The Context of Emotional Responses to Athletic Injury: A Qualitative Analysis

Lynne Halley Johnston and Douglas Carroll

This study used grounded theory to describe the emotional responses of athletes following injury and their situational and temporal contexts. Sixteen seriously injured athletes were interviewed. The NUD*IST (Nonnumerical Unstructured Data Indexing Searching and Theorizing) computer program was used to search, store, explore, and organize the qualitative material. The main emotional responses, appraisals, events, and behaviors that emerged from the analysis were represented diagrammatically. Frustration and depression were the prevalent emotional responses throughout rehabilitation, although the situational corollaries differed as recovery progressed. In the early phase of rehabilitation, frustration and depression resulted from disruption to normal function, in the middle phase they were provoked by a negative appraisal of rehabilitation progress, and at the end of rehabilitation the main instigator was impatience to return to sport. Whether to risk returning prematurely to sport emerged as a key theme, as did the confounding effects of exercise withdrawal symptoms in extremely committed athletes. The results were considered in terms of both cognitive appraisal and risk models.

Research has clearly shown that athletic injury has a substantial psychological impact. Studies examining differences between injured and uninjured athletes have revealed greater negative affect, lower self-esteem, and higher levels of depression and anxiety among injured athletes (4, 14, 19, 21). Comparisons of athletes pre- and postinjury have found greater mood disturbance, lowered self-esteem, and increased depression following injury (14, 19, 31). Studies that have charted emotional state over the period of injury have generally found a move from negative to positive affect over time (6, 18, 19, 23, 30, 31). The degree of this shift appears to depend on actual and perceived rehabilitation success (18).

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A noticeable feature of existing research is its concern with two theoretical models: stage or grief models (1, 17, 22, 26, 27) and cognitive appraisal models (2, 11, 29, 33, 34). Although this focus has assisted theoretical refinement, it has not led to a full description of the emotional responses to injury and their circumstances and context. Methodology has also been a constraining influence. In most studies, the Profile of Moods States has been the preferred measurement tool (4, 7, 18, 21, 30, 31). Thus, it is hardly surprising that the emotional responses most frequently cited are those tapped by the Profile of Mood States subscales: tension, depression, anger, vigor, fatigue, and confusion. Similarly constraining are inventories solely assessing depression and anxiety (4, 14).

Although the way in which emotions change over time has received preliminary exploration (6, 18, 19, 23, 30, 31), most researchers have paid the temporal dimension little heed, aggregating responses from different stages in the rehabilitation process. There has also been a tendency to combine data from chronic and acute injuries and to include participants with fairly minor injuries. It has been argued that research should focus on athletes with injuries that prevent sport participation for at least 3 weeks (8).

Such considerations suggest that it may be less than optimal to rely exclusively on a quantitative approach. It indeed appears that current quantitative research has produced a somewhat fragmented and imprisoned representation of the injury experience, and researchers have argued for the adoption of a qualitative approach (2, 21). A qualitative approach allows the researcher to openly include the subjective experiences of injured athletes, permitting an insight into the way athletes appraise the injury episode and the emotions they experience. Indeed, any comprehensive account of athletes' emotional responses to injury must surely include the athletes' subjective experiences. Ironically, to date there is only one published qualitative study on the psychological impact of athletic injury (25). Although it helpfully illuminates a model of the psychosocial processes associated with athletic injuries, only 7 athletes were interviewed and one of the interviews was conducted 15 years after the initial injury. There certainly appears to be scope for additional qualitative research.

Grounded theory (10) may be a useful research approach in this context. The central principle of grounded theory is that the concepts which account for participants' interpretations of their experiences must emerge from the data. It has been described as "a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (32, p. 24). The present study then, was undertaken to examine athletes' emotional responses to injury as well as their situational and temporal contexts using grounded theory methods.

**Method**

Participants were recruited via four main routes: Posters were placed at various sites around a university campus; letters were sent to all sports teams at a university; a sports medicine specialist at a university medical practice was asked to
distribute details to patients; and details of the study were orally presented to first-year undergraduate sport students. The principles of theoretical sampling (5) directed the selection of participants. This method involves concurrent analysis and collection of data. “The emerging theory guides the sampling of further data to broaden or expand its generalizability” (25, p. 311). Criteria for inclusion restricted recruitment to individuals who had sustained a severe injury within the preceding 12 months or were currently injured, such that they were or would be unable to participate in sport or exercise for at least 21 days. Severity classification was based on a National Athletic Injury/Illness Reporting System (15). Injuries did not have to be incurred within a sporting context, although all but one were.

Data were collected using an “unstructured” interview format and a demographic questionnaire. The questionnaire included questions on sports involvement and current and previous injury details. All interviews were conducted in a private interviewing room located within a university department. Participants were asked to describe the sequence of events from injury onset until full return to participation, or until the time of interview if still injured. All interviews began with the question: “Please talk me through your experience of the injury and how you felt throughout.” Standardized probes were consistently used in all interviews to clarify and to elicit detailed information. Participants gave informed consent for interviews to be tape-recorded. Interviews ranged from 30 to 120 min duration. Copies of the transcribed interviews were sent to all participants to check the accuracy of the transcription. All transcripts were returned and some minor modifications were made (e.g., spelling errors). Data collection was terminated after the 16th interview when theoretical saturation (10) was judged to have occurred (i.e., no new themes were emerging from the interviews).

Sixteen competitive and recreational athletes were recruited (11 males and 5 females). Ages ranged from 18 to 60 years ($M = 22.8$, $SD = 10.3$). Occupations included student ($n = 12$), fitness instructor ($n = 2$), lawyer ($n = 1$), and professional soccer player ($n = 1$). The main sport for each participant was rugby ($n = 4$), soccer ($n = 3$), football, basketball, and badminton ($n = 2$, in each case), and swimming, running, and squash ($n = 1$, in each case). Level of participation was recreational ($n = 3$), university ($n = 8$), county and national league ($n = 2$, in each case), and professional ($n = 1$). The number of hours of sports involvement prior to injury ranged from 3 to 30 hr per week ($M = 11.5$, $SD = 6.9$). Ratings of injury severity, on a scale from 1 = low to 5 = high, ranged from 2 to 5 ($M = 3.5$, $SD = 1.0$). Injuries were incurred at various stages of the sport season: preseason ($n = 2$), early ($n = 7$), middle ($n = 3$), late ($n = 1$), and no defined season for sport ($n = 3$). Details of all injuries, their timing relative to the interview, and participants’ main sporting activity are shown in Table 1.

Data Analysis

All interviews were converted into the QSR NUD*IST (Nonnumerical Unstructured Data Indexing Searching and Theorizing) computer package (24). At this
Table 1 Injury Details, Time Span Between Injury and Interviews, and Injury Status at Interview

<table>
<thead>
<tr>
<th>Participant</th>
<th>Main sport</th>
<th>Injury</th>
<th>Time span between onset of injury and interview</th>
<th>Injury status at time of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tom</td>
<td>Football</td>
<td>Fractured radius</td>
<td>First interview 5 days postinjury</td>
<td>First interview, arm in cast</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Second interview 9 weeks postinjury</td>
<td></td>
</tr>
<tr>
<td>Ron</td>
<td>Badminton</td>
<td>Strained ACL</td>
<td>8 days postinjury</td>
<td>Second interview 1 week after cast removal</td>
</tr>
<tr>
<td>Alan</td>
<td>Soccer</td>
<td>Fractured ankle &amp; ligament damage</td>
<td>10 weeks postinjury</td>
<td>Still injured, can now bear weight</td>
</tr>
<tr>
<td>John</td>
<td>Soccer</td>
<td>Sprained ankle</td>
<td>12 weeks postinjury</td>
<td>Still injured, due to return in 5 months</td>
</tr>
<tr>
<td>Jen</td>
<td>Badminton</td>
<td>ACL rupture</td>
<td>12 weeks postinjury</td>
<td>Recovered, returned to sport 6 weeks ago</td>
</tr>
<tr>
<td>James</td>
<td>Rugby</td>
<td>Strained knee ligaments &amp; cartilage damage</td>
<td>12 weeks postinjury</td>
<td>Still injured, attending physiotherapy</td>
</tr>
<tr>
<td>Linda</td>
<td>Basketball</td>
<td>ACL rupture</td>
<td>12 weeks postinjury</td>
<td>Six weeks prior to ACL reconstruction</td>
</tr>
<tr>
<td>Carol</td>
<td>Squash</td>
<td>Fractured scaphoid</td>
<td>12 weeks postsurgery</td>
<td>Two weeks of physiotherapy remaining</td>
</tr>
<tr>
<td>Mike</td>
<td>Rugby</td>
<td>ACL rupture</td>
<td>21 weeks postsurgery</td>
<td>Rehabilitation, retirement from all contact sport</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Participant</th>
<th>Main sport</th>
<th>Injury</th>
<th>Time span between onset of injury and interview</th>
<th>Injury status at time of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam</td>
<td>Running</td>
<td>Knee injury, undiagnosed</td>
<td>26 weeks postinjury</td>
<td>Chronic condition, not being treated</td>
</tr>
<tr>
<td>Sally</td>
<td>Basketball</td>
<td>Torn ankle ligament</td>
<td>26 weeks postinjury</td>
<td>Returned to sport, still weak</td>
</tr>
<tr>
<td>Paul</td>
<td>Swimming</td>
<td>Tendinitis</td>
<td>26 weeks postinjury</td>
<td>Began alternative activity 3 months ago</td>
</tr>
<tr>
<td>Ken</td>
<td>Soccer</td>
<td>Torn ankle ligaments</td>
<td>30 weeks postsurgery</td>
<td>Returned to main sport 12 weeks ago</td>
</tr>
<tr>
<td>Sean</td>
<td>Rugby</td>
<td>Groin strain</td>
<td>30 weeks postsurgery</td>
<td>Returned to sport 16 weeks ago, still injured</td>
</tr>
<tr>
<td>David</td>
<td>Football</td>
<td>Chronic shoulder injury</td>
<td>52 weeks postinjury</td>
<td>Returned to alternative activity 48 weeks ago</td>
</tr>
<tr>
<td>Laura</td>
<td>Rugby</td>
<td>1. Spiral fracture tibia</td>
<td>86 weeks postinjury (first injury)</td>
<td>Retired from rugby, resumed noncontact alternative activity 17 weeks ago</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Compound fracture tibia</td>
<td>52 weeks postinjury (second injury)</td>
<td></td>
</tr>
</tbody>
</table>
stage all original names were changed to pseudonyms. The NUD*IST computer program allows the researcher to store, explore, and browse documents in a way that supports organization and rigorous analysis while maintaining the complexity and context of the material. It facilitates the creation and management of categories in a flexible index system that is pictorially represented in a hierarchical tree structure. Coding is conducted directly on screen. Data can be further interrogated using the results of index searches as subsequent data.

Data were coded from the open-ended questions according to the constant comparative method (10). The first stage involved a detailed examination of the transcripts where the text was closely scrutinized and data related to emotional impact of injury were highlighted. This procedure involved dividing the text into hundreds of “meaning units” (meaningful, verbatim pieces of information). The second stage of analysis involved identifying common features between meaning units and collapsing meaning units into distinct categories. For instance, the following meaning unit was originally part of a category labeled “indicators/information sources”:

I was able to gauge the recovery by the amount of pain I was in. The less pain I was getting the more successful I felt the rehabilitation was. As time has gone on, the pain has been getting less and less. (Alan)

This is referred to as “creating categories” (32).

The third stage of the analysis involved comparing and contrasting the data, and continually redefining and uniting categories at greater levels of abstraction, until no more encompassing categories emerged and theoretical saturation occurred (10). The constant comparisons made between cases allowed us to develop three higher order categories: events and behaviors, appraisals, and emotions. For instance, the meaning unit above was eventually coded as an event that influenced the appraisal of rehabilitation progress. It was coded as a “pain cue” within the category “rehabilitation appraisal cue.” Throughout the period of data analysis, the “dynamic process” of recovery emerged as a central concept. This was facilitated by the logical progression of each interview, as most interviewees reported their “story” in chronological order. To facilitate incorporation of the temporal dimension within the pictorial representation of the data (Figure 1), each category was set in its temporal context. Further analysis was conducted that distinguished events and behaviors, appraisals, and emotions according to their temporal context.

We used a number of methods to establish credibility (13). First, the principle researcher was injured for the full duration of data collection and analysis. The injury necessitated foot surgery and affected normal function for 30 days and full sporting activity for 90 days. A diary of cognitions and emotions was kept on a daily basis throughout the period of incapacitation. This enabled the principle researcher to acknowledge her own assumptions and biases regarding the effects of injury, a process referred to as “bracketing” (25). Second, detailed discussions took place throughout the full duration of analysis with two qualitative researchers, both of
whom were familiar with the grounded theory protocol. These researchers provided feedback regarding data interpretation, coding of categories, and development of Figure 1, a process known as "peer debriefing" (13). A final method of establishing credibility involved writing theoretical memos throughout analysis. Theoretical memos were written at each "node" within the hierarchical tree structure in NUD*IST. Writ-

Figure 1 — The situational and temporal context of athletic injury.
ing memos has been emphasized as an important element of analysis and should not be omitted (32). Memos help the analyst to “gain analytical distance from materials . . . [and assist] movement away from the data to abstract thinking, then in returning to the data to ground these abstractions in reality” (32, p. 199).

Figure 1 summarizes the prominent events, behaviors, and appraisals associated with athletes’ emotional responses following injury. The key at the top of Figure 1 shows which of the three higher order categories each subcategory refers to. The temporal sequence is depicted by the direction of arrows from the top down. It may be useful to refer to Figure 1 when considering the results.

Results

Immediately following injury onset, participants reported feelings of shock and disbelief. Many individuals did not immediately acknowledge the severity of the injury, although those with a previous history of a similar injury did. Following the initial shock of the injury, all individuals appraised the severity of their injuries. Three injury markers influenced these initial appraisals: pain, visibility, and mobility. Individuals who had previously experienced a similar injury made more accurate appraisals of severity than those without a previous injury. The latter initially tended to be overly optimistic. The predominant emotion reported during the first few days postinjury was anxiety. At this stage, participants did not appreciate the practical implications of their injury.

Contact with medical personnel resulted in two main appraisals: reappraisal of injury severity, and appraisal of treatment received. These in turn resulted in a variety of primarily negative emotions. Appraisals of treatment received were often negative and led to feelings of anger. The overriding provocation was dissatisfaction with treatment. Common grievances were perceived lack of knowledge, failure to provide satisfactory treatment, and perceived lack of empathy, understanding, and respect from doctors.

Emotional responses attendant on severity reappraisal differed between those with or without a previously similar injury. If medical prognosis was congruent with the optimistic appraisals of those without prior injury, feelings of relief and reassurance followed. If incongruent, reactions of shock and disbelief were triggered. Shock was frequently followed by feelings of anxiety and depression at the thought of prolonged rehabilitation. In contrast, for those with a previously similar injury, anxiety was frequently consequent on appraisals. However, when diagnosis was incongruent with their own beliefs, participants reported feeling dissatisfied with the information. This in turn led to anger, confusion, and anxiety.

The early stages of rehabilitation were characterized by participants’ awareness of incapacitation and lack of mobility. This was associated with athletes’ increased awareness that the injury was disrupting their normal daily activities and sporting involvement. This was a greater concern for those with lower limb injuries who were in plaster casts and reliant upon crutches. Awareness of the extent of
disruption to normal function was exacerbated by a plethora of daily hassles, which in turn engendered feelings of frustration and depression:

When you break a leg you can hobble into the kitchen and you can make a drink, but you can't carry it anywhere... it's silly little things like that you come to try and do and then you just get even more frustrated when you find out that you can't do it. (Laura)

Exposure to others playing sport amplified athletes' awareness of sporting disruption by highlighting missed sporting opportunities and thwarted goals. This led to feelings of jealousy, regret, anger, depression, and frustration. The more closely matched they were in terms of age, sex, and type of sport played to the observed athletes, the greater the concern. Such reactions were particularly discernible when athletes watched teammates performing without them. The injured athlete tended to withdraw from former sporting contacts at this time, reflected in an increased sense of isolation:

I'd go to training and just be on the side lines and everyone's there thinking, Oh there's [James], he's injured. Everyone knows what you've done. No one gives a stuff really. They'd come over and ask how you're getting on, but they are not really interested because they're still playing. (James)

The central theme associated with the main period of rehabilitation was pre-occupation with rehabilitation progress. In assessing their progress, athletes used a range of cues including pain, mobility, visibility, and social support. Informational and emotional support (9) relating to progress was usually provided by physiotherapists, other injured athletes, and previously injured sporting friends. Individuals who appraised their rehabilitation as successful felt happy and relieved, which reinforced a belief in an ultimately successful outcome. This sense of optimism appeared to encourage adherence to the rehabilitation regime.

Several of the athletes appraised their rehabilitation progress negatively. For these individuals, frustration, depression, and apathy resulted, which in turn negatively affected their adherence to rehabilitation. The most extreme response came from a male rugby player who was forced to retire at the age of 21 from all contact sport. Apathy appeared 1 month postinjury. The individual stopped attempting to attend university classes, fell behind in work, watched television all day, and spent the evenings drinking alcohol. Indeed, depression and drinking led this individual to contact a help line for alcohol abuse:

When I got my plaster off after 6 weeks, I started drinking a lot more really, and it got a bit out of hand. Basically that was just part of the apathy. I would just sort of get drunk at night and just not do anything all day, sometimes it was a bottle or two of spirits a day, it was getting a bit silly. (Mike)

Reappraisal of rehabilitation progress continued throughout the main rehabilitation period in a cyclic fashion. Throughout this time exercise withdrawal ef-
fecteds exerted a confounding effect. The predominant emotional corollaries were irritability, depression, and guilt. The main triggering factor appeared to be direct exposure to others playing sport, although the main stated cause of withdrawal symptoms was lack of physical activity per se. Reactions were greater in the more incapacitated participants as well as those who had invested the most time in sport prior to injury:

So I knew that I needed to rest to sort of recover, but at the same time I didn’t want to. So I was thinking I have to go training, I’ve got to, I’ve got to go and play. I think the worst was Saturdays. I would just feel so angry and frustrated, because I wasn’t playing. It’s like being injected with a drug and you have got to have it, you’ve got to do it. (Sean)

The most intense emotion experienced toward the end of rehabilitation was impatience to return to sport participation. Two enduring factors were associated with this reaction: exposure to others playing sport and exercise withdrawal effects. Athletes with the most protracted injuries were noticeably more impatient. Athletes’ heightened impatience was associated with one central appraisal: whether to risk returning to sport participation prematurely. Clear differences were noted between those who did return and those who chose to wait. Participants who did return tended initially to have underestimated the severity of their injury. These individuals displayed the most extreme symptoms of exercise addiction, openly admitting that they found it impossible to stop playing sport. They tended to focus on short-term sporting goals while ignoring possible long-term injury effects. Typically, such individuals set unrealistic rehabilitation goals, attempting to do too much too soon. Many of these individuals did not receive informational support. An example of premature return to sport was clearly described by Laura, who incurred an almost identical yet more serious injury in her first match back. Had she been referred to a physiotherapist following the initial fracture, the risk of the second, career-ending injury may have been reduced.

Several participants preferred not to risk returning to sport prematurely. They were likely to have undergone surgery, followed by a long and painful rehabilitation. They were also more likely to have incurred injury in the past, to have made realistic appraisals of injury severity and rehabilitation progress, and to have received physiotherapy treatment as well as informational and emotional support.

Athletes’ gradual resumption of sport participation was associated with lower sport confidence. This was related to a fear of reinjury or injury to another body part. Fear of injury manifested itself in several ways: being hesitant, holding back, not giving 100% effort, being wary of injury-provoking situations (particularly situations similar to the context of occurrence), and heavily strapping the injured body part. For those with a previous history of injury to a particular body part, the fear of reinjury was intensified because they knew they had a weakness there.

The only strategy athletes used to alleviate their fear of reinjury was to actually test the injured body part through sport involvement. For athletes in contact
sports, this was achieved by making testing tackles. Athletes who avoided injury and performed well during their initial matches reported that their confidence returned and their fear of reinjury diminished over time. Consequent to this was a shift to positive affect. Unfortunately, some participants did not immediately perform well, and this was more noticeable in individual rather than team players. A negative performance was associated with depression and diminished confidence, which continued to negatively affect sport performance.

Discussion

The results of the analysis confirmed several findings from previous quantitative research. Injury in athletes clearly affects mood, with the most extreme emotional reactions generally occurring in athletes with the most severe injuries (6, 18, 21, 23, 30, 31). Depending on perceived rehabilitation progress, negative emotions tended to diminish over time, while positive emotions tended to increase (18). Previous research enumerates frustration, depression, anger, and anxiety as the most commonly aired emotional responses to athletic injury (3, 4, 6, 14, 18, 21, 23, 30, 31). While these emotional responses emerged as salient from the analysis, so too did a range of others, such as guilt, shock, jealousy, and fear. The latter group tended to occur immediately postinjury or with eventual reentry into sport, periods receiving little attention from existing quantitative research (4, 14, 18, 21, 30, 31).

The benefit of using the grounded theory approach in this study is that it enabled us to move beyond description toward an understanding of why certain injured athletes experience particular emotional responses at specific times. Figure 1 summarizes the central emotions, appraisals, events, and behaviors, and it helps explain the relationships between these categories within a time-specific social context. While frustration and depression emerged as the most prominent emotions, the situational corollaries differed as the athlete moved through the process of recovery. During the early phase of rehabilitation, frustration and depression resulted from incapacitation and the consequent disruption of normal function and sport involvement. In the middle phase, depression was associated with a negative appraisal of rehabilitation success, leading to apathy and poor adherence to treatment. By the end of rehabilitation, increased impatience to return to sport was the main instigator of frustration and depression. Anger was prevalent during the early stages of rehabilitation (23), and contact with medical personnel emerged as a key provoking factor.

Exercise addiction and associated withdrawal effects emerged as a prominent theme throughout the main phase of rehabilitation. The possible confounding influence of exercise withdrawal effects in “addicted” injured athletes has received limited attention in previous research. However, as early as 1969, injury was reported to precede neurotic breakdown more in psychiatric patients with an “athletic” than a “non-athletic” orientation (16). Recently, in a comparison of runners and former runners who were sidelined due to injury, it was reported that the sidelined group exhibited
"symptoms commonly noted in withdrawal from addictions" (4, p. 881). In the present study, exercise withdrawal effects were most evident in athletes with the largest investment in sport and in those who were most incapacitated.

Two types of model have dominated our understanding of the psychological response to injury in athletes: grief or stage models (1, 17, 22, 26, 27) and cognitive appraisal models (1, 11, 33, 34). More recently, a "risks model" has been developed using the grounded theory protocol (25). The validity of grief or stage theory has been challenged within both the grief (28, 37) and sport injury literature (2, 29). Two arguments can be leveled against the application of grief or stage theory to athletes’ emotional responses following injury. First, existing research supports the notion of individual variation, determined by the interaction of personal and situational variables, rather than a predetermined progression through stages (3, 30, 31, 33). Second, drawing an analogy between individuals who suffer permanent loss or bereavement and athletes who suffer temporary and relatively minor incapacitation can be regarded as inappropriate or even insensitive. Thus, the results of the present study shall be considered in terms of the risks model (25) and a version of the cognitive appraisal model developed for athletic injury (34).

The three higher order categories that emerged from the present analysis—events and behaviors, appraisals, and emotions—are incorporated within the basic structure of the cognitive appraisal model. However, neither the risks model (25) nor the cognitive appraisal model (34) adequately addresses the temporal dimension of athletes’ adaptation to injury, a key feature of the present data. The cognitive appraisal model refers to recognition of the injury, as does Phase 2 of the risks model in terms of acknowledging the injury. All athletes in the present study recognized their injury. However, some, particularly those who had not experienced a previous similar injury, failed to acknowledge the severity of the injury. Two basic psychological processes described in the risks model, “running the risks” and “opening to messages,” are supported by the present analysis. Athletes’ appraisal of whether to risk returning prematurely to sport during late rehabilitation corresponds to the third phase of the risks model. Although this emerges as an important dilemma, previous quantitative research pays little attention to the risk of premature return to sport following injury. “Opening to messages” refers to messages from the body, such as pain and muscle stiffness, or messages from health professionals, such as information regarding injury severity and progress. This corresponds to the severity appraisal and rehabilitation cues in the present study.

The concept of social support features in both models. Both consider that social support is afforded mainly through interactions with the sports medicine team. Although the current study highlighted the physiotherapist as a key provider of social support, it also identified currently or previously injured athletes as important providers. In addition, social support emerged as a factor in helping the athlete accurately appraise rehabilitation progress and readiness to return to sport. Future research could usefully examine further the role of social support in this context, using qualitative
research methods, given the inherent difficulties in questionnaire measures of social support (20).

Although the cognitive appraisal model has been influential in recent years (29, 34, 35), many of its components lack empirical support and others have been examined only from the perspective of health care providers (12, 36). While it has been championed as providing a blueprint for empirical testing (29), it fails to capture adequately the dynamic nature of the recovery process. Future models should either encompass the temporal dimension or include separate two-dimensional models for different temporal phases. Representing athletes' emotional responses in this way would help sport psychologists understand exactly when specific interventions are required.

In summary, the results of the present study provide a detailed temporal description of the process of recovery from athletic injury. The qualitative approach realized a greater diversity of emotional responses than that which customarily emerges from existing quantitative research. Further, a fuller account of the emotional impact of injury is afforded by embedding affective responses within their situational and temporal contexts.

References


