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# The Emotional Implications of a Hypertrophic Cardiomyopathy Diagnosis in a Retired Athlete: An Autoethnographic Approach

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**Abstract:** The purpose of this study was to advance knowledge and understanding of the emotional implications retired athletes experience when diagnosed with hypertrophic cardiomyopathy. This study employed an autoethnographic method to explore the consequences of living with this potentially life-threatening heart condition from a first-person narrative, using the account-making model of coping and loss as framework. The results illuminate the lived experience of someone diagnosed with hypertrophic cardiomyopathy and subsequent forced transition out of high-performance sport. This study provides practitioners with insights into this topic so that relevant and tailored interventions can be implemented to help retiring athletes who are diagnosed with hypertrophic cardiomyopathy cope with the career transition process. Notably, this paper also offers a full, complete autoethnography rather than extracts of autoethnographic writing typically provided in journal articles due to formatting restrictions. Thus, we showcase the valuable contribution this methodology has to offer scholars and practitioners.

**Keywords:** autoethnography; career transition; existential; sport; retirement

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## 1. Introduction

When an athlete is faced with retirement, it can be a significant event that impacts their relationship with significant others, emotions, and self-perception (Barker-Ruchti and Schubring 2016). Research has found that athletes facing an involuntary transition out of sport are likely to face more severe symptoms associated with loss due to the athlete not feeling psychosocially ready to retire and not being active in coping strategies such as pre-retirement planning (Taylor and Lavallee 2005). However, to date, very few studies have investigated the experiences of those forced to retire (Park et al. 2013).

The career transition literature has highlighted aspects that can lead to a smoother transition even when faced with a lack of planning for retirement. A study by Willard and Lavallee (2016) highlighted the importance of maintaining a close social network, mitigating against potential transitional difficulties. The education level of the athletes upon retirement can also play a significant role, making the transition out of the sport less problematic (Cosh and Tully 2015). Despite research recognizing the mediators that influence the career transition process (Knights et al. 2016), along with the unique personal attributes and perspectives that individuals bring (Giannone et al. 2017), assumptions regarding the intense and longer lasting reactions that some athletes have towards the involuntary retirement process are still apparent.

Researchers have acknowledged that retirement from sport is not just a singular event but a process that evolves over time (Barker-Ruchti and Schubring 2016). As such, it is important to shine light not just on the immediate aftermath following retirement from sport but on the ongoing social and psychological adjustments proceeding the event (Cavallerio et al. 2017). Identity foreclosure has contributed to the adjustment difficulties athletes face following retirement due to the amount of time and effort one dedicates to

their sports career (Park et al. 2013). The reconstructing of one's identity has also been found to be a major challenge (Menke and Germany 2019).

Although researchers have found the psychological adjustment to career transitions to be both positive and negative, the true nature surrounding the psychosocial impact of career-ending injuries associated with sport has been seldom reported (Arvinen-Barrow et al. 2019). Knowing the disparity that exists, regarding the length and severity of retirement stressors, including the effect upon one's life satisfaction when retiring due to injury opposed to a normative, predictable career transition (Lavallee et al. 1997), additional research is required that adds depth to our knowledge and understanding concerning the influential role that the injury and/or health condition plays throughout the career transitional process and adjustment to life without sports participation (Park et al. 2013).

Extant career termination models (Taylor and Ogilvie 1994) have highlighted how a successful transition is dependent upon personal and situational factors with the predictive nature of the model determining those individuals with a diverse identity, greater resources, and a high level of perceived control over their retirement, contributing to a smoother adjustment upon retirement (Park et al. 2013). The conceptual model developed by Taylor and Ogilvie (1994) emphasizes the transitional nature of retirement from sport, accounting for the gradual alteration in goals and emergence of specific challenges, years after their exit from sport (Park et al. 2013). Knowledge has been extended through research surrounding the key psychosocial dimensions that influence an athlete's retirement from sport, highlighting that sports termination is a process in which psychological symptoms can ebb and flow for many years after the event (Knights et al. 2016).

Despite advances within the career transition literature, there are gaps that require further exploration. One criticism of research to date has been the reliance upon retrospective rather than process-based studies. These studies have only provided a snippet of the athlete's experience, making it appear straightforward, sequential, and not unique to the individual experiencing their own specific version of the transitional process (McKenna and Thomas 2007). It has made life challenging for those looking to offer the right support for athletes experiencing a career termination either as a career trainer or professional offering support through counselling (Knights et al. 2016). Therefore, there is a need to explore the meaning construction behind one's psychosocial experience when transitioning out of elite-level sport, knowing narrative coherence has been of benefit in overcoming involuntary life events or disruptions (Becker 1997).

A study by Pitcho-Prelorentzos and Mahat-Shamir (2019) described unexpected career-ending injury as a traumatic event due to the lack of guidance, support, and uncertainty. The results highlighted how people constructed meaning as being marginalized and alienated by society in sport and general, shattering their core beliefs around their sense of self and how they fit within the world. Retirement was viewed through the lens of degradation, void, and ambiguity. Pitcho-Prelorentzos and Mahat-Shamir (2019) has called for meaning reconstruction in the wake of loss so that individuals are able to process what happened, reorder their priorities, and understand the implications regarding their identity and lives as they progress throughout the transitional process whilst addressing any finished business that may exist (Pitcho-Prelorentzos and Mahat-Shamir 2019).

The constructionist approach to meaning can advance both theoretical and practical understanding of retirement from sport. Existing theoretical models fail to point towards the exact factors that lead to a traumatic response or how we can enable athletes to progress through the transitional process to reach closure (Taylor and Ogilvie 1994). The conceptual model's ability to generalize therapeutic interventions based on the retirement difficulties that an athlete may be facing fails to account for the individuality and unique experience of the person to meet their specific needs on a deeper level.

One model that has helped advance knowledge and understanding about loss and illness across numerous societal domains is the account-making model (Harvey et al. 1990). This model proposes that a central component involved in the stress recovery process is the construction of a story, or account, about the traumatic event (i.e., its nature, why it

happened, how one feels about it, and what it means for the future). This account, which represents the person's understanding of their situation at a particular point in time, is then refined and elaborated on as he or she gains perspective on their plight.

Research using the account-making model has shown that people develop their story through a series of seven steps that may be linear or may involve back and forth movement over time: 1. traumatic event, involving shock (feeling overwhelmed or numb); 2. outcry, involving emotional expression (and may include a sense of panic, despair, exhaustion, and hopelessness); 3. denial, early stage of account-making activity often begins, possibly involving escapism (avoidance and isolation); 4. intrusion (continues initial account-making involving flooded stage (distraction, obsessive overview); 5. working through, involving intensified account-making activity where the reality of the traumatic event is repeatedly confronted (over time, these activities produce a personal and elaborated story of the experience that includes descriptions, attributions, characters, plots, memories, emotional expressions, behavioral expectations, and future plans); 6. completion, involves the acceptance of the elaborated account (this becomes the basis for a new identity that allows the individual to make use of unique experiences, interests, and skills in constructive ways); and 7. identity change, with behavioral expectations in line with account. Ultimately, the new identity may include an active concern for the welfare and guidance of others who are faced with similar circumstances (i.e., generativity; Erikson 1963).

In sport, the account-making model has been used to explore the realities of a career transition with a rugby player experiencing a problematic career transition due to retirement from the sport. Grove et al. (1998) and Sparkes (1998) have demonstrated the beneficial application of the account-making model for Olympic-level athletes experiencing distressful reactions due to retirement. This model provides a framework to better understand how people cope with extremely stressful experiences, with 65% of retirement studies reviewed by Park et al. (2013) emphasizing negative reactions by athletes in retirement.

The need for research that develops a better understanding of how the decision-making process to retire connects to the transitional experience with athletes forced into premature retirement has been raised (Park et al. 2013). Applying a qualitative approach to gain a more in-depth understanding of retired athletes' difficulties experienced throughout the retirement process (Knights et al. 2016) is met through the application of the account-making framework. The account-making model can guide people to write about their own experience as it happened so that they can unravel the context whilst providing readers with an opportunity to gain knowledge and insight (Grove et al. 1998).

The career transition literature has also called for research to document and understand the psychosocial impact of career-ending injuries, especially because of the mental health and inflated suicide rates documented within professional cricket (Roberts et al. 2015). Athletes diagnosed with hypertrophic cardiomyopathy, primary heart disease characterized by the disorganization of the myocardial infrastructure, the chaotic alignment of myofibers, and scaring due to myocyte death and repair (Maron 2002; Maron et al. 1994; Cecchi et al. 2003; Spirito et al. 1997), immediately retire from competitive sport in most cases.

A rationale for career termination has been supported through observational studies that have found hypertrophic cardiomyopathy to be the main cause of death (Newman et al. 2022). Contemporary studies of patients who have engaged in high-intensity and competitive sporting pursuits have added to our understanding regarding the greater risk associated with sudden cardiac death (Tobert et al. 2021; Dejgaard et al. 2018; Turkowski et al. 2018).

Hypertrophic cardiomyopathy affects 1 in 500 people within the UK and is associated with a 1% average risk of sudden cardiac death (Maron et al. 1994; Christiaans et al. 2009). In the majority of cases, hypertrophic cardiomyopathy is characterized as a common hereditary condition, and investigations of a clinical nature with those at risk of having the inherited condition or carrying the gene responsible in the diagnosed family member are recommended (Christiaans et al. 2009). As our medical knowledge concerning the condition improves, it has been found that we should not discriminate based upon age, with age at

diagnosis being dependent upon sex, genotype, and disease gene (Newman et al. 2022). Whether the condition is prevalent in a specific gender is difficult to determine due to the underrepresentation of women in published studies to date (Spirito et al. 1997; Girolami et al. 2018; Eifert 1992). It is worth noting that the athlete's heart, a physiological change in the left ventricle hypertrophy (LVT), is different to a pathological version whereby the space inside your left ventricle becomes smaller rather than bigger, therefore impeding the functional capacity of the affected person and restricting their ability to compete in high-intensity sporting pursuits. With both conditions mimicking each other, it becomes a challenge to effectively diagnose an athlete with hypertrophic cardiomyopathy, but when examined, distinct differentiations in clinical features and potential outcomes can be observed (Tobert et al. 2021; Turkowski et al. 2018). Intensive physical activity can exacerbate the potential for sudden cardiac death with affected individuals by triggering other associated sequalae. Due to the heterogenous clinical course of the condition, medical personnel generally air on the side of caution by restricting the level and intensity of exercise with affected individuals (Dejgaard et al. 2018). When people are diagnosed with the condition, they are faced with complex conversations with significant others, medical management, and adjustments to their life and daily routine (Girolami et al. 2018). Other manifestations resulting from diagnosis with hypertrophic cardiomyopathy include the prevalence of mood disorders, anxiety disorders, and substance misuse when compared to the general population (Christiaans et al. 2009).

Heart-focused anxiety, where patients become apprehensive and fearful of sensations or stimuli prompted by anxieties related to cardiac-related symptoms due to the potential catastrophic consequences (Eifert 1992), further adds to the implications of being diagnosed with the condition. The literature has been sparse when identifying the potential biopsychosocial predictors of heart-focused anxiety in hypertrophic cardiomyopathy and other cardiac-related conditions (Zuchowski and Chilcot 2021).

The aim of this research is to advance knowledge and understanding of the emotional implications retired athletes experience(d) when diagnosed with hypertrophic cardiomyopathy, a potentially life-threatening heart condition. To date, there are no studies that have examined individuals' accounts of living with this condition, nor the psychological implications of being forcibly retired from competitive sport because of this diagnosis. Therefore, the two objectives within this overall aim were to, first, capture the lived experience(s) of an athlete diagnosed with hypertrophic cardiomyopathy and their subsequent transition out of high-performance sport by producing an autoethnography. Second, by producing an autoethnography, we offer practitioners accessible insight into this phenomenon so that relevant and tailored interventions can be implemented to help retiring or retired athletes cope with the transitional process. To help achieve this aim and objectives, more detailed guiding questions were used to frame autoethnographic writing (see Section 2.2).

## 2. Taking an Autoethnographic Approach

Autoethnographic research investigates a particular phenomenon from a first-person perspective, offering opportunities to describe processes and contexts that are often overshadowed (Strean 1998). This involves the researcher connecting the personal to the cultural by placing themselves within a social context of the research. Autoethnographic writing answers the call by Coffey and Atkinson (1996) for the need to make disciplined, principled choices and strategic decisions with regard to how to represent and reconstruct social worlds. Therefore, my (the first author) research endeavors will be presented through writing about my experience and placing these accounts directly within the body of the text (Sparkes 2000) using a first-person narrative or conversational structure using reported speech if interacting with another (Barker and Barker-Ruchti 2016). Writing in this context brings moments of clarity, connection, transformation, and examination whereby the self, others, and culture are positioned as ever changing rather than balanced throughout the entirety of the narrative (Jones 2005). A diagnosis with hypertrophic cardiomyopathy as an aspiring athlete precipitates within this space. This narrative needs to be positioned in a

way that connects rather than distances oneself from others diagnosed with hypertrophic cardiomyopathy, the rugby culture, and those surviving to tell their tale of transition and recovery. Rather than simply looking at the phenomena from afar, my narrative will situate me within the story so that I can walk the readers through my own personal journey (Prewitt 2010) to uncover rather than bracket feelings, biases, and assumptions (Morse and Richards 2002). Therefore, this autoethnographic study specifically explores my own narrative of navigating the diagnosis of hypertrophic cardiomyopathy whilst having an athletic career and my life post-diagnosis.

An autoethnographic research design encourages the reader to reflect on the effectiveness of this approach (Gilbourne and Richardson 2006). The connection between my lived-body and sense of self allows for a symbiotic relationship to be formed between myself and the reader, where I can share parts of my life that can then help us understand experiences of being diagnosed with hypertrophic cardiomyopathy as an aspiring or professional athlete, as opposed to people with this condition isolating themselves from the world in and outside of sport (Prewitt-White 2019). As Ellis (1997, 2004) suggests, writing and reading autoethnographic texts hold therapeutic, theoretical, cognitive, and emotional benefits. In this autoethnography, I offer insights into how sport and being diagnosed with hypertrophic cardiomyopathy influenced my relationship with my partner, parents, and colleagues, along with the connection between my lived body and sense of self. You, the reader, will see that "experiencing limit situations and existing are the same" (Jaspers 1971). My own diagnosis with hypertrophic cardiomyopathy will bring a sudden realization that my being in the world is fundamentally towards death (Heidegger 1962). I describe how the "boundary situation" encouraged me to evaluate the authenticity towards my way of living (May 1983), triggering a sense of urgency to take ownership of one's existence whilst I am still alive (Sartre 2007). In doing so, this autoethnography offers the lived experiences of a former athlete who has been diagnosed and is living with hypertrophic cardiomyopathy. Shifting from a traditional third-person, objective perspective to an autoethnographic position provides a detailed, emotional, and heartfelt experience to be uncovered through the exploration of a depth and breadth approach (Gilbourne et al. 1996; Gordon and Lindgren 1990).

Notably, the work of researchers as storytellers has been contested for its academic rigor and worthiness, often dismissed and trivialized (Vickers 2002). This is largely due to misconceptions regarding the research process and content of the research (Gummesson 2000), as well as the lack of a theoretical framework in some autoethnographic work (Holt 2003). Applying Richardson's (2000) criteria for interpreting and constructing an autoethnographic account, dramatic recall, strong metaphors, and unusual phasing to engage, involve, and challenge the reader will be used (Foley 2002; Sparkes 2002) to overcome these challenges. The account-making model of coping with loss (Harvey et al. 1990) will also provide a framework for understanding how I coped through each phase of the transitional process.

Ultimately, taking an autoethnographic approach addresses increasing calls for scholarly research to generate and apply new ideas, knowledge, and vantage points (Vickers 2002) whilst meeting dominant forms of representation and power head on to recoup marginalized representational spaces (Tierney 1998). Providing an autoethnography examining the nexus of the lived body in the context of a juxtaposed athletic and ill self provides a valuable advancement in knowledge on career-ending athletic transitions, in particular for those athletes diagnosed with potentially life-threatening genetic conditions such as hypertrophic cardiomyopathy. While sports injuries and hypertrophic cardiomyopathy diagnosis hold similarities, this autoethnography highlights specific differences through the emphasis on subjective, interpersonal, and phenomenological experiences. Thus, taking an autoethnographic approach in this study adds to the literature on athletic career-ending transitions, that has almost exclusively focused on sports injuries (Gilbourne et al. 1996; Gordon and Lindgren 1990; Rose and Jevne 1993). Knowledge and understanding around the lived experiences of this marginalized group will help health practitioners, (sport)

psychologists, and social support networks in providing a more holistic approach when supporting the athlete through similar traumatic experiences.

### 2.1. The Participant: Who Am I?

I was diagnosed with hypertrophic cardiomyopathy at the age of twenty-six when presenting with clamping pain across my chest, lasting for approximately ten minutes in duration. At the time of diagnosis, I was playing competitive rugby union. There was little to find on examination, but I was informed by medical personnel that I displayed an abnormal echocardiogram (ECG) showing left ventricular hypertrophy and relatively deep Q-waves inferiorly and laterally with right axis deviation sinus rhythm.

I was also informed that the resulting ECG suggested asymmetric septal hypertrophy, where I was given the full Bruce protocol treadmill test, walking for 12 min without any significant symptoms, only stopping because my target heart rate had been reached. During this period, I was advised to decondition for a period of three months where no intensive physical activity was allowed.

When the size of my heart did not decrease, I was given the diagnosis of hypertrophic cardiomyopathy with annual heart checks provided. In 2012, a 24 h tape revealed 16 episodes of second-degree heart block with Wenckebach with pauses up to 2.5 s in duration. A previous Holter monitor detected non-sustained ventricular tachycardia (VT) with a triplet of 100 beats per minute advocating for an implantable convertor defibrillator (ICD) to be considered as I was at higher risk of sudden cardiac death due to my relatively young age and non-sustained VT.

Once a medical advisor had spoken about the potential risks of exercise, I was told in no uncertain terms to stop all manner of physical activity with immediate effect. Living with the condition has meant wholesale lifestyle changes, annual checkups for both my son and I, and a strain put on relationships due to the quality and type of support received. Living with the condition has created gaps in my day-to-day life and changed me physically and psychologically as a person. I now suffer from mood disturbance and anxiety relating to my condition due to the real and imagined symptoms, contributing to fear regarding the potential consequences.

Hypothetical associations can be made between the implications of suffering a career-ending injury and the diagnosis of hypertrophic cardiomyopathy. Each group has lost the subjective feeling of control. The perception of control not only facilitates mental health and successful development (Seligman 1991) but is closely related to enhanced feelings of self-efficacy. This can play a crucial role in behavior change and adjustment (Bandura 1997).

The resounding difference between the two groups is the potential for death when diagnosed with hypertrophic cardiomyopathy and being faced with one's own immortality. Not only is a person diagnosed with hypertrophic cardiomyopathy confronted with the death of a career but an encounter with one's finiteness. Psychologically, it is a significant cross to bear for athletes, families, and partners. There are no warning signs for these 'so called' healthy individuals, the first pathology being death. Addressing the concept through an existential lens adds an additional layer to the account-making model. It serves as the catalyst (if a hypertrophic cardiomyopathy survivor) to focus on how we, as athletes, construct meaning around each of the stages of the account-making model when faced with a termination and subsequent transition out of sport (Ronkainen et al. 2020) whilst becoming aware of our responsibility for living our own lives and decisions we make (Cooper 2003).

