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The narrative construction of a de-stigmatised identity: an Olympic athlete's stories of living with bipolar disorder

Erin Prior, Anthony Papathomas and Daniel Rhind

School of Sport, Exercise, and Health Sciences, Loughborough University, Loughborough, UK

ABSTRACT

There is limited research offering experiential knowledge of severe mental illness in elite athletes. Adopting a narrative approach, this study explored how an Olympic athlete constructed his illness identity and how this construction shaped his experience of living with bipolar disorder. We conducted five semi-structured interviews with Darrel, a male Olympic athlete diagnosed with bipolar disorder, over a ten-month period in the lead-up to the Paris 2024 Olympic Games. 10 hours of data were collected, with interviews an average of 90 minutes in duration. Interviews were transcribed verbatim and analysed using dialogical narrative analysis, attending to both the content of Darrel's stories and the ways in which he told them. Through various storytelling strategies, Darrel constructed a de-stigmatised illness identity that reinforced his sense of self as an athlete. His narratives emphasised athletic accomplishment despite – and sometimes because of – his bipolar disorder. He distanced himself from the stigmatised stereotypes of severe mental illness by telling stories of his high functioning. Emotionally difficult moments were laced with humour, while manic episodes were portrayed in a glamourised way. These narrative strategies appeared to manage self-stigma and resist the potentially marginalising meanings associated with mental illness in elite sport. However, such storytelling also has implications for how others perceive and respond to athlete distress. For example, the glamourisation of mania may lead staff to underestimate the severity of the athlete's mental illness. This study demonstrates the value of narrative methods for exploring how athletes make sense of severe mental illness and construct identities within the cultural context of elite sport.

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Despite a recent surge in research examining athlete mental health, relatively few studies have explored the lived experiences of athletes with severe forms of mental illness (Pereira Vargas et al., 2024). Severe mental illness (SMI) is defined as a mental, behavioural, or emotional disorder resulting in serious functional impairment that substantially interferes with one or more major life activities (National Institute of Mental Health, 2023). Severe mental illness diagnoses include schizophrenia, bipolar disorder, and borderline personality disorder, with prevalence estimates approximately 1% of the population and rising annually (see Wu et al., 2023).

Existing literature on severe mental illness in sport has focused primarily on prevalence (e.g. Åkesdotter et al., 2020), risk factors (e.g. Hughes & Leavey, 2012), diagnostic challenges (Currie et al., 2019), and treatment (e.g. Reardon & Factor, 2010). Although such work

CONTACT Erin Prior e.e.prior@lboro.ac.uk School of Sport, Exercise, and Health Sciences, Loughborough University, Epinal Way, Loughborough LE11 3TU, UK

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provides essential clinical insight, it provides only a partial understanding of the issue, offering little experiential knowledge regarding how athletes make sense of and live with severe mental illness (Pereira Vargas et al., 2024). This not only constrains theory and practice but also perpetuates the marginalisation of athletes experiencing severe mental illness, whose voices remain underrepresented within sport psychology literature. Therefore, although understanding prevalence, risk factors, diagnosis, and treatment is vital, an exploration of how athletes experience and interpret severe mental illness is equally necessary.

Qualitative research has made a valuable contribution to understanding how athletes experience mental illness, with studies exploring depression (e.g. Lebrun et al., 2019), eating disorders (e.g. Papathomas et al., 2015), schizophrenia (e.g. Carless, 2008), and borderline personality disorder (Pereira Vargas et al., 2024). Within this growing body of work, narrative methods are increasingly adopted, offering a means of examining how athletes make sense of and share their experiences through storytelling. Thus, narrative approaches explore how individuals construct meaning and identity in relation to their mental illness, and how such stories are shaped by the cultural values and expectations of elite sport. Qualitative accounts have begun to highlight tensions between narratives circulating within elite sport and athlete experiences of mental illness, demonstrating an intersection between athletic and illness identities (e.g. Busanich et al., 2014; Papathomas & Lavallee, 2010; Pereira Vargas et al., 2024).

Narrative identity is a person's internalised and evolving life story, whereby an individual narrates to themselves and to others, who they are, how they came to be, and where they think their lives may be going in future (McAdams, 2018). These stories are not constructed in insolation; they are co-constructed through dialogue between storytelling others and dominant stories that circulate within cultures and institutions (Smith & Sparkes, 2008). Although individuals have agency in the stories they tell, they are still shaped or constrained by others, and the master narratives that prevail within the culture an individual operates within (Smith & Sparkes, 2009b). Master narratives are 'culturally shared stories that guide thoughts, beliefs, values, and behaviours' that override all other stories (Syed & McLean, 2022, p. 8).

In the context of mental illness, the medical model functions as a dominant master narrative which powerfully shapes how those with mental illness are understood by themselves and others, telling a story of personal deficit, symptoms, and treatment (Frank, 1995). Such master narratives can be drawn upon by individuals to develop a narrative illness identity, that is, a storied understanding of one's mental illness and attitudes towards having a mental illness (Yanos et al., 2010). For example, one individual's understanding of their mental illness may be shaped by dominant biological explanations such as a chemical imbalance or brain deficit (Deacon & Baird, 2009). This model can offer coherence and relief from self-blame; however, it may also reinforce stigma and reduce treatment optimism (Schomerus et al., 2012). In contrast, some individuals construct counternarratives, rejecting the traditional 'mentally ill person' label in search of narrative authenticity – the alignment between a person's story and their lived experience (Albee & Joffe, 2004; Kirkpatrick, 2008; Ochs & Capps, 1996). For some, rejection of a certain illness identity can foster empowerment and improved psychological wellbeing (Thoits, 2016), though it may come at a social cost if others reject or invalidate storytelling that does not fit within the commonly accepted narratives of mental illness (McAdams, 2006; Woods et al., 2019).

Master narratives circulating within elite sport culture have the potential to shape how athlete mental health and illness are understood. Chief among these is the performance narrative which emphasises discipline, sacrifice, and achievement (Douglas & Carless, 2006). Closely aligned is the sport ethic – a culturally reproduced perception of what it takes to be an athlete (Hughes & Coakley, 1991). The sport ethic is a powerful ideological framework that promotes and legitimises values, expectations and certain behaviours, shaping how athletic identity is governed (Black, 2025; Coakley, 2015, 2017). These values and expectations include a sacrificial commitment to sport, a relentless pursuit of distinction, the normalisation of risk and pain, and a refusal to acknowledge limitations (Hughes & Coakley, 1991). These narratives are legitimised by athletes, coaches, and support staff

within elite sport environments, collectively reinforcing a culture that glorifies strength and normalises physical and psychological self-sacrifice (Papathomas, 2018). Given the perceived incompatibility of mental illness and successful sporting performance (see Bauman, 2016), athletes may perceive experiencing mental illness as a failure to conform to these norms of elite sport, threatening their athletic identity (see Sparkes, 1998). Therefore, the culture of elite sport and the existence of mental illness stigma can impact how athletes living with mental illness construct their illness identity, make sense of their life experiences, and tell their mental illness stories.

Cultural expectations surrounding masculinity may further amplify these pressures, particularly in male-dominated elite sport contexts where physical and mental toughness are deemed paramount (see McKenzie et al., 2022). The sport ethic mirrors broader societal ideals of hypermasculinity including toughness, stoicism, bodily sacrifice, and ignoring vulnerability (Acee, 2016; Hughes & Coakley, 1991). Accordingly, studies consistently suggest that men, compared to women, hold more stigmatising beliefs about mental illness and are less likely to disclose their mental illness experiences (see Batterham et al., 2013), perhaps due to the perception that experiencing mental illness transgresses gender ideals including masculine strength and self-reliance (see Boysen, 2017). Thus, both cultural narratives within elite sport and wider society can impact how male athletes construct their illness identity and have the power to constrain how they tell their mental illness stories, sometimes silencing them altogether.

The process of constructing an illness identity is both deeply personal and inherently social (Smith & Sparkes, 2008). Thus, exploring how athletes story their mental illness experiences can provide insight into the interplay between personal meaning-making and cultural constraint in the construction of mental illness identity. In sport, these negotiations are particularly complex. The cultural dominance of the performance narrative, the sport ethic, and masculine ideals may lead to the perception that illness and athletic identity are in conflict. Therefore, it is crucial to consider how athletes construct illness identities that both conform to and resist dominant cultural scripts. Narrative inquiry is uniquely positioned to explore these tensions, including how athletes navigate, reproduce, or challenge prevailing meanings of mental illness and sporting performance.

Several studies have demonstrated the value of exploring mental illness in sport through a narrative lens. For example, Carless (2008) explored how involvement in sport and exercise can support men experiencing severe mental illness to reconstruct a meaningful identity and sense of self. Their findings illustrated how involvement in sport provided narrative resources that countered dominant deficit-based understandings of mental illness, enabling individuals to create and share positive personal stories. Jewett et al. (2019) proposed that although aligning with the performance narrative may initially support narrative coherence for athletes, it may become problematic when circumstances such as illness, injury, or retirement threaten athletic identity. Further, Åkesdotter et al. (2024) examined how the pervasiveness of the performance narrative shaped athletes' understandings and experiences of mental illness, influencing behaviours such as avoidance of help-seeking. Pereira Vargas et al. (2024) provided one of the few narrative explorations of athletes living with severe mental illness, exploring how two powerlifters diagnosed with borderline personality disorder constructed their mental illness identities. One athlete accepted and aligned with medical understandings of mental illness, using this to construct understandings of the self. The other rejected biomedical discourses, telling a counternarrative that enabled narrative authenticity and agency. These findings highlighted how athlete understandings of mental illness can be used to construct identity and shape their experience, demonstrating the importance of exploring athlete stories of mental illness.

Despite a growing focus on athlete mental illness, narrative explorations of severe mental illness such as bipolar disorder within elite sport remain absent. As such, how athletes understand and experience bipolar disorder, and implications regarding how they can be best supported within elite sport settings is unknown. This absence is notable given the distinctive characteristics and challenges associated with bipolar disorder – a condition marked by episodes of elevated mood ('mania', or when less severe 'hypomania') and depressed mood (American

Psychiatric Association, 2013). Although not universal, manic episodes are often characterised by a decreased need for sleep, rapid speech, racing thoughts, and engagement in high-risk activities (Daley & Reardon, 2021). Depressive episodes involve depressed mood, and changes to sleep, appetite, or cognition, resulting in distress or functional impairment (American Psychiatric Association, 2013). Experiencing bipolar disorder is likely to have a significant impact on an athlete's quality of life and functioning, which in the context of elite sport, includes potential for negative impact on sporting performance. As symptoms worsen, concentration, decision-making, and organisation may be affected, with longer-term symptoms in the negative domain such as avolition and amotivation having the potential to negatively impact commitment and ability to sustain elite-level sports participation (Currie et al., 2019).

Given the limited understanding of how athletes diagnosed with bipolar disorder experience and interpret their mental illness, there is a need for research that captures their subjective, storied accounts. By examining how an elite athlete constructs their mental illness identity and how these constructions shape their experiences of living with severe mental illness, this study seeks to contribute to a deeper understanding of the lived experience of severe mental illness within elite sport. This will be addressed with two research questions:

(1) How does an Olympic athlete construct their mental illness identity?

(2) How do constructions of severe mental illness shape experience?

Method

Philosophical underpinnings

Narrative inquiry involves analysing the stories people tell as a way of understanding experience and action (Polkinghorne, 1995). Focusing on socially constructed meanings, narrative inquiry is typically underpinned by an interpretivist epistemology and relativist ontology (Papathomas & Lavallee, 2014). As such, this narrative study explored the experiences of an Olympic athlete living with bipolar disorder in elite sport using an interpretivist paradigm. Interpretivism assumes a relativist ontology and social constructionist epistemology. According to relativism, reality is subjective, meaning multiple socially constructed realities exist (Ponterotto, 2005). A social constructionist epistemology proposes that knowledge is co-constructed, with the researcher and participant co-creating an understanding of the participant's lived experience (Holstein et al., 2013). Findings are therefore shaped by both parties bringing their experiences and understandings to the research topic (see Poucher et al., 2020). From a dialogical perspective, knowledge is co-constructed through dialogue between individuals and dominant stories that circulate within society (Smith & Sparkes, 2008). Thus, potential dominant stories were considered throughout the data analysis.

Positionality

As an applied sport psychologist and former elite athlete, I (Erin Prior) occupy an insider position that affords me insight into the cultural expectations of high-performance sport. These experiences have shaped my understanding of the values, expectations, and pressures that may inform how athletes construct and manage their identities. Insider status enabled empathy and rapport with Darrel but may have influenced what I attended to in the stories shared. My research focuses on athlete mental health and illness within elite sport. However, I do not necessarily subscribe to the medical narrative of mental illness. This inevitably influenced the questions I asked, the language I used, and my interpretation of Darrel's story. For example, when Darrel used stigmatised language aligned with the medical narrative, I would ask further questions regarding his understandings of mental illness and why he adopts such language. Anthony Papathomas is a reader in mental health in sport whose

research focuses on male athletes' mental health. Daniel Rhind is a professor of sport psychology with expertise in athlete welfare and safeguarding within sport. Anthony's conceptual expertise supported study design and development, with both co-authors acting as critical friends.

The participant

Following institutional ethical approval, we used purposive sampling to recruit an elite athlete diagnosed with a mental illness. Two participants were initially recruited; however, one participant withdrew from the study due to mental health concerns. One White British, male, Olympic athlete diagnosed with bipolar disorder took part in the study. Darrel (pseudonym) was aged 27 at the time of the first interview and had received a formal diagnosis of bipolar disorder 7 years prior, aged 20. At the time of the interviews, Darrel had been competing at an elite level for 10 years. He competes in an individual sport that includes mixed and single-sex team events when competing internationally. At the time of the interviews Darrel was considered a professional athlete, training full-time within the British Olympic Programme and had previously competed at both the Rio 2016 and Tokyo 2020 Olympic Games. Despite being deselected part-way through data collection, Darrel continued to train full-time and remained in receipt of some funding from his national governing body. Given the potential for narratives circulating within the elite sport environment (e.g. the performance narrative, notions of masculinity), the authors were interested in Darrel's mental illness story as a male athlete experiencing bipolar disorder.

Data collection

Prior to participation, we provided Darrel with detailed study information and requested written informed consent to discuss his understanding of mental health and illness – specifically bipolar disorder, how his understandings may impact his experience of living with bipolar disorder, and his experience of receiving mental health support from sporting staff. We conducted five semi-structured interviews, three in-person and two online for geographical and scheduling convenience. Semi-structured interviews were chosen to encourage a deeper insight into the athlete's experiences (see Sparkes & Smith, 2013). We collected 10 hours of data across 10 months in the lead up to selection for the Paris 2024 Olympic Games, with interviews an average of 90 minutes in duration.

Interviews comprised open-ended questions, whereby additional questions and probes were developed organically in relation to answers provided from the participant (DiCicco-Bloom & Crabtree, 2006). Each interview guide had a unique focus based on previous interviews with Darrel. The first interview guide was designed to introduce Darrel to discussing his experiences of living with bipolar disorder. Questions included: 'what does mental health mean to you?', and 'can you tell me something about your experiences of mental illness?'. The second interview focused on Darrel's conceptualisations of mental health and mental illness, and his experience of being diagnosed with bipolar disorder. Questions included: 'how did you feel when you were diagnosed with bipolar disorder?', and 'how would you say your diagnosis impacted the support you received from the sport?'. Our third interview took place after Darrel had been deselected from the Olympic programme and focused on his mental health in relation to this, with questions such as: 'how has your deselection impacted your mental health?', 'have you experienced any manic or depressive episodes since deselection?'. The fourth interview encouraged Darrel to reflect on how he had told his story in previous interviews with questions such as: 'what is the impact of talking about your mental health and/or illness in a humorous way?', and 'we've previously discussed how you sometimes use stigmatised language when discussing mental illness, why do you think this is?'. Our fifth and final interview served as an opportunity to clarify any previous discussions and to reflect on the research process together. Questions included: 'what parts of your experience of bipolar do you feel

are useful to you as an athlete?', and 'how have you found this process of talking about your mental health and experiences of living with bipolar?'. Probes used throughout our interviews to further encourage narratives responses included, 'can you share an example of when this happened to you?', 'how do you make sense of [an experience]?', 'what did that feel like in the moment?'.

Data analysis

We used dialogical narrative analysis to analyse the interview data, an approach that understands stories as artful representations of lives, combining a focus on the content of the stories told and why something is said (Frank, 2012). Dialogical narrative analysis is explicitly concerned with the narrative resources that help structure stories, what stories do for people, and why people choose a certain story to live by (Frank, 2012). The lead researcher transcribed interviews verbatim and immersed themselves in the data by reading and re-reading the interview transcripts. Following each interview, data which spoke to the research questions were highlighted and initial analytical thoughts were noted in the margins. The second researcher also read the transcripts in-between interviews and initial thoughts were discussed between them and the lead researcher. This process informed future interview guides based on points of interest or a need for clarification.

We asked four types of dialogical questions of the data informed by Frank's (2012) work. First, resource questions, concerned with the narrative resources used to help structure stories included what resources does the storyteller draw upon to shape their experiences? What resources does the storyteller borrow from the wider stock of cultural narratives to tell their story? An example of a narrative resource (i.e. a story already circulating in the setting) is the sport ethic. This may shape how Darrel shares his mental illness story due to expectations regarding what it means to be an athlete. Second, affiliation questions, considering how stories can appeal to or repel others, included to whom does this person's story connect them to, and who is placed outside this connection? For example, stories stigmatising others with mental illness diagnoses may place these individuals outside of connecting with Darrel. Third, identity questions concerned with how stories can help an individual to construct their identity included how is the storyteller's identity shaped by the story they are telling? What stories give people a sense of who they are, and how do these stories do this? As an example, Darrel may tell stories demonstrating high levels of functioning, shaping his identity as someone who is not a 'typical' person with mental illness and reinforcing his athletic identity. Finally, function questions, which consider why stories are told in a certain way include, what does each story do for and on the person? What does this story do for and on other people? For example, telling stigmatised stories of others with mental illness and juxtaposing this with stories of his own high functioning may allow Darrel to distance himself from others with mental illness diagnoses. Data was sought in the transcripts to answer each of these questions, while acknowledging that stories were not there to be 'found', rather they were constructed between Darrel, the researcher, and dominant stories within society (see Riessman, 2008).

The authors considered both big and small stories within the data (see Georgakopoulou, 2006). Big stories are the biographical narrative content of the story where a participant tells grand narratives of their life by recounting specific life-shaping episodes, connecting these episodes to create a life story (Phoenix & Sparkes, 2009). Small stories are tellings of ongoing, future, or hypothetical events or are considered 'breaking news' (see Georgakopoulou, 2006), which arise in interaction and are oriented towards an audience. Darrel told big stories, retrospectively making sense of past events, and a series of small stories involving hypothetical accounts and stories of unnamed others that served to position his identity rather than provide a coherent life narrative (see Bamberg & Georgakopoulou, 2008). Small stories were identified not by their completeness or length, but by the identity work they performed, specifically, how Darrel positioned himself in relation to others and to culturally available narratives. By considering both big stories and small stories, we were able to consider how Darrel reproduced, resisted or reworked cultural master narratives as he told his mental illness story.

Methodological rigour

We aligned with the relativist approach of judging qualitative research outlined by Smith and McGannon (2018) and employed various strategies to ensure methodological rigour in the present study. Researcher reflexivity – acknowledging one's positionality – is crucial as researchers' assumptions and potential perspectives impact how data are gathered, interpreted, and presented (Krane & Baird, 2005). To ensure reflexive awareness, the second author – an experienced qualitative researcher in mental health and illness – acted as a critical friend. Throughout the interviewing and analysis process, both the first and second author engaged in discussions regarding the first authors' construction of knowledge to encourage further reflection, and exploration of alternative interpretations (see Tracy, 2010). Credibility was sought by spending a substantial amount of time with the participant (i.e. 10 hours of interviewing, conducted over a period of 10 months), and returning to the data multiple times throughout the analysis process. Numerous quotations are also presented when discussing the athlete's story to demonstrate width (i.e. the quality of interviews and data analysis) (Smith & Caddick, 2012).

