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

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Keywords:	asthma, sports, embodiment, vignettes, identities
Abstract:	<p>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.</p>

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4 **Conformers, Contesters, and Creators: vignettes of asthma identities and**
5 **sporting embodiment**
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11 **Abstract**
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14 examine the different ways in which sportspeople experience asthma, a condition that
15 affects 5.4 million people in the UK. To date, sociological phenomenology has been
16 under-utilised both in relation to health and illness experiences and vis-à-vis sporting
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25 heuristic framework to assist healthcare and sports professionals in understanding
26 asthma experiences as lived in everyday life, and potentially in developing more
27 appropriate and effective care regimes for sportspeople in order to improve the quality
28 of that everyday life.
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Conformers, Contesters, Creators: vignettes of asthma identities and sporting embodiment

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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3 **UK, 2014; de Lara & Noble, 2007)**; asthma affects one in five homes, with around
4
5 4.3 million adults having asthma (Asthma UK, 2014a) and around 1.1 million
6
7 children; 2014b). Asthma is one of the most common chronic illnesses and whilst
8
9 usually not considered a ‘serious’ illness, nevertheless, during 2011–2, there were
10
11 over 65,000 hospital admissions for asthma in the UK **costing the National Health**
12
13 **Service (NHS) around £1 billion a year (Asthma UK, 2014;** Royal College of
14
15 Physicians, 2014). Three people die every day in the UK from asthma-related
16
17 problems, despite many of these deaths being avoidable (Asthma UK, 2014). **Sport**
18
19 **and exercise, for those with asthma, are encouraged by medical professionals**
20
21 **and bodies, such as Asthma UK (2014), so long as the asthma is deemed to be**
22
23 **‘well controlled’.** This underlines the importance of investigating the lived
24
25 experiences of sportspeople with asthma, given the current dearth of qualitative
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27 research in this domain, particularly in non-elite adult sportspeople, many of whom
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29 are affected by exercise-induced asthma or bronchoconstriction.
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35 Exercise-induced asthma (EIA) occurs when asthma symptoms are provoked
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37 by exercise (Wilmore et al., 2008), and is found in about 80%–90% of all asthmatics
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39 (McArdle et al., 2007). Whilst asthma has been found to influence **daily** physical
40
41 activities, sporting preferences and participation levels (Colland et al., 2004), physical
42
43 training poses a particular problem for asthmatics given that the majority of **those**
44
45 **diagnosed with asthma** are at least susceptible to EIA (Pedersen & Saltin, 2006). On
46
47 the one hand, exercise provides a potent stimulus for bronchoconstriction (Carlsen &
48
49 Carlsen, 2002), whilst on the other, regular physical activity demonstrates physical
50
51 and psychosocial benefits and is deemed important in asthma rehabilitation and
52
53 education (McArdle et al., 2007). Sport therefore appears to act as a ‘double-edged
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55 sword’ for many sportspeople with asthma. This ‘sword’ may become more
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3 multifaceted when considering an individual's readiness to accept a diagnosis of
4 asthma, and how this interacts with the strength of their 'athletic identity' (Brewer et
5 al., 1993). This complexity means there are risks associated with reducing asthma
6 treatments to single types of interventions and a 'one-size-fits-all' approach, and the
7 latter is unlikely to be effective (Douwes et al., 2010).
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14 When people with asthma experience their symptoms, they engage in a
15 process that is culturally informed (Becker, 1999) and also subculturally contoured
16 (Allen-Collinson & Owton, 2012). It is important therefore better to understand the
17 lived experiences of sportspeople with asthma who may become acutely aware of, and
18 attuned to, their breathing in ways that link the physiological, the psychological, the
19 social, and the environment (Allen-Collinson & Owton, 2012). Despite its reported
20 prevalence, and with some key exceptions (e.g. Tiihonen, 1994; Owton, 2012, 2013a,
21 2013b, Allen-Collinson & Owton, 2012), there is a distinct dearth of qualitative
22 literature on the lived experience of asthma amongst sports participants, particularly
23 utilizing a 'carnal sociology' (Crossley, 2005) framework. As Wacquant (2014)
24 notes, this approach takes seriously the (sometimes embarrassing) notion that social
25 agents are motile, sensuous, and suffering creatures of flesh and blood, doomed to
26 death, and importantly this proposition applies equally to the sociologist/researcher as
27 to the participants studied. As Wacquant (2014: 10) continues, 'Carnal sociology is
28 based on a bet (or a dare): that we can turn carnality from problem to resource for the
29 production of sociological knowledge'.
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50 The qualitative research project described below was therefore initiated with
51 the aim of addressing the research lacuna regarding qualitative and carnal sociological
52 inquiry into asthma and sporting embodiment. Before describing the research, for
53 those unfamiliar with a sociological phenomenological framework, we first provide a
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3 brief overview of this perspective which is now producing a developing corpus of
4
5 research portraying sports participation and sporting embodiment in various domains
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7 (Hockey and Allen-Collinson, 2007; Allen-Collinson, 2009; **Owton**, 2012; **Allen-**
8
9 **Collinson & Owton**, 2012).