### 2.2. Writing an Autoethnography: Analytical Writing

There is no one way of crafting an autoethnographic account. Therefore, what follows is a description of the process I undertook to craft the autoethnography, which might support the reader in understanding both the methodological approach and context to the autoethnography provided in this paper. Importantly, the process of writing an autoethnog-

raphy is also a form of analysis (Ellis and Bochner 2000) and so whilst this description appears linear, there are references to continuous processes which were almost cyclical in nature.

Prior to writing the autoethnography, a series of guiding questions framed around the intersecting themes of (a) coming to terms with, coping with, and accepting the diagnosis, (b) what and/or who influenced by coping mechanisms and motivation, and (c) the impact of transitioning out of sport were created to shape the writing process and achieve the overall aim and objectives of the research. These were as follows: How have previous sports-related injuries facilitated the coping process? What does the way in which I have coped tell me about myself? How has rugby culture impacted the way in which I cope? What influence did my peer group have on my transitional experience? What motivates me now? How did I react to the termination and subsequent transition out of sport? What influence has a transition out of sport had upon family/partner relationships? In addition, to capture the methodological benefits of the autoethnographic approach, I also asked myself 'What therapeutic benefits, if any, have been served by writing this paper?'. Importantly, when responding to these questions, I wanted to capture my lived experiences within the cultural contexts of two largely opposing groups: being an athletic rugby player and being from a marginalized group of suffers with hypertrophic cardiomyopathy.

Ultimately, the complex lived body examined in this autoethnography is best understood chronologically. Therefore, I initially reflected upon the role of sport in my adolescent development as a child born to a Jamaican Indian mother and White British father. I then focused on the influence of rugby union when scouted after winning the Suffolk Cup before attending eastern counties trials by an academy whose first team played in the Rugby Premiership. My focus shifts to brief stints with clubs as a front row forward in the National League over a couple of seasons when studying for my undergraduate and latterly postgraduate degree in Sport and Exercise Science. I then examined my new lived experience when diagnosed with hypertrophic cardiomyopathy as a recent postgraduate, the catalyst towards a non-normative transition out of sports participation. My final reflections reference the significance a full rupture of the patella tendon and break of the fibula and tibia had on my ability to cope with further career setbacks and the subsequent termination of a short and frustrating career. I then analyze how conscious choices were made to stay closely connected to sport. My various roles as a lecturer in Sport and Exercise Science/Psychology at higher and further education institutions a year after my diagnosis provided a sense of direction and purpose when alternative careers of interest involved some form of intense physical requirements. Qualifying as an Accredited British Association Sport and Exercise Scientist (Psychology Support) in March 2022 enabled me to merge my knowledge and experience by working ethically with other high-performing organizations, teams, and individuals, giving me a true sense of identity and belonging through being part of a closely connected team before moving into the realms of research as a means of giving back to other athletes diagnosed with hypertrophic cardiomyopathy; these experiences are explored with an emphasis on how they helped me cope with early retirement and how experiences within sport could still be influencing my life today. Simultaneously, these chronological features of my lived experience were mapped to the account-making model which was reengineered using rugby terminology and used as a framework for understanding how I coped with the stressful experience (Harvey et al. 1990) over time. Thus, I wrote a series of chronological accounts that mirror the seven stages of the account-making model, including the 'traumatic event' (immediate career termination), up until the present day, where I have had time to reflect upon and adjust towards adopting a new identity (identity change and transition). Implementing the account-making framework focused my attention on those events that are pertinent and most meaningful to the research questions. Writing was completed retrospectively with the aim of writing a stage of the account-making model every other day until completion. Rereading my account and reflecting on those parts of self I addressed through the written word occurred continuously following meetings with my co-authors. Through the process

of autoethnographic writing, I utilized the process of critical reflective practice (Lee et al. 2020) to help make better sense of myself, relative to the social structures and culture I experienced (Ellis and Bochner 2000; Butryn 2009; Grant and Zeeman 2012; Purdy et al. 2008), both as a rugby player and person with hypertrophic cardiomyopathy, to ensure that my interpretations are as accurate as possible. This process was carried out to ensure that there is a high level of personal validation and continuous debriefing.

For this paper, autoethnographic accounts that specifically address career termination from high-performance sport and consequential transition are provided. Specific parts of my narrative will be discussed, with priority given to my interpretation of the events that unfolded. Only significant aspects of my lived experience will be presented in this paper, and these are illustrated under each of the stages of Harvey et al.'s (Harvey et al. 1990) account-making model as an organizational framework.

Checks and balances were implemented to ensure that the work is of a high quality. I referred to Sparkes' (Jones et al. 2013) criteria to ensure that my work comprises three interrelated components, 'auto' (personal), 'ethno' (cultural), and 'graphy' (writing), so that my narrative can be evaluated as a piece of autoethnographic work, examining the intersections of the personal and cultural lived experience. In addition to Richardson's (2000) criteria highlighted above, characteristics used by Jones et al. (2013) to inform the autoethnographic approach were also used as an additional layer of reference throughout my writings. The most prominent is ensuring that my work contributes to existing research; embraces vulnerability with purpose; and builds a reciprocal relationship with my audience through my shared experience so that it triggers a response.

My narrative intentionally reflects on the nuances of my experience and sheds light on those salient parts of self, demonstrating how my own story can diminish silent authorship, providing a voice that has been denied to others (Sparkes 2020; Adams and Herrmann 2020). My co-authors acted as methodological reviewers, using their knowledge and experience to determine whether my study is meeting the essential criteria for strong autoethnographic research. Analytic triangulation of the data will be used so that plausible interpretations can be achieved (Wolcott 1994). Narratives generated throughout this study have been read extensively between myself and co-authors so that the most prominent aspects of my own personal experiences of living with the condition and retirement from competitive sport can be pinpointed (Faulkner and Sparkes 1999). Formal touch points with co-authors as research supervisors took place every two weeks to ensure that my voice, thoughts, and emotions were coming across accurately through the written word within my narrative. Informal discussions also took place consistently each week as I engaged in discussions with significant others who shared parts of my lived experience with hypertrophic cardiomyopathy and transition out of high-performance sport. This process ensures that authenticity, integrity, and honesty weave a common thread throughout my narrative so that biases are uncovered and relevant themes are embedded whilst ensuring that the results are tailored to the needs of the community, meeting this study's aims.

## 3. Results

I will introduce my narrative with a brief insight into the influences that shaped my identity as a 'rugby player' and 'human being'. The influence of my athletic identity as a rugby player and over reliance on using "the game" as a vehicle for social interaction potentially contributed to future emotional and social adjustment difficulties once participation in the sport ceased (Brewer et al. 1999).

Exposure to a boarding school environment in the United Kingdom quickly made my mixed heritage apparent as I suffered inherent racism, with the sport of 'rugby union' becoming my saving grace. Rugby was a pleasant experience as I immediately became one of "them". Color and background were forgotten, leaving me with the freedom to express myself away from the classroom. Rugby provided a platform where I was on a level playing field, part of a team that came together to achieve the same objective rather than an isolated and lonely outsider.

My life felt as if it depended on the "game". I was not the most extroverted and found it difficult to "fit in", but 'rugby' provided the foundation on which to spark conversation and feel part of something special. Knowing 'rugby' provided me with opportunities on a social level, I did everything to recover from a serious knee injury, when breaking the tibia, fibula, and suffering a full rupture to the patella tendon. The ability to recover developed the strength of character that saw me pursue my dreams and aspirations of professional academy and National League representation.

Rugby provided my family with the opportunity to spend quality time together, to socialize and meet other people of like-mind, and to forge friendships over the years. The 'game' has provided so many memorable moments and been a huge focus for over 18 years. Identifying as a 'rugby player' automatically tailored conversations around this very existence.

Rugby influenced who I was and who I had become not only in the eyes of the beholder but in the eyes of significant others who surrounded my day-to-day interactions. I was a 'rugby player' above all else, and life experiences appeared to be attached to a sport that had formed my character. A sport that had taken me out of the shadows and into the light...

### *3.1. Traumatic Event*[1]

Rugby was not just a sport but a lifestyle. It was my classroom, one in which I studied meticulously, always looking at where improvements to my game could be made. You will follow me on my own personal journey where you will witness and feel the significance of the sport in my life at this time.

I will provide you with a description of the event that caused immense shock, literally bursting my bubble as I experienced feelings of overwhelm and numbness, my life pointing towards a downward spiral of despair and self-destruction. It was a period where my very existence became shattered and my relationships fraught with those I loved.

You can choose to step into my shoes and experience the immediate thoughts, emotions, and reactions that accompanied me through this dark and bleak period or formulate your own ideas, opinions, and judgements through challenging the perspective by viewing my experience through your own set of eyes and seeing the traumatic event as if it were your own.

I invite you to question the reactions and emotions that I encountered as you step in and out of my lived self. Give yourself permission to be open to my own personal experience so that we can create rich dialogue that generates discussion and furthers our own knowledge and understanding around the immediacy of emotions that a traumatic event can create for an athlete forced into retirement.

My account began in March 2005. I woke with a clamping pain wretched across my chest. The pain was excruciating, suffocating, and confusing. A delay occurred before cortisol flooded my bloodstream and the mind to body connection triggered into action. I carried my beleaguered frame gingerly towards the direction of my parents' bedroom. People say, "a picture speaks a thousand words", as the panic-stricken glare etched across my parents face despite their efforts to cover up their worry through words of reassurance.

I stretched out my hand and reactively blurted "mum what is happening to me?" as I needed to hear the words "everything will be alright" from the person who cared and nurtured me for the last 25 years. Transported via ambulance to the hospital was a nerve-racking experience and one where I felt extremely vulnerable. Hearing the paramedic's medical assessment "your arteries appear to be blocked" immediately sent my mind into overwhelm.

I did not talk much, only when prompted by the ambulance crew with "yes" or "no" responses to questions thrown in my direction. Inner dialogue consumed my thoughts as I began to question my previous performance exploits and identity as a rugby player. My metaphorical forensic suit was pulled on as I started to examine and re-examine everything

that I had done throughout my life to initially find out the 'what' before searching for the 'why' that had contributed to my lived experience.

Life had existed in a vacuum, and the calm equilibrium that structure had brought was exchanged for a frenetic swinging of the emotional pendulum. Punches swung back and forth, as I waited anxiously for a knockout blow to pinpoint how someone seen externally as fit and healthy shifted to a person with potential internal health complications.

The opponent changed frequently and often. One minute I was fighting with the inner voice and then the external voices of the medical team. Questions "do you smoke?" emphasized that I was someone who must have failed to live the athlete lifestyle, someone who had deluded themselves. Whenever I responded with a "No", the puzzled and bemused look across their faces could easily be interpreted as "You liar" as my mind entered a threat state, creating its own colorful interpretations.

Despite what felt like an interrogation, I never received any answers. The only response(s) I got was from my own vein attempt at self-compassion and to keep the hope that rugby was still very much my present and not my past. I kept telling myself "I go to the gym every day and train three times a week with a match on Saturday" to quieten my inner dialogue and wild assumptions that were at play. We arrived and I was whisked into the Accident and Emergency Department for further examination and unease.

Time was like walking in thick dark treacle. Waiting for the verdict felt like an eternity. My eyes stayed transfixed on the Consultant Cardiologist's mouth as I waited anxiously for it to open. The words "you have a slightly enlarged heart" spilled with scripted precision as I felt a deep sense of relief and relaxation.

Memories of a physiology lecture absorbed the focus of my prefrontal lobes as I remembered that the hypertrophic effect was representative of athletes having trained at significant levels to bring about positive physiological change within the body. The tension in my face and muscles subsided momentarily as the pendulum shifted again.

Facts and figures flowed in quick succession as judge and jury explained how my heart was abnormally thicker than normal. It was a severe medical condition, one that carried a life sentence. I found myself losing consciousness, my vision blurred and body warm. I felt clammy and cold as the reality and shock of the situation set in.

I was in a very lonely place and longed for my father to tell me "Everything is going to be alright", just to have someone comfort me or put an arm around me, but this was not my father's way. My mind, body, and soul shut down as I was oblivious to anything spoken externally between my father and the consultant. Upon regaining some composure, I found myself asking "the question", the most important and only thing that consumed me was "can I die from this?", to which the consultant responded sharply, "yes, you can".

My world turned upside down. The room spun uncontrollably, catching a glimpse of the lime green hospital bed to my left, I felt the urge to lie down. Ice cold sweat trickled down my back and my legs collapsed from underneath me. I felt faint and uneasy longing to lie down and recover from the bombshell, yet my inner voice told me "Hang in there", as if asking to lie down would have been a sign of weakness, not characteristic of a rugby player. In my mind, I had just been told that I only had so long to live.

### *3.2. Outcry*[2]

The approach taken by the Doctor of Cardiology was highly questionable. Nobody could understate the medical expertise that was greatly admired, yet the lack of empathy when providing a diagnosis of hypertrophic cardiomyopathy to someone from an athletic population, knowing the disruption and potential psychological implications the diagnosis may hold, was inexcusable.

I was unprepared for the news that would change the course of my life forever. A change that created a huge void in my daily routine and made me question whether I had the strength to push on through and whether I wanted to live a life that no longer held significant purpose and meaning.

Staring upwards, I saw the consultant looking sternly over her glasses in my direction. Going through my own pre-performance routine, learned and acquired over the years within the sport, to lower my anxiety and focus on the present moment, I asked, "Can I still play rugby and train?". A question that carried much weight and a response that potentially had me smiling or looking down at the end of a double barrel shotgun.

In hindsight, it seems a strange question to ask and a weird sequence to the questions that carried such magnitude. All I sought was hope, to which the consultant spoke without thought or remorse "No, you cannot play any competitive or physical sport again, but you live in a nice area so you can go for walks". Although I listened and nodded, I was numb to the words as anything entering my mind became jumbled and distorted.

Out of politeness, learnt from my upbringing, I did my best to look in the consultant's direction, so she felt acknowledged and heard, but I found myself looking through her, failing to comprehend or attach meaning to the words she now spoke. If I had passed her in the corridor 5 min post-consultation, I would not have recognized what she looked like or who had delivered such damning news.

I felt like I was having what people describe as an out of body experience, one in which I felt uneasy, uncomfortable, and in a panic-orientated state. It was not me in the room but a person who looked identical in appearance. My mind did its best to distance myself from reality, waiting patiently for the dream to be broken.

Voices were heard and an interchange took place, but I could not recollect what had been said or by whom. My prefrontal cortex, the part of one's brain used for thinking, decision-making, and emotional control, had been overloaded and stressed. My inner self was left battered and bruised.

Thoughts held similarities best described as an existential crisis as I told myself "This isn't true", followed by "why me". I felt nauseous and unprepared for such direct and hard-hitting news. Experiencing a period of loneliness was immediate as the room fell silent and I felt myself drifting off into my own tiny bubble. Nobody could come close to understanding what it was that I was experiencing.

My body felt exhausted and drained from the emotional lows as I struggled to find or hold hope of positivity in that moment. All I longed for was to be me again and distance myself from the apparent reality. Although I was crying on the inside and feeling deeply vulnerable, I never would have expressed my true thoughts and feelings. My character had been molded through years of participation in a sport that was not allowed to reveal signs of weakness or insecurities. It was "not the done thing" as I could not show chinks in the armor to the opposition (e.g., hypertrophic cardiomyopathy). I was not prepared to reveal my authentic self on the pitch where the battle would have been lost before it had begun.

I longed for that hand to reach out and tell me everything would be okay, but it never came. Instead, I received the sharp edge of another knife ready to piece my skin and plunge deep to cause inner hurt and psychological damage. Feelings of despair washed away each layer of dignity and source of composure that had been grasped momentarily. I held the belief that a cure for the condition must exist and awaited news of the medication and procedure required to rectify the problem and get my life back on track (Sparkes 1998). Never would it cross my mind that it would involve something as significant and explicit as a heart transplant.

When my mind cleared from the groggy, concussed state, I picked up on the words spoken by the consultant: "there is currently no cure for the condition, it is just a question of monitoring it". My emotional expression shifted inwards as I felt extremely insular. My self-esteem was rocked, and a sickening feeling grew in the pit of my stomach. It was now a condition that would take complete ownership of my life as survival became a matter of chance rather than having the means to enact control through medication, operations, or a change in lifestyle.

The ricocheting noise of each nail being banged into the awaiting coffin rang loudly in my mind as it seemed nothing would allow me to live and continue as before. Accepting

that the person and athlete that had been curated years post-diagnosis was ready to be buried was unfathomable, yet the consultant gave little hope for survival.

Attempting to hide my feelings was more difficult than initially anticipated. Suppressing my emotional expression was similar when on the field of play. Situations of hopelessness meant trying to control one's emotions to prevent the opposition from reading your anguish through your own negative body language. My true psychological core was shining brightly when the Cardiac Consultant made a vain attempt at boosting my self-esteem whilst still protecting her professional opinion.

Unlike before, I could detect the trepidation in her voice as she spoke nervously and guarded each word like a psychiatrist working with a serial killer. Her tone was less direct, staring in the direction of her computer screen, the words came out softly, "a number of people live fairly normal lives and live for a long time with the condition", she said, being careful with the words selected so as not to provide me with false hope or to question her opinion.

At first, I had wanted to question her use of the word normal, as what did normal really mean, but I felt tired and exhausted and just wanted to leave without extending the pain through questioning the nature of my diagnosis. The negativity had become suffocating and contributed to my sense of despair as I found myself outside of my comfort zone. I had been forced to fight against all those positive characteristics embedded over the years as an athlete, rugby player, and now sports practitioner. My situation felt surreal, my profession as an Applied Sport and Exercise Scientist (Psychology Support) a lie considering the teachings often spoke about turning negative experiences into positives, something I was unable to shift.

Memoirs concerning the day appeared condensed and short. The time spent in that consultation room was lengthy and drawn as I felt every ounce of energy sapped from my body. Focus weighed largely upon the negatives, something academics and practitioners within the discipline of sport psychology train the athlete not to engage in. I was unable to control the part of the brain that seemingly focused on the negatives despite the years of applied training as a British Association of Sport and Exercise Science (Psychology Support) practitioner. Questioning the discipline and Cognitive Behavioral Therapy (CBT), that the National Health Service (NHS) in the United Kingdom where I live supports wholeheartedly as the philosophical approach of choice, my life-changing event shaped my own personal philosophy as an applied practitioner when finding an existential lens to be of greater benefit.

An existential perspective does not shy away from facing life's many challenges. Instead, it helps us to recognize that that we have freedom and responsibility as part of our existence to face these challenges with courage and responsibility and to live life on our terms. Positioning the lens from the outside in, the medical prognosis by the Consultant Cardiologist demonstrates a possible lack of experience when dealing with a niche, athletic population.

A lack of empathy and care was exploited, something medical textbooks are inept at teaching. Instead, I was expected to fly solo without accessibility to support networks as a means of maneuvering through the sense-making process and accepting/acknowledging the diagnosis, hearing from those who lived with the condition.

I remember leaving the room feeling lonely, afraid, and completely isolated from reality. I knew of nobody who either had the condition or accessibility to case studies I could read of athletes who had faced a similar demise. Yes, I had my parents, but not even they could offer any sense of clarity to what I witnessed and experienced. The long and winding road appeared to be a very bleak and lonely one without any prospects along the way.

Consultant Cardiologists needed to learn and understand not only the emotional expression that athletic populations who are diagnosed with the condition potentially exhibit but ways in which to best support this population through the transitional period. Instead, these medical practitioners were adding fuel to the fire as the symptoms I faced

were being exacerbated rather than diminished. Significant life events such as a forced transition out of sport can increase the likelihood of negative affective symptoms such as 'feeling blue', sad, and/or tired as the person becomes more passive and withdrawn, heightening the potential for depressive symptoms to become worse and even severe (Martell et al. 2001).

