘over 5 times.’ Importantly, this data was collected during the footballers’ competitive season. Research is therefore warranted to explore how and why players are trying to lose weight during their competitive season. Such research is of particular importance given the potential and severe short and long-term consequences of common weight-loss behaviours such as under-eating, restrictive eating, over-exercising, and excessive focus on food and weight for elite athletes (e.g., poor performance, and long term mental and physical health conditions) (Greenleaf et al., 2009; Mancine et al., 2020; Sundgot-Borgen & Torstveit, 2010).

Similar to Junge and Prinz (2019), the present study revealed that those who responded that they ‘currently’ needed psychological support reported higher scores for depressive and anxiety symptomology. Specifically, footballers scored three points higher on the depression scale (PHQ-9) and four points higher on the anxiety scale (GAD-7) compared to those who responded they did not want psychological support. This is clinically relevant as a five-point change on the PHQ-9 and a six-point change on the GAD-7 is significant (Bischoff et al., 2020; Kroenke, 2012).

Higher eating disorder scores were not associated with ‘currently’ needing psychological support, nor was the effect size meaningful. This finding warrants a prompt and thorough investigation as this could indicate that players do not recognise eating disorder symptoms as distressing. It is possible that eating disorder behaviours such as excessive weight monitoring and strict dieting are normalised in the footballers’ sporting environment; such behaviours are suggested to be normalised in other elite sporting environments due to athletes’ focus on ‘eating for excellence’ (Williams, 2012). Indeed, footballers may even find a sense of comfort and achievement by engaging in eating disorder behaviours as elite sporting environment often praises those athletes who demonstrate a sole dedication to sport and

winning by engaging in sacrificial acts (e.g., strict dieting) for sporting success (McMahon & Penney, 2013; McGannon & McMahon, 2019; Papathomas & Lavallee, 2014).

Additionally, findings demonstrate that starting status was significantly associated with depression scores, such that those who indicated starting 'every-game' had significantly lower depression scores than those who started 'no games.' Further, footballers who indicated starting 'every-game' had scores 3 points lower on the depression scale (PHQ-9) (see Table 4.3) compared to those who responded they did not start games – this meaningful difference is nearly clinically significant (Kroenke, 2012). Thus, future research is needed to explore how non-starting players can be better supported. Footballers who are not regularly starting games may require additional 'checking-in' from staff to allow for the prevention and early identification of mental ill-health. In this study, 'part-time' student athletes had an elevated risk of reporting eating disorder symptoms. This is the first study to highlight this association. Again, research is warranted to understand this finding further, however, it is very likely that balancing the demands of being a part-time student whilst competing at the highest level could make elite athletes more vulnerable to experiencing mental ill-health (Brown et al., 2021).

Apart from this, findings from this study do not support previous research linking competition level, injury status, and age to depression, generalised anxiety, or eating disorder scores (Junge & Feddermann-Demont, 2016; Junge & Prinz, 2019; Kilic et al., 2021). Among numerous factors, it is possible that this difference is a result of measurement variation, therefore future quantitative literature would benefit from homogenous instrument choices such as those recommended by the IOC in the SMHAT-1.

4.4.1. Implications

In the present study, 90% of participants believed that receiving psychological support would have helped them during their football career and 86% indicated they wanted or needed

psychotherapeutic support at some point during their career. This is more than double that of professional women footballers competing in Germany and Switzerland (40%) (Junge & Feddermann-Demont, 2016; Junge & Prinz, 2019). Concerningly, despite 86% saying they wanted or needed psychological support in this study, only 50% of players reported that psychological support was available at their club. Of that 50%, only 28% reported receiving psychological support from their club. Interestingly, 38% reported receiving support from outside their club. These findings suggest that despite players wanting and having access to help at their club, or through their club, many are choosing not to use it. Research is needed to explore barriers to accessing and utilising psychological support within clubs. Then, research is eventually needed to explore and evaluate the current psychological services that are being offered to ensure they are appropriate for the footballers' wants and needs. Additionally, 14% of players were 'unsure' if psychological support is available at their club. Thus, professional football clubs should place a focus on player and staff education and awareness, and ensure signposting is in place to increase clarity around what is available and how to use and access it (Confectioner et al., 2021).

It is critical that football clubs encourage help-seeking behaviours given this study demonstrated higher help-seeking intentions scores were significantly associated with lower scores for depression symptoms. To increase elite footballers' help-seeking behaviours, sporting organisations could focus on reducing stigma and creating an environment where athletes feel psychologically safe to express their mental health needs and concerns, both at the individual and team level (Purcell et al., 2022; Vella et al., 2022).

More specifically, findings showed that players are most likely to seek help for their mental health from their 'intimate partner.' Therefore, practitioners working with elite women footballers in England should provide footballers' partners with education and information

surrounding mental health and look to offer them support resources for their own mental health. This recommendation aligns with recent work by Purcell et al. (2022) who proposed an evidence-informed framework grounded in an ecological system approach to promote mental health in elite sport. In this framework, they highlight the importance of coaches, teammates, support staff, and families in supporting elite athletes' mental health while also looking after their own mental health (Purcell et al., 2022).

4.4.2. Strengths and limitations

This study makes several significant contributions to the literature and has addressed recent recommendations made in the previous chapter and across the sport and mental health literature – both of which are strengths. A significant strength of this study was the inclusion of multiple mental ill-health questionnaires—i.e., depression, anxiety, and eating disorder symptoms questionnaire. Majority of studies in elite sport have focused on exploring one 'type' of mental illness and often concern retired athletes (Gouttebarge et al., 2019; Tahtinen et al., 2021). The inclusion of all three allowed for novel findings to be generated and for comparisons to be made. For example, depression and anxiety scored were associated with footballers 'currently' needing psychological support, however, higher eating disorder scores were not. This, in-turn, prompted the recommendation to be made for further research relating to players' experience with eating disorder behaviours.

Another strength of this study was the inclusion of questionnaires and use of cut-off scores from the IOC's SMHAT-1. To date, inconsistent scales and cut-off scores in mental health and elite sport research has made comparisons across studies extremely difficult, in turn researchers have called for consistent scales and cut-off scores to be used (Poucher et al., 2021; Tahtinen et al., 2021). By using validated questionnaires and recommended cut-off scores from the IOC, this study goes some way in responding to these recommendations.

One final strength of this study was the participation rates, as well as in the pilot study. Given the difficulty in accessing elite athletes, particularly elite women footballers (Culvin, 2019), inclusion of 115 WC and WSL footballers is a significant strength of this study. In the future, doing so without a partnership with governing body—i.e., NewCo—or with the players union (i.e., PFA) will be extremely difficult. Notably, such partnerships could sway players' responses as they might feel they need to respond a certain way. The pilot study was large, yet participation was welcome. This was a strength of this study as the pilot study helped shape some of the questions in the study. Importantly, the high participation rates in the pilot study suggests a strong appetite for mental health research in tier 3 and 4 and could be an area for future researchers to explore.

As with any study, there are some limitations. Firstly, there is the potential for participation bias as we cannot ascertain that all players in the WSL and WC were offered the opportunity to complete the study. Secondly, this study relied on self-report measures which can be seen as a significant limitation. Self-report measures rely on people having self-awareness and insight as well as being honest (Demetriou et al., 2014). Further, self-report measures may reproduce the possibility that people are not able or willing to talk about mental health issues, thus, there is a possibility of participants under-reporting or not answering questions truthfully (Demetriou et al., 2014).

Thirdly, there was some missing data for some of the participants' questionnaires which negatively impacted sample sizes for certain analyses. While there are many ways to handle missing data, I opted to remove any participants from analyses of specific questionnaires if they did not provide a complete set of data for that particular questionnaire. I did not, however, remove these participants from the entire study. This approach aligns with other studies that used the same mental health questionnaires (see Shevlin et al., 2022). I understand that this

approach may have reduced statistical power, however, I did not want to introduce any further bias by engaging with imputation, particularly given we had sufficient power for our analyses even without the missing data (*a priori* G*Power calculation suggested that a minimum sample size of 90 would be needed). Another reason for the decision to remove missing data is that the mental health questionnaires used in this study were short; for example, the GAD-7 only has seven questions. Thus, a participant with one item missing on the GAD-7 would be missing 15% of the data for that questionnaire. This then lends itself to the debate of how much missing data is acceptable. I emphasise that mental health questionnaires are also very sensitive to change, meaning the response to one question may result in a participant meeting (or not meeting) the clinical cut-off for mental ill-health symptoms, which I did not feel was appropriate.

Additionally, following recommendations provided by the IOC (Gouttebarge et al., 2021), a cut-off score of ≥4 was used for classifying eating disorder symptoms using the BEDA-Q. However, the IOC has provided very little insight into how this cut-off score was derived. Since many studies are now using the IOC's proposed cut-off score of ≥4 (i.e., Kilic et al., 2021), it is important that this criterion is validated against best evidence practice, such as clinical interviews. It also important to note that I did not statistically adjust for multiple comparison, yet this approach was deemed most appropriate as all the analyses were hypothesis driven and based on *a priori* statistical plan. Finally, due to the large number of analyses that were run, there is a risk of inflated type I error. However, due to the exploratory nature of this study, correcting for multiple testing was not considered appropriate (Bender & Lange, 2001).

Finally, there are some limitations in terms of wording and the questionnaires used. In this study, there was no questionnaire regarding well-being or psychological distress questionnaire. This was decided due to a lack of validated options with athletes and primarily,

to keep the survey short in order to increase compliance rates. In the future, however, researchers could include a questionnaire such as the IOC recommended Athlete Psychological Strain Questionnaire (APSQ) which would allow for insight beyond just mental ill-health prevalence rates. Additionally, this study did not include questions around race, socioeconomic status, and sexuality all of which are well known to negatively impact mental health in the general population due to factor such as disparities in living conditions, service opportunities, and additional stressors such as racism and homophobia (Cooper et al., 2013; Rees et al., 2021). In this study, sexuality would have been interesting to explore given the high rate of 'out' players in the women's game. Thus, future researchers should consider adding questions around sexuality and potentially gender identity. One final note, there are practitioners who formally support mental health who were not listed on the survey regarding the question about psychological support – one example being a mental health nurse. While the list of practitioners was those most likely to be employed to provide mental health support to elite athletes according to the literature (e.g., sport psychologists, counsellors, therapists, clinical psychologists) (Moreland et al., 2018), future researchers may wish to adapt or broaden this list.

4.5. Conclusion

This study explored mental ill-health, potential risk factors, and help-seeking intentions in elite women footballers in the top two tiers of English football. Findings from this study extended existing literature by exploring possible underlying factors that might increase the risk of mental ill-health with elite women footballers in England. This study revealed that prevalence rates for eating disorder symptoms in elite women footballers were significantly higher than rates of depression and anxiety and higher than women footballers competing in other countries. Further, results indicated that nearly all elite women footballers wanted psychological support at some point during their football career (86%) however, many were

either not offered support by their club or chose not to use it. The findings presented in this chapter highlight the need for future research to explore the challenges women footballers face in relation to their mental health as very few of the established risk factors were significant in this study. Specifically, research should focus on players' mental health experiences in relation to the ongoing professionalisation of the women's game in England given the well-known negative impact that transition time periods can have on mental health in elite athlete populations and the general population. This in turn may help to inform more appropriate support for this population.

Drawing on recommendations within this study, the next chapter includes qualitatively explores the mental health challenges elite women footballers face, specifically in relation to their sporting context and the ongoing professionalisation of their sport.

Chapter Five

An exploration of elite women footballers' mental health challenges during professionalisation

5.0. Abstract

This chapter explores elite women footballers' experience of the mental health challenges they have faced in relation to their rapidly changing sporting context, specifically, the ongoing professionalisation of their sport. To date, no research has qualitatively explored elite women footballers' experiences of mental health in England despite the significant and wide-ranging changes which have impacted the women's game in recent years. Between May and November 2021, semi-structured interviews were conducted with 21 elite women footballers competing in the top two tiers of women's football in England (WSL=8, WC=13). Using reflexive thematic analysis, four themes were constructed to best represent the mental health challenges that women footballers encountered in relation to their sporting context: a) Unexpected realities; b) A narrowing self-identity; c) Clashing body image ideals; and d) Shifting social support. Within their elite football context, players struggled to navigate these key challenges often due to power imbalances between players and staff and limited support. Some players developed coping strategies, while others saw such challenges manifest into what they considered to be more serious mental health struggles (e.g., depression, disordered eating) which required clinical support.

5.1. Introduction

The previous chapter responded to calls for research to explore the mental health of elite women footballers, beginning with prevalence rates of mental ill-health (Culvin, 2019; Culvin & Bowes, 2023). Findings from Study Two revealed 11.2% met the cut-off for moderate to severe depression symptoms and 11% for anxiety symptoms, and 36% met the cut-off for severe eating disorder symptoms. Notably, 14% of players self-reported having received a clinical mental diagnosis from a mental health practitioner or their doctor. Importantly, despite many players not meeting the cut-off for mental ill-health symptoms, 86% of all players indicated they wanted and needed psychological or mental health support. However, no further insight into support needs or wants was gathered. Ultimately, while Study Two provided important insight into mental ill-health prevalence rates and help-seeking intentions, further research is needed to explore elite women footballers lived experiences with mental health challenges.

As outlined in Chapter One, there is limited research exploring mental health with elite women footballers, particularly interpretively or qualitatively (Appendix A mental health and elite women's football studies). One study that did include the player voice was undertaken with semi-elite players competing in England by Bramley et al. (2024). It explored six footballers from tier 3 and their mental health experiences. Players suggested that balancing work and football and the rapidly increasing demands of the women's game due to professionalisation at the higher levels was difficult to navigate and took a toll on their mental health. It highlighted the ongoing professionalisation of women's football to be a time of significant change and transition for players in the women's game in England.

At the elite level, Culvin's work on professionalisation highlighted the need for research specific to mental health and elite women footballers in England, noting the

importance of focusing on players' lived experiences and centralising footballers' voices. While mental health was not the focus of Culvin's (2019) work, she found women footballers in the top tier of English women's football (WSL) were experiencing insecure workplaces, limited financial stability, a lack of support, increased performance pressures, and few post-career playing options all of which were negatively impacting their mental health (Culvin, 2019). As a result of her findings, she called for research specifically dedicated to mental health and understanding players' experiences regarding challenges they face (see Chapter One; Culvin, 2019, p. 307).

In mental health and elite sport research, there is a similar lack of athlete voice and qualitative research. Instead, the majority of research is quantitative and involves self-report questionnaires. Notably, 84% of mental health and elite sport research has involved quantitative methods (Kuettel & Larsen, 2020). While quantitative research is important in allowing for insight into the presentation of mental ill-health symptoms across populations, it often comes at the expense of understanding individuals lived experiences (Pereira Vargas et al. 2021). Given mental health is highly personal, influenced by one's sociocultural context, impacted by numerous psychosocial and contextual factors, and relatively unexplored with elite athletes, researchers have highlighted the need for qualitative knowledge (Kuettel & Larsen, 2020; Lundqvist & Andersson, 2021; Pereira Vargas et al., 2021). As noted by Pereira Vargas et al. (2021), "[Q]ualitative knowledge is essential for understanding human experience as it allows for an in-depth exploration into the social reality of a person, groups, and cultures, as well as the behaviours, perspectives, and experiences of people's lives" (p. 2).

Recognised by Kuettel and Larsen (2020), it is the interpretive and qualitative work in this research area that has facilitated much of what is known and understood about mental health with elite athletes. Such research has provided insight, for example, into how athletes make

sense of their mental health (mainly mental illness) within their sporting context (see review by Pereira Vargas et al., 2021), in addition to offering understandings surrounding risk factors to mental health within specific elite sporting environments, (Kuettel & Larsen, 2020). For example, Wood et al. (2017) interviewed professional men's footballers who had a history of mental health challenges and found an overarching feeling of 'survival' impacted their mental health overtime as they constantly felt they need to prove themselves, often to the determent of every other area of their life. While this is just one example, it is from such lived experiences that understandings of mental health are advanced and that support and policy across clubs and sporting organisations for athlete mental health can be informed.

The overarching aim of this study is to explore the challenges to mental health that elite women footballers in England experience in relation to their football context and the ongoing professionalisation. More specifically, it sought to explore players' own reflections on their lived experiences. As noted by Pereira Vargas et al. (2021) qualitative research in this area often fails to provide insight into the sociocultural context in which the population included in research exists. Therefore, addressing this limitation, Chapter One provides contextual insight into elite women's football in England and throughout the findings section presented below, further insight into the sociocultural context is offered. To undertake this study, qualitative methods were used. Two questions guided this study: (1) "how do players experience their mental health in relation to their football context?" (2) "in what ways do footballers experience their mental health to be impacted?"

5.2. Methodology

5.2.1. Philosophical approach

To meet the aims presented above, this study was guided by a social constructionist approach, a relativist ontology, and constructionist epistemology. Ontological relativism maintains that reality is fluid, multiple, and dependent on the meanings given to objects, events, and practices (Poucher et al., 2020). Epistemological constructionism suggests that knowledge is constructed through transactions between the researcher and participant which are subject to different interpretations and mediated by values (Poucher et al., 2020). This approach was selected as it allows for the exploration of mental health challenges within the socio-cultural context of women's football. Constructionism includes a focus on the role of society, culture, and power relations that contribute to individuals' constructions of their experiences which was important for this study (Poucher et al., 2020). Chapter Two provided a justification for including constructionism within the overarching pragmatic approach adopted in this thesis.

5.2.2. Participants

Following approval by the institutional ethics board, 21 elite women footballers were interviewed, all of which were between 20 and 30 years of age *(*M_{age}=24.95, *SD*=3.17). Eight of the participants competed in the WSL and 13 competed in the WC. Seven of the players had competed at both the WSL and WC level at some point in the last two years, meaning they either switched levels, or their team had been relegated or promoted. Research took place at the end of the footballers' 2020/2021 season, meaning a handful of participants were transitioning to new clubs or indeed away from the game completely. Specifically, for the then-upcoming season, 15 of the 21 players were signed with a club, two had not yet signed, two had signed for clubs outside of the WSL or WC level for the following season and two players were considering retirement. Eleven of the footballers were working or attending university

alongside their football career. Two of the players included had competed at the WC level in 2019/2020, yet they were still included.

Importantly, participants were not required to have had a clinical mental health diagnosis to participate in this study. Nor were they screened for any underlying mental health issues prior to the interviews. To date, most qualitative research concerning elite athletes and mental health has focused almost entirely on athletes with clinical mental health diagnoses (Pereira Vargas et al., 2021). Such an exclusive focus does not allow for individuals with less 'severe' challenges or sub-clinical experiences to be included (Coyle et al., 2017). Further, such an approach assumes that diagnoses reflect the reality of mental health challenges that individuals face which is not always the case. Notwithstanding this, four participants shared that they had received a clinical mental health diagnosis at some point in their lifetime, such as depression, anxiety, or an eating disorder, and nine players expressed that they had, or were currently experiencing, a period of poor mental health.

Table 5.1 Player information

Participant[1]	Age	Football career status[2]	League for 2020-2021[3]
Toni	22	Full-time	WSL
Megan	23	Full-time	WSL
Morgan	23	Full-time	WSL
Faye	25	Full-time	WSL
Gemma	25	Full-time	WSL
Sam	28	Full-time	WSL
Elle	29	Full-time	WSL
Jess	30	Full-time	WSL
Alex	20	Part-time **	WC
Dylan	21	Part-time **	WC
Isabel	21	Part-time **	WC
Taylor	22	Part-time *	WC
Sara	23	Part-time **	WC*
Spencer	25	Part-time *	WC
Olivia	25	Part-time *	WC
Erin	26	Full-time **	WC
Riley	26	Part-time **	WC
Kelsey	27	Full-time	WC
Jen	29	Part-time *	WC
Tara	29	Full-time	WC
Anna	29	Part-time *	WC*

Notes: [1] Pseudonyms used
[2] Other job alongside football = *, University student = **
[3] Competed at WC level in 2019/2020 and in a lower tier in 2020/2021*

5.2.3. Interviews

Semi-structured interviews were used due to their suitability for exploring sensitive topics such as mental health and flexibility for both the interviewee and the interviewer (Elmir, 2011). The flexibility of this interview style allows for more natural and dynamic conversations

to take place between the interviewee and interviewer as it invites and affords participants the opportunity to share stories, perspectives, and experiences (Smith & Sparkes, 2016). In turn, this interview style allows for knowledge to be co-constructed between the interviewer and interviewee which is a key feature of constructionism.

The interview guide was designed, in-part, around questions from Study Two and constructed around a set of open-ended questions which were then split into five parts (Appendix H player interview guide) (DiCic-co-Bloom & Crabtree, 2006). The first part, which was intended to build rapport and gain insight into the context in which the players competed, involved questions about their sporting background (e.g., "can you tell me about your sporting background?"). This opening questioning can be referred to as a "grand tour question" which provides the participant with the scope to reveal the details of their experiences according to their priority and personal significance (Spradley, 1979). Secondly, participants were asked about their current sporting environment, specifically after the changes to the leagues; for example, "What is it like for you now?"; "In what ways is your experience similar or different than before?". These questions were followed by multiple questions surrounding the footballers' experiences with mental health in relation to football: "Have you experienced football to impact your mental health?"; "Do you have any stories of specific moments or time periods where your mental health was impacted?". The third part involved questions related to their experience and views regarding cultural attitudes towards mental health in the women's game "How do you feel mental health is discussed within the women's football environment?" and fourth, they were asked about the availability of support "Do you feel mental health is supported at your club? If so, how? If not, why not?"; "What recommendations do you have for mental health to be better supported?". Final questions included: "Do you have anything else to add?"; "How did you feel about being interviewed on this topic?". These ending

questions were included to gain insight into the footballers' experiences of talking about mental health.

After the interview guide was designed, two pilot interviews were conducted; one with a professional footballer who competed outside of England but had previously competed in England, and another with a retired professional footballer from England. Feedback on both the interview's questions and style were obtained. As a result, one section of the interview guide was removed where players had originally been asked about their definitions of 'mental health' and 'poor mental health'; specifically, "how do you define mental health or mental illness?". These more 'technical' questions were removed from the interview guide as they were either answered without needing to be asked or, as one player in the pilot study said, it made her feel like she was being assessed. Instead, these topics were explored more naturally throughout the interviews which also offered participants more space to share their experiences.

5.2.4. Procedure

In the introductory email to clubs for the previous study (Study Two), information for this study was also provided (Appendix I information sheet). Additionally, players who took part in Study Two were offered the opportunity to leave their email at the end of the survey if they were comfortable with being contacted for an interview study. Importantly, this question sat at the end of the survey and was separate to their results; meaning, if they responded 'yes' that they would like to take part and were willing to leave their email, they were then taken to a separate page to leave their email which was separate to their survey responses. This was done so that their questionnaire results remained anonymous. Twenty-five footballers left their email form Study Two, all of whom were contacted a few months later to take part in the interview study. Half of the footballers who were contacted responded and five ended up taking part in this present study.

Recruitment for this study was also carried out through social media posts via the platform 'X' (formerly Twitter) (see Appendix J for recruitment advert). A link for players was included in the posts where they could input their email. Once the advert was posted to X, personal connections across the game were leveraged to drive participation sign-ups. Social media posts were also circulated by this study's wider research team among dozens of coaches and players within their own networks. Roughly ten participants were recruited via social media directly through the advert, with five players directly contacting me via shared connections.

In addition to social media posts, snowball sampling was during the first 10 interviews. Snowball sampling is a recruitment technique often used with "hard-to-reach populations" where the researcher asks the participant to pass on information for the study to teammates or other players (Robinson, 2014). Importantly, players were never asked to provide me with their teammate's contact information, they were only asked to pass on the study advert and my contact information.

Interviews took place between May and September 2021. All interviews were conducted online using Microsoft Teams video due to COVID-19 restrictions preventing in-person meetings. Each participant was interviewed once, and interviews lasted between 60 to 123 minutes ($M_{duration}$=74 minutes); this totalled over 24 hours of data (sum=1465 minutes). Prior to each individual interview, participants were sent a study information sheet, consent form, and instructions for accessing Microsoft Teams (Appendix K Microsoft Teams access sheet). At the beginning of each interview, participants gave written and verbal consent to participate and were offered the opportunity to ask questions. Following institutional ethical approval and GDPR, interviews were digitally recorded on Microsoft Teams, transferred to a secure password-protected file, and then the original files were deleted. Once the interviews

were transcribed verbatim, the recording was deleted from the password-protected file and each participant was assigned a pseudonym (e.g., Toni). Pseudonyms, rather than numbers, were used to represent each player as a way of personalising the conversations and respecting players' experiences. This approach was particularly important given players in this study often expressed that they felt like 'just a number' in their football environment.

5.2.5. Data analysis

I transcribed interview audio files verbatim, which aided in my immersion with the data (Braun & Clarke, 2006). Reflexive thematic analysis (RTA) was then applied, with inductive logic used to construct, analyse, and report shared meanings generated among the data (Braun & Clarke, 2019). This method aligned with my philosophical approach for this study as it allowed for patterns and themes to be generated while attempting to make sense of participants' experiences.

I used Braun & Clarke's (2019) six reflexive phases of analysis as a resource throughout the analysis process. I re-familiarised myself with the data by re-reading the transcripts and noting stories or moments that felt particularly important to the research questions. I then used a mixture of semantic (explicit) and latent (implicit) coding and went through each individual transcript by hand. By using both semantic and latent coding, sensitivity towards participants' explicit descriptions of their experiences as well as the construction of their experiences was achieved. Specifically, semantic codes were identified through explicit meanings communicated by the participant (i.e., data was not interpreted beyond what was said by the participants), whereas latent codes were produced by my interpretations of what participants communicated (i.e., underlying ideas, patterns, and assumptions) (Byrne, 2022). An example of a coded section of data from this chapter is provided within Table 5.2.

I then began collating codes together which had similar meanings to produce preliminary themes, for example: (1) how mental health is understood, (2) how it is impacted within football, and (3) how it is supported. I used these broader themes to further organise the quotes and then combined these into themes which were refined over multiple meetings with critical friends.

Table 5.2 Examples of coded data extracts

Data	**Codes**
I was devastated too much from football I think… that was a big lesson… my mental health was really bad, looking back now I don't know if I was depressed, I don't know maybe… more anxiety I would say but I was sleeping for two or three hours a night.	- Self-worth and well-being connected "too much" to football - Attempts to describe struggles / clinical definitions
I was just getting massively affected by football massively, being mistreated, being thrown in, thrown out, I kind of didn't know what to do so I was getting really bad panic attacks and I'd go to training and there was one time that I just cried in the middle of the pitch during a session, it was awful and I don't even know what happened I just cried, I think one of the girls might have said pass the ball quicker	- Feeling disrespected and a loss of control - Impact of culture and feeling unable to speak out - Breaking point moment with mental health
In terms of my eating I did struggle a little bit, because I started like calorie counting over the summer but I do understand how important fuel is for football but it was more like on my off days I would calorie count a little bit to make sure I wasn't eating too much	- Food seen as a performance tool / performance narrative - Fear of eating too much

5.2.6. Research quality

Here, I ask the reader to make judgements about the rigour and quality of the chapter using the following criteria: (1) credibility, (2) meaningful coherence, and (3) significant contribution (Smith & McGannon, 2018; Tracy, 2010). I enhanced credibility using four mechanisms. First, data is presented through thick and detailed quotes to allow transparent

conclusions to be drawn (Burke, 2016). Second, I used member reflections which are used to gather additional data or insight; member reflections should not be confused with 'member checking' which is where participants are asked to confirm the validity of findings (Tracy, 2010). To do this, I had follow-up discussions with roughly six participants who expressed a willingness to be contacted for future research or further conversations during their interview. These conversations helped generate honest feedback, insights, and interpretations from participants on the co-constructed themes; for example, players helped to elaborate on the themes I generated and also provided further stories or experiences which helped me further generate themes (Burke, 2016; Poucher et al., 2020). Third, throughout the entire research process, my supervisory team with expertise in mental health research and qualitative research challenged my understandings. My supervisors had ethical clearance to see the data, however they primarily contributed during the latter stages of the analysis process after I had already coded data and drawn out relevant quotes. In these later stages, they challenged my interpretations, pushed me to reflect on my own experiences, and helped ensure themes did not overlap in meaning.