Results and discussion

Within this section we provide direct quotes with interpretive insights into how Darrel constructed an illness identity through telling his story.

Constructing a de-stigmatised illness identity

Although Darrel accepted his bipolar diagnosis at the time of being diagnosed – he rejected the stigmatised, negative connotations of having a mental illness. Throughout interviews, Darrel distanced himself from the culturally dominant medical narrative of severe mental illness. Specifically, he told stories that sought to separate his experience from stories of weakness, deficit, and lack of functioning. Darrel constructed an alternative, and for him, less stigmatised illness identity, through a variety of storytelling strategies. These include reinforcing his athletic identity by demonstrating his high levels of functioning and sporting accomplishments despite his bipolar diagnosis; telling exaggerated stigmatised stories of others with mental illness; enhancing the tellability of his mental illness story using humour and telling glamourised stories of mania to downplay the severity of his mental illness; and leaving difficult stories of mental illness untold. How Darrel constructed his illness identity using these storytelling strategies will be explored in the following sections.

Reinforcing an athletic identity

Throughout our conversations, Darrel would often briefly discuss his experiences of bipolar before swiftly moving to stories of his athletic achievements, positioning bipolar as something that doesn't impede his performance:

> The next year, after the Olympics I went absolutely nutty. Serious, serious mania . . . But I ended up with some of the best performances over that year. I was the most consistent I'd ever been. The highest standard. Good season.

Darrel repeatedly returned the focus of the conversation to his sporting performance after discussing his mental health: *'Some very positive mental health moments in 2018, and some incredibly low ones. Fascinating combinations including going on like regular 4-day benders. Yeah, it was an interesting time period . . . Still qualified third in the world'*. In emphasising his ability to perform at a high level despite experiencing manic and depressive episodes, Darrel constructed an illness identity that both preserved his athletic identity and distanced himself from a typical illness identity characterised by weakness, deficit, and decline (see Gergel,

2014). In doing so, he countered common assumptions that mental illness necessarily impairs functioning or prevents elite performance. This positioning can be understood in relation to a pervasive master narrative within sport known as the performance narrative – 'a story of single-minded dedication to sport performance to the exclusion of other areas of life and self' (Douglas & Carless, 2009, p. 215). Darrel's storytelling appeared to draw upon this dominant narrative, as he was perhaps compelled to demonstrate that he remained a capable, high-performing athlete despite his diagnosis.

Darrel also positioned bipolar as helpful to him as an athlete: *'It's definitely useful to think that it's a superpower. There's a Kanye West song where he says, "it's [bipolar] not a curse, it's a superpower", and I do agree, for me at least it's not a wildly bad thing'*. Frank (2000) suggests that we become who we are by giving precedence to some experiences over others. For Darrel, framing his bipolar as a 'superpower' that enhances his performance can be understood as a counternarrative to the typical mental illness story of deficit and decline. This not only resists stigma but also aligns with the values of the sport ethic that circulate within elite sport which emphasise a relentless pursuit of distinction and a refusal to acknowledge limitation (see Hughes & Coakley, 1991). Constructing bipolar disorder as an advantage may allow Darrel to align his illness identity with these expectations. These narratives are further shaped by hypermasculine ideals such as ignoring vulnerability (Acee, 2016), which may constrain how male athletes like Darrel interpret and share their mental illness experiences. As such, the interplay of the sport ethic and masculine ideals both guides and limits the stories Darrel can tell about his mental health, shaping the narrative strategies he adopts.

'I don't go to shit and live the life of some mad hermit': telling stigmatising stories of others

Darrel distanced himself from a typical illness identity by telling stigmatised, hypothetical small stories of what he *could* be like, if he was like others with mental illness:

> I'm not up till 4 in the morning plucking my eyebrows or polishing the wall with a toothbrush, kind of thing. It's not that I go crazy . . . It's not like I'm spending two weeks a month nocturnal and living in the attic, pinning things to the walls and shrieking 'I've found it! I've found it!'. I'm able to exist pretty reasonably . . . It's not like you've developed schizophrenia. Not that I necessarily know about schizophrenia. It's not like you've gone crazy or lost the plot or you've no idea what's going on . . . If every year for a month or two I was running around screaming about the voices, muttering incantations, and sacrificing birds to the Gods, I might be significantly more concerned about my mental health, about my bipolar and the fluctuations it brings me. But as I don't go to shit and start muttering incantations and start living the life of some mad hermit, I'm not particularly worried about it.

Invoking stigmatised cultural imagery of mental illness, Darrel presented brief narrative fragments, contrasting his own experiences with hypothetical depictions of others experiencing mental illness:

> If I was becoming a dishevelled wreck, having to go back to my parents' house to remember how to eat three meals a day and wash frequently . . . I don't believe that I've had a manic phase where I'm going to be found living in a forest with twigs in my hair, dining on the bowels of rats . . . I've not ever gone doolally. I think actually, I'd be perfectly clean shaven, dressed really, really smartly, and trying to have business meetings with high executives.