It was a journey that would trigger anxiety. Each step was taken in the dark with little clarity from knowledge or scientific rigor to catch me should I fall. I was asking myself "what else could I do" whilst family and close friends were interested in trying to provide me with false hope, a belief that I would be back playing "in no time at all".

I interpreted these words of encouragement as flippant remarks that contributed to the panic I had started to feel. As conflicting as it sounds, I still needed to hear words of encouragement and be given a fighting chance from medical personnel. They were exposed to scientific literature that would have quietened my negative emotional expression despite my mind, character, and identity aligned and continually craving involvement as a rugby player. Instead, my mind aimlessly filtered out the messages when a negative connotation was attached rather than listen to the substantiated evidence. I felt that the lack of available resources other than stern warnings not to research information on the internet negatively impacted on the potential quality of the adjustment that I made during this period of the career transitional process (Taylor and Ogilvie 1994).

Feelings of anxiety and despair started to subside, revealing themselves every so often since the initial diagnosis. Instead, feelings of anger and rage directed firmly towards the consultant for her earlier flippant response when asked whether I would be able to play rugby again, "No, you cannot play any competitive or physical sport again, but you live in a nice area so you can go for walks", started to consume me. It was evidenced by the lack of understanding towards the situation by those in patient-facing positions. My identity was fractured and everything I had worked hard to become in terms of skills and application lost value in that moment (Cosh et al. 2013).

Emotional outbursts became more frequent means. I vented my frustration in ways that showed no signs of vulnerability. It was my way of coming to terms with the loss I had now experienced. Although sounding somewhat dramatic, my world had literally collapsed as I repeatedly asked myself "why me". I now sought more meaningful ways to express my discontent, looking for scapegoats to point the finger of blame and smooth over the cracks that began to appear in my character and identity.

Feelings of anger towards friends who smoked and lead sedentary lifestyles consumed my inner being as I believed they had earned the honor of being diagnosed with some health-related condition. It was they who were more worthy of such news as it was a condition that would not have ripped them inside out and forced them to question their very existence. I kept asking myself "why couldn't it have been one of them" when other people were asking "how did I get it", and "that can't be right". Perhaps my own behavioral response, subconscious or otherwise, disrupted the ability of those closest to provide adequate support due to the noticeable change in social dynamics resulting from my own diagnosis.

Inevitable questions of "what else could I do" entered my thinking as I switched from emotions of anger to ensuing panic. For it was the fear of the unknown that was eating my flesh and leaving me with the empty carcass from which to live and survive. Without sport as a means of a cathartic release from all the pent-up anger I had inside, this new chapter proved challenging due to the unexpected and uncertain nature of the situation. The emotional expression I experienced was exacerbated because of feeling abandoned and rejected not just by the rugby culture that had nurtured me for so long but by friends and family who viewed me differently. My own insecurities expressed themselves in a negative and reactive manner (Carapinheira et al. 2018).

My whole personality appeared to change suddenly as a direct result, and I was not liking the look of the person starring back at me in the mirror each morning. It would be wrong of me to even assume that I dealt with the prognosis in a mature or stable manner.

Anger was channeled through blame and emotional outbursts at those who I believed had given me the HCM gene and in my mind ruined my life. Inevitably I had become part of the blame culture, losing the positive characteristic(s) learnt and embedded as a rugby player as the automatic response to fight back in the face of adversity had been suppressed.

Momentarily the pain eased and allowed me to direct my anger and frustrations away from myself, but in the aftermath, I would lock myself away in my room and breakdown in tears. I felt shame and hurt at the way I had treated those I loved dearly and questioned whether the condition had contributed to the person I had become or was it a part of me that just lay dormant.

Although not a regular church goer, I attended Sunday school as a young lad with my parents. In adulthood, church attendance was sporadic, mainly restricted to the religious festivals over the Christmas and Easter periods. However, I believed in God and would pray in the changing room as part of my pre-match routine. It helped to settle the nerves and gave me a sense that I was not alone when going into battle. I now started to question the limited faith I had and mulled over the question-and-answer session in my mind, "Why me", repetitively, quickly followed by "If there was a God then I would not have this condition". These comments were tame in comparison to the tone of the inner critic who started to become more ill-disciplined and aggressive towards God and religious beliefs that I reluctantly held in the weeks that passed.

Part of my self-abuse involved acting inauthentically. One woman whom I was seeing at the time was many years my senior. In hindsight, she provided that nurturing motherly support I craved. She was from mixed heritage like me, and I longed to find a connection after the rest of my identity was fragmented and lost.

Generally, I held no attraction. My diagnosis created identity conflicts as I felt a sense of panic and anxiety, questioning who I was as a person whilst searching for that challenge and excitement I had lost by not playing. Deep down, I felt extremely vulnerable but would never have wanted to admit it as my life felt surreal, like I was living in a dream, one in which I wanted to end. I did not know how to deal with the situation, and people were not forthcoming in offering support or confronting what had happened head on.

I assumed that my approach to the diagnosis was part of my identity, established over the years within rugby environments. To me, "they" were the opposition who I refrained from casting any shadow of doubt as to how much pain I was suffering, physically or psychologically. Values associated with rugby were inclusive of being stoic, 'a real man', and not complaining about hardship (Howe 2001). Even after 'playing the game', I felt a sense of loyalty to uphold the values that had been drilled and refined over years spent within the confines of rugby culture.

In a strange but comforting way, I had learnt to deal with feelings of isolation and loneliness from a young age. I had to fend for myself in a world with other people, creating a solid foundation on which to continually progress through life's transitions, both in and out of sport. With my mother's family living overseas, I only had my birth parents to turn to for support. Subconsciously, I had accepted that I was alone and needed to confront and deal with personal experiences in isolation.

Not having a wide network of people to turn to had been a fundamental part of my life, beginning with the boarding school culture that influenced how I viewed myself and subsequently handled situations growing up. Had I had strong social support networks that I was able to access and feel better protected (Eggleston et al. 2020), my transition out of sport may have been less problematic, but I only ever trusted the opinions of a select few. Focusing my mindset and directing the spotlight inwards on myself pushed me to deal with the situation on a personal level, developing mechanisms to confront the ensuing feelings of panic and despair.

My ability to search, test, and learn from a variety of coping mechanisms evolved from my own life experiences that were eventually woven into my day-to-day life, mechanisms that may have been lost or not even found had I relied heavily on the support of others to find solutions to my problems. Perhaps my extended family would have complicated

my transition out of high-performance sport, but I had little interaction with them. How could they know what was right when they did not have the same lived experience of a life-changing diagnosis when pursuing a career in elite-level sport?

Keeping my extended family in the background felt constructive, although when applying the lens of sport psychology, I was merely using an emotion-focused strategy to regulate my emotional expression. Rather than confront how I was feeling head-on, I chose to use a scapegoat to divert my pain, anguish, and despair. This was difficult when I learned that the condition was genetic. Releasing the trigger of verbal ammunition in my family's direction gave an immediacy of catharsis. All the pent-up anger that had been bottled fired off as I blamed my family, "not mine", for ruining my life, knowing how hurtful the distance I had placed between myself and my immediate bloodline would be. I was angry at the fact that I had lived my life outside of their shadows, yet they still managed to invade and intrude on my life in the most destructive way.

Creating this fabricated account meant I had scapegoats at whom to vent my frustrations and anger towards without them having the opportunity to respond and defend themselves. This provided the ideal scenario in which to vent and then search for ways to cope with my new reality.

Hate is a term that is often used flippantly. However, I feel justified using such vocabulary when the red mist descended, and the emotional pain and reality of the diagnosis hit hard. When told your life as an athlete is over, it sounds insignificant when verbalizing it out loud. I describe it as feeling akin to internal torture, my mind flooded with such "hatred" towards "them" as the flames of my anger grew. Only when experiencing such devastation firsthand can you distinguish accurately and honestly between the contexts of dislike for others.

When the page turned towards the new chapter in my life, I remember thinking that I am just another number in the hypertrophic cardiomyopathy ratio of 1 in 500 people diagnosed with the condition (Maron 2002). Feelings of isolation and loneliness became more pronounced as whilst the consensus viewed it as a relatively common genetic cardiac disease, I was the only one in that ratio whom I knew had been diagnosed with the condition.

My anger was raw and suppressed as I questioned how many "athletes" were amongst the neatly packaged statistical ratio. It was the lack of clarity and blanket approach to those diagnosed with the condition that contributed to my anger and immediate frustration. When in the bubble of high-performance sport, every athlete believes that they are going to "make it" and be successful, and I was no different. Naively, you feel that you are different from "everyone else", a term I would use to describe the general population, yet here I was, a statistic that did not differentiate me from anyone else with a hypertrophic cardiomyopathy diagnosis.

My blatant and purposeful use of the word "is" opposed to "was" was because I still considered myself an athlete during this period. Surrendering the term "is" was as good as admitting defeat and giving up hope of ever playing rugby again. I did not want to engage in any form of support for fear that the values I learnt and embedded through my days as a 'rugby player' were questioned or shamefully broken. My perspective on 'getting support' was that it portrayed a weakness that others within the rugby culture would never have predicted, let alone understood, if I confided, outpouring my emotional expression towards another regarding my critical event (McKenna and Thomas 2007).

A paradox was at play where I sought direction and certainty, yet I wanted to maintain the persona of the 'rugby player', an identity that portrayed a stoic, masculine persona that refused to talk about and discuss my thoughts and feelings. Keeping the tension bottled up without an outlet to release all the pent-up emotion and confusion ended up being targeted in the direction of others or through destructive behaviors that I knew would drive a wedge between friends and family. My default was to push others away by acting like I did not care about anything or anyone when deep down I was hurting and felt a sense of

hopelessness as my life was all mapped out until I received the devastating news that life felt all but over.

### 3.3. Denial[3]

The events that unravel throughout this section will address the coping mechanisms that I applied subconsciously. These strategies were an attempt to get through one day at a time over the course of a year and a half. Extracts will be used to portray the back-and-forth movements between the voices in my head and their interactions with my lived self, acknowledging how my exposure as a male rugby player contributed to such conflicts.

I became something of a loner during this period. I rarely hung out with people who were entirely from an athletic population, and my close friends became non-existent. I knew these people would be happy to see me, but I felt uncomfortable about feeling like an outsider, my memories a distant past, their memories new and invigorated, so I avoided any possibility of revisiting old ground, like Gareth, the retired rugby player in McKenna and Thomas's (2007) research paper.

Most of the time I was with my parents or alone in the confines of my room avoiding the opportunity for additional social interaction. The most extravagant trips were to the supermarket or the hospital. Withdrawing and losing contact with teammates, my self-esteem depleted, a common occurrence amongst athletes experiencing a transition out of sport (Butt and Molnar 2009). I began to distance myself from conversations about sport, rugby, or otherwise as I became increasingly irritated and sour at the prospect that the likelihood of me returning to "the pitch" was marginal, even though I kept fighting against the truth inside me.

The pitch was that sacred place where I felt at ease and where I was able to express myself as a person and display my masculine traits as a rugby player. Never did I visit "the ground" or any other ground for that matter after my diagnosis. Referring to "the ground" was a term of endearment. One that gave acknowledgement to where my teammates, friends, and coaches were based, a place where strength, unity, and commitment to the game were harnessed. It was now a place where I would feel like a misfit, someone who no longer lived up to those characteristics and instead would be inauthentic, trying to fit into a place where I felt I no longer belonged (McKenna and Thomas 2007).

To watch the game I loved instead of participating felt like self-harm, a form of brutal punishment that was bound to have significant mental repercussions. Avoidance felt like an appropriate strategy as I did not want to put myself into a position where I looked vulnerable or to reveal any sign of weakness. From a mental perspective, I believed that I had been broken and defeated by the condition, a time to "hang up the boots", a metaphorical saying when players acknowledge that it is time to retire. However, I was 26 and not ready to retire as my body was still in peak physical condition. I aligned to a different rugby player, a player whose identity was that of the consummate professional, the one that plays through the pain and always comes back stronger and fitter than before.

Actions speak louder than words, and yet words were all that I had to hang onto. If I was to act on the identity I identified with then, I would run the risk of sudden death. Self-protection was an important coping mechanism and yet a double-edged sword. Addressing the concept of escapism allowed me to distance myself from the potential euphoria from ex-teammates, coaches, supporters, friends, and even family who may have persuaded me to play due to the illusion my physique still presented. I was reluctant to hear the positive support flippantly thrown in my direction for fear of the memories that would again be stirred to the surface (McKenna and Thomas 2007). However, the emotional-coping strategy of avoidance exacerbated thoughts of failure, that I had let people down, including friends outside of the sport who looked up to my achievements and spoke to others about my accomplishments. Now they would have nothing to say.

Avoiding contact with friends, coaches, or ex-teammates meant that these conversations would not rise to the surface or make others feel awkward in my presence. My thought process was confused and paradoxical as I did not want to be in a position where

I was forced to remember "the good old days", yet I did not want people to forget the "memories" or "me" in the process. It was a period where I needed to try and understand what was happening/had happened but only in private reflection and without the external influence of others to add to my confused state. I was not prepared to lose that part of my lived self that was still woven deep into the fabric of who I am and with whom I still identified. I think part of me was extremely afraid of the reaction that "others" would have when/if attempting to confide, providing a negative result to my vulnerable inner self.

Suffering a serious knee injury, albeit several years earlier, allowed me to prepare myself mentally for the stages I would have to experience throughout the rehabilitation if I were to "get back" on the field of play. Told by medical "experts" that it looked highly unlikely I would recover to play competitive rugby after the broken tibia, fibula, and full rupture of the patella tendon gave me a mental blueprint of what isolation and not feeling part of the team felt like. Watching the team from the outside in, to not having your teammates make contact to check how the rehabilitation had been progressing, put me in the "psychological driving seat" when it came to my subsequent diagnosis with HCM.

My mind was programmed into thinking that I was just injured, a dark and lonely place I had already experienced, before returning stronger and against the odds. Proving the "experts" wrong coincided with my growth mindset and natural stubbornness that it "would be" achieved again. Although my searches reiterated what had been told by the medical personnel, I still did my best to dismiss the information even when printed with clarity and precision in black and white. Rugby was a culture that had taught me to adopt a warrior mentality, injuries and challenges just being "part and parcel of the job", an expectation to continue despite ill health or risk of further injury (Arvinen-Barrow et al. 2017), ensuring I kept fighting and "played to the whistle".

Only when the whistle sounded was it time to acknowledge that the clock had stopped and the curtain called, signaling the end of the metaphorical game. I was still "playing on", oblivious that the strange-looking referee, dressed in a suit, shirt, and tie, had called time on the end of a short career. Bloodied and beaten I persisted, staring into the eyes of the opposition, a poker-faced mentality where the inner self was in pain but the outer shell gave nothing away. Many believed that I was coping with my situation, giving off signals that encouraged people to dismiss the condition as trivial and less serious than medically noted.

Interests in "the game" petered out immediately as I flicked past the sports pages in the newspaper, reading every other article from football to more remote sports but leaving the rugby section to the imagination. I refrained from watching any rugby match on the television. I knew that my father would attempt to discuss and revert to my own playing days had we watched together so avoidance became my best tactic. The result would often be mentioned over dinner but not with any conviction, and no attempt was made to generate conversation based on headline news.

There was a reluctance to focus outwardly on my rugby pursuits as I reflected silently to myself on what I had lost and the isolation that I was feeling. In the presence of my family, I attempted to put a brave face on the situation as the learnt messages of 'do not show signs of weakness' played. Getting to grips with my new life, a life without rugby, declined from impossible to challenging, but the void of no physical activity being present within my day-to-day calendar felt traumatic, incomprehensible in fact.

I feared for my future and felt lost in a blackhole of nothingness. Everything in my life had been built on solid foundations and dreams, a career that involved physical fitness or outdoor pursuits to years of studying the discipline of Sport and Exercise Science. I had fought hard to achieve the qualifications required after years of advice from my parents saying "it would give you a larger scope of potential career paths and ones that offered more monetary rewards for the time invested".

These "choices" were no longer "choices" as my options became narrowed and the "choices" I had were those that were forced upon me. My 'new normal' involved no exercise or intense physical exertion. When allowing myself to be hooked by the thoughts, feelings,

and sensations experienced as a reaction to my new reality, I could find myself reverting to feelings of overwhelm, panic, and despair.

Pursuing a career within academia was not a choice I considered as the "not good enough" story became ingrained over the years by teachers who openly disclosed their lack of confidence in my academic ability. Lecturing, however, kept my toe dipped within the industry whilst providing an opportunity to share my experience as a former rugby player within an applied theoretical landscape of sport and exercise psychology.

In hindsight, it became unhealthy as it enabled me to maintain the identity of a rugby player for two hours, a criticism made by a colleague conducting a mandatory lesson observation. The observers felt that I needed to use examples from other sports, although I was reluctant as it helped me to live in the body of the person that I was not ready to relinquish. Effectively, I became two people living distinct and separate lives, the person living with a potentially life-threatening heart condition in parallel with the mythical fit, healthy, and aspiring professional rugby player within the same body.

Students became my spectators, people I could influence in a positive way based upon my insights and performances whilst allowing me to avoid and escape the reality of my lived experience. I had the psychological resources to cope through years of research and applied work to confront my "new normal" but no experience of applying these skills and personal resources to a critical life incident that involved the self (Kenttä et al. 2016).

Choices I made with defiance were ones surrounding the condition. For example, support groups, where people with the same or similar variations of Cardiomyopathy talk about their experiences of living with the condition. Medical personnel are on hand to offer advice and notify advances in knowledge that have come about through research. My father felt that it was a great idea, something we should attend together. Why on earth would I want to attend something that calls out for sympathy, listening to the hard luck stories from people who are not in the same situation as me?

Not only was my father trying to "make me see sense", but he joined forces with my mother, a coming together of allies fighting for the same cause. Did they not understand my predicament? How would attending a form of 'group therapy' with people 20 or 30 years older with the condition be helpful? I found the situation tiring and frustrating. If I had the condition with one hundred percent conviction, then perhaps I may have given the idea serious thought and consideration. However, they were not from an athletic population, nor were they living my 'new normal', so question marks hung like a dark cloud, clouding my better judgement.

My father attended the event alone whilst my mother voiced her own discontent at my absence and for not supporting him. It was a period when I was self-absorbed, selfish, and cared only about myself. If these people in attendance were of no benefit or could not help me in finding a solution, then I considered them redundant. I carried the same mindset from my days as a rugby player.

If anything, I felt that my attendance would make matters worse. Rather than avoiding the topic of conversation, I would be forced into thinking about my 'new normal', potentially consuming my thinking hours after the event had passed, alone and without support. Ironically, injured athletes, depending upon how they interpreted and received the support provided, influence their ability to cope with the situation on a psychological and emotional level. Avoidance potentially prolonged my ability to adapt, learn, and grow from the experience if having the courage to face "my new normal" (May 1983).

When my father returned, he brought with him handfuls of information. I was stubborn and disinterested, not bothering to ask him how the workshop went or what information was discussed. Instead, I listened attentively as he spoke to my mother in the kitchen. I did not want to give any inclination that they were right or receive the usual sarcasm my mother would use to delight in the fact that she was right and I was wrong. Our aims and objectives were different.

My aim was to escape from the reality of a situation that paradoxically was viewed through the lens of being surreal whilst 'they', my parents, wanted to confront it and gather

information that informed and proved the medical personnel correct. My parents' refusal to listen to my own concerns even subconsciously upset me. I felt like a child, incompetent, trapped in the concealed enclosure of my own mind and unable to voice my concerns. It was like I lost a sense of control as my parents looked at the world through their perspective instead of a willingness to look and see the situation through my eyes.

Nobody I shared my life with outside of work cared about the person I used to be. These individuals were interested in the boring, solemn, and introverted individual now labeled the academic, lecturer, friend, boyfriend, son, or father figure. These were identities that I cared far less about. However, I grew to love the adrenalin-fueled lecture theatre, a place where I was able to leave that person at the door and step into the rugby player persona once more.

Time flew by as I seemingly entered a state of flow, an enhanced state of consciousness and aligned combination of body and mind. People appeared interested in listening to the application of specific techniques when applied to a real-life rugby environment. Lecturing had become therapy in reverse as it allowed me to identify what I believed I was and not what I had become. My approach to the traumatic event revealed that I was potentially more invested in the identity of the "rugby player" than I initially knew or believed, triggering a heightened tendency towards identity foreclosure culminating in longer periods spent denying my new lived reality (Kerr and Dacyshyn 2000; Lally 2007).

It felt enthralling and fueled my excitement when I was in front of the students in the lecture room, but when the drug wore off, normality hit, and the depressive feelings and emotions associated with loss were immense. Entering a state of deep inner reflection, the questions of "why me" and "what if" percolated to the surface as I obsessively reviewed what had happened. My life was sedimented in the past, feeling unable to shift my narrative to one that highlighted my present.

I questioned whether those students ever believed in my accounts as a rugby player, looking down from their seats in the lecture theatre at a meagre, out of shape person that resembled my 'new normal' rather than that of the athlete. My perception of how I looked correlated with feelings of inauthenticity, like I was living a lie. Body image was a source of distress that blurred the internal lines within my own mind as I longed to stick with the athletic identity, yet my physical body was becoming that of a "normal" human being (Warriner and Lavallee 2008).

Nonetheless, these experiences were a release, a form of therapy that allowed for escapism from my present self whom I had not learnt to love nor hold with self-esteem. All the pent-up frustrations and anger could be channeled momentarily through my enthusiasm for 'the game', using it as a vehicle to generate interest in the theoretical underpinnings through a real-life context(s).

Stepping inside the shoes of the 'new me' pulled me apart. I sought environments that gave me my steady fix of dopamine, making me feel alive rather than stuck in the laborious life that I now lived. Others did not acknowledge my demise, either through ignorance or not knowing the person I now mourned. Inadvertently I interpreted this insight to be a negative result due to the lack of empathy shown (Harvey et al. 1990).

I was caught up in a vicious pattern, one that ignited the fire in my belly before relapsing back into the dismal place that was now my reality. I shut myself away and flooded my mind with continuous thoughts around "what could" have been. In my mind, I saw myself making it as a professional rugby player and used the knee injury and HCM diagnosis as excuses to protect my ego. Perhaps I was not good enough even had I been fit and healthy.

My life was very much in fight or flight mode. I found it easier to avoid situations that reminded me of what I had lost, distancing myself from people that existed within these high-performance sport bubbles. Life was akin to a balloon slowly seeping air as I felt the muscular frame of my body start to diminish alongside the deflated feelings and emotions of my mind. Resilience, a character trait I was once proud to align with, became a strength that was now overplayed. Subconsciously, my resilient nature caused me to cling on to

what had gone long before I realized, a loss that would be forever, not a momentary lapse of months or years.

I fought to maintain my composure and identity as a rugby player. Something that was easier amongst those who never knew my life before HCM. People who knew me in a friendship, teammate, or coaching capacity would now see me as a "had been", someone who had had their time and was now on the metaphorical 'scrap heap'. Like most athletes, I found it challenging to accept that my role as a rugby player was over and retained the continuation of my past persona by referring to myself as an ex-athlete (Butt and Molnar 2009). A title, if needing to choose, that would be interpreted and assumed as being more interesting than "University Lecturer". Those who did not know my life before HCM gave unconscious permission to tailor my story to suit my needs, reliving the past as if it was my present or future, accounts that were fabricated to create and generate more interest.

It was a period in my life that was embroiled in shame and guilt (Butt and Molnar 2009). I found my values compromised as the warrior mentality absorbed and lived as a rugby player turned to cowardice, a man unable to be authentic and meet the situation head on. Instead, here was a person who shied away from who they were or the consequences of what had happened, ironically a sign of weakness that I did my utmost to avoid.

It would have taken far greater mental strength than any training session or match to stand up and tell others my 'new normal' narrative. The easy road was to take the avoidance-driven path, one that avoided the reality of the situation and isolated myself from being forced into a position where I would be expected to own up to the reality of my "new normal", a place in which others could prize open the cracks, revealing the vulnerable true inner self that lay hidden from external view.

### *3.4. Intrusion Phase*[4]

When the doom and gloom started to clear, I became slightly more accustomed with the statistic of being 1 in every 500 diagnosed with the condition. I had not come to terms with the condition in its fullest capacity but the possibility that there was a "small" chance of me having HCM allowed me to look deeper into what it would mean for "someone" should they be diagnosed. It was through periods of deep reflection that the reality of the situation became clear and apparent.

My masculinity began to be stripped away. Friends with whom I previously trained with for three years passed comment about how small I had become, "look at the size of your arms they are little boy's arms now", breaking into fits of laugher, normally considered as harmless 'banter', but now it was different. Words began to stick and sink deeper, holding an emotional weight that impacted upon my self-esteem (Nichols 2018). Instead of having the opportunity to rectify the problem, I was forced to detrain and confront the fact that I was now a person with a heart condition.

Deep down I longed to confide in those I held in high regard, people away from the sport and family who were invested in the condition on a psychological level. However, my condition was received with a distinct lack of empathy and instead of feeling like I was able to talk I shut down, continuing to risk my life just to prove to others that I was the same person as before. Interpreting my attempt to confide as a negative result (Harvey et al. 1990), I felt I regressed, even if momentarily, to a place of escapism.

Knowing alcohol and heart conditions were not compatible, I still engaged in the drinking games, an inner anger raging quietly inside as the inner voice asked, "Why are they allowing this knowing my condition?". I was angry at myself for tossing my values to one side and at them for showing little regard for my feelings, emotions, and being focused on themselves.

My rebellious self was engaged as I regressed back towards the 'outcry' stage, depressive patterns, and little care for life as my deep-held beliefs and values were lost, engaging in ill-advised behavior. My situation felt like an opportunity to poke fun and joke at my expense, the last straw being a photograph of myself that was revealed. They proceeded in

shouting and pointing "That's the Lowie we want not this one", lowering my self-esteem (Werthner and Orlick 1986) as changes in body image became noticeable.

Language had a far more significant impact, reinforcing what I felt. The food I ate began to sit more readily on my waistline, and the effects of muscle hypertrophy had started to reverse as my body weight reduced. Reality around the 'new normal' started to develop as I recognized that my body was in decline.

Even when attempting to convince myself that nothing had changed, friends told me otherwise: "I remember when you were like an Ox and I couldn't control you", another sniggered, and stated "even I could easily control you now", as reference to our play fighting or scuffles in town. Mirror images reflected signals of change, confirmed by the ill-fitting clothes, making each inch lost in muscle a damaging reminder.

Regression towards the 'outcry' stage occurred momentarily, feeling anger towards others who chose not to take my situation seriously, resulting in humiliation and then panic as I worried about how others in the world would now view me if so-called friends longed for the other person, the "rugby player". Despite the "banter" and inner turmoil that their comments created, it sparked both a want and a need to learn and know more about the reality of the "new me". Comments received held up the mirror of recognition as my best attempts to forget or maintain the persona of the "rugby player" were failing miserably.

One of the first things "they" tell you, a classification I had given to anyone medical I judged as evil and incompetent due to their diagnosis of HCM, was not to research on the internet. Studying Sports Psychology at postgraduate level, telling a human being not to think about or not to do something activates the brains immediate response to focus on the "don't do" instruction. After considering the probability that having the condition was more than just a fleeting thought, I found myself "logging on", a term used by frequent internet users, typing "hypertrophic cardiomyopathy" into the Google search engine.

My personal vendetta had begun. My initial search threw up pages and pages of what can only be described as horrific information relative to HCM. I searched for hours, and days, turning into months, for that glimmer of hope for anything "they" had missed.

Exhausting all internet-related avenues became tiresome, not providing the result that I sought. My brain had become so detached from reality that it was like living in a personal cult where I had brainwashed myself into believing the narrative I wanted to hear, entirely of my own doing. I convinced myself that I was the one who was right and the medical personnel with all the knowledge, qualifications, and expertise in the field had misdiagnosed the condition.

An obsessive review of the condition materialized when in isolation, having time to think about the "slight" possibility that I may never play rugby let alone participate in physical activity within my lifetime. I use the word "slight" with trepidation. Based on personal facts and evidence gained through reflections and self-questioning, the scales were tipping fairly in my favor.

For someone aged 25 years and reaching what most consider the twilight years of one's sporting career, training nearly every day since the age of 16, I had every reason to be skeptical. Whenever I attempted to gain some reality and perspective of the situation, my mind immediately focused on how much I used to bench, squat, and deadlift, something someone with a potentially life-threatening heart condition would be unable to do let alone survive, making the realism of potentially having the condition vanish from my thoughts.

Each day that passed moved me a step closer to the HCM badge of "dishonor". The tug of war between remaining in the body of the rugby player who had carried me for so long and the "other person" who was trying desperately to be me was fraught with tension. A natural dislike for one another emerged even though one would have never had been possible without the other. HCM was not something you could possibly wear with pride as it was a symbol of being sick, weak, and needy.

These characteristics were alien to the person I used to be in the past compared to the person I was learning to become. Since early childhood, I had been conditioned by the testosterone-fueled sporting environment, culture, teammates, and coaches that a

fearless, mentally strong, and resilient persona were characteristics that pushed you to the next level.

To relinquish those characteristics meant giving up the important parts of self that made me the person I am today. Thoughts were generated, yet contaminated, as I assumed and reviewed obsessively about how others would associate and fix negative connotations to my new identity despite my attempts to engage in the values that had been instrumental in overcoming challenges in the past.

Stories I heard from other people with the condition reinforced these beliefs as they had embraced the "poor me" persona, yet here I was, a former athlete who had to live with the shame and humiliation of not fulfilling my ambitions (Kanemasu and Molnar 2014) instead of being part of a community of so-called "HCM Warriors" who in my mind were weak and fragile. I had a tough time embracing this part of myself as it felt like a ginormous disconnect forcing me into a deep internal depression as I battled frantically with my own thoughts and feelings.

When sporting spectacles provoked discussion within our household, I contributed as boldly as before and talked about the "ifs" and "buts", but now the effects were different. I started to internalize everything, and it made me feel depressed when on my own and with time to think. Feelings of guilt consumed me as I became distracted by thoughts of letting my parents down. When "playing the game", it was an opportunity for my parents to remove themselves from the monotony of the household chores and spend quality time with each other.

My father loved to talk and meet people at the various clubs and venues that we visited over the years, talking about the game and what I needed to work on in training for the week ahead. It felt like I had robbed them of any enjoyment, sidelined with something not physically visible. I interpreted the situation with a sense of embarrassment when my father had to explain to his friends about the reasons for my premature retirement.

During sporting occasions, I was totally engrossed. All thoughts of me having the condition vanished as my focus became absorbed on what was happening on the screen in front of my eyes. Once the 'match' or 'race' had finished, when the discussions had ceased, the postmortem of my own career and inevitable condition began. I started to reminisce in my mind's eye all that I and those closest to me had lost.

Photographic images fluctuated between specific game-related situations, triggering somatic responses of adrenaline and cortisol being released into my blood stream. Going to the movies in my head stimulated my neuromuscular pathways bringing neural misfiring's to my rusty and disused muscles. Each image brought with it a sense of reality, stepping back down memory lane.

Opening my eyes brought back the true realization, circumstances that had taken over my life, washing away the positives and muddying my thoughts with raw pain and negative emotions. The question of "why me" circulated, flooding the prefrontal cortex and shifting the blood flow to the amygdala, the irrational and illogical mechanism of the brain, as I regressed to feelings of overwhelm and shock as the traumatic event jolted me into my "new normal".

I felt there was a disconnect, a gap that emerged, preventing my parents and I from discussing previous sporting exploits openly and honestly. My parents did not want to say or do the wrong thing. Not knowing what to say stifled the conversation with a natural reluctance on my behalf as I felt guilt and failure towards them. Isolating myself, my thoughts and feelings made it uncomfortable to discuss and express myself authentically.

It gave the impression that I had regressed into the stage of denial when in and around significant others, yet talking about my previous life with total strangers who had not known the "rugby player" felt comfortable and unfiltered. I think I was fearful that my confiding would be received with a negative result by those who knew me (Harvey et al. 1990) and avoided the opportunity to express how I was feeling.

Paradoxically, those who knew me seemed more interested in the "new me". Those who never knew the old person were more interested in the life of the "rugby player". I

assumed that the 'rugby player' identity was a positive role model, intriguing and easier to form connections with their own selves than the 'other person' with HCM. Emotionally I felt exhausted, living in the past felt dishonest and shameful when meeting new people who had no insight prior to my prognosis.

I always found myself referring to my exploits as a rugby player instead of who I was today. Receiving negative results when it came to confiding with significant others shaped my narrative, blending the shame I felt concerning my diagnosis and failure to meet the demands of the sport. It created an internal fear with thoughts circulating around how others would perceive me if they knew the "real me".

Academic achievements I assumed were not enough to separate me from the rest of society and give that "wow" factor. I still craved the need to feel like "a somebody", someone different from the norm, a person who was one of the few rather than a person amongst many. I always hated school, education, and being amongst teachers within a classroom setting, and now I felt I was becoming one of 'them', those people in a profession I despised.

Who I was made me feel inferior, ashamed, and normal, just the same as everybody else with no difference, excitement, or manliness about what I was currently doing. Pursuing a career in a field perceived as more sensitive due to the exploration of one's thoughts, feelings, and emotions (i.e., psychology) seemed at odds with that of a rugby player. Disclosing thoughts, feelings, and emotions would be considered weak and fragile.

I guess living in the past was my way of proving my masculinity to those who did not know me whilst holding onto the identity I internalized as being more exciting. My present self, inclusive of the HCM condition, was used as an excuse for my impending failure to make it in the world of professional sport.

The intrusion phase lasted for approximately two and a half years as I tried to make sense of what had happened, reflecting alone and in isolation as I found it hard to even understand the emotional expression I was facing and trying to confront. Certain elements were shared with significant others, but it mainly touched on brief headline news and cliche responses whenever someone asked how I was feeling.

What I shared was dependent upon the audience with little issue talking about rugby, who I played for, and my knee injury rather than a brief snippet concerning my heart condition. Talking about my diagnosis and transition out of high-performance sport felt challenging.

When, on occasion, the conversation evolved around my condition, I felt myself regressing back towards memories of the traumatic event, triggering thoughts and feelings associated with panic around what the future self looked like, merging into denial, as I longed to hang on to the person that had now been dead and buried, the metaphorical coffin a quarter of the way into the ground.

Although negative results at confiding influenced my regression and halted my progress in coming to terms with the "new me", this was always short-lived. These occurrences forced me to look towards ways of accepting my new reality. I found myself researching the condition even if to search for evidence that dispelled the diagnosis. However, it proved to be the catalyst to move towards embracing more of the "new me" as I had to start accepting that life had changed and others who were significant in my life no longer associated me with the "rugby image" and persona.

On occasions, I opened up to my parents after reflecting intently, often in isolation, about my situation. My mum was often the person that I would find challenging as she too could not understand or comprehend how I had the condition. Although it looks like she was siding with my perspective and dismissing the medical knowledge we had received, it was not the support I was after when reiterating "I just don't know how you could have a heart condition, you don't have anything wrong with you", that made me respond through the eyes of despair, "Well I obviously do have it or else I would still be playing wouldn't I!".

My father was far more diplomatic and provided a positive result that was received with a greater degree of empathy for what had happened and did not intend on burying his head in the sand. Instead, he looked to pull the emotion out of the situation by trying to make a horrendous situation more accepted and livable.

My father would often insinuate that the condition was not as bad as it could have been, using the thickness of the heart measurements as tangible data in which to form his argument in a diplomatic way. Although my father attempted to be that pillar of support, these responses to my question "Is it bad Dad?" only stemmed the flow of stress and anxiety momentarily and often depended upon my own mental state as to how I would respond.

Even on occasions, these positive responses to my questions were met with panic, despair, and exhaustion as I felt like my father was just trying to be positive rather than honest with what was happening to me. Triggered emotional expression was a factor of formulating counter arguments within my mind before the question had even been asked.

If my condition was not that bad, then how come I was told I could potentially die from it? At times, it felt and must have looked like I had gone mental, as no sooner had I argued about the severity of my condition than I would suddenly attempt to counter my own argument and deny that I must even have hypertrophic cardiomyopathy.

The intrusion phase was complicated as it ebbed and flowed whilst I tried to obtain a better grasp of my situation and find myself within the "new" story that had been created. Although I spoke and presented about my aspiring rugby career with relative ease with those who did not know me, it became a double-edged sword.

During the presentation around sport psychology or conversing with others, I often felt ignited with enthusiasm, adrenaline pumping through my body as images of the past flickered through my mind like an online cinema, until those occasions ended abruptly. Emotionally, I felt dire, exhausted, depressed, and obsessive as I reflected heavily on what I had lost as a person, a rugby player, in terms of lifestyle, and my potential career in the game.

These memories felt real, like I was back on the field of play, laughing and joking with the rest of the "lads" when my actual lived reality proved far more mundane. Photographs from games and even school photographs triggered memories of the past, individuals that I had played with, people with whom you put your body on the line with, and these reflective moments took me to some dark places.

Thoughts often deviated to wishful thinking, wishing my life and mere existence had stopped when diagnosed, a regular accomplice that appeared during the aftermath of engaging with and reliving those aspects of self that I loved most. I struggled to live with the person I had become since my "other" self had died a slow and painful death. These thoughts, feelings, and reflections stayed with me for several years as I struggled with the Jekyll and Hyde persona of living in my past whilst trying to forge a new life and identity for the future.

### *3.5. Working Through Phase*[5]

Throughout this phase, opportunities to closely examine the attempts that I made to move beyond the barriers of the intrusion phase became present. Gaining perspective coincided with the ending of a meaningless relationship. It was a time when visibility surrounding my life's direction appeared blurred and lifelong goals ruined. My diagnosis was instrumental in creating a situation that my parents would never approve of. Indirectly, it was my way of rebelling and creating further emotional upheaval and turmoil, providing distance and a veil to shift direction away from the real issue at hand, my career termination and diagnosis with hypertrophic cardiomyopathy.

Several meaningless relationships void of emotion and feelings served as a means of escapism. Each meaningless encounter stroked my ego, sending a deeper message that I was still attractive to the opposite sex despite not training and being able to play the game I loved. A byproduct of these 'flings' was an instant hit of positive hormones, dopamine, and endorphins released into my bloodstream, something I craved and received when stepping

onto the rugby field. I guess 'they' were my fuel, a drug to provide not just a high but a sense of self-worth I feared losing.

My life had become a series of intense patterns that went from extreme highs to exceptional lows, feeling ashamed for weeks after seeing these women. Coincidentally, another significant turning point occurred at this juncture in my life when meeting a woman who later became my partner. Had my train not been delayed then our paths never would have crossed.

For the first time in years, I reversed back inside my authentic self, revealing my condition after a few weeks of dating, something that would normally have been unspoken, instead looking to portray a masculine image of someone indestructible. My attempts at confiding intensified as she passed no judgment and listened to my immediate feelings.

Since my diagnosis, I had not talked openly. I gained a greater sense of control surrounding my life and its various branches. My narrative around being seen as different and weak, an ingrained figment of my imagination, began to loosen its grip. My partner fell in love with the person standing in front of her, not someone diagnosed with a life-threatening heart condition or the former rugby player. I interpreted this as a positive result as my attempt to confide was received with empathy; I had been listened to attentively, providing humanity with a new perspective.

Receiving positive support and being understood was a moment of triumph. Knowing somebody of the opposite sex could still view me as masculine and not as soft and weak paved the way to search and outsource further opportunities to offload my stress and anxiety. Although reluctant to attend meetings with people suffering from a similar demise, I started to openly discuss my condition with immediate friends, family, and even strangers.

Although I had taken a large step in not feeling ashamed of being diagnosed with the condition, opportunities to talk reiterated reasons why I had not 'made it' in my intended career within the sport of rugby union. It provided a smoke screen, a safety blanket to save some pride and dignity. I was still uncomfortable confiding in deep and meaningful conversation concerning the condition with friends I had grown up with over the last 20 years as I still wanted to be perceived as strong and secure by those that I knew. The last thing I wanted was any form of self-pity.

Reassurance was something often sought during the months and years that followed my diagnosis. I bombarded questions in the direction of my father even though it was my mother who was more aligned with my trail of thought. My mother would respond every so often in unstructured fashion, "I don't know how you have got something like this, it just doesn't make sense", yet reassurance needed to come from my father.

Although it was my mother whom I sought emotional support from when the initial pain, anxiety, and fear had set in, it was my father who I believed in more. As shameful as it sounds, I basically held my father in higher regard when it came to more intellectually challenging situations. My father, like me, had been exposed to a public school education before working as a fund holding manager for a surgery in Suffolk. This put him as "first pick", a term used by all youngsters when it came to selecting who you wanted on your football team based solely on who you believed was the better player.

My father often attempted to soften the blow and give me hope in a clever and diplomatic manner. He never provided false hope but worded sentences in a way that highlighted how fortunate I had been when the situation and diagnosis could have been far worse. In my mind, I knew the tricks my father tried to play, attempting to make me have a positive outlook, but I knew it was my father's natural instincts to protect me from the truth (Park et al. 2013).

Often, I would receive responses from my father such as "Well you only have a slight thickness of the heart muscle in comparison to others" or "it's just precautionary at this stage". My preference is for an honest and direct response, but the words my father spoke seemed somewhat comforting and reassuring during a period of heightened uncertainty.

Had my father been direct and reiterated the consultant's diagnosis, I would have reacted emotionally, dismissive about the truth, pushing back against anything that tried to

break my resilience. I would have questioned the possibly of having such a "thing", using all the evidence, anecdotal or otherwise, to disprove of another person's opinion.

Proving others wrong had positive repercussions throughout my life whether academically or in a sporting context as it gave me the inner strength to fight back and prove others wrong. Naming hypertrophic cardiomyopathy, a "thing" felt refreshing as it dismissed the significance of the condition, making me feel more mentality at ease, created a sense of stability.

Even knowing my father probably had no answer to the spontaneous questions I threw up, such as "Dad how come I was fine for all those years and playing at a high level and training near enough every day, but nothing happened to me then?". My father never looked at me directly when not having an exact answer as he knew that his responses were based purely on hope rather than scientific fact. Dad had the natural knack of siding with positivity but maintained that it was only his belief and should not be taken as pure unadulterated truth(s).

My father's perspective acted as a source of self-protection for both him and I because if I should ever learn the truth and significance of what I potentially faced over the next months, years, and journey ahead, I would never be able to question the response that he had given as he was right in either case.

For those who know and relate to the board game *Monopoly*, my father had cleverly picked up his "get out of jail free" card and would be able to progress pass "go" without carrying the added burden of shame or guilt for providing me with misguided hope. Living in an isolated state when initially diagnosed and dealing with the consequences meant that I had shifted towards a more open and expressive self as I started to interact with those who cared.

It would be foolish for me to say that all encounters were rewarding as the emotions were still too raw to discuss. Often, arguments and emotional outbursts would evolve from the most trivial of discussions. One argument stemmed from my own selfishness when my partner wanted to join the gym to benefit her own health and wellbeing.

My interpretation and map of the world saw it as a negative result as my attempts to confide were received with a lack of empathy towards my suffering. Putting herself first was seen as an act of selfishness on my behalf. Knowing how physical activity was a huge part of my life felt like a lack of consideration as she told rather than communicated her intentions.

The significance of the situation was huge in my mind yet trivial in the minds of others who could interpret it as selfish, controlling, and manipulative. The feelings of neglect and emptiness were so strong. I felt isolated once again, feeling that nobody really knew what I was truly experiencing and going through. I broke down and hated myself for arguing but also felt ashamed of the mess I had become.

Searching for sympathy, I picked up the phone to talk to my parents, but grunts and prolonged silences ensued. My father even changed the subject to something that he was engrossed in on the television, making me feel empty, alone, and unheard as what I was going through was insignificant. I asked sternly for my mother, you are not even listening", to which my father tamely responded, "yes I am but something just caught my eye for that moment". I felt my mood changing, anger mixed with frustration causing me to snap "just put mum on the phone please".

Unsure of what it was I sought, my mother attempted to offer support and sympathy through directing blame towards my partner, saying "I don't know why she has to go to the gym all the time?". Already in a fragile emotional state, I found that her response neither supportive nor sympathetic. I wanted someone to just step forward and tell me to "grow a pair", a common phrase referring to being a man, as in my mind I questioned my own selfishness as to why anyone should put their lives on hold to tiptoe around me!

It was apparent that I had regressed into the 'intrusion phase', as although I made attempts to confide in others, my mind was continuously obsessing over what I had lost, my body image, and wishfully wanting to be back on the fresh green grass of the rugby

pitch (Harvey et al. 1990). My mind fluctuated continuously, one minute searching for some form of acknowledgement that the way I was reacting was appropriate and the next reminiscing over what I had lost and whom I had now become. Studies have found the significance of body image and its correlation with the construction of an identity in sport to be important (e.g., Sparkes 1998), highlighting the potential disruption when sport and physical activity are no longer available.

I was accountable for the argument that ignited. I had become selfish and encapsulated by the condition. I now needed people to be straight and force me to confront the demons that remained. I knew I had to let go of the jealousy and insecurities around losing the other person as my thoughts ran wild.

Assumptions were created that my wife would no longer find me attractive, constantly comparing myself to athletic individuals, soon to be like her own physique and therefore become more desirable. I knew I would lose either way unless I allowed trust to become a cornerstone of our relationship. I had to let her lead her life in the direction she wished for without my condition holding her back and changing love into resentment.

Defying doctor's orders, I attempted to workout at home whilst my other half was gym-bound to overcome the insecurities that played in my mind, silencing the inner critic that turned up constantly. Compromising my own health was a reaction to the insecurities that showed up, yet my inner being told a different story as cracks began to appear behind the outer shell.

I felt the need to lose weight, tone up, and stay on par with the new image that my wife would portray. I already felt the changes to my body during the years of inactivity. The fact that not only would my partner be doing something that I had longed to do, a part of me felt that a wedge would be thrust between us as the attraction and support would start to dwindle. It was a natural occurrence, with research finding that athletes perceive the decline in their physical selves after years of hard work and commitment to be extremely stressful and threatening to their self-esteem (Warriner and Lavallee 2008).

I was forced to come to terms with the condition and to encounter more intensified account-making around how the transitional period could either immerse me with bitterness towards my other half or be there to love and support her through a new chapter in her life. I decided upon the latter and obsessively reviewed these emotions to gain further insight into what they were revealing before they began to stabilize.

Initially, the attempts to confide provided a negative result with those closest to me. My partner seemed to swap roles with my parents as the years passed. Flippant responses demonstrated a significant lack of empathy, resulting in many a heated exchange. The realization became noticeable that she too lacked the knowledge of what I, an athlete, was going through.

When talking and seeking empathy about career paths I should have followed, my partner would generally respond with comments such as "your too old now" or "you need to forget it as you can't do it and you know you can't, so you need to get over it". All I wanted was to talk, unearth my raw emotions and express how low and depressed I was feeling.

Landing a job as a College Lecturer just compounded my low mood. I felt pushed into applying. Rather than challenge my desire to find work in the context of an environment that held little interest I saw it as an opportunity to escape conflict surrounding my earlier desire to confide when met with a negative result.

It was the opposite of my past life where I felt the need for an active lifestyle or a position where my qualifications had the best fit. The environment provided the context in which to isolate myself from those involved in high-level sports participation and afforded me the opportunity to mention "rugby" or my "heart condition" on my terms.

Knowing previous attempts to confide had been met with a lack of empathy or consideration for what I was experiencing, I was able to carefully select aspects of self that I wish to reveal within the confines of my new environment. Repercussions of those negative attempts at confiding meant that I was more reluctant to reveal my authentic self

to others as I was forced to reconsider what it was and what I am now experiencing. I found it a confusing chapter of my life as no sooner had I managed to confide in my partner it now felt that things had once again changed for the worse as I assumed she thought I just needed to "man up" and get on with life rather than reminisce on a life that once was but is no more.

Not having the recognition that I felt my qualifications and years of experience deserved influenced the low mood and feelings that I was experiencing. I did enjoy the role, and it caused me to question my values and beliefs. Life now seemed to be centered around the job and standard of living rather than what I felt was best for me. My partner would often say "well what are you going to do, you need the money" rather than considering my wellbeing and happiness after the turmoil relative to the diagnosis. The job of College Lecturer in Sport was often the scapegoat for more deep-rooted underlying issues as I attempted to cope with the condition and lack of sports participation.

I still needed to air my frustrations and pent-up anger that had been exacerbated as a direct result of working in a role that I felt was forced upon me. Emotional outbursts were often targeted towards senior management, college, and its principles as the workload did not equate to pay, making me feel like a pawn to the institution. Whilst I felt aggrieved at the way in which I was treated, most of the outbursts covered the deeper underlying issue of not achieving my personal goals in rugby union.

Each time I confided in my parents, I ended up feeling angry and frustrated. They did not appreciate the importance and significance of sports participation held for a former athlete. This merged with my father's tendency to change the subject towards his interests relative to the horseracing industry made me feel alone, isolated, and confused as I believed nobody understood or cared. My father made me feel like I was moaning about something of such insignificance as when in mid-sentence he would change the conversation to the horse or the race that was about to run. The lackluster support I gained from such interactions where horseracing appeared higher on the agenda than my health was turned to my advantage. I started to recognize the patterns that would emerge as I lay in wait for my father to be distracted by a horse or a specific race and revel in the excuse for an emotional outburst. Although momentarily it gave me the impetus to get the pent-up emotions off my chest, I soon experienced feelings of shame and guilt in the aftermath.

Similar patterns followed as I started to quiz my partner about the condition. It was a test, putting her knowledge to the sword as I subconsciously used the subjectivity of the feedback as a measure of how much she really cared. I needed to justify why I was the person I was by ensuring she knew the extent to which the condition and diagnosis had affected me. Although she had fallen for the person, there seemed to be a desire for her to know the physique of the man I once was, a result of my own insecurities.

My partner had been a support, attending hospital appointments, but it never felt like it was enough. Instead, her lack of appreciation concerning the scientific facts behind the disease gave me an excuse to release the tension I was experiencing through arguments that materialized. My father felt he understood my situation having played sport, yet his main pursuit was that of a marksman who competed at Bisley, and he never experienced the trauma of significant loss.

Nor did my father have to cope with the emotion caused from being forced down a new path that was unexpected, ending one's hopes and dreams. My father's sport was one which he would have enjoyed with or without an HCM diagnosis.

Interpreting my attempts to confide in significant others as a negative result meant severe fluctuations as far back to the 'outcry' phase involving emotional expression. I felt exhausted by my attempts to talk with significant others due to each episode being received with a lack of empathy or knowledge with regard to how I was coping. Reflecting on this period during the career transition journey made me aware of my tendencies to avoid conflict and appease others even if it was at the duress of my personal health and wellbeing.

Escaping and avoiding the need to discuss my career transition issues (Grove et al. 1998) were a byproduct of how I saw others interpret my initial attempts to confide in them, thus providing a context for self-protection when in the company of others. Instead, I often reflected alone as I tried to make sense of how I was coping in relation to how others had received my diagnosis and termination from high-performance sport.

Talking about 'rugby' and the psychological implications of performance were not too challenging, rather they were welcomed as they allowed me to maintain that identity from a distance, building rapport with the students. Merging my transition out of the sport due to a potentially life-threatening heart condition was not so forthcoming when instigating conversations as I naturally avoided any potential chinks in the armor for fear of negative reprisals. I felt trapped within my own head as I did not have an outlet at work or home to release the emotional turmoil that built up internally.

Revisiting the most significant part of my life's journey to date gave recognition to the need for confiding in people independent of my immediate family and friendship groups. Increasing my awareness around the need to talk openly and honestly around my thoughts, feelings, emotions, memories, sensations, and urges gave me the impetus to try and be more open. Starting to read some of the literature surrounding the topic of career transitions with athletic populations allowed me to recognize similarities in the struggles I had faced and the new challenges I was facing.

Previously, I kept these troubles to myself, although attempts at deconstructing myths and stigma surrounding the profession, recognized through my own working practices as an Applied Sport and Exercise Scientist (Psychology Support), were challenging. Labels of 'weakness' and 'mentally ill' rung true, causing me to distance myself further from psychological assistance having experienced a lack of empathy when attempting to confide in those close to my inner circle of friends and family.

People reinforced a stigma that would go against the identity I had tried to cling onto for so long. A paradox was at play as I knew the importance of accessing psychological services from a professional and applied perspective. However, if I was to personally seek psychological support, it would go against the voice of reason, disregarding an identity so deep rooted within the masculine dimension that is rugby union. Injuries were viewed as part of the game and as character building, a part of the job (Arvinen-Barrow et al. 2017), so to not recover and then access the support of an external professional source would be considered as having a lack of character and someone not suited to the game.

The rugby boots that had been kept in the back of my car "just in case" held a deeper meaning and intent. I could not throw in the towel and concede defeat as such a decision would signal the loss of identity as a rugby player. Any hope of a cure or misdiagnosis would slip through my fingers like a dropped ball in rugby, proving "others" right. My boots were living proof that I was (and potentially still am) a 'rugby player'.

Conclusions concerning the meaning and purpose behind my old worn-out rugby boots occurred through continual dialogue with a friend of a friend, someone known to me but far from being part of my inner circle. Subconsciously I knew that there were reasons behind my actions, but talking it through and engaging in intensified account-making allowed me to feel heard, understood, and to make sense of the tangled thoughts that I carried. As I spoke and they listened, I no longer felt alone and isolated. For the first time, someone was prepared to hear my voice concerning the pain and trauma, responding with a positive result rather than turning the tables to reflect their own situation or circumstances.

The person had known me prior to my diagnosis, missing much of the raw emotion and behavioral changes that occurred in the earlier years. I felt like they listened without preconceived ideas around who I was as the "rugby player" or the person that stood in front of them today, making confiding easier. What was important was that I did not feel judged or condemned for my behavior and attempts to cope with the diagnosis, they just held a genuine interest in what had happened to shape my life and the person I was today.

I wanted to "make a difference" to the lives of others who faced similar circumstances in the future (Erikson 1963). Writing my unfiltered narrative fueled with emotions, thoughts,

and feelings experienced throughout my diagnosis was a fantastic opportunity to get a marginalized voice heard, the voice of someone diagnosed with HCM (Vickers 2002). Concerns about my own mental health and wellbeing were front and center of people's minds as they questioned the personal cost and sacrifice I would experience through having to revisit years of trauma that had been suppressed for so long.

Elaborating on my account has enabled me to unravel the complicated parts of myself and take committed action towards entry into the working through phase, providing a platform for others to learn and grasp a better understanding of the potential emotional implications that retired athletes experience when diagnosed with a potentially life-threatening heart condition. Through writing and articulating the key moments in my career transitional journey, I will be better equipped with the knowledge and understanding concerning how best to manage myself, allowing psychological and authentic growth to occur that places me in a stronger position to help and support others diagnosed with HCM in the future.

Recalling my personal account stirred up memories of things I believed I had dealt with. I had chosen the avoidance-driven path, failing to have the courage to confront the emotions associated with my retirement from high-performance sport (Corlett 1996). Sharing my narrative within an academic context presented an opportunity to delve deeper and find the courage to choose a more aligned path towards speaking up and sharing my insights with significant others.

When you read my account, parts may feel messy, unrelated, and confusing yet fit together perfectly as the pieces of my personal jigsaw interlock together. Clarity will percolate to the surface, with reasons behind my behavioral response(s) evolving as you navigate through the often winding and treacherous roads. Hopefully, my story will encapsulate you within the emotional context in which I lived as my emotions become shared. Sharing my personal account will allow you to make your own choices as to the thoughts, feelings, emotions, and memories that are stirred, giving you the opportunity to relate or dismiss what is written as what has been pertinent for me may not hold similarities for you.

Writing in an unfiltered way, without fear of immediate reprisal, made it a psychologically safe space in which to share my thoughts, feelings, emotions, and fears. Prior to writing my account, I had felt out of control, confused by the lack of empathy towards my situation and attempts at confiding with significant others. I was hurting deeply on the inside, but I did my best to hide the pain for fear of being seen as weak and pathetic. I chose to keep my emotions locked away and withdraw as much as feasibly possible from friends and family who I assumed were finding it challenging to provide the adequate support I required.

Encounters with significant others have been depressing, even embarrassing, all of which have been an unfortunate and potentially necessary byproduct of my own career transitional journey. If I am afforded the opportunity to move forward and live a life with meaning and purpose, then these experiences are required to allow for deeper reflection and to 'know thyself' (Corlett 1996). Confrontations with my significant others left me feeling ashamed.

These episodes allowed me to reflect and break down my behavior into parts so I could gain reasoning behind my actions. It gave me a deeper insight behind the thoughts that had been behind the trigger prior to it being pulled. I was blind to the therapeutic qualities that writing held, something that would not have occurred if it was not going to be a challenge and had the goal of a qualification attached. Otherwise, I would not have had the motivation to start the process even if suggestions had been made surrounding writing's positive therapeutic effects. Instead, the task would have been perceived as homework, demotivating for someone that detested school.

My mind created negative connotations with the methodology. The explanation of what autoethnography entailed resembled similarities to a diary extract, putting my masculinity at risk should anyone investigate further. Reading and collecting other extracts,

personal stories of athletes experiencing non-normative events that suddenly put their identity at risk due to the need to transition out of a career in high-performance sport due to injury, ill health, or otherwise, was an important coping strategy identified in the social psychology literature (Carver et al. 1989; Lazarus and Folkman 1984).

Writing an autoethnography pushed me towards the literature where others had similar experiences, allowing me to contextualize their emotional reactions in comparison to my own. I was able to validate my own responses and move a step closer towards 'completion' and 'identity change' (Grove et al. 1998) as I began to better understand the emotional implications athletes face when confronted with a non-normative event, resulting in immediate retirement.

The date 1 December 2012 is unforgettable. "M", professional footballer and friend, had died from a cardiac arrest when playing five-a-side with friends in London. "M" was diagnosed with HCM when undergoing a medical assessment. His own transition out of high-performance sport had started months before.

"M" was someone who was not prepared to change their life and give up the one thing that he loved and lived for; football was his everything. He continued to play down the football pyramid, highlighting the significance that sport played in his own life but the challenges himself and others faced when attempting to transition into a life outside of sport, demonstrating signs of identity foreclosure (Park et al. 2013). Sport is a way of life for many of these athletes who are diagnosed, like drugs and alcohol being a necessary part of life for those with addictive behaviors.

"M's" untimely death, aged 27, brought a sense of clarity when reflecting on my own emotions and the behavioral changes that became evident during this segment in my life. The continual fight with myself and others was related to an unwillingness to let sports participation slip through my fingers. Death, however, was something I longed to happen during the initial 24 months after my diagnosis. Some would say I was suffering from depression (Wood et al. 2017), yet I had no medical clarification, and my preference was to steer clear of 'weak' and uncharacteristic labels. Although, even today, I still hit the 'brick wall', wishing life would be no more, I now recognize it to be the easier option rather than dealing with and overcoming what life throws your way.

"M" was the epitome of someone who exercised their own free will and chose how he wanted to live his life rather than being inauthentic and living a life that others enforced upon him. Looking in the mirror, I saw a person who hid behind the bravado as my actions failed to replicate my words as I refrained from all types of physical activity once the initial consultation had confirmed my worst fears.

I had surrendered to the condition and was controlled by it. Until I reflected on conversations between "M" and myself, I realized he had fought whereas I had fled. Since learning of "M's" death, I had the opportunity to reflect with an inquisitive lens, seeing similarities and differences in our respective outlooks on life. It stimulated confiding activity with significant others as I felt an obligation to ask questions, gaining an impartial worldview of others within my network. An academic in career transitions and sport psychology concluded through our discussions that there was a high probability that it was "M" who fled rather than having the courage to step towards the reality of the condition.

We will never know the truth, but we can speculate that "M" had a reluctance to give up his identity as a footballer, evident through our brief discussions. Through playing, he was able to forget he had the condition, demonstrate his worth through the talent he still possessed and have others talk about him as the 'footballer' rather than someone with a heart condition.

My life changed significantly. Arguments, ill feelings, and resentment are aspects of self that had not shown up when I could train, play, and compete at a high level, revealing part of my character that I despised. What I learnt through my writings and piecing parts of my life together when confiding in others was that I was not alone. Other athletes had similar experiences to my own, but instead of looking at life through a narrow lens, I started to observe how everyone's experience is also unique to them.

Rather than view "M" as an idolized hero, a life that he chose not to significantly adapt and change and mine as cowardly, deciding to step towards another direction, I instead saw them as different, the key similarity being the diagnosis, nothing more and nothing less. Unlike "M", who was unable to detach from 'football', through the reading and positive confiding results that evolved, the transitional process became one in which I evaluated my own meaning in life, recognizing the need to reassess my values and personal beliefs, to be aligned with my future decisions and behaviors and move forward successfully throughout the transitional process.

The conversations were a form of diagnostic framework to check whether "M" had similar experiences and responses to situations. Connected by the condition and our love of sport made us forget that we suffered the same fate in a strange way. When talking to individuals from a non-sporting population, barriers, resentment, and negative thoughts appeared prevalent even when they meant well.

Paradoxically, it illuminated the differences, making you acknowledge the condition, experiences of loss, and isolation that they failed to appreciate due to the lack of real-life experience in being diagnosed with HCM. Opportunities to confide with significant others created both positive and negative results. However, I was better equipped at taking a more balanced view and acknowledging which people and situations were of benefit to my own mental health, allowing me to step forward rather than regressing and becoming hooked by the thoughts that are stimulated during the negative attempts to confide with people who did not understand (Grove et al. 1998).

Text messages and emails from our conversations have never been opened since "M's" death. These messages serve as a timely reminder that each of us are on our own respective journey towards death, igniting a degree of urgency and responsibility in making decisions that will best serve myself and others in the short and long term (Cooper 2003).

Instead of moving onwards and attempting to be dismissive about the reality surrounding the situation, I found that my deepened sadness and grief towards "M" and his family and the strength of recognition concerning the magnitude of the life I had left behind were fundamental to my personal growth. I knew that if I was to learn and live authentically, then I needed to find the courage to confront and accept the situation that had been bestowed upon me.

Brief opportunities to confide with "M" helped confront the reality of the situation. It provided context around how serious the diagnosis with HCM was by bringing a sense of urgency to find my authentic self because of my daily routine being disrupted (Jaspers 1971). It brought my own life back into the spotlight where I had the choice to learn about oneself now that death, guilt, suffering, and struggle had been thrust into my vision (Yalom 1980), providing the opportunity to radically adjust my perspective on life whilst alive.

Remaining open and curious were important characteristics, as I learned from everyone that crossed my path. Whilst the negative results at confiding reverted me as far back towards the stage of 'outcry', I developed personal resources around resilience and mental toughness that allowed me to keep moving forwards after each setback. Each setback provided a high dose of cathartic energy that allowed me to vent and release the pent-up tension.

However, in the moment, responses fueled feelings of isolation, contributing to episodes of depression when hearing reactions such as "Your too old to play sport now... Your career would be over now anyway; It was good while it lasted; I don't see how you have got this condition; It isn't that bad; Go and do whatever you want; I don't care", made me acknowledge the magnitude of the words we say and the impact they have upon another person's wellbeing and transitional experience out of sport.

When my mood was low, my partner used to interrogate me and rather than address the issue for fear of her response, I used the job as a scapegoat. My internal reality was very different to the external persona I presented. I was seething, resentful, unfilled, and angered at what my diagnosis with HCM had stolen. My partner often said to me "I had to

do something with my life", forcing me into a decision I knew was not right, but I had little support in which to explore other avenues so was left feeling hopeless and alone.

My partner and parents tried to support me, but the advice they gave made the situation worse as I often remarked "you have not got a clue what I am going through." The outbursts were supported via anecdotal accounts from retired athletes who suffered a similar fate or those in deep depression. Each account supplied me with the ammunition to respond egotistically, "I told you so", a form of justification to cover the guilt I felt towards my loved ones for the anger and frustration that I pointed in their direction.

Searching for opportunities to converse with people who had expertise in career transitions with athletes, opposed to medical who attended to the public, felt of potential benefit if I was to be heard and acknowledged. Athletes diagnosed with the condition proved useful as it allowed me to openly confide and elaborate on my account. I could then work through and develop a more in-depth understanding of the emotional responses I displayed when in relation with other people.

Conversations with others who had faced similar scenarios, challenges, and situations as an athlete diagnosed with HCM brought a sense of relief. I had not acted out of character when considering the magnitude of the circumstance that had changed my life forever. My behavior became normalized through the sharing of similar examples by retired athletes, and it was in those moments that I started to feel human again.

In the years post-diagnosis, I felt detached from other people's reaction to my condition. To others, my condition felt downplayed, almost irrelevant, and nothing of concern. For the first time, I started to feel that I had begun to rejoin the pack and feel part of the team. My team consisted of the athletic hypertrophic cardiomyopathy community, research supervisors, and medical cardiologists who had experience working with athletes diagnosed with the condition that could help me to break through the tackle and get over the try line.

### *3.6. Completion*[6]

When placing an existential lens on my experiences, the 'working through' phase afforded me the opportunity to truly reflect and look at what was going to provide meaning in my life and allow me to live authentically whilst being able to take full responsibility for my own actions (Cohen 2003). Through confiding in people such as "M", I was able to determine that I still had the freedom to choose not only when it came to how I would relate to my personal situation but through the exploration of other possibilities that would influence and impact my life from here on in (Heidegger 1962).

Studying sports and exercise science prior to being diagnosed aligned perfectly with a career in sport. Taking my personal experience of having played 'rugby' combined with my own experience of losing a potential career in the game felt aligned to helping others along their own athletic journeys. Stepping into the elite sporting environment as a practitioner being a sign of reaching 'completion' was not as black and white as the account-making model suggests (Harvey et al. 1990).

Logic says I would have gravitated directly into rugby as an applied practitioner, yet I avoided the sport, the environment, and all the associations I had made as a player over the years. It was clear avoidance, a protective coping strategy, knowing I did not trust myself to "be okay"; however, I was still not ready to hand over every piece of my past life (Lally 2007).

Another twist in the road raised personal questions concerning my professionalism. To feel like a "somebody" again, I felt an underlying urge to get back involved in professional sport. It may not feel like a monumental change, but to give it consideration, it was an important step after my avoidance of high-performance environments. I felt my own career had stagnated, partly not knowing what avenues were available for further exploration but largely due to my diagnosis, making me devoid of confidence and holding me back (Blinde and Stratta 1992).

Working within the elite sporting environment as a Trainee Sport and Exercise Scientist (Psychology Support) held questionable motives. I was unsure as to (1) did I want to fulfil my own narcissistic desires, (2) did I want to help others become the best versions of themselves, or (3) a combination of the two? Thankfully, I took the decision to engage in the British Association of Sport and Exercise Sciences (BASES) Accreditation route, giving me the support, knowledge, and supervision to discuss these motives and ensure that my practice was professionally aligned, a route that prevented me from doing damage to individuals, teams, and organizations if using their environment as self-clinical therapy.

Although rugby union was still not on the agenda, I did start working within professional football, where conversations relative to my rugby-playing days occurred but in moderation. Wearing the club attire and feeling part of a team within a high-performance environment was enough to stroke and settle my ego. Contributing knowledge, expertise, and experience through the lens of a former athlete to develop and inform others within their own respective careers felt therapeutic. I was once again making a dent within the sporting industry by having something meaningful and significant to contribute when it came to the lives of others.

What my role as a 'Performance Psychologist' contributed to my own transition out of sport was a wider level of reading and research that helped to develop and increase my possession of coping skills subconsciously. Molding my own philosophical approach throughout my training meant that I was able to slowly recognize that my belief system around seeing others as fully functioning people, able to self-actualize and find solutions from within, could align with my own lived experience (Maslow 1968).

Rather than file my experiences away mentally without great anguish I used what had been viewed as a negative experience to delve deeper into examining the choices that I had made and those that were on the horizon. It was an opportunity to develop my sense of courage and commitment through a recognition of how short life can be and through the self-knowledge generated through deep reflection to act on the choices that were best aligned with who I was becoming despite the anxiety and inner voice trying to convince me otherwise.

Regarding learning about myself, deep underlying patterns had been formed because of the boarding school institution. Revisiting those dark days where I felt very much like a recluse forced me into longing for people to recognize me as a former athlete. Sport had accelerated my integration when others saw me as different. I had been so immersed and infatuated with 'making it' as an athlete that the loss of the athlete role impacted negatively upon my overall sense of self (Brewer et al. 1999).

Paradoxically, my situation highlighted that whilst I had taken significant steps forward and chosen a path that utilized my own personal experience and academic knowledge, helping those on their respective athletic journeys, my story was still incomplete as I had not managed to reach acceptance, accepting that I was no longer the 'rugby player'. Hypothetically, staying involved with elite-level sport may have lengthened the time it took to reach acceptance. My inability to file this chapter of my life away mentally without anguish was apparent. It created identity foreclosure because of not exploring alternative non-sports-related avenues (Park et al. 2013).

Acceptance of my 'new normal' was a distinct shade of grey as my outlook was vastly different when my life became consumed by the 'traumatic event'. Those positive results at confiding provided me with the opportunity to continually learn about myself and grow psychologically; however, I have not been able to wholeheartedly relinquish the prominence of the athletic role, often finding myself in situations where I have tried to reclaim it (Sparkes 1998).

When my wife had told me on numerous occasions "you're past it now, you need to get over it, you would have retired now anyway", it was acknowledgement that I played rugby and was enough to stroke my ego. I no longer felt annoyed or irritated at hearing her tell me "You would have retired anyway" as it shifted my perspective to a far healthier acceptance than fantasizing about a career that was no longer my 'new' reality. Coaches

and managers within the high-performance environment are generally more direct due to the pressure and time constraints to get things right, an approach I was accustomed to and may have proved of benefit on occasion.

Future steps towards 'completion' have swung on a pendulum, with the journey never progressing in a straight line. No sooner have I felt like I have turned a corner than I find myself looking back at the same reflection of my past. I hold no apologies for my journey not being smooth and seamless as living with HCM as a former athlete is far from straightforward.

When I question and reflect on my motives for pursuing a professional role within the context of professional football as opposed to 'rugby union', some may consider it selfish due to the big names and potential glamour of the work. If applying a neuroscience lens, people would be able to see that my brain was still seeing the 'rugby' environment as one that contained threat and a culture to be avoided if I wanted to be safe. Avoidance still played a crucial role in providing self-protection as I knew that if placing myself within the adrenaline-fueled atmosphere that was befitting the rugby environment come match day, an occasion I sorely missed, the likelihood would be that I would regress back through the stages in two distinct but dangerous ways.

I was still afraid that I may still be institutionalized within a culture that valued 'cultural capital', inclusive of hegemonic masculinity and being stoic by dealing with 'critical moments' like a real man and enduring the pain and hardship (Howe 2001) that were symptomatic of playing the game. Even though I had reached a place of enhanced mental and physical health, I was reluctant to test the possession of coping skills due to the difference in dynamic between the relationships that I would inevitably hold as an ex-player. Rugby was characterized by painting over the cracks, standing by your teammates, and having the courage to fight until the bitter end. Avoidance was my only safety net.

Part of me felt unready to confide in people who had embedded these values as their moral compass for living day to day for fear of them lacking empathy. I questioned whether I would be strong enough to resist the temptation of engaging in some form of physical training to escape my own inner demons or avoid the fact that I was now different and lacked the masculinity required to be embraced as part of the 'brotherhood' within the context of rugby culture.

I felt an inner reluctance to give up my identity as a "rugby player" and was happy to share this part of self within the context of a different environment. I would be one of many rugby players if joining a rugby club environment where my own career would pale into insignificance amongst athletes who had reached the pinnacle of the rugby pyramid. A footballing environment would see me recognized as the "rugby guy", a solitary and distinguished identity.

Fearful of the repercussions, I assumed others within the confines of a highly masculine environment would perceive me as weak, fragile, and insecure. I believed they would not be compassionate or understanding towards my feelings or emotional state, forcing me to regress by engaging in mindless banter at my expense (Ronkainen et al. 2020). I viewed myself as weak mentally post-diagnosis, afraid others would see the same fragile state within this sporting discipline.

My story was incomplete, not managing to wholeheartedly reach 'acceptance', as evidenced when working within the professional football environment. Attempting to impress the Academy Manager, fighting to be considered for a paid position at the club, I introduced the theme of 'cognitive diversity' through collaboration with a professional rugby club.

When the Academy Manager of the rugby club invited us to come and visit their environment, my prefrontal lobes flooded with panic and anxiety, unable to converse and decide. I believed I had taken huge strides and was beginning to accept my life without rugby, but this situation proved otherwise. Other members of staff looked in my direction, expecting a response as I stared blankly in their direction. Upon hearing someone repeatedly saying my name was what caused me to snap back to the present moment. My

mind had reverted to the past, knowing the ground and environment from my playing days, before accepting the offer with trepidation.

On reflection, I realized that the scars ran deep and I struggled to reach acceptance and own the "new me", especially when in the company of others involved in the game of rugby union; when in the presence of the other, it stoked the flames of the past, those places I thought I had buried in my mind. The professional football environment was not the place to talk about my concerns and to expose vulnerability when results were all that truly mattered.

Patterns extended in other areas of my life as I cut off from sharing my true feeling and emotions from my wife who just "didn't get it". She was cold and direct, a negative result at confiding that had me regressing back into brief moments of isolation to deal with the situation alone. My initial response was one of remorse for the person I used to be, then anger, frustration, and the humiliation of appearing fragile, shifting me further from the core values I held, inclusive of courage, resilience, and growth.

My life was not in accordance with the account-making model (Harvey et al. 1990), where the stages felt very linear; instead, I jumped back and forth between the stages depending upon the situation, people, and specific events occurring at that time. I became increasingly frustrated with the fact that life still had an air of inauthenticity as I moved away from the valued direction that I strived for, instead avoiding and lacking the courage to confront the situation head on.

It often felt like I was living a double life, not too dissimilar from that criminal mastermind you would never suspect of something untoward. Waiting for the walls to collapse and reveal my true self, afraid of exposing the body and mind I believed I had buried some five years ago. Even though the flesh had decomposed, the remains were enough to piece together the picture of who I was and longed to be.

Risk-taking behavior became prevalent when working within the context of professional football. I looked to fit in, covering over the emotional cracks experienced through living with the condition and therefore highlighting a lack of enhanced mental and physical health. Being conscious about my own body image and the parallels of looking in athletic shape within these high-performance environments (Brewer et al. 1999), I decided to perform forty-five minutes of exercise completed on the stationary bike each Friday morning, hopeful other staff would acknowledge the effort I made.

The risk was calculated, although the Consultant Cardiologist had stated in no uncertain terms that intensive physical activity was a definitive "No", a meeting of self occurred, telling the other part of me that "we can meet halfway". Moving closer to the gym environment that I often avoided due to my competitive nature, fearing I would not trust myself to work within safe parameters, was a huge sign of progress, especially in terms of enhanced mental and physical health and feelings of greater controllability over the condition.

Inner resentment still boiled, sending strong signals that I had a long road to travel should I reach full 'acceptance' of my situation. The internal dialogue occasionally played off the life I had left behind, but I noticeably had more control over my behavior, not getting hooked by my inner dialogue. If, on occasion, I did become hooked, I needed the time to quietly reflect in isolation to understand what was behind the thoughts and consequent behavior I was displaying so that I could explain with clarity if I was to confide in another why it was happening. I felt that when I regressed through the sequences of the account-making model I bounced back quickly, and the power of these stages were less destructive.

What I noticed at this juncture in my life was that my story, a rugby player diagnosed with a potentially life-threatening heart condition, played an important role in protecting my ego and self-worth. I had a reason behind my level of inactivity, why I was working in a professional football environment opposed to rugby, and what made me look at sport psychology as a profession. These narratives circulated in the background as a form of self-compassion, although a resistance remained when it came to owning this part of myself and bringing it authentically into the foreground.

Perhaps losing my mother to cancer on 1 December 2015 changed my perspective on life. My parents never told me that my mother had been diagnosed some 24 months prior. I only learned of her diagnosis when she had taken a turn for the worst, and it became impossible to hide. The days merged into nights; tired and emotionally exhausted, I watched helplessly as the cancer ate my mother from the inside out. Encountering my mother's 'finiteness', facing my own a few years previously, made me more reflective about how I had chosen to live my life since my diagnosis. I found myself being more explorative regarding the choices I wanted and needed to make in the future (May 1983).

I found it tough to make sense of all that had happened. Here was a person that had only ever put others first and made sacrifices to give me a far better start in life than the one she had endured. These reflections became more poignant during the short time I watched my mother's body deteriorate. I felt I inherited many of her traits, such as resilience, determination, fighting through adversity, and proving others wrong that many may label as stubbornness, yet these elements moved me forward to start accepting my own story and filing that chapter away mentally without anguish.

My mother had her reasons for not wanting to reveal her terminal diagnosis; she did not want to burden my father or myself with her troubles. One can assume that my mother felt that we lacked true understanding of what it was she was going through. When we were about to leave the chemotherapy day clinic, my mother said to the nurse whom she had a strong affinity with, "I am feeling really low, I just feel in such a low mood". Like myself, my mother hid her true thoughts, feelings, and emotions from those significant in her life, thinking twice before engaging in confiding activity.

Other parts of myself still lay hidden for fear of coming across as weak or people questioning my character as a "former rugby player". Even when my mother slipped away on the 1st December 2015, I showed little emotion or vulnerability to close family and friends. Institutionalized by the 'rugby culture' even during the most difficult periods of my life, I remained stoic when my father and wife openly displayed their own vulnerabilities. Life just moved on in a similar vein to that of the rugby environment.

Living through those final months of my mother's life gave me perspective. I did not want to waste time working in environments that were toxic. I wanted to work where I felt I could make a real difference to the lives of others. My authentic self needed to be brought into the environment, using my narrative as a catalyst towards teaching others to live a life without regret. I started to find a deeper motivation as my life had felt devoid of 'meaning' that contributed to my inherent psychological dysfunction.

Moving into the rugby environment now felt right. A slight but insignificant jangling of nerves and anxiety was experienced as I felt like I was "coming home". I was amongst familiar surroundings; commonalities found immediately with the Director of Rugby regarding mutual players we both knew, played with, or coached came with ease. Taking time away from the sport had allowed me to have a better grasp of my own shortcomings as a rugby player irrespective of my HCM diagnosis and therefore went a long way to helping others reveal potential blind spots.

Miraculously, I now felt at ease talking about my condition and the reason behind my retirement with those whom I shared commonalities with as a player. Ironically, the fact that nobody cared enough to delve deeper into the context surrounding my heart condition helped me move forward and gain a deeper level of acceptance. When diagnosed, I wanted the opposite, to know that people were concerned, not for me, but for the potential loss to the team, and not receiving those gestures caused pain and anguish. I realized for the first time that it was just part and parcel of the culture, one that failed to dwell on challenging moments, instead acknowledging them, and moving forward.

It felt therapeutic to recognize that nothing had changed over the years. People were similar in their approach and mentality, meaning that the assumptions I had made were wide off the mark. Moving forward was no reflection on me as a person or rugby player. Challenging situations needed to be forgotten quickly in a result-driven business when people's livelihoods were dependent upon success. Once back within the context of a

professional rugby environment, I began to grasp and understand my own experience as a retired former player, knowing that a coping mechanism often used was the concept of "harmless banter".

At first, interactions felt awkward, and then I became permeable to the rugby culture once more, stopping myself from taking the "harmless banter" to heart when coaches referred to me as "just another failed rugby player who has taken up a background role". Upon reflection, it was just their way of acknowledging that they recognized you as an ex-player and therefore respected and accepted you into their inner circle and tight-knit environment. I had become "one of them", a band of brothers bounded together by the game, seeing the 'banter' as a means of being a positive result.

Enhanced feelings of mental and physical health surfaced as I felt so much stronger since my diagnosis having put life into perspective. I believe one of the key coping skills that I possessed was having the 'self-knowledge' to 'self-manage' myself in a wide range of situations. I have spent years undertaking the rigorous self-examination and intellectual hard work that has been part of the process after recognizing that a deficiency of knowledge of self was what had caused many of the problems I faced since my initial diagnosis (Corlett 1996).

'Knowing thyself' allowed me to have an enhanced feeling of controllability within and around the rugby environment. Avoiding places such as the weights room, where the lure to get involved or where the impact of the environment, such as the changing room after a victory, could affect my mental health, was purposefully considered so as not to regress through the stages of the 'account-making model' and maintain forward momentum.

Feeling part of the system and gaining acknowledgement from players for the work that we completed together felt significant, a positive result where if the time was right, I disclosed elements of my own story. When the Director of Rugby asked specifically for my support in addressing relevant challenges, it gave me a strong sense of meaning and purpose, correlating with my torch light shining inwards to examine and find more sustainable sources of meaning in my life. Not being viewed as different but as a key part of the system felt like my story was moving more towards completion (Harvey et al. 1990).

Banter was another form of escapism. It allowed me to avoid discussions relative to career transition issues, portraying an image of resilience even when feeling deep pain and anguish at what could have been. I managed my thoughts, feelings, and emotions far better than in the years preceding my diagnosis but on occasion, the drive home surfaced memories of my playing days from the past. Watching the game footage to identify psychological issues within the team or challenges specific players were facing just exacerbated the void that I felt.

My mind would subconsciously drift, seeing myself performing on the big screen. On occasion, I would break down, afraid that my wife would appear and see me at my most vulnerable. I held deep regrets over the sacrifices I made, with nothing more than missed goals and opportunities to show for my efforts, contributing to my difficulties in adapting to my life without sport (Werthner and Orlick 1986).

Although what seemed like cosmic shifts in accepting the "new me", it felt like I carried the pain, hurt, and frustration into other areas of my life. I was well versed in living two lives. When in and around the professional sports environment, I appeared like my life was under control, but with a reluctance to potentially disclose deeper and salient aspects of self since being diagnosed with HCM. It meant that frustrations, anger, and resentment festered and boiled away inside me until reaching breaking point. My frustrations were directed towards my wife, a person who failed to grasp the difficulties I faced, reiterating "you need to get over it as that time has now passed and you need to start looking forward". I rarely felt listened to or understood, forcing me to become reluctant to disclose my true and authentic self when experiencing negative results in confiding activity with those closest in my life.

Partaking in exercise was three-fold. Trying to fill the void with something familiar that had enhanced mental and physical health benefits was important although each time

I exercised my mind and body were flooded with dread, anxiety, and a fear of having a sudden cardiac arrest. Body image was something that I was extremely mindful of, and even when/if exercising, it just was not the same as training for my specific sport.

All the bodily worries were tied into this as my mind became preoccupied with weight gain, loss of muscle mass, pain, and fatigue along, with thoughts and assumptions that my wife would no longer find me attractive (Warriner and Lavallee 2008). Perhaps these thoughts and feelings were exacerbated because of continuous negative results when attempting to confide and receiving a lack of empathy.

Close friends who has not seen me since my diagnosis goaded me, saying "look at the size of your arms they are like little boy's arms now" in jest. These comments made me conscious of the way I looked compared to when we trained together. Instead of reacting, I was able to control my emotions rather than retaliate. Whether I had shown signs of maturity and 'acceptance' towards the "new me" would be difficult to answer. However, it felt like I was better equipped to cope and look to move forward, seeing life through many different lenses rather than occupying a narrow perspective.

Comments made regarding my past life inadvertently provided a deeper exploration of self. It was confirmation and justification that I may have denied and looked to escape, isolating myself away from friends, family, former coaches, and athletes, only to bask in the presence of people who only knew the person standing in front of them.

Those close confidants, although providing negative results when it came to confiding, drove my inner self to move away from the 'they' (Heidegger 1962) and to explore, away from the context of high-performance sport, other roles and projects that provided a deeper meaning and purpose in my life. The completion of my own personal story was about finding my own voice, rather than being silenced, devalued, and misunderstood by the dominant culture on which professional sport and the people within it resides.

Walking away from a lecturing job in further education seemed like an erratic decision but one I embraced. As a result of the 'critical moment(s)' faced inside and outside of my athletic pursuit and the conclusive 'discontinuity' (Ronkainen et al. 2020) of my respective sport, I found myself still dissatisfied with life and was searching for that clear, authentic philosophy for living. I now grasped that despite my diagnosis with a potentially life-threatening heart condition, rugby was not my only path in life; I had the freedom and choice to choose whether I wanted to align to my values of courage and resilience and overcome what was a traumatic experience.

Recognizing that I was still battling with the existential concern of what a meaningful career would look like (Ronkainen et al. 2020) since transitioning out of high-performance sport, the account-making process allowed me to explore what I found meaningful and move my thinking outside of the narrow perspective contained solely within professional sport.

In 2018, I was divorced. A long-term relationship had come to an end, creating emotional confusion, heartache, and a period that I found difficult to identify with. My upbringing was submerged within cultural and societal norms where divorce was not acceptable. My diagnosis had been instrumental in creating a person that I would have seen as unrecognizable as I started to find my voice despite the negative results at confiding. I needed to start again, make mistakes, learn from them, and grow into the "new me", starting with a business that ignited a sense of meaning and purpose but saw my wife and I expose different visions for the future.

On reflection, it was another shift towards completion. I found love and support with a person who appreciated the person I was instead of attempting to mold me into what others expected me to become. They listened, acknowledged, and supported me through the continuous sense-making around my thoughts, feelings, emotions, and challenges that percolated to the surface because of my HCM diagnosis and early retirement from competitive sport. Receiving positive results when confiding helped me to feel more in control of my life as I moved towards a new and exciting future.

Life was not plane sailing. During the Christmas period of 2018, I suddenly nose-dived into a depressed state. I awoke to feeling a deep sense of regret, feeling like I had nothing to offer the world, and my life held a deep sense of meaninglessness. I questioned whether and how my father could be proud of me, why my partner wanted to be with someone whose career had taken a downwards trajectory and why I had not been gifted the easier option of death over life.

Regressions back towards the start of the account-making model were shorter in duration. Moments of clarity were clouded with periods of darkness as I shifted back to the 'outcry' phase, trying hopelessly to come to grips with the uncertainty surrounding my future (Erikson 1963). Rather than focus exclusively on the past, my partner was future-orientated, utilizing what had happened to affect my future in new and positive ways.

My default was to push my partner away as my brain switched to the "whys" rather than the "why nots" when asking myself what she ever saw in me during those moments of low energy. I failed to grasp what I was experiencing and needed time and space to reflect alone (Harvey et al. 1992), moving into the 'intrusion' phase as my prefrontal cortex became flooded with disruptive thoughts, creating a sense of overwhelm.

Insecurities still reside within me, occasionally questioning the picture I have painted to significant others in my life. Trigger points are often aligned to times I find myself alone, reflecting deeply on "what could have been?", associated with watching a major sporting event, documentary, and even movies that are packed with adrenaline and scenes of camaraderie. I still wrestle with the illusion of "what if", as scenarios play out in the form of a more heroic identity compared to the roles that have been forced upon myself, emotions that are contained and hidden, stored within my own internal notebook.

In life there are monumental turning points; losing my parents within four years of each other forced me to move forward and take control. I needed to 'accept' what had happened and use the possession of coping skills acquired as a catalyst towards creating something that was of benefit to others facing a transition out of high-performance sport when diagnosed with a potentially life-threatening heart condition.

Moving through my account towards 'completion' of my story gave acknowledgement to the unique qualities that enabled my recovery from a potential career-ending injury when breaking the tibia, fibula, and experiencing a full rupture of the patella tendon to then shattering my pelvis and hip bone. These characteristics formed the backbone of the coping skills I possessed in overcoming my non-normative transition out of sport (Knights et al. 2016) inclusive of mental toughness, commitment and a drive, and determination to succeed.

Every characteristic transitioned seamlessly into the world of business leadership, personal development, and working with high-performance teams and individuals. It brought strength and forward momentum to the lives of others both as current and former athletes to those facing trauma and adversity.

This was a deeply challenging period in my life, but the diagnosis and subsequent transition out of high-performance sport allowed me to reflect on the emotions alongside several of the tensions, dilemmas, and challenges that created conflict and influenced my decision-making whilst recognizing how far apart I was living from my values (van Deurzen and Adams 2016). One of the coping skills that enhanced my mental and physical health was the acknowledgement that I had the freedom to choose my own attitude towards my given set of circumstances now and in the future.

Greater awareness of who I was as a person enabled me to start living life on my terms so that I could take responsibility and make more conscious choices aligned to my values (Algera and Lips-Wiersma 2012). Achieving greater 'acceptance' and ownership over my circumstances translated into positive reactions received when sharing who I am now rather than the athlete I was before, kindling interest and inquisition. I had held the belief that my diagnosis was a sign of fragility and weakness, connotations that resembled a less than

masculine image. I now observed the opposite; people were in awe, commenting positively about the transition I had made, and the achievements accrued since my diagnosis.

Given a choice, I would always choose turning professional as an athlete or a career in the armed services over my current professional portfolio. However, the person I am today is far superior to the athlete I once was, stripping away the layers to reveal the core of who I am. Earlier years were spent aligning to the 'they' within the context of the rugby culture (Heidegger 1962). My 'critical moment', a diagnosis with HCM, provided a powerful opportunity to grow and develop into the person I am rather than conforming and avoiding personal responsibility, learnt characteristics that had delayed my progression towards the 'completion of my story'.

The road to 'completion' has been long and winding. My destination is clearer, igniting passion for life through finding my new 'meaning' and 'purpose' whilst recovering far quicker when regressing back through the sequences of the account-making model. Witnessing the camaraderie of a team's changing room, celebrating success together, or the happiness that athletes bring not only to fans but to those they love makes me momentarily consider how boring my life is in comparison. However, I am now equipped to hold it as a small part of 'who I was', allowing me to create impact in the lives of others.

Articulating my thoughts, feelings, and emotions throughout my autoethnographic account has been therapeutic. Confronting my identity and stripping back my inauthentic self as a "former" not "current" rugby player has allowed me to disclose, accentuate, and articulate a greater sense of who I am, learning not only about my strengths but also my areas of fragility. Talking about my story in an aligned way shines the light on different parts of myself that may be unexpected, opening up the opportunity to choose whether to commit to change if specific parts of the self are misaligned to one's new beliefs and values.

Upon reflection, I was now embarrassed to even refer to my former self, using my heart condition as an excuse for not making it as a "rugby player". When discussion touches on my earlier career and diagnosis, I am open and less reserved. Discussing the emotional turmoil that a forced transition had upon my life feels natural and authentic, a part of my life that has shaped who I am today.

Self-protection appears infrequently and subconsciously when referring to my diagnosis and the journey experienced. Readers and listeners alike may view my narrative as narcissistic and even esoteric, yet character traits such as 'resilience' and a 'can do' attitude have often shone through. Perhaps there is a part of me that still does not want to appear weak and fragile. However, I would like to think that my narrative has shown the courage and mental resilience to keep moving forward, especially when considering the insurmountable setbacks experienced throughout my journey with HCM and the immediate transition out of high-performance sport.

With more knowledge comes a deeper level of understanding and compassion rather than people making judgements based on appearance. Often, comments in the past were akin to "but you look okay", making me feel awkward, ashamed, and as if I was searching for excuses to justify my failings for not making it as a professional rugby player. Now, people are more accepting as they have a mental blueprint on which to place the condition against.

You often hear people who participate in sport talk about how they got injured and hence why they never made it professionally. I became more aware of how I internalize those conversations, judging the other person, believing that they are just using an excuse for their failings. I recognized that I too was resistant to disclose my own condition for fear of it being viewed in this negative manner, choosing to hide and stay silent rather than expose the guilt and shame.

Now these cases were in the public eye, it changed the dynamic, making it interesting to hear from someone who had gone through a similar experience, someone they could connect with. People wanted to know more; it felt genuine, and I was happier to reciprocate without the filters or added drama. There were more positive results when confiding

where people responded with empathy towards my diagnosis and the potential life the condition stole.

What was fundamental was not being treated like a child within my relationship. As Berne (1964) stated in his model 'Transactional Analysis', the healthiest and most respectful transactions occur when both people are communicating from the adult state. When my partner brought me an Apple Watch, with an inbuilt heart rate monitor, it was looking at ways in which I could still exercise whilst taking adequate precautions. I internalized this gesture as a positive result as I felt listened to and heard. She accepted and recognized that exercise had been my life and living without it created a huge void, making me depressed and low in mood. Rather than argue, she attempted to see the world through my perspective, compromising, ensuring that certain forms of exercise were adhered to, keeping me within safe parameters.

Knowing that rugby vanished from my life forever in 2005, I now acknowledged that HCM will be a part of me until my last breath. This simple truth was cathartic as I continued to learn, grow, and develop through our intimate relationship with each other. Giving it recognition and acknowledging that without it other facets of my life would never have materialized is intriguing. HCM has helped to break down personal barriers regarding self and developed my inner courage to come face-to-face and confront the "real me" as I am able to mentally file my narrative without anguish.

Writing this account has unraveled the knots and provided meaning to the behaviors and actions I was so often ashamed of. I feel that each step has created greater clarity whilst getting to know the "real me" at its core. Writing around completion has been challenging as I have swung back and forth like a pendulum, questioning whether I have moved any closer to embracing who I am now rather than carrying my past into my future. It has been messy, confusing, and has helped me conclude that life is never straightforward, a series of learning opportunities to create better choices for ourselves in the future.

When reflecting on my journey, I am able, perhaps for the first time, to see and recognize the person I was compared with the person standing before you today. Without writing an autoethnography, I do not believe that the gap would have appeared as large, leaving questions unanswered and sedimented beliefs sustained. My diagnosis with HCM is no longer filled with embarrassment, and the resentment towards myself and others has subsided.

Completion of my story has held positive intentions, yet stepping outside of high-performance sport has been challenging. As an Accredited Sport and Exercise Scientist (Psychology Support), we teach our clients to step outside of their comfort zone, yet I am confronted with a constant inner battle, preventing me from making substantial inroads with my business, Class of Courage, supporting others facing significant life-changing trauma.

Imposter syndrome still has its place on the top table, although writing about my story via blog posts has demonstrated a strong 'acceptance' and 'completion' of my story. What has been challenging, often causing me to freeze, is when speaking openly about my diagnosis via video blogs.

My mind is awash with thoughts that contribute to the physical nerves and emotions experienced when reverting to those 'places' I have tried to forget. Possibly my inner dialogue is still hooked with thoughts concerning how my story will be perceived by others who either do not know me or whom have the condition and are able to challenge my narrative immediately, not allowing sufficient time for me to articulate a response, as my brain detects a potential threat and triggers self-protection.

Shining an awareness on what would have been considered a blind spot in the past has allowed me to work on developing the courage to get my voice heard via other mediums. Even though I am uncertain at how my story will be received, I know that the outcome in supporting others who are diagnosed with a potentially life-threatening heart condition when trying to forge a career as an athlete is of utmost personal importance (Corlett 1996).

### 3.7. Identity Change[7]

The process of writing my autoethnography has provided an invaluable space in which to think through and reflect on how encountering such an unanticipated and traumatic event (Jarvis 2012) stimulated new learnings about oneself as a person, family member, and professional within the domain of sport psychology. When we encounter something unsurprising, unfamiliar, that is shrouded in 'negativity', it stimulates the process of reflection and questioning (Gadamer [1975] 2004), triggering our need to extend our knowledge because of the disruption caused to our normal routine and continuity in living (Jarvis 2012).

My 'critical moment' when diagnosed with a potentially life-threatening heart condition when attempting to forge a career in professional sport became fundamental to confronting who I had become through societal interactions and recognizing that I was unable to continue 'doing life' in exactly the same way as I had before, forcing me to revisit and closely examine my personal values, beliefs, and practices (Ronkainen et al. 2020). It was a moment in my life that generated cosmic shifts and awakenings as I became more attuned to the relatedness I had in a world with others, developing a stronger, deeper, and new sense of connection, curiosity, moral awareness, and openness to experience (Saeverot 2013).

Speaking my truth has allowed me to move through and even embrace those painful experiences as being part of who I am to move closer towards who I am becoming. Acknowledging the high potential for sudden cardiac death because of my diagnosis and my parents passing within a few years of the other brought my own finitude into focus. It created the realization that being in the world is fundamentally being towards death (Heidegger 1962), triggering a level of urgency to take responsibility for my life and the choices that I now make (Cooper 2003) whilst also being able to file that part of self away mentally, without great anguish to focus and open up new and 'meaningful' possibilities that will evolve in the future.

My career transition out of competitive sport provided me with my own unique perspective on life. It gave me the opportunity to explore, be curious, and facilitate my own self-awareness by taking a stand on my own existence and to then make conscious choices regarding my own future paths in life (Ronkainen et al. 2020).

Diagnosed with HCM whilst an aspiring rugby player, with a high probability of death if continuing my present life trajectory, challenged me to redefine what was meaningful in my life as what provided me with a sustainable source of identity had disappeared (e.g., athletic performance; rugby player; teammate; brotherhood). The transition out of sport and attempts at living with the 'new me' became a sense of urgency now I had come face-to-face with my own demise (Sartre 2007) as I looked to deal with the limitations and tragedy of my individual and collective identities that generated a new sense of meaning (Strenger 2011).