14 **Sociological phenomenology and sports studies**

16 The key tenets of modern-day phenomenology (the study of things as they appear in
17
18 consciousness) are generally attributed to the philosopher, Husserl (1970), who
19
20 advocated the phenomenological method for investigating phenomena as the ‘things
21
22 themselves’ via the suspension or bracketing of our ‘hitherto existing convictions’
23
24 (1970: 76). Thus, phenomenology requires that we do not simply participate in the
25
26 world in our mundane, routine, taken-for-granted ways, but attempt to bracket or
27
28 stand aside from this ‘natural attitude’ so as to: ‘...contemplate what it is to be a
29
30 participant in the world, and how things present themselves to us’ (Sokolowski, 2000:
31
32 48). Such bracketing is not an unproblematic quest for sport sociological researchers,
33
34 **and indeed for sociologists in general**, as has been noted (see for example Allen-
35
36 Collinson, 2011a), **given that we are all culturally and social-structurally**
37
38 **embedded and so cannot entirely ‘stand outside’ of our socio-cultural location,**
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40 **including our language forms (Allen-Collinson, 2011a).**

45 With regard to sports studies, Kerry and Armour (2000) highlighted the
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47 ‘promise of phenomenology’ some time ago, **and a body of work has been slowly**
48
49 **emerging both before and since this time** (see for example, **Rail, 1992**; Hockey
50
51 and Allen-Collinson, 2007; Allen-Collinson, 2009; Hogeveen, 2011; Martínková and
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53 Parry, 2011; Müller, 2011; Allen-Collinson & Owton, 2012). Phenomenology has
54
55 been found of relevance to sport sociologists, particularly with regard to its focus
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3 upon the ‘lived body’ (*Leib*), the body as lived in the ‘lifeworld’ (*Lebenswelt*), that is
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5 the ‘local’ world of everyday, including the intersubjective communities of which we
6
7 are a part. In terms of the corporeal, the existential phenomenologist, Merleau-Ponty
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9 (2001), argued for the centrality of the body in our ‘being-in-the-world’, and in his
10
11 later work (1969) utilises the terms ‘flesh’ (*chair*) and ‘flesh-of-the-world’, so as to
12
13 highlight our fleshy being, our ‘corpo-reality’ (Allen-Collinson and Owton, 2012: 3),
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15 the bodily-groundedness of lived experience. To date phenomenological – and
16
17 sociological phenomenological - insights have been drawn upon by researchers
18
19 investigating a range of sporting and physical cultural domains. These include: the
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21 acquisition of skill in sports (Standal and Moe, 2011), running and scuba diving
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23 (Allen-Collinson and Hockey, 2011), freerunning (Clegg and Butryn, 2012), long-
24
25 distance walking (Crust et al. 2011), boxing (Allen-Collinson & Owton, 2014),
26
27 various forms of martial and self-defense arts (e.g. Samudra, 2008, Spencer, 2013),
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29 golf (Ravn and Christensen, 2014) and soccer (Hughson and Inglis, 2002) to give just
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31 a flavour of this developing literature.
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36 So, we might ask, what does the specific nexus of sociology and
37
38 phenomenology offer the sociologist of sport? Bringing a sociological lens to bear
39
40 on insights drawn from phenomenology, we argue, allows researchers to bring to the
41
42 fore the considerable impact of social-structural forces upon our lived sporting
43
44 experience. As Allen-Collinson and Hockey (2011: 332) note, the sociological lens
45
46 allied with phenomenology emphasizes the ‘structurally, politically and
47
48 ideologically-influenced, historically-specific, and socially situated nature of human
49
50 embodiment and experience’. More social and sociological forms of phenomenology
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52 have of course a considerable tradition, exemplified by the work of Schütz (1967),
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54 whose interest in the lifeworlds of intersubjective communities is of particular
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3 salience. Feminist and queer phenomenological perspectives have also provided
4 further insights into, amongst other things, the specificities of gender, age, ethnicity
5 and sexuality in our being-in-the-world, including in the sporting world (see for
6 example, Young, 1998; Ahmed, 2006; Chisholme, 2008; Allen-Collinson, 2011b).
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11 Drawing upon a phenomenologically-inspired approach, Frank's work (1993,
12 1995) provides a means of studying stories of illness through an examination of the
13 body, a perspective that is apposite for the current study. Frank argued that, 'people
14 telling illness stories do not simply describe their sick bodies; their bodies give their
15 stories their particular shape and direction' (Frank, 1995: 27). Referring to
16 Kleinman's (1988) sophisticated analyses of the interweaving of bodies, cultures, and
17 lives, Frank reinforces the importance of understanding how bodily symptoms are the
18 *infolding* of cultural traumas into the body and as these bodies continue to live and
19 create history, these symptoms *unfold* into the social space of that history. Frank's
20 (1995) focus is on *body problems* and he posits four general problems of
21 embodiment: control, body-relatedness, other-relatedness, and desire. Furthermore,
22 each body problem is a problem of *action*: to act, a body-self must achieve some
23 working resolution to each problem. Frank (1995: 30) provides a continuum of
24 possible responses via a matrix of four ideal typical bodies: the disciplined body, the
25 mirroring body, the dominating body and the communicative body. He also creates
26 three basic narrative types: Restitution, Chaos, and Quest, as useful devices. To
27 avoid risking creating yet another 'general unifying view', however, Frank
28 emphasises that no actual telling conforms exclusively to any one of the three
29 narratives, but rather he suggests that these narratives encourage closer attention to
30 the stories an ill person tells.
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3 Having portrayed the phenomenologically-inspired theoretical framework that
4 guided our research and provided a lens to analyse and understand the lived and
5 sensory experiences of asthma and sporting embodiment, we now describe the
6 research itself and the methods used to generate the vignettes presented below. These
7 are utilised in an effort to provide the reader with an evocative, detailed and
8 empirically-grounded insight into the lived experience of sportspeople with asthma.
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16 **Research approach and methods**

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

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49 Loosely-structured, 'life-world' interviews were conducted by the first author,
50 in an attempt to 'understand themes of the lived daily world' from the participant's
51 own perspectives (Kvale and Brinkmann, 2009: 10). An open 'go with the flow'
52 approach was adopted, allowing the introduction of new issues as each interview
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3 proceeded, and thus the interviews became more interviewee orientated,
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5 commensurate with the phenomenological approach (Allen-Collinson, 2009; Crust et
6
7 al., 2014) we adopted. Follow-up interviews were conducted with all participants,
8
9 and the rough interview guide was also open to new and unanticipated directions to
10
11 account for individual differences and emergent themes (c.f. Charmaz, 2004).
12
13 Schwalbe and Wolkomir (2002) reinforce the importance of ongoing data analysis
14
15 and note that, to delay analysis until ‘all the data are in’ is to miss the chance to make
16
17 midcourse adjustments and seek precisely the data needed to strengthen an emerging
18
19 analysis. Initial data analysis therefore identified certain avenues to follow up in
20
21 subsequent interviews, and as interviewing progressed, richer stories were generated.
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25 In addition to our phenomenologically-inspired analysis, drawing upon
26
27 Giorgi’s (1997) empirical-phenomenological method, data were also analysed via an
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29 inductive narrative analysis that was instrumental in developing the ‘ideal types’.
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31 Narrative inquiry was employed using stories to describe human experience and
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33 action (Oliver, 1998), as narratives have been argued to provide a structure for our
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35 very sense of selfhood and identity (Smith and Sparkes, 2009a, 2009b; Sparkes,
36
37 2004). Crossley’s (2000) steps of narrative analysis were employed and involved
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39 repeatedly reading through the whole interview transcript five or six times to gain
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41 familiarisation and a general gist of emerging and significant themes. The second
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43 stage involved grasping principal elements of the *personal narrative*, which included:
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45 narrative tone, imagery, and themes (McAdams, 1993). In addition to these forms of
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47 analysis, Denzin’s (1989) Interpretive Biographical Analysis was employed,
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49 specifically to explore epiphanies or turning-point experiences, moments of
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51 existential crisis when a person’s identities can be forcefully and dramatically called
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53 into question.
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3 The purpose of empirical phenomenological research is not focused upon
4 abstraction and theorisation, but rather upon the detailed, rich description of
5 phenomena, and we have therefore sought to keep theorisation to a minimum. From
6 a sociological perspective, however, it can be argued that in order better to
7 understand something we must go beyond mere description, and proceed to interpret
8 it, including via classification. Sociological typologies have thus proved useful in
9 addressing various illness conditions (see for example, Schneider and Conrad, 1981;
10 Frank, 1995). Drawing upon this approach, and for heuristic purposes, we
11 constructed a threefold typology of sporting asthma identities or being-in-the-world,
12 based on the ideal types of: Conformers, Contesters, and Creators. Commensurate
13 with a phenomenological perspective, and with Frank's (1995) insights, we wish to
14 stress the fluidity and context-dependency of these ideal types. Our participants,
15 perhaps unsurprisingly, did not always fit neatly and squarely within the categories of
16 the typology and at certain times might change from one dominant aspect to another.
17 For example, during the period of winter training, cold air may provoke an asthma
18 'flare up', resulting in more 'conformer-like' behaviour as people seek to manage
19 their symptoms with an inhaler. The typology has thus been generated for heuristic
20 purposes, given the uncertain and elusive nature of asthma, and we fully
21 acknowledge the mutability and flux of felt identities and ways of being-in-the-world.
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45 Whilst a typology is analytically useful in describing 'ideal types', we also
46 want to represent people's stories in a less 'dry' fashion, one that is more evocative
47 and narratively-rich, in order to explore the beliefs, values, attitudes, perceptions,
48 thoughts and meanings drawn upon by our participants. We have thus chosen to
49 present the empirical data, generated by the participant interviews and thematised
50 into the threefold typology, via means of vignettes. Vignettes are short narratives
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3 written to show specific scenarios (Sparkes and Smith, 2013), and can be used to
4 represent data (as here) or to collect the responses that the vignettes of a particular
5 situation elicit (Sparkes and Smith, 2013). The vignette approach, we hope, will thus
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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.

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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3 again'. Conformers appear constantly to strive for this restored state of health,
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5 including via use of their inhaler(s)¹, which can serve as a 'quick fix' in reducing
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7 symptoms such as wheezing and difficulty in breathing. Conformers seek to 'control'
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9 asthma symptoms, primarily via the use of inhalers, and thus to gain some
10
11 predictability vis-à-vis their condition, commensurate with Frank's (1995) concept of
12
13 the 'disciplined body' that seeks control and predictability. As emerged from the
14
15 data, it is often their reliance upon medical regimes, particularly the use of inhalers,
16
17 that allows Conformers to have this control and to 'silence' their symptoms,
18
19 permitting them to carry on without undue disruption to their everyday sporting lives.
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21 Typically, our Conformers indicated: 'I'm in control... mind over matter'. Jennifer
22
23 exemplifies this ideal type.
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28 **Jennifer:** I am asthmatic but I've never really considered that I am. It's just
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30 me. From the physical point of view I don't suffer with it because I take my
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32 inhaler. When it flares up, it's rubbish, but if it doesn't then it doesn't really
33
34 worry me. All I have to do is take one in the morning and one in the evening
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36 and that seems to work and I have my blue relief inhaler which I take as and
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38 when I need it.
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41 One time it flared up and I just kept coughing and coughing and coughing
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43 so I went to see the asthma nurse. She said, 'increase your inhalers', but it
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45 didn't make any difference. She said, 'come back and see me' three times and
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47 then, 'oh, I think you should see a doctor now'. I saw the doctor and he goes,
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49 'yep, you need antibiotics'. Maybe if someone had done something a bit about
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51 it before I might not need antibiotics; I might have had some sleep. It was
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53 horrible not sleeping, because as soon as I lay down, I just coughed and
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55 coughed and coughed. For 3 months I was like that. After that, I always use
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3 my inhaler twice a day.
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5 But there's two things really: there's the tight chest where you're kind of
6 short of breath or a bit wheezy and then there's the other extreme where you
7 literally can't get any air into your lungs. That's happened twice now at night -
8 as you're waking up, you realise you can't breathe and it's horrible as you wake
9 up, 'Oh god, I can't breathe' and I panic. It's a bit scary, but I get my inhaler
10 and take that and I kind of go back to normal.
11
12