Finally, credibility was established through reflexive diaries which were kept on a secure cloud platform. Reflexive diaries helped me recognise personal meanings and subjectivities within my own understanding of mental health and the context players were situated in. For example, one area I specifically reflected on was my approach to conversations regarding food and weight, having previously struggled with these areas and not wanting to project my own experiences. When these topics came up – which they did across almost all interviews – I engaged with my experience where appropriate as to help add to the interaction, and not to shift focus on my experience. At times, I drew on aspects of my own experiences with this topic primarily by drawing on my past research—for example, I offered findings from the quantitative study around eating disorders (e.g., that 36% met the cut-off for eating disorder

symptoms) and my MSc research to facilitate conversation. This way I was able to demonstrate an understanding of the topic at times where delving into my own story felt out of place.

Meaningful coherence (Smith & McGannon, 2018; Tracy, 2010) was achieved via discussions with critical friends, primarily my PhD supervisors. Additionally, an expert outside of my research team—a researcher in professional women's football—served as a critical friend during the analysis process. This helped me generate clear and coherent findings which were meaningfully connected to the concept of mental health and the footballers' unique context (Tracy, 2010). Finally, significant contribution was achieved by the novelty and originality of this project in terms of my approach (e.g., qualitative methods) and research focuses (e.g., elite women footballers in England during the ongoing professionalisation, mental health challenges).

5.3. Findings

The following section present four themes which were generated to represent key challenges that women footballers experienced in relation to their mental health and the on-going professionalisation: a) Unexpected realities; b) A narrowing self-identity; c) Clashing body image ideals; and d) Shifting social support. Theme titles include quotes from players to illustrate each theme's focus and essence. Throughout this section relevant literature and theory is used to draw out findings where important. Further literature and theoretical links will be made in the discussion section.

5.3.1. Unexpected realities: "Is this actually professional?"

The first theme represents a conflict between the players' expectations of what they thought 'professional' football would and should be like compared with their actual

experiences. Players said the professional football environment was filled with unexpected and harsh realities which impacted their football careers (part-time or full-time) and mental health.

Two unexpected realities were frequently mentioned in these interviews: (1) shifts in team culture, and (2) mistreatment of players, specifically by managers. For example, Sara (WC) shared how professionalisation unexpectedly impacted her team culture:

> We were all quite close knit, so we were buzzing that we were going to get paid because that was something I never even considered when I was younger […] but, then when we went up that season, everything sort of fell through the cracks. It wasn't a very nice environment to be in, he [the manager] brought in a lot of new players who obviously were attracted to the status so getting paid and stuff. There was quite a lot of inequality in the team and my manager was a bit toxic to put it nicely. […]. I was just miserable going to training, it was like survival of the fittest, like everyone just wanted to play whereas before we'd come from having an amazing team where everyone played. So, that was my first experience in professional women's football, so, yeah, probably not the greatest introduction.

For Sara the "survival of the fittest" culture and "win-at-all-cost" approach at her club—driven by staff—conflicted with the pre-transition collective culture that brought her and her teammates enjoyment at football and performance success. In cultures where the win-at-all-cost approach exists, winning is felt to be more important than the whole person which can impact individuals' mental health (Carless & Douglas, 2013; Douglas & Carless, 2017; Wood et al., 2017). This shift in culture felt particularly acute for some, including Sam (WSL):

> Having lived this year [as a professional footballer], I've got so much sympathy for the male footballers because this year has literally been a pantomime or a circus, that's how I describe it […]. I get that it's football at the highest level, that's what we have been

> told continuously this year, that "it's football" and "that's football" and "that's football" (long pause) but that doesn't mean people need to forget we are human beings [...] I guess that's what we loved about the club [previous staff and team culture] was that we were told football doesn't have to be like that…that you can be good people and still play pretty football and have a good career and that's why it was such a drastic change but that's what I mean, it was the new people brought in and those above them.

Sam expressed that the shift in her team culture was shaped by their new staff, full-time professional status, and heightened entanglement with the men's club. In turn, Sam felt her team was forced to adopt the practices and values of the men's game such as this win-at-all-cost-approach. Ultimately, the harsh environment of men's football—often defined as ruthless, aggressive, and macho (Roderick, 2006; Tonge, 2021)—made Sam feel empathy for the men's players yet also deeply frustrated about the state of her own game. 'Being professional' seemingly now meant that her team would be better off with the staff, and even cultural norms and values, from the men's game.

It was also clear that players felt let down by lack of communication and the mistreatment they experienced from staff; another significant challenge to their mental health. This was the opposite of what they had expected from their new, 'professional' setting. Tara (WC) explained that this felt particularly acute given everything the women had given up to make their football career work (e.g., full-time and established jobs, higher salaries, moving away from home):

> The way players were treated was awful from the management and just communication. I think that's actually the main thing coming down to it, just some days you wouldn't even be spoken to, so that wasn't great. Also, just like probably the sympathy and sensitivity towards things like this is our life and its not easy because we aren't paid

> millions and we are away from family and it can be tough and sometimes I don't think they [the managers] have realised we have given up everything just for not a lot, so yeah I think that's probably it – the sensitivity of it and communication.

Tara continued to share that she and her teammates often felt like numbers and were often 'dehumanised.' Dehumanisation occurs when athletes' emotional and psychological needs are disregarded in favour of the pursuit of winning, and is represented by the denial of their human characteristics, such as their emotional responsiveness and need for interpersonal warmth and respectful communication (Larkin et al., 2020).

In some cases, players spoke about being actively dehumanised, mistreated, and disrespected by staff. For example, Gemma (WSL) said:

> I was getting massively affected by football massively, being mistreated, being thrown in, thrown out and basically, I didn't know what to do so I was getting really bad panic attacks.

Tara explained that mistreatment occurred when players were not spoken to at training, not provided information when significant changes were made (e.g., Gemma being "throw in and out" of the starting line-up each week), punished or ignored when they asked coaches questions, shouted at by managers for no reason, and made to feel incompetent in front of the team during training.

Both Tara (WC) and Gemma (WSL) explicitly shared how navigating dehumanisation and mistreatment was a challenge for their mental health. Both understood that how they were being treated was not appropriate or 'professional,' yet, they also felt the need to comply or else they could be replaced by other players. While both Tara and Gemma expressed that they were able to navigate this challenge by switching teams at the end of the season, not all players

have such flexibility and may be forced to put up with mistreatment, leave the game, try to change the culture, or hope that they are transferred to a team where the culture is better.

Some footballers accepted mistreatment as an aspect of elite football culture, while other players took active steps to change the culture by speaking up about their needs to staff or by supporting their teammates more intentionally. Those players who did voice their concerns expressed that they were often ignored or further mistreated which at times left them feeling even more powerless and hopeless.

For example, Sam (WSL) talked about having a meeting with her manager after weeks of experiencing mistreatment from them. In response, Sam—a starter up until this meeting—was benched (relegated to being a substitute) for several weeks and made to feel guilty that she brought up any such concerns. Sam explained that this interaction resulted in her having on-and-off panic attacks and anxiety for the weeks to follow as she questioned her decision to sign professional and the environment she was now in:

> I always wanted to sign pro so I couldn't turn that down, but I guess it's that old saying 'you don't know what you got until its gone.' I don't regret leaving [her old job] because I wanted this opportunity and I wanted to learn from it… but this has made me realize how happy I was last year and how settled and comfortable. […] I think just this year there has been [voice shakes] just a lot of things have happened that set off certain triggers [crying] and I knew I wanted to get help before I ended up in a situation that previously where I just really didn't want to be here [reference to suicidal thoughts].

Like Sam, several players shared stories of overt mistreatment from managers when trying to help themselves or teammates. Significantly, these were often described by players as 'breaking point' moments for their mental health. Jen (WC, footballer) relayed the following story:

> I have a good one [sarcastic laugh]. One of the younger girls came to training and she was crying like crying her eyes out so I took her aside and was like "are you okay?" and I was trying to help calm her down. Then the manager was like, "come on training is about to start" and so I said, "okay give me a minute just dealing with my mate" to which point he started shouting at me like "you don't fucking listen to me" so I went over to him and said, "look she's really upset" and he continued shouting at me so I was like, "are you going to let me explain what's happening here or are you just going to keep shouting at me?" and he said, "I don't want to hear anything out of your mouth, why don't you just fuck off and go home?" I tried to explain what was happening and he was literally like "I don't care what's happened, all you've done is talk back to me, not listened to my authority, if you are not going to listen to me just fuck off and go home." So I got in my car, and I calmed myself down. But, then I went back into training and finished the session (long pause) but, even now, I am like why did I do that? Why did I go back [to training]? I should have just gone home. I don't know why I didn't just go home.

Jen's account demonstrates how performance-driven cultures and power dynamics create impossible conflicts for players to navigate. For example, Jen wanted to demonstrate she was a 'true professional'—able to handle the harsh comments and unbothered by her manager—so she returned to training instead of going home. However, by going back into a harmful environment, she felt guilty. While Jen questioned herself—"why did I go back?"—she also questioned the environment she and her teammates were in where mistreatment was allowed happen; this was a question many footballers asked as it impacted their mental health or that of their teammates.

Heightened focus on performance and an adoption of the win-at-all-cost approach allowed for mistreatment of players to occur. This, in turn, can negatively influence women's team cultures and many players' mental health. To navigate these stressors, players often expressed a need to maintain a holistic identity to keep them balanced. However, this represented a further challenge as maintaining a more balanced self was extremely difficult in their current context.

5.3.2. A narrowing self-identity: "Who can I be here?"

Situated in the elite football context, players struggled to maintain a multidimensional identity as they often felt they had no time for anything else but their athletic self. As they committed more time to football, they identified more and more with their 'athletic identity' which is part of one's self-identity (Lamont-Mills & Christensen, 2006). The increasing dominance of their athletic identity impacted their mental health as players' self-worth hinged on their football performance more than it previously had and came at the cost of other identities that were important to them. For example, Erin (WC) said:

> You invest so much into it, like football is everything to you and without it, you don't know who you are. So, if football goes bad, everything goes bad […] I don't think people understand the investment that you put into it but, yeah my struggles with mental health were definitely because of football, a large part of it at least.

Like Erin, Faye (WSL) expressed the impact their transition had on their athletic identity and self-worth:

> The more pressure there is to perform and win, means the more you attach your value and your worth to the sport and how you are playing, how you are performing, how

> many minutes you are getting in, how you are doing in training sessions. So, I have found times now where I haven't had a good training session and I found it affecting the rest of my day and how I interact with friends and family and how I feel about myself and that's where I've had to sit back and been like I am more than a performance, I am more than a training session, I am more than a footballer […]. I have to tell myself, 'you are more than a footballer' but you don't really see yourself as two different people, quite often you are just that (Faye).

Like Faye, the footballers were aware of their life being increasingly consumed by football and their intensified athletic role but were faced with pressure and expectation to keep it that way by a progressively professionalised sporting environment which—in the men's game—has been normalised as 'what it takes to make it' (Roderick, 2006; Roderick & Gibbons, 2010). Ultimately, players struggled to separate themselves from football which led to feelings of frustration and guilt as they acknowledged the consequences of their narrowing identity. For example, Jen (WC) expressed the impact of her narrowing identity on her relationships and mental health:

> I was always over tired, over doing it, and trying to impress and not getting much in return, you know it's important to impress in football so I would never miss a session. I would be going to the gym in the morning before work, going to work, and then training so I clearly had the need to constantly be going above and beyond […] It's just knackering. Like, I am good for nothing like nobody gets the best of me I don't think when you are working full-time and playing full-time like you are not recovered ever and you know your sleep is atrocious. I am tired at work, I am tired at football, I am good for nothing at home, so it's difficult.

Jen expressed an ongoing internal conflict between knowing what was 'right' for her relationships and mental health, yet she wanted to do everything she could to improve her football performance. For her, the consequences of not proving herself at football outweighed the steps she knew she needed to take for a more balanced self—i.e., not attending the extra morning sessions. Over time, this imbalance led to what Jen described as "the worst" her mental health had been.

This finding aligns with Brown & Potrac (2009) who found that elite athletes' narrowing identity can contribute to serious mental health related problems as players attempt to navigate their way through the professional game. However, in contrast to nearly all available literature which suggested that elite athletes accept their narrow identity as 'sacrifice' for sport (Coyle et al., 2017; Trainor et al., 2023), the footballers in this present study acknowledged the consequences of this, with many actively attempting to expand their athletic identity outside of football through activities and trying new hobbies. Kelsey (WC) shared her experience:

> I was really far away from everyone and I wasn't playing so yeah I felt myself getting there [depressed] […]. I spoke to a sport psychologist who tried to help me get into different distractions to make sure that football wasn't the only thing in my life. I started playing a little bit of golf and guitar - literally trying anything to try to distract me from just being upset in football.

Kelsey shared that although she tried to separate herself from football, she lived in shared accommodation with her teammates, had limited extra money for activities or transport, and was hours away from her family which made it difficult to escape football and nourish other areas of her life. While financial remuneration and living conditions are improving for

many players in the WSL and WC, they currently present as barriers to players broadening their identity beyond the game.

While Kelsey expressed that trying new things "helped a little," her perceived inability to escape her narrowing identity had detrimental impacts on her mental health and it left her feeling hopeless and like she had failed at something she should be able to do. She shared how the long-term toll of her strong athletic identity and her environment negatively impacted her mental health which resulted in her contemplating if she should leave football:

> I could do this all year again and it just wouldn't be healthy [voice shaking] […] I just have had such an unhealthy relationship with football just in every way. The injuries, what's gone on this season [crying] (long pause) I think if it [football] was like an ex or something you would just get rid of them, but with football it's constantly there, it's your comfort blanket and taking yourself away from it is so weird.

In contrast to Kelsey, Sara (WC) shared that she had successfully broadened her identity which had a significant positive impact on her mental health; "Where I am now compared to where I was before is two very different people and that's just because I have taken my self-worth away from football. It is more like I go to football now, football doesn't come to me". For Sara, taking time off football, moving home, and beginning therapy helped her to remove self-worth from football and broaden her identity.

Footballers' awareness of the dangers of their narrowing identity will likely support their mental health in the long-term as it is well-documented in literature that broadening athletic identity while in sport is a way to protect athletes' mental health during sport and through transitions (see Andronikos, 2018; Knights et al., 2016). What poses a challenge, however, is the short-term barrier to doing so and the impact this has on mental health. These challenges include pressures and conflicting messages around food and body image.

5.3.3. Clashing body image ideals: "What am I actually supposed to look like?"

The footballers described a general heightened focus on their body since turning professional. As Jess (WSL) said, "We are professional now, it's not like 10 years ago where some of the players weren't as physically in shape. It's a different ball game now, it's full time-professional and you're expected to look like an athlete." Expectations to 'look like an athlete' were driven by footballers' internal environments (e.g., clubs, managers) often in the name of performance and externally (e.g., media, sponsors) for purposes of promoting the game and selling the sport. Ultimately, footballers felt pressure to be both sporty and feminine. Players expressed feeling uncertain and conflicted and often dissatisfied with their body image in light of these heightened expectations which led to them experiencing body image distress and engagement in unhealthy food and weight behaviours.

Elle (WSL) described her experience of heightened body pressures, mainly from within her internal sporting environment:

> I do think there's a really big issue with it [body image] in women's football. The rapid increase in the standard and the money in the English league has led to sport scientists thinking "okay let's try and get a 1% increase in performance by looking at skin fold and body fat" but I think that might have worked in the men's game where you don't need to put much else with it to support it [psychological and nutrition support] but I know with my experience, and seeing other players in my team, I think doing skin folds is really detrimental [to mental health] and not always in an obvious way. Even for me, I have never been tiny and I have never been big so I am not that fussed, but doing skinfolds and then everyone comparing their skinfold value… yeah, it just slowly seeps in.

Elle's account highlights that current sport science practices are being drawn from the men's game, which are not always physiologically or psychologically appropriate for women footballers.

Other footballers discussed internal expectations around body fat composition to be a source of stress and anxiety. This was largely due to a lack of nutrition support to meet these ideals and unknown and unrealistic expectations placed upon players from staff. Kelsey (WC) and Toni (WSL) expressed this:

> It's really hard because we aren't educated too much on what to eat […] like some of the things we get told to do are a bit absurd, like lower your carbs. Some people were cutting out carbs at one stage because that was like the 'in thing' to do? (Kelsey)

> Yesterday one of the fittest players on the team came back in the yellow (instead of green for body fat testing) so we were all confused […] like how can she be the fittest player and be in fat club? Like its mind blowing and I'm not in it [fat-cub] but, I am but I am bigger than everyone in fat club and I'm not huge so it's just madness like its mad […] I definitely think it's one of the things that affects people's mental health the most. (Toni)

As expressed by Toni, footballers shared that they are tasked with meeting body compositions expectations from sport science staff, yet they are provided with limited clarity around where certain standards come from or what the ideal body composition is for fitness and football performance. For example, Toni's teammate was the fittest on her team yet did not look the most athletic and had higher body fat than other players which made Toni wonder why such an emphasis is placed on body-fat testing for women, particularly given the potential mental health consequence of this testing.

The frequency of body-fat testing and the lack of clarity around the 'ideal' body composition resulted in players feeling that their bodies did not fit into elite football. Gemma (WSL) shared that this feeling for players is largely because managers and sport science staff see the male body as ideal for performance (e.g., no curves or body fat), which is impossible for many women athletes. Gemma shared her experience:

> The manager made the comment twice to me [that I was bigger last year]. I haven't been big in my entire life, I have curves, I am a woman, I am not shaped like some athletes where they are flat, I have curves because it runs in my family, you know? I have no luck with that kind of thing, like, I look like a female, and I don't care? I still play football the same, so it doesn't matter. I literally asked people on my team that like 'was I fat last year?'

Gemma's account highlights how the elite football context maintains that a more female body shape (i.e., having curves) is viewed as unlucky in relation to professional sport and performance, which only adds to pressures players face around body image and can cause significant harm to mental health. For example, Olivia (WC, footballer) internalised this messaging and felt anything less than a supposedly perfectly lean body was detrimental to her performance. This resulted in Olivia's engagement with frequent self-weighing and a hyper-fixation on food:

> I think that's where a lot of where my struggles mentally with food and weight came [skin-fold and body composition testing]. I know they do the testing for your period cycles and hydration, but I couldn't get over the fact that we were doing it so much. Then I was like oh okay well that's what the pros are doing, that's what you do at this level, then that must be right […] I do still weigh myself too much…which I am trying to get out of, I think that's so hard to get out of mentally when you do it […] If I weigh

> too much then I am just in a bad mood for the rest of the day, which is not good, and I know it is not good and I just can't… I have never really been able to get out of it, I automatically think I am going to play shit if I am heavier it is just so frustrating cause like I say this back and it just sounds so stupid but I'm like 'oh my god I'm too heavy' and if I get out of breath at training I think to myself it's because I gained two pounds.

Aligning with current literature, Olivia highlighted how frequent self-weighing and body-related feedback from coaches can have significant long-term implications on women athletes' body perceptions and health-related behaviours (Bennett et al., 2017; Coker-Cranney & Reel 2015; Muscat & Long, 2008). Importantly, recent best practice guides by Mathisen et al. (2023) highlighted that an overemphasis on the importance of body composition for sports performance and frequent body composition assessments may promote body dissatisfaction, body image disturbance, and eating behaviour which can have severe long-term implications such as low energy availability and higher rates of injury. Further, they explained that the presumed association between body composition and competitive success is preliminary and focused primarily on endurance sports, which does not account for the different physiological needs of women competing in power-based sports like football (Mathisen et al., 2023).

Players also expressed that the ongoing professionalisation has led to increased pressures and importance placed on body image for external reasons – such as promoting the game, attaining sponsorship deals, and selling the sport. Different to men footballers, for women the ideal body image for performance may differ from that which is expected off the pitch which causes conflict. Footballers shared stories that align with findings from Culvin (2019) who found women footballers are tasked with the responsibility of promoting and selling the sport, often through their appearance. As described by Jen (WC), this conflict makes

players feel they need to "look a certain way." Jen shared the "danger" this pressure has on players' mental health:

> Players feel they have to look a certain way or, you know, have their [social] accounts on public – it's something I did eventually but me and my partner spoke about it and we decided it will help get my name out there, but it is not something I was particularly comfortable doing and it is good and bad for the game, like, as a footballer like the fans and stuff it's good to have that contact and the tags on social media and stuff but I do think it is a dangerous game, I think there is a lot of pressure.

As she wanted to help grow the game and attain paid sponsorships, Jen made her account public which was not something she was truly comfortable doing. Like other footballers, she felt conflicted as she knew her appearance which was described as more conventionally attractive according to feminised ideals, was part of why she was gaining followers. This was a conflict for her as it made her feel guilty, but she also felt she had to do this to attract attention and potential sponsorship deals to make extra money.

Like Jen, players expressed that making extra money through sponsorship deals was particularly important for them as many women footballers are often making just enough money to live (Culvin, 2019). This ongoing conflict was experienced by several footballers and was often reinforced by clubs promoting similar messaging. Erin (WC) shared her experience:

> Clubs still subtly sexualize female footballers and I don't think they do it on purpose (laughs), I do think they do it on person, that was a complete lie (laughs). They try to do it subtly, but it doesn't go unnoticed, so certain people end up the face of more things than others because of their appearance. So, I think it does make girls quite self-conscious and insecure.

Erin shared that the 'subtle' sexualisation of players was highlighted by clubs selecting the same player(s) for marketing who are almost always 'conventionally attractive' which emphasises a more traditional female form and conflicts with the body type players thought they needed to perform well on the pitch. Ultimately, the conflicting expectations left footballers feeling like they could not 'win' in terms of their body image. As Kelsey (WC) said, "You aren't just supposed to be skinny, you also need to look athletic, and you need to be strong and it's just a lot of different areas to cover." Kelsey further emphasised that this ongoing conflict left her constantly unsatisfied with her body image which resulted in unhealthy thoughts surrounding food and weight:

> Even on your break it's always constantly there. You always have that thing in the back of your head that is never letting you relax, like you feel guilty no matter what you eat. […] I just have a really weird relationship with food and I don't think I've ever had an eating disorder, but I have an unhealthy relationship with food definitely.

Together, this theme highlighted that footballers felt overwhelmed by the various and often conflicting body type expectations. In turn, they experienced unhealthy relationships with food and weight which were often, damaging to their football performance. Further, a lack of expertise among staff in leadership positions within clubs also enforced and heightened players' insecurities around their bodies. Conversations that require nuance and specialist insight were typically reduced by players—and staff—to simple, and often damaging, narratives around performance and food.

5.3.4. Shifting social support: "Who do I speak to now?"

The footballers wanted to speak about the various challenges they were encountering, particularly as they recognised their mental health was impacted at times. However, they described a shift in terms of what they felt they could share and with whom. They expressed

that before becoming professional, they relied on their family, friends, and teammates for regular social and emotional support. Yet, players described changed relationships due to various factors such as less frequent interactions with their previous support networks because of moving further from home and time constraints. For instance, Megan (WSL) expressed that when she turned full-time, she felt less able to disclose her mental health struggles to her family:

> I would just tell myself to get over it. My sister works in the city and she leaves at six in the morning and doesn't get back until eight or nine at night and I am moaning about my five-hour days, and she is out for 12-hour days? So, I would just try to sort of put everything into perspective, like how lucky am that I get to do this? So, it's telling yourself that and kind of getting over myself.

Megan minimised the demands of her football career compared to her siblings' as she felt she was supposed to feel "lucky" and needed to be "grateful" for her full-time career as a footballer as it is considered the 'dream career' especially in the UK (Culvin, 2019; Roderick & Gibbons, 2010). Megan's experience aligns with Roderick & Gibbons' (2010) research with professional male footballers where players expressed that 'true' feelings towards their football career are often silenced as players are perceived to be "lucky" to be able to play the game as a career. Ultimately, withholding struggles from others can lead to athletes feeling emotionally isolated which can negatively impact mental health.

Conversely, some players relied on their partners or family for support more than they had before the professionalisation as they felt less comfortable disclosing to teammates. Footballers shared that stakes were now higher and competition amongst teammates was more acute which made them more reluctant to disclose struggles. Isabel (WC) explained her experience:

> I was speaking to my dad about this yesterday because it's ruthless [the environment] like all the time, relentless, you are constantly competing against the person next to you. If someone isn't nice to you, say if someone isn't nice to you in the office it might just be because they don't like you, but say someone's not nice to you at football it could be because they are trying to play mind games with you to get ahead of you. So I think that's like yeah there just so much politics and people will form friendship groups and it's tough when you are trying to be friends with someone who plays the same position as you and you are competing against each other like... like it is so difficult.

Isabel expressed that not feeling able to talk to teammates was a source of internal conflict and often left her feeling lonely given most of her day was spent with her teammates as she trained and lived with them and is also far from home. Her experience with limited social support aligns with previous research involving professional footballers where a lack of social support, specifically low social support from teammates, was associated with depression and anxiety among footballers in both quantitative and qualitative research (Gouttebarge et al., 2015a; Woods et al., 2022).

In turn, players often withheld and concealed their struggles by using less-than-healthy coping mechanisms such as denial, distraction, avoidance, over-exercising, and hyper-focusing on nutrition and performance. For example, Sara (WC) convinced herself she wasn't struggling by focusing only on her football performance:

> I just convinced myself I didn't struggle with my mental health, I just convinced myself that nothing was wrong and distracted myself. I think a lot of people do that in football and just get on with it. […] Your football brain is on all the time, so I think it's easy to switch off you as a person. I think that's what I was doing. I was going to football four, five times a week and I was playing at uni as well and I would just switch everything

> off, I went to football, and I was just like 'I am at football now' and then I would go home and not process things and I think it's easier to do that when you are in an intense environment.

For Sara, her "football brain" allowed her to "just get on with it" which helped her to heighten her focus on football and in the short-term this helped her performance. However, the psychological impact of concealing and her ability to "switch everything off" impeded her awareness of how much she was struggling until she reached a breaking point:

> When I look back, I was in that mental state constantly, I didn't even feel depressed or down, I just always was. When I look back now it's scary that I was so far from who I was. […] I didn't have any experience with any bad mental health, I didn't have a scratch on me going into women's football. So, I don't think you always know how bad it is until you get to a point where you're like "What do I do?".

After several months of withholding these different struggles from her teammates, friends, and family, Sara was unable to get out of bed for training because of her mental health and she ended up taking time away from professional football, which is exactly what she was trying not to do by concealing. Like Sara, several other footballers avoided using their previously established support systems (e.g., friends, family, teammates) until they experienced near, or actual, emotional breakdown.

