Suck It Up: Opinions and Attitudes about Mental Illness Stigma and Help-Seeking Behaviour of Male Varsity Football Players

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ABSTRACT

The purpose of this qualitative study was to understand the attitudes and opinions of varsity football players toward mental health and help-seeking. The insights gained from this study may contribute to a greater understanding of how stigma functions in a competitive, elite-level football team. The authors concluded that the competitive edge required for success in elite athletics conflicts with mental health issues and illnesses. Components of the stigma process (labelling, stereotyping, separation, status loss, and discrimination), along with the impact of gender on stigma toward mental illness and help-seeking behaviours, are explored. Recommendations are made to broaden the scope of mental health initiatives for student athletes.

Keywords: mental health, mental illness, stigma, qualitative, stimulus text, varsity football players, masculinity

RÉSUMÉ

Le but de cette étude qualitative était de comprendre les attitudes et les opinions des joueurs de football universitaires en ce qui concerne la santé mentale et la recherche d'aide. Les leçons tirées de cette étude peuvent contribuer à une meilleure compréhension du fonctionnement de la stigmatisation dans une équipe de football compétitive au niveau élite. Les auteurs ont conclu que l'avantage concurrentiel nécessaire pour réussir dans l'athlétisme peut entrer en conflit avec la santé mentale. Des composantes du processus de stigmatisation (l'étiquetage, les stéréotypes, la séparation, la perte de prestige, et la discrimination), ainsi que l'impact du genre sur la stigmatisation envers la maladie mentale et la recherche d'aide, sont explorées. Des recommandations sont faites pour élargir la portée des initiatives de santé mentale pour les étudiants-athlètes.

Mots clés : santé mentale, maladie mentale, stigmatisation, étude qualitative, texte stimulus, joueurs de football universitaires, masculinité

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Mental health problems and illnesses are common and will affect one in five Canadians in their lifetime (Health Canada, 2002). Despite the conception that athletes, especially football players, are "machines" who push themselves through physical pain and injury (Sabo, 1998), it is problematic to dismiss them as immune to mental health problems and illness. Researchers have shown, in fact, that athletes at the varsity level in North America struggle with depression (Brewer, 1993; Reardon & Factor, 2010), addictive disorders (Green, Uryasz, Petr, & Bray, 2001, Lisha & Sussman, 2010; Miller et al., 2001), and anxiety (Kamm, 2008). This paper explores the stigma associated with mental illness for athletes and the difficulties they may face in seeking help for mental health problems.

Accessing professional services is a recommended pathway to successful recovery and management of mental health problems or illnesses (Davidson & Roe, 2007); however, researchers have demonstrated that the stigma associated with mental health disorders is a significant barrier to accessing these services (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan & Kleinlein, 2005). Stigma is defined as the devaluing, disgracing, and disfavouring by the general public of individuals with mental illnesses (Abdullah & Brown, 2011). Even more detrimental than the stigmatizing attitudes of others are the effects of internalizing negative stigmatizing messages, or believing the negative perceptions of mental illness to be true of oneself. Researchers have shown that internalizing stigma leads to low self-esteem and contributes to unnecessary suffering (Hartman et al., 2013; Vogel, Wade, & Heckler, 2007).

Stigma is a social construct that serves social functions (Smith, 2007), including protecting group survival, and thus "people will stigmatize those individuals whose characteristics and actions are seen as threatening or hindering the effective functioning of their groups" (Neuberg, Smith, & Asher, 2000, p. 34). Effective functioning of a group would be characterized as fulfilling a role, sharing resources, creating effective communication, protecting individual members, creating a common group identity, and forging stable bonds between members (Neuberg et al., 2000).

