

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

Article Information

Article first published online: September 25, 2018
<https://doi.org/10.1177/1363459318800142>

Dominic Malcolm, Loughborough University, UK
d.e.malcolm@lboro.ac.uk
Emma Pullen, Bournemouth University, UK
epullen@bournemouth.ac.uk

Corresponding Author: Dominic Malcolm, School of Sport, Exercise and Health Sciences, Loughborough University, Loughborough LE11 3TU, UK. Email: d.e.malcolm@lboro.ac.uk

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 lack of 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.

Estimations of the proportion of national populations incurring sport-related injuries (SRIs) each year range from 3.1% in Germany to 18% in the Netherlands (Malcolm, 2017). The most comprehensive 'British' study to date (in terms of sample size and diversity) concluded that 8.1% of the England and Wales population sustained 29.7 million SRIs per year, of which 9.8 million injuries were defined as potentially serious, requiring treatment or restricting usual activities (Nicholl et al., 1995). Yet as a consequence of classification difficulties, perceptions of relative lack of seriousness, and perhaps also the only recent recognition of sport and exercise medicine as a medical specialism (2005 in the UK), SRI has not been prioritised on public health or medical research agendas (Finch, 2012). Concomitantly, SRI has been largely neglected in both more recent epidemiological work (Grice et al.'s (2014) small but recent study is a notable exception) and medical sociology. The underlying premise of this paper is that SRIs are both significant in terms of public health and speak to a broader trope of chronic conditions within the sociology of health and illness.

As a consequence of this relative neglect, 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). Another 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 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.

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 there is a body of qualitative research exploring public populations’ experiences of SRI, 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).

In light of these limitations in current understanding, this article offers the first analysis of empirical data relating to a broad range of non-elite cross-gender sport, exercise and injury experiences. To contextualise these experiences in relation to the broader study of the sociology of health and illness, this paper focuses on the core theoretical concept of biographical disruption (Bury, 1982). The aim 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 (specifically education and age or youthfulness) which shape the experience of developing chronic conditions. We argue that 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. Initially, therefore, we explore the way biographical disruption has been used in studies of health and illness.

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).

Yet fundamentally biographical disruption is premised on the belief, ‘that meaning and context cannot be easily separated’ (Bury, 1991: p.453). Monaghan and Gabe (2015) 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 has been placed on temporal dimensions of biographical disruption (Brooks et al., 2015; Richardson et al., 2006), 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 citing research subjects whose health problems were triggered, e.g., by a change in work duties or the stress of daily living. 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 biographical disruption 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, the co-authors/researchers recruited 20 participants using a selective sampling technique (Creswell, 2013). Both (a male in his 40s with limited engagement in exercise, and a female in her 20s with extensive and elite sport experience) participated in the interviewing process, conducting six and thirteen interviews respectively, plus one joint interview.

Recruitment began by publicising the study at various sports clubs/facilities. The selection of clubs was based on existing knowledge of local sports facilities and convenience. In addition to the sports featured in Table 1, attempts to enrol respondents included tennis, football, running and private gym/health clubs were unsuccessful. Where possible, 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 enabling access to those who were currently experiencing the most marked health problems. The study inclusion criteria were, aligning with the emergent design, open-ended in regard to socio-economic background (occupation), gender, type of injury and sport played, but not age (due to ethical restrictions all participants were required to be over 18 years old). Given that this was uncharted research territory, a cohort broadly inclusive of the ‘grassroots’ experience of SRI was desired. Consequently, no more than three interviewees from any one sport or site were enrolled into the study.

Sex	Pseudonym	Age (years)	Occupation	Primary Sport(s)	Primary injury(ies)
-----	-----------	-------------	------------	------------------	---------------------

Female	Lucy	48	Shop assistant	Kitesurfing/Multisport	broken pelvis, ripped bowel, dislocated knee, anterior cruciate ligament reconstruction, prolapsed disc, broken ribs, nerve damage
Female	Martha	29	PE Teacher	Athletics	Achilles tendon strain
Female	Heather	27	PE Teacher	Netball	Anterior Cruciate Ligament injury
Female	Julia	20	Student	Volleyball	Anterior Cruciate Ligament injury
Female	Amy	33	Self-employed	Volleyball	Overuse shoulder injury
Female	Sophie	26	University lecturer	Volleyball	Grade 2 tear of Achilles tendon
Female	Lisa	30	Motorbike mechanic	Roller Derby	Dislocation of posterior tibial tendon
Female	Lena	40	Solicitor	Running	Knee injury
Female	Christina	36	Receptionist	Martial Arts	Knee ligament tear
Female	Carly	30	Social Worker	Martial Arts	Cartilage damage
Female	Sarah	40	University researcher	Skiing/Multisport	Anterior Cruciate Ligament injury, back strain, hip damage
Male	Matthew	30	Airline Pilot	Cricket	Grade 3 full tear of Achilles tendon, Deep Vein Thrombosis
Male	James	26	Clerical Assistant	Running	Undiagnosed – ongoing neural pain
Male	Mark	56	Programme Manager	Triathlon/Running	Ligament damage to the knee and ankle
Male	Mike	53	Transport Manager	Cycling/Gym/Mountain Walking	Grade 2 tear of Achilles tendon
Male	John	20	Student	Bodybuilding	Overuse shoulder injury
Male	Marcus	40	HGV Driver	Rugby	No specific injury
Male	Seth	22	Student	Rugby	Shoulder hyper-extension
Male	Daniel	43	Bank Manager	Running	Hamstring injury

Male	Edward	29	PE Teacher	Rugby	Broken vertebrae
------	--------	----	---------------	-------	------------------

Whilst participants were spread across a variety of ages (20-56) and relatively evenly split between females and males (11/9), the sample was entirely ‘white’ and 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 (competitive and more formally organised) and exercise 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. Interview questions were structured around three topics: participant biography/background; experience of, and motivation for, participating in sport/exercise; and experience of injury, rehabilitation and treatment. 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, 2006). 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 briefly contextualise what SRIs can entail, before exploring the biographical disruption experienced, and interviewees' attempts at biographical repair. Our approach integrates the presentation of data and its analytical interpretation. Interviewees are identified according to pseudonyms.

Contextualising SRI

The majority of injuries described were musculoskeletal, although three people had experienced injuries that were life-threatening (Lucy's broken pelvis, broken ribs, ripped bowel etc. sustained in a kite-surfing accident; Matthew's deep vein thrombosis (DVT) due to immobilisation after detaching a tendon playing cricket) or potentially life-altering (Edward's broken vertebrae from playing rugby). The frequency of reported injury was closely related to the types of sport/exercise undertaken. Edward recalled that in the last twelve years he had 'been to A&E 30 times with either myself or with a friend; easily 30, probably 40 actually',

but even those in relatively low risk, non-contact sports also described injury management as routine. 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. As with the literature on SRI in elite sport, gender was not found to be a particularly significant mediator of injury experience.

During the research both the complexity of recording SRI information (Finch, 2012) and the inadequacy of categorizing SRI as isolated incidents became increasingly apparent. First, not all participants had received a medical diagnosis, and whilst many injuries could be broadly classified as musculoskeletal, specifics including anatomical location were often unclear. Mark, for instance, had fallen whilst running six months before interview. Initially advised by a physiotherapist to take ibuprofen, rest, and elevate and ice his leg, a GP referral subsequently led to an ankle x-ray (despite him also complaining of knee pain) from which he was advised ‘you’ve got nothing broken ... it’s just soft tissue damage, but it’s going to take 8-12 weeks to sort out’. Second, the majority of participants had experienced multiple injuries since taking up sport and exercise activities, some which had become chronic as they continued to (self-)manage them. Especially when combined with a lack of medical diagnosis, it was therefore sometimes difficult to accurately chart injury incidents over time. Sarah, for instance, described ‘nearly two years’ of difficulties which initially seemed to stem from an ACL injury whilst skiing. During post-operation rehabilitation she pulled a groin muscle and developed back pain which a physiotherapist identified as pelvis weakness and misalignment. Her GP referred her to a (generic) musculoskeletal service, which sent her to a Sport and Exercise Medicine consultant, who referred her to an osteopath. Her sense of ‘going round in circles’ led her to question whether her experiences as a child gymnast were the root cause of her

current problems. The lack of diagnosis and the temporal dimensions of SRI inform the biographical disruption encountered.

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 the sudden rupture to routine and existential shock of biographical abruption (Locock *et al.* 2009) than the biographical flow of everyday life, e.g. attributing restricted abilities to ageing (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. SRIs entailed pain which disrupted everyday living, previously cherished freedoms and imagined futures. It strained social relations and invoked specific 'coping', 'strategy' and 'style' responses to biographical disruption.

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). Mark described the initial pain of his injury as unprecedented and 'excruciating', 'paralysed is another way of putting it'. An extensive icing regime which 'felt obsessive for the first couple of weeks' reduced the pain, but he continued to have problems climbing stairs, experienced some 'really, really, really sharp pain' doing rehabilitation exercises, and was generally very tender (e.g. he recalled his anxiousness at being disturbed by his partner getting in or out of

bed). Lisa, who was ‘taken out’ by an opponent during a rollerderby competition, experienced pain ‘but it wasn’t like a horrendous, “I’ve broken my ankle” kind of pain’ and so played on. She felt ‘fobbed off’ when a GP diagnosed a sprain and subsequently found the pain ‘getting worse all of last year ... continuous aggravation’ such that she couldn’t walk to work, drive a car or motorbike, or participate in various leisure activities (running, swimming, surfing). Thinking it would heal with rest she ‘just kind of stuck with it’, but as the pain became more all-encompassing – ‘it was proper affecting everything’ – she was referred to a specialist and subsequently underwent an operation to correct a displaced tendon. Those who experienced life-threatening injuries conveyed the sense that the disruption associated with pain and pain management ‘takes over your life’ (Matthew), such that it ‘becomes part of you and you probably don’t realise what pain you’re in until it goes away’ (Lucy).

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). Martha, a runner, described how two years of having an Achilles tendonitis (from which she developed lower back pain, SI joint stiffness and hamstring pain) had entailed ‘disruption to your whole routine’, depriving her 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.

Lisa summed up the scale of the disruption she experienced in stating, ‘Everything I enjoy doing I just couldn’t do’.

Imagined futures (Brooks et al., 2015) were prominent in interviewees' consciousness. Sarah stated that, 'I'm getting really fed up now ... it's been nearly two years [since the initial ACL injury] and I feel like I'm going round in circles'. Matthew whose use of warfarin to combat DVT threatened to end his career as a pilot similarly explained; 'It sort of turns your world upside down a bit ... 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' - a number of interviewees explicitly reflected 'why me?'. There was usually an identifiable action (Matthew, for instance, noted that a change in the batting order disrupted his usual warm-up routine which may have contributed to his tendon damage) but also a sense that one 'should' (be able to) exercise. SRI could therefore lead to a fundamental re-structuring of both one's sense of self and future trajectory (Bury, 1982), because only resolution of a current injury would 'let me get my life back' (Lucy).

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. Mark, unable to complete a sentence expressing the significance of the disruption to holiday plans his running 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', John noted how the consequences of a shoulder strain which stopped him from going to the gym spiralled; '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. Julia tore a calf muscle which stopped her from playing volleyball for four months and described the resentment the injured may experience, even towards those 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.

She went on to describe 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'.

The dislocation stemmed from the centrality of activity to their lives. Some described how they had met their partners through sport, or considered themselves 'lucky' to have this particular shared interest (Lucy), but also how family members 'hate it' (Edward) when they are injured (cf. Dashper, 2013). Thus, managing SRI, like coping with heart disease, can 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, Sarah described how ‘being someone who’s used to training and things, I think I took the rehab [post-ACL operation] a bit beyond maybe what I should’ve done and ended up pulling my groin ... trying to progress too quickly’. Similarly, Daniel described being ‘on a bit of a high’ after completing his first marathon (despite a hamstring injury that stopped him from training in the weeks prior to the event):

[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’ (Lena); and turning into ‘a bit of a slob’ and entering a spiral of inactivity and weight gain (Heather). 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 centres upon 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). Indicatively, while age was seen as a contingency which increased the risk of 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. Rather, in the context of SRI, biographical repair is mediated by expectations about one’s future quality of life (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 sometimes ineffectual) healthcare support available to them.

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 continued frustration and introspection (Allen-Collinson, 2005). Matthew, six months after detaching a tendon, and no longer taking warfarin for his DVT, had returned to the gym to do exercises advised by his physiotherapist and to ‘catch up’ ‘fitness wise’. He 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’. Mark, similarly explained that as he began exercising after his running fall, ‘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 not only created ‘embodied uncertainty’ (Morden et al., 2015: 894), but a sense that pain indicated the *self-exacerbation* of an existing condition. The bodily distrust experienced is a variant of Sparkes’ (1996) ‘fatal flaw’; a permanent and inescapable weakness locatable within a particular part of anatomy that becomes identity defining. 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. Julia, for instance, reflected on the week leading up to her torn calf muscle during which ‘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 – Julia 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). Even Lena, a relatively novice jogger 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'. While research suggests that elite athletes are frequently overtly stigmatised when injured (Roderick, 2006), non-elite participants do not experience stigmatisation from other participations (for these were seen as routine if unlucky events) or family members (some of whom were happy to have more time with their partners) but 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 (see for instance the experiences of Lisa and Matthew above). Moreover, in contrast to professional athletes who 'learn[ed] to conceal certain injuries from critical audiences' (Kotarba, 1983: p.141), those with musculoskeletal conditions described a 'prolonged series' of 'distressing and isolating' attempts to seek help (Busby et al., 1997: p.90). For instance Sophie, a volleyball player,

described how what her GP initially thought to be ‘probably just a strain’ failed to get better. Consequently, eight months later she had a private physiotherapy consultation and MRI scan which led to a diagnosis of ‘fat pad syndrome’. The discomfort – ‘to the point where ... I couldn’t even walk on my crutches’ – led to consultation with a second physiotherapist, referral to a consultant, diagnosis of an ‘over-mobile meniscus’ requiring an operation (costing £2800), 4 months after which (the time of interview) she was still in rehabilitation.

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. Carly, a martial artist recalled that GPs were ‘sometimes disapproving’, while Marcus, a rugby player, 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, like James (a runner experiencing on-going neural pains) illustrated how SRIs often fail to fit the diagnosis-treatment-recovery paradigm (Kotarba, 1983): ‘I just thought they’ll [the GP will] just say rest or something, from what people told me like’. Concern was also 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’ (Martha). Fewer than half of SRIs are thought to be professionally medically treated (Nicholl et al., 1995) and research suggests that those with previous experience of SRI are especially *unlikely* to seek medical aid (Grice et al., 2014).

Primarily though interviewees believed that state healthcare was not intended for them but was primarily orientated towards work rather than leisure. For example James went on to describe how over a two year period he paid privately to see a chiropractor, masseur and three

physiotherapists and have two MRI scans. Eventually, out of frustration, he saw his GP who referred him to a musculoskeletal specialist, with unsatisfactory yet fully anticipated consequences:

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?”

Three alternative strategies were available to manage future uncertainties (Morden et al., 2017). 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’ (Julia). However, it was clear that self-treatment was often fuelled by frustration at the immersion in a non-normal life. Sarah’s frustration at her compounded and extended injuries post-ACL damage meant that she found monthly NHS physiotherapy appointments 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’.

Second, the injured frequently acquired help from family, friends and others within their sport. Julia again described how a teammate, who was a physiotherapist, initially advised her when she tore her calf muscle:

[She] 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".

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' (Carly). Christina, also a martial artist, had 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'.

Third, 16 of the 20 interviewees described their use of private medical care. This ranged from one-off surgical procedures, to on-going care from physiotherapists, massage and sports therapists, osteopaths, chiropractors, psychologists, and acupuncture and costing up to an estimated £200,000 (Lucy). This was invariably contextualised within a sense of frustration at the lack of progress made during, or negative prior experiences of, NHS treatment. It was frequently seen as a last resort and sometimes entailed treatment 'hopping' to find the 'right' clinician. 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 and ontological security. Mark stated that during the six months since he had fallen whilst running, 'if there was anything at all that would have helped I'd have done it', while Martha, during her two years of limited running due to an Achilles tendonitis (and compounded injuries) talked of her actions aimed at, 'maintaining me as a person'.

Conclusion

We can therefore see that even if SRIs are generally perceived to 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 readily available and/or 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 adversity (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. This is, however, the first study to systematically interrogate the interdependence of SRI and biographical disruption and analysis of clinical populations may be fruitful developments in future research. Ultimately though, the examination of a cohort such as this is necessary if the sociology of health and illness is to more comprehensively understand the notion of biographical disruption that is widely accepted as informing the experiences of chronic illness.

References

- Allen-Collinson J (2005) Emotions, interaction and the injured sporting body. *International Review for the Sociology of Sport* 40(2): 221-240.
- Allen-Collinson J and Hockey J (2007) 'Working out' identity: distance runners and the management of disrupted identity. *Leisure Studies* 26(4): 381-398.
- Braun V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3(2): 77- 101

- Brookes HL, Rogers A, Sanders C and Pilgrim D (2015) Perceptions of recovery and prognosis from long-term conditions: The relevance of hope and imagined futures. *Chronic Illness* 11(1): 3-20.
- Bury M (1982) Chronic illness as biographical disruption. *Sociology of Health and Illness* 4(2): 167-82.
- Bury M (1991) The sociology of chronic illness: a review of research prospects. *Sociology of Health and Illness* 13(4): 451-468.
- Busby H, Williams G and Rogers A (1997) Bodies of knowledge: Lay biomedical understandings of musculoskeletal disorders. *Sociology of Health and Illness* 19(B): 79-99.
- Carricaburu D and Pierret J (1995) From biographical disruption to biographical reinforcement: The case of HIV-positive men. *Sociology of Health and Illness* 17(1): 65-88.
- Creswell JW (2013) *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. Thousand Oaks, CA: Sage.
- Dashper K (2013) Getting better: An autoethnographic tale of recovery from sporting injury. *Sociology of Sport Journal* 30(3): 323-339.
- Eime RM, Charity MJ, Harvey JT and Payne WR (2015) Participation in sport and physical activity: Associations with socio-economic status and geographical remoteness. *BMC Public Health* 15: 434-37.
- Elo S and Kyngäs H (2008) The qualitative content analysis process. *Journal of Advanced Nursing* 62: 107-115.

- Faircloth C, Boylstein C, Rittman M, Young ME and Gubrium J (2004) Sudden illness and biographical flow in narratives of stroke recovery. *Sociology of Health and Illness* 26(2): 242-261.
- Finch CF (2012) Getting sports injury prevention on to public health agendas – addressing the shortfalls in current information sources. *British Journal of Sports Medicine* 46(1): 70-74
- Finlay L and Gough B (2003) *Reflexivity: A Practical Guide for Researchers in Health and the Social Sciences*. Oxford: Blackwell.
- Grice A, Kigsbury R and Conaghan P (2014) Nonelite exercise-related injuries: Participant reported frequency, management and perceptions of their consequences. *Scandinavian Journal of Medicine and Science in Sport* 24: e86-e92.
- Guba E and Lincoln Y (1994) Competing paradigms in qualitative research. In Denzin N and Lincoln Y (eds) *Handbook of Qualitative Research*. London: Sage: 105-117.
- Hanold M (2010) Beyond the marathon: (De)construction of female ultrarunning bodies, *Sociology of Sport Journal* 27: 160-77.
- Harris M (2009) Troubling biographical disruption: Narratives of unconcern about hepatitis C diagnosis, *Sociology of Health and Illness* 31(7): 1028-42.
- Kortaba J (1983) *Chronic Pain: Its Social Dimensions*. London: Sage.
- Larsson A and Grassman E (2012) Bodily changes among people living with physical impairments and chronic illnesses: Biographical disruption or normal illness? *Sociology of Health and Illness* 34(8): 1156-69.

- Locock L, Ziebland S and Dumelow C (2009) Biographical disruption, abrupture and repair in the context of Motor Neurone Disease. *Sociology of Health and Illness* 31(7), 1043-1058.
- Malcolm D (2017) *Sport, Medicine and Health: the medicalization of sport?* London: Routledge.
- Malcom N (2006) “Shaking it off” and “toughing it out”: socialization to pain and injury in girls’ softball. *Journal of Contemporary Ethnography* 35(5): 495-525.
- Messner M (1992) *Power at Play: Sport and the Problems of Masculinity*. Boston, MA: Beacon Press.
- Monaghan L and Gabe J (2015) Chronic illness as biographical contingency? Young people’s experiences of asthma. *Sociology of Health and Illness* 37(8): 1236-53.
- Moore L, Frost J and Britten N (2015) Context and complexity: The meaning of self-management for older adults with heart disease. *Sociology of Health and Illness* 37(8): 1254-69.
- Morden A, Jinks C and Ong BN (2015) Risk and self-managing chronic joint pain: looking beyond individual lifestyles and behaviour, *Sociology of Health and Illness*, 37, 6, 888-903.
- Morden A, Jinks C and Ong BN (2017) Temporally divergent significant meanings, biographical disruption and self-management for chronic joint pain. *Health* 21(4): 357-374/

- Nicholl JP, Coleman P, and Williams BT (1995) The epidemiology of sports and exercise related injury in the United Kingdom. *British Journal of Sports Medicine* 29(4): 232-238.
- Nixon HL (1992) A social network analysis of influences on athletes to play with pain and injuries. *Journal of Sport and Social Issues* 16(2): 127-35.
- Richardson JC, Ong BN and Sim J (2006) Is chronic pain biographically disruptive? *Social Science and Medicine* 63: 1573-1585.
- Roderick M (2006) Adding insult to injury: workplace injury in English professional football. *Sociology of Health and Illness* 28(1): 78-97
- Rousseau N, Steele J, May C and Exley C (2014) ‘Your whole life is lived through your teeth’: Biographical disruption and experiences of tooth loss and replacement. *Sociology of Health and Illness* 36(3): 462-476.
- Sanderson T, Calnan M, Morris M, Richards P and Hewlett S (2011) Shifting normalities: interactions of changing conceptions of a normal life and the normalisation of symptoms in rheumatoid arthritis. *Sociology of Health and Illness* 33(4): 618-633.
- Smith B and Sparkes A (2005) Men, sport, spinal cord injury, and narratives of hope. *Social Science and Medicine* 61(5): 1095-105.
- Sparkes A (1996) The fatal flaw: a narrative of the fragile body-self. *Qualitative Inquiry* 2(4): 463-494.
- Sparkes A (1998) Athletic identity: an Achilles’ Heel to the survival of self. *Qualitative Health Research* 8(5): 644-664.

Sparkes A and Smith B (2002) Men, sport, spinal cord injury and the construction of coherence: narrative practice in action. *Qualitative Research* 2(2): 143-171.

Williams SJ (2000) Chronic illness as biographical disruption or biographical disruption as chronic illness? Reflections on a core concept. *Sociology of Health and Illness* 22(1): 40-67.

Young K (1993) Violence, risk and liability in male sports culture. *Sociology of Sport Journal* 10(4): 373-396.