Footballers expressed a need for support, yet their support networks – upon which they had previously relied—especially teammates, has been shifted by aspects of professionalisation. Players frequently opted to conceal their struggles instead of disclosing which led several players to experience worsening mental health symptoms. Alongside shifts in player support networks and issues surrounding disclosure, players expressed needing more

formal and professional support—specifically mental health support—as they navigated the many challenges that accompany their career.

5.4. Discussion

While there are multiple factors that can negatively impact an individual's mental health, the findings from this chapter focused on four key challenges experienced by participants in relation to the ongoing transitions in elite women's football in England: unexpected realities of their career, a narrowing self-identity, conflicting body image messages and ideals, and shifting social support. For many of the players, these challenges negatively impacted their mental health over time, particularly when they were unable to navigate them. Additionally, footballers expressed that these key challenges were interrelated, with changes in their personal enjoyment of football, feelings of loneliness, and constant uncertainty surrounding their decision to pursue a football career.

One significant finding from this chapter is that the footballers—the majority now closely linked with men's professional football clubs—felt they needed to comply and accept values and norms that are inherent in the men's professional game to 'make it' in their new set-up. This was a source of tension for the women footballers as they believed many of the norms were not beneficial for performance and that they negatively impacted on their mental health. One example was the adoption of the 'win-at-all-costs' approach across many of the teams, an approach common in professional sport – specifically men's football (Tonge, 2021)—and is well-documented to negatively impact athletes' mental health (see Kavanagh, 2014; Henriksen et al., 2020a; Wood et al, 2017). The footballers expressed that this approach was primarily driven by staff and that many of these staff members were recently brought into the women's game after working in the men's game.

A significant problem with the 'win-at-all-costs' approach is that it allows for the dehumanisation of athletes, hinders psychological safety, and normalises mistreatment of athletes (e.g., bullying, abuse), particularly by those in power positions such as managers (Kavanagh, 2014; Henriksen et al., 2020b; Wood et al., 2017). Footballers shared stories of emotional and psychological mistreatment (e.g., being actively ignored by staff, belittled in front of teammates), and some players described prolonged instances of bullying from managers which impacted their mental health (for definitions of 'abuse' and 'bullying' see Kavanagh, 2014, pp. 14-28). Across the literature, it is well-documented that all forms of mistreatment can negatively impact athletes' mental health and have been specifically linked to eating disorders and self-harming behaviours (Stirling & Kerr, 2013; Willson et al., 2023). When footballers tried to speak up about mistreatment, they were almost always ignored or dismissed by those in power which had further negative impacts on their mental health —often leaving them feeling hopeless. This is examples is indicative of an environment where there is a lack of 'psychological safety.' As noted by Edmondson (2018), "In psychologically safe environments, people believe that if they make a mistake or ask for help, others will not react badly" (p. 15). Ultimately, these interactions sent footballers a stark message that despite now being 'elite' and 'professional' sportswomen—somewhat trailblazers a new era for the women's game—the reality was that they still had little power over the culture and conditions of the women's game.

Players expressed that the all-consuming nature of their career and sporting environment heightened their athletic identity, often to the detriment of other areas of their life important to them (e.g., family, friends, relationships, hobbies). This 'narrowing of self' described by the footballers has previously been documented by elite athletes when entering elite or professional sport (Edison et al., 2021; Lally, 2007). Literature indicates that elite athletes' most common response to entering elite sport is to 'live the part of the athlete' which includes an acceptance

of a narrowing self-identity (Carless & Douglas, 2013; Coyle et al., 2017; Trainor et al., 2023). For example, in recent research with elite athletes, they all justified their narrow and strong athletic identity as just part of 'what it takes to make it' in elite sport and presented no desire to expand it, even when they recognise the negative impact it has on their mental health (Trainor et al., 2023).

In contrast to findings by Trainor et al. (2023), this present study showed footballers wanted to nourish other areas of their life and recognised the dangers of a narrow athletic identity on their relationships, mental health, and long-term health (financial, emotional, psychological, and relational). The footballers' self-awareness of their narrowing identity is possibly due to the fact that during childhood and adolescence, when identity formation takes place, they developed multiple identities as women's football pathways were far less available and the potential to play women's football professionally was not yet established. For example, Gledhill and Hardwood (2014) found that women footballers in England engaged in multiple avenues during adolescence with an equal focus on academia due to limited future football opportunities. Further, and different to young men, there was a lack of acceptance for women to commit to football over other avenues such as academia. Thus, many of the footballers who took part in this current study likely had established other identities and interests that were important to them alongside football. Therefore, the shift to a sole focus on football for many of the players is likely to have a bigger impact on this specific population than other sporting populations whereby athletic identity was perhaps more established during formative years.

Despite footballers' self-awareness and desire to be 'more than a footballer,' internal expectations and beliefs around 'what it takes to be an elite footballer' and external barriers such as time constraints and being far away from home, made nourishing other areas of their identity hard to do. This tension of wanting to be "all in" and establish oneself within football,

yet, at the same time, wanting to nourish and develop other areas of their life and their identity, was present across all interviews and a source of challenge to players' mental health. For several players in this study, failed attempts to break away from their narrowing athletic identity resulted in extreme feelings of guilt and frustration which negatively impacted their mental health. Collectively, these findings are important for those working with this population to consider as different support approaches might be warranted. For example, Hilton (2022) reported that helping elite athletes broaden their identity might require 'unconventional' ways of doing so due to the uniqueness of their career and environment. Expanding on her recommendation, it is important that each population is looked at when providing support around identity. For example, women footballers regularly expressed family as an important part of their identity and shared that they wanted to nourish this area more. Thus, it might be considered that players' families are allowed into the football environment more regularly to spend time together, where safe and appropriate. Further, in terms of helping players expand their identity, there may be moments where this is more advantageous; for example, during long injuries such as ACL injury, there may be opportunities to help athletes nourish other identities important to them.

Food, weight, and body image was another area where footballers described feeling conflicted and felt unable to successfully navigate. Footballers described an ongoing physique tension between their on-pitch body where increased muscle mass was needed for performance, and their off-pitch body where a leaner physique was expected or desired by themselves or others. This conflict often resulted in players engaging in unhealthy food and weight behaviours; including, hyper fixation on nutrition, frequent self-weighing, and intentional under-fuelling, especially during time periods they perceived less fuel was required such as off-days, off-season, and injury. This conflict was driven in-part by heightened expectations around their bodies from outside their sport (e.g., media appearances) in the name of "selling

the sport" and from within their sporting environment, often in the name of "performance" (e.g., body composition testing).

Footballers shared conflicting messages about body image from within their football environment. For example, players expressed that frequent body-composition testing did not feel fit for purpose as footballers with extremely high fitness levels were being told they had "too high" body fat and were often provided very little explanation. While some were able to ignore it, others described heightened feelings of dissatisfaction about their body. Collectively, the sporting context and societal expectations meant that footballers feel they 'can't win'. Understanding the variety of short-term and long-term health problems that can accompany body image concerns (e.g., eating disorders and depression), it is crucial that those working in women's football acknowledge and tackle wider structural pressures which can contribute to these body image challenges for players (Mancine et al., 2020; Stice, 2002).

Further, the footballers in this study perceived that men footballers were less likely to be impacted by body-fat testing, body image struggles, and eating distress, and suggested support staff were not equipped to provide support for women in this area. Thus, it is possible that women footballers are more likely to withhold struggles from support staff regarding body image, food, and weight and possibly feel more comfortable seeking support for mental health challenges which are perceived to be more common or accepted issues in men's football, such as depression or anxiety. Importantly, this finding indicates that women are likely to assess the legitimacy of their struggle(s) in relation to the context they inhabit—i.e., male football culture. These findings potentially provide some insight into findings from Chapter Four which indicated high eating disorder scores in elite women footballers were not associated with players who currently needed psychological support, yet high depression and anxiety scores were associated with those needing psychological support.

Across the interviews, players shared that they needed and wanted more formal and informal mental health support since becoming full-time or part-time. However, they expressed not wanting to burden family and friends and feeling like their teammates were not as able to help due to their own struggles or feeling like competition between them was too strong. In-turn, players often withheld different struggles which, over time, were of negative impact to their mental health.

Collectively, players felt that more formal support was required to help them navigate these different challenges. However, despite saying this, players were rarely willing to use the support provided to them by their club. One significant reason for this was feeling that those employed to support them would not understand the challenges they face. This perception is likely driven by the fact that few people have actually asked the women footballers, 'what challenges are you and your teammates facing in relation to your mental health?' and 'what challenges do you and your teammates face in relation to using club-provided mental health support?'. While this chapter provides insight to the first question, the next chapter attends to the latter.

Taken together, it is critical that players' experiences with mental health shape and guide the support options from clubs and that the support offered is tailored towards the challenges that they face as elite women footballers in England. An apt place for clubs to start is with the four challenges expressed by the women themselves offered in this chapter.

Future research directions

There are many research avenues for researchers to consider. Researchers could explore how elite women footballers navigate, or make sense of, one or more of specific challenges to mental health identified in this chapter—e.g., identity or body image. A more specific focus on one of the challenges mentioned in this study could allow for vital insight which could facilitate

improved understandings and resources to better support this population. Additionally, research is needed to explore how elite women footballers cope or look after their mental health. Understanding the ways in which footballers cope with challenges could provide further insight into the context in which they exist. Findings could then be used to create resources for other players to help them manage their mental health more effectively.

Research is also needed to explore protective factors for mental health. Kuettel and Larsen (2020) highlighted some potential protective factors including feelings of autonomy, positive and secure personal and sporting relationships, and adequate recovery, however, few studies have actually explored these protective factors. One final recommendation concerns 'psychological safety'—a somewhat newer concept in sport psychology research (Taylor et al., 2022). Researchers could explore the relationship between psychological safety and mental health experiences as well as help-seeking behaviours amongst elite women footballers. Explorations into what psychological safety looks like in specific sports, or for specific populations in specific sports, could allow for critical insight into sporting populations which could be used by organisations to create a psychologically safer environment for specific athlete populations. A psychologically safer environment could positively impact mental health and reduce distress for athletes.

Strengths and limitations

This study had many strengths and some limitations. One notable strength includes the population explored. Access to 21 elite women footballers during such a unique time for the women's game is a significant strength of this study. Another strength of this study was the philosophical and methodological approach utilised. By using interviews—for example—insight into the players' lived experiences was gathered and new insight was attained. For example, players expressed navigating their identity was an extreme challenge and often

negatively impacted their mental health. Players voiced not wanting to be 'just a footballer' despite this being the 'dream career.' This finding sits in contrast with previous research with elite athletes (e.g., Trainor et al., 2023) and would likely not have been uncovered without qualitative research.

Another strength of this study was the inclusion of players with a spectrum of mental health experiences, opposed to inclusion of only those with clinical mental health diagnosis or severe mental health challenges which is common in the mental health and elite sport literature (see Pereira Vargas et al., 2021). Involving footballers with potentially less severe challenges or undiagnosed mental illness, allowed for individuals to take part who often do not fit the research criteria in this topic area, yet who do experience challenges to their mental health. This was an important feature of this study as it allowed for insight into challenges that players face which can lead to worsening mental health if left unresolved or allowed to worsen.

For data collection, video calls were used which can be seen as a strength and a limitation of this study. Due to COVID-19 in-person interviews shifted to virtual interviews via Microsoft Teams video calls. Researchers have historically argued that virtual interviews are secondary to in-person interviews as face-to-face interviews are more personal and produce better quality data (Keen et al., 2022). Since the pandemic, however, researchers have recgonised the many benefits of virtual interviews, such as saving time and money of travel, and extreme flexibility for both parties (Keen et al., 2022; Oliffe et al., 2021).

For this study, virtual interviews were a strength as it allowed players to take part in the interviews in the comfort of their own home, or in a place where they felt safe and able to share. The population in this study is high-profile population and the topic they were being interviewed about is sensitive, thus virtual interviews provided greater opportunity for comfort and privacy then in-person interviews likely would have. For example, conducting interviews

virtually removed the fear that the participants could be recognised or overheard if interviews would have taken place in-person. Also, virtual interviews allowed for flexibility in timing which was really important given the demands of their schedule.

5.5. Conclusion

This study offers novel insight into the challenges elite women footballers face with their mental health. Through the use of qualitative methods—specifically interviews—four themes were generated to represent the challenges they face in relation to their mental health and their sporting context: specifically, the ongoing professionalisation. These challenges included, unexpected realities of their career, a narrowing self-identity, conflicting body image messages and ideals, and shifting social support. For many of the footballers, it was the combination of these different challenges paired with limited resources to help them navigate these which led to periods of significant struggle with their mental health.

Research is needed to explore barriers to accessing and utilising psychological support within clubs, and subsequently evaluate the current psychological services that are being offered—beginning with exploring player and staff perceptions and experiences of the support offered. Tending to this recommendation, Chapter Six qualitatively explores player and staff experiences with the current support provisions offered by clubs for players' mental health needs.

Chapter Six

Player and staff perceptions of mental health support within elite women's football in England

6.0. Abstract

Both the quantitative (Chapter Four) and qualitative (Chapter Five) studies in this thesis indicated that women footballers in the top two tiers of English women's football wanted professional psychological support. Specifically, 86% indicated they wanted or needed psychological support at some point during their career, with 90% of players stating that receiving support from a psychologist would have helped them during their football career. Despite 50% reporting that psychological support is available at their club, only 28% reported to have used it, while 38% reported using psychological support from outside their club. The aim of this chapter is to explore player and staff experiences of mental health support within women's football and the challenges related to its utilisation. While the players' voices remain the focus of this study, staff accounts are included to allow for a more holistic view of club provision. Data from 21 player interviews and 10 staff interviews was collected and analysed via RTA. Analysis generated four key barriers to using support: a) Negative consequences of using support; b) Support gatekeepers; c) Misaligned support pathways; and d) Poor quality care. The findings strongly suggest that the current support offered to players is misaligned with their wants and needs. Clubs were perceived to not adequately care about player mental health or, more specifically, their needs as women footballers. This in turn impacted players' utilisation of the available support.

6.1. Introduction

The ongoing professionalisation of women's football in England has led to considerable changes both in the game and the lives of players (see Chapter One; Culvin, 2019). Elite women footballers in England face unique challenge in relation to their new career and sporting context, in addition to 'normal' challenges that elite athletes encounter – i.e., performance pressures, media attention, injury (Kuettel & Larsen, 2020; Rice et al., 2016). Specifically, as demonstrated in Chapter Five, elite women footballers encounter challenges such as navigating a new football culture, mistreatment by staff and stakeholders, identity conflict, heightened food, weight, and body image concerns, and shifting social support. Given these challenges to mental health, players, media, and the UK government (see Carney review commissioned by Department for Culture, Media & Sport (DCMS)), have highlighted the need for elite women footballers to be provided with appropriate mental health support to help them navigate these challenges.

The call for mental health support for elite women footballers can be seen in Carney's independent review into women's football, 'Raising the Bar' (Carney, 2023, p. 115). This review recommended that all elite women's football teams employ a full-time performance psychologist to help with wellbeing and mental health, as well as the development of pathways to address more clinically defined problems (Carney, 2023, pp. 100-124). Currently there is no requirement for the WSL or WC clubs to have a full-time mental health member of staff. Without this, players are unlikely to be accessing support and instead are potentially using their own money to fund outside support, relying on the NHS, or receiving support from the PFA. Support from the PFA is available to players who are currently competing in the WSL or have previously competed in the WSL. A large proportion of players in the WC retain access to the PFA's services having previously represented clubs in the top division. The PFA partners with

Sporting Chance, a specialist organisation that provides its athlete members with free mental health support (Professional Football Association [PFA], n.d.).

The importance of providing athletes with formal mental health support is demonstrated across mental health and elite sport literature—for example, numerous consensus statements have called for clubs and sporting organisations to better support athlete mental health (see Henriksen et al., 2020a; Moesch et al., 2018; Prior et al., 2022; Schinke et al., 2017). 'Formal' mental health support (hereafter, 'mental health support') refers to counsellors, psychologists and other certified or licensed practitioners and specialists (Cosh et al., 2024). Providing athletes with mental health support is important for numerous reasons, such as, the prevention of serious mental health issues, to help athletes establish ways to protect their mental health during their elite sports career, and to support athletes as they navigate the many highs and lows that accompany an elite sporting career (Henrikesen, 2020a; Moesch et al., 2018).

Despite the importance of supplying players with support, findings from this thesis (Study Two) indicated that only half of elite women footballers are provided with support through their club. Further, findings indicated that even when players do have access to support at their club, many are not using it. More specifically, Study Two found that 86% of elite women footballers indicated they wanted or needed psychological support at some point during their career, yet only 50% of players indicated that support was available at their club. Of those who noted support was available to them at their club, only 28% reported to have used the support. Additionally, 38% of all footballers reported using psychological support from outside their club. Barriers to seeking support or using the support are not understood within this population, yet the gap between their appetite for support and its use makes this an area which warrants attention.

To date, research surrounding help-seeking has suggested athletes are notoriously less likely to seek support for mental health compared to the general population for mental health symptoms and disorders (Castaldelli-Maia et al., 2019; Gulliver et al., 2012). Researchers have indicated barriers to help-seeking for athletes include numerous individual, cultural, and organisational/structural barriers. For example, at the individual level, low mental health literacy and lack of personal recognition of symptoms, negative past experiences with support, and fear of being seen as weak have all been documented as significant barriers to accessing support (Bauman, 2016; Miller at al., 2024). Researchers have also highlighted that culture plays a significant role in help-seeking, for example, in a study with 12 professional men ice hockey players, Crawford et al. (2023) found 'old school norms' such as and traditional and stigmatising views towards mental health issues hindered help-seeking. In contrast, ice hockey players who were situated in cultures where mental health is more outwardly supported suggested they were significantly more willing to seek support. Notably, their study focused on help-seeking for mental and physical challenges—e.g., mental health issues and concussions. Organisational and structural barriers to help-seeking include limited support options and lack of signposting at the organisational level. For example, Miller et al. (2024) explored help-seeking with elite men and women track and field athletes in the UK and found a lack of signposting to be a significant barrier.

Irrespective of Miller et al. (2023) who included elite women athletes, the majority of research in this area has primarily included elite men athletes (e.g., Buck, 2022; Crawford et al., 2023; King, 2019; Wood et al., 2017), or US collegiate athletes (e.g., Bissett & Tamminen, 2022; Cosh et al., 2024). Research with women athlete is extremely limited however researchers have suggested elite women athletes are likely to face unique barriers to using mental health support compared to men athletes and the general population which may hinder help-seeking and utilisation. For example, Castaldelli-Maia et al. (2019) suggested women

athletes may face unique sociocultural barriers such as limited resources, fear of being seen by staff as ‘too emotional’ or ‘too feminine’ if they present with needing psychological support, and power dynamics (Castaldelli-Maia et al. 2019; Kennedy, 2021). To date, however, insight into elite women athletes’ experiences with mental health support provided by their club—including experiences surrounding barriers and challenges to utilisation—have rarely been explored.

Taken together, the aim of this chapter is to explore player and staff experiences of mental health support within women’s football and the barriers players encounter to using the support. While the players’ voices remain the focus of this study, both players and staff are included in this study as to allow for insight from two levels of the system in which elite women footballers operate and make decisions surrounding help-seeking (Purcell et al., 2019). This multi-level approach is comparable to recent qualitative explorations in elite sport regarding other topic areas such as nutrition (e.g., Logue et al., 2021). More specifically, this approach has been used with studies concerning elite women’s football in England (e.g., McHaffie et al., 2022a; McHaffie et al., 2022b). For example, McHaffie et al. (2022a, 2022b) explored nutrition culture and menstrual support perceptions and experiences with parents, players, and staff to provide contextually relevant insight. Notably, this study specifically involved staff who provide psychological support to players (e.g., sport psychologists), have the potential to impact their mental health or the power to influence support availability (e.g., managers, coaches), or are well-placed to refer athletes to mental health support (e.g., sport science, chaplains).

Guiding this study are the following research questions: “what experiences do elite women footballers and staff have of club mental health support?” and “what barriers do footballers encounter with using support?”.

6.2. Methodology

6.2.1. Philosophical approach

This study was guided by a social constructionist approach which allows for a focus on the individuals' experiences and the meanings individuals create for their experiences. This approach is useful when exploring the experiences of not only players, but also staff with diverse roles and responsibilities (Poucher et al., 2020). Importantly, constructionism attends to the role of society, culture, and power relations that contribute to individuals' constructions of their experiences which is important for this study (Poucher et al., 2020). This philosophical approach was selected in response to findings from Chapter Four and Chapter Five. Chapter Two provides further detail around how constructionism fits into the overarching philosophical approach of pragmatism adopted for this thesis.

6.2.2. Participants

In addition to the 21 elite women footballers from Chapter Five, 10 staff members were recruited for this study. The eligibility criteria for the staff included the following: (1) must be performance personnel (e.g., coach, manager, sport science) or support personnel (e.g., psychologist, chaplain, doctor); and (2) must work in the WSL and WC on a full-time, part-time, or voluntary basis. The 10 participants held a variety of roles: coach (n=1), assistant manager (n=2), sport psychologist (n=3), chaplain (n=2), sport science practitioner (n=2). The sample consisted of two males and eight women across the two leagues: WSL (n=5) or WC (n=5). Six of the 10 participants were on a part-time contract, yet most expressed that their hours consisted of a full-time schedule. No participants in this study worked at the same club during the time of data collection. This allowed for insight to be gathered from staff members associated with 10 different clubs across the two leagues.

Table 6.1 Participant characteristics

Participant[1]	Title	Career status	League for 2021/2022
Jill	Assistant manager	Full-time	WSL
Clare	Sport psychologist	Full-time	WSL
Maria	Sport science	Part-time	WSL
Matthew	Sport psychologist	Part-time	WSL
Carrie	Chaplain	Part-time—voluntary	WSL
Shannon	Assistant manager	Full-time	WC
Annabelle	Sport science	Full-time	WC
Pete	Coach	Part-time	WC
Tori	Sport psychologist	Part-time	WC
Olivia	Chaplain	Part-time—voluntary	WC

Notes: [1] pseudonyms used

6.2.3. Individual interviews

In addition to the player interviews (detailed in Chapter Five), semi-structured interviews were conducted with this sample of staff (Appendix L staff interview guide). Interviews began with questions relating to each participant's background and journey working in elite sport; for example, "What led you to your role now? And, how has your experience been?". This was followed by multiple questions surrounding the participant's role in relation to players' mental health: "What do you understand your role to be in relation to players' mental health?"; "How has this role been defined or presented to you?"; "Have you had formal education or training?"; "Is there something that has helped with your understanding or that would help?". Questions that followed related to their experiences supporting players and the broader support culture within their team, club, and organisation; "What has your experience been like supporting players?"; "Do you feel the pathway is set up for players in your team? Or at your club?"; "What have you noticed has helped players with mental health and help-

seeking?"; "What do you think negatively impacts their mental health and help-seeking?". Final questions focused on staff members' perceptions of what they think would help with mental health and help-seeking: "In what ways can this area be improved?". Questions were broad and open-ended, allowing participants to provide an in-depth account of their experiences.

One pilot staff interview was conducted with a member of the broader supervision team who had experience working as a sport psychologist. Due to conflicts of interest (e.g., being a member of the broader supervisory team) this interview was used as a pilot study instead of being included in the data set. After this pilot study was conducted, a meeting was held to gather feedback surrounding the questions asked, as well as their experience of the more procedural aspects of the research—i.e., ease of joining the video call and filling out the consent form. The participant suggested that, at times, more pointed women-football-specific questions could be asked to ensure relevant stories were shared. Tending to this feedback, probes were added throughout the interview guide. For example, in Part 1, staff were asked about their journey to and through coaching women footballers, as well as their experience—i.e., "what is it like working with women players?". This feedback was important as some of the staff interviewed had previously worked on the men's side or in different sports entirely. Additionally, probes surrounding social media and sporting pressures were added to the question list: "What aspects of being a professional women's footballer do you think impacts players' mental health?".

6.2.4. Procedure

Recruitment was primarily done through social media on 'X' (previously Twitter) and through snowball sampling. An advert was posted from my personal social media account which contained a link where those interested could leave their email via Qualtrics (Appendix

M staff recruitment advert). Fifteen staff working in the WSL and WC left their email and all were contacted. Of those 15, five responded to the email sent out to them and took part in the interview. The other five staff in this study were recruited through personal connections and through snowball sampling where I asked the first five participants to pass on the study information to those they felt would be interested.

Interviews with staff took place between June and November 2021. My goal was to begin staff interviews after all player interviews had been conducted. However, I was dealing with a hard-to-reach population therefore some interviews took place prior to finishing player interviews. Many staff in women's football work in another job alongside their career in football meaning several participants requested that their interview take place during the footballers' off-season: off-season runs from the end of the WSL and WC season in May to the beginning of preseason in July.

All interviews were conducted using Microsoft Teams video due to COVID-19 restrictions preventing in-person meetings. With the exception of one participant who was interviewed twice for reasons of previous time constraints, each participant was interviewed once. Interviews lasted 50 to 90 minutes ($M_{duration}$=69 minutes, SD=14.234); this totalled over 13 hours of data. Prior to each individual interview, staff were sent a study information sheet, the consent form (Appendix I), and instructions for accessing Microsoft Teams (Appendix K). At the beginning of each interview, participants gave written and verbal consent to participate and were offered the opportunity to ask questions. Following institutional ethical approval, interviews were digitally recorded on Microsoft Teams, transferred to a secure password-protected file and then the original files were deleted. Once the interviews were transcribed verbatim, the recording was deleted from the password-protected file and each participant was

assigned a pseudonym. Pseudonyms were used instead of numbers in efforts to respect each participant's personal story.

6.2.5. Data analysis

Aligning with the aim and philosophical approach for this study, RTA with inductive logic was applied. Braun & Clarke's (2006; 2019) six reflexive phases of analysis were used throughout for analysis. The phases were primarily used as a guide opposed to a set of linear steps that must be rigidly followed.

To begin, I transcribed the staff interview audio files verbatim which allowed for initial immersion of the data (Braun & Clarke, 2006). After interviews were transcribed, I read all staff interviews and highlighted quotes, stories, and moments that felt important to the research aims and questions. Additionally, I revisited all player interviews and specifically explored areas where I had coded data in relation to 'support availability'.

After I read each interview, I began the coding process. I coded each interview by hand through a mixture of semantic and latent coding. An example of coding is presented below (see Table 6.2). Codes were then compiled and organised into initial themes. After the initial themes were generated, a meeting was held with my supervision team who reviewed and challenged my interpretations. In this meeting, and throughout the many following meetings, they provided alternative interpretations and helped me explore themes further. This process was cyclical, and themes were continuously refined.

