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Conformers, Contesters, and Creators: vignettes of asthma identities and sporting embodiment

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Abstract

Through a phenomenologically-inspired approach, the purpose of this article is to examine the different ways in which sportspeople experience asthma, a condition that affects 5.4 million people in the UK. To date, sociological phenomenology has been under-utilised both in relation to health and illness experiences and vis-à-vis sporting embodiment. Drawing on in-depth interview data from non-elite sportspeople (*n* = 14), all of whom had been diagnosed with asthma, ranging in degree of severity, here we explore asthma sporting embodiment via a threefold asthma identity typology. The findings are communicated through vignettes, assembled from participants' accounts, in order to highlight the multifaceted and multilayered 'voices' of sportspeople with asthma. Transforming data in this way can, we argue, resonate with others – both those with asthma and those without – to give a 'feel' for asthma experiences and sporting embodiment. This form of typology may be useful as a heuristic framework to assist healthcare and sports professionals in understanding asthma experiences as lived in everyday life, and potentially in developing more appropriate and effective care regimes for sportspeople in order to improve the quality of that everyday life.

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Introduction

In this article, we draw upon 'carnal sociology' (Crossley, 1995; Wacquant, 2014) perspectives and employ a phenomenologically-inspired approach to explore the ways in which sportspeople experience asthma and adopt various 'asthma identities'. Around 5.4 million people in the UK are currently receiving treatment for asthma, representing one in every 12 adults and one in every 11 children (NHS UK, 2014). In this article, we employ sociological phenomenology, a perspective that to date has been under-utilised both in relation to health and illness experiences generally **(Allen-Collinson & Pavey, 2014**) and vis-à-vis illness and sporting embodiment specifically (Allen-Collinson, 2009; **Allen-Collinson & Owton,** 2012). Drawing upon interview data from non-elite sportspeople (*n* = 14), all of whom had been diagnosed with asthma, here we explore asthma embodiment in sport via a tripartite typology of asthma identities. Although we use the term 'identity', this is not to posit a fixed, immutable concept of identity, but rather to explore different ways of 'being-in-the-world' with asthma. The typology is illustrated through vignettes, in an attempt to bring to life the multifaceted and multilayered accounts of participants' lived experiences.

Asthma is a common, multifactorial, and often chronic respiratory illness that can result in episodic or persistent symptoms and in episodes of suddenly worsening wheezing that can prove fatal (Royal College of Physicians, 2014: 1). **Asthma is particularly prevalent in the UK, which, it is thought, might be related to the estimated 21 million (44%) adults suffering from at least one allergy (Allergy**

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UK, 2014; de Lara & Noble, 2007); asthma affect**s** one in five homes, with around 4.3 million adults having asthma (Asthma UK, 2014a) and around 1.1 million children; 2014b). Asthma is one of the most common chronic illnesses and whilst usually not considered a 'serious' illness, nevertheless, during 2011–2, there were over 65,000 hospital admissions for asthma in the UK **costing the National Health Service (NHS) around £1 billion a year** (**Asthma UK, 2014;** Royal College of Physicians, 2014). Three people die every day in the UK from asthma-related problems, despite many of these deaths being avoidable (Asthma UK, 2014). **Sport and exercise, for those with asthma, are encouraged by medical professionals and bodies, such as Asthma UK (2014), so long as the asthma is deemed to be 'well controlled'. This** underlines the importance of investigating the lived experiences of sportspeople with asthma, given the current dearth of qualitative research in this domain, particularly in non-elite adult sportspeople, many of whom are affected by exercise-induced asthma or bronchoconstriction.

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Exercise-induced asthma (EIA) occurs when asthma symptoms are provoked by exercise (Wilmore et al., 2008), and is found in about 80%–90% of all asthmatics (McArdle et al., 2007). Whilst asthma has been found to influence **daily** physical activities, sporting preferences and participation levels (Colland et al., 2004), physical training poses a particular problem for asthmatics given that the majority of **those diagnosed with asthma** are at least susceptible to EIA (Pedersen & Saltin, 2006). On the one hand, exercise provides a potent stimulus for bronchoconstriction (Carlsen & Carlsen, 2002), whilst on the other, regular physical activity demonstrates physical and psychosocial benefits and is deemed important in asthma rehabilitation and education (McArdle et al., 2007). Sport therefore appears to act as a 'double-edged sword' for many sportspeople with asthma. This 'sword' may become more

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multifaceted when considering an individual's readiness to accept a diagnosis of asthma, and how this interacts with the strength of their 'athletic identity' (Brewer et al., 1993). This complexity means there are risks associated with reducing asthma treatments to single types of interventions and a 'one-size-fits-all' approach, and the latter is unlikely to be effective (Douwes et al., 2010).

When people with asthma experience their symptoms, they engage in a process that is culturally informed (Becker, 1999) and also subculturally contoured (**Allen-Collinson & Owton,** 2012). It is important therefore better to understand the lived experiences of sportspeople with asthma who may become acutely aware of, and attuned to, their breathing in ways that link the physiological, the psychological, the social, and the environment (**Allen-Collinson & Owton,** 2012). Despite its reported prevalence, and with some key exceptions (e.g. Tiihonen, 1994; **Owton,** 2012, 2013a, 2013b, Allen-Collinson & Owton, 2012), there is a distinct dearth of qualitative literature on the lived experience of asthma amongst sports participants, particularly utilizing a 'carnal sociology' (Crossley, 2995) framework. As Wacquant (2014) notes, this approach takes seriously the (sometimes embarrassing) notion that social agents are motile, sensuous, and suffering creatures of flesh and blood, doomed to death, and importantly this proposition applies equally to the sociologist/researcher as to the participants studied. As Wacquant (2014: 10) continues, 'Carnal sociology is based on a bet (or a dare): that we can turn carnality from problem to resource for the production of sociological knowledge'.

The qualitative research project described below was therefore initiated with the aim of addressing the research lacuna regarding qualitative and carnal sociological inquiry into asthma and sporting embodiment. Before describing the research, for those unfamiliar with a sociological phenomenological framework, we first provide a

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brief overview of this perspective which is now producing a developing corpus of research portraying sports participation and sporting embodiment in various domains (Hockey and Allen-Collinson, 2007; Allen-Collinson, 2009; **Owton**, 2012; **Allen-Collinson & Owton,** 2012).

Sociological phenomenology and sports studies

The key tenets of modern-day phenomenology (the study of things as they appear in consciousness) are generally attributed to the philosopher, Husserl (1970), who advocated the phenomenological method for investigating phenomena as the 'things themselves' via the suspension or bracketing of our 'hitherto existing convictions' (1970: 76). Thus, phenomenology requires that we do not simply participate in the world in our mundane, routine, taken-for-granted ways, but attempt to bracket or stand aside from this 'natural attitude' so as to: '…contemplate what it is to be a participant in the world, and how things present themselves to us' (Sokolowski, 2000: 48). Such bracketing is not an unproblematic quest for sport sociological researchers, **and indeed for sociologists in general,** as has been noted (see for example Allen-Collinson, 2011a), **given that we are all culturally and social-structurally embedded and so cannot entirely 'stand outside' of our socio-cultural location, including our language forms (Allen-Collinson, 2011a).**

With regard to sports studies, Kerry and Armour (2000) highlighted the 'promise of phenomenology' some time ago, **and a body of work has been slowly emerging both before and since this time** (see for example, **Rail, 1992;** Hockey and Allen-Collinson, 2007; Allen-Collinson, 2009; Hogeveen, 2011; Martínková and Parry, 2011; Müller, 2011; Allen-Collinson & Owton, 2012). Phenomenology has been found of relevance to sport sociologists, particularly with regard to its focus

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upon the 'lived body' (*Leib*), the body as lived in the 'lifeworld' (*Lebenswelt*), that is the 'local' world of everyday, including the intersubjective communities of which we are a part. In terms of the corporeal, the existential phenomenologist, Merleau-Ponty (2001), argued for the centrality of the body in our 'being-in-the-world', and in his later work (1969) utilises the terms 'flesh' (*chair*) and 'flesh-of-the-world', so as to highlight our fleshy being, our 'corpo-reality' (Allen-Collinson and Owton, 2012: 3), the bodily-groundedness of lived experience. To date phenomenological – and sociological phenomenological - insights have been drawn upon by researchers investigating a range of sporting and physical cultural domains. These include: the acquisition of skill in sports (Standal and Moe, 2011), running and scuba diving (Allen-Collinson and Hockey, 2011), freerunning (Clegg and Butryn, 2012), long-distance walking (Crust et al. 2011), boxing (**Allen-Collinson & Owton**, 2014), various forms of martial and self-defense arts (e.g. Samudra, 2008, Spencer, 2013), golf (Ravn and Christensen, 2014) and soccer (Hughson and Inglis, 2002) to give just a flavour of this developing literature.

So, we might ask, what does the specific nexus of sociology and phenomenology offer the sociologist of sport? Bringing a sociological lens to bear on insights drawn from phenomenology, we argue, allows researchers to bring to the fore the considerable impact of social-structural forces upon our lived sporting experience. As Allen-Collinson and Hockey (2011: 332) note, the sociological lens allied with phenomenology emphasizes the 'structurally, politically and ideologically-influenced, historically-specific, and socially situated nature of human embodiment and experience'. More social and sociological forms of phenomenology have of course a considerable tradition, exemplified by the work of Schütz (1967), whose interest in the lifeworlds of intersubjective communities is of particular

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salience. Feminist and queer phenomenological perspectives have also provided further insights into, amongst other things, the specificities of gender, age, ethnicity and sexuality in our being-in-the-world, including in the sporting world (see for example, Young, 1998; Ahmed, 2006; Chisholme, 2008; Allen-Collinson, 2011b).

Drawing upon a phenomenologically-inspired approach, Frank's work (1993, 1995) provides a means of studying stories of illness through an examination of the body, a perspective that is apposite for the current study. Frank argued that, 'people telling illness stories do not simply describe their sick bodies; their bodies give their stories their particular shape and direction' (Frank, 1995: 27). Referring to Kleinman's (1988) sophisticated analyses of the interweaving of bodies, cultures, and lives, Frank reinforces the importance of understanding how bodily symptoms are the *infolding* of cultural traumas into the body and as these bodies continue to live and create history, these symptoms *outfold* into the social space of that history. Frank's (1995) focus is on *body problems* and he posits four general problems of embodiment: control, body-relatedness, other-relatedness, and desire. Furthermore, each body problem is a problem of *action:* to act, a body-self must achieve some working resolution to each problem. Frank (1995: 30) provides a continuum of possible responses via a matrix of four ideal typical bodies: the disciplined body, the mirroring body, the dominating body and the communicative body. He also creates three basic narrative types: Restitution, Chaos, and Quest, as useful devices. To avoid risking creating yet another 'general unifying view', however, Frank emphasises that no actual telling conforms exclusively to any one of the three narratives, but rather he suggests that these narratives encourage closer attention to the stories an ill person tells.

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Having portrayed the phenomenologically-inspired theoretical framework that guided our research and provided a lens to analyse and understand the lived and sensory experiences of asthma and sporting embodiment, we now describe the research itself and the methods used to generate the vignettes presented below. These are utilised in an effort to provide the reader with an evocative, detailed and empirically-grounded insight into the lived experience of sportspeople with asthma.

Research approach and methods

Ethical approval was granted by the relevant university ethics committee prior to data collection. Purposive, criteria sampling was used to recruit participants, initially using convenience sampling in terms of having access to friends and colleagues with asthma, subsequently supplemented by a snowballing process (Patton, 2002: 237), where existing participants recommended potential others. The key criteria for selection were: 1) having a clinical diagnosis of asthma; 2) receiving ongoing medical treatment for asthma; 3) being an active sportsperson or a 'retired' sportsperson, **in terms of participation in sporting or physical cultural activities on a regular and frequent basis (at least once per week) for a minimum of 5 years.** Eventually, a sample of 14 non-elite sports participants with asthma was selected, 10 of whom were currently active in sports/physical cultures (4 males; 6 females), and 4 of whom were 'retired' sportspeople (2 males; 2 females); Table 1 provides detailed participant information.

Insert Table 1 here

Loosely-structured, 'life-world' interviews were conducted by the first author, in an attempt to 'understand themes of the lived daily world' from the participant's own perspectives (Kvale and Brinkmann, 2009: 10). An open 'go with the flow' approach was adopted, allowing the introduction of new issues as each interview

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proceeded, and thus the interviews became more interviewee orientated, commensurate with the phenomenological approach (**Allen-Collinson, 2009**; Crust et al., 2014) we adopted. Follow-up interviews were conducted with all participants, and the rough interview guide was also open to new and unanticipated directions to account for individual differences and emergent themes (c.f. Charmaz, 2004). Schwalbe and Wolkomir (2002) reinforce the importance of ongoing data analysis and note that, to delay analysis until 'all the data are in' is to miss the chance to make midcourse adjustments and seek precisely the data needed to strengthen an emerging analysis. Initial data analysis therefore identified certain avenues to follow up in subsequent interviews, and as interviewing progressed, richer stories were generated.

In addition to our phenomenologically-inspired analysis, drawing upon Giorgi's (1997) empirical-phenomenological method, data were also analysed via an inductive narrative analysis that was instrumental in developing the 'ideal types'. Narrative inquiry was employed using stories to describe human experience and action (Oliver, 1998), as narratives have been argued to provide a structure for our very sense of selfhood and identity (Smith and Sparkes, 2009a, 2009b; Sparkes, 2004). Crossley's (2000) steps of narrative analysis were employed and involved repeatedly reading through the whole interview transcript five or six times to gain familiarisation and a general gist of emerging and significant themes. The second stage involved grasping principal elements of the *personal narrative*, which included: narrative tone, imagery, and themes (McAdams, 1993). In addition to these forms of analysis, Denzin's (1989) Interpretive Biographical Analysis was employed, specifically to explore epiphanies or turning-point experiences, moments of existential crisis when a person's identities can be forcefully and dramatically called into question.

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The purpose of empirical phenomenological research is not focused upon abstraction and theorisation, but rather upon the detailed, rich description of phenomena, and we have therefore sought to keep theorisation to a minimum. From a sociological perspective, however, it can be argued that in order better to understand something we must go beyond mere description, and proceed to interpret it, including via classification. Sociological typologies have thus proved useful in addressing various illness conditions (see for example, Schneider and Conrad, 1981; Frank, 1995). Drawing upon this approach, and for heuristic purposes, we constructed a threefold typology of sporting asthma identities or being-in-the-world, based on the ideal types of: Conformers, Contesters, and Creators. Commensurate with a phenomenological perspective, and with Frank's (1995) insights, we wish to stress the fluidity and context-dependency of these ideal types. Our participants, perhaps unsurprisingly, did not always fit neatly and squarely within the categories of the typology and at certain times might change from one dominant aspect to another. For example, during the period of winter training, cold air may provoke an asthma 'flare up', resulting in more 'conformer-like' behaviour as people seek to manage their symptoms with an inhaler. The typology has thus been generated for heuristic purposes, given the uncertain and elusive nature of asthma, and we fully acknowledge the mutability and flux of felt identities and ways of being-in-the-world.

Whilst a typology is analytically useful in describing 'ideal types', we also want to represent people's stories in a less 'dry' fashion, one that is more evocative and narratively-rich, in order to explore the beliefs, values, attitudes, perceptions, thoughts and meanings drawn upon by our participants. We have thus chosen to present the empirical data, generated by the participant interviews and thematised into the threefold typology, via means of vignettes. Vignettes are short narratives

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written to show specific scenarios (Sparkes and Smith, 2013), and can be used to represent data (as here) or to collect the responses that the vignettes of a particular situation elicit (Sparkes and Smith, 2013). The vignette approach, we hope, will thus 'breathe life' into the lived experiences of sportspeople with asthma. For each ideal type, a description is provided and then a vignette illustrates the narrative of a participant (with pseudonym) who exemplifies this ideal type. The narrative is drawn verbatim from each participant's transcripts. We first consider Conformers.

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Conformers: ***A minute ago I was healthy, now I am sick, in a minute I'll be healthy again.***

Those whom we have identified as Conformers **(participants 3, 4, 10, 11, 14)** were likely to describe actively 'managing' their asthma by conforming to medical conceptualisations of the compliant patient who accepts the asthma diagnosis, complies with, and adheres to the medical regime advised by healthcare professionals. In the case of our participants, it was usually a General Practitioner (GP) who prescribed treatment, whilst an asthma or respiratory nurse would often be tasked with promoting treatment compliance and asthma self-management (see also Morice and Wrench, 2001). As Becker (1999) highlights, Western societal attitudes inform the way in which it is valued to be individually responsible for one's own illness in terms of its management.

Conformers appeared generally to be managing asthma and its biographical consequences by adopting the restitution narrative: 'Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again' (Frank, 1995: 77). For sportspeople with asthma, however, it seems more accurately to be conceptualised as: 'A moment ago I could breathe, now I'm having difficulty, but in a moment I'll be able to breathe

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again'. Conformers appear constantly to strive for this restored state of health, including via use of their inhaler(s)[1], which can serve as a 'quick fix' in reducing symptoms such as wheezing and difficulty in breathing. Conformers seek to 'control' asthma symptoms, primarily via the use of inhalers, and thus to gain some predictability vis-à-vis their condition, commensurate with Frank's (1995) concept of the 'disciplined body' that seeks control and predictability. As emerged from the data, it is often their reliance upon medical regimes, particularly the use of inhalers, that allows Conformers to have this control and to 'silence' their symptoms, permitting them to carry on without undue disruption to their everyday sporting lives. Typically, our Conformers indicated: 'I'm in control… mind over matter'. Jennifer exemplifies this ideal type.

> **Jennifer:** I am asthmatic but I've never really considered that I am. It's just me. From the physical point of view I don't suffer with it because I take my inhaler. When it flares up, it's rubbish, but if it doesn't then it doesn't really worry me. All I have to do is take one in the morning and one in the evening and that seems to work and I have my blue relief inhaler which I take as and when I need it.
>
> One time it flared up and I just kept coughing and coughing and coughing so I went to see the asthma nurse. She said, 'increase your inhalers', but it didn't make any difference. She said, 'come back and see me' three times and then, 'oh, I think you should see a doctor now'. I saw the doctor and he goes, 'yep, you need antibiotics'. Maybe if someone had done something a bit about it before I might not need antibiotics; I might have had some sleep. It was horrible not sleeping, because as soon as I lay down, I just coughed and coughed and coughed. For 3 months I was like that. After that, I always use

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my inhaler twice a day.

> But there's two things really: there's the tight chest where you're kind of short of breath or a bit wheezy and then there's the other extreme where you literally can't get any air into your lungs. That's happened twice now at night - as you're waking up, you realise you can't breathe and it's horrible as you wake up, 'Oh god, I can't breathe' and I panic. It's a bit scary, but I get my inhaler and take that and I kind of go back to normal.
>
> Now, it's just become just a part of my routine. Every time I get ready for a game, it's boots, shin pads, inhaler, towel; it's just part of my kit. But then sometimes, you can't just stop. Like when I'm playing sport, because you're just in the zone; other things take over and you think about that instead of your asthma. I don't tend to listen to my body - I tend to just take my inhaler and it fixes it. Or, if I can't take my inhaler because I'm in public and I feel stupid, then I'll try and, just relax and just breathe. If I can get to my blue inhaler, then obviously I'll take that but if I can't, you just try and kind of try and… just breathe slowly. I'm in control, mind over matter.

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In contrast to the Conformers, but holding some similarities in attitudes and perceptions regarding the 'mind over matter' approach, another distinct ideal type emerged from data analysis: the Contesters.

Contesters: *Fighting a (losing) battle*

Asthma UK (2014) promotes the belief that asthma does not necessarily need to be a performance issue or stop sufferers from participating in sport. This can lead to

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conceptualisations of 'beating it', 'overcoming it', or 'kickin' it', and Contesters often drew upon such formulations in portraying asthma experiences. Some Contesters **(participants 1, 7, 8, 12, 13)** demonstrated a 'fighter attitude' and expressed feeling it necessary to prove their self-worth through setting themselves sporting challenges to 'overcome asthma'.

Fighting asthma conforms to a culturally-valued mode of being-in-the-sporting-world, replete with aphorisms such as: 'no pain, no gain', 'pushing the limits', 'mind over matter'. Whilst such a mode of being may have certain strengths, there can be a dark side, for when their asthma symptoms become so severe or constraining that they cannot 'click out of illness', Contester can perceive this as 'failure' and self-blame for not being 'strong enough'. Contesters construct narrative accounts that draw upon notions of 'beating asthma', 'overcoming asthma', with metaphors cohering around 'fighting', 'attack', 'a constant battle', and 'struggling' to get their breath. Not only is asthma perceived as an attack on breathing, but also an attack on their very being-in-the-world, their sense of self, particularly the sporting self, and this can generate anger and frustration, as Ashley indicates below.