An individual whose behaviour or circumstances threaten the effective functioning of a group may be subjected to the stigma process of labelling, stereotyping, separation, status loss, and discrimination. The first component of stigma, *labelling*, is a process whereby groups are created as a result of gross oversimplification based on single characteristics, and subsequently linked to stereotypes (Link & Phelan, 2001). *Stereotypes*, the second component, are defined as "beliefs about the characteristics, attributes, and behaviours of people who are categorizable as a member of a particular social group" (Corrigan & Shapiro, 2010, pp. 908–909). Some of the negative stereotypes associated with the group labelled "mentally ill" include that individuals in this group are dangerous, incompetent, and/or have a weak character (Brockington, Hall, & Levings, 1993; Taylor & Dear, 1980), are violent or criminal (Cutcliffe & Hannigan, 2001), or are simple-minded and childlike (Wilson, Nairn, Coverdale, & Panapa, 1999). The third component that propels stigma is the *separation* of "us" from "them," whereby "they"—the group that shares the label and its negative associations—are defined as essentially different from "us" (Link & Phelan, 2001). Goffman (1963) noted that this reduces the labelled individual "from a whole and usual person, to a tainted, discounted one" (p. 3), eventually resulting in what Link and Phelan (2001) refer to as the fourth and fifth components of stigma, *status loss* and *discrimination*.

In sum, Link and Phelan (2001) argue that stigmatization is "entirely contingent on access to social, economic, and political power that allows . . . the components of stigma to unfold" (p. 367). This means that

groups that hold significant power over the lives of individuals—including landlords, employers, health care providers, criminal justice professionals, policy-makers, and the media—should be priority target groups for reducing mental illness stigma (Corrigan, 2004).

Stigma plays an important role in help-seeking behaviour and ultimately can influence men's health. As a result of their fear of being stigmatized, for example, men are less likely to seek help for problems such as depression, substance abuse, and stressful life events, and they therefore underuse professional mental health resources (Mansfield, Addis, & Courtenay, 2005). One explanation is that help-seeking may be perceived as a sign of weakness and potential incompetence (Robertson & Fitzgerald, 1992), both of which, as a result of learned patterns through socialization (Sabo, 1998), are undesirable characteristics in men.

Personal stigma, or people's own stigmatizing attitudes, has been linked to lower help-seeking in adults and adolescents (Cooper, Corrigan, & Watson, 2003), and personal stigma is higher in male students across college campuses (Eisenberg, Downs, Golberstein, & Zivin, 2009). Researchers have shown that student athletes have reported a fear that they will be stigmatized by various groups such as teammates, coaches, and fans, and that this stigma will affect campus celebrity status, playing time, and trust levels with coaches and teammates (Brewer, Van Raalte, Petipas, Bachman, & Weinhold, 1998; Linder, Brewer, Van Raalte, & DeLange, 1991; Watson, 2005). In addition, athletes may hold negative attitudes regarding a counsellor's ability to relate to their lifestyle (Watson, 2005). Martin (2005) found that male athletes in high school and college were more likely than female athletes to stigmatize sports psychology, and suggested that those participating in contact sports may have more negative views than those participating in non-contact sports. Similarly, Naoi, Watson, Deaner, and Sato (2011) found that, for mental health issues, American male athletes preferred to seek help, in order of preference, from family, friends, coaches, teammates, doctors, and—lastly—sports psychology consultants. These researchers also found that student athletes preferred discussing performance-related topics (such as concentration/focus, dealing with pressure and/or stress, and confidence) and academic concerns to discussing mental health concerns (depression, anxiety, eating disorders), injury, alcohol and drug issues, and career concerns.

The relationship between traditional masculinity and help-seeking stigma was recently studied by Steinfeldt and Steinfeldt (2012) in a football-specific context. They profiled 245 college football players and found three diverse clusters of players who varied in the degree to which they conformed to masculine norms such as winning, emotional control, risk taking, violence, power over women, self-reliance, and so on. On the basis of the findings, three groups were produced for evaluation. "Non-conforming players" (33% of participants) reported the lowest levels of conformity to masculine norms. "Paradoxical competitors" (36% of participants) reported mixed levels of conformity; for example, these men had conformed to masculine norms like winning and heterosexual self-preservation and had scored low on items like playboy behaviour and risk-taking. Finally, "high conforming players" (31% of participants) reported the highest levels of conformity to masculine norms. Of note, the non-conforming cluster also reported the lowest levels of stigma with regard to help-seeking, while levels of stigma increased in the other two groups.

The purpose of this qualitative study was to understand the attitudes and opinions of varsity football players toward mental health and help-seeking. The insights gained from this study may contribute to a greater understanding of how stigma functions in a competitive, elite-level football team as well as to the development of anti-stigma strategies and a mental health framework for this target population.

METHOD

Participants

Participants consisted of eight full-time male students, with an average age of 22 years, playing varsity football at a large Ontario university. Three of the participants were in their fifth year of undergraduate study (37.5%), two were in their third year (25%), one was in his first year (12.5%), and two were in their first year of graduate studies (25%). Three of the participants played offensive positions (37.5%) and five played defensive positions (62.5%). Participants were recruited using volunteer sampling. After the researchers received ethical clearance to conduct the study, initial recruitment and information letters were distributed to the head coach to circulate among all 89 players via the team email list. Interested players were invited to contact the researchers if they were willing to participate in the study. The sensitive area of study and the difficulty of recruiting busy student athletes resulted in a sample of only eight participants.

Interview Procedures

Before beginning the interview, participants were briefed on the purpose and structure of the interview, asked to read an information sheet, and sign a consent form. They were told they could withdraw their consent at any time. Interviews lasted 90–120 minutes and were digitally recorded. The formal interview began with broad questions to gain an understanding of the participant's experience as a player on a varsity football team, the role of football in his life, and his relationships with teammates and coaches (e.g., "When you think about who you are as a person, describe how much being a part of a football team shapes your sense of identity.").

The rest of the interviews were structured around the use of stimulus text (Törrönen, 2002). Stimulus text refers to a "description, narrative, story fragment, picture continuum, or collage that is more extensive than a question, sentence, or proposition" (Törrönen, 2002, p. 344). In other words, the intent of stimulus text is to generate discussion using a text that participants observe and then comment on. It is particularly useful for engaging participants in discussion around issues that are "otherwise delicate and difficult to discuss" (Törrönen, 2002, p. 357). All participants were presented with two stimulus texts in the same order.

Participants were first asked to read a short article excerpt titled "McKinley's Apparent Suicide Casts Light on Athletes' Risk of Depression," written by Jon Wertheim (2010) in *Sports Illustrated*. The story reported on a National Football League (NFL) athlete's experience with mental illness. In this study, the excerpt was used to "encourage the interviewees to compare their own conceptions and experiences to the world constructed in the stimulus text" (Törrönen, 2002, p. 354). In other words, the world constructed in the stimulus text described the experiences of a professional football player with mental illness stigma and, by extension, the broader health issue concerning masculinity, health beliefs, and behaviours. Questions included, for example, "What is your first reaction to this story?", "Based on what you read, what is your impression of Ricky Williams?" and "How do you think you would react to him?"

The strengths of using this approach were twofold. First, as Törrönen (2002) has pointed out, it can be difficult for researchers to elicit responses to direct questions about values or personal issues, particularly those that are difficult or uncomfortable to discuss or with which participants are unfamiliar. In this study, the stimulus text acted as a reference point to which participants could "relate their way of being and doing in the world" (p. 355). Additionally, in light of the gender of the participants and the stigma around the topic of mental illness, the researcher anticipated that a stimulus text would— "in its distant and safe setting or frame" (p. 355)—be perceived as less threatening, allowing participants to "express their distance or proximity in relation to the subject positions and the world evolving in it" (p. 355). Thus, interview questions and prompts were designed to elicit participants' opinions and attitudes as they compared their experiences or observations to the stimulus text.

Participants were then asked to watch the second stimulus text, which was a minute-long public service announcement in video form produced by the NFL called "Lean on Me," featuring NFL Hall of Famer Michael Irvin encouraging men to speak about their problems (NFL Lifeline, 2012). This particular stimulus text was selected because of its progressive content set in a highly traditional masculine domain like the NFL. According to Törrönen (2002), stimulus text used in this way becomes a provoker and is intended to "question established social practices and cultural conventions by representing anomalies, liminal states, extreme phenomena, or taboos" (p. 356).

Data Analysis

Following Creswell's (2009, 2013) exploratory qualitative approach, data analysis procedures began with a verbatim transcription and careful reading of all transcripts to gain an overall sense of the data. To ensure intercoder reliability (Frey, Botan, & Kreps, 2000), coding of the data was conducted using the following procedures: The coders (the authors) worked to iteratively narrow down a list of themes that had emerged from the data. Next, the two coders met to present, discuss, and agree on the definitions of the themes and coded units. Disagreements between the coders were resolved through discussion. In this manner, the coders reached 100% agreement on the identification of the themes. Following phenomenological approaches outlined by Moustakas (1994), and based on the themes, the researchers then identified "significant statements" in the data that illustrated each of the themes and were intended to "provide an understanding of how the participants experience the phenomenon" (Creswell, 2013, p. 82) (see Table 1).

RESULTS AND ANALYSIS

Based on the qualitative analysis described above, four main themes emerged (see Table 1): (a) perceived public stigma (participants' own perception of public stigma); (b) personal stigma (people's own stigmatizing attitudes, which may or may not agree with their perception of public stigma or perceived public stigma; Eisenberg et al., 2009); (c) social function of stigma (Neuberg et al., 2000; notions of group survival and contribution to the football team); (d) masculinity and toughness ("strongly endorsed health-related beliefs that men are independent, self-reliant, strong, robust and tough" [Courtenay, 2000, p. 1387]). Each of these themes will be discussed below with examples from the interview transcripts.

Table 1
Themes Emerging from the Data and Their Definitions

Theme	Definition	Example of Significant Statement
1. Perceived public stigma	The participants' own perception of public stigma	"I would say some guys that are not tough enough mentally to play or be involved in competition, in a world of competition—because that is the life of football, it's competition all over the place—they will try to use that to justify their lack of will."
2. Personal stigma	People's own stigmatizing attitudes, which may or may not agree with their perception of public stigma or perceived public stigma (Eisenberg et al., 2009)	"If you show [a teammate who has mental illness] your support and you show you understand his weaknesses, they are going to associate those weaknesses with you and they are going to associate you with being weak-minded."
3. Social function of stigma (Neuberg et al., 2000)	Notions of group survival and contribution to the football team	"I would try to be there for this guy, but it depends though. . . if it's a guy who works hard and pushes it, I am going to help him for sure. . . . But if it's someone who is just slacking and just comes up to me . . . maybe I don't feel like it's genuine or maybe I don't feel like he deserves it, so maybe I would refer him to somebody."
4. Masculinity and toughness	"Strongly endorsed health-related beliefs that men are independent, self-reliant, strong, robust and tough" (Courtenay, 2000, p. 1387).	"The guys who are really, really good have that high mental strength . . . There are no excuses . . . they can play through it and perform well even with those kinds of injuries."

Perceived Public Stigma

Participants in this study reported the perceived public stigma (i.e., the individual's perception of the public's perception toward an issue) was that mental illness is a reflection of weak character. Collectively, participants hypothesized that these perceptions could be fuelled by a general lack of education about mental health disorders, the lack of visible symptoms affirming mental illness as a real medical condition, and social expectations that individuals who withstand immense physical distress in a game like football should have equivalent mental strength. This latter factor is consistent with Addis and Mahalik (2003), who noted that health problems become more salient if they are perceived to threaten a person's strengths. Elite athletes pride themselves on having the mental toughness to compete consistently, to overcome setbacks such as

losses or injuries, and to perform under immense pressure. Mental health problems thus directly threaten the mental toughness that athletes strive to build and could perhaps lead an athlete to internalize negative public stigma more thoroughly than would a non-athlete. Researchers like Vogel et al. (2007), moreover, found that men may internalize stereotypes about mental illness more fully than women do. Taken together, this could suggest that males who are elite athletes may be more likely to self-stigmatize, thus contributing to unnecessary suffering.

The majority of the participants suggested that mental illness could be used as a crutch, an excuse, or a scapegoat in different contexts; for example, several participants speculated that some teammates might use mental illness to justify their lack of will to compete or to avoid training and practices:

> I would say some guys that are not tough enough mentally to play or be involved in competition, in a world of competition—because that is the life of football, it's competition all over the place—they will try to use that to justify their lack of will . . . It's hard [to separate] those that use that as an excuse and those who have good will and have those issues.

Another participant suggested that teammates may use mental illness to justify bad life choices (financial, relational, and academic). In one such example, the participant said,

> It's not even that they are depressed, it's because they made bad decisions. That's where I am kind of on the fence: Do I help this person? Do I genuinely think he is sad or depressed? Or is he just drinking because he messed up before and now he has nothing to do and is looking for a way out instead of dealing with his problems?

One participant noted that mental illness might be viewed as a crutch within a certain timeframe, but if the problems persisted past a certain point and players understood that this was not healthy, then the illness would be legitimized. The participant noted,

> They have an education program for concussions but they don't have it for symptoms [of mental illness]. It's like, "Well, I have been depressed for a week. Well, snap out of it, you are giving yourself that crutch." But if it's been 3–5 weeks that should ring an alarm, you should be able to identify.

Conversely, another participant suggested that being mentally ill for an extended period of time was unacceptable: "I would try to help them out but at a certain point you have to get better . . . you have to figure this out for yourself and come through. Pretty much just 'man up,' we have a game on Saturday."

In sum, mental health problems were presented as a weakness by several participants—particularly if they are perceived as the individual's choice—and in this example are linked to masculinity. On the other hand, some participants stated that an individual was not to blame for his or her mental illness and that is should not be seen as weakness.

Personal Stigma

Elements of the stigma process discussed earlier (i.e., labelling and stereotyping, separation, status loss, and discrimination; Link & Phelan, 2001) were noted in several participants' comments throughout the interviews. The perception of being weak was considered to be a threat to in-group status. One participant illustrated this conflict, saying, "Players might hate on you and think you are weak . . . I wouldn't want everyone talking about it behind my back.... That would be the biggest thing: fear of my peers not accepting me."

Fear of peer rejection was echoed by other participants, who noted that teammates who didn't understand mental illness would use negative labels and stereotypes like *freak* or even *pussy*, *sissy*, or *wuss*, all of which would serve to categorize that person as weak or as separate from the group's identity. Smith (2007) explained that "the labeling process (a) brings attention to the group's stigma, (b) stresses that this is a separate social entity, and (c) helps to differentiate the stigmatized group from the normals" (p. 469). Thus, labels are important to keeping the stigma alive.

In a similar vein, rejecting a peer who had a mental illness was also seen as a survival strategy by creating distance in a competitive group setting. One participant discussed stigma by association, whereby his public support for a player with mental illness would reflect negatively on him. In his own words, stigma became leverage for teammates to abuse:

> If you show [a teammate who has mental illness] your support and you show you understand his weaknesses, they are going to associate those weaknesses with you and they are going to associate you with being weak minded. . . . You never know when they are going to use that to make fun of you, when they are going to use that to hurt you when they need to take your spot.

Sherif (1962) noted that people may not personally agree with the public stigma but they sometimes adhere to it to survive in the group. Competition is a consistent element within the team, where players vie against each other for top spots. Thus maintaining status as a competitor is critical. As one participant explained, "There are 90 people out here who are giving it their all. . . . If you can't fix it then take a year off and come back. You can't just be on the team and be around and be here and there."

From this angle, an individual struggling with mental illness threatens the team's "effective functioning" (Neuberg et al., 2000, p. 34) and is cast out until he is well enough to return and contribute. In these examples we see elements of the power situation that feeds stigma processes (Link & Phelan, 2001).

Social Function of Stigma

Participants' personal commentary regularly revealed a circumstantial acceptance of mental health problems and illnesses, often contingent on individual and group factors. At the individual level, participants tended to be more empathetic, more accepting, and more likely to get personally involved in a person's recovery based on several conditions, including the "ill" person's reliability and trustworthiness, work ethic, and willingness to compete. When asked what he would do if a teammate opened up to him about mental illness, one participant said,

> I would try to be there for this guy, but it depends though, eh? It is weird to say that, but if it's a guy—regardless if he is senior or freshman—if it's a guy who works hard and pushes it, I am going to help him for sure . . . But if it's someone who is just slacking and everything and just comes up to me . . . maybe I don't feel like it's genuine or maybe I don't feel like he deserves it, so maybe I would refer him to somebody. So I would try to help him, but on a different level. I would be more personally involved with somebody that I feel like, regardless of potential, just works hard and has good ethics.

Other participants listed reliability, work ethic, trustworthiness, or similar positive characteristics as indicators of an individual's contribution, and ultimate integration and acceptance on the team. It could be suggested that individuals who struggle with mental illness but who have aligned themselves with team

values such as those described above are still contributing to the team's success and, as a result, might not be stigmatized as a weak link.

Not being viewed as a weak link on the team was significant for many study participants, particularly when these perceptions involved the coach. One participant observed that coaches might value the team's best interests, which is "a matter of personal interest first," over those of the individual players. An analogy that surfaced multiple times in discussing perceived coach stigma was that of a "factory." In the words of one participant, "if you can't do the job, then there is going to be someone who can do it for you." Another participant said, "[The coaches] won't rush to help you with that because they are going to say, 'Oh, next guy in line doesn't have any problems like that. I don't need to deal with that. . . . Get the hell out of here and I will put the next guy in.'"

Thus, stigma is once again enabled by a power dynamic in which the coach controls playing opportunities of the players who, ultimately, are competing against each other for the top spots. Fear of losing status with the coach has been echoed by researchers in other studies that explore barriers to college athletes seeking help for psychological issues (e.g., Brewer et al., 1998; Linder et al., 1991; Watson, 2005).

Masculinity and Mental Toughness

When shown the NFL Lifeline Video featuring Hall-of-Famer Michael Irvin, the majority of participants agreed he was an appropriate choice to discuss highly stigmatized issues. Collectively, participants highlighted the physical capital of Irvin: his dominating physical presence, an intense message conveyed with a deep, male voice, and his overall tough, masculine appearance. In applying the idea of capital to masculinity, Coles (2009) noted that the size, shape, and use of the male body "becomes a resource in projecting an image of masculinity," and is highly valued in this regard (p. 38). In other words, Irvin's physical capital expresses his alignment with the values of traditional masculinity: strong and tough. Irvin's credibility was further increased by his personal experiences with mental health problems and his success on the field in spite of this. One participant observed,

> you need someone who has succeeded to talk about [mental illness] because you don't want people to think about failure and [mental illness] at the same time. . . . You need serious people that the peers, the teammates, the players, and the friends of the players see as a tough guy talking about mental illness.

Other suggestions made by participants for mental health role models included elite athletes in sports other than football, athletes who had played in Canadian Interuniversity Sport and now played professionally or had experienced success despite mental health problems, and position coaches who had "an alpha male look." One player stated that while a male role model was critical, he would have to talk to a female when it came to actually receiving help.

The "tough guy"—Irvin, in this case—embodies the culture of football that the participants have been exposed to since they began playing. As one participant noted, in childhood men are taught that "when you are a little girl, it's like, 'you can cry, tell me what is wrong.' And when you are a little guy, it's like, 'suck it up, you're a boy, you're not supposed to do that.'"

This mentality of "sucking it up" reflects what Sabo (1998) described as the "pain principle": a learned pattern, not only in male athletes but in many nonathletic men, that teaches them to "deny their authentic

physical or emotional needs and develop health problems as a result" (p. 327). This attitude also reflects a strong conformity to masculine norms.

While Steinfeldt and Steinfeldt (2012) concluded in their study of male football players that men vary in the degree to which they conform to masculine norms and not all of the participants in their study conformed to masculine norms, our data demonstrate a more uniform conformity to masculine norms. The notion of "sucking it up" was embraced by the participants and appears to serve different purposes. Playing through injury, for example, seemed to help players achieve "alpha male" or "big dog" status in the field of play and, ironically, high mental strength was attributed to these same players. One participant noted, "the guys who are really, really good have that high mental strength. . . . There are no excuses . . . they can play through it and perform well even with those kinds of injuries."

This concept of "performing"—indeed, many participants noted that football players are actors and the field could be compared to a theatrical stage (Steinfeldt et al., 2011)—is in some ways problematic. Much of the "macho act" is a tactic to mask weakness. One participant recalled that after being hit hard, "I got up and it was because I didn't want to show weakness to the guy that just smacked me, I screamed something like, 'Whoa, I don't care! Hit me harder next time!'"

Other strategies to mask weakness or injury include taking "tons of painkillers just to play" or hiding concussion symptoms from athletic therapists. With that in mind, it is not inconceivable that hiding and performing through mental health problems may be common. In a similar vein, one participant observed, "all that is important for coaches or people at this school is if we perform: perform on the football field and perform at school."