Table 6.2 Example of a coded data extract

Data	Codes
I am a professional athlete, I am the person people see on the television, I shouldn't be ill well its very normal to not be well, especially with the pressures of being a professional athlete in any sport so yeah I think there needs to be just so much more education and so much more support (Footballer)	- Perceptions of what it means to be an athlete in relation to mental health and support - Education for athletes as well as those in their sporting environment
Are we actually helping them? Like probably not because in the situations so far, its been too late, so I guess maybe its made me question how good of a job we are doing (Sport science)	- Questioning current mental health support options

6.2.6. Research quality

The reader is asked to make judgements about the rigour and quality of the chapter using the following criteria: (1) resonance, (2) credibility, and (3) significant contribution (Burke, 2016; Smith & McGannon, 2018; Tracy, 2010). I enhanced resonance by a focus on aesthetic and evocative writing, starting with the theme titles. Quotes from the players were framed as questions. The purpose of this is to capture the reader's attention and potentially allow the reader to resonate with the questions personally. Further, literature concerning the general population was interwoven in the findings to allow for resonance.

Similar to Chapter Five, credibility was established through thick description, member reflections, and multivocality. Member reflections consisted of follow-up discussions with three members of staff. These conversations generated honest feedback and insights on the co-

constructed themes (Burke, 2016; Poucher et al., 2020). Multivocality was used via inclusion of players and staff in different roles, whereby two different perspectives were sought. Credibility was also established through the use of reflexive diaries. Finally, this study is heuristically and practically significant as it expands and challenges current literature regarding mental health support for elite athletes and uses player and staff voices. As Tracy (1995) said, "[significant research contributions] make visible what is hidden or inappropriately ignored and generate a sense of insight and deepened understanding" (p. 209).

6.3. Results

The following findings represent key challenges that the women and staff identified with the mental health provision offered by and through clubs. Four themes are presented to best represent their experiences and the barriers to using support: a) Negative consequences of using support; b) Support gatekeepers; c) Misaligned support pathways; and d) Poor quality care. Quotes from players or staff are differentiated below using 'footballer' or noting their staff role next to their pseudonym. Importantly, all names within quotes have been removed and replaced with pseudonyms.

6.3.1. Negative consequences of using support: "Is seeking support worth it?"

Players talked about various potential consequences of using mental health support. These included losing playing time, taking time off, and being judged as a 'problem' within the team by the manager. Worries about these consequences hindered players' use of support. Toni (WSL, footballer) explained the potential short and long-term consequences of using support at her club:

> On paper, the provisions are good. Like, we have a psychologist…but not many people even use the psychologist […]. I suppose it's still that fear of it getting fed-back, that's

> just the biggest barrier I find in getting help because either the coach would drop you or it would look bad on your character because they think maybe she is going to bring down the energy of the group. So, it's the fear of short-term being dropped, but also long-term, if you are continuing to have problems, that they think you will impact the performance or the mood…like 'energy zappers' I think is what they call it here, but it is very hard to be positive all the time.

Toni's fear of being dropped, and lack of trust in the psychologist, meant her and her teammates rarely sought support. Different to Toni, Alex (WC, footballer) sought support, yet her concerns about the consequences intensified after seeing the psychologist which left her feeling paranoid and anxious:

> I saw the psychologist, but I think there was like a lot of kind of anxiety. Like if I spoke to them would they tell the manager how I was feeling? Would I not get selected because I wasn't feeling great? […] I think as much as people will say that this is confidential, do you 100% trust that it is? Like if I was to say I am having a breakdown and football is stressing me out, are they going to be like go have a week off? And then that's another week of not being selected and things like that so it's kind of trying to find the comfort in having the conversation with someone and knowing that it kind of stays between you two and only gets told to who you want it to be told to.

Alex's fears about the consequences of seeking support were heightened due to her status in the team as a player on a one-year contract, and her playing position as second goalkeeper where substitutions are rarely made throughout a football season. Like Alex, many of the players are not on contracts longer than one or two years and therefore, using support was seen by footballers as a significant risk given any time off felt like missed opportunity to prove themselves on the pitch and earn a future contract (Culvin, 2019). This finding aligns with

previous research concerning professional male ice hockey players which found 'hierarchical status' acts as a barrier to seeking support—i.e., younger players with less contractual security are less likely to seek support, especially if they do not deem the support to be confidential (Crawford et al., 2023).

A fear of being dropped often left players in a tricky position with regards to choosing between playing football and protecting their mental health, which Jess (WSL, footballer) explains below:

> There is support if you need it at the club, but I think the biggest barrier [to seeking help] is not being picked… certainly, from my experience, that's the worst position, just not playing… like you want to be playing but then by not [seeking help] you are putting your own health at risk and not making people aware of your health issues just to play it's like a real catch-22 isn't it?

This 'catch-22' described by Jess, can also be considered a 'double-bind' a term coined by Bateson in 1956 (Rieber & Vetter, 1995): a double-bind occurs when an individual faces two or more contradictory messages—overtly or covertly—and they can leave people feeling anxious, uncertain, and confused. For example, Jess has access to support from her club which suggests they care about her mental health and that she should seek support, yet she also believes disclosing will result in her being on the bench.

Players' mistrust in the mental health provision was primarily driven by wariness around the manager's decision-making. Isabel (WC, footballer) and Toni (WSL, footballer) explained their experience:

> In [women's] football, managers are looking for an excuse not to play you. It's this politics thing, it's not always about the best player, it's like who is the easiest player not

> to play […] and you just don't want to give a manger any reason to drop you pretty much. (Isabel)
>
> If players could just have these conversations about mental health just in general on like a human-to-human level, not a manager-to-player level, it would take away that fear [of using support]. I am not saying that managers now need to become professional psychologists, like that's ridiculous, but just like on a basic human level to be able to go in and be able to say 'I am feeling like a three or a five today' and like that doesn't mean they can't perform well, but more so if they misplace that one pass maybe don't jump down their throat. I just think that would be really helpful, but I think that's a long way off (long pause). I think sometimes they give a fuck about some players and like less so or not about others. (Toni)

While Isabel did eventually use support, Toni opted to stay silent about her struggles. Like Isabel and Toni, other participants resisted support as they feared giving the manager a reason not to play them. This aligns with findings by Culvin (2019) who found that elite women footballers felt that they constantly needed to be 'perfect professionals' to secure their place in squads and prove themselves in professional football in England (Culvin, 2019). In this context, being a 'perfect professional' often meant staying silent about mental health struggles.

The constant need to be the 'perfect professional' is not only psychologically taxing for players, but it also meant that players had to navigate who and what they could disclose to powerful others such as managers (Culvin, 2019). Thus, conflict existed for nearly half of the players interviewed who shared that they had to talk to their managers to receive mental health support, which itself was a barrier. Dylan (WC, footballer) expressed her route to support was through her manager which was not preferrable:

> You have to reach out to the general manager to say, 'can I speak to someone?' which is kind of awkward because if you are struggling, you don't want to speak to the manager first, you just want to speak to a psychologist. […] I just want to go straight to someone else if you need to go see someone you don't want to say to someone like 'oh I'm really, really struggling…'

Like Dylan, players did not want to ask their manager for mental health support, even if they had a positive relationship with them. One reason for this is that they often deemed their manager's understanding of mental health to be limited, or they were hesitant to burden them with additional 'problems'.

Isabel (WC, footballer) believed her manager maintained the belief that mental health problems negatively impact performance, which meant she did not seek support; she expressed, "They don't understand that - yes - you may be low in mood, but if football is that person's escape then they are still going to play with freedom on the pitch." Isabel went further and shared her personal experience with this, whereby her performance was not impacted by her "low period" with mental health:

> I was in a very low mood but I was playing the best football week in and week out and I was one of the best players in the team and I think it's like the blurred lines of like yes sometimes it [poor mental health] may impact your football, but I think sometimes they [staff] think it effects your football more than it does and I think it can be held against you which means players hold it in more.

Isabel's account challenges the general assumption that mental health problems always detrimentally impact performance.

All the staff interviewed recognised why the players fear using the support, yet many maintained that their club would not take away playing time if a player was struggling with their mental health and needed support. However, limited positive examples of this were provided in practice by the staff. Instead, Carrie (WSL, Chaplain) shared a different experience at her club:

> They [the managers] just don't accept mental health, they just see it as a weakness and it shouldn't be there in footballers and this is why there is trouble. The players know that if they present with mental health issues, the chances of them playing in the team at the weekend are slim and then someone else takes their place and if they have a good game then you're on the bench for the next five months and so, yeah, it doesn't help team unity or anybody at all…

Carrie's account highlighted that potentially losing time on the pitch was a reality for some players at her club dealing with mental health struggles. With many players on one-year contracts, being on the bench for an extended amount of time is a serious consequence. Carrie's experience, although rare across the staff interviews, is critical to acknowledge for two reasons. First, other staff interviewed might not have felt comfortable sharing this which means that similar experiences to Carrie might occur more often than were reported by staff. Additionally, irrespective of staff experience, many of the players interviewed personally experienced or witnessed teammates encounter negative consequences for using support—as expressed through their accounts. So, while staff and clubs may presently be more understanding towards the mental health of athletes, footballers' past experiences (first-hand or vicarious) will likely influence their perceptions, attitudes, and behaviours towards current and future utilisation of club-provided mental health support (Brown et al., 2018; Gulliver et al., 2012). Importantly,

staff who have seen players face consequences for using support are potentially less likely to refer players in the future for mental health support (Moreland et al., 2018).

Despite the footballers' desire for club-supported mental health provisions, the perceived potential consequences of using support remains a significant barrier for them. Players' precarious and short-lived careers, and limited trust in mangers' understandings of mental health, meant they rarely used the support offered to them. This was true even when they had a good relationship with the employed psychologist and had access to support at their club, both of which are well-documented recommendations in the sporting literature to increase athletes' utilisation of mental health support (King et al., 2019; Miller et al., 2024). In addition to the power imbalances demonstrated throughout this theme, players further experienced power imbalances as they felt they could not seek support unless they had an "acceptable issue" or were severely struggling; this is expanded upon below and referred to as 'support gatekeeping'.

6.3.2. Support gatekeeping: "What can I actually seek mental health support for?"

There appeared to be widespread uncertainty amongst players regarding the role and suitability of mental health support within a club environment. Players reported feeling restricted with regards to what they can use mental health support for and when they can use it. This was compounded by existing hesitations around the perceived 'consequences' for accessing support. Participants shared that they deemed mental health support to be only available for certain issues, for those 'really struggling' with their mental health, or both. For example, Olivia (WC, footballer) shared that asking for support for certain mental health challenges, such as struggles with food or body image, was not acceptable:

> I feel like if you go to the coaches about certain things psychologically, I think they would see that as a weakness and I think a lot of players think they would get dropped

> so they don't do it, they don't open up about things in the fear that it would affect them and how strong you perceive them, like, I am not going to play her because she is struggling with food issues.

Like Olivia, Jess (WSL, footballer) expressed that food, weight, and body image issues are one of the most significant mental health issues in women's football yet, a rarely discussed topic in relation to mental health:

> In terms of like the eating disorder thing, I think that's not looked into enough or talked about enough especially in women's football or women athletes. So, you know like when people come in from the PFA and stuff to talk about mental health? That's more performance-related and anxiety and depression and dealing with injuries but the actual eating disorder side is not talked about as much so that's probably a topic that could be talked about more.

Jess's account highlights how club-supported mental health sessions, though seemingly innocuous, effectively act to 'topic gatekeep' what players talk about, and this can unintentionally limit players' understandings of what they can seek help for. By clubs and the PFA not speaking about food, weight, and body image concerns, it perpetuates the message that this is not a topic you should seek support for. For example, Olivia who struggled with food, weight, and body image concerns, internalised this message and expressed that this is not something she should share with the dedicated personnel at her club. Ultimately, by speaking with the support at her club about other challenges, yet purposefully withholding her struggles with food, weight, and body image, she engaged in partial disclosure which can be dangerous as it can lead to inappropriate or insufficient support being offered to individuals (Pereira Vargas, 2023). Partial disclosure is largely driven by individuals feeling pressure to produce a story that is understood and 'acceptable' to the context they are in (Åkesdotter et al., 2023;

Pereira Vargas, 2023)—in this context then, one that does center around food, weight, or body image issues.

In this context, despite food, weight and body image issues being a topic "everyone is conscious of" (Toni, WSL footballer), it was not considered to be a topic players could openly discuss in a serious manner. This notion was reinforced across all staff accounts as they expressed the significance of food, weight, and body image issues in women's football, yet no staff reported any player directly seeking support for it. Player and staff awareness of this issue came from experiencing banter between teammates and from observing behaviours such as hyper-fixation on eating healthily, cutting out carbs, and self-deprecating humor. For example, Toni (WSL, footballer) shared one example regarding the players on her team who are required to do extra fitness, "the players in it call it 'fat-club'. They do it, I guess, to make light of it. […] They (players) make jokes about it, but you can tell it isn't really [a joke] …they're put out by it."

Other topics considered 'off-limits,' yet very important to this population, were relationship struggles and career dissatisfaction. The psychological impact of viewing topics as off-limits, meant players partially disclosed, like Isabel, when they used support. Or players concealed their struggles out of the fear of being invalidated, which only led to further distress. Alex (WC, footballer) shared her experience of this:

> Its when you have an issue that's relevant to you and you tell someone and they just turn around and are like 'mate, get on with it' and it's like - okay - I have been doing that for so long [voice shaking] and now I am getting to the point where I am telling you I can't get on with it anymore [voice shaking].

Alex feared being invalidated for her struggles with her football career. This fear might stem from the potential consequences of doing so, or due to specific gendered reasons, such as

internalising the need to be "grateful" for her career as a footballer (Culvin, 2019). Yet, it is significant that mental health literature indicates that both career dissatisfaction and relationship struggles can be linked to higher psychological and emotional distress, low mood, and the exacerbation of mental health issues, specifically in women in the general population (Viertiö et al., 2021). Further, research concerning elite athletes in the UK (Longstaff & Fockett, 2018) and with professional male footballers in Europe has found career dissatisfaction to be associated with higher rates of depression and psychological distress (Goutterbarge et al., 2015a, 2015b). Thus, struggling with these issues and the impact they can have on mental health needs to be understood and discussed more openly with this population.

In addition to feeling restricted to speak about certain topics, participants expressed that they felt a certain level of struggle was needed to use the mental health support offered. For example, Gemma (WSL, footballer) shared that at her club players could only use support if they were "really struggling", as determined by the manager:

> There was nothing on mental health, not from what I can remember and I'm somebody who is big on it so I would openly speak about it if I had to and there is nothing. There was a men's psychologist and I used them, but it was the men's psychologist… not the women's psych. [the manager] really only ever gave players that if they felt (pause), if she felt, they really, really needed it, it wasn't like 'this is an opportunity for anybody at any time like if something goes on here is the person.'

Since the manager only allowed players who were really struggling to see the men's psychologist, it meant that many players did not receive support, and, also, footballers who did receive support felt judged and ostracised by others at the club. Gemma shared her experience with this:

> The men at the club were tip toeing around me, they wouldn't even say morning because clearly in their head they thought it would be wrong to say morning, do you think I am going to swear at you and not reply to you or punch you in the face?

Sam (WSL, footballer) who experienced similar support gatekeeping at her club, spent months debating if her mental health was bad enough to get support, and felt "it would have been easier" to get support if she had a clinical mental health diagnosis:

> I was embarrassed, and I was like no there's people way worse off than me like, 'I am just having a bad day, I don't need help' […] I think one of the things that hard is that I have never labeled myself as having depression or anxiety because I have never been clinically diagnosed. Sam's desire for a diagnosis was not because she necessarily needed one to understand her own mental health, but because she thought that it would have legitimised her struggles as worthy which would have enabled her to ask for support without the fear that her manager could dismiss her request.

Like Sam, a handful of players shared that a diagnosis would have made it easier to receive support which is significant as research indicates that elite athletes often avoid mental health labels due to perceived stigma (Pereira Vargas, 2023). Sam's account highlights yet another double-bind that women footballers experience; that a diagnosis might facilitate support for mental health, yet could also result in being judged and ostracised, like Gemma was. Interestingly, 'acceptable' diagnoses mentioned by footballers were anxiety or depression, but notably, not food, weight, and body image issues. This finding aligns with previous research which indicated that certain diagnoses are 'acceptable' in elite sport and others are not depending on the specific context (Pereira Vargas, 2023). One potential explanation for this is that women footballers primarily exist in a male-dominated culture whereby issues surronding food, weight, and body image are less likely discussed—often such issues are viewed to be of

more impact to women. In turn, women could see such issues as less worthy or acceptable in their culture.

In summary, players deemed certain topics to be off-limits and certain levels of struggle to be required to access support which resulted in partial-disclosure or waiting until their mental health was "bad enough" to receive support. Players' perceptions of what they could seek support for and how bad their mental health needed to be, was often shaped by, or dependent on, the pathways and support options (or lack thereof) available at their club.

6.3.3. Misaligned support pathways: "Why is support only ever about performance or suicide prevention?"

Participants described mental health support at their clubs to be misaligned with their current needs. Players described support to be performance-focused which included psychological skills and team-focused support around winning and mindset. Or the other option described was clinical mental health support which was reserved for more serious mental health problems. While both types of support are needed, most participants did not deem their needs to be severe enough to get clinical mental health support, but also wanted support beyond performance-focused psychology.

The players often wanted a middle ground which was expressed by Sara (WC, footballer): "I needed a counsellor like I needed somebody to rationalise how I felt […] but it's never supported in the right way, it's always about confidence [on the pitch] or like suicide prevention." Because players wanted support to help them navigate the challenges they were currently experiencing (Chapter Five), they were often frustrated when met with performance-focused psychology support. Faye (WSL, footballer) and Dylan (WC, footballer) expressed their experiences:

> We have had a few sessions as team with a sport psychologist and again… that was just mainly tailored around winning and the mindset you need to win; it wasn't wellbeing and how are you feeling it was more to get…to benefit the team performances, not to benefit the individual. (Faye)

> When I wanted to speak to her [the sport psychologist] to let out what I was feeling, I was fine with that because that helps you get everything off your mind but when she was trying to do these little things with me before the game like drawing…like drawing squiggly lines [about her performance that week]… that just did not help me, it just wound me up… I'm really not down for that. (Dylan)

Faye and Dylan wanted mental health support but were only offered support tailored towards mental skills for performance. While well-intended, being offered this type of support at a time when they needed more mental health focused support reinforced the idea that the club only cared for their wellbeing in relation to performance.

Notably, all participants in this study recognised the importance of performance-focused support, yet they expressed that they first needed support to help them navigate the current challenges they were experiencing. This meant that players wanted and needed individual support to navigate contextual challenges such as the transition to full-time professional and social media concerns, as well as support outside of football, which they deemed was different to the support men footballers needed. This is not to say men's players do not also experience such stressors, but that there are specific additional stressors on women—alongside new football stressors—which they felt they had not been prepared for in the same way male players coming through academies have been. Jen (WC, footballer) and Sara (WC, footballer) highlight struggles and stressors they encountered as women footballers

to demonstrate that they need different support than the performance-focused psychology support offered to the male footballers:

> Women's mental health is very different to the men's side so I don't think they should just treat it the way they treat men's mental health especially in the women's game … I think social media is a huge platform at the minute, so I think the burden on mental health and social media is really important. (Jen)

> It's so different to men's football, there's no longevity in women's football unless you're like Alex Scott who manages to go into a massive career in football and stuff, so you have to get your shit sorted to have a career outside of football. And, as you know, it's not well researched enough to know what happens to players and after football for women. […] I know players who don't know who they are [since football is their whole world] and I think I am quite driven not have football be the centre of my universe but for other players, like what do you do when football is taken away? Or when you are struggling with stuff? […] I's just always too late [when support is provided to players], it's always after someone is depressed or whatever. (Sara)

Jen and Sara both highlighted that support options and pathways currently mirror the men's game and are not specific to women's footballers' needs in their current context. Further, irrespective of performance highs or lows, footballers shared that they wanted mental health support, yet as Sara said, support is "just always too late" and "always after someone is depressed." The performance-focused support offered to women's players aligns with the men's game whereby mental health is discussed in relation to performance or through a more medicalised lens (Bennett, 2020; McGinty-Mister et al., 2023; Wood et al., 2017).

A performance-focused approach aligns with the elite sporting culture which is focused on performance and elite athletes' conceptualisations of mental health. For example, research has indicated that athletes (primarily male participants) conceptualise mental health in relation to their performance; meaning mental health is only a priority when it becomes a 'problem' to their ability to perform (Bennett, 2020; Coyle et al., 2017; Kennedy, 2021). Notwithstanding the question of whether this is a suitable approach to men's football, the players in this study wanted a more holistic and all-encompassing approach to mental health with support offered to cover challenges outside of performance, alongside clinical support and prior to the manifestation of more serious mental health symptoms.

Importantly, many of the factors mentioned by players, such as social media and transitions, are also encountered by elite men footballers. However, women players feel they have not been adequately prepared for these new challenges and are now trying to deal with many changes and challenges all at once without the skillset, resources, and support; with the lack of preparedness, in part, due to pathways at youth levels not being set up to prepare them appropriately (Gledhill & Harwood, 2014). This was expressed by Tori (WC, sport psychologist):

> Our pathway hasn't prepared them enough for the cut-throat challenge that is football [in the top flight], and I think that will be triggered for people, but they have not been given the skills to be able to manage that or they have not been given the experience to be able to manage different aspects of it.

Tori explained that because the pathway did not prepare women for professionalisation, players need more holistic mental health in addition to more acute and urgent support. Instead, however, Tori felt clubs overly focused on clinical pathways and crisis referral protocols. The importance of each club having a clinical pathway for players who encounter more serious

mental health problems is evidenced by the FA's requirement for each club in the WSL and WC to submit evidence of their referral processes. However, several staff shared that submitting their pathways for approval was a simple 'tick box' exercise as players' perspectives were never explored. Although the FA required clubs to submit mental health pathways during the 2020/2021 season, several support staff shared that their clubs wrote and submitted the required documentation but never integrated the support into the club. The consequence of this meant that many clubs were (still) reactively supporting players' mental health. Jill (WSL, assistant manager) described dealing with mental health as akin to *"*fighting fires":

> Where women's football is at the moment as an evolving professional sport means that people change all the time, whether it's players moving clubs, coaches moving clubs, all the members of staff like it's really, really challenging to create a process that is more than just one season or just a few weeks but I think it's because people don't get the process embedded well enough so it's just becomes about fighting fires like "oh my god quick this person needs some help" and "oh my god this person needs help", but never actually embedding processes into the sport and what that looks like and actually having it there and available.

Jill's account highlights a reactive approach, which is exactly what the players voiced as a problem in the current provisions.

Beyond immediate crisis-type support offered by clubs, infrastructure to support people with long-term mental health needs was limited across clubs. Gemma (WSL, footballer), who experienced mental illness, received support from outside her club—through the PFA. However, the union was only able to offer her 12 free sessions. Gemma shared her experience:

> I got 12 free sessions (sarcastically laughs) but after that you have to pay but we don't pay for injuries like I don't pay for an MRI if I have hurt my knee so then why are we

> paying for mental health? […] How is a physical injury different to a mental injury? It isn't … it's the same thing and if not worse because a mental injury sometimes effects your physical injury.

Gemma's frustration was rooted in her need for continued mental health support—beyond 12 sessions—as well as her experience of the available support constantly being treated as less important than physical health support. Not only does she want and need more support, but as she compared her mental health to her physical health, she highlighted again how important mental health is to her and the rest of the footballers.

This theme highlights how the pathways designed to support players with mental health issues are misaligned with what the women footballers currently need, as expressed by participants in this study. The misalignments are likely due to changing and evolving understandings and conceptualities of mental health in elite sport and society (Ekelund et al., 2023; Lundqvist & Andersson, 2021), a lack of funding currently put towards wellbeing and mental health at women's clubs (Carney, 2023), differing competencies and philosophies across the employed sport psychologists (Roberts et al., 2016), and limited insight into women footballers' needs—hence the importance of this research.

6.3.4. Poor quality care: "Why are we at the elite level without elite support?"

Across most clubs, the quality of support provided to footballers was not sufficient in helping players take care of their mental health needs, which was in-part impacted by the misaligned pathways expressed above. This was shared by Jen (WC, footballer):

> I don't think it's spoken about at all in my experience and I think, especially in the women's game where people are balancing so much and making difficult choices and you know you are playing at the elite level, but you haven't got the elite support in my

> opinion… you are still sacrificing loads, but you know, no financial reward and like… there is no support I don't think.

Not only did Jen want more support to help her navigate the new and heightened challenges to mental health (Chapter Five), but by the club not providing her with "elite [level] support" she was reminded that elite women footballers "sacrifice loads" yet receive little financial rewards nor mental health support.

Elle (WSL, footballer) shared that her club hired someone she deemed not qualified, which sent a powerful message that players do not deserve "elite [level] support" and undermines the importance of their mental health, which was a barrier to her using support:

> We had a member of staff for the last year and she is only doing her masters in counselling now but she has been like an allocated staff member if you needed to speak to her about anything and I know some girls do book in one-to-one sessions with her and she has been doing the wellbeing kind of practice with us but, like no disrespect to her, but I don't think she is qualified to like a certain level with it so it is great that she is there but I am always a bit cautious because I think…I don't know…yeah perhaps it is such a big area I think you do need to maybe have a bit more background and like my interpretation of it is that maybe the more qualified the more they [the club] have to pay.

Elle's frustration with the club's hire was echoed by many others in this study. The collective frustration expressed across accounts indicated how important mental health is to elite women footballers, as well as their awareness of what effective support actually is. This extends the mental health and elite sport literature highlighting that women footballers do not just want more support for mental health at their club, they want effective, qualified support (Crawford et al., 2023; Miller et al., 2024).

Across nearly all interviews, mental health support was viewed by participants and staff as a 'tick-box' or a token gesture from clubs which made players less motivated in accessing support. Sara (WC, footballer) explained this:

> It [mental health support] seems a little bit like a tick box sometimes. They [the club] are like 'there is support' and 'have mental health days' and they get in like the one-off session with a sport psych who tells you how to be more confident in football and she's like not that useful at all like half the people I know in football have no problems with confidence, like that's the last thing on their list.

The perceived lack of sincerity from their club about how seriously mental health is taken hindered players' use of the support. It also negatively impacted individual engagement with day-to-day procedures implemented by the clubs to try and monitor wellbeing and mental health, such as daily wellness monitoring, a tool that many clubs use to help identify mental health issues. Jill (WSL, assistant manager) explained:

> I think people see it [wellness monitoring] as an easy first step and a way to open up the conversation […] but Ryan [the general manager] had no interest in it. He would rip somebody's head off because they weren't doing what he wanted them to do and we [the staff] would be like, 'that player reported low mood, no sleep, anxiety, like they are probably not on their best game'…but he just didn't care about that. So, this stuff is only important if all the people there think it's important and are prepared to use it otherwise what's the point? […]. Even if we pushed it and championed it and made it part of our conversations, players would say 'what is the point of filling this in because nobody gives a shit about mental health and wellbeing right now because look how I have been treated everyday.'

Jill's account revealed power dynamics and highlighted that mental health provisions (such as daily wellness monitoring) will have little impact if the footballers' environment is toxic or non-responsive to mental health problems shared by the players. A 'non-response' toward athlete disclosure—i.e., Ryan ignoring players wellness reports where they shared anxiety – is reflective of harmful sporting cultures, whereby performance is prioritised to the detriment of athlete mental health (Henriksen et al., 2020b; Schinke et al., 2022). As Henriksen et al. (2020b, p. 398) note: "Environments with toxic cultures, abusive behaviours, and poor mental health literacy in which coaches and staff neglect athletes' mental health and self-care can seriously impede athletes' functioning and ability to thrive." Importantly, Jill's account highlights a misalignment between herself and Ryan. Due to Ryan's positioning as the manager, and Jill as the assistant, his position on mental health held more weight.

