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Abstract
To date, research into disordered eating in sport has focused on the prevalence and the identification of putative risk factors. Findings suggest that elite female athletes participating in sports with a focus on leanness or aesthetics are at greatest risk (Smolak et al. 2000). A paucity of research remains as to the period after onset and how existing sufferers manage their illness over time. In line with the principles of interpretative phenomenological analysis (IPA), this study ógives voiceô to four athletes who have experienced disordered eating, documenting their personal accounts and interpreting these accounts from a psychological perspective. In-depth, semi-structured interviews were conducted and verbatim transcripts were analysed according to the procedures of IPA. Three superordinate themes emerged from the data: the struggle to disclose, social support needs, and identity challenges. Athletesô stories provided rich descriptions of their subjective disordered eating experiences. Their accounts give critical insight into the impact of eating disturbance on the lives of athletes. Future research should continue to identify athletes with existing eating problems in order to improve understanding as to how such individuals can best be helped.

Athlete experiences of disordered eating in sport

Disordered eating is a useful umbrella term for a broad spectrum of problematic eating practices, ranging from unhealthy weight control methods to the severe pathology associated with anorexia nervosa and bulimia nervosa (Shisslak *et al*. 1995). Thompson and Sherman (2009) discuss, with reference to the 2008 Olympic Games in Beijing, how competitive elite sporting environments and cultures might increase disordered eating risk in athletes. The problem is such that the International Committeeôs Medical Commission devised a thorough position stand addressing the issue (Sherman and Thompson 2006). Specifically, the position stand offered detailed information on the ófemale athlete triadô (interrelated conditions of disordered eating, amenorrhea, and osteoporosis; Yeager *et al.* 1993), and guidelines as to how best prevent, manage, and treat this condition. The goal of understanding disordered eating within sport has developed into a popular and important line of inquiry for many researchers.

The core hypothesis, based on a growing research base, is that intense pressures to be thin for performance gains may trigger onset in vulnerable individuals (see Dosil, 2008). Findings have generally shown that elite female athletes participating in sports with an emphasis on leanness or aesthetics, are at the greatest risk of disordered eating (Smolak *et al.* 2000). This tentative conclusion has emerged from an abundance of prevalence studies, including a recent study indicating that female athletes in lean sports are more than twice as likely to experience clinically disordered eating patterns as non-athletes (Torstveit *et al.* 2008).

Prevalence studies are important, but they should not form the chief focus of all disordered eating in sport research (Currie 2007). Although studying prevalence provides an indication of the number of athletes with disturbed eating habits, and the

types of sports that present the most risk, such studies give little insight into how disordered eating is phenomenologically experienced over time. A few studies have also identified key personal risk factors (e.g. Fulkerson *et al.*, 1999, Monsma and Malina 2004) but these are limited by snapshot, cross-sectional designs that cannot identify whether a given risk variable is a cause, a symptom or a maintenance factor (Jacobi *et al.* 2004).

To counter the dearth of developmental research, Petrie and Greenleaf (2007) recently suggested an approach whereby causal variables are assessed longitudinally, in order to establish their precedence in relation to outcome, thus qualifying them as *risk factors*. Their psychosocial risk factor model, adapted from Stice (1994), suggests that a complex interplay between various mediators (e.g. sport pressures, body dissatisfaction, restrained eating) and moderators (e.g. perfectionism, social support, self-concept) determine whether an individual develops eating pathology. Critically, Petrie and Greenleafôs model may be viewed as overly prescriptive, limiting understanding of risk factors to those that have been preconceived. Petrie and Greenleaf acknowledge that qualitative, inductive approaches may reveal factors previously unconsidered, thereby illuminating existing understanding of athletesô experiences of disordered eating. Further, their modelôs etiological emphasis, although useful for the development of prevention strategies (Jacobi *et al.* 2004), addresses only one facet of the illness. Issues relating to disorder maintenance and management are of equal importance but are rarely addressed in athletic samples. Indeed, Currie (2007) suggests that the most important issue to address is how best to help athletes with existing disordered eating issues.

For the wider population, studies have shown that help in the form of professional treatment involves identifying, and subsequently eliminating, key

maintenance mechanisms such as perfectionism and strict dieting (Fairburn *et al.* 2003). There are, however, few empirical investigations that directly address athletesô disordered eating experiences over time resulting in minimal insights into issues of maintenance and/or management. Further, researchers rarely examine how disordered eating might impact on athletesô personal ólifeworldô. Consequently, support efforts for this population may lack specificity and, ultimately, efficacy. Studies that focus on individual athletes with actual disordered eating experiences, describing the illness process, are essential if clues to appropriate management strategies are to emerge. Although therapist knowledge of the specific sport context is reportedly useful in providing athlete patients with appropriate support (Johnson 1994), there are few avenues for these professionals to retrieve such information. Resultantly, as detailed by anecdotal evidence (e.g. Sherman and Thompson 2001), athletes feel ambivalent towards treatment options and believe that their experiences are not understood by therapists. Research that gives voice to athletesô subjective perspectives on their struggles with eating may improve therapistsô and sport practitionersô understanding and sensitivity to what is a unique experience, albeit an experience that is culturally and contextually shaped and limited by the narrative resources available at the time.

This study aims to qualitatively explore athletesô experiences of disordered eating. Interpretative phenomenological analysis (IPA; Smith and Osborn 2003) will be used in an attempt to construct participantsô understandings of their experiences as disordered eaters, providing an alternative insight into disordered eating. Weaver et al. (2005) suggested that the understanding of disordered eating is often limited to the identification of behavioural responses, with scant consideration for the personal meanings individuals assign to their illness experiences. This study looks to redress this imbalance by highlighting athletesô personal perceptions whilst also placing these

perceptions in the context of relevant, existing literature. As stated by Schwartz and Cohn (1996, p. 2) with regards to disordered eating research ï ñtheories, figures, research, and methodology are based on real peopleò. The following report looks to bring such people to the fore in a manner absent from more traditional methodologies.

Methodology

Recruitment and selection

After receiving clearance from the university ethics committee, four females responded to materials recruiting individuals with experience of disordered eating within an elite sport context. Small, purposively selected and carefully situated samples are the norm in IPA work (Smith et al. 2009). We duly invited them to take part in an intake interview designed to explain the research focus and data collection methods, build rapport, and confirm the suitability of their experiences in relation to the study aims. The intake interviews lasted between 40 and 60 minutes, also allowing for the completion of information and consent forms. Clinical diagnosis of either bulimia nervosa or anorexia nervosa was not a prerequisite for inclusion in this study. The rationale for this decision was to avoid omitting individuals with clinical symptoms that had simply not received a formal clinical diagnosis. Further, athletes studied in the literature more often experience disordered eating as opposed to specific clinical eating disorders (Smolak *et al.* 2000). These symptoms can be physically and psychologically damaging in their own right (Chamay-Weber *et al.* 2005).

Helen, Sally, Nina, & Rachel (Pseudonyms)

We have provided a brief contextual synopsis for the participants, each of whom is of white ethnicity. The descriptions are in our words and reflect our interpretations of the athletesô stories.

Helen is twenty-four years old and pursuing an academic career. As a young child she developed a passion for sport that was encouraged by her parents. Aged eight she began ice-skating, which having quickly progressed to an elite level, soon became her life focus. Years later, while training for a national event, Helen collapsed on the ice. She was sixteen and weighed 35kg.

Sally is a twenty-three year old Masters-level student who also has a history in elite figure-skating. Desperate to follow in her older sisterôs footsteps she began competing as early as five years of age. Immensely talented and committed, Sally would later be victorious in national and international events, before being employed by a professional dance company. Her experience was characterised by calorie restriction, bulimic episodes, and clinical depression.

Nina is a nineteen year old undergraduate student currently competing as a tri-athlete for Great Britain. She excelled at swimming as a child, before her school physical education teachers recognised her talent for triathlon. A year ago she was clinically diagnosed as having bulimia nervosa. At the time of the study, even though her binge-purge cycles have ceased, she engages in severe food restriction and has lost considerable weight.

Rachel is eighteen years of age, the youngest of the four participants, and is also an undergraduate student. A naturally gifted distance-runner, she represented English schools (a representative squad of the best school aged athletes in the country) just over two years prior to participating in this study. This proud achievement was clouded by a preoccupation with weight and bulimic episodes. She no longer participates in athletics.

Interpretative phenomenological analysis

A core goal of IPA is to describe the participantôs subjective view of the world and the topic under investigation (Smith *et al.* 1997). IPA seeks an óinsiderôs perspectiveô (Conrad 1987) on individualsô ólived experiencesôand suggests this is achieved through a dynamic process involving both rich description and the researcherôs own interpretations of these (Smith *et al.* 1997, van Manen, 1990). Smith (2004, p. 40) encapsulated these two goals by stating that ñthe participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social worldò.