13 Now, it's just become just a part of my routine. Every time I get ready for
14 a game, it's boots, shin pads, inhaler, towel; it's just part of my kit. But then
15 sometimes, you can't just stop. Like when I'm playing sport, because you're
16 just in the zone; other things take over and you think about that instead of your
17 asthma. I don't tend to listen to my body - I tend to just take my inhaler and it
18 fixes it. Or, if I can't take my inhaler because I'm in public and I feel stupid,
19 then I'll try and, just relax and just breathe. If I can get to my blue inhaler, then
20 obviously I'll take that but if I can't, you just try and kind of try and... just
21 breathe slowly. I'm in control, mind over matter.
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41 In contrast to the Conformers, but holding some similarities in attitudes and
42 perceptions regarding the 'mind over matter' approach, another distinct ideal type
43 emerged from data analysis: the Contesters.
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52 **Contesters: *Fighting a (losing) battle***

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54 Asthma UK (2014) promotes the belief that asthma does not necessarily need to be a
55 performance issue or stop sufferers from participating in sport. This can lead to
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3 conceptualisations of ‘beating it’, ‘overcoming it’, or ‘kickin’ it’, and Contesters often
4
5 drew upon such formulations in portraying asthma experiences. Some Contesters
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7 **(participants 1, 7, 8, 12, 13)** demonstrated a ‘fighter attitude’ and expressed feeling it
8
9 necessary to prove their self-worth through setting themselves sporting challenges to
10
11 ‘overcome asthma’.
12

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14 Fighting asthma conforms to a culturally-valued mode of being-in-the-sporting-
15
16 world, replete with aphorisms such as: ‘no pain, no gain’, ‘pushing the limits’, ‘mind
17
18 over matter’. Whilst such a mode of being may have certain strengths, there can be a
19
20 dark side, for when their asthma symptoms become so severe or constraining that they
21
22 cannot ‘click out of illness’, Contesters can perceive this as ‘failure’ and self-blame for
23
24 not being ‘strong enough’. Contesters construct narrative accounts that draw upon
25
26 notions of ‘beating asthma’, ‘overcoming asthma’, with metaphors cohering around
27
28 ‘fighting’, ‘attack’, ‘a constant battle’, and ‘struggling’ to get their breath. Not only is
29
30 asthma perceived as an attack on breathing, but also an attack on their very being-in-
31
32 the-world, their sense of self, particularly the sporting self, and this can generate
33
34 anger and frustration, as Ashley indicates below.
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39 Sportspeople are often willing to fight asthma by engaging in sport, sometimes
40
41 at the expense of making their asthma worse and consequently, at times jeopardising
42
43 their health (Allen-Collinson & Owton, 2012, **Allen-Collinson**, 2013a, 2013b).
44
45 Sport, then, constitutes a ‘double-edged sword’; it is beneficial, holds meaning, and
46
47 they enjoy it, but conversely, participation can be health-hazardous. In accord with
48
49 research by Williams et al. (2008) many of our participants argued that they would
50
51 rather participate in sport or physical cultures, even ‘at the expense’ of their asthma.
52
53 Contesters recounted how they tended ‘not to hold back’ in relation to sporting action,
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3 and some were even found to engage in deleterious, risk-taking behaviour. Ashley
4
5 provides an example of this particular identity type.
6