In contrast to Jill's account, Riley (WC, footballer) shared that daily wellness was well received at her club:

> We do wellness reports and stuff like that which is a daily reminder and reflection, like how did I sleep? How was my mood? What do I feel like? So, that's quite good in the mornings, we do that every day. And, if I am not picking up on it [patterns/changes] then the coaches honestly will pick up on it and be like, 'you have had three or four bad nights of sleep now, and like is everything okay?'

The contrast between accounts is driven by differences in the 'mental health environment' where Riley, unlike Jill, experienced support to be integrated across her club which facilitated personal engagement with daily wellness regimes. Both accounts indicated that the authenticity of mental health support is driven by both the quality of formal mental health support provided by clubs and by the day-to-day interactions with staff. In essence, employing a competent and

trusted member of staff for mental health is a good step, but will be of little impact without a club-level commitment to positive player mental health.

In direct contradiction to players' desires, players and staff expressed that several clubs did not have any form of consistent psychological support at their club throughout the season. The lack of support created role confusion for staff. For example, Anabelle (WC, sport scientist) was tasked with supporting players with mental health despite having no training in it. She explained her experience:

> I am just very aware that I am not trained in that and it's such a special area and there was one girl in particular… I was really concerned for her mental health. She relied on me a lot and she made that very very clear that she relied on me so I think it was hard because I had lots of different roles and I was wearing a lot of different hats and that took a lot out of me, especially when I wasn't sure if I was saying the right things or not. It was all just a bit awkward, and I didn't know how to go about the situation.

Anabelle acknowledged that her lack of competency negatively impacted her own mental health as well as the care the players were getting. Anabelle ultimately ended up leaving women's football due to what she deemed a very poor culture of care for players and staff. Like Anabelle, staff expressed that a qualified psychologist should be the minimum requirement for players in the WSL and WC, yet no such requirements currently exist in the WSL and WC (Carney, 2023). Gemma (WSL, footballer) echoed Anabelle:

> I know that there's not [enough mental health support] in the women's side in fact so I think for me right now I still believe there is so much more that can be done. I feel like sometimes you are just kind of there to succeed and that's the only reason why you are there sometimes […] a lot of the time, I don't think I was even a number, I thought I was a bit shit on the ground. So, you know like to be able to feel wanted is the most

important thing, isn't it? And I suppose for me I have had a massive love hate relationship with football and I have thought about quitting many, many, many times.

Gemma highlighted that the lack of mental health support offered by her club made her feel that she is "just kind of there to succeed." For Gemma, feelings of dehumanisation were perpetuated by the lack of quality mental health care and support provided to her which made her question if football – in its current state – is worth it in relation to the toll on her mental health. Nearly all participants described a lack of quality mental health support and a lack of genuine commitment within clubs to support it. This continues to reinforce the message that elite women footballers' needs are (still) not a priority in elite women's football.

To make support more accessible and available for elite women footballers is not the only answer. This theme goes further to show that if support is not provided in a way that feels genuine and appropriate to players' needs, there could be a detrimental impact on their mental health, as well as their relationship to the environment and sport itself.

6.4. Discussion

Participants highlighted several key challenges with the mental health support which hindered their use of it, including negative consequences for using support, gatekeeping, misaligned support pathways, and poor quality care. Despite players wanting formal support for mental health concerns, many avoided using it when it was available. Players who did use support often engaged in partial disclosure, ceased utilisation after several sessions, or considered themselves 'lucky' for having trusted psychological support at their club.

One indisputable and novel finding from this chapter is the lack of power women footballers experience over their mental health needs, and the impact this has on their use of the support and their psychosocial health. Several players described that a lack of support

exacerbated their mental health problems and reinforced a message that their needs and wants were not important, and that performance is currently the priority in elite women's football. At times, unequal power dynamics and lack of mental health understandings by staff were explicitly demonstrated in players' stories. For example, one player shared that her and her teammates could only use the men's team psychology support if the manager perceived the players' mental health to 'be bad enough.' Less overtly, players often had to go through their manager to receive mental health support which was considered a deterrent.

Examples above highlight the limited opportunity for agency and autonomy amongst women footballers, both of which are critical for mental health support utilisation (Crawford et al., 2023; Pereira Vargas, 2023). Denying players access to support, or covertly discouraging it, can have serious consequences for an individual, such as worsening mental health struggles, self-stigma, and lack of future disclosure (Pereira Vargas, 2023). Being denied support, or being met with a negative response, impacts those around the individual, not just the player. Despite previous research suggesting that coaches and managers are an appropriate route for players to seek support through (Mazzer & Rickwood, 2015), findings from this study highlight that managers hold significant power over women footballers' careers and livelihoods and are not always, in the current context of the women's game, appropriate gatekeepers for mental health support.

Another novel finding is that the mental health support offered to the players rarely aligned with what they wanted and needed within the current context of the game. It is important to stress that their support does not align with the well-established principle that mental health support should be contextually informed (Henriksen et al., 2020a); meaning athletes' personal factors, as well as their cultural and environmental contexts, should be accounted for in terms of support provided (Castaldelli-Maia et al., 2019; Schinke et al., 2018).

One reason for this misalignment is likely due to the support pathways mimicking the men's game as WSL and WC clubs exist in paternalistic relationships with established men's club. In men's football, mental health support is heavily performance-focused and mental-skills focused (e.g., imagery), with less support as available for mental health challenges or 'subclinical' problems, except in severe clinical cases (Bennett, 2020; Tonge, 2021). Women footballers wanted professional support for mental health and more severe struggles, irrespective of their performance. However, unless they were very severely struggling with their mental health, they were offered performance-focused support. Importantly, it is very possible that male footballers also want support which isn't delivered through a performance lens and would prefer for more holistic support which should also be considered in future research.

Players in this study expressed not wanting to use the support at their club due to the psychologists' focus on performance. It is possible that the performance psychologists employed by the club are restricted by the club or manager in what they are able to work with athletes on; for example, psychologists might be told to work solely on performance skills and tools as opposed to broader wellbeing concerns or enhancement. It is also possible that those employed to positions to support mental health are not adequately trained to do so effectively. For example, sport and performance psychologists are trained to support performance and wellbeing concerns, yet are rarely trained to support more serious mental health concerns (Roberts et al., 2016). Yet sports psychologists are commonly employed by sporting organisations to support athlete mental health (Moreland et al., 2018). Notably, there are currently no standardised or league-mandated qualification requirements for club-based mental health support personnel across the WSL or WC, nor any best practice guides publicly available. It is entirely possible that clubs are hiring individuals who are simply not qualified

to navigate this space appropriately, which was a concern raised by participants—both staff and players—and a barrier to players using support.

Considering the recent recommendations made by the Carney review—that WSL and WC clubs should have mental health support such as a performance psychologist and that mental health provisions should be benchmarked against "mental support in the men's game" (Carney, 2023, p. 101)—this study provides novel insight into some of the barriers currently experienced and the impact of those on players' psychosocial and mental health which are important for the FA/NewCo and clubs to consider. Specifically, findings from this study indicate that performance psychologists might not always be the best equipped to deal with the challenges women footballers encounter. Drawing on the challenges to using support, clubs should focus on implementing culturally-informed and women-informed mental health provisions to support players as they continue to navigate the many challenges that accompany the ongoing professionalisation and their career as a footballer.

Importantly, staff echoed the concerns expressed by players regarding mental health support. Staff interviewees shared stories of being punished or disregarded for supporting players with their mental health by one or two 'powerful' figures—primarily managers. This finding supports the players' accounts which highlighted the negative impact that one person can have on their mental health (see Chapter Five, theme one) and their experiences of the limitations of club-provided mental health support. The inclusion of staff in this study also provided insight into the powerlessness that many club personnel feel in supporting players given their 'rank' in the elite sporting system, ultimately indicating that there are staff in positions of power with far more influence than the psychological support staff. For example, staff indicated that managers—often striving for on-pitch results—had far more power than psychological support staff who were focused on preserving player mental health. This means

that as long as this stark power imbalance exists, player mental health will continue to be treated as a lesser priority.

Competitive, results-driven football environments are inherently, and by design, tailored towards performance and on-pitch success. However, there must be an overt and deliberate effort—especially at this juncture—to rebalance the priority of mental health in women's football. Recommendations on how to do so are provided in the following chapter (see 7.4).

Future research directions

This exploratory study has provided numerous avenues for future research. One area that researchers could explore with this population are facilitators to help-seeking. Notably, research surrounding facilitators has received limited attention amongst elite athletes (see Cosh et al., 2024), yet could provide critical insight. For example, Miller et al. (2024) included a focus on facilitators and found that sport specific online platforms have been vital to normalising conversations around mental health within the elite track and field community in the UK. The athletes in their study specifically noted one platform—started by athletes—where individuals could share stories and find various resources for mental health support (Miller et al., 2024).

Additionally, given the multitude of mental health support options (e.g., psychologist, mental health nurse, counsellor, psychotherapist) and formats (e.g., within-club support, outside of club support, telehealth, group sessions), future research could explore athletes' preferences and experiences with different services. While there is unlikely to be a one-size-fits all approach, this could help influence the support options that align with players' wants and needs. Notably, and similar to Crawford et al. (2023) and Miller et al. (2024), the focus of this study was on individual experiences of support and help-seeking and was not specifically

focused on commonly studied help-seeking variables such as athletes' attitudes or intentions (Cosh et al., 2024). Thus, while the exploratory approach was appropriate for the aims of this present study, future research could more specifically focus on help-seeking attitudes or behaviours.

Strengths and limitations

This study had several strengths and limitations. One significant strength of this study was the inclusion of both staff and player experiences. By including staff and players, a deeper and more nuanced understanding was provided surrounding the systematic and contextual barriers women footballers experience in relation to accessing psychological support at their clubs. This approach allowed for novel and context-specific insight. Another strength of this study was the inclusion of staff in diverse roles—outside of just the inclusion of sport psychologists. This approach allowed for critical insight into power dynamics amongst staff, a lack of role clarity, and inconsistencies in provision and mental health training across clubs.

A number of the strengths mentioned here can also be seen as limitations. For example, inclusion of staff voice meant there was less room for players' voices. To make up for this potential limitation, considerably more player quotes were used throughout the findings than staff. At the same time, by centralising players' voices more in-depth understandings of staff experiences were sacrificed. Further, the inclusion of different roles of staff could be seen as a limitation, however, this decision was made due to not all clubs having a sports psychologist.

6.5. Conclusion

This study qualitatively explored staff and elite women footballers' experiences and perceptions of the mental health support provided by clubs for players—and specifically the barriers preventing its use by players. Four main themes were generated to highlight the

challenges to using support, including negative consequences of using support, support gatekeepers, misaligned support pathways, and poor quality care. Participants highlighted that while support is sometimes available at clubs, it is rarely tailored towards players' needs and is often 'gatekept' by their managers—both of which are significant barriers. Additionally, participants felt they needed to be severely struggling with their mental health in order to seek support from their club, which hampered utilisation.

Importantly, the findings from this study highlight that systematic factors significantly challenge players' willingness to use support. For example, players highlighted power dynamics and the fear of being punished impacted their comfort with using support when available at their club. Further, findings from this study provided much needed insight into player and staff perceptions of the appropriateness of the current support, not just in terms of availability, but also in terms of alignment with what players actually need. It was evident that much of the support available to players was support tailored towards performance enhancement, or framed through a performance lens, which was frustrating to players as many of them wanted mental health support irrespective of their current football performance. A further barrier to using support was the quality of the support provided; very few participants felt those offering support were actually qualified to provide appropriate care.

Together, this chapter provides critical insight into perceptions and experiences of the current support offered to players within clubs for mental health. It provides important and novel findings for clubs to consider when looking to provide players with more tailored and appropriate mental health support in the future.

Chapter Seven

Final discussion and conclusion

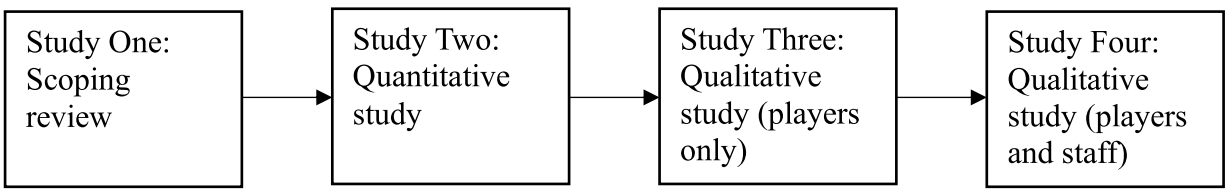
7.1. Introduction

The overarching aim of this doctoral thesis is to advance understandings of mental health challenges among elite women footballers in England's WSL and WC, and to explore barriers players face when accessing mental health support at clubs. To do this, four aims were established (see Chapter One). In addition to these aims, this thesis also seeks to draw on empirical findings to provide recommendations for practice and policy and suggestions for future research. While the first four aims were explicitly accomplished in the previous empirical chapters, the latter aims are met in this chapter where I will outline key discoveries, implications, and recommendations. The following section will recap the approach taken and key findings in each study and explain how this work has filled significant gaps in literature.

7.2. Overview of empirical studies and contributions to knowledge

To briefly summarise the four empirical chapters in this thesis: Study One systematically reviewed how mental health and mental illness has been explored with elite women athlete populations in terms of research aims, methods, and theories; Study Two gathered the prevalence of mental ill-health symptoms of elite women footballers and help-seeking intentions; Study Three explored challenges women face in relation to their mental health within their current football context; and Study Four examined player and staff experiences and perceptions of the barriers that footballers face to using mental health support provided by clubs.

Figure 7.1 Study by study



Study One

A scoping review was conducted to examine current literature focused exclusively on the mental health and mental illness of elite women athletes. This review identified the methodology used by researchers, explored the use of theory throughout the studies, and provided an overview of their purpose in order to identify how research with this population has been undertaken. Further, it identified gaps in the literature and provided recommendations for future research. In total, just 24 studies—since 1996—met the review criteria. Of these studies, 20 used quantitative methods (83.3%) and nearly all were focused on identifying mental ill-health prevalence rates. More specifically, 18 of the 20 quantitative studies focused on identifying eating disorder or disordered eating prevalence rates (90%). Importantly, across the 20 quantitative studies, 34 different scales were used. Nearly all studies were focused on women athletes who compete in lean-physique or endurance sports (e.g., gymnastics, running), with few studies focused on those in power-based or contact sports (e.g., football, basketball, lacrosse). Ultimately, this review highlighted the restricted sample population of mostly US collegiate athletes, overreliance on quantitative methods, and a heavy focus on eating disorder and disordered eating prevalence rates. This demonstrates an ongoing need for sport scholars to expand research samples, methods, and aims. Findings also highlighted the need for greater methodological diversity to advance the conceptual and theoretical understanding of elite women athletes' experiences of mental health.

While numerous reviews have focused on mental health and elite athletes, this review appears to be the first to exclusively focus on studies concerning women football players and mental health and mental illness. This review has significantly contributed to literature in its synthesis of 24 studies, gender-focused discussion, and recommendations for future research. More specifically, this review was vital for informing the subsequent studies in this thesis—

allowing for more informed decisions to be made in terms of study focuses and philosophical and methodological decisions.

Study Two

Informed by findings from Study One, a quantitative exploration of mental ill-health symptoms in elite women footballers in England followed in Study Two. Using an anonymous online survey, 115 elite women footballers participated (WSL=63, WC=52). The survey measured personal and player characteristics and included the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder scale (GAD-7), Brief Eating Disorder Questionnaire (BEDA-Q), and General Help-Seeking Questionnaire (GHSQ). Notably, findings indicated that 36% of footballers displayed eating disorder symptoms, 11% displayed moderate to severe anxiety symptoms, and 11% displayed moderate to severe depression symptoms. Further, this study found that just 28% of players reported using psychological support from their club, despite 86% reporting that they wanted or needed psychological support. In addition, despite 50% of players reporting that psychological support was available at their club, 38% reported receiving help from outside of their club. Significant associations emerged between starting status, expressed need for psychological support, student-athlete status, help-seeking intentions scores, and mental ill-health symptoms.

This study represented the first to explore mental ill-health symptoms in this population—offering novel insight and responding to many researchers calls for a better understanding of the mental health of this population (see Culvin, 2019; Culvin & Bowes, 2023). Findings from this study provided important insight into this population which helped inform the following studies. For example, players' responses surrounding psychological support and their help-seeking intention scores highlighted the need to better understand barriers to using support at their clubs.

Study Three

Study Three qualitatively explored the challenges to mental health that elite women footballers encounter, specifically in relation to their sporting context and the ongoing professionalisation of football. Between May and November 2021, semi-structured interviews were conducted with 21 elite women footballers in England (WSL=8, WC=13). Using reflexive thematic analysis, four themes were constructed to best represent the challenges encountered in relation to their sporting context: a) unexpected realities; b) narrowing self-identity; c) clashing body image ideals; and d) shifting social support. Within their elite football context, players struggled to navigate these key challenges, often due to power imbalances between players and staff and limited support. Some players developed coping strategies, while others saw such challenges manifest into what they considered to be more serious mental health struggles (e.g., depression, disordered eating) which required clinical support.

This study makes several novel contributions to the literature. The use of qualitative methods to focus on elite women footballers' lived experiences was important given less than 13% of studies in mental health and elite sport literature use qualitative methods. Further, this study highlighted aspects of the footballers sporting context—specifically, in relation to its ongoing professionalisation. This allowed for novel contextual insights which go beyond highlighting individual risk factors—such as personality characteristics—which remain a strong focus of current mental health and elite women athlete literature.

Study Four

Study Four explored player and staff experiences of mental health support within women's football and the challenges of its utilisation—often referred to as barriers. While the players' voices remained the focus of this study, staff accounts were included to allow for a

more holistic view. Data from 21 player interviews was used, and an additional 10 staff interviews were collected and then analysed via RTA. Analysis generated four key barriers to using support: a) negative consequences of using support; b) support gatekeepers; c) misaligned support pathways; and d) poor quality care. The findings strongly suggest that the current support offered to players is misaligned with their wants and needs. Clubs were perceived to not care enough about player mental health and, more specifically, their needs as women footballers. This in turn impacted players' utilisation of the available support and their mental health.

This study significantly contributes to the relatively limited research concerning mental health help-seeking in elite sport, particularly with women. Methodologically, this study uniquely involved players and staff which provided deeper insight into factors that are impacting help-seeking. Empirically, the findings from this study challenge much of the current literature by highlighting environmental factors that hinder players' use of in-club mental health services. To date, the majority of research and interventions in this area is focused on the athlete—for example, increasing their self-awareness and mental health literacy. While well-intended, findings from this study highlighted barriers to using support extend far beyond the individual footballer and are instead mainly influenced by environmental and sociocultural barriers. Therefore, this study contributes new focuses for research and interventions.

Before moving on, it is also worthwhile to provide an overview—at the broadest level—of the novelty of this thesis' empirical studies and set this work within the ecosystem of existing literature it has contributed to.

Broader contribution to knowledge

By focusing exclusively on elite women athletes, this work contributes to the gender-gap in sporting literature; only around 6% of research is focused on women or female athletes (Cowley et al., 2021, 2024). More specifically, and despite the substantial growth of research concerning mental health and elite athletes over the last ten years—only around 7% of such studies have specifically focused on elite women athletes (Kuettel & Larsen, 2020). Further, in elite football and mental health research, women footballers account for only 7.7% of the total participants explored across 13 studies (Woods et al., 2022). Specifically, only three studies focused exclusively on elite women footballers and mental health (Appendix A), none of which have centralised the experience of women footballers in England in the top two tiers. Ultimately, while research in women's football has grown exponentially in the last five years, this growth has not included mental health (see Okholm Kryger et al., 2022).

Importantly, this work also advances what is known about the mental health of women in "non-lean" physique athletes. To date, the majority of studies concerning elite women athletes and mental health research have focused on the lean-physique athlete population and individual sport athletes, mostly at the US collegiate level (see Study One). This means that women competing at the semi-professional and professional levels in power sports and team sports are not well accounted for in current literature. By looking specifically at elite women footballers in England, this thesis offers insight into the challenges this specific population faces in relation to their mental health and highlights the importance of exploring mental health experiences through players' lived experiences.

Methodologically, this thesis also adds to the limited—yet growing—body of research which uses both quantitative and qualitative methods in mental health research (see Åkesdotter, 2023; Buck, 2022; King, 2021). This thesis' quantitative study established important—and

previously undetermined—prevalence rates of mental health issues facing women footballers in England. While the statistics provided foundational insight and understandings of the mental health of the broader population of elite women footballers, the qualitative studies provided rich, in-depth insight into their experiences of mental health, which—in mental health and elite sport research—remains an uncommon approach (Kuettel & Larsen, 2020).

Together, this thesis, is the first of its kind to explore the mental health of elite women footballers in England and in doing so responds to numerous calls from players and academics for research within this specific population (Culvin, 2019; Culvin & Bowes, 2023)

7.3. Key discoveries

This section will explore three key discoveries which have been identified from this thesis as a whole. First, mental health challenges among elite women footballers are influenced and perpetuated by environmental factors during the ongoing professionalisation which has been slow to adapt to women's needs. Second, access to mental health support within their current system is often misaligned with players' specific needs—with 'supply' often not meeting 'demand.' Lastly, here are potential long term consequences—for players, staff, and the wider game—should the players' environments and mental health provisions not be improved with a 'system-wide' approach.

7.3.1. New challenges to mental health and 'hand-me-down' norms

This thesis has found that challenges to players' mental health can be driven, or worsened, by sporting environments that are not intentionally built around the athletes and their unique needs. While elite sport and mental health literature has historically focused on exploring individual characteristics and risk factors—such as personality traits like perfectionism (see

Study One; Pascoe et al., 2022)—this thesis draws focus towards the broader and more 'systematic' challenges to mental health in this context.

To illustrate this point, one indisputable finding from this thesis is the impact that legacy practices and norms transferred from the men's professional game has had on women players' mental health—overtly and covertly. Players disclosed that elements of their new sporting context (i.e., professionalised set-ups) were largely borrowed from—or inspired by—elite men's football. This is likely to be a direct result of the women's teams being embedded in established men's clubs meaning the women's teams are operating in the confines of established elite men's football culture. To take one example—team culture. Players recognised a rapid adoption of a 'win at all costs' approach throughout their clubs, influenced by the men's professional game. It is worth noting that this ethos has been proven to negatively impact men's mental health too (Bennett, 2020; Culvin, 2019; Roderick, 2006; Tonge, 2021; Wood et al., 2017). This thesis found that this approach leaves players feeling dehumanised and that it can normalise mistreatment from staff, consistent with previous literature concerning elite athletes and elite male footballers (Henriksen et al., 2020a; Kavanagh, 2014; Wood et al., 2017).

Other examples of 'hand-me-down' norms include practices such as body fat testing which has become more embedded throughout women's football in recent years, with limited consideration of the potential impact this might have on women, or indeed a lack of evidence to prove that such practices positively impact on-pitch performance. This raises the question as to why such male-centred environmental practices have been so quickly and unquestionably transferred to women's teams.

Players also expressed that they had experienced a significant narrowing of their identity as the women's game has become more professional. For example, as they became full-time players with more intense training schedules, and the 'extra-curricular' demands of being a

footballer grew—e.g., commercial and media responsibilities—their lives quickly became more football-centric than ever before. Notably, while both men and women footballers take on extra sponsorship opportunities, the women discussed needing to take on extra sponsorship opportunities in order to afford their careers as professional players; in the WSL salaries are estimated to be £25,000 to £27,000 a year, and those in the WC are as low as £4,000 a year which is significantly lower than national average in the UK which is estimated to be £34,000 a year (Carney, 2023; Office for National Statistics, 2023). In comparison, the average player's salary in the top men's league in England—the Premier League—is over £3 million per year (Carney, 2023).

Literature to date has highlighted this 'narrowing identity' phenomenon amongst athletes as they enter elite sport (Edison et al., 2021; Lally, 2007) and has indicated elite athletes tend to accept this narrowing as 'part of what it takes to make it', even when they know it is negatively impacting their mental health (Carless & Douglas, 2013; Coyle et al., 2017; Trainor et al., 2023). However, this thesis found that among elite women footballers, this narrowing was actively rejected by many players as it was a source of mental health distress, driven in part by their inability to nourish other aspects of their lives whilst also facing insecurities that come with being an elite women footballer (e.g., financial instability, one-year contracts, limited post-career playing options) (Culvin, 2019).

Therefore, this work has gone some way towards illustrating how the environment of elite women's football directly impacts the individual athlete. The challenges faced by these athletes, explored throughout thesis, are unique and resultant of an environment that has arguably failed to evolve and adapt to the needs of a new professional population.

7.3.2. Mental health 'supply and demand' misalignment

This thesis argues that despite the many positives of professionalisation for the women's game, the mental health support at clubs—the 'supply'—has not kept pace with the players' desire and need for support—the 'demand.' Despite players actively wanting and seeking support, findings indicated that many clubs have either failed to provide the necessary mental health support or provided support that was misaligned with what the players needed and wanted. This suggests that the 'problem' with help-seeking, extends beyond the individual to the system in which support is provided. Throughout this research, many players disclosed that their footballing environment did not feel conducive to seeking and receiving mental health support. In essence, players and staff expressed that professionalisation has felt selective to areas of the game that were deemed most important for on-pitch performance, meaning areas such as mental health have not kept pace.

As highlighted throughout this thesis, there are numerous challenges that the women face that warrant increased mental health support. For example, the entire professionalisation process is one of numerous transitions—at the individual level and organisational level—which are well-documented in literature to negatively impact athlete mental health, putting them at risk for ill-health (Pilkington et al., 2024; Stambulova et al., 2021). These changes have contributed to their needs and wants, as well as their openness to engaging with mental health support and related conversations.

It is worth outlining what this thesis found with regards to the appetite for mental health support among the population studied, before discussing club provisions. Women footballers, unlike some other sporting populations (mainly men) documented in literature, expressed a willingness to use support and talk about mental health; this aligns with research with the general population which suggests women are more willing to seek mental health support than

men (Pattyn et al., 2015). This diverges from findings of previous literature that paints mental health as somewhat of a 'taboo topic' among athlete populations (e.g., Gouttebarge et al., 2021; Hainline & Reardon, 2019) and, more specifically, something that is only important to athletes when their athletic performance is suffering (Bennett, 2020; Coyle et al., 2017; Kennedy, 2021). The footballers within this study viewed their mental health as inseparable from their identities and something that warrants ongoing attention and support, irrespective of performance or ill-health. Notably, this also showed that how 'mental health aware' this population is—contrary to assumptions across the sporting literature that athletes themselves need to be educated on mental health. This is important context to note before discussing the barriers to help-seeking and the misaligned support experienced.

Ultimately, this research reveals that the accessibility and quality of mental health support available to elite women footballers—the 'supply side'—is inconsistent and often misaligned with what the players required. Nearly half the participants in this thesis suggested that mental health support—of any kind—was either not at all available, or only available to them on a case-by-case basis, accessed via the staff who support the men's team, meaning only those who were significantly struggling were provided with support. Again, this demonstrates a failure of the wider ecosystem—specifically, at the club and organisational level—to provide the necessary provisions to women players. Even at those clubs where support was more regularly offered, provisions often did not align with the players' needs, or they were deemed inadequate by players and staff (Study Four).

