Disruptive illness contexts and liminality in the accounts of young people with Type 1 diabetes

<table>
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<tr>
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<tbody>
<tr>
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<tr>
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Abstract

We utilise Bury’s (1982) biographical disruption to examine young people’s experiences of type 1 diabetes. Our findings show that young adults adopted various ‘subject positions’ across different illness contexts. The subject positions deployed are intended to produce a particular kind of normal embodied identity unaffected by diabetes. First, participants concealed their illness in public spaces and challenged cultural stereotypes of diabetes to maintain a normal illness biography. Disruption was ever present and required careful negotiation to avoid exposure of illness in public. Young adults upheld a ‘normal public presentation’. Second, they resisted the medical system’s pressure to adhere to glucose targets asserting and maintaining a subject position of ‘independent and autonomous young adults’. Here, disruption was transient and temporary, present in the clinic but not always beyond. It remained in the background for much of the time until it was reinforced by parents or at meal times. Third, young adults acquired a ‘pragmatic subject position’ with diabetes viewed as complex but manageable, no longer a target for resistance. Frank’s (1995) ‘narrative restitution’ is adopted to describe the transition to life with ‘normal’ illness. We argue that illness experience was ‘liminal’ and reflected the subject positions adopted by young adults.

Disrupted illness biographies

Bury (1982) introduced the concept of ‘biographical disruption’ to denote how illness leads to a breakdown of normality in the structure of people’s lives. This impacts on sense of self and leads to redefinition of, and adjustment to the change in circumstances. A previously illness-free self requires readjustment and renegotiation in relation to relationships and social activities. Bury’s concept outlined what subsequently became the focus of scholarly debate resulting in somewhat polarised accounts in which chronic illness (more commonly referred
to today as a ‘long term condition’, which drops the assumption that a progressive illness necessarily has to be ‘chronic’) is either disruptive or not disruptive (Pound et al 1998; Larsson and Grassman 2012). Perhaps in anticipation of such polarisation Bury (1988) later included the concept of illness significance and consequence, to stress the multidimensional nature of illness experience. This seemed to be a turning point in the intellectual debate inviting more sophisticated conceptualisations of illness. The distinction was applied to highlight both how people ‘make sense of’ and directly ‘experience’ illness (Sanders et al 2002). When placed in the context of older age the meanings take on a different form, with biographical disruption questioned and redefined. A significant body of sociological literature evolved from Bury’s ideas which might be divided into parallel lines of enquiry with illness experience viewed as either normal, disruptive, or both.

The literature on ‘biographical disruption’ has predominantly examined the experiences of ‘older’ people. There are a few exceptions, however, that report the accounts of younger groups which we discuss below (Saunders 2017). Since the 1990s the notion of ‘normal illness’ has been well articulated to illustrate how disease does not automatically lead to disruption in the way that Bury claimed. For instance, if examined in relation to social context ‘disruption’ might be negated or avoided. Williams (2000), showed how disruption resulting from illness was anticipated by people in the context of economic adversity, which in turn reduced its impact. Likewise, Carricaburu and Pierret (1995) found that homosexual men viewed contracting HIV as ‘biographical reinforcement’ since it offered a sense of belonging and membership of a community of men diagnosed with HIV. Similarly, ‘biographical flow’ extended the normal illness argument with stroke representing a continuation of biography rather than a disruption to it (Faircloth et al 2004). In much of the published research on biographical disruption the context of ageing features prominently in people’s accounts. The connotations of ageing, which include physical decline are assumed to play a prominent part in how people define ill health as inevitable. Pound et al (1998) reported that physical and mental decline was viewed by stroke survivors as an inevitable part of ageing over which
individuals exercised little control and were compelled to accept. The narratives of normal age led the authors to conclude that stroke survivors do not in fact experience biographical disruption.

The normal illness thesis has subsequently been challenged by authors seeking to demonstrate a more fluid theorisation of illness experience, with normality and disruption interconnected not separate. Disease can still be disruptive in old age, and people’s responses need not be wholly ‘passive’. Sanders et al (2002) found that normal and disrupted accounts coexisted in people with osteoarthritis. Pain and disability were both normal and disruptive. The increasing fluidity in how accounts of chronic illness are presented in the literature gives rise to the importance of context and contingency where illness may increase, decrease or even disappear, described previously as a state of ‘shifting normalities’ (Sanderson et al. 2011). Saunders et al (2018) report ‘biographical suspension’ in people with sciatica, whose anticipated future recovery from pain, often perceived as temporary, gave rise to a state of liminality which manifested in different types of suspension. Much of this ‘suspended’ disruption can be explained by the perception that sciatic symptoms are an injury not a disease and therefore temporary. Monaghan and Gabe’s (2015) study of children with asthma depicted illness as largely unremarkable and only disruptive at certain junctures. Whilst Larsson and Grassman (2012) claimed that the general ‘anticipation’ of developing chronic illness in old age did not mean that people viewed it as normal. Following in this vein, Saunders (2017) presents young adults with inflammatory bowel disease as experiencing recurrent disruption, which is intermittent and unpredictable. Disruption here is conceived, not in terms of a single disruptive event such as a ‘flare up’, but as a pattern of cyclical and recurrent disruption caused by the disease. The two young adults in this study learnt to accommodate the anticipation of relapse; the recurrent pattern almost viewed as a personal resource with which to prepare for future disruption. Saunders (2017) further illustrates the co-existence of normal and disruptive biographies shifting between each other. Long periods of normality without ‘flare ups’ are
replaced by intense phases of recurrence and disruption moving in and out of focus. The disease was not all consuming but characterised by fluctuating patterns of latency and relapse.

The concept of liminality has previously been deployed to depict these fluctuating patterns to describe the tension brought about by illness onset, with people negotiating their pre and post-diagnostic identities where the self-concept shifts. Liminality is a situation where individuals do not fit into any one space, classification or definition, but somewhere in between. They may have a diagnosis but do not experience illness or shift between a normal and abnormal illness identity. It is neither a state of illness or wellness as in the case of chronic fatigue (Brown et al. 2017). A cancer diagnosis could reinforce negative risk perceptions of recurrence or mortality, preventing a return to life as normal (Trusson et al. 2016). Liminