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‘Everything I enjoy doing I just couldn’t do’: biographical disruption for sport-related injury

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Abstract

This paper draws on interview data with a population of non-elite sports/exercise participants (n=20) to illustrate the interrelationship between biographical disruption and sport-related injury (SRI). It argues that contrary to the significance implied by their prominence on current public health agendas, SRIs can have a devastating personal impact, comparable to the more extreme variants of biographical disruption depicted in the literature on chronic illness. It seeks to explain the apparent incongruence between biophysical severity and subjective assessment of impact, by invoking notions of community normalization and imagined futures, and identifying the unavailability of what subjects evaluate as effective medical support. These factors combine to problematise the attainment of biographical repair. It further highlights how biographical contingencies such as youthfulness, distinction through exhibiting responsible citizenship and the sense of failure to exert bodily self-management through exercise, perpetuate and escalate both biographical disruption and chronic illness. The paper thus illustrates the aetiological interdependence of biographical disruption and chronic illness as exercisers exacerbate relatively minor ailments due to their reluctance to modify habitual routines.
The problems of accurately harvesting data on sport-related injury (SRI) are widely recognised (van Mechelen et al., 1992). Indicatively, the International Classification of Diseases provides no category that is either all-embracing, or exclusive to SRI. Quantification problems are compounded by the non-standardised definitions studies employ (e.g. variously embracing ‘sport’, ‘exercise’ and/or ‘recreation’ injuries) and the demographics of the population surveyed (younger and male cohorts consistently return the highest rates of SRI). Competitive, contact, team sports have the highest injury rates, whilst gentle, rhythmic, low impact forms of exercise (e.g. swimming) entail the lowest risk of injury. Whether injury is defined according to medical consultation, time off work, or exercise cessation is also important as approximately just 40% of SRIs are presented to healthcare professionals (van Mechelen et al., 1992).

But despite such problems, epidemiological studies provide clear evidence that SRI represents a significant health concern. Estimations of the proportion of national populations incurring SRIs each year range from 3.1% in Germany, to 8.1% in England and Wales, and 18% in the Netherlands (Malcolm, 2017). The most comprehensive ‘British’ study to date (in terms of survey design and sample size) concluded that there are 29.7 million injuries per year sustained from sport participation in England and Wales. Of this figure, 9.8 million injuries were defined as potentially serious, requiring treatment or restricting usual activities (Nicholl et al., 1995). SRIs should not be assumed to be biomedically minor, for they are similar to other conditions presented to Emergency Medicine departments in terms of treatment modality, financial cost, and longevity of impact (Burt and Overpeck, 2001).

These indicative signs of social cost have not been translated into the prioritisation of SRI on public health and medical agendas (Finch, 2012). Moreover, given current policy initiatives to increase the role of physical activity in population health self-management (AMRC, 2015), one must assume the potential for SRIs to be increasing in number. Perhaps
it is no coincidence that the Netherlands has both the highest recorded incidence of SRI and is one of the most highly ranked nations in the Global Physical Activity Observatory (www.globalphysicalactivityobservatory.com). Paradoxically, moreover, the impact of SRI on subsequent activity can be considerable with 35-60% of patients failing to return to sports participation a year after SRI, and relatively few ‘non-returners’ substituting sport with less vigorous forms of health promoting exercise (Andrew et al., 2014).

In the absence of a consensus over the quantified data, a qualitative assessment of the impact and ‘costs’ of SRI has a distinct potential impact. Consequently this paper deploys the concept of biographical disruption (Bury, 1982) to contextualise the injury/illness experience of a population of non-elite sports/exercise participants. We argue that contrary to the significance implied by current prominence on public health agendas, SRIs can have a devastating impact comparable to the more extreme variants of biographical disruption depicted in the literature on chronic illness. We seek to explain this phenomenon with reference to the biographical contingencies of SRI ‘patients’ and further posit that a combination of their sense of future trajectory (Richardson et al. 2006) and conscription to contemporary notions of the personal responsibility towards bodily self-management (Morden et al. 2017) are particularly important in this regard. First, however, we explore what is known about the qualitative experience of SRI and the way biographical disruption has been used in studies of health and illness.

Qualitative Studies of SRI

As a consequence of classification difficulties, perceptions of relative seriousness and perhaps also the only recent recognition of sport and exercise medicine as a medical specialism (2005 in the UK), SRI has been largely neglected in the sociology of health and
illness. Consequently, some of the most relevant literature explores generic musculoskeletal disorders (Busby et al., 1997) or is primarily orientated around osteoarthritis-induced joint pain (e.g. Morden et al., 2015; 2017). A notable exception, however, is the work of Kotarba (1983). Locating professional athletes’ experiences within a broader study of chronic pain, Kotarba (1983) argued that the lack of an obvious visible presence to many SRIs meant discomfort/pain could only be made manifest through social interaction. This, however, was mediated by emotions such as guilt which led athletes to conceal SRIs to avoid their athletic identity being ‘spoiled’. Moreover, because chronic pain/injury can be extremely complex and often fails to fit a diagnosis-treatment-recovery paradigm, those with chronic pain/injury find ways to cope through a socially interactive process, such as lay diagnosis or biographical re-storying of the self (Kotarba, 1983).

A wider range of studies focussing on sociological and psychological aspects of SRI within elite/professional/‘serious’ sports has developed within sport science. This research depicts participants as normalizing a relatively high risk of injury and developing a relatively high tolerance of pain. Initially this was attributed to the premium on competitive success (Nixon, 1992), the strength of athletic identities (Sparkes, 1998) and role of sport in the creation and maintenance of notions of masculinity (Messner, 1992). However, subsequent studies of non-elite sporting populations, and young female sports participants (Malcom, 2006), have illustrated that this ‘culture of risk’ - evident in activities ranging from football (Roderick, 2006) to running (Hanold, 2010) - is not simply a product of ‘a violent and hazardous workplace, replete with its own unique form of “industrial disease”’ (Young, 1993: p.373), but is a cross-gender social experience intimately connected with sport and exercise cultures per se.

Three bodies of work on the experience of SRI among the non-elite sports population merit particular mention. Allen-Collinson and Hockey have used autoethnographies of SRI to
explore aspects of emotion management (Allen-Collinson, 2005) and identity ‘work’ undertaken by injured runners (Allen-Collinson and Hockey, 2007). Dashper (2013) similarly employs autoethnography to explore how the experience of equestrianism-related facial injury problematised the interaction of athletic and gendered identities. Finally, Sparkes expanded upon a (post-)elite athletic autoethnographic experience of exercise-induced lower back pain (Sparkes, 1996) via explorations of the ‘disabling’ experiences of men who received spinal cord injuries (SCI) through playing rugby (e.g. Sparkes and Smith, 2002). Such life-changing injury ‘shatters’ and ‘evaporates’ the sense of self as both masculine and athletic, leading to feelings of frustration, anger and depression.

Thus while a body of qualitative research exploring the experience of SRI among the public population exists, it is far from extensive and exhibits a notable bias towards the gendered, autoethnographical and phenomenological dimensions of SRI. The work invariably contains a focus on sport-specific subcultures thus limiting wider applicability. In producing accounts which depict a more-or-less full recovery from injury or sport-induced disability, the work illuminates the extremes of the SRI-experience spectrum. In relation to conceptual approaches, biographical disruption is briefly mentioned by Sparkes (1998) and Allen-Collinson and Hockey (2007), and more extensively employed by Sparkes and Smith (2002), but is more often eschewed in favour of a social psychological or micro-sociological emphasis on symbolic interaction and developments in the use of patient narratives (e.g. Smith and Sparkes, 2005). The research reported here is, therefore, the first to integrate empirical data relating to a wide range of cross-gender sport, exercise and injury experiences with this core theoretical concept in the sociology of health and illness. The aim therefore is both to illustrate the personal and social significance of SRI as a health issue, and develop a more sophisticated use of biographical disruption by giving particular emphasis to the
changing social structural health contingencies which shape the experience of developing a chronic condition.

**Biographical Disruption**

The notion of biographical disruption, introduced by Bury (1982), has helped demonstrate and legitimise the importance of the lay voice relative to biomedical diagnosis in the analysis of illness (Williams, 2000). Bury argued that becoming ill was often a ‘critical situation’ which led to three elements of biographical disruption. First, illness disrupts taken for granted assumptions and behaviours. Specifically, while most of the time we are oblivious to the functioning of our body (an absent presence), illness brings our bodily state to the forefront of consciousness. Second, illness disrupts our explanatory frameworks, leading us to re-think our biography; why me, why now, what has caused this? It leads to a questioning of the sense of self and of one’s future trajectory. Third, illness disrupts the way we deploy our resources; physically in terms of time and effort, socially in terms of the activities we pursue and financially. Bury therefore concluded that chronic illness had meaning in terms of both practical consequences – for individuals and families there is a cost of devoting time and money to manage an illness which impinges on work and home life – and symbolic significance, or the ‘profound effect on how individuals regard themselves, and how they think others see them’ (Williams, 2000: p.44). He identified a repertoire of potential responses:

Coping – what individuals come to *think* as they learn how to tolerate the effects of chronic illness, i.e. feelings of personal worth, normalisation of the condition or limiting the scope of impact.
Strategy – what people do to manage the impact of symptoms, such as adapting work, domestic tasks and physical activities, or partitioning off aspects of life that are no longer viable.

Style – how people present their changed physical appearance and/or social circumstances, from fully embracing to actively denying the chronic condition.

Subsequent studies, while frequently stressing the need for a wider-ranging or more nuanced application, accept and develop the basic premises of biographical disruption. Indeed, the foundational significance of the concept is illustrated by the assemblage of derivative terms. For instance, biographical abruption refers to disruption so severe that it entails a sudden ending or a breaking off from normal life by people simply unable to imagine how life can go on (Locock et al., 2009). Biographical reinforcement refers to the way in which chronic illness can make a pre-existing identity even stronger (Carricaburu and Pierret, 1995). Biographical continuity or flow refers to the way illness may not be experienced as ‘an imminent invader of everyday life, but rather part of an ongoing life story’ (Faircloth et al., 2004: p.244). Finally biographical repair/reinstatement refers to the incorporation of illness into ‘normal’ life, for instance by embracing the impairment, (re-)defining life as normal, minimising the social consequences of illness, or engaging in behaviour designed to demonstrate normalcy to others (Sanderson et al., 2011).

Fundamentally biographical disruption is premised on the belief, ‘that meaning and context cannot be easily separated’ (Bury, 1991: p.453). Monaghan and Gabe (2015), for instance, point to biographical contingencies such as age, class, gender, social deprivation and co-morbidities, in determining suffering. Harris (2009) argued that biographical disruption is dependent on a personal history of health, social exclusion and financial hardship, the prevalence of the condition within an individual’s immediate social network
(‘community normalisation’), and the actions and responses of physicians. Increasing emphasis (Brooks et al., 2015; Richardson et al., 2006) has been placed on temporal dimensions of biographical disruption, and the implicit morality of ‘normalisation’ (Sanderson et al., 2011) and self-management (Morden et al., 2017).

A number of critiques and suggestions for future research have been voiced. In addition to calling for greater attention to be paid to timing, context and circumstance (addressed in the aforementioned studies), Williams (2000) evoked consideration of the role of biographical disruption in the aetiology of chronic illness (rather than assuming that the former derives from the latter). He further noted that as an essentially adult-centred model of illness, research be extended to embrace chronologically more diverse populations. Fourth Williams (2000) called for more work on the relationship between illness, biographical disruption and social reflexivity, citing health promotion, screening and surveillance as responsible for invoking a kind of ‘body McCarthyism’ in ‘late modernity’ as citizens are ‘increasingly advised and instructed, encouraged and cajoled, on how best to manage ourselves and ride the emotional waves of everyday life’ (p. 57). It has also been suggested that static notions of biographical disruption be avoided (Morden et al. 2017), and that chronic illness should not be dichotomised as either unexpected-traumatic or anticipated-unproblematic, as biographies can be disrupted by routine and foreseeable events (Larsson and Grassman, 2012).

The examination of SRI closely resonates with this agenda for future research. First, the examination of a relatively young – or perhaps ‘youthful’ - cohort shifts analytic focus to a group whose deteriorating physical condition cannot simply be explained as a normal function of normal ageing. In the sense that the conditions exercisers experience are rarely life-threatening, and impinge upon employment in only a minority of cases, SRI illuminates the different dimensions of timing, context and circumstance (e.g. expectations for activity,
leisure, and social relations) in understanding the subjective experience of illness. SRI further enables an exploration of biographical disruption as the cause rather than the consequence of chronic illness and, in light of the development of physical activity health promotion which increasingly locates sport/exercise as a form of health risk self-management (AMRC, 2015), SRI exposes the connection between biographical disruption and social reflexivity in an increasingly consumption- rather than work-oriented society.

Method

This paper utilises a qualitative methodology derived from a transactional epistemology (Guba and Lincoln, 1994) and a semi-structured interview method. Following ethical approval, 20 participants were recruited using a selective sampling technique (Creswell, 2013). Sampling began by publicising the study at various sports clubs/facilities. The researchers made personal visits to recruit participants who self-identified as (currently or previously) regularly engaging in a range of sport and exercise activities. Snowball sampling was used where additional contacts were made available. The study inclusion criteria were open ended in regard to socio-economic background, gender, type of injury and sport played. Field notes were used to record demographic data throughout the data collection process and this included the duration, frequency and type of SRI participants had experienced. The process of recording injury information was complex for a number of reasons. Firstly, not all participants had received a medical diagnosis, and whilst the majority of injuries can be classified as musculoskeletal, the anatomical/clinical definition was unclear. Secondly, participants’ injuries were increasingly temporal in nature. The majority of participants had experienced multiple chronic injuries since taking up sport and exercise activities, some which they continued to manage, and therefore, especially when combined with a lack of
medical diagnosis, was sometimes difficult to accurately chart injury incidents over time. What became clear through the field notes was the temporal nature of SRI and the inadequacy of quantifying SRI as isolated incidents.

Whilst participants were spread across a variety of ages (20-56) and relatively evenly split between females and males (11/9), the sample exhibited a middle-class bias with many possessing higher education qualifications. This was not wholly unexpected given the well-documented link between physical activity and socio-economic status (Eime et al., 2015). The sample incorporates participants from a wide range of sports – athletics, cricket, rugby, netball, martial arts, roller derby, triathlon, volleyball – but it was notable that many engaged in a combination of both organised sports and independent exercise activities. For most, therefore, a rigid distinction between sport and exercise (the former being competitive and more formally organised) is not meaningful in this context. Participation stemmed from a combination of socio-emotional and health-related motivations.

Participants were fully informed about the aims and scope of the study, their rights to anonymity and withdrawal, and provided written consent. Interviews took place at mutually convenient locations, such as participants’ homes or coffee shops, lasted 20-120 minutes, and were audio recorded to facilitate a professionally transcribed written (verbatim) record for analysis. Field notes were taken during the interview in order to adopt a reflexive positioning or self-awareness of interview dynamics in addition to noting interesting issues that emerged during the interview process (Finlay and Gough 2003).

As with many studies of biographical disruption (e.g. Faircloth et al., 2004; Monaghan and Gabe, 2015; Morden et al., 2017) thematic data analysis was employed. Thematic analysis makes inferences from interview data to the contexts of their use based on a coding procedure that identifies paradigmatic and/or thematic categories (Braun and Clarke,
The coding procedure employed was based on identifying thematic distinctions deductively informed by the research context. The two researchers independently read the interview transcripts to familiarise themselves with the data and engaged in a dialogue to develop conceptual tags under which thematic distinctions or units could be coded (Elo and Kyngäs, 2008). Thematic distinctions encapsulating salient meanings illustrative of the conceptual tags were identified, and ordered in a tabular form that consolidated and displayed the data. This allowed for cross-checking of interview data in order to verify the representation of themes. In what follows we explore the incidence of SRI, the biographical disruption experienced, and interviewees’ attempts at biographical repair. Interviewees are identified according to their primary sport/exercise activity, or the activity during which their main injuries (first) occurred. As with the literature on SRI in elite sport, gender was not found to be a particularly significant mediator of injury experience.

The frequency of SRI

While by definition those who volunteered to take part in this research would likely consider their SRIs to be significant, respondents were broadly representative of larger epidemiological survey data (e.g. Grice et al., 2014). The majority of injuries described were musculoskeletal, affecting joints (particularly elbow, knee, shoulder) ligaments, tendons, cartilage and muscles. Two had experienced injuries that were life-threatening (multiple injuries sustained in a kite-surfing accident) or potentially life-altering (vertebrae broken playing rugby). Moreover, as the epidemiological literature suggested, the frequency of reported injury was closely related to the types of sport/exercise undertaken. For instance, martial artists noted that making coaches and other fighters aware of one’s injuries was a routine part of training, and that herbal treatments and anti-inflammatories were used ‘all the
time’. When asked about the medical demands associated with playing rugby an interviewee recalled, ‘I reckon [in twelve years] I’ve been to A&E 30 times with either myself or with a friend; easily 30, probably 40 actually’. For respondents participating in these high risk activities, injuries were an important part of identity construction (Messner, 1992).

While those who took part in relatively low risk, non-contact sports also described injury management as routine, incidence was reluctantly accommodated rather than identity-affirming. This was largely contextualised in relation to an individual’s commitment to the sport, for ‘when you train so much you’ve got to kind of accept that at some point something’s going to go wrong’ (volleyball player). Others cited the ageing process. A 40-year-old who participated in a range of sports/physical activities reflected, ‘as you get older you get used to having niggles all the time (laughs) ... I guess mainly just the odd tweak in the calf, or may be just general aching after doing something I’ve not done for a while’.

Crucially though, while age was seen as a contingency which increased and partly normalised SRI, as befits a youthful cohort, and in contrast with other studies of musculoskeletal injuries (Busby et al., 1997; Morden et al., 2017; Richardson et al., 2006), nobody employed age as a narrative resource to interpret their condition. The central characteristic of SRI experiences, rather, was their on-going and/or escalating nature. A cricketer described how a calf muscle injury led to deep vein thrombosis and blood clots on the lung. A runner described how two years of Achilles tendonitis resulted in lower back pain, SI joint pain in the pelvis, and a hamstring injury. While, due to self-selection, the degree of SRI experienced probably exceeds that of the broader exercising population, its resonance with existing epidemiological studies (Nicholl et al., 1995; Grice et al., 2014) suggests that it is likely to be similar in kind.
SRI as biographical disruption

As illustrated in Rousseau et al.’s (2014: 472) study of tooth loss, ‘what is assumed to be a relatively mundane and insignificant event can be devastating and biographically disruptive’. Accordingly, the kind of biographical disruption reported by interviewees with SRI had much more in common with biographical abruption (Locock et al. 2009) than flow (Faircloth et al. 2004). Frequency contributed to the normalisation of injury within the sporting community, but while impairment was clearly not unanticipated (Morden et al., 2017), there was little sense in which SRIs were perceived as ‘normal illnesses’. Rather, they were concurrently expected and problematic (Larsson and Gassman 2012), disrupting corporeal assumptions, explanatory frameworks and the mobilisation of resources.

As with musculoskeletal disorders more generally, ‘pain frequently emerges amidst the activities of daily living and pain management becomes routinised’ (Morden et al., 2015: 894). Pain ranged from ‘excruciating, to the point where I’m still actually bracing myself when I go upstairs’ (volleyball player), to a ‘continuous aggravation … you kind of get used to it hurting all the time’ (roller derby participant). Moreover, the impact of sports injury was often omnipresent: ‘all the time I’m conscious of it. I know that I’ve been sat here for kind of two, three minutes, and I can already feel that I should probably be moving the position that I’m in because it starts to get uncomfortable’ (netballer). Pain management ‘just to get yourself through’ (rugby player) was ubiquitous, whether used to enable exercise or facilitate sleep (cf. Allen-Collinson 2005). Interviewees typically conveyed the sense that the disruption associated with pain and pain management ‘takes over your life’ (cricketer), as ‘it becomes part of you and you probably don’t realise what pain you’re in until it goes away’ (triathlete).
With SRI ‘shatter[ing] … previously taken-for-granted assumptions about the world’ (Sparkes, 1998: p.653), exercising habits become fundamentally problematised. For this reason the disruption that SRI causes to exercisers’ identities might best be described as biographical abruption, for many imagined ‘life simply not happening at all – the story is already over’ (Locock et al., 2009: p.1048). In contrast to Allen-Collinson and Hockey’s (2007) relatively successful maintenance of athletic identity, a cyclist/gym user described how injury changed a highly regimented life into ‘disruption to your whole routine’. Injury could deprive exercisers of the primary source of pleasure in their lives:

I had something in a way to look forward to, every day. I’d turn up at the track, … and then I’d run and I was in a different world … the injury really affected me … I just lost everything – I lost the routine and didn’t really know what to do with myself (runner).

Another stated that ‘Everything I enjoy doing I just couldn’t do’ (runner).

Imagined futures (Brooks et al., 2015) were prominent in interviewees’ consciousness. A volleyball player stated that, ‘I just think I’ll be limited … [the injury] makes me accept that I’ll be limited forever’. A cricketer similarly explained; ‘At the moment I can’t see a point in the future where I’m going to be 100% fit. I think I’m always going to carry an injury at least like somewhere in my legs … I just don’t see any light at the end of the tunnel’. The incidence of SRI was seen to be ‘unfair’ and only resolution of a current injury would ‘let me get my life back’ (runner). A number of interviewees explicitly reflected ‘why me?’ SRI could therefore lead to a fundamental re-structuring of both one’s sense of self and future trajectory (Bury, 1982).

While some experienced significant economic hardship (due to ceasing or changing employment; the use of private healthcare is discussed further below), SRI primarily involves a sense of loss and fragmentation (Sparkes, 1998) or ‘dys-appearance’ (Harris, 2009).
Physical impairment and social dislocation were deeply intertwined (Allen-Collinson, 2005; Dashper, 2013), manifest in a dual sense of lost freedom and loneliness. A runner, unable to complete a sentence expressing the significance of the disruption to holiday plans an injury posed, illustrated the inability to escape (even temporarily) from such restriction:

[It’s] just heart-breaking to be honest. I mean where we stay is in the middle of a forest. It’s absolutely beautiful because it literally is in the middle of a forest. It’s just lovely, and to not be able to run [pause] I waited and waited.

The sense of lost freedom related to both a corporeal constraint on movement as well as diminished confidence. In contrast to Allen-Collinson and Hockey’s (2007: p.390) reassurance at continuing to ‘look like distance runners’, a gym user noted difficulties, ‘when you see your body changing and getting smaller and fatter … [when I] socialise as well … I don’t feel confident going up to someone and talking to them’.

Strained social relations frequently accompanied physical impairment. Interviewees described how their partners or family members ‘hate it’ (rugby player) when they are injured (cf. Dashper, 2013), or how SRI meant that a shared interest that previously consolidated key relationships became divisive. The depth of social dislocation was further evident in the resentment the injured expressed towards those around them whose actions appeared to recognise their ‘illness’ and thus legitimate their sick role:

That’s one of the most annoying things that someone that is not injured can try to do … say, ‘Oh I understand what you’re going through’. I was thinking, ‘No you don’t, because you know, there you are playing, you’re jumping’ … [it] feeds that kind of envy. (volleyball player)
A second volleyball participant described the contradictory emotional experience of trying to maintain a normal routine by doing rehabilitation exercises at their usual training:

Everyone was amazing. All the girls were super supportive … [but] whilst I was doing my little exercises and they were playing volleyball just next to me … I had thoughts such as ‘I hate you all’ and ‘you don’t know how lucky you are because you can jump, and you can run, and you can move’.

Managing SRI, like coping with heart disease, can therefore be ‘burdensome, necessitating “hard and heavy work” including physical, relational and social capital’ (Moore et al., 2015: p.4).

Interviewees exhibited the full repertoire of ‘coping’, ‘strategy’ and ‘style’ responses characteristic of biographical disruption (Bury 1982). In this respect self-perceptions and subsequent actions mirrored those of elite sports participants in that they too constructed and embraced a culture of risk (Roderick, 2006). This was particularly evident in the primary form of ‘coping’ with SRI, namely attempting to play through pain and with injury. For instance, a cricketer who damaged an Achilles described playing on despite having ‘never felt any pain like that before’, and thinking, ‘I’ve done something really bad here’. Similarly, a runner described being ‘on a bit of a high’ after completing their first marathon (despite being injured):

[I] thought well if I’ve done that I can keep going, whack some painkillers down. But no, it caught up with me … I was running probably to the point that I was in agony for about a week, week and a half, and then I rested it and it just went, so back on it again.

Consequently, like Kotarba’s (1983) professional athletes, many noted that feelings of guilt shaped the injury experience. However, the guilt recreational athletes’ expressed was
more multidimensional, experienced in relation to: having ignored the early signs of injury and consequently exacerbating the condition; taking time off work for an injury which was seen, to some extent, as avoidable; ‘failing’ to attend to the demands of a young family while being ‘sat around for a couple of days … [when I] didn’t actually feel ill’ (runner); and turning into ‘a bit of a slob’ and entering a spiral of inactivity and weight gain (netballer). Thus SRI undermined personal self-worth and interviewees undertook considerable efforts to manage the impact of the symptoms on their lives, frequently adopting presentational ‘styles’ which effectively concealed the existence of their condition through denial.

**Biographical Repair**

Resolving biographical disruption may require the ill/injured to undergo aspects of biographical repair. Fundamentally the notion of biographical repair revolves around the notion of normalcy, either in terms of a return to previous routines, establishing a new normal, and/or presenting to others as normal (Sanderson *et al.* 2011). However, in the context of SRI, biographical repair is mediated by life expectancy (Richardson *et al.* 2006). While SRIs are (generally) not life-threatening and (certainly longer-term) do not preclude people from what many others see as ‘normal’ (i.e. relatively physically ‘inactive’) lives, ‘normal’ for this population centres upon a return to sport/exercise participation. Thus, in comparison to elite athletes, while this cohort did not experience a loss of a ‘gloried self’, they *were* affected by the demise of a disciplined body (Sparkes, 1998: p.656). In their attempts to construct biographical repair, the injured are hindered by the limited (and/or ineffectual) healthcare support available to them. In the conclusion we suggest that broader social discourses of the importance of exercise and the body, and a reflexive sense of failed or compromised ability to self-manage health, compound the biographical disruption of SRI.
While objectively speaking relatively close to being physically normal, those with SRI were subjectively distant from, and indeed exhibited more limited scope to achieve, ‘normalcy’. For instance, in contrast to other studies of biographical disruption, no interviewees spoke of creating a new normal through replacement activities, experiencing heightened normality through compensatory attempts to seek pleasure in other aspects of life, or of finding new meaning through, e.g., strengthened relations with loved ones. Furthermore, unlike Allen-Collinson and Hockey (2007) who successfully re-designed and resumed training, interviewees seemed unable to ‘reset’ normality by adjusting their lifestyle/pace to incorporate their condition, or expressed confidence in being able to self-manage (Sanderson et al., 2011).

Rather, the primary emotional responses to SRI were frustration and introspection (Allen-Collinson, 2005). A cricketer described how, ‘every week I seem to tweak or just tear my hamstring … [I’m having] constant problems with my legs that are just getting nowhere fast at the moment’. A runner explained, ‘I was getting discomfort on my hip and I’d not had that sort of discomfort before … I thought … Have I modified my running style and as a consequence causing difficulties elsewhere?’ I don’t know’. Thus these musculoskeletal injuries did not just create ‘embodied uncertainty’ (Morden et al., 2015: 894) but a sense that pain indicated the self-exacerbation of an existing condition. The bodily distrust these experiences entail is a variant of Sparkes’ (1996) ‘fatal flaw’. Moreover, through the conceptual lens of biographical disruption, the risk entailed in ‘fighting to maintain a normal life’ almost always ‘result[ed] in moving into a totally disrupted normality’ (Sanderson et al., 2011: p.625).

Indeed so problematic was biographical repair that ‘normal’ was not conceived of in terms of SRI resolution, but in terms of exercising regardless of injury. For instance, an interviewee who had recently taken up jogging said, ‘I did the normal thing where you rest it
for a bit, and it feels better again so you start running on it again and it hurts again’. A more experienced runner reflected that, ‘the week before I tore my calf muscle I felt a bit of pain in my knee … but as usual, that’s what I normally do if I felt pain or aching and you just don’t think about it much, “just keep going”, and I did’. While interviewees were conscious that their attitudes towards pain and injury were somewhat peculiar – a rugby player claimed that, ‘the boundaries that athletes have for pain, and the discomfort and damage that they’re willing to do to their body, is different to what a normal person would be willing to accept’ - their attitudes and behaviour were contextually ‘normal’. The repertoire of coping, strategy and style aligned therefore to minimise the practical consequences and the symbolic significance of the biographical disruption of SRI, but often further hindered prospects of returning to normality in terms of resuming previously attained activity levels. The notion of community normalisation is useful in this respect, where the impact of a diagnosis is ‘enmeshed with a sense of community; in particular the degree to which … [the condition is] normalised or stigmatised within their particular community networks’ (Harris, 2009: p.1038).

While research suggests that the injured are frequently overtly stigmatised in elite sport (Roderick, 2006), non-elite participants experience stigmatisation through dislocation from the community’s ‘normal’ of active participation (Dashper, 2013). Whilst injury puts athletic participation in abeyance, identity and biography can be neither reinstated nor resolved (Sanderson et al., 2011).

Existing studies suggest that medical encounters frequently feature in biographical repair. However, while the degree of biographical disruption indicated that interviewees would have strong motives for accessing healthcare, most tended to do so only when their injuries required emergency medical aid or became particularly acute. Moreover, in contrast to professional athletes who ‘learn[ed] to conceal certain injuries from critical audiences’ (Kotarba, 1983: p.141), and those with musculoskeletal conditions who described a
‘prolonged series’ of ‘distressing and isolating’ attempts to seek help (Busby et al., 1997: p.90), interviewees provided a range of reasons why those with SRIs rarely seek medical help. Like musculoskeletal injuries more generally, many were self-treated as interviewees’ general experiences were that healthcare professionals found such disorders ‘difficult to diagnose precisely and treat effectively’ (Busby et al., 1997: p.84). A perceived lack of medical expertise and a sense that GPs expressed disinterest compounded these trends (Allen-Collinson, 2005). This was particularly the case for those in high-risk sport. A martial artist recalled that GPs were ‘sometimes disapproving’, while rugby players said that the attitude of A&E staff was ‘like “oh no, not again”. They put you at the back of the queue’. But others, including runners, recalled similar experiences of primary and secondary care being ‘totally unhelpful’, or illustrated how medical scepticism was embedded in the lay knowledge of sport communities, explaining that they had not sought treatment because, ‘I just thought they’ll just say rest or something, from what people told me like’. In general, concern was expressed in relation to the speed with which interviewees thought GPs would seek to timetable their recovery, for example describing the recommendation to take twelve weeks off from sport as ‘just not practical’ (runner). As noted, fewer than half of SRIs are thought to be professionally medically treated (van Mechelen, 1992) and research suggests that those with previous experience of SRI are especially unlikely to seek medical aid (Grice et al., 2014).

Interviewees believed that medicine could not help them because state healthcare was primarily orientated towards work rather than leisure. For example, a runner described a very unsatisfactory yet anticipated experience of being seen by a musculoskeletal specialist:

I went and saw this person and … she was just like “oh, right, so you’ve been running?”

“Yeah I’ve been running”.

“Alright, Ok, so what’s the problem?”
I was like “the problem’s not that I can’t run.” … and I was like I knew this would happen … she didn’t quite get it … She almost laughed at me, like, “But you’re active, What’s the problem?”

While other musculoskeletal injury patients and the GPs they consult exhibit and reflect a sense of blamelessness (Busby et al. 1997), interviewees perceived strongly judgemental attitudes towards their somewhat ‘self-inflicted’ conditions (Allen-Collinson 2005).

Three alternative strategies were available to manage the future uncertainties (Morden et al., 2017) experienced. The first, self-treatment, could be based on knowledge acquired through health-related qualifications, or ‘simply having been all my life surrounded by athletes and players … so I’ve known a lot of people who have done it before and described it, how I felt’ (volleyball player). However, it was clear that self-treatment was often fuelled by frustration at the immersion in a non-normal life. Monthly NHS physiotherapy appointments were found to be, ‘just too long to be left on your own … I start wandering off and looking at the internet and trying to find solutions myself (laughter) … I’ve diagnosed myself with all sorts of things (skier)’. Secondly, the injured frequently acquired help from family, friends and others within their sport. One interviewee described how a teammate who was a physiotherapist,

suggested that if it was a torn muscle, then they wouldn’t do anything for me in the hospital … “they’re going to give you a pain killer and they’re going to say you’ve got to not put any weight on that leg for three days. You’re going to wait in hospital. You’re going to be in pain” (volleyball player).

Others tentatively argued that the relative merits of lay and medical knowledge were not clear: ‘people that have been in martial arts for 20 years might know more about the injuries than a doctor possibly’. A second martial artist had themselves become recognised as a mini-expert
on injuries within their sport; ‘They all come to me actually. I’ve got sort of sprays, creams, you name it, I’ve got it in my bag’. Finally many people with SRIs – indeed, 16 of the 20 interviewees – accessed private medical care, ranging from one-off surgical procedures, to on-going care from physiotherapists, massage and sports therapists, osteopaths, chiropractors, psychologists, and acupuncture. The main motives for this included the timing of treatment to enable them to work or practice their sport unhindered, and perceptions that sport-specialist healthcare providers had greater expertise in treating, and understanding of, injured exercisers. Interviewees especially liked healthcare providers who asked them about sport-related functionality, emphasised the importance of remaining active in a way that they (the injured) saw as constructive (for their sport), or explicitly oriented treatment towards resuming exercise and sport activities. Fundamentally, however, such engagements were driven by both feelings of desperation - ‘if there was anything at all that would have helped I’d have done it’ (runner) – and ontological security - ‘maintaining me as a person’ (runner).

**Conclusion**

We can therefore see that even if SRIs generally have relatively minimal biophysical consequences, evoking the lay voice illustrates that they are clearly significant in subjective terms. SRIs are relatively frequently experienced, particularly biographically disruptive and difficult to resolve. They are both expected and problematic (Larsson and Grassman, 2012). The sense of trauma can be explained in terms of: a) the subcultural norms of sport and injury (Nixon, 1992), which create a particular kind of community normalisation (Harris, 2009); b) the sense of self-infliction generated through various social encounters; and c) lack of effective medical assistance for musculoskeletal injury (in general), combined with the SRI-specific disjuncture between patients’ recovery expectations and the attitudes and priorities
expressed by healthcare providers. However, the degree of disruption/abruption stemming from conditions with relatively ‘minor’ life-limiting consequences, must also be understood in relation to particular biographical contingencies and trajectories.

This research supports Williams’ (2000) hypothesis that the relatively affluent might experience greater biographical disruption due to their higher life expectations and unfamiliarity at coping with diversity (see also Harris, 2009; Richardson et al., 2006). The interviewees whose experiences are analysed here were socially privileged in the sense of being largely middle class and, if not young per se, maintaining the kind of activity levels most frequently signifying youthfulness. None reported co-morbidities. They equated exercise with sociality, freedom and their most significant social relations. It was not that SRI necessarily inhibited all aspects of daily living, but restricted what they saw as the most highly valued aspects of life at a point in the lifecourse where their imagined futures (Brooks et al., 2015) entailed relatively little discomfort or restriction. The resultant estrangement they experienced from these highly meaningful social experiences was particularly difficult to overcome because in many cases exercise was a strategy deliberately evoked to manage future health uncertainties (Morden et al., 2017).

But it might also be argued that the degree of biographical disruption stems from the interviewees’ reflexivity regarding such social privilege and distinction. Through their participation in leisure activities which accrue reflected cultural capital, especially those exercise which contributed to a proactive strategy of health self-management (i.e. running rather than rugby), interviewees had behaved in a way that contemporary physical activity health policy celebrates as responsible citizenship. This might, in part, explain why previously they had found sport and exercise so fulfilling and had given it such a central place in their lives and identities. But as Sanderson et al. (2011) note, normalities evoke moralities, with attempts to ‘reset’ normality through embracing illness as part of ‘normal life’
the most morally virtuous position. Unfortunately for the injured exerciser, however, disrupted normality is both the most common and the most morally challenging response to illness/injury. One could, for instance, argue that these individuals had gone from exemplars of health self-management to conspicuous failures; from strongly conforming to becoming unable to undertake responsible citizenship; from having morally ‘correct’ choices embedded into lifestyle to such choices being frustratingly unobtainable.

Finally SRI provides a clear challenge to assumptions about the linear causation of chronic conditions and biographical disruption (Williams, 2000). Respondents’ injuries often started as relatively minor ailments but were exacerbated into chronic conditions by the reluctance to accept life-modifying implications (i.e. exercise cessation). Specifically, the primary consequence of SRI was social rather than clinical; it not only removed the individual from an activity which they had been socialised into valuing highly, but was largely subject to lay healthcare knowledge/practice rather than professional medical help. It did not entail a (significant) search for medical legitimation or resolution but, ironically perhaps, additional and different modes of health self-management. Indeed the frequently held perception that SRI is self-inflicted (albeit more so for certain high-risk sports than for others) is a consequence of the interdependence and processual interchange of biographical events and physiological deterioration.

No doubt the apparent conflation of chronic illness and biographical disruption was partly attributable to assembling a research sample through non-clinical settings, and a population whose medical needs have only recently been formally recognised. We also recognise that as the first study to systematically interrogate the interdependence of SRI and biographical disruption it has not been possible to explore the gendered, classed and potentially ‘raced’ dimensions of these phenomena. However, the examination of a cohort such as this is necessary if the sociology of health and illness is to more comprehensively
represent the social experience of chronic illness/biographical disruption and if the prevention and treatment of SRI is to gain prominence on public health agendas (Finch, 2012).

References