In a society that stigmatises people with mental illness, stereotypes are also learned by individuals who later experience mental illness themselves (Ilic et al., 2012). This can threaten their sense of self and result in self-stigma and a negative social identity (Major & O'brien, 2005). Thus, Darrel engaged in identity deflection (see Thoits, 2016) by drawing upon and reproducing the medical master narrative of mental illness and societal stigma to tell hypothetical, small stories of others with mental illness whilst resisting such narratives when telling stories of his own experiences. These stories enabled Darrel to distance himself from a stigmatised illness identity while maintaining aspects of the illness identity that are useful to him (e.g. that his bipolar enhances his performance), thus not outright rejecting his illness identity. Elite athletes' high social visibility within their community can increase their internalised mental health stigma (Beasley & Hoffman, 2023), making them more likely to use identity deflection as a form of stigma resistance to protect both their wellbeing and their

social capital within elite sport culture (Thoits, 2016). This may be particularly salient for athletes experiencing severe mental illness who are less common within the athlete population (see Ströhle, 2019). The way athletes narrate their mental illness experiences can serve as a crucial means of managing how they are perceived and preserving their social standing. Thus, Darrel's storytelling may have functioned to shape audience perceptions, mitigating stigma and helping him maintain his social capital.

Enhancing the tellability of a mental illness story

Storytelling is a social activity which runs from one teller recounting a story to others who listen and become 'co-tellers who respond with reactions, queries, or relevant narrative details' (Ochs & Capps, 2001, p. 64). Stories can move audiences to respond in certain ways (Riessman, 2008); therefore, it is worth reflecting on *how* an individual tells their story to a certain audience and what response they are trying to elicit. Darrel's stories of emotionally difficult moments were injected with dry, sarcastic humour, often reflected in his tone. Darrel perceived a lack of mental health support from sporting staff, particularly the performance lifestyle advisor, when he was experiencing low mood. Recounting his experience of seeking support from the performance lifestyle advisor, Darrel shared:

> Yeah, I think if I was like visibly a looper . . . I think there'd be a lot more like push to you know, 'how have you been?', following up to make sure Darrel keeps his fucking shit together . . . but also if it seems to be going fine and then you know, I go like *warning flag!* Which, *I did* . . . she [performance lifestyle advisor] literally said, 'shall we talk about it next Friday?'. 'Ah cool, I'll just wallow till then . . . thanks!'.

Darrel told stories of his lack of mental health support with a sense of incredulity and a sarcastic tone. When we reflected that Darrel often talked about his experiences of bipolar with a sense of humour and asked why this was the case, Darrel said: *'far better to be buoyant about dark subjects than fucking miserable!'*. Narratives do things *for* humans (Smith & Sparkes, 2009), as such, the stories a person tells and how they tell them may serve a function and be useful to them (see Frank, 2012). Humour has long been considered a healthy and effective coping strategy (Samson & Gross, 2012), and powerful antidote to negative emotions (Vaillant, 2000). One explanation for the use of humour when discussing difficult topics is that the change of perspective associated with humour enables a distancing from negative situations (Martin & Lefcourt, 1983). Another explanation is that the negative event gets reappraised from a less threatening point of view, allowing the individual to look directly at what is painful but – by reappraising the situation – in a less harmful way (Vaillant, 2000). As such, humour may serve as an emotion regulation strategy for Darrel, allowing him to tell his story of living with bipolar in a way that reduces emotional distress. Some stories may be deemed untellable because they are so intimate that they are too personal, too embarrassing, or too frightening (Smith & Sparkes, 2011). Humour, however, can make co-narration desirable (Norrick, 2004), with stories told with humour becoming more tellable, and audiences becoming more likely to listen.

Darrel increased the tellability of his mental illness story by glamorising his manic episodes:

> I've had this a number of times when I've been manic, but alcohol, its efficacy just reduces vastly. It becomes like an *energising fuel* rather than an intoxicating substance . . . I drank nearly 2 [bottles of] vodkas a night and at no point was I away with it. It was jolly, and merry, and silly, and having fun, but at no point was I ever away with it . . . Fantastic. Had a fucking whale of a time. No sleep . . . but I was loving it, having a wonderful, wonderful time . . . Fucking great craic. Absolutely wonderful craic. Buzzing. Love life. Energetic. Creative. *Manic*. Class . . . summertime . . . fuck it. It was class.

Selves and identities are created through the process of storytelling. In selectively telling his story of bipolar (i.e. only portraying perceived positives in a glamourised way), Darrel presented a softened, less stigmatised mental illness identity to his audience. Stories of the difficulties of living with bipolar disorder may feel untellable and too difficult for both the storyteller and the audience (see Jackl, 2022). Portraying a glamourised experience of mania may make his experience of bipolar more palatable for both himself as the storyteller, and for the lead researcher as the audience.

When asked why he shares his experience of bipolar in a glamourised and often humorous way Darrel explained:

> Because it's humorous rather than all sad and depressing. 'I have bipolar so that makes me really fragile. I can be really, really depressed or I can go crazy and alienate people and spend all my money and do things I regret terribly'. That sounds fucking awful! Or 'I sometimes get stuck being sad and it's a bit shit. Please help me if I ever make it clear that I'm not in a great place'. *Or* 'I'm manic and it's class. I have so much energy, and I'm creative and expressive and I'm a fucking headcase so it's mental, but it's class'. Like, very different perspectives on exactly the same thing.

People use stories to shape their daily realities (Smith & Sparkes, 2009a). Darrel suggested that he purposefully tells a humorous, glamourised story of living with mental illness. By consciously framing his experiences of bipolar and choosing how he tells his story, Darrel demonstrated narrative agency – the ability to control the development of a story's plot and characters (see Atkins & Mackenzie, 2013). Experiencing narrative agency and telling what he deems to be a more palatable and positive mental illness story may not only positively impact Darrel's life, but also his identity.

The stories left untold

We must not only attend the stories that are told but also ponder which stories are left *untold* (Smith & Sparkes, 2011). What is not said can be just as important as what is verbalised (Correia & Caetano, 2024). As Scott (2018, p. 14) suggests, 'Paradoxically, silence speaks volumes: by saying nothing, a voice sounds all the more audibly'. Stories left untold are considered a form of communication (Ben-Asher et al., 2020), an unspoken conversation (Zerubavel, 2006), 'a relational phenomenon', and as such, 'a way to express experience' (Blix et al., 2021, p. 11).

As interviews progressed, we reflected that Darrel rarely spoke of his depressive episodes, instead choosing to share stories of mania and athletic accomplishments:

> It seems I am very intentionally not getting bogged down with the negative of the situation . . . if I had spent the past month and the months going forward thinking about how my team have cut me off and my support staff think I'm useless and not up for it, my coach doesn't care about me enough to message me and the country's turned its back on me, blah, blah, blah, Jesus Christ, I wouldn't be having a good time.

The act of not telling a story can occur either intentionally or involuntarily (Correia & Caetano, 2024). For example, negative emotionally charged past experiences may result in a non-conscious process of omitting information as a defensive mechanism (Kaźmierska, 2004). Alternatively, a storyteller can exert narrative agency, making a choice not to tell a story that may cast them into an undesirable light or contradict the identity they are constructing (Jackl, 2018; Spector-Mersel, 2011).

Darrel acknowledged his avoidance of reflecting on and discussing emotionally difficult events during our conversations. Telling his story in a way that avoided emotionally difficult moments may serve various functions for Darrel. Avoidance is recognised as a widely used emotion regulation strategy (De Castella et al., 2018), employed by many to avoid difficult situations and the emotions attached to these events. Darrel may therefore engage in multiple emotion regulation strategies when sharing his story of living with bipolar (i.e. humour and avoidance). By leaving stories of depression and the detrimental side of mania left untold, Darrel's illness identity is further softened which may protect his self-esteem and mental health.

Applied implications

The present study explored how an elite athlete experiencing bipolar disorder constructed his mental illness identity through storytelling, including extended biographical accounts (i.e. big stories) and brief, interactional tellings such as humour, hypotheticals, and comparisons to others (i.e. small stories). The findings provide a deeper understanding of the lived experience of severe mental illness within sport and pose implications for other elite athletes experiencing severe mental illness.

Reinforcing his athletic identity and emphasising his high functioning was deemed of particular importance to Darrel, helping him to construct a softened, destigmatised mental illness identity that rejected associations with deficit and decline. For athletes more broadly, maintaining an athletic identity can support the development of an acceptable, less stigmatising illness identity, helping them come to terms with their mental illness. Although this process may serve a protective function for athletes' psychological wellbeing (see Thoits, 2016), it may also come into tension with master narratives circulating within elite sport. These dominant cultural stories, focused on performance, mental toughness, and ignoring vulnerability, may constrain how athletes narrate experiences of mental illness, particularly when such experiences appear to contradict expectations of what it means to be an athlete. Consequently, some athletes may reject their illness identity or leave their mental illness stories untold, potentially limiting the catharsis, understanding, and support that can come from narrative sharing.

Narratives are central to the negotiation of identity. This identity work occurs through both coherent life stories and brief, everyday small stories through which athletes position themselves in relation to stigma, performance expectations, and anticipated audience responses. As such, it is essential that athletes have opportunities to tell their own stories and align with narratives authentic to their sense of self (Pereira Vargas et al., 2024). Such storytelling enables athletes to develop personal understandings of mental distress and mental illness. However, when an athlete's story diverges from the commonly accepted narratives of mental illness there is a risk that their account may be misunderstood or dismissed (Woods et al., 2019). When people feel compelled to supress or distort their stories to meet social expectations, their mental health may be compromised (Crossley, 2000a). This pressure to conform can lead to inauthentic storytelling that misaligns with lived experience and can foster a fragmented or imposed illness identity (see Crossley, 2000b; Ochs & Capps, 1996). Conversely, opportunities to share stories that are met with understanding, support, and empathy can promote wellbeing and self-understanding (Douglas & Carless, 2009). Those working with athletes experiencing mental illness should therefore consider adopting narrative therapy and encourage narrative exploration on the athlete's own terms, avoiding pushing master narratives such as medicalised framings of mental illness that may not resonate with the athlete's lived experience. Instead, practitioners should listen closely to athlete voices, encouraging athletes to articulate their own narrative paths, even when these stories challenge the dominant assumptions of elite sport culture.

Sharing experiences of mental illness can come at a cost for athletes, with those who disclose mental illness diagnoses less likely to be selected for teams and more likely to be paid less than their counterparts (Merz et al., 2020). Within severe mental illness, symptoms such as mania tend to be more heavily stigmatised than others, often garnering less sympathy and understanding than depressive episodes (Wolkenstein & Meyer, 2008). This stigma may be further compounded when athletes narrate their experiences in ways that appear to glamourise their symptoms. How an athlete's mental distress is understood is often negotiated through small stories which can powerfully shape how others within the sporting environment respond to athlete distress. For example, staff may take a less compassionate view if an athlete's account does not fit familiar narratives of mental illness, potentially underestimating the severity of their experience and not recognising when support is needed. It is therefore crucial that support staff understand that athletes will tell their mental illness stories differently, perhaps as a way to protect themselves from a stigmatised illness identity, as seen with Darrel. Sporting staff must remain attentive to these narrative dynamics, responding with empathy and curiosity rather than judgement. By critically considering why an athlete might frame their story in a particular way, staff can avoid misinterpretation, foster trust, and ensure that meaningful support is offered.

Humour can also influence how athletes' mental illness stories are perceived and acted upon. Humour is a well-documented coping strategy for those experiencing mental illness (Samson & Gross, 2012) that often appears within small stories told in everyday interactions. However, its use in storytelling may lead audiences such as coaches or support staff to underestimate the severity of an

athlete's difficulties. This misinterpretation can affect not only the type of support offered but also the urgency with which intervention is sought. In the present study, Darrel shared how he experienced a delay in receiving mental health support after disclosing low mood to a performance lifestyle advisor. This illustrates how the form of an athlete's small story disclosures, including the tone, emotion, and narrative framing, can shape how others interpret their experiences, sometimes obscuring the severity of an athlete's distress.

In light of this, sport psychologists should work collaboratively with athletes to explore the function of humour in their storytelling and the ways it might shape how others (e.g. sporting staff) perceive their experiences. Athletes should be supported to reflect on alternative ways of telling their mental illness stories that appropriately capture the severity of their difficulties and their need for support. This work requires sport psychologists to understand narrative identity theory, particularly how mental illness identities are constructed through storytelling and influenced by the dominant narratives circulating within elite sport. This involves attending carefully to athletes' small stories, as sites where stigma management, identity deflection, and unmet support needs may be expressed indirectly. Sharing this narrative knowledge with fellow sporting staff where appropriate would further enhance collective understanding of mental health presentations and reduce the likelihood of misinterpretation, such as underestimating the severity of an athlete's difficulties.

Finally, it is important to recognise how organisational and cultural attitudes towards mental illness can shape support practices within sport. For example, some sporting staff perceive that the most appropriate response to an athlete experiencing mental health difficulties is to step away temporarily from the sporting environment (see Prior et al., 2024). Although a leave of absence may be beneficial in some cases, such practices can also reflect and reproduce assumptions that mental illness is incompatible with elite sport and the ideals of the sport ethic. Framing withdrawal from sport as the default response risks reinforcing a stigmatised mental illness identity, positioning the athlete as unable to meet the demands of elite sport. This, in turn, may detrimentally impact the athlete's sense of self, belonging, and recovery. Careful consideration is therefore needed to ensure that support strategies do not inadvertently marginalise athletes experiencing mental illness but rather enable them to remain connected to valued aspects of their athletic identity where appropriate.

Future directions

The present study joins few other studies (e.g. Pereira Vargas et al., 2024) in exploring the lived experiences of athletes with severe mental illness diagnoses. Narrative methodologies have a lot to offer in providing an insight into how athletes construct their illness identities and the implications this may have within the elite sport environment. Future research could adopt dialogical narrative analysis to further explore how athletes experiencing severe mental illness negotiate their identities within elite sport environments. This approach recognises stories as relational and dynamic, shaped through dialogue with others and broader cultural narratives that define what it means to be an elite athlete or experience mental illness. Applying a dialogical lens would allow researchers to explore how athletes position themselves in relation to dominant sporting discourses such as the performance narrative, the sport ethic, and mental toughness, and how they may resist or reproduce these narratives in their mental illness stories. Future research should consider how do athletes negotiate an illness identity alongside an athletic identity? How might an athlete's illness identity help or hinder them in seeking mental health support? How may an athlete's story connect with or repel others and how might this impact how an athlete is supported within the elite sport environment? Such work could also explore how athletes' stories of mental illness are received and responded to by elite sport staff and how this may influence athlete help-seeking behaviours. Finally, in keeping with the principles of dialogical narrative analysis, future studies could involve collaborative storytelling, inviting athletes to co-interpret their narratives or respond to researcher reflections.

Conclusion

Telling stories of severe mental illness can help athletes to construct their own illness identity and make sense of their experiences. The stories an athlete tells also have the power to shape their experience of their mental illness with positive and/or negative implications. On the one hand, athletes can construct destigmatised illness identities that can support their living with severe mental illness. On the other hand, how athletes share their mental illness stories may detrimentally affect how others relate to them and their mental illness experience, with the potential to impact the mental health support athletes are offered. Athletes should be encouraged to construct their own understandings of their mental illness experiences through storytelling, with sporting staff implored to listen and support athletes accordingly.

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