Embracing the rigorous examination of self was a coping skill that I possessed; as Socrates suggests, "examining both myself and others is really the very best thing a man can do, and the life without this sort of examination is not worth living" (Plato 1961), viewing a deficiency of knowledge concerning the self as causing many of the problems that athletes face (Corlett 1996). What was now of primary importance was the recognition that I had the courage to step forward, take responsibility, and choose my behaviors through accessing my own potential possibilities rather than accepting the views, attitudes, and actions determined by the collective within high-performance sporting environments or society (Heidegger 1962).

I was able to look beyond the 'they' and break away from a culture that either devalued, misunderstood, and would look to silence alternative narratives to those grounded in the context of winning at all costs (Douglas and Carless 2006, 2008). Using the account-making model as a framework enabled me to see how my past could influence my present in new and positive ways through the recognition that I had much to contribute to the lives of others outside of the sporting arena.

Finding 'meaning' and 'purpose' through the construction of a more 'authentic' sense of self was anxiety-provoking as it meant moving from a secure place that had been formed over many years to a place involving uncertainty (Corlett 1996). In pursuing life's 'new' direction, setting up Class of Courage, a business that supports people who have experienced significant life-changing trauma that has changed the direction of their life-long pursuits, has been an opportunity to develop a deep sense of courage, to keep moving forward despite the setbacks and not knowing what the outcome for the business will be (Corlett 1996). Writing my autoethnography has enabled each thread to be pulled and closely examined when it has come to my own lived experience as a former athlete diagnosed with hypertrophic cardiomyopathy. It has given me greater confidence in my ability to be my authentic self and talk openly, honestly, and with vulnerability about my own lived experience with members of the Class of Courage community. Although Class of Courage is not focused on people's personal challenges of a clinical nature, writing my autoethnography has generated a loose blueprint concerning the potential thoughts, feelings, and emotions other people within the community may have experienced at each stage. Autoethnographic writing allows for greater contextual and emotional intelligence, leading to a better rapport and advanced signposting to other professionals should specific setbacks occur.

My personal experiences have added a sense of realism to the theory, creating systemic shifts towards my own view of the world and how I am more 'accepting' of my condition and subsequent situation. Instead of avoiding specific situations or the opportunity to converse in relation to my condition, giving temporary relief from the feelings of anxiety, I am more decisive in making the choice to meet the challenge head on. Life felt harder when diminishing the core of who I truly am, making the ability to make those subsequent choices even more challenging in the long term.

Owning who I am and what I stood for saw life move in an upward trajectory as Class of Courage won a prestigious global business award that gave a positive result in determining that I had something meaningful and significant to contribute to a wider community outside of sport. Finding that sense of 'meaning', 'purpose', and 'authenticity' through having a voice and not being afraid to speak out created opportunities to work with sport and corporate clients through the opportunity to give back and share my knowledge with others.

When I started to feel an enhanced sense of controllability through reflections and answers to the difficult questions that related to the meaning surrounding my existence and who I now was in this world with other people, I began to feel a strong, flexible, and clear sense of self that translated into enhanced mental and physical health. Once I sensed 'completion' of my story after going through the process of how I now saw myself, I was able to recognize that I had another important identity, to serve others beyond the sport of rugby union.

I felt invigorated and excited to share my story and what I had learnt and could utilize to help others through their own respective journeys of transition into a 'new' life outside of sport. When accepted onto a business mentoring course, the opportunity to share my thoughts and ideas with a small group of like-minded individuals was anxiety-provoking yet exciting. The positive result received from the group gave me the impetus to start sharing my story and creating a platform that could successfully support other people.

Lacking the business acumen meant a need to rely on the input of others and create a support network that allowed me to bounce ideas to what key aspects of my story resonated most. People with significant life-changing trauma could then takeaway, implement, and 'redefine what is possible'. My first insight was to break away from a pure focus on sport and open the core of what I wanted to develop and achieve to members of the public, people who had been involved in national disasters, military operations, and life-changing accidents to create a strong sense of community and social support.

Sharing my story and getting my voice heard amongst a marginalized group of people diagnosed with hypertrophic cardiomyopathy when participating in competitive sport has

seen me explore numerous avenues through social media and blog posts through group interaction. Finding my 'new' meaning and purpose has seen me educate and advance knowledge surrounding the emotional implications that retired athletes experience when diagnosed with hypertrophic cardiomyopathy, forcing an end to their athletic career.

Placing the lens of a practitioner onto the context of an athlete diagnosed with HCM when attempting to forge a career in professional sport has a vital role to play in the support of the athlete's transition. Rugby players in the paper by Arvinen-Barrow, Hurley, and Ruiz (Arvinen-Barrow et al. 2017) indicated that verbalizing and articulating their thoughts and feelings with a 'Sport Psychologist' helped to shift them closer to 'acceptance' and grasp the reality of their situation.

With that in mind, I have used an existential approach as a main resource in terms of my coping armory rather than the traditional application of a mental skills approach that looks to apply an intervention to either reduce or eliminate the symptoms (Corlett 1996). My 'critical moment(s)' provided the opportunity to follow the advice of Socrates over 2500 years ago that proclaimed to 'know thyself' both personally and professionally through undertaking a rigorous process of self-examination (Simons and Andersen 1995) and self-discovery (Corlett 1996).

Although this occurred naturally through the positive results received during confiding activity where people started to listen rather than advise or solve my problem, it gave me the freedom and autonomy to make choices that determined the direction my life would head. It provided the space to experience the anxiety that was attached to my own free will. In doing so it gave me the opportunity to explore, be curious, and increase the self-knowledge around the 'self' to grow psychologically (Wadsworth et al. 2020).

Exploration of the 'self' through the application of the account-making model as a workable framework allowed me to acknowledge and recognize the key existential themes that percolated to the surface. If not addressed, these had the potential to hold me back from reaching 'completion' or taken longer and been problematic with an inability to file mentally without signs of great anguish.

I soon recognized that I needed (a) a 'new' sense of meaning and purpose in my life, (b) develop the courage to exercise my freedom to make choices whilst taking responsibility for those choices I make to determine the future direction of my life, (c) stand up and face my 'critical moment(s)' despite the limitations that my diagnosis had placed upon me so that I would grow psychologically, and (d) the recognition that my experience is unique and mine, like other beings in the world, cannot be understood in isolation from the context in which the experience occurred (Vos et al. 2015). An existential approach when working with athletes who have suffered injury and/or critical moments has been seen to be effective (Hector et al. 2017; Mortensen et al. 2013).

Reading and researching the existential philosophical approach has allowed me to recognize and acknowledge the key existential themes that are apparent within each of our respective lived experiences. Adopting this lens has enabled me to delve deep and find the courage to move forward despite the inevitable uncertainty that life now holds. Rather than view my experience through negative perceptions, I can transform the pain and disruption resulting from my diagnosis and subsequent transition out of high-performance sport so that my experience contributes to my own life and the lives of others (Harvey 1996).

Constructing my story using the account-making model as a viable heuristic framework has given structure to the 'critical moment' that I experienced. It has helped me to understand my dilemmas and specific challenges that I faced before being able to elaborate on my account and share my story with others. Talking openly and authentically about my situation with the aim of advancing knowledge and understanding of the emotional implications retired athletes experience when diagnosed with hypertrophic cardiomyopathy has been instrumental in movement towards closure.

Owning my story as part of me was important, as was the recognition that without that experience not just as a 'rugby player' but as an athlete going through a life-changing event molded and shaped the characteristics that I continue to carry with me today. Knowing that

I had the freedom to choose the direction that I wished my life to head in was significant in the development of courage. Despite the setbacks over the years, I have managed to keep moving forward regardless of the uncertainty surrounding the outcome of the situation, with the urgency to live life on my terms made ever more apparent through the potential of death awaiting each waking day.

Knowing that my time as an athlete is now over, the sense of loss apparent, I have looked at all that has been learnt through my time as a 'rugby player', an athlete experiencing career termination via a non-normative event and the influence this has had on my role as a Sport and Exercise Scientist (Psychology Support). We are no longer two separate people. All aspects of the self have merged into a single body to give me the resources to face my situation head on, disclose my story with meaningful others, and use all parts of the self to contribute to athletes facing an HCM diagnosis that forces an immediate transition away from their sporting pursuit now and in the future. I no longer want to stay silent but use the courage I have developed through my experience to face life's inevitable challenges and enhance my life for the better.

## 4. Discussion

Hypertrophic cardiomyopathy has hit the headlines in recent years, a condition the rich and famous are not immune to. Since the infamous incident of soccer player Fabrice Muamba in 2012 and, more recently, Christian Eriksen of Denmark collapsing on the field of play at the European Football Championships in 2021, publicity concerning the condition has increased astronomically, along with its potential ramifications, with football being such a global phenomenon.

This study adopted a relatively new approach within the sport career transition literature. Research acknowledges that athletes respond in different ways to the retirement process and therefore posed an inherent need to understand these differing reactions considering that responses can last for years upon leaving sport (Park et al. 2013). Applying an autoethnographic account inspired and instructed a better understanding of the emotional implications retired athletes experience by drawing upon my personal account when diagnosed with hypertrophic cardiomyopathy as an aspiring 'rugby player'. Rather than looking at the social phenomena, I walked the reader through my personal journey (Prewitt 2010).

Hiding behind the third person narrative and bracketing my thoughts, feelings, and emotions, directed towards others and onto myself, was not an option. I exposed the truth behind who I was at the time of diagnosis towards who I was becoming throughout the transitional process. Research has tended to position the reader as a 'detached neutral observer' (Goodall 1997) when highlighting the severe psychological adjustment issues associated with athletes experiencing involuntary retirement, normally a result of career-ending injuries (Park et al. 2013; Lavallee et al. 1997).

Research addressing the psychological impact of being diagnosed with a potentially life-threatening cardiac disease, hypertrophic cardiomyopathy, when aspiring to become a professional athlete has been sparse. To my knowledge, only one study has focused on the psychological challenges of exercise restriction with an athletic adult population diagnosed with cardiomyopathy (Luiten et al. 2016). Other studies used asymptomatic adolescents and competitive young athletes (Berg et al. 2018). Only three out of the twenty-five participants were aged over the age of 18 years in the latter study. This research combined participants with other cardiac conditions, although still severe, as part of their cohort rather than an exclusive focus on participants diagnosed with hypertrophic cardiomyopathy.

To our knowledge, this is the first study to have used an autoethnographic account. I describe my own personal experience of an involuntary termination out of high-performance sport, creating a backdrop for deep reflection, analysis, and discussion. Sharing the most significant aspects of my experience, created the context in which we, the reader(s) and I, can process and contextualize the experience of an aspiring athlete

diagnosed with a potentially life-threatening heart condition. My personal account shines light on a space where the heart of the experience(s) is often difficult to capture.

Research suggesting 'potential' solutions through the testing of theories and hypotheses with populations and circumstances unrelated to the researcher(s) (Vickers 2002) shifted to a personal approach that explored actual experience when going through an involuntary career termination. My own termination from sport aligned with the literature that suggested that retirement was a prolonged and distressful experience that lasted years after the event (Park et al. 2013). The emotional turmoil continues to impact my life and relationships eighteen years prior to my diagnosis with hypertrophic cardiomyopathy.

My findings confirm 'the potential' psychological challenges faced by involuntary retirement (Arvinen-Barrow et al. 2017), offering a transparent and affirmative connection between my narrative and the existing literature. Athletes with a strong athletic identity at the time of retirement prolonged the duration of the adjustment process (Lavallee et al. 1997). In a systematic review by Park et al. (2013), 34 out of 35 studies found that when identity foreclosure was present, it signaled a more disruptive transition, especially when the opportunity to explore alternative avenues was not available given the abrupt nature of the termination (Brewer et al. 1999) and therefore not feeling psychologically ready to retire, something experienced when my fledgling career ended abruptly. I owed much to the sport of rugby union and whilst not the only sport I played whilst at boarding school it was the one sport where I excelled, gaining recognition and adulation from parents, peers, and friends that I failed to receive through other means. However, due to the recognition I received because of my competency and sense of belonging from being part of a team, I had no reason to explore other avenues, contributing to a more challenging transition out of sport (Menke and Germany 2019; Sparkes 1998). Athletes should consider exploring new and alternative avenues away from sport with their immediate support networks encouraged to give praise and recognition for other aspects of their character away from the week-to-week accomplishments often found to embody one's identity around competitive sport.

Taylor and Ogilvie (1994) gave indication to the concerns surrounding practitioners' aptitude to deal with the complex interaction of stressors that are paramount when athletes retire and move through the career termination process. Concerns capsulated the practitioner's ability to deal adequately with the stressors identified during termination and subsequent retirement having not participated in elite sport themselves. Other foreseen challenges concerned the lack of opportunity to establish solid relationships that gave permission to open and disclose thoughts relative to the retirement process.

My autoethnographic study, whilst context-bound, offers recommendations concerning the management of these critical life events and subsequent career termination experiences. Sport Psychologists and neighboring professionals could find benefit in applying an existential approach to the career termination process after research had acknowledged the inherent complexity around conversing with significant others about the situation and adapting to the change. Existential philosophy steers away from 'cookbook' approaches (Fishman 1999), considering the person before the athlete negating the need to have played sport at the 'elite level'.

Rather than the practitioner seeing themselves as a technical problem solver (Holt 2003) with the need to rush and fix things through a mental skills approach, they place their faith in the athlete and their subjective experience. It creates a fundamental shift in attitude whereby the existential approach no longer places responsibility on the practitioner to find solutions to solving the athletes' problems but merely acts as a guide and facilitator within the context of the dialogue that occurs. The existential approach places the client and their experience at the center of the therapeutic process, bringing their own knowledge and expert psychological knowledge that they possess to the forefront of the conversation (Cooper 2003). In doing so, the Sport Psychologist can delve deeper in exploring the 'meaning' and narrative that is connected personally to the athlete's identity rather than just suggesting that a strong athletic identity can be problematic.

Aging athletes who like athletes diagnosed with a potentially life-threatening heart condition are confronted with one of life's givens, that of finitude, lends itself to personal reflection. Individuals can clarify what termination of their athletic career means personally beyond the sport's subculture and gender dynamics, identifying a future course of action that is both authentic and meaningful. My own narrative explored and uncovered many of the key existential themes where an existential lens applied by a trained professional would have helped address those 'critical moments' and discontinuity of sport in my life (Ronkainen et al. 2020). Compared to other applied behavioral approaches, the existential approach offers flexibility, where the athlete has the freedom to explore how they find meaning in their life. Through the power of deep exploration, they can generate new attitudes and perspectives towards an authentic mode of living (van Deurzen and Adams 2016) whilst recognizing that despite conditions placed upon us, we have the freedom to choose and overcome even the most inconceivable of circumstances.

My narrative extends Taylor and Ogilvie's conceptual model (Taylor and Ogilvie 1994) by providing an in-depth and personalized account of an athlete experiencing a non-normative transition out of high performance. Uncovering the pertinent themes experienced through the unpredictable and unanticipated nature of the transition will help develop research through exploration of the differences that exist when compared to normative transitions. The lack of opportunity for pre-performance planning means that the individual needs practitioners who can address and respond to the situation in the moment (Schlossberg 1984) whilst advancing conceptual models that include mechanisms that will help the athlete to transition out of sport as smoothly as possible.

Researchers, practitioners, and those reading my narrative will gain a deeper understanding concerning the diverse elements that were at play throughout my transition inclusive of being male, within a team-sport, and those cultural-specific characteristics that valued stoicism, bravery, and courage. Each of these elements combined brings an informed approach as we can better acknowledge the thoughts, feelings, and emotions that may be present for athletes experiencing non-normative transitions within high-impact, male-dominated, and team-orientated sports.

Application of the account-making model (Harvey et al. 1990) as a framework for understanding my own transition out of high-performance sport could assist practitioners in having a better knowledge and understanding concerning the challenges, thoughts, and emotions experienced at each stage through engaging empathically in account-focused interactions (Grove et al. 1998). Generating knowledge and understanding through my own experience potentially gives greater insight into what resources are available to the athlete.

Overall, the application of the account-making model to act as a framework for telling my autoethnographic account has contributed and extended the existing body of research around the career termination and transition literature. It has generated further knowledge and insights, affirmed previous hypotheses, and raised attention around the occurrence of non-normative transitions and the mechanisms required to adjust and cope with this type of transitional process. Had I decided not to write on the edge and share my own personal experience of a former athlete diagnosed with a potentially life-threatening heart condition, we would not help others to connect, raise questions, and generate further discussion with those that wish to know more (Vickers 2002).

My personal narrative demonstrates a need to educate and better inform those closely involved in the initial and ongoing support of an athlete experiencing a non-normative transition out of sport. I demonstrated a need for conceptual models to include how significant others, such as medical personnel, friends, and close family members connected to the athlete's life, can best support when knowing the potential risks of depressive conditions materializing through non-normative events (Park et al. 2013) and the impact and potential setbacks that my own narrative brought to light.

Furthermore, the literature has generated a knowledge base pertaining to situations that are most common contributors to an athlete developing depression. These insights

allow for early signs of risk to be acknowledged so low-intensity preventive support can be offered by medical practitioners and close family members before more significant clinical issues arise (Lundqvist 2020). However, much of the research has focused on those individuals who still have access to athletic structures and environments as opposed to individuals excluded from the high-performance environment when battling with news of a potentially life-threatening heart diagnosis.

For example, Lundqvist (2020) suggests support for those athletes who have experienced an overall change to their life can be assisted in retaining or finding things that they find personally meaningful in the way of activities alongside access to supportive factors within the environment. My autoethnographic account testifies my entire life revolved around sport with my interpretation of termination guided by a strong internal and external moral code (McKenna and Thomas 2007). Participation in activities that I found meaningful included sporting/physical activity, yet this was restricted because of my diagnosis with hypertrophic cardiomyopathy. Upon exiting the high-performance environment, I was not offered any support, resulting in tension around my personal values of loyalty and trust.

Sharing the whole human experience raises the need to develop a specific methodology to evaluate and disseminate applied knowledge. It would allow for a different and more adequate approach towards evidence-based interventions that prevent athletes diagnosed with a potentially life-threatening heart condition having problematic transitional experiences out of sport. My story has paved the way for future studies to account for the unique and often important differences that exist for those experiencing a non-normative transition out of sport. A substantial and more well-informed scientific and applied knowledge base can be built, increasing the likelihood that optimal support is offered at each stage to prevent a prolonged transitional process by adding to the emotional distress and bleak outlook already being experienced.

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## Notes

1 Lasted twenty-four to forty-eight hours from the moment the cardiac episode occurred to approximately two weeks when a Consultant Cardiologist first informed me of my impeding diagnosis.

2 Lasted six to nine months in duration as I was in total disbelief considering my life had always involved sport and rugby. It was the first time in my life that I had no direction or structure.

3 Lasted eighteen months to two years as I looked to deny all evidence pointing favorably to me having the condition and live a life that proved otherwise.

4 Lasted approximately two and a half years as I used my diagnosis as an excuse for not making it as a rugby player and began to research the condition and disclosure certain parts of the event with specific people over others.

5 Lasted approximately six years due to the positive and negative results received when confiding.

6 Lasted approximately six years working as a BASES Accredited Sport and Exercise Scientist (Psychology Support) to five years setting up Class of Courage and working as a Trainer and Facilitator in corporate business.

7 Lasted approximately five years in duration.

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