For Peer Review

Sportspeople are often willing to fight asthma by engaging in sport, sometimes at the expense of making their asthma worse and consequently, at times jeopardising their health (Allen-Collinson & Owton, 2012, **Allen-Collinson**, 2013a, 2013b). Sport, then, constitutes a 'double-edged sword'; it is beneficial, holds meaning, and they enjoy it, but conversely, participation can be health-hazardous. In accord with research by Williams et al. (2008) many of our participants argued that they would rather participate in sport or physical cultures, even 'at the expense' of their asthma. Contesters recounted how they tended 'not to hold back' in relation to sporting action,

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and some were even found to engage in deleterious, risk-taking behaviour. Ashley provides an example of this particular identity type.

Ashley: I'm just the unlucky one in the family. I've got a weak immune system. When I was young, I had lots of little harsh hopes that it might go away and told I would grow out of it, but it didn't and it'll probably be there for the rest of my life. I seem to be growing right into it and *blooming* into this stage. Now, I am much more aware of being asthmatic. Pretty depressing because I'm moving **two** steps forward and **two** steps back and I just can't pre-empt like that I'm gonna have an attack. I might get caught out when I'm playing sport and suddenly can't breathe and realise I have nothing with me. So I'm not particularly organised…

I'm really annoyed when I can't train because I love training and it's my sport that's actually doing me good and it's doing my lungs good. I won't hold back but it probably taking me ages to get my breathing back. I like pushing myself very hard and like the idea of knowing I have to stop to be sick but I'm used to dealing with that. It's the 'no pain, no gain' mentality, it's an uncomfortableness… and it probably does limit performance, but I've not noticed that it's really impaired me. My release is my fitness and my sport. That's how I get rid of all my tension and anger. If I'm wound up, I'll go for a run, or a swim or something.

So I get annoyed not feeling healthy and not felt healthy for quite a long time. I couldn't count the number of admissions into hospital. I used to be really fit and athletic; I thought sport'd make me stronger. Gradually I've got less fit and less athletic [laughing] and now I'm really unfit and non-athletic [laughing]. Asthma's killed my ambition and my dream of being a

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> sportsperson. But you don't want to admit that you're as ill as you actually are. I want to live my life how I want to live my life and I am sick to death of it being dictated by every single condition under the flipping sun.

Not only did Contesters fight against their asthma and its symptoms, they also appeared in some instances to fight against medical professionals and prescribed medical treatments, even when suffering acute episodes of asthma. As Becker (1999: 13) notes, this contestation may be grounded in resistance to the power of medical professionals, and because people fear not receiving appropriate treatment. For our Contesters, their anger and frustration with medical professionals were at times palpable, particularly when they felt the latter did not attempt to understand the lifeworld of sportspeople with asthma. As Ashley went on to say:

> Doctors are rubbish and incompetent. One doctor said to me, 'well don't do anything'. So, I nearly punched him with lack of understanding about the world's life ... I said, 'well hand me the tablets, I'll die now then'. I'd rather get on without doctors. I won't go to an asthma clinic either because I don't have much faith in them. I've had similar experiences before when I was younger. I don't really believe that anybody can help me...
>
> But I believe you can click out of illness if you are determined enough. I'm not a superhero and lots of day I've failed, but nothing will stop me from beating it. I just wish there was just like a shop where I could go into and say 'I'm sick. Fix me. I'd like a new pair of lungs please'. I don't care how much it costs. I always say if I could get a lung transplant, all will be well [laughs].

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Resistance to the power of healthcare professionals was, for some of our Contesters, tempered by their own somatic knowledge; they listened to their own bodies in deciding whether professional advice or specific healthcare was necessary, as Becker (1999) similarly noted. As we have argued elsewhere **(Allen-Collinson & Owton, 2012),** sportspeople with asthma often engage in fine auditory attunement and 'deep listening' to the body and asthma symptoms. Whilst Becker (1999: 12-13) highlights the ways in which people with asthma more generally 'listen' to their bodies, 'anticipating as well as monitoring the symptoms of the illness, wheezing or shortness of breath', Hockey and Allen-Collinson (2007) portray the ways in which sportspeople become acutely aware of, and attuned to their breathing. Commensurate with our sociological phenomenological approach, such 'auditory work' and careful monitoring were found to be multi-sensory, as participants also 'listened to' their proprioceptive feelings – those experienced in the deep spaces and tissues of the body, such as the lungs. Contesters' frustration and lack of faith in medical professionals were thus tempered by such somatic attunement. This heightened somatic awareness was even more prominent in the accounts of our third asthma identity type, the Creators.