The principles of IPA are rooted in phenomenology. They draw heavily on the philosophical works of Husserl (1970) and Heidegger (1962), whose phenomenological perspectives refute positivist theories of knowledge in favour of the view that an individualôs personal reality should be accessed through first person accounts of lived experience. IPA is therefore concerned with an individualôs personal perceptions of a given experience, rather than attempting to produce objective statements regarding this experience (Smith 1996). It leans towards Heideggerôs hermeneutic phenomenology, which suggests we cannot bracket out our biases, but rather that we interpret experience based on our cultural and historical background, our ópre-understandingsô.

IPA was considered as a methodological tool due to its origins and regular presence in psychological inquiry, which is the authorsô area of specialism. Additionally, the dual commitment of IPA to the principles of phenomenology and hermeneutics make it a good fit in terms of yielding rich participant descriptions and combining these with psychological interpretation. IPA offers a subjective, meaning-centred approach that can illuminate, and add to, existing understanding of disordered eating in sport. Smith and Sparkes (2008) state that original versions of IPA present a

form of neorealism. Problematically, a neorealist perspective is philosophically untenable in that a contructivist epistemology cannot co-exist with a realist ontology (Smith and Deemer 2000). However, Eatough and Smith (2008) recently stated that as IPA is still becoming established there is room for reflection and development with regards to methodology, and they encourage dialogue with other philosophical stances. We therefore propose that IPA can function harmoniously as a ómethodological toolô with interpretivist underpinnings that assert multiple realities without sacrificing any of the principal objectives of IPA research.

Data collection and analysis

Typically IPA studies involve in-depth semi-structured interviews to elicit verbal accounts (e.g. Cottee-Lane *et al.* 2004), though the level of structure can vary. Limiting interview structure and the use of open-ended questions helps place the participant as expert, enabling unforeseen topics to emerge (Smith 1995). For this study, the broad opening question ï ñCan you tell me about your life around the time you first began to display symptoms of disordered eating?ò ï was designed to encourage the participant to lead the interview. Subsequent questions were not pre-set but rather dependent on participant responses as a process of co-construction of meaning was embarked upon. A small number of broad probes (e.g., Social relationships? Sport? Treatment?) were also prepared though rarely called upon as participants invariably addressed such issues in due course. This interview strategy was considered imperative to stay loyal to the fundamental principles of IPA. Interviews were conducted by Anthony Papathomas at his University office and lasted for between 90 and 129 minutes. Anthony has conducted other qualitative work on eating disorders (see Papathomas & Lavallee 2006) and has taken a counselling skills training course. As soon as possible after each interview, Anthony and David Lavallee

spoke on the phone. Here, Davidôs experience as a counselling psychologist provided emotional support if needed, as well as encouraging reflexivity and informal, preliminary analysis. Interviews were recorded digitally and transcribed verbatim.

Data analysis, guided by the procedures of IPA (Smith 1995, Smith and Osborn 2003), involved reading each transcript several times to achieve a sense of familiarity of the account as a whole. Loose annotations were made that identified and summarised initial points of interest. These early impressions were later transformed into several, inductive conceptual themes reflective of the participantsô accounts. Connections were then made between these themes and those that related to each other were clustered into superordinate categories. Once all participant interviews had been analysed in this way they were cross-referenced to each other. Specifically, Smith (1996) encourages a cyclical process whereby themes are compared across cases and, where warranted, merged. This inductive ócross-interrogationô enables commonalities and discrepancies across participants to be highlighted (Smith 2004).

Analysis continued into the writing-up phase with themes organised into a logical narrative account and illustrated using participant quotations. In turn, rich verbatim extracts were subject to the researcherôs own overt, analytical interpretations. The goal was to provide a critical and conceptual commentary placing the participantsô ódescriptionsô into a wider social context (Larkin *et al.* 2006). The researcher is empowered to be speculative and can ask questions such as ñdo I have a sense of something going on here that maybe the participants are less aware of?ò (Smith and Osborn 2003, p. 51). On this basis, tentative inferences were made, which with the phenomenological account still central, do not always agree with the views of participants. It is this process that is essentially the ódô in IPA. As with the interviews, analysis was led by Anthony with David acting as a ócritical friendô through each

analytical stage (Smith and Sparkes 2002). Davidôs role here was not to confirm or verify interpretations but to stimulate alternative views and encourage reflection on existing ones

Results

Three superordinate categories emerged from the data and have been organised into a coherent narrative that is representative of the participantsô lived experiences. These were: the struggle to disclose; social support needs; and identity challenges. Quotations, selected for their richness and capacity to relate to other themes (Smith and Osborn 2003), are interspersed with our interpretations. The reader should note that given that participants were reflecting on past life experiences, their accounts reflect what meanings these experiences hold at the point of interview. These constructions are contingent on all subsequent experience, present context, and the narrative resources and motivations of the time (Reissman, 2008). Accounts, therefore, may be different to what experiences once meant and what they may come to mean in the future. Frank (1995) also addresses this issue when he states ôthe stories we tell about our lives are not necessarily those lives as they were lived, but these stories may become our experience of those lives...Life moves on, stories change with that movement, and experience changesô (p. 22).

The struggle to disclose

Participants found it difficult to disclose their disordered eating behaviours to others. They perceived a stigma to mental illness that contradicted their identities as athletes and duly experienced feelings of shame and embarrassment. Efforts to disguise their weight concerns and disordered eating behaviours were often successful but led to feelings of isolation and prevented participants from receiving proper support.

Coupled with this eagerness to conceal was a desperation to disclose. This conflict proved an ongoing struggle and is most prominent in Ninaôs narrative:

> I was just a recluse. I would make excuses to not go and see people or not go out and socialiseé obviously I put on a front to say that I was fairly happy and you know, ñoh Iôm having a crap seasonò, you know, ñIôm just a bit bummed, bit de-motivated by it allò, but I wouldnôt tell them I was binging or purging at all. I didnôt want them to know

Ninaôs lack of disclosure forces her to withdraw from relationships to the extent she feels óa recluseô. This seems easier than suffering the burden of deceit involved with constantly concealing her true, disordered self. It also reduces the risk of undermining her social identity via other elite athletes knowing about her mental weakness. Inevitably, with support avenues closed, Nina descends into an emotionally unstable mental state. It is amid this psychological trough that the need to disclose is at its greatest, surpassing any fears of shame:

> in the end I had to tell them because it was only fair that they knew really, and I needed help at that time and I think I thought, you know, Iôve got to tell them because I need to start getting help with ité and thatôs what I did

Nina duly experienced many benefits from her disclosure, particularly in terms of social support. Sallyôs experience of disclosure was initially less successful. Sally was fearful of her mother who was demanding of success and hugely involved in her skating career. As Sally moves into the professional ice show arena her struggle to disclose intensifies:

> I was suicidal a lot of the time and I think he (boyfriend) was just really concernedé and I was just soé I canôt even explain really how I was like and he was the one that suggested going to see the GPé I kind of wanted to tell someone that was out of the loop because there was no one really, even my boyfriend worked for the same company

Feeling suicidal, Sally struggles to communicate into words what her mental state was like at this point. She desperately wants support and is aware it is dependent on disclosure. Sally is unable, or unwilling, to disclose to people within the show, which rules out most, if not all, of the people she knows. In direct contrast to Nina, the fear of stigmatisation outweighs the need for support in what is an ongoing struggle for

Sally. Although she eventually confides in her GP/physician, she only discusses her depression and not her disordered eating issues.

Social support needs

Participants discussed the impact of receiving and not receiving social support on their respective experiences. A lack of social support, a lack of understanding, fear of burdening others, and parental support emerged as the key themes.

A lack of social support

Given the previously identified óstruggle to discloseô, there was a perceived lack of social support across the board. Rachel expressed a distinct sense of isolation from her peers:

> I felt like my friends, none of my friends were like runners or training as much as I was so there was no one else close to me had, like, anything to compare it to, I donôt know if they did, but at the time it was like, only meé that felt crapé about it (weight)

As none of Rachelôs friends compete to the same level, she feels alone when facing the associated stressors. In highlighting a lack of opportunity to ócompareô experiences with others, Rachel underlines her naivety with regards to weight-related concerns and how best to confront them. Without peers to act as a frame of reference she naturally feels unguided and uncertain, which contributes to her distress. How typical are her experiences? Are her fears justified? In Rachelôs world, she is the only person that feels dissatisfaction with her body weight.

The demands of sport may also limit peer support by more simple means. Often athletes are required to move away from home to receive expert coaching and consequently, as in the case of Sally, leave behind important friendships:

> I donôt know, I guess I kind of just wanted to be looked after but I wasnôté I had two really close female friends at home that Iôd known for fourteen years but when I moved away they, I donôt know what happened really, I lost touché it was such a big hole in my life not having those close friends there

Wanting to be ólooked afterô is an almost childlike desire and perhaps indicative of the vulnerability and helplessness Sally feels amid incessant pressures to lose weight. The óholeô metaphor connotes the impact of lost friendships. There is an incompleteness, a gap in resources, that hinders Sallyôs ability to cope.

A lack of understanding

Some of the athletes perceived a lack of understanding of mental illness and this was considered a barrier to receiving social support: ñI just donôt think he knew how to deal with it himself really, a lot of people I donôt think do know how to approach those issues with someone. Just turn a blind eye really I thinkò. Sally suggests the nature of mental health conditions makes it difficult for potential support providers, her boyfriend in this instance, to know exactly how they might help. In many ways psychological issues are covert and taboo. This taboo makes broaching the subject awkward and comprehending it, a struggle. As she implies, it may be less threatening for people to turn a blind eye and avoid than to assist.

A lack of knowledge and understanding was not limited to lay people, as indicated by those athletes who experienced consultations with medical professionals. Nina expressed great dissatisfaction with an eating disorder specialist:

> é seeing the psychotherapist his opening sentence for me was ñwhy do peacocks have such nice, pretty, fanned feathers?ò and I was like ñwell, to attract a maleò, ñyes, thatôs why women have, you know, fat round the breasts and you know the thighs and everything, you know, to attract the maleòé they donôt see it as a sporting issue

The therapistôs peacock analogy represents a crude attempt at cognitively reframing Ninaôs perception of the feminine ideal. Her frustrations are palpable as the analogy bears little relevance to her experiences as an athlete with disordered eating. Her speedy intolerance however is perhaps also indicative of an underlying discomfort with psychological therapy. This interpretation seems feasible given the following statements that contradict Ninaôs frequent, repeated claims that she is in the process of

óseeking helpô: ñI donôt like saying Iôm seeing the psychologistéî I stereotype it as youôve got a head issueò. Clearly, the stigma associated with professional support perturbs Nina seemingly more than her disordered eating does. It serves as official confirmation of her mentally ill status, thus impeding on her sporting self-concept.

Fear of burdening others

Participants were not always ready to take advantage of potential support. The following passage from Sally illustrates this well:

> I just feel guilty about off loading on to themé I feel I just donôt want to worry them and I donôt want to, I feel like I can just, you know, Iôll get through it on my own really butéî I havenôt reallyé I just donôt want to come across as someone thatôs just constantly, you know, not moaning but, like, getting down

She uses the term óoff loadingô, which carries quite stark negative undertones of somebody selfishly inflicting óallô of onesô problems onto a reluctant other. Believing she will burden her friends she fears their opinion of her may be lessened. This is a distressing prospect for Sally who duly attempts, albeit unsuccessfully, to óget throughô alone.

Parental support

Parental support was of great significance to all athletes and it was usually discussed in terms of its perceived beneficial effects. As Helen began to lose weight, her parents intervene:

> They always expressed concerns and had chats with me although at that stageé I didnôt really think anything was the matter. So I just told them ñI donôt know what youôre going on about but thanks for being concernedò and, like, you know, ñitôs nice to know if something was the matter with me youôd be thereò

As Helen does not perceive herself to have a problem she is content in brushing aside her parentsô concerns. Their efforts appear not to be wasted, however, as she is made aware that support is available should she need it. Accordingly, when she eventually becomes aware of her problem, she turns to her parents first: ñI just went home and

cried and cried with my mum and said to my mum that I wanted to go back to the doctorsò.

Identity challenges

Disordered eating experiences impacted greatly on each athleteôs identity. Many of the challenges centred on the participantsô athletic identity and were therefore specific to athletesô experiences. Constituent sub-themes consisted of the disordered self versus the athletic self, the struggle to withdraw, a continued struggle and making sense of illness.

The disordered self versus the athletic self

First and foremost, athletes experienced a huge discrepancy between their athletic-selves and disordered-selves. The struggle between the two figured throughout each narrative, often impacting on the other key themes. The conflict became more overt as pathological behaviours persisted and worsened:

> I would compromise my training to have a binge, thatôs how unbothered I was about myself as an athleteé being such a competitive and committed person to my sport, to not be too fussed about missing a session or, you know, cutting it short to have a binge. That kind of reflects how low in my trough I was

Ninaôs bulimic symptoms contrast significantly with her conception of an athlete as ócompetitive and committedô. Moving from this conception to being ónot too fussedô represents a serious threat to her athletic self. She continued:

> I just want to stay in bed with the curtains drawn and just withdraw and as I said thatôs not what I feel like normally, thatôs not who I am, you know, normally I canôt wait to get out of bed to see the day, to do training

Nina rejects her disordered, unmotivated self, stating óthatôs not who I amô. Her subsequent outline of her former self, energised and motivated, is prefixed by the word ónormallyô emphasising this as her órealô identity ahead of her current óabnormalô one. As the disorder persists however, the less of the órealô Nina we see and this is clearly troubling for her.

The struggle to withdraw

Each of the athletes experienced a struggle as to whether or not they should withdraw from their respective sports:

> Rachel: Itôs just like, you donôt want to do something but you know, well I knew, I felt like I had to, it was something I had to do. There was no way I could turn round to anyone and say ñoh look I donôt want to do it anymoreò
> Interviewer: Why was that?
> Rachel: ...because I felt like it was what I didé (long pause)é it was just what I did and I couldnôt turn round to anyone and say ñI canôt do it becauseé ò, it just didnôt even seem like a possibility, it didnôt seem like there was an option. Just something I had to do

Rachelôs sporting experiences deteriorate such that she would rather stop competing yet she feels obliged to continue. She reasons ñit was what I didô, which implies that being an athlete is so ingrained in her sense of self that a lack of motivation and enjoyment will not interrupt her involvement in anyway. The view is reinforced by significant others, emphasising an athletic social identity that acts as an added pressure to persist. If she is no longer Rachel the athlete, who is she? The prospect of such identity loss is too daunting to contemplate.

The athletes who managed to successfully cease competitive sport described a broadening of identity as an important element of the process:

> I know most of them (fellow skaters) didnôt do GCSEs. Theyôve gone from skating to the show, they donôt know anything else out of that, whereas I did know that there is more to life than just that, and I think thatôs what I realised when I left the show when I went to uni and thatôs what made me so much happier and made the problems less

Sally perceives her background in education gave her an awareness that there may be more to life than sport. This perception is illustrated when Sally commences higher education and becomes successful. Achievement in a different domain serves to broaden Sallyôs identity and ease the withdrawal process. Helenôs experiences are of a similar vein:

> I actually did have a brain and that I could use it and I started to do really well soé I think that I found something else that I was good at so it hasnôt upset me too much

The link between success in academia and a less troublesome move out of sport is reiterated. A new, or broadened, sense of self reduces feelings of identity loss.

A continued struggle

Once removed from the elite environment there was some alleviation of the severity of disordered eating symptoms, although all the athletes discussed a continued struggle with issues regarding food and weight:

> I still think sometimes oh I need to, like, I should be this weight and a lot of the time Iôm just not really that happy or content with what I see in the mirror or when I weigh myself and I mean obviously Iôm not doing it for sort of the sporting reasons but itôs still there really, like underlying, itôs still sometimes there and I go through stages. Iôve almost come to terms with the fact that maybe I will always have that

Sally expresses a continued dissatisfaction with her body and weight. She emphasises that although the appearance-based pressures of elite figure skating are gone, her concerns persist. Sally accepts some dissatisfaction may pervade her life, indicating a permanent change in self. Helen reflected on her own enduring issues:

> when you have an eating disorder it just doesnôt last for that period of time that you have it, it does carry on into your life and sometimes you donôt always get over it. I would never let myself lapse into that situation again now because I can see the signs but I think you always carry a little bit of your past with you

As with Sally, the implication is that though the absence of sporting pressures eases concerns about weight, many issues prevail albeit less dominantly.

Making sense of illness.

Participants often tried to find something meaningful from their experiences. This was useful in terms of making sense of illness. Helen provided a sound example of how she has drawn positives from her ordeal:

> you should never regret something thatôs happened but be glad itôs happened and learn from it, so Iôm glad itôs happened because Iôd never do it again. Iôm always, always aware nowé Iôm glad to have lived that experience

Helen sees futility in harbouring regrets, instead choosing to be happy at having gained valuable knowledge and experience. A lesson has been learnt that ensures she is óalways awareô and will avoid such extreme behaviour in the future. Perceiving a positive outcome is important in terms of understanding and acceptance. Rachel was

also able to draw positives though not all elements of her experience were considered beneficial:

> God if I hadnôt have changed coaches and started to hate it so much, if Iôd just kept doing it because I enjoyed it, then maybe Iôd have got to that level. If I watch races on telly Iôm like ñoh I wish I was still racing and competing and enjoying it as I used toò

Rachel expresses a deep regret at having changed coach. She feels the change contributed to her disordered eating and ultimately not reaching her full potential. By regretting the past, as opposed to accepting it, Rachel is unable to properly move forward with her life.

Discussion

This study adds to existing knowledge of disordered eating in sport by documenting athletesô personal meanings and subjective experiences of the life as lived. We now discuss the three emergent categories in relation to appropriate literature and research and in terms of their implications for sport practitioners and therapists. Given the cases in this study are not representative we do not provide practitioners/therapists with specific or definitive guidance as to how individual athletes be treated but rather offer how an appreciation of the sporting context might inform some decisions on practice.

The struggle to disclose emerged as a significant stressor for athletes as they grappled with a fear of disclosure and a need to disclose. Most of the athletes felt ashamed of their illness and, fearing further stigmatisation, took various steps to conceal it. Similarly, Petterson *et al.* (2008) recently found that in patients with bulimia, the need to preserve dignity and avoid stigmatisation was so great that a ódouble lifeô was led whereby dishonest strategies of concealment were employed. Other research has found that feelings of shame and fear of stigma are prominent barriers to help-seeking (Hepworth and Paxton 2007) and not fully disclosing in

treatment settings (Swan and Andrews 2003). This stigmatisation may be accentuated in an athletic domain where mental strength is valued both culturally and in terms of individual identity. Developmentally, identity formation is dependent on what, at the end of childhood, individuals mean to themselves and to significant others (Erikson 1977). Disclosure may endanger these established personal and social understandings of self, thus posing a threat to identity. Therapists encountering athletes in treatment settings, or coaches who suspect disordered eating, should be mindful that ones status as an athlete may magnify perceived stigma potentially minimising their willingness to disclose.

Echoing Ninaôs narrative specifically, it is further suggested that the act of concealment is in itself exhausting, mentally and physically, leading to feelings of shame and social isolation (Petterson *et al.* 2008). It is this negative affect and lack of social support that contributed to athletesô desperation to disclose and the consequent conflict with their desire to conceal. Regardless, three athletes avoided disclosure until near emotional breakdown. This finding is again consistent with the Petterson *et al.* (2008) study that found that eventually the need to talk becomes stronger than the need to hide. This is a painful process to endure that a therapistôs concerted efforts to de-stigmatise (see Gowers and Shore 1999) might prevent. Researchers in psychology should look to explore how perceived stigma differs between athletes with disordered eating and sufferers in the ónormalô population, as well as its impact on their life experience and their ability to disclose and receive appropriate support and treatment.

Athletes generally perceived a lack of social support with their eating problems and were dissatisfied with much of the support they did receive. This is consistent with a previous study by Tiller *et al.* (1997) that found eating disorder patients experienced impaired social networks, reported lower levels of actual

emotional support, and were more dissatisfied with received support than their healthy counterparts. Even after they had disclosed, athletes feared appearing to be a burden to support givers and so were less likely to make use of them. Given the largely negative impact of disordered eating on care-givers (Honey and Hasle 2006) this fear of burden may not be without foundation. Further, there was some concern expressed with regard to the competence of therapists, particularly with regards to understanding a sporting case, which discouraged athletes to engage with professional support. This corresponds with the findings of Sherman and Thompson (2001), who suggest athletes with eating problems often feel misunderstood by mental health practitioners. That is, athletes feel their experiences are not fully appreciated by professionals who are more practiced in dealing with non-athletes. To counter this misunderstanding, disordered eating specialists may benefit from an appreciation of sport and its associated cultures. Gardner and Moore (2006) express a similar sentiment when they suggest treatment of mental issues in athletes can be facilitated by knowledge of the sport experience.

Athletes described the absence of support as something that added to the difficulty of their experiences. Whether this finding translates as the presence of social support potentially assisting recovery is an issue for debate. Rorty *et al.* (1999) reported that individuals in remission from bulimia possessed a greater number of emotional support suppliers than those who were symptomatic. Due to the cross-sectional nature of this study it is difficult to decipher the causal direction of this relationship. Specifically, does increased social support facilitate recovery or vice-versa? The narratives of the participants suggest the former, as symptoms were alleviated after disclosure and the availability of support. Longitudinal studies are needed to investigate the impact of social support, from a multidimensional

perspective, on disordered eating over the entire course of the illness. Such studies will be particularly useful with athletic samples where social support research has predominantly focused on the impact on either coping with injury or performance (Holt and Hoar 2006) rather than disordered eating issues.

Identity issues, in particular the presence of a strong athletic identity, shaped many aspects of the athletesô experiences. Athletic identity has been defined as the degree to which an individual identifies with the athletic role and its related social status (Brewer *et al.* 1993). Brewer and Cornelius (2001) further conceptualised athletic identity as a three-factor multidimensional construct whereby the first order factors of social identity, exclusivity and affectivity contribute to the overall higher order factor of athletic identity (Brewer and Cornelius 2001). Social identity is considered the extent that an individual adheres to the athlete role, exclusivity refers to the extent that self-worth is determined solely by performance and negative affectivity is the extent that negative affect occurs given unsuccessful performance (Hale 1995).

Athletes in the present study perceived their disordered self as incompatible with their athletic conceptions of self and this caused considerable stress. Identity theorists suggest large discrepancies between ówhat isô and ówhat should beô, or óthe real selfô and óideal selfô, can be a source of anxiety (Adams and Marshall 1996). To this end, disordered eating represents a threat to athletesô athletic identities, with its associations with vulnerability creating distance between the real and the ideal. Such a óbattle for selfô places a great burden on athletes and contributes significantly to the overall anguish of the disordered eating experience. Athletes often coped by attempting to reject the disordered self as a temporary, intruding, entity that will eventually submit to the real athletic self. Smith and Osborn (2007) noted a similar

process in individuals who experienced unwanted changes in self as a result of chronic back pain. To speculate, though such rejection of an unwanted self may, temporarily, preserve the preferred self, it may also serve as a form of denial which hinders recovery. Therapists may need to consider methods as to how a disordered self can be acknowledged, and consequently addressed, without it encroaching on the preferred self.

Although withdrawal from sport was often considered a potential escape from sporting pressures and associated disordered eating, all the athletes found the idea troubling and, to a large degree, unfeasible. Upholding the role of an athlete to oneself and others (social identity), was too pivotal an aspect of the self (exclusivity) to simply move on from. Athletes seemed ready to endure psychological illness rather than risk identity loss. This preference stands to reason given individuals with strong athletic identities traditionally find transitions out of sport difficult and emotionally disturbing (Grove *et al.* 1997). Athletes who eventually did manage to withdraw, did so by broadening identity through an alternative endeavour (e.g., academia), thus reducing the exclusivity of their athletic identities. Again, this is consistent with other citations of more successful transitions out of sport (e.g. Grove *et al.* 1997). This finding represents an important consideration for therapists, and the coaches they advise, who often insist on complete cessation of sporting activity, particularly if the athlete has anorexia nervosa and is symptomatic (Sherman and Thompson 2001). It may be beneficial to devise ways to broaden athlete identity to facilitate this process. It is, however, worth noting that a more successful transition did not translate to a complete alleviation of symptoms, supporting suggestions disordered eating in sport can be pathological and chronic as opposed to purely behavioural and transient (Papathomas and Lavallee 2006).

Narrative psychologists suggest individuals subject to trauma, experience a disruption of their life narrative that serves as a threat to identity (Crossley 2000). Participantsô efforts to seek positives from an essentially negative experience can be viewed as an attempt at regaining coherence and meaning through narrative restructuring. Such a process is crucial to psychological well-being (Smith and Sparkes 2008) and links well to similar perspectives that suggest understanding, acceptance and an evolving identity are important if an individual is to move on from a deeply troublesome experience (Harvey *et al.* 1990). The harbouring of regrets however, as evident in Rachelôs narrative, may well thwart such progress. Those approaching treatment from a counselling standpoint may encourage the formation and telling of narrative accounts of experience.

In conclusion, the use of qualitative methods, and specifically IPA, has provided an alternative account of how athletes themselves perceive the experience of disordered eating in sport. Athletesô personal perspectives can provide therapists with knowledge of how sport impacts disordered eating. The conflict between the disordered self and the athletic self poses a major threat to identity and manifests itself in terms of increased feelings of shame and stigma, which can limit access to appropriate sources of support. A reduction in the exclusivity of athletic identity may be necessary to ease identity loss should a move away from sport be desired. The largely retrospective interviews used in this study enabled access to disorder development and process. Future research should look to build on retrospective accounts by conducting a number of prospective interviews with athletes in the midst of disordered eating.

Having reflected on this work we would like readers to consider, amongst other things, the following when making a judgement: Are athlete quotes sufficient in

number and length so as to allow voices to be heard? Are the selected quotes moving and emotionally engaging, providing feelings of empathy and social connection? Are interpretations grounded in the data, logical, indicative of sound, existing psychological theory and welcoming of critique and alternative interpretations? Further, and with specific reference to the topic of disordered eating, might the constructed accounts help professionals gain some appreciation of how athletes make sense of their disordered eating experiences and the psychological impact it has on their lives? Could it provide a source of support for athletes themselves who may be struggling to understand the reasons for their experiences? Might the perspectives shared here reduce athletesô feelings of isolation and stigma? Could athlete readers be encouraged to seek professional help? Finally, we would like to take this opportunity to emphasise that the ideas expressed in this paper are indicative of a socially constructed reality contingent to a particular time and space. Our suggestions are not final and we encourage other researchers to direct diverse qualitative methods and other ways of knowing towards what we believe to be a critically important topic of study.

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