7 **Ashley:** I'm just the unlucky one in the family. I've got a weak immune
8
9 system. When I was young, I had lots of little harsh hopes that it might go away
10
11 and told I would grow out of it, but it didn't and it'll probably be there for the
12
13 rest of my life. I seem to be growing right into it and *blooming* into this stage.
14
15 Now, I am much more aware of being asthmatic. Pretty depressing because I'm
16
17 moving **two** steps forward and **two** steps back and I just can't pre-empt like that
18
19 I'm gonna have an attack. I might get caught out when I'm playing sport and
20
21 suddenly can't breathe and realise I have nothing with me. So I'm not
22
23 particularly organised...
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27 I'm really annoyed when I can't train because I love training and it's my
28
29 sport that's actually doing me good and it's doing my lungs good. I won't hold
30
31 back but it probably taking me ages to get my breathing back. I like pushing
32
33 myself very hard and like the idea of knowing I have to stop to be sick but I'm
34
35 used to dealing with that. It's the 'no pain, no gain' mentality, it's an
36
37 uncomfortableness... and it probably does limit performance, but I've not
38
39 noticed that it's really impaired me. My release is my fitness and my sport.
40
41 That's how I get rid of all my tension and anger. If I'm wound up, I'll go for a
42
43 run, or a swim or something.
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47 So I get annoyed not feeling healthy and not felt healthy for quite a long
48
49 time. I couldn't count the number of admissions into hospital. I used to be
50
51 really fit and athletic; I thought sport'd make me stronger. Gradually I've got
52
53 less fit and less athletic [laughing] and now I'm really unfit and non-athletic
54
55 [laughing]. Asthma's killed my ambition and my dream of being a
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3 sportsperson. But you don't want to admit that you're as ill as you actually are.
4
5 I want to live my life how I want to live my life and I am sick to death of it
6
7 being dictated by every single condition under the flipping sun.
8
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11
12 Not only did Contesters fight against their asthma and its symptoms, they also
13
14 appeared in some instances to fight against medical professionals and prescribed
15
16 medical treatments, even when suffering acute episodes of asthma. As Becker (1999:
17
18 13) notes, this contestation may be grounded in resistance to the power of medical
19
20 professionals, and because people fear not receiving appropriate treatment. For our
21
22 Contesters, their anger and frustration with medical professionals were at times
23
24 palpable, particularly when they felt the latter did not attempt to understand the
25
26 lifeworld of sportspeople with asthma. As Ashley went on to say:
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32 Doctors are rubbish and incompetent. One doctor said to me, 'well don't
33
34 do anything'. So, I nearly punched him with lack of understanding about the
35
36 world's life ... I said, 'well hand me the tablets, I'll die now then'. I'd rather
37
38 get on without doctors. I won't go to an asthma clinic either because I don't
39
40 have much faith in them. I've had similar experiences before when I was
41
42 younger. I don't really believe that anybody can help me...
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46 But I believe you can click out of illness if you are determined enough.
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48 I'm not a superhero and lots of day I've failed, but nothing will stop me from
49
50 beating it. I just wish there was just like a shop where I could go into and say
51
52 'I'm sick. Fix me. I'd like a new pair of lungs please'. I don't care how much
53
54 it costs. I always say if I could get a lung transplant, all will be well [laughs].
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3 Resistance to the power of healthcare professionals was, for some of our
4 Contesters, tempered by their own somatic knowledge; they listened to their own
5 bodies in deciding whether professional advice or specific healthcare was necessary,
6 as Becker (1999) similarly noted. As we have argued elsewhere (**Allen-Collinson &**
7 **Owton, 2012**), sportspeople with asthma often engage in fine auditory attunement and
8 ‘deep listening’ to the body and asthma symptoms. Whilst Becker (1999: 12-13)
9 highlights the ways in which people with asthma more generally ‘listen’ to their
10 bodies, ‘anticipating as well as monitoring the symptoms of the illness, wheezing or
11 shortness of breath’, Hockey and Allen-Collinson (2007) portray the ways in which
12 sportspeople become acutely aware of, and attuned to their breathing. Commensurate
13 with our sociological phenomenological approach, such ‘auditory work’ and careful
14 monitoring were found to be multi-sensory, as participants also ‘listened to’ their
15 proprioceptive feelings – those experienced in the deep spaces and tissues of the
16 body, such as the lungs. Contesters’ frustration and lack of faith in medical
17 professionals were thus tempered by such somatic attunement. This heightened
18 somatic awareness was even more prominent in the accounts of our third asthma
19 identity type, the Creators.
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Creators: a new sense of self and ways of managing asthma

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45 Creators (**participants 2, 5, 6, 9**) appear generally to experience less anxiety and
46 panic regarding their asthma than do the other two types, and seem to view asthma as
47 a practical issue to be addressed, rather than a threat to identity. Creators are willing
48 to take responsibility for managing their asthma and to try out different ways of
49 achieving a degree of control over symptoms, including seeking out alternative or
50 complementary therapies. Asthma, for Creators in particular, seems to be
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3 experienced as a learning experience, involving a slow, focused process of finding
4 breathing rhythms, patterns, and flow in their sport in order actively to manage
5 asthma. Creators learn to listen to their bodies as a source of valuable information
6 and so appear to be finely somatically attuned, having some similarities with
7 Contesters on this dimension. Additionally, they also seem to be highly associated
8 with their bodies, in Frank's (1995) terms, and to seek out help and support when
9 needed. Frank (1995) refers to the Communicative body-self, which is associated
10 with itself and also dyadic; for this body-self, communication is less a matter of
11 content than of self-other alignment. In this sense, asthma as a learning experience
12 involves a degree of responsibility-sharing with others, such as family members,
13 friends, doctors, sports coaches. Those participants who talked of asthma as a
14 learning experience seem generally (but not always) to feel in control and less anxious
15 about their asthma due to having developed various mind-body skills and techniques.
16 They also report drawing upon alternative/complementary remedies and therapies,
17 whether in addition to, or instead of, conventional, allopathic treatments. Asthma as a
18 learning experience also coheres in many ways with Shilling's (1993) concept of the
19 body as an unfinished project, one 'which should be worked at and accomplished as
20 part of an individual's self-identity' (1993: 4-5). Thus, Creators indicated developing
21 a long-term, even lifelong way of 'being-in-the-asthma-world', which involves
22 various types of 'somatic work', and 'tuning in' to the environment (see also Allen-
23 Collinson & Owton, 2012). Kate exemplifies the Creator ideal type.

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52 **Kate:** I see myself as a healthy person who has to deal with asthma rather
53 than an asthmatic. I don't feel ill with it, just something to manage really...

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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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3 been able to manage it quite well. I have always been keen to want to, once it is
4 stable and managed, to try and reduce the dose as much as possible. They
5 recommend that you don't self-medicate but I'm quite aware of the maximum
6 prescribed effective dose...
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11 I enjoy knowing that I'm not answerable to anyone for what I'm doing
12 and I also enjoy knowing that if I do well in anything that it's been my own
13 prescription. It's better for me in the long run if I listen to what my body's
14 saying rather than just following some program. I know what's better for me.
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20 Over 10 years, I've worked out how my body responds to different
21 training in terms of increases in fitness, speed and strength. After training
22 sessions, I work out how that feels and whether I need to push harder on the
23 next session or ease off. You can feel when it's getting too much, when you're
24 working really hard, I feel sick or something then you should probably stop, you
25 can feel your chest getting tight, you can feel yourself getting out of breath. It is
26 like a learning process of knowing when, of knowing your body and knowing
27 how, how much you can cope with and how it feels when you're not going to be
28 able to cope.
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40 It's something that I'll always have to be aware of because if I take my
41 eye off the ball, then things can get progressively worse. I'll always be a little
42 bit dependent. I'm not confronted with it on a daily basis it's only every now
43 and then...
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49 I don't see it as an attack, but like an onset of bronchoconstriction. I
50 simply notice being there in a mindful way then simply rest a little bit. It's
51 really whatever works for you. Just talking to myself 'you'll be fine if you just
52 relax' and calming down and then I sort of imagine myself, from an external
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3 point of view taking in a deep breath and slowing releasing it. It helps me get
4
5 back into the normal pattern of breathing. When I'm having an episode, I'd
6
7 rather just do something quietly where I don't have to be fighting it all the time
8
9 and then eventually it'll pass...