To illustrate this point, players shared that personnel within the club are often underqualified to support with mental health issues, and staff were unable to support on those issues they deemed most relevant to their contexts. The mental health support offered to them was often anchored around performance or more severe and clinically-focused mental health

issues; which aligns with support provided to elite male footballers (Bennett, 2020; Tonge, 2021). These two forms of support make sense in relation to previous research which has highlighted elite athletes—mainly men—conceptualise mental health in relation to performance, meaning they often only recognise or attend to mental health challenges when their performance suffers or when their mental health reaches clinical levels (Bennett, 2020; Coyle et al., 2017; Kennedy, 2021). Women footballers, however, want support with more everyday challenges, including adjusting to life as a professional and those encountered away from the pitch (e.g., breakups). As noted by the players in this research, it is the everyday challenges that can have significant negative impacts on mental health over time. In short, whilst the footballers want access to proactive, holistic mental health support, they are often met with siloed support, available to some only at the 'extremes.'

On the 'demand side' of help-seeking—i.e., the players—there are failings across the women's game in empowering athletes to seek and embrace support. Across almost all interviews conducted within this thesis, players cited feeling fearful of the potential consequences of using support or being overtly rejected when asking for support—this was expressed by players without support at their club and for those players within club environments where support was available. This feeling of fear was compounded by the fact that players' pathways to accessing support was often through their managers—those figures within the club that are responsible for on-pitch decisions such as squad selection and playing time. Further, some of these figures were generally dismissive of mental health concerns—presenting further tensions surrounding disclosure and help-seeking for players.

The combination of several of these factors—both on the 'supply' and 'demand' side of clubs' mental health systems—causes problems for players. While the quality of club provisions must be improved, and aligned with what the players feel they need, without

psychologically safe pathways enabling players to seek support, there will continue to be fatal flaws in the system. To illustrate this point, one WSL player interviewed had access to a full-time sports psychologist at her club. However, she actively chose not to seek support—despite wanting it—due to a genuine fear that her playing time would be restricted. She feared being seen as "negative energy" in the squad, to quote her coach.

First and foremost, players need to have access to high-quality, relevant, and safe support networks in their clubs. They also need to feel empowered to seek and to use it—agency and autonomy is important. Both having support and seeking support must, however, be complemented by club level acceptance and care surrounding mental health—to do this requires systematic shifts in systems and cultures, extending beyond the footballers. As of current, the emphasis and responsibility—both in practice and in the sport psychology literature (e.g., Confectioner et al., 2021)—is often placed on players needing to be more 'mental health literate' or 'more wiling' to seek support. Instead, focus must be placed on changing aspects of the system which negatively impacts mental health and targets barriers to support utilisation—such as managers gatekeeping mental health support (see Study Four).

7.3.3. The consequences of provision misalignment

This thesis has indicated that there are potential consequences of any misalignment between the 'supply' and 'demand' of mental health support within clubs. For players, consequences include worsening and unresolved challenges to mental health, decreased football enjoyment, limited career satisfaction, and early retirement. Findings also suggested there are consequences for staff such as having to fill mental health roles which exceed their competencies and emotional capacity. One member of staff, for example, expressed that the knock-on impact of the lack of support for players resulted in her leaving the women's game entirely.

Interviews also highlighted that some players would be willing to take time away from football, drop down the leagues, or even leave the game to better protect their mental health. This highlights, once again, how central mental health is to this population. The importance of mental health to this population is significant as it contradicts assumptions within research, policy, and practices which suggests athletes are often unaware of their mental health struggles or are unwilling to speak about their mental health unless their performance is significantly struggling. Thus, it is extremely noteworthy that players are willing to leave the game, irrespective of their on-pitch performance; meaning, even if they are performing well, they would leave the game if they felt it necessary for protecting their mental health.

I would be remiss not to mention the short and long-term consequences of mental health struggles, which can be severe mental illness and possibly death by suicide. For example, there are significant social and economic impacts of long-term mental health challenges such as stigma, discrimination, poverty, and loss of relationships. Further, while mentioned rarely throughout interviews in this thesis, there have been media reports of players discussing thoughts of suicide and there have been reported deaths by suicide in the women's game.

There is a significant opportunity in women's football for clubs to ensure that players feel more respected and psychologically safe in their sporting environment. A focus on enhancing and tailoring the systems in which footballers exist and supplying the appropriate support mechanisms can go a long way to helping players navigate challenges with mental health and in helping to create a culture of elite women's football such that it protects future generations of players.

7.4. Implications and recommendations

Since this research first began, women's football has gone through a period of continued transformational growth in England—recently referred to as the 'Lioness effect' by the BBC

(Samuels & Fagg, 2024). Following the Lionesses' EURO 2022 win, attendance records for WSL and WC matches have been broken, grassroots football participation has rocketed, media interest has grown, and the WSL has been touted as potentially the first billion-pound women's football league in the world (Wrack, 2023). Women's professional football in England is also in the process of a management and governance overhaul, with a new independent company—'NewCo'—set to take over the running of the WSL and WC in time for the 2024/2025 season. The new independent governance structure means that for the first time since the formation of the WSL in 2011 and WC in 2014, the FA will no longer run the leagues, with an independent, club-owned structure set to give the women's game more control over its future.

This thesis has found that while the outside 'off-pitch' context has continued to change drastically—media attention, sponsorship opportunities, investments—players and clubs have been forced to adapt to a new working context, often without the necessary support, particularly surrounding mental health. In light of such key discoveries highlighted in this chapter, recommendations follow which are intended to directly target the current misalignments between the mental health 'supply' and 'demand' within women's football. These recommendations are targeted primarily at the club and organisational level, with recommendations also made for practitioners at the governance level (e.g., for the FA and NewCo).

As players continue to navigate ongoing change in the women's game, these recommendations are intended to provide empirically driven guidance to clubs, club personnel, and decision-makers around the provision of mental health support which specifically addresses challenges to players' mental health. Importantly, the following five recommendations include ways to address the structural and cultural challenges which negatively impact footballers' mental health—for example, bullying, win at all costs approach,

and working conditions. Together, the following recommendations build on and advance the guidance issued in the Government-backed review of women's football, led by Karen Carney MBE, which suggested that "gold standard physical and mental health provision" should be implemented in the WSL and WC (Carney, 2023, recommendation 3.2).

Recommendation one: Clubs must invest in full-time, qualified mental health support

Although participants—players and staff—expressed the need for high quality support, many (over half) expressed having no access to any type of support or having to use the men's support. Others also highlighted receiving inconsistent support from sport psychologists or one-off team sessions. Therefore, it is critical that full-time qualified personnel are hired to provide players with consistent mental health support, that is not tied to performance goals and is independent from team selection.

Further, it is vital that staff make clear their competences and boundaries in supporting mental health as this will vary depending on the type of staff employed and their training pathway. For example, sport and performance psychologists have differing competencies and philosophies in relation to their role in supporting athletes with mental health which—if not defined from the outset—can result in 'blurred lines' for players and staff as to their role in supporting mental health (Roberts et al., 2016). These different competencies can be due to numerous reasons, including country of training, training route, personal philosophies, and experience.

In light of the Carney review's recommendation that performance psychologists must become mandatory within clubs, considering the different roles and remits of sport and performance psychologists, as well as the women's needs, is particularly important. While this recommendation is well-intended, it is important that those hired are not restricted to performance-based issues (see recommendation two), but that they are able to support a wide

spectrum of issues that the women have said they face in their sporting context, both on and off the pitch. Importantly, those hired to fill the 'mental health role' at clubs, should have a strong referral network and a thorough understanding of different types of practitioners and therapies as it is unlikely that any one individual can support all players. This will require investment from clubs in salaries so as to not deter the best and most qualified candidates from applying.

In order for this recommendation to be effective, financial buy-in and structural buy-in from clubs is needed. Meaning, clubs need to ensure the staff hired in this role are supported and able to do their job, without feeling restricted by those in more 'powerful' positions—such as managers. As noted in Chapter Six, power dynamics between more performance-oriented staff (i.e., managers) and support staff can impact the effectiveness of the mental health support provided to players. Thus, clubs must focus on not just hiring a member of staff to but also on creating a structure for this individual to effectively work with the players.

While providing support within clubs is important, it is also critical to note that some players will not always want to speak to someone internally at the club. Thus, internal support options must also sit alongside better signposting to other available support networks—such as the NHS or to the PFA—so that players can make informed decisions around appropriate support.

Recommendation two: Extend player support beyond mental ill-health and performance

This thesis has uncovered a misalignment between the mental health support offered by clubs to players, and what players say they need. Players desire a broader range of mental health services—beyond just support for mental ill-health or performance-focused psychological support. They also want support that aligns with challenges they face as women footballers—

for example, navigating transitions, food, weight, and body image issues, daily hassles, balancing jobs alongside football, and financial worries.

Mental health has historically been understood in society and sport through an illness and medicalised lens. In turn, many of the services offered have been primarily focused on treating and reducing symptomology, or, based on improving performance and honing related individual psychological skills. However, mental health is increasingly understood as something much broader than this which, coupled with the increasing stresses placed on elite players, has left a significant gap in service provisions (see WHO 2014 definition). This gap has been highlighted by the athletes in this thesis.

At the club level, a way to help align services with players' needs is to offer a broader range of support options—including access to life coaches, counsellors, therapists, psychotherapists, counselling psychologists, clinical psychologists, and wellbeing practitioners. Each player has different needs and preferences, and so this could help players receive more tailored support. One example could be a footballer who has experienced severe injury for the third time and has post-traumatic stress. Some research suggests that specific therapies such as eye movement desensitization and reprocessing (EMDR) could be extremely helpful for a period of time (Curdt & Eggleston, 2023). Sport psychologists will likely not be EMDR trained, which is why having a competent full-time individual at each club to help connect players with best-fit practitioners is important.

Providing players with the option to seek external support and different types of therapies can also help provide players with more autonomy and agency over their mental health, both of which are believed to enhance help-seeking behaviours in athletes and the general population (Crawford et al., 2023). Further, allowing players to access support away from football could sever the link between mental health and 'performance' and take pressure

off the sport psychologists, providing them more room to improve the environmental and systematic areas that are negatively impacting mental health of players. For example, working with managers around how they communicate with players.

Beyond supplying players with individualised support, clubs must focus on bettering the context that the footballers exist in which are negatively impacting on their mental health. For example, clubs must focus on changing and challenging cultures and power structures (e.g., bullying, win-at-all costs mentality) which are having a detrimental impact on players. To do this, clubs should ensure they have safe reporting measures in place for players and staff to report instances of bullying and mistreatment. Taking responsibility away from the players, clubs must work to create psychologically safe environments—which can be done through education as well as by hiring the most appropriate staff. While a seemingly cliché recommendation, it is critical to note the importance of hiring staff who view footballers as humans, not just footballers, and who demonstrate this daily in their on-pitch and off-pitch practices.

Recommendation three: Tailor-made support for the unique challenges women footballers face

Participants throughout this thesis also shared that 'misalignment' came in the form of support not being wholly tailored towards their needs as women players. For example, some of the issues players want support with were deemed as 'unacceptable' or 'unworthy'—such as, career dissatisfaction, relationship struggles, and body image concerns. Clubs must work to broaden the conversation to empower players to seek support for issues outside of this narrow scope—while also working to actively remove or lessen some of these challenges at a wider-systematic level. These topics 'worthy' of support, and more broadly this more open conversation around mental health, must be informed by the players themselves. To take one

example of misaligned 'supply' of support, players pointed out that topics like 'resilience' and 'confidence' were regularly included in their support options or were the focus of team sessions, but they found these irrelevant and insensitive to their present challenges and, ultimately, disconnected from their current context. Said differently, the focus placed on footballers becoming more 'resilient' rather than challenging stressful and often harmful cultures was perceived by players as significantly misaligned with their current context and their needs.

There are many areas that continue to feel off-limits for players to disclose within their sporting context—i.e., body image dissatisfaction. At the player-level, one way to better support footballers with these challenges is to provide space for such topics through group sessions or education sessions. Team or group sessions could help provide footballers a safe place to work through some of these challenges, remove discomfort around certain topics, help one another through shared experiences, and allow players to feel less alone. Such sessions can also help provide information to players regarding strategies and resources available to them, as well as help players unpick some of the more systematic factors which have facilitated or impacted some of their challenges.

Outside of the players, focus must be placed on removing some of the challenges they currently face by targeting staff and removing unneeded stressors for players. For example, it is well-documented that comments from coaches on body-weight across all sports can have significant negative long-term implications on women athletes' body perceptions and health-related behaviours (Coker-Cranney & Reel, 2015; Kroshus et al., 2014a; Kroshus et al., 2014b; Muscat & Long, 2008). Education for staff about the impact they can have on players should be mandatory. Additionally, safe reporting measures for players and staff who witness or experience harmful comments about their body should be in place within clubs, and these

measures should be well understood by the players. Further, this specific challenge could be targeted at the policy level—i.e., with the removal of body fat testing or skin-fold testing for women footballers. This policy recommendation is particularly pertinent when we consider that research connecting such testing to performance in power-based women athletes is extremely limited (Mathisen et al., 2023). Yet, even if there were established performance benefits for elite women footballers, it begs the question, "at what point do performance-orientated goals outweigh the cost of mental health concerns?" (Perry, Pereira Vargas, Culvin, & Bowes, 2024, *forthcoming*).

Support required will vary from player to player, even from club to club, and will be in constant flux. Player voices must take an active role in guiding these conversations across the club ecosystem. For them to feel empowered to do this requires a psychologically safe team environment and pathway for seeking support.

Recommendation four: Implement safe help-seeking pathways and ethical practice

Throughout this thesis, it is clear that a lack of psychological safety was one key barrier to players accessing mental health support. Pathways were often unclear or badly signposted, and often players were required to report issues to their manager. Naturally, given the power dynamics at play—and the feared on-pitch repercussions—this acted as a strong deterrent to accessing support. Even among those players who said access to support was clear or directly available, players still feared the consequences of using support. This can be improved with an established, confidential club pathway and a healthier reporting culture.

The implementation of a transparent reporting process could be established to firstly improve psychological safety among players, and also to provide practitioners with a clear and easy-to-follow blueprint when it comes to handling player cases. Players must have confidence in the reporting system and know that any mental health concerns expressed will be handled

with care and confidentiality; not ‘leaking’ to any unnecessary players or staff. Also, practitioners must know at which point they should escalate or refer any concerns to other personnel. Having these boundaries established and understood both on the ‘demand’ side and the ‘supply’ side of mental health provision, can ensure better psychological safety.

Beyond the design and implementation of a safe reporting pathway, attention must also be paid to confidentiality and ethical practices at the club-wide level. Findings from this thesis align with previous research suggesting confidentially, or perceived lack thereof, is a significant barrier to athletes using support (Crawford et al., 2023). The employed practitioner should actively inform players and staff of the agreed processes and rules around confidentiality and provide examples of what this looks likes in practice. Importantly, education for managers and staff is also needed around what is appropriate and not appropriate for them to ask the sport psychologist or employed practitioner when it involves players. Such education may go some way to tackling issues of confidentially in elite sport—for example, sport psychologists working at the academy level in football have discussed managers attempting to dig confidential information out of them (Feddersen et al., 2023).

Recommendation five: Encourage and facilitate open mental health dialogue

An open club-wide mental health culture is important for making specific player and staff interventions stick. Simply put, wider buy-in is needed for interventions to have the most impact. Surrounding many of the ‘supply’ and the ‘demand’ challenges disclosed by participants was a largely dismissive mental health culture at clubs. In contrast to a dismissive culture—where players feel unsafe in disclosing mental health concerns or fear their concerns not being heard—is one that is ‘mental health positive.’ Meaning, players and staff feel comfortable discussing mental health where needed, safe in seeking support for mental health concerns, properly supported in terms of resources, and actively encouraged to look after their

mental health. Steps to encourage such a culture include ongoing and tailored education for staff and players, and an unwavering club-level focus on listening to players' voices.

Education is key for shifts in culture to occur. Specifically, staff-targeted education sessions are important due to the influence of staff on players' mental health (Crawford et al., 2023). Such sessions should include a focus on relevant challenges experienced by women players, current barriers they face in seeking support, and ways in which they can help support their mental health. The proximity between players and staff within a club environment means that staff are central to influencing change. With this, it is vital that education sessions challenge staff to reflect on their potential roles in creating such challenges. There must be comprehensive, club-wide acceptance and understanding of the power staff hold, and their ability to positively (or negatively) influence the psychological safety of players.

Beyond these foundational sessions, staff should be trained in how to respond to athletes seeking support—for example, how to respond when an athlete discloses mental health issues. Proactive education on this is important for both the staff member and the athlete; for example, research indicates that disclosure experiences significantly impact athletes' decisions to seek help in the future (Gulliver et al., 2012). This means a positive reaction—for example, one met with empathy, understanding, and support—could influence the players' engagement and commitment to receiving psychological support in the future (Gulliver et al., 2010). Further, it is important that staff reflect on their beliefs around mental health and are provided space to consider how they have responded to athletes in the past.

A continued focus must also be on centralising the athlete voice at the club level and broader organisational level. Athletes are often best placed to shape interventions and club cultures, and without the players' voices and experiences being heard, their concerns and needs are unlikely to be properly addressed. Providing space at the team-level, club-level, and

organisational level for players to safely bring forward concerns, struggles, and ideas for improving the game is of central importance as the women's professional game continues to grow and take shape. Space can be provided through various taskforces and working groups as well as frequent conversations with player—again, this can be done at the club level and within the FA and NewCo. Examples of this on the global scale with FIFPRO can be seen with the Mental Health Taskforce—a player-led taskforce regarding issues that impact mental health (FIFPRO, 2022). The result of this taskforce was the creation of the 'post-tournament blues guide' which was sent to all teams in the women's EURO 2022. This is just one example of the power of bringing players together to build awareness and understandings of population-specific challenges.

7.5. Future research avenues

From the outset, an aim of this thesis has been to provide recommendations for future research given the newness of mental health research in elite sport, especially concerning elite women footballers. Recommendations are provided in each empirical chapter with several additional avenues offered here. Firstly, there is opportunity for researchers to more pointedly focus on matters of intersectionality, such as ethnicity, sexuality, and social class, in relation to women footballers and their mental health. Experiences of oppression and discrimination are well-documented to impact on mental health experiences, understandings, and support opportunities in the general population. For example, women from minoritised ethnic backgrounds are at an increased risk of having poor mental health and tend to receive lower-quality mental health support (Alghamdi et al., 2023; Watson et al., 2019). Yet, in elite sporting research, explicit focuses on these areas are scarce.

Women's football in England provides a unique population to explore diverse populations and matters of intersectionality, especially in relation to social class and sexuality

as football tends to attract players from a wider range of social backgrounds and there are notable numbers of 'out' gay, lesbian, and bisexual players in the women's game. While not a focus of this current thesis, further research could explore whether this might result in additional stress or indeed offer protective factors for players' mental health. For example, relationships between players might actually protect mental health as a source of critical social support during their football career. However, relationship breakdowns might create extreme difficulties for players competing in the same teams or leagues which also warrants attention. Additionally, a focus on diversity is important as current campaigns include a focus on bringing more players from diverse backgrounds in the women's game (see Walker-Khan, 2022). As of present, it is understood that only around 9.7% of elite women footballers in the WSL come from diverse or minority ethnic background—which is significantly less than in the professional men's game (Trehan, 2022).

Research exploring mental health in relation to severe injury in elite women footballers is another important area for future researchers to explore. To date, researchers have suggested injury impacts athletes' mental health (Haugen, 2022), yet this topic area is relatively unexplored in elite women's football and is particularly important due to the high rates of lower-limb injuries in the women's game, specifically ACL (Horan et al., 2023; Volpi et al., 2016). To the best of my knowledge, only one study has sought to explore this research area with women footballers. In research by Perry, Pereira Vargas, & Papathomas (in preparation), findings indicated that elite women footballers engage in self-starvation post-ACL injury as a way to realign their disrupted performance narrative. For the footballers, engagement in self-starvation offered a way to 'win' at something during a time period where opportunities to do so were scarce.

Research is also warranted to better explore the experiences of elite women athletes with believed or established neurodivergence, such as ADHD or ADD. For example, in Study Two several footballers wrote ‘ADHD’ as a mental health diagnosis, yet literature concerning elite women athletes’ experiences are scarce. Research with the general population has highlighted that women with ADHD are impacted differently and receive diagnoses later in life when compared to males, meaning they may need more support navigating this during their football career (Attoe & Climie, 2023; Young et al., 2020).

Researchers could explore certain aspects of the ongoing professionalisation more pointedly, such as heightened—and gendered—media attention (e.g., which often focuses on appearance and perceived attractiveness) and the negative and positive impact this has on mental health. More specifically, research is needed to explore social media abuse and the potential impact this has on the mental health of elite women athletes—especially elite women footballers who exist in a male-dominated sporting culture such as football. Research by Kavanagh et al. (2019b) identified four types of online abuse—physical, sexual, emotional, and discriminatory—all of which should be explored further with elite women footballers. Focusing more specifically on some of these changes and challenges, might allow for more nuanced recommendations and interventions to be generated.

Methodologically and theoretically, there are numerous avenues for researchers to consider. While this thesis used cross-sectional methods, researchers may wish to use longitudinal research methods to explore changes to mental health among elite women footballers over the course of a season or more. Researchers could use narrative as both a method and a theory to explore players’ lived experiences to better understand how they make sense of their mental health experiences within their cultural context (see Papathomas & Lavalle, 2014; Pereira Vargas, 2023). Additionally, researchers could use Bronfenbrenner's

ecological systems theory to explore the systems at play which can positively or negatively impact mental health during a particular event or time period. Using narrative theory or Bronfenbrenner's ecological systems theory, provides researchers the opportunity to explore individuals' experiences while also considering the wider contextual and structural factors which contribute to their experience.

7.6. Strengths and limitations

In addition to strengths and limitations being offered in each empirical study chapter, several general strengths and limitations of this thesis are offered here. First, taking a pragmatic approach to this thesis was a significant strength. Doing so facilitated practical studies and recommendations; this is important particularly in this area as researchers have highlighted a gap between research and practice and called for pragmatic and practically-driven research (Keegan et al., 2017; Prior et al., 2022).

Another strength of this project was the utilisation of both quantitative and qualitative methods. In using quantitative methods for Study Two, prevalence rates were gathered using the IOC recommended questionnaires as well as a validated help-seeking questionnaire—another strength being the use of validated questionnaires, which researchers in elite sport and mental have continued to call for (see Gouttebarge et al., 2021). The use of qualitative methods for Study Three and Study Four allowed insight into players' lived experiences which provided critical contextual insight that could not have been gathered through quantitative methods.

In addition, I believe my positioning—specifically being a 'semi-insider' as a woman and (ex) player—was a strength of this thesis. The majority of research in sport science, including mental health with women athletes, has been conducted by male academics (Cowley et al., 2024). As suggested by Cowley et al. (2024) being a woman who researches women provides a better opportunity to research 'with' participants instead of 'on' them. Further, it is

understood that research in this area tends to be less holistic and gender sensitive; this is potentially due to men conducting studies on women and missing out on specific biological, as well as sociocultural factors, both at the design and analysis stage of the research project (Cowley et al., 2024; Elliot-Sale et al., 2021).

One of the most significant strengths of this thesis is the access and engagement of elite women footballers. It is well known that research concerning elite athletes tends to find it difficult to access to this population (Culvin, 2019; King, 2021; Miller et al., 2024). Now, due to even further heightened professionalisation, it is likely that accessing players in the way that has been done throughout this work will be nearly impossible. For example, I was able to access the population at a time where players had far more flexibility in terms of their time and club involvements, and when there were less club-driven restrictions and protocols for taking part in external research.

It is important to acknowledge that parts of this thesis were undertaken during the global COVID-19 pandemic, which can be seen as both limitation and a strength. The specific potential implications of COVID-19 are detailed more throughout the previous chapters, but it would be remiss not to mention it here in relation to the projects' limitations as a whole. I undertook this studentship at the beginning of January 2020 and the UK's first national lockdown began two months after, in March 2020. This influenced several aspects of the project including data collection and recruitment, and potentially the data gathered—primarily the quantitative study which took place at the end of the first full season since COVID-19.

In terms of recruitment, COVID-19 hindered my ability to go to each club to speak about the project with players and staff in-person. This would have potentially allowed me to ascertain that all players were offered the opportunity to participate. At the same time, the rapidly professionalising status of women's football during this research project might not have

allowed me access to each club, irrespective of COVID-19. In terms of collecting data, adjustments were made such as virtual interviews instead of in-person interviews. Further, it is well-documented that lockdown had a negative impact on mental health of the general population in the UK (Kwong et al., 2021) as well as athletes' mental health globally (Carnevale Pellino et al., 2022; Perry, Bowes, & Culvin, 2022; Reardon et al., 2021) meaning the prevalence rates from Study Two were potentially impacted. That said, most of the stressors and challenges identified by the players were not specific to COVID-19 and I would suggest are generalisable outside of this context.

On the plus side, the majority of participants in this thesis suggested that the pandemic offered a time for them to reflect on their mental health due to reduced distractions and obligations such as media appearances. Ultimately, on balance, conducting this research project during the pandemic and during a time of significant change to the women's elite game in England, was considered a significant strength of this project.

On a more personal level, COVID-19 was also a strength and limitation. It hindered my ability to make a research community in-person and challenged me to be flexible in the early days of my PhD in relation to supervision meetings and limited social support. While I was fortunate to have a UK family allow me to stay with them during lockdown, as an international student who had just moved from Loughborough to Preston to begin my PhD, I found this time extremely challenging. At the same time, lockdown provided me with the opportunity to immerse myself in British culture in a way I could never have before due to my living conditions. Additionally, it provided me further time and space to reflect on the complex topic of mental health without normal day-to-day distractions.

Another aspect of this project that can be seen as both a limitation and a strength is the rapidly changing landscape of the women's game in England. Situated in the appendices is a

timeline that I kept of some of the changes that were occurring while I was undertaking this thesis (Appendix N). While the aim of this thesis was not to capture every aspect of professionalisation that can challenge mental health, it was important that I remain aware of the wider changes that were occurring given the importance of the context when exploring mental health. One limitation of this is that it was at times difficult to neatly define the transition stages due to the non-linear nature of professionalisation. Ultimately, I made the decision to look at professionalisation since 2018/2019, opposed to trying to neatly define different stages to explore for this thesis.

Finally, I end this section with a limitation and a future consideration for researchers. This thesis included both WSL and WC footballers. This decision was due to many players competing in both leagues at some point over the last two years and due to many WC players maintaining full-time contracts. It can be argued, however, that the standards and support available between the top teams in the WSL and the bottom teams in the WC are no longer comparable. While the ambition is for the gap in resources, media attention, and player pay between footballers competing in WSL and WC to tighten, the reality is that the differences in the established standards are only widening. Future researchers may wish to look at both tiers together, or separately, to explore player experiences going forward.

7.7. Conclusion

Despite the ongoing call from academics and players themselves, mental health research with elite women footballers in England has remained an understudied line of research until now. This doctoral thesis includes first-of-its-kind research studies concerning mental health and elite women footballers in England. This work has made significant progress in this area of research by providing insight into mental ill-health prevalence rates, challenges players face that impact their mental health, and barriers they encounter to seeking mental health

support at their clubs. This thesis goes further in offering robust recommendations for practice—driven by empirical findings—to target some of the tensions and challenges that are negatively impacting players' utilisation of mental health support at clubs.