In this case, the participant may not believe he would have the support and openness at an institutional level to seek help for mental health problems or illnesses. In fact, the participants unanimously agreed that, in their experience, any mental health–related education provided through the university centred on performance-based mental training or concussion education.

LIMITATIONS AND IMPLICATIONS FOR PRACTICE

There are several limitations to be noted. The main limitation of this study is the small sample size. The schedules of these busy student athletes, along with the sensitive topic under investigation, made recruitment difficult; however, data saturation appeared to have been achieved, with repetition of key themes across participants evidenced. In addition, the sampling method used may have limited diversity in experience as it relied on volunteer participation. In other words, participants who did not come forward may have had greater experiences with mental health problems and illnesses, but elected not to do so because of the stigmatized nature of the topic. As well, the focus of this study was primarily on male football players, so future research could explore opinions and attitudes of other male varsity athletes in other sports (Messner, 1992). The selection of the stimulus texts is another possible limitation in that these stimuli could have influenced participant perceptions. The article excerpt and short video were selected to allow the participants to freely explore this sensitive and potentially threatening topic through a constructed world. Future research could vary the stimuli used. Finally, the gender of the researcher as a female must be acknowledged as potentially

biasing the male research sample; however, several participants did note that, had the researcher been male, they would have been uncomfortable expressing opinions about sensitive topics.

Early interventions, beginning in high school, might screen athletes to identify potential areas of future mental illness and areas of well-being (emotional, psychological, and social) to target for development (e.g., Keyes, 2009). This approach could be beneficial in developing resiliency to stressful life events, as well as coping techniques (Mental Health Commission of Canada, 2012). Serious elite athletes in high school may go on to pursue athletic careers in post-secondary institutions where the stakes are higher, the pressure to perform in the classroom and in their sport increases, and the need to maintain a social life in a new environment away from home becomes important. Equipping student athletes with the tools to develop and sustain good mental health (independent of their sport performance) in high school, and as they transition into university, could be valuable in reducing mental health problems and illnesses.

In a similar vein, communication skills training may be a particularly useful avenue to explore in reducing the likelihood of mental health problems and illnesses, as well as to increase social capital, especially in male athletes. For example, O'Neil (2008) found that restricted emotionality, or the fear of or inability to express basic emotion, was the most significant predictor of depression in men. Communication skills training may help men become more comfortable not just talking about personal issues but also actively exploring ways to resolve various emotional problems. This recommendation is reflected in Cohen and Wills's (1985) functional model of social capital. In other words, simply having people to talk to can play a major role in moderating an individual's response to stressful events and perhaps inhibiting eventual mental illness.

CONCLUSION

Taken together, these findings and the supporting literature demonstrate that the environment of a competitive elite sport team comprises the power element needed to enable stigma components (e.g., labelling, stereotypes, separation, status loss, and discrimination; Link & Phelan, 2001), thereby allowing stigma to survive. Mental illness was repeatedly linked to weakness, which threatens an athlete's self-perception of mental strengths, threatens status within the group, and threatens status with the coach. Stigma was also seen as a strategy to protect one's survival in the team, as well as to cast out individuals who threatened the team's success. Participants noted the lack of mental health resources and speculated that such a tool would be potentially valuable in addressing the mental health needs of football players.

While the literature illustrates that adhering to aspects of traditional masculinity (being tough, independent, strong) seems to evoke health problems in men and impede help-seeking, the NFL Lifeline video demonstrates that masculine and physical capital can be leveraged to enable conversation around highly stigmatized issues. Most participants stated that they would like to see an increased emphasis on mental health in the football domain and noted that a program or resource designed to that end would be useful or beneficial.

This research could potentially inform mental health promotion and stigma reduction in other varsity male team sports, as well as initiatives for female athletes. Based on the literature and the qualitative findings, coaching staff seemed to strongly influence the decisions and behaviours of participants and thus they should be targeted for anti-stigma initiatives. In the United States, the issue is just starting to be addressed.

In the Fall of 2013, the National Athletic Trainers' Association (NATA), in collaboration with the National Collegiate Athletic Association (NCAA), published a set of nine guidelines to help athletic support staff and administrators provide support to student athletes with mental health concerns (Neal et al., 2013). Similar efforts to support the mental health of student athletes need to be initiated in Canadian universities.

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