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Creators: ***a new sense of self and ways of managing asthma***

Creators **(participants 2, 5, 6, 9)** appear generally to experience less anxiety and panic regarding their asthma than do the other two types, and seem to view asthma as a practical issue to be addressed, rather than a threat to identity. Creators are willing to take responsibility for managing their asthma and to try out different ways of achieving a degree of control over symptoms, including seeking out alternative or complementary therapies. Asthma, for Creators in particular, seems to be

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experienced as a learning experience, involving a slow, focused process of finding breathing rhythms, patterns, and flow in their sport in order actively to manage asthma. Creators learn to listen to their bodies as a source of valuable information and so appear to be finely somatically attuned, having some similarities with Contesters on this dimension. Additionally, they also seem to be highly associated with their bodies, in Frank's (1995) terms, and to seek out help and support when needed. Frank (1995) refers to the Communicative body-self, which is associated with itself and also dyadic; for this body-self, communication is less a matter of content than of self-other alignment. In this sense, asthma as a learning experience involves a degree of responsibility-sharing with others, such as family members, friends, doctors, sports coaches. Those participants who talked of asthma as a learning experience seem generally (but not always) to feel in control and less anxious about their asthma due to having developed various mind-body skills and techniques. They also report drawing upon alternative/complementary remedies and therapies, whether in addition to, or instead of, conventional, allopathic treatments. Asthma as a learning experience also coheres in many ways with Shilling's (1993) concept of the body as an unfinished project, one 'which should be worked at and accomplished as part of an individual's self-identity' (1993: 4-5). Thus, Creators indicated developing a long-term, even lifelong way of 'being-in-the-asthma-world', which involves various types of 'somatic work', and 'tuning in' to the environment (see also Allen-Collinson & Owton, 2012). Kate exemplifies the Creator ideal type.

> **Kate:** I see myself as a healthy person who has to deal with asthma rather than an asthmatic. I don't feel ill with it, just something to manage really…
>
> If I get wheezy for several days a week, for several consecutive weeks, I just increase my own dose. If that doesn't work then I go and see them. I've

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been able to manage it quite well. I have always been keen to want to, once it is stable and managed, to try and reduce the dose as much as possible. They recommend that you don't self-medicate but I'm quite aware of the maximum prescribed effective dose...

I enjoy knowing that I'm not answerable to anyone for what I'm doing and I also enjoy knowing that if I do well in anything that it's been my own prescription. It's better for me in the long run if I listen to what my body's saying rather than just following some program. I know what's better for me.

Over 10 years, I've worked out how my body responds to different training in terms of increases in fitness, speed and strength. After training sessions, I work out how that feels and whether I need to push harder on the next session or ease off. You can feel when it's getting too much, when you're working really hard, I feel sick or something then you should probably stop, you can feel your chest getting tight, you can feel yourself getting out of breath. It is like a learning process of knowing when, of knowing your body and knowing how, how much you can cope with and how it feels when you're not going to be able to cope.

It's something that I'll always have to be aware of because if I take my eye off the ball, then things can get progressively worse. I'll always be a little bit dependent. I'm not confronted with it on a daily basis it's only every now and then…

I don't see it as an attack, but like an onset of bronchoconstriction. I simply notice being there in a mindful way then simply rest a little bit. It's really whatever works for you. Just talking to myself 'you'll be fine if you just relax' and calming down and then I sort of imagine myself, from an external

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point of view taking in a deep breath and slowing releasing it. It helps me get back into the normal pattern of breathing. When I'm having an episode, I'd rather just do something quietly where I don't have to be fighting it all the time and then eventually it'll pass…

Now I feel healthier and better than I've felt. I am fitter than I've been in years. I feel very confident in handling my asthma and it's now so much a part of what is normal. I just deal with it on a regular basis. Keep an eye on it. I think I've just sort of accepted it as a bit of me.

For Peer Review

Via the above three vignettes, we have sought to give a 'feel' for the different asthma identities and ways of being-in-the-world that emerged from participants' accounts of living with asthma as sportspeople.

Conclusion

Asthma is a widespread, chronic respiratory illness **that can have considerable corporeal consequences for those who suffer its bodily-disruptions. The personal accounts of people who continue to engage in sports and physical activities on a regular and frequent basis, despite the considerable somatic and psychological dys-ease generated by asthma, are therefore of interest.** Drawing on in-depth interview data from non-elite sportspeople with asthma, in this article we have explored and analysed participants' accounts of **their lived experience of the** asthma-sport nexus. Commensurate with the sociological phenomenological approach adopted, we have sought to avoid undue abstraction and theorization, but rather to 'give voice' to participants' own lived experiences of asthma and dealing with its deep somatic and often highly corporeally disruptive consequences.

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Representing the data via vignettes was chosen in an effort to 'breathe life into' the data, to resonate with others and to give a feel for what it is to be the person in the sporting-body-with-asthma. Whilst the vignette representational form is relatively new to sport sociology and sports studies generally (Sparkes & Smith, 2014), as Frank (2012) notes, vignettes can provide powerful representational forms, and may even help people acknowledge why they might need to employ different narratives. The use of a typology too may be useful as a useful framework to assist in identifying and understanding different ways of being-with-asthma in the (sporting) world. It is not, as we emphasize above, meant to provide a fixed, trait-type typology, but rather to provide the kind of 'simple structure' to which Frank (2012: 48) refers. Our typology was thus constructed for heuristic purposes, to help identify, illustrate and analytically explore particular ways of being-in-the-sporting-world with asthma, whilst also acknowledging, as highlighted by participants themselves, that these ways of being are complex, shifting, mutable and context-dependent.

With regard to the use of a sociological-phenomenological framework, combined with the use of vignettes, we suggest that this particular approach can provide an insightful means of exploring how it feels - at a particular, phenomenal level – to be a sporting person with asthma. Whilst we could have chosen to represent participants' accounts via a more traditional ethnographic 'realist tale' (Sparkes, 2002), which undoubtedly has its own strengths, here we wished to explore a representational approach to date underutilized in sport sociology and sport studies more generally. Representing data in this way can, we hope, resonate with readers – whether with asthma or without – to give a 'feel' for asthma experiences and sporting embodiment lived in combination. We are not suggesting that this is the only (or even the best) way to seek to

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convey (however partially, as phenomenology always highlights) the lived reality of our participants, but we hope it does help generate some insight into, and empathic resonance with, their particular being-in-the-sporting-world, and the kind of embodied ways of knowing they use in order to live with asthma in that world. Such somatic knowledge and ways of knowing, we argue, allow and encourage us to portray experience and to theorize '*from* the body' as well as about the body (Williams and Bendelow, 1998; Allen-Collinson, 2011a). Engaging with this form of 'carnal sociology' (Crossley, 1995) helps to remedy the long-standing imbalance between abstract theorizations *about* the sporting body and more grounded, 'bodyful' accounts of sport and exercise as lived experience.

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Notes

1. Inhalers for use in the management of asthma tend to be for two key purposes: preventive, to reduce systems longer-term (brown inhaler); and instant relief via immediate bronchodilation ('reliever' blue inhaler).

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Table 1 Participant information

Participant	Age	Sports / physical culture participation	Asthma type (if indicated)	Ideal type	Asthma severity
1	23	Football, golf, skiing	Brittle asthma EIA	Contester	Severe Uncontrolled
2	60	Ex marathon runner, cycling	Brittle asthma EIA	Creator	Severe Controlled
3	87	Ex-professional ballerina (current very light physical activity)	Late onset	Conformer	Mild Controlled
4	33	Horse riding, running	Allergies Not EIA	Conformer	Severe Controlled
5	31	Marathon runner	EIA	Creator	Severe Controlled
6	22	Swimming	EIA	Creator	Mild Controlled
7	24	Football, cycling, swimming	EIA	Contester	Severe Uncontrolled
8	24	Ex rugby; football, cricket	EIA	Contester	Mild Uncontrolled
9	72	Walking	Late onset	Creator	Mild Controlled
10	70	Ex-squash player, gym skiing	Late onset	Conformer	Mild Controlled
11	33	Running, exercise, aerobics		Conformer	Mild Controlled
12	49	Golf player/climber	Late onset	Contester	Mild Uncontrolled
13	36	Running, martial arts	Allergies EIA	Contester	Changing Controlled
14	24	Footballer, running, cycling	Allergies EIA	Conformer	Mild Controlled

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