From a research perspective, this project demonstrates the importance of focusing on mental health challenges within one specific population, providing space for players' lived experiences through qualitative research, and the importance of 'zooming out' during analysis to allow for contextual influences to be accounted for, instead of just focusing on individual's personal characteristics. While time-consuming research, without looking at players' lived experiences and the larger factors and systems these experiences are situated within, we risk designing and implementing interventions that are misaligned with players' mental health needs.

Together, this thesis offers novel insight, challenges current literature, and presents numerous opportunities for researchers, practitioners, and clubs to better support the mental health of current and future elite women footballers in England

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Appendices

Appendix A

Table of mental health and elite women's football studies

Table of Mental health and women's football studies

Author; year	Aim	Participants (participants [men: women], mean age, sport, competition level, country)	Methods (Study design, data collection, measurements)	Key findings
1. Abbott et al. (2021)	Examine the prevalence of disordered eating (DE) in elite men and women soccer players and the influence of perfectionism	137:70 Non-athlete controls =179 Men *Mage*=21, *SD*=5 Women *Mage*= 23, *SD*= 4 Tier 4 and above English and Scottish leagues	Quantitative Cross-sectional Eating disorder symptoms (EAT-26), perfectionism (CPQ-12), and demographics (age, sex)	Women footballers had lower DE scores than non-football women (11% to 25%). Findings showed higher perfectionism scores on the CPQ-12 were a significant predictor of DE risk, in both men and women.
2. Bramley et al. (2024)	Provide insight into the prevalence of mental ill-health and the complexities of how mental health is perceived, interpreted, and experienced in tier 3 women footballers in England	0:103 (for survey) 0:6 (for interviews) Age=18-35 Tier 3 England	Mixed-methods Cross-sectional Distress symptoms (Kessler-10), depression symptoms (CES-D), anxiety symptoms (GAD-7), ED symptoms (SCOFF), and demographic information (e.g., age, club, years of experience, selection status, and playing position)	Women footballers displayed high rates of distress symptoms (49.5%), depression symptoms (44.7%), anxiety symptoms (20.4%), and (22.3%) ED symptoms. Interviews highlighted individual and environmental risk factors; for example, stress balancing demands between football and work.
3. Foster et al. (2017)	Explore the level of anxiety and its relationship with interleukin (IL)-10 (anti inflammatory cytokine that modulates mood	0:52 Footballers played professionally in championships in the state of São Paulo, Brazil	Quantitative longitudinal case-control	The PMS group showed no significant differences in IL-10 level in different phases of their menstrual cycle before or after the game. Footballers with PMS (59.6%) had higher levels of anxiety than group without PMS.

	swings) amongst elite women footballers			
4. Junge & Prinz (2019)	Determine prevalence and risk factors of depression and anxiety symptoms in across 17 elite teams of women footballers in Germany	0:290; first league=184, lower league=106 *Mage*=21.5, *SD*=4.2 Football (Semi)professional Germany	Quantitative Cross-sectional Depression (CES-D), anxiety (GAD- 7), support availability (e.g. current need and use of psychotherapeutic support), and personal and player characteristics (e.g. match experience, level of play, starting status, injury status)	First league footballers had similar depression prevalence rates to general population. Second league players had higher depression prevalence rates than first league players and women in the general population of similar age. Across both leagues, 45 players reported currently wanting or needing psychotherapeutic support, yet only 16% received support.
5. Junge & Feddermann-Demont (2016)	Explore the prevalence of depression and anxiety in top-level football players in comparison to the general population, and to analyse potential risk factors	(211:182) Under-21= 78 Men *Mage*=24.8, *SD*=2.27 Women *Mage*=20.95, *SD*=3.76 All first league and four U-21 football teams Switzerland	Quantitative Cross-sectional Depression symptoms (CES-D), anxiety symptoms (GAD-7), and player characteristics (e.g., current injuries).	8.5% of women footballers reported moderate levels of depression and 4.5% reported severe depression symptoms. 1.1% reported moderate anxiety and 0% reported severe.
6. Kilic et al. (2021)	Explore the prevalence of mental health symptoms among Australian professional footballers compared	149:132 Former pro footballers = 81 Men *Mage*=24.3, *SD*=4.8 Women *Mage*=22.8, *SD*=4.0	Quantitative Cross-sectional Sport psychological distress (APSQ), psychological distress (K-10), anxiety (GAD-7),	Mental health symptoms were deemed by the researchers to be common among men and women Australian professional footballers and among retired men professional footballers. In women footballers,

	with former players and explore associations with recent injury and psychological resilience	A-League and W-League Australia	depression (PHQ-9), sleep disturbance, alcohol & substance misuse, disordered eating (BEDA-Q), gambling (NORC), psychological resilience (CD-RISC), and demographic and player characteristics (e.g., injury age, gender, height, weight, duration of professional football career, field position)	disordered eating scores were higher than male footballers in addition to anxiety, depression, and sleep disturbance symptoms. Higher level of psychological resilience was associated with decreased reporting of mental health symptoms for men and women. Across both genders, severe injury in the past 6 months was associated with increased rates of gambling and disordered eating symptoms.
7. Prather et al. (2016)	Explore the prevalence of stress fractures, menstrual dysfunction, and DE attitudes in women elite soccer players	0:220 (middle school=75; high school= 81; college=28; professional=36). *Mage*=16.4, *SD*=4 NCAA D1 & professional United States	Quantitative Cross-sectional Disordered eating (EAT- 26), body mass (BMI), menstrual history, stress fracture history confirmed by a physician, and demographic and personal characteristics (e.g. age, height, injuries)	Findings indicated 17.9–19.4% professional players and NCAA D1 athletes had menstrual dysfunction. Of this population, 8.3–17.8% had scores on EAT-26 suggesting they were at moderate risk for ED.
8. Wilinski (2012)	Explore the relationship between gender-identity, the perception of the body, depressiveness, and aggression in women football players who represent different competition levels	0:94 *Mage*=20.77 Football Premier League & second league Poland	Quantitative Cross-sectional Sex role inventory (BSRI), body image questionnaire, depression inventory, hostility (BDI), and demographic and personal characteristics (e.g. weight, height)	This study found that football does not take-away women players femineity however, it does protect a high level of femineity with masculinity. Further, findings indicated that women footballers have androgynous gender identities, a higher level of masculinity than among non-training women, a more favourable perception of body-as-process, a higher evaluation of body-

				as-object. And, along with an increase of masculinity and a decrease in indirect aggression at higher competition levels

Appendix B

Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	The review title includes 'scoping review'	p. 40
ABSTRACT			
Structured summary	2	Following the journal's guidelines, an unstructured abstract is provided. It includes objectives, amount of studies included, charting methods, results and conclusions	p. 41
INTRODUCTION			
Rationale	3	Although there are existing reviews on mental health in elite sport, no review has systematically screened articles for methods and theory exclusive to elite women athletes	pp. 42-45
Objectives	4	To explore the way(s) that mental health or mental illness has been studied exclusively with elite women athletes. We focused on (1) identifying the methodology used in research concerning mental health or mental illness and elite women athletes, (2) exploring the use of theory in these studies, and (3) providing an overview of the research purposes with the aim of identifying gaps in the literature and providing recommendations for future research.	p. 46
METHODS			
Protocol and registration	5	This study has not been officially registered	n/a

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Eligibility criteria	6	Only English peer-reviewed articles were included in the present review. Elite athletes' mental health is an emerging and 1996 was a pivotal year specific to women athletes, therefore we limited the search to the last 24 years.	8-9
Information sources	7	The search strategy was applied in the following databases: SPORTDiscus, PsychINFO, CINAHL, and MEDLINE	p. 50 See section 3.2.3.
Search	8	Key terms of the database search are explained and an example for one database (SPORTDiscus) is provided	p. 50 See section 3.2.3.
Selection of sources of evidence	9	Inclusion and exclusion criteria are described in detail	p. 46 See section 3.2.2.
Data charting process	10	Data charting process involved all members of the research team. The final chart included year of publication, study aim/purpose, characteristics of study populations (e.g. sporting level, sport-type), type of design, measurements used, identification of theory, key findings, and limitations.	p. 50 See section 3.2.3.
Data items	11	The 24 included studies are presented and Table 3.1. Even further insight into the studies is provided in Table 3.2 and 3.3	pp. 52-60 See Table 3.1
Critical appraisal of individual sources of evidence	12	Not conducted in a systematic way	n/a
Synthesis of results	13	Not applicable for scoping reviews.	n/a
RESULTS			
Selection of sources of evidence	14	We describe the selection process including the different stages (identification, screening, eligibility, and inclusion). Figure 3.1 presents the flow chart	p. 49 Figure 3.1

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Characteristics of sources of evidence	15	Characteristics are discussed and an additional table—see Table 3.1—provides characteristics of each included study (e.g, authors, year, aims, sample, location, sport, methodology, use of theory and main findings and limitations).	pp. 52-60 See Table 3.1
Critical appraisal within sources of evidence	16	Not required for scoping reviews.	n/a
Results of individual sources of evidence	17	Table 3.1 provides an overview of all the study aims, methodology, and theory of each individual article which relates to the rationale of the study.	pp. 52-60 See Table 3.1
Synthesis of results	18	Table 3.2 provides study characteristics, Table 3.3 offers sport-type information, and Table 3.4 presents the screening tools used across the included studies.	pp. 61-68 See Table 3.2,3.3, 3.4
DISCUSSION			
Summary of evidence	19	The discussion, linked to the review questions and objectives, includes an overview of concepts, themes, and types of evidence	pp. 72-85
Limitations	20	Discusses limitations of the scoping review process and the results.	p. 83
Conclusions	21	Provides a general interpretation of the results with respect to the review questions and objectives, as well as provides potential implications for future research.	pp. 72-85
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	On credit author statement—please see published version.

Appendix C

Scoping review search terms

Example of Search 1: SPORTDiscus (EBSCO) (Conducted 03/2020)

1.clinical OR counsel* OR help-seeking OR help seeking OR mental health care OR mental health disorder* OR mental health service* OR mental health stigma* OR mental health sympt* or mental* ill* OR mental* tough* OR mental well* OR psyc* assistance OR psych* help OR psych issue* OR psych* support* OR psych* service* OR psych* therap* OR psych* well* OR depression OR anxiety OR disordered eating OR eating disorder OR substance abuse

AND

2. elite OR elite-level OR elite level OR high level OR high-level OR professional OR national OR international

AND

3. sport* OR athlete*

AND

4. female* OR wom?

Appendix D

Introduction email to clubs, welcome letter, and information sheet

Introduction Email

Dear [X],

I hope you are well!

I am a PhD student at the University of Central Lancashire and I am exploring Mental Health in Elite Women's Football. As part of a funded studentship, I am teaming up with a team of experts in elite women's football to research the mental health challenges faced by elite female footballers in the Women's Super League and Women's Championship throughout their athletic career.

On behalf of our research team, I am contacting you regarding your possible involvement in the first 2 studies. To briefly explain the first two studies:

Study 1 involves a questionnaire that is online, anonymous and will take around 15 minutes. The aim of this study is to explore the prevalence of mental health symptoms of current players in the Women's Super League and Women's Championship.

Study 2 involves remote interviews (30-90 minutes) with players, performance personnel and support personnel to attain a holistic understanding of mental health in the Women's Super League and Women's Championship.

If possible, and appropriate, we would like you to circulate the study link for the questionnaire to the players- the study link is below! Once the link is passed on, it will be up to each player to decide whether they would like to voluntarily participate in the study. If a player chooses to participate, the link will include an online consent form prior to the questionnaire. After the players complete the questionnaire, they will be able to leave their email on a separate page (which cannot be linked back to their anonymised questionnaire) if they wish to be contacted to participate in Study 2. For more details about the study, I have attached the 'Study information sheet' that the players will see online prior to their decision to voluntarily take part, or not take part, in the study

In addition to our request that you circulate the link to the players for the questionnaire, I may contact you in a couple of months to ask you to please send an information sheet from the research team to the performance and support personnel at your club inviting them to participate in an individual interview regarding mental health in elite women's football.

Study link for players: https://uclan.eu.qualtrics.com/jfe/form/SV_a2W9FG4RmNj8Oup

Please take your time to read over the attached information sheet and contact me with any questions! I can be contacted at cyperry@uclan.ac.uk

I look forward to hearing back from you!

Welcome letter (attached in email as PDF)

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

Dear X,

I hope you are well!

I am a PhD student at the University of Central Lancashire and I am exploring **Mental Health in Elite Women's Football.** As part of a funded studentship, I am teaming up with a team of experts in elite women's football to research the **mental health challenges faced by elite female footballers** in the ***Women's Super League*** and ***Women's Championship*** **throughout their athletic career.**

On behalf of our research team, I am contacting you regarding your possible involvement in the first 2 studies. To briefly explain the first two studies:

> *Study 1* involves a questionnaire that is **online, anonymous** and ***will take around 15 minutes.*** The aim of this study is to explore the prevalence of mental health symptoms of current players in the Women's Super League and Women's Championship.
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In addition to our request that you circulate the link to the players for the questionnaire, I may contact you in a couple of months to ask you to please send an information sheet from the research team to the performance and support personnel at your club inviting them to participate in an individual interview regarding mental health in elite women's football.

Please take your time to read over the attached information sheet and contact me with any questions! I can be contacted at **cyperry@uclan.ac.uk**

I look forward to hearing back from you!

Best Wishes,

Carly Perry, BA, MSc,

PhD Student

University of Central Lancashire

Player participant information sheet & consent form (attached in email as PDF)

Invitation paragraph

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives, and GP before taking part. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

To explore the mental health issues and challenges that elite female footballers encounter. Specifically, this study focuses on elite female footballers currently competing in the Women's Super League or Women's Championship.

Why have I been invited to take part?

This study specifically focuses on currently competing footballers in the Women's Super League or Women's Championship. You have been invited to take part in this study because you meet these requirements.

Do I have to take part?

Your participation is voluntary, and you are free to withdraw your participation at any time, without explanation, and without incurring a disadvantage.

What will happen if I take part?

You will be asked to complete a questionnaire that is comprised of several different questionnaires. You will be asked questions regarding your personal and player

characteristics and you will be asked to fill out several short questionnaires regarding your mental health.

How long will it take and where?

It will take around 15 minutes. The questionnaire will take place online, you will be sent a link. Therefore, you can engage in the questionnaire in a place that is comfortable and convenient for you.

Who will be carrying out the procedure?

The lead investigator is Carly Perry, who is a doctoral researcher at the University of Central Lancashire.

What will my information be used for?

The research will be carried out for a study within a PhD thesis and to help understand the mental health of elite female footballers. It is very important that you know your personal information will not be passed onto anyone in your club or anyone in the WSL or Women's Championship. Only the first researcher, Carly Perry, will have access to your original data before anonymisation.

How will my data be used?

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Your data will be collected electronically through an online questionnaire.
How will my data be stored?	Personal data will be stored on the University's secure network with appropriate access controls and not on individual computers or in cloud-based storage solutions unless a solution has been approved for use by the University.
How long will my data be stored for? What measures are in place to protect the security and confidentiality of my data?	University of Central Lancashire will keep identifiable information about you for 5 years after the study has been completed, securely stored on the University's IT system.
Will my data be anonymised?	Yes. The questionnaire is online and will be anonymised with no possible way for the researchers to know who completed the questionnaire.
How will my data be used?	Your anonymised data will be used for the completion of a PhD thesis and may be published in scientific journals.

Who will have access to my data?	Your anonymised data will be shared with the project supervisors. The anonymised results will also be available to external markers and reviewers of the thesis.
Will my data be archived for use in other research projects in the future?	The anonymised data will be archived and may be used in future research projects, each of which would be subject to ethical approval.
How will my data be destroyed?	Digitally erased by Carly Perry

Are there any risks in taking part?

The questionnaire asks you about your mental health which might be difficult and/or distressing for you to reflect upon. In this event, you will be free to pause or terminate the questionnaire at any time.

How do I withdraw from the study?

If you engage in the online questionnaire, you can withdraw at any point during the questionnaire. However, you will be unable to withdraw after you submit the questionnaire as submission anonymises the data subsequently making withdrawal after this impossible given the researchers will be unable to decipher whose data it is.

Who can I contact if I have further questions or complaints?

If you have any questions regarding this study please contact the researcher, Carly Perry on cyperry@uclan.ac.uk or contact Dr. Jessica Macbeth at Jlmacbeth@uclan.ac.uk. If you have any concerns or complaints regarding the conduct of this research, the University Officer for ethics can be contacted via OfficerforEthics@uclan.ac.uk.

Support Resources

If you feel distressed or are worried about your mental health after taking part in this study, please reach out to one of the resources below:

- Your GP
- Professional Footballers' Association: All services are private and confidential, current or former players (or concerned friends and family) can contact the PFA Charity: Contact them (24/7 counselling hotline) 07500000777 or wellbeing@thepfa.co.uk
- Mind: Call this Mental health organization's support line 0300 123 3393 or info@mind.org.uk

Appendix E

Player survey recruitment advert

Appendix F

Qualtrics pilot study feedback

- Date of study: November 2nd – November 11th, 2020
- Participants: 50 total participants from tier 3 & 4
- Summary of recruitment: I contacted two managers and one sport psychologist that I know who, at the time of the study, were working in tier 3 and tier 4 women's football clubs.

Tier	Feedback
Tier 3	"It looks good. It was clear and easy to follow, nice work."
Tier 3	"I thought it was perfect, took less than 5 minutes and was easy to follow."
Tier 3	"Very easy and no problems with understanding it. Very good"
Tier 4	"It is fine. Look at the wording of question 22. Also, maybe ask which mental illness?"
Tier 4	"OK just two comments from me. 1.I did not understand what dual career athlete means- can you add an info button? 2.The last question on who I would I to help for if I was having suicidal thoughts felt like it might benefit from adjusting for respondents who answer 'no' to having had suicidal thoughts earlier in the questionnaire. I could answer it as a hypothetical on what I think I might do, but I honestly don't know because I have never been in that situation Maybe a line to add that a best guess is ok? Or maybe a sentence to say you appreciate the respondent may not have found themselves in that situation and to give responses of what they think they would most likely do in that case. Overall, easy to answer and like that there's options to give other responses if the set answers don't suit.
Tier 3	"For Q11, why does it not let you type other? And, for Q13, I feel like this is not totally clear, are you looking at damaging coping strategies or just any coping strategy?"
Tier 3	"I actually enjoyed it, it wasn't too long and relatable tbf. There isn't that much support I feel, well Idk if there is… but yeah it was good! Very clear. Well done you."
Tier 4	"Yeah was fine-really quick and easy to do."
Tier 3	question #3: Extra bracket question #4: Maybe replace the word league with 'tier'? As some people may have played within the same tier for a number of years but changed leagues within that time. For example, 5 years ago first southern prem game and 2 years ago switched to a northern prem team. So technically have played within the tier 5 years. Change of word might help clarify for those in that situation. question #7: Yes (if so please indicate the total time this injury will prevent you playing matches for) or something similar? Question #9: "yes, dual career 'athlete'; add 'athlete to the end of dual career.' Question #10: • instead of 'lack of inner drive, maybe 'lack of motivation?' • instead of 'lack of confidence,' maybe 'lack of confidence in ability' Question #19.

	• For the question that reads “Little interest or pleasure in doing things.” Instead of “things” could you say ‘daily activities ‘or ‘social activities’ just to specify here. • More sensitive wording? #19.9 “thoughts that you would be better off dead or of hurting yourself in some way.” Instead, “thoughts that you do not want to be alive anymore?” Question #22: “sounds picky but can you swap the direction of the answers. Like start with ‘Never’ on the left and ‘Always’ on the right. Question #28: Instead of “if yes, your email” say “Please note, ….”

Appendix G

Qualtrics survey

Information sheet

This study is part of a larger project titled "Mental health in Elite Women's Football" which is funded by the University of Central Lancashire.

Please read the information below. Then, if you wish to participate, please confirm that you have read the information sheet and agree to the conditions on the consent form.

Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP before taking part. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

To explore the mental health issues and challenges that elite female footballers encounter. Specifically, this study focuses on elite female footballers currently competing in the Women's Super League or Women's Championship.

Why have I been invited to take part?

This study specifically focuses on currently competing footballers in the Women's Super League or Women's Championship. You have been invited to take part in this study because you meet these requirements.

Do I have to take part?

Your participation is voluntary, and you are free to withdraw your participation at any time, without explanation, and without incurring a disadvantage.

What will happen if I take part?

You will be asked to complete a questionnaire that is comprised of several different questionnaires. You will be asked questions regarding your personal and player characteristics and you will be asked to fill out several short questionnaires regarding your mental health.

How long will it take and where?

It will take around 15 minutes. The questionnaire will take place online, you will be sent a link. Therefore, you can engage in the questionnaire in a place that is comfortable and convenient for you.

Who will be carrying out the procedure?

The lead investigator is Carly Perry, who is a doctoral researcher at the University of Central Lancashire.

What will my information be used for?

The research will be carried out for a study within a PhD thesis and to help understand the mental health of elite female footballers. It is very important that you know your personal information will not be passed onto anyone in your club or anyone in the WSL or Women's Championship. Only the first researcher, Carly Perry, will have access to your original data before anonymisation.

How will my data be used?

Your personal data will be stored on the University's secure network with appropriate access controls and not on individual computers or in cloud-based storage solutions unless a solution has been approved for use by the University. The university of Central Lancashire will keep identifiable information about you for 5 years after the study has been complete securely stored

on the University's IT system and will be digitally erased by Carly at the end of the 5 years. Your anonymised data will be used for the completion of a PhD thesis and may be published in scientific journals. Your anonymised data will be shared with the project supervisors. The anonymised results will also be available to external markers and reviewers of the thesis The anonymised data will be archived and may be used in future research projects, each of which would be subject to ethical approval.

Will my data be anonymised?

Yes. The questionnaire is online and will be anonymised with no possible way for the researchers to know who completed the questionnaire.

Are there any risks in taking part?

The questionnaire asks you about your mental health which might be difficult and/or distressing for you to reflect upon. In this event, you will be free to pause or terminate the questionnaire at any time.

How do I withdraw from the study?

If you engage in the online questionnaire, you can withdraw at any point during the questionnaire. However, you will be unable to withdraw after you submit the questionnaire as submission anonymises the data subsequently making withdrawal after this impossible given the researchers will be unable to decipher whose data it is.

Who can I contact if I have further questions or complaints?

If you have any questions regarding this study please contact the researcher, Carly Perry on cyperry@uclan.ac.uk or contact Dr. Jessica Macbeth at Jlmacbeth@uclan.ac.uk. If you have any concerns or complaints regarding the conduct of this research, the University Officer for ethics can be contacted via OfficerforEthics@uclan.ac.uk.

Support Resources

If you feel distressed or are worried about your mental health after taking part in this study, please reach out to one of the resources below:

- Your GP
- Professional Footballers Association: All services are private and confidential, current or former players (or concerned friends and family) can contact the PF Charity: Contact them (24/7 counselling hotline) 07500000777 or wellbeing@thepfa.co.uk
- Mind: Call this Mental health organization's support line 0300 123 3393 or info@mind.org.uk

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Consent form

1. I confirm that I have read and have understood the information sheet for the above study, or it has been read to me.

2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

3. I understand that taking part in the study involves a series of questionnaires regarding mental health.

4. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions.

5. I understand that if I withdraw from this study data collected prior to my withdrawal will be retained but no further data will be collected

6.I understand that the information I provide will be held securely and in line with data protection requirements at the University of Central Lancashire.

7. I understand that completed copies of participant information sheets, consent forms and questionnaire information will be in electronic form and will be retained for 5 years. This data will be stored in accordance with UCLan guidelines on a password protected area of the UCLan OneDrive as well as in a shared folder in a private Microsoft Team within Office 365, only accessible to the researchers.

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8. I freely give my consent to participate in this research study.

I have read these conditions and give consent:

- o Yes
- o No

Part 1.

The first set of questions are about you and your football career.

Q1 What **league** do you *currently* play in?

- o Women's Super League (WSL)
- o Women's Championship (WC)

Q2 What is your year of birth? _____

Q3 Are you from the UK? **If not**, how many months or years have you lived in the UK?

- o Yes
- o No, how many months/years have you lived in the UK? _____

Q4 In which **year** did you play your **first** match in the WSL or Women's Championship?

- o _____

Q5 Have you played International Football?	o Yes, what age groups? _____ o No
Q6 How often are you a **starter** for your team?	o Every game o Most games o Some games o Few games o No games
Q7 Do you currently have an **injury** that prevents you from regular training or play?	o Yes, please indicate the total time this injury has prevented (or will prevent you) from training. _____ o No

Q8 Have you ever been clinically diagnosed with a mental illness?	o Yes, please provide the diagnosis you were given if you are comfortable disclosing this _____ o No o Other, please explain
Q9 Are you on a **paid contract** at your football club?	o Yes o No o Other, please explain _____
Q10 Are you a **student-athlete?** (e.g. are you currently enrolled at college or university alongside your football career?)	o Yes, college o Yes, university (part-time) o Yes, university (full-time) o No o Other, please explain _____

[Code] Skip To: Q11 If Are you a student-athlete? (e.g. are you currently enrolled at college or university alongside yo... = No

Q10.1 Does your football club fund your education?	o Yes o No o Other, please explain _____
Q11 Is football your **full-time** occupation?	o Yes o No o Other, please explain _____

[Code] Skip To: Part 2 If Is football your full-time occupation? = Yes

Q12 What are the reasons that football is *not* your full-time occupation? **Please tick all that apply**	☐ My contract does not cover my living expenses ☐ My club has not offered me a full-time contract ☐ I do not want football as my sole occupation ☐ Other, please explain _____
Q12 What are the reasons that football is *not* your full-time occupation? **Please tick all that apply**	☐ My contract does not cover my living expenses ☐ My club has not offered me a full-time contract ☐ I do not want football as my sole occupation ☐ Other, please explain _____

Part 2.

This set of 4 questions is about your performance and coping strategies.