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11 Now I feel healthier and better than I've felt. I am fitter than I've been in
12
13 years. I feel very confident in handling my asthma and it's now so much a part
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15 of what is normal. I just deal with it on a regular basis. Keep an eye on it. I
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17 think I've just sort of accepted it as a bit of me.
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22 Via the above three vignettes, we have sought to give a 'feel' for the different
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24 asthma identities and ways of being-in-the-world that emerged from participants'
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26 accounts of living with asthma as sportspeople.
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30 31 32 **Conclusion**

33
34 Asthma is a widespread, chronic respiratory illness **that can have considerable**
35
36 **corporeal consequences for those who suffer its bodily-disruptions. The personal**
37
38 **accounts of people who continue to engage in sports and physical activities on a**
39
40 **regular and frequent basis, despite the considerable somatic and psychological**
41
42 **dys-ease generated by asthma, are therefore of interest.** Drawing on in-depth
43
44 interview data from non-elite sportspeople with asthma, in this article we have
45
46 explored and analysed participants' accounts of **their lived experience of the** asthma-
47
48 sport nexus. Commensurate with the sociological phenomenological approach
49
50 adopted, we have sought to avoid undue abstraction and theorization, but rather to
51
52 'give voice' to participants' own lived experiences of asthma and dealing with its
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54 deep somatic and often highly corporeally disruptive consequences.
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3 Representing the data via vignettes was chosen in an effort to ‘breathe life
4 into’ the data, to resonate with others and to give a feel for what it is to be the person
5 in the sporting-body-with-asthma. Whilst the vignette representational form is
6 relatively new to sport sociology and sports studies generally (Sparkes & Smith,
7 2014), as Frank (2012) notes, vignettes can provide powerful representational forms,
8 and may even help people acknowledge why they might need to employ different
9 narratives. The use of a typology too may be useful as a useful framework to assist in
10 identifying and understanding different ways of being-with-asthma in the (sporting)
11 world. It is not, as we emphasize above, meant to provide a fixed, trait-type typology,
12 but rather to provide the kind of ‘simple structure’ to which Frank (2012: 48) refers.
13 Our typology was thus constructed for heuristic purposes, to help identify, illustrate
14 and analytically explore particular ways of being-in-the-sporting-world with asthma,
15 whilst also acknowledging, as highlighted by participants themselves, that these ways
16 of being are complex, shifting, mutable and context-dependent.
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34 **With regard to the use of a sociological-phenomenological framework,**
35 **combined with the use of vignettes, we suggest that this particular approach can**
36 **provide an insightful means of exploring how it feels - at a particular,**
37 **phenomenal level – to be a sporting person with asthma. Whilst we could have**
38 **chosen to represent participants’ accounts via a more traditional ethnographic**
39 **‘realist tale’ (Sparkes, 2002), which undoubtedly has its own strengths, here we**
40 **wished to explore a representational approach to date underutilized in sport**
41 **sociology and sport studies more generally. Representing data in this way can,**
42 **we hope, resonate with readers – whether with asthma or without – to give a**
43 **‘feel’ for asthma experiences and sporting embodiment lived in combination.**
44 **We are not suggesting that this is the only (or even the best) way to seek to**
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3 convey (however partially, as phenomenology always highlights) the lived reality
4 of our participants, but we hope it does help generate some insight into, and
5 empathic resonance with, their particular being-in-the-sporting-world, and the
6 kind of embodied ways of knowing they use in order to live with asthma in that
7 world. Such somatic knowledge and ways of knowing, we argue, allow and
8 encourage us to portray experience and to theorize '*from the body*' as well as
9 about the body (Williams and Bendelow, 1998; Allen-Collinson, 2011a).
10 Engaging with this form of 'carnal sociology' (Crossley, 1995) helps to remedy
11 the long-standing imbalance between abstract theorizations *about* the sporting
12 body and more grounded, 'bodyful' accounts of sport and exercise as lived
13 experience.
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32 feedback and comments on earlier drafts of the article. Also, we would like to thank
33 the research participants for sharing their lifeworlds of asthma and sport.
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40 Notes

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43 1. Inhalers for use in the management of asthma tend to be for two key purposes:
44 preventive, to reduce symptoms longer-term (brown inhaler); and instant relief
45 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