Q 13 What are the **most important factors** responsible for any **performance low**s during your professional football career? **Please tick a maximum of 4 answers**	☐ Lack of inner drive or motivation ☐ Psychological problems / mental stress ☐ Lack of confidence ☐ Overloaded by the combination of work/school and football training/matches Overtraining ☐ Injury ☐ Fatigue ☐ Unsure ☐ Other, please name _____
Q14 What are the **most important factors** responsible for any **low moods** during your professional football career? **Please tick a maximum 4**	☐ Conflicts with the club-management ☐ Conflicts with the coach ☐ Conflicts within the team ☐ Conflicts with partner ☐ Too little support/recognition by the coach ☐ Separation/divorce, illness or death of someone close to you ☐ Injury ☐ Difficulties/pressures in your relationship/family ☐ Low performance ☐ Worry about contract extension ☐ The press, media, public pressure ☐ Financial problems ☐ Leadership pressure (e.g. being captain or having multiple roles on the team) ☐ Too little support from friends ☐ Other, please name _____

Q15 What helped you to **cope** with any **low moods** during difficult times during your professional football career? **Please tick a maximum of 4 answers.**	☐ My family ☐ My teammates ☐ My partner ☐ My friends ☐ My coach or someone from the coaching staff ☐ Professional help from a psychologist/doctor/psychotherapist ☐ Training/physical activity ☐ My belief in God / religion ☐ Medication ☐ Relaxation/rest/retreat ☐ Distraction ☐ A hobby ☐ Other, please specify _____
Q16 Have you ever engaged in any of the following **coping strategies** to deal with **low mood or psychological challenges**? **(Check all that apply)**	☐ Excessive exercise ☐ Excessive focus on healthy eating habits ☐ Self-harm ☐ Substance abuse and misuse ☐ Gambling ☐ Overeating ☐ None ☐ Other, please explain _____

Part 3

This set of questions is about the available support at your club

Q17 Is there a psychologist or an individual that falls within the remit of psychology (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) **available to you at your club?**	o Yes o No o Unsure o Other, please explain _____

[Code] Display This Question:

If Are you a student-athlete? (e.g. are you currently enrolled at college or university alongside yo... = Yes, college

Or Are you a student-athlete? (e.g. are you currently enrolled at college or university alongside yo... = Yes, university (part-time)

Or Are you a student-athlete? (e.g. are you currently enrolled at college or university alongside yo... = Yes, university (full-time)

Or Are you a student-athlete? (e.g. are you currently enrolled at college or university alongside yo... = Other, please explain]

Q17.1 Is there a psychologist or an individual that falls within the remit of psychology (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) available to you through your education?	o Yes o No o Unsure o Other, please explain _____
Q18 At any point in your career to date do you think you would have **benefited** from seeing one of the professionals mentioned above?	o Yes o No
Q19 Have you ever **wanted** or **needed** support from a **psychologist** (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist)?	o Yes, currently o Yes, at different times o No

Q20 Have you **ever** received counselling or treatment from a psychologist (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) outside your club?

- o Yes
- o No

Q21 Have you **ever** received counselling or treatment from a psychologist (e.g. sport psychologist, performance psychologist, counselling psychologist, clinical psychologist) inside your club?

- o Yes
- o No

Part 4

This section is about your mental health. Please read the statements and respond to the best of your ability.

Q22 Over the **last two weeks,** how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				

5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching the television				
8. Moving or speaking slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

Q23 If you checked off <u>any</u> problems above how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

- o Not difficult at all
- o Somewhat difficult
- o Very difficult
- o Extremely difficult

Q24 Over **the <u>last 2 weeks</u>**, how often have you been bothered by the following problems? Please tick the answer that best applies to you

	Not at all	Several days	More than half days	Nearly every day

1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Having trouble relaxing				
5. Being so restless that it was hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

Q25 **Over the last 4 weeks**, how often have you been bothered by the following problems? Please tick the answer that best applies to you.

	Never	Rarely	Sometimes	Often	Usually	Always
1. I feel extremely guilty after overeating						
2. I am preoccupied with the desire to be thinner						

3. I think that my stomach is too big						
4. I feel satisfied with the shape of my body						
5. My parents have expected excellence of me						
6. As a child, I tried very hard to avoid disappointing my parents and teachers						

Q26 Are you trying to lose weight now?	o Yes o No
Q27 Have you tried to lose weight (over the last 4 weeks)?	o Yes o No
Q28 If yes, how many times have you tried to lose weight (over the last 4 weeks)	o 1-2 times o 3-5 times o Over 5 times

Part 5.

Final Section, this section includes two questions about help-seeking and mental health

1. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people? Please indicate your response a that best describes *your intention to seek help from each help source that is listed*.

Type	Extremely likely	Moderately likely	Slightly likely	Neither likely nor unlikely	Slightly unlikely	Moderately unlikely	Extremely likely
Intimate partner (e.g., girlfriend, boyfriend, partner)							
Friend (not related to you)							
Parent							
Current teammate							
Current manager or staff							
Other relative/family member							
Mental health professional (e.g. psychologist, social worker, counsellor)							
Phone helpline (e.g. Lifeline							

Doctor/GP							
Minister or religious leader (e.g. Priest, Rabbi, Chaplain)							
I would not seek help from anyone							
I would seek help from another not listed above (e.g. past football coach). Please list who in the space provided.							
(If no, leave blank)							

2. If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people? Please indicate your response that best describes your intention to seek help from each help source that is listed.

	Extremely likely	Moderately likely	Slightly likely	Neither likely nor unlikely	Slightly unlikely	Moderately unlikely	Extremely likely
Intimate partner (e.g., girlfriend, boyfriend, partner)							

Friend (not related to you)							
Parent							
Current teammate							
Current manager or staff							
Other relative/family member							
Mental health professional (e.g. psychologist, social worker, counsellor)							
Phone helpline (e.g. Lifeline							
Doctor/GP							
Minister or religious leader (e.g. Priest, Rabbi, Chaplain)							

I would not seek help from anyone							
I would seek help from another not listed above (e.g. past football coach). Please list who in the space provided.							

Thank you for taking your time to participate!

Q30 The next phase of the research will involve interviewing players and support staff to explore these issues in more depth. Would you like to leave your email so the researcher can contact you to participate in a *confidential interview*?

Please note, your email will be saved *separately* from your responses in this questionnaire as the questionnaire is anonymous.

- o Yes
- o No

Appendix H

Player interview guide

Topic	Questions	Probes
Part 1. Sporting background	Can you tell me about your sporting background?	• Can you share one of your favourite memories?
	What is football like for you currently?	• Daily schedule? • Enjoyment? • Commitments, culture and expectations? • Transition experience? • In what ways is your football experience similar or different than before the professionalisation of everything? • How this been for you?
Part 2. Personal mental health experiences and football	In what ways do you currently or have you experienced football to impact your mental health? Do you have a story or an example?	• Do you have any stories of specific moments or time periods where your mental health was impacted? • Did you notice this or any changed? (e.g., behaviors, feelings, performance?) • How long did this last for you? • How do you think about it or that experience today? • How does that make you feel?
	In what ways does your football career play a role in your mental health experience?	• Has professionalisation influenced your mental health? Awareness? Support? • Can you explain how you experience your mental health day to day? • Is there anything that you feel significantly influences your mental health, positively or negatively?

Part 3. Mental health and women's football	How do you feel mental health is discussed within the elite women's football environment?	• Do you have an examples?
	If a teammate were struggling with mental health, would this be understood amongst your teammates? How would your team respond?	• Do you have an example or a story? • What did you experience/ what was that like for you? • Did you notice any changes? (Performance? Social occasions?) • How did you feel they were supported?
Part 4. Support availability at clubs	How do you feel footballers are supported with their mental health?	• At your club? and more broadly in the WSL or WC? • If so, how? • If not, why not? And, in what ways are they not? • Do you have any examples or stories where you or your teammates were supported with mental health? • How do you feel this helped? Or, what could have helped more for in the future?
	Can you explain to me what happens if you want to access support at your club?	• What is the process like? • How did you learn this process? • Have you or would you seek support? • If not, what were the barriers?
	What do you believe would help the footballers with their mental health?	
Part 5. Ending	Is there anything else you would like to add?	• Or that you think is important for me to know?
	How did being interviewed about this topic make you feel?	• Did any of your responses surprise you?

Appendix I

Study 3 & 4 Information sheet Qualitative Study

Invitation Paragraph

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP before taking part. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

The ***overriding aim*** of this study is to gather an understanding of the mental health challenges faced by elite female footballers in the WSL or Women's Championship. This study explores the experiences and mental health knowledge of elite female footballers. Additionally, this study aims to understand the ways in which performance personnel (e.g. coaches, managers, directors) and support personnel (e.g. lifestyle support, psych, doc, wellbeing) feel mental health is discussed in the football environment and ways in which footballer's mental health can be better supported.

Why have I been invited to take part?

You have been invited to take part in this study given your involvement as a current player in the WSL or Women's Championship or because you are a member of the performance staff (e.g. coaches, managers, directors) or support staff (e.g. lifestyle support, psych, chaplain, doctor) at a club in the WSL or Women's Championship.

Do I have to take part?

Your participation is voluntary, and you are free to withdraw your participation at any time, without explanation, and without incurring a disadvantage.

What will happen if I take part?

After you and Carly determine a time that is most convenient for you, a 30 to 90 minute audio-recorded interview will take place over Microsoft Teams video call. Carly will ask you questions about your role in the WSL and Women's Championship and then the researcher will ask you questions regarding mental health.

How long will it take and where?

It will take anywhere from 30 to 90 minutes; however, there is no time limit and you are free to pause and take a full break at any time during the interview. The interview will occur remotely through Microsoft Teams.

Who will be carrying out the procedure?

The lead investigator is Carly Perry, who is a doctoral researcher at the University of Central Lancashire.

What will my information be used for?

The research will be carried out for a study within a PhD thesis and to help understand the mental health of elite female footballers and their awareness. It is very important that you know your personal information will not be passed onto anyone in your club or anyone in the WSL or Women's Championship. Only the first researcher, Carly Perry, will have access to your original data before anonymisation.

How will my data be used?

Further information on how your data will be used can be found in the table below.

How will my data be collected?	The data will be audio-recorded during interviews.
How will my data be stored?	Personal data will be stored on the University's secure network with appropriate access controls and not on individual computers or in cloud- based storage solutions unless a solution has been approved for use by the University.
How long will my data be stored for? What measures are in place to protect the security and confidentiality of my data?	University of Central Lancashire will keep identifiable information about you for 5 years after the study has been complete securely stored on the University's IT system.
Will my data be anonymised?	Yes. After your interview is uploaded, it will be transcribed verbatim and anonymised. Only Carly, the student researcher, will have access to the original file. Carly will verbally reassure you of this.
How will my data be used?	Your anonymised will be used for the completion of a PhD thesis and may be published in scientific journals.
Who will have access to my data?	Your anonymised data will be shared with the project supervisors. The anonymised results will also be available to external markers and reviewers of the thesis.

Will my data be archived for use in other research projects in the future?	Your anonymised data will be archived and may be used in future research projects, each of which would be subject to ethical approval.
How will my data be destroyed?	Digitally erased and paper copies will be shredded.

Are there any risks in taking part?

The interview may involve you discussing experiences that you find or have found distressing. In this event, you will be free to pause or end the interview at any time.

How do I withdraw from the study?

You can withdraw at any point during the interview, without having to give a reason. If any questions during the interview make you feel uncomfortable, you do not have to answer them. If you withdraw from the study we will not retain the information you have given thus far, unless you are happy for us to do so**.** You do not need to offer any reasons or explanation for why you wish to withdraw from the study. If you wish to withdraw after the interview, you will have 3 weeks from the interview to withdraw. If you wish to withdraw, please contact Carly Perry cyperry@uclan.ac.uk

Who can I contact if I have further questions or complaints?

If you have any questions regarding this study please contact the researcher, Carly Perry on cyperry@uclan.ac.uk or contact Dr. Jessica Macbeth at Jlmacbeth@uclan.ac.uk. If you have any concerns or complaints regarding the conduct of this research, the University Officer for ethics can be contacted via OfficerforEthics@uclan.ac.uk.

Support Resources

If you feel distressed or are worried about your mental health after taking part in this study, please reach out to one of the resources below:

- Your GP
- Professional Footballers Association: All services are private and confidential, current
- or former players (or concerned friends and family) can contact the PFA Charity: Contact them (24/7 counselling hotline) 07500000777 or wellbeing@thepfa.co.uk
- Mind: Call this Mental health organization's support line 0300 123 3393 or info@mind.org.uk

Consent form

1. I confirm that I have read and have understood the information sheet for the above study, or it has been read to me.	
2. I understand that I may withdraw from this study at any time without having to give an explanation.	
3. I understand that this aspect of the research will involve a 30 to 90-minute interview over Microsoft Teams video call.	
4. I agree to the interview being audio recorded and understand that this recording will be used for the research only and will not be used out of context and will be securely stored.	
5. I understand that all information about me will be treated in strict confidence and I understand that the information I provide will be used for research only and that the information will be anonymised.	
7.I understand that the information I provide will be held securely and in line with data protection requirements at the University of Central Lancashire.	
8. I understand that the audio files will be saved in the project-specific shared drive and the consent recording will be retained for 5 years and then destroyed by Carly.	
9. I freely give my consent to participate in this research study and have been given a copy of this form for my own information	
Participant name: Date: Signature:	

Appendix J

Player interview recruitment advert

First post: July 7th 2021 (11:30am) Twitter

Appendix K

Microsoft teams interview instructions

Participant's Guide to Accessing Microsoft Teams for Research Interviews

This guide has been written as a step-by-step walkthrough for how to access Microsoft Teams for a research interview.

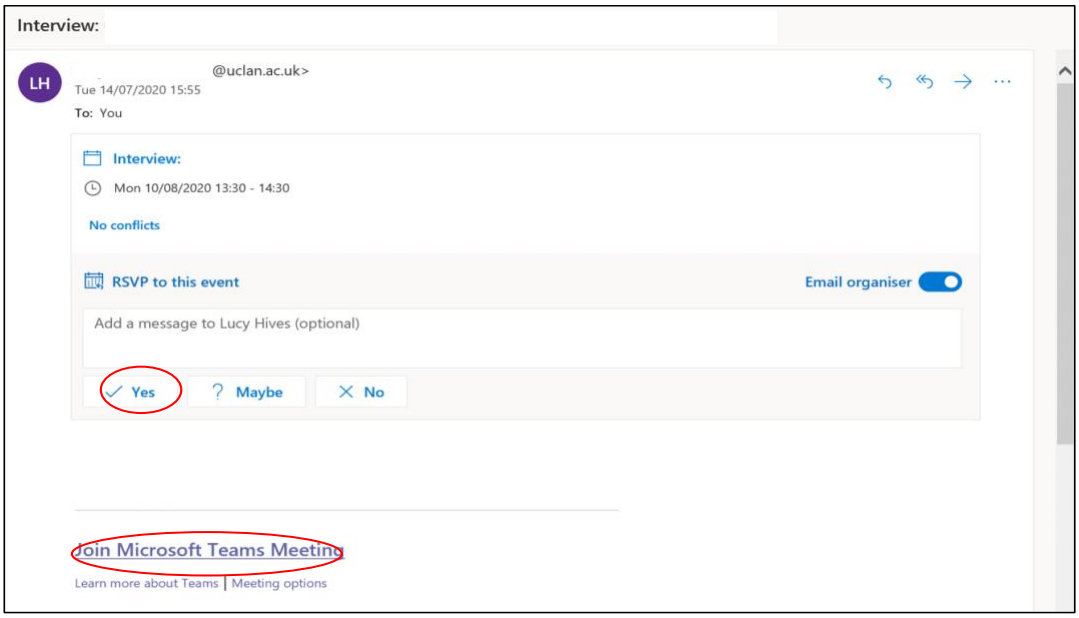
Please follow each of the steps below, in turn, which take you through what you will need to do 1) before your interview and 2) on the day of your interview.

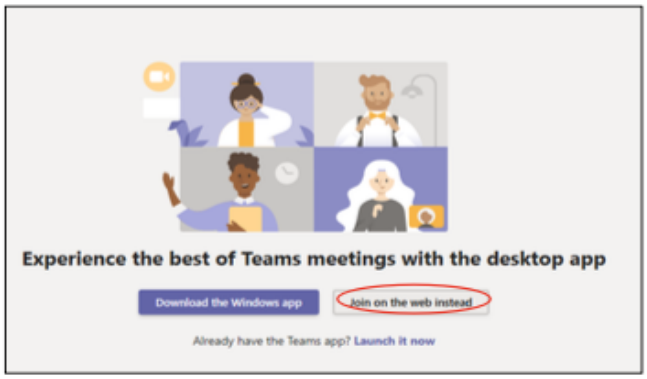
For the interview, please make sure you have **one** of the following:

- A computer or laptop
- A smartphone with the Microsoft Teams app installed.

1) Before your interview:

a. Once we have set up your interview date/time, you will receive an email which will look like this:





NOTE: If you are using your smart phone for this, once you click the link inside the invitation email, the meeting will open automatically in the Microsoft Teams app.

c. If asked if whether Microsoft Teams can use your camera and microphone, please select "yes".
d. You can enter your name (this doesn't need to be your full name or real name) and decide whether you want your camera to be switched on or off. The researcher may also turn off your camera.
e. Click "join now". If you are a little early the screen will say "when the meeting starts, we'll let people know you're waiting". Once the interviewer joins the meeting, this will begin automatically.
f. Once the interview ends, you can hang up.

Appendix L

Staff Interview Guide

Topic	Questions	Probes
Part 1. Coaching/Sporting background	What is your role at the club? And, what was your journey like to get here?	• Enjoyment? • Experience working with women? • In terms of working with women, has this influenced your career path? / How you relate to players?
	What is it like at this level now/ what has your experience been working at this level?	• What changes have you noticed? Professionalisation? • Time commitment? • Expectations? • Culture? • Enjoyment?
Part 2. Mental health understanding and perceived knowledge	What is your role surrounding the mental health of the players? And how have you come to attain your understandings of this role and topic?	• Education? • Workshops? • Personal interest? • Player welfare requirements? • Personal experience?
	Do you feel that you have had sufficient training during your academic studies and professional training in mental health related topics?	• If yes, expand • If no, why not?
	What do you think are the core gaps in support personnel's knowledge when it comes to mental health in women's sport?	• Have you seen these gaps manifest in real life? • How do you think these gaps could be addressed? • Do you have any examples or stories of how they have been addressed?
Part 3. Mental health and elite women's football in England	What is the conversation around mental health like amongst your club?	• Is mental health discussed? Supported? • Have you seen any changes in the way mental health is discussed? Stories? Example?

	What aspects of being a professional women's footballer do you think impacts players' mental health?	• Do you have any examples? • When did you come to notice this? • Is the culture of influence? • Would this be similar in the men's game? • Media? Pressure?
	How do you experience the mental health of your players to be currently?	• Examples of behaviours that make you believe this? • In what ways has professionalisation helped and impacted mental health?
	Can you share an example or a time of when you have seen a player struggle with their mental health? or when you worried about them?	• Examples? (e.g. Injury? Transition? Retirement? Sexuality? • What behaviours did you notice? • How did you support them • How did this impact you?
	Do you feel that the footballers have enough support for their mental health?	• If so, by whom and how? Examples? • If not, why? What stands in the way? How could support be better provided?
	What do you believe the footballers need to help with their mental health in the future?	• Examples of how this could be done? • Who would be best placed to support their needs?
Part 4. Ending	Is there anything else you would like to add?	
	How did being interviewed about this topic make you feel?	

Appendix M

Staff recruitment advert

First tweeted October 18th, 2021

Appendix N

Timeline of women's football events across thesis

Date	Significant moments	Relevance / notes
07/02/2020	Gilly Flaherty —West Ham Captain—speaks to BBC about her mental health. • https://www.bbc.co.uk/sport/av/football/51359936	Important moment as a well-known women's footballer shares her mental health experience. This is one of the earliest 'reports' of a player in the WSL publicly speaking about mental health.
23/10/2020	Telegraph article regarding body image and eating distress in WSL: "Weight charts, 'fat clubs' and disordered eating: the hidden health crisis in women's football" • https://www.telegraph.co.uk/football/2020/10/23/weight-charts-fat-clubs-disordered-eatingthe-hidden-health-crisis/	This article provide contextual insight into areas of the women's game which warrant immediate attention. During this time period, the majority of news surronding the women's game was about structures, game schedules, and the growth of the game – this article highlighted an area personal and pressing for the players themselves.
11/2020	Five American world cup winners sign to WSL on loan: Alex Morgan (Tottenham), Samantha Mewis (Man City), Rose Lavelle (Man City), Christen Press (Manchester United), Tobin Heath (Manchester United)	Significant moment for the growth of the WSL and the increasing standard of the league.
3/11/2020	Women's FA cup paused during COVID-19 but men's continues: "Women's FA cup pause during November's Lockdown, while the Men's competition has been given special dispensation to continue" • https://www.telegraph.co.uk/womens-sport/2020/11/03/womens-fa-cup-paused-november-mens-competition-continues/	The impact of COVID-19 on the women's game can be seen in academic research (see Clarkson, Culvin, Pope, & Parry, 2020).
05/04/2021	Birmingham city women (WSL) send formal letter complaining about work conditions at their club. • https://www.bbc.co.uk/sport/football/56642488	This letter highlighted that 'professional' players were still not expressing professional working conditions. This was a significant moment as it was led by the players and was a call to action.
12/05/2021	Courtnay Ward-Chambers—London Bees—on mental health and physical health. • https://www.skysports.com/football/news/11095/12303581/london-bees-courtnay-ward-chambers-on-mental-health-battle-and-	WC speaking out about her mental health to the media

	physical-struggle-to-regain-full-feeling-in-her-leg	
14/05/2021	Millie Bright—Chelsea—shares that mental health awareness is getting better in Sky Sports article: "Millie Bright: Chelsea and England defender says mental health awareness has improved in football." • https://www.skysports.com/football/news/11668/12305832/millie-bright-chelsea-and-england-defender-says-mental-health-awareness-has-improved-in-football	As noted by Millie Bright, some players feel the mental health support and awareness is improving. Notably, Millie is at a top club where mental health support is likely more implemented and available then at women's clubs with less finical stability
15/06/2021	Molly Bartrip shares her mental health experience on BBC (The One Show)	In this interview, she shares her lived experiences with mental health issues and offers insight into the pressures she faced in football.
16/08/2021	Fara Williams—most capped player for England—discusses mental health struggles in FIFA interview. • https://www.fifa.com/about-fifa/medical/news/fara-williams-mental-health-interview	One of the most recognised players in women's football history in England shares her experience with mental health.
23/12/2021	Two days before Christmas Coventry United Women's team folds. • https://www.theguardian.com/football/2021/dec/23/coventry-united-womens-championship-voluntary-liquidation	Example of the instability of the women's game at the WC level in England—providing contextual insight into the career fragility and conditions that women players are encountering.
26/01/2022	Elite (WSL and WC) women footballers in England receive maternity cover. • https://www.theguardian.com/football/2022/jan/26/female-footballers-in-england-get-maternity-cover-after-landmark-change	Significant moment for elite women footballers in England—example of their needs being listened to.
31/01/2022	NWSL players entitled to 6 month paid mental health leave. • https://www.espn.co.uk/football/story/_/id/37625100/nwsl-board-governors-approves-new-labor-agreement	Global women's football example of the importance and 'movement' surronding the topic of mental health and support for players. This policy change was player-led and was —to the best of my knowledge—the first of it's kind to allow for a 6 month mental health leave for professional women's players.
24/02/2022	Molly Bartrip—Tottenham—shares her experience with mental health. • https://www.skysports.com/watch/video/sports/football/12550614/molly-bartrip-my-story	Video interview highlighting her lived experiences with mental health and anorexia.

10/06/2022	Fara Williams speaks out about 'fat clubs' and mental health. • https://www.independent.co.uk/sport/football/fara-williams-english-mbe-wsl-lioness-b2098163.html	Fara talks about her experience with fat clubs during her professional football career. Notably. research from this thesis (Study Two) included in this article
31/07/2022	Lionesses win EUROS	Pivotal moment for women's football in England. Since this win, there has been a substantial increase in TV viewership and match attendances at games for the national team and the WSL. Additionally, and participation rates across all age groups in England have skyrocketed
03/10/2022	Sally Yates independent review of NWSL reveals systematic abuse of players. • https://int.nyt.com/data/documenttools/full-report-soccer-abuse/91e8cbcf0cd27905/full.pdf	Global significance highlighting corruption and systematic abuse in the NWSL. For decades US women's soccer has been seen at the professional level and national team level as 'leaders' in women's football globally—particularly in terms of standards and challenging conditions (e.g., the equal pay lawsuit). This was another big moment where players challenges conditions and spoke out about their organisation. At the same time, this highlighted that even the most 'progressive' and 'professional' women's football teams are vulnerable to systematic abuse and other forms of mistreatment.
15/10/2022	Claire Rafferty speaks about her experience with mental health and an eating disorder • https://www.womeninfootball.co.uk/news/2022/10/15/guest-feature-claire-rafferty-opens-up-about-eating-disorders-for-world-mental-health-day/	For global mental health day, Claire shared her experience with an eating disorder. She highlighted personal and cultural challenges which negatively impacted her mental health.
03/04/2023	England Lionesses switch to blue shorts after players voice period concerns. • https://www.theguardian.com/football/2023/apr/03/england-lionesses-new-kit-blue-shorts-player-period-concerns	Example of women's players needs being listened to.
23/06/2023	Newcastle United Women becomes first full-time professional club in the FA Women's National League (tier 3) history.	Critical moment highlighting the growth of the women's game in England. Previously only teams in tier 1 and tier 2 had professional teams. Notably, since

	• https://www.newcastleunited.com/news/latest-news/newcastle-united-women-becomes-full-time-professional-club/	this announcement many teams in the FA Women's National League have made their teams semi-professional and/or offered a handful of players fully professional contracts.
18/08/2023	Chair of the WSL announces that the WSL can be the first billion-pound women's football league in the world. • https://www.theguardian.com/football/2023/sep/18/wsl-can-be-first-billion-pound-womens-football-league-in-the-world-says-it-chair	Announcement made by the chair of the WSL highlighting the financial growth of the women's game in England.
13/07/2023	Independent review of women's football commissioned by DCMS and led by Karen Carney MBE is published. See published review: • https://assets.publishing.service.gov.uk/media/64aee9cbc033c1000d8061e9/Raising_the_bar_-_reframing_the_opportunity_in_women_s_football.pdf	This review considered all levels of the women's football pyramid and offered various recommendations for improving the 'pyramid' as a whole. Many of the recommendations were targeted at the elite level, highlighting a need for increased standards and mental health care for those in the WSL and WC.
11/2023	Around this time, it was announced that a new organisation ('NewCo') would takeover the top two tiers of women's football in England. Nikki Doucet was later appointed CEO. • https://womensleagues.thefa.com/nikki-doucet-appointed-as-newco-ceo/	Elite women's football in England will be run by independent organisation called 'NewCo.' Significant moment in history of the women's game as this means the FA will no longer run the professional game for women in England.
11/2023	Sheffield United women's player Maddy Cusack dies by suicide September 20th, 2023. One of the many articles published since Maddy's death is below. • https://www.bbc.co.uk/news/uk-england-derbyshire-67558218	The tragic death of Maddy sent shockwaves throughout the women's football community—in addition to the broader communities she was part of. Maddy's parents highlighted the reality for many players in the WC—low pay, extreme football pressures, and dual-careers.
03/12/2023	UK government backs Carney review recommendations. See government's response: • https://assets.publishing.service.gov.uk/media/656a1e710f12ef070e3e0104/Government_response_to_independent_review_-_reframing_the_opportunity_in_women_s_football.pdf	Important moment for the women's game as UK government responded to Carney's review by backing her suggestions.
30/04/2024	PFA, FIFPRO, & Nike launch 'Project ACL'	The launch of this women-focused study represents a significant moment in the

	• https://www.fifpro.org/en/supporting-players/health-and-performance/fifpro-pfa-england-nike-leeds-beckett-university-launch-project-to-reduce-acl-injuries-in-women-s-football	game and research. With women rarely the focus of sport science research, this project recognises the need to place women at the centre of research.
14/05/2024	Arsenal announces Emirates Stadium as Arsenal Women's main home for 2024/2025 season. • https://www.arsenal.com/news/emirates-stadium-becomes-arsenal-womens-main-home	Growth of the women's game as Arsenal Women make the men's stadium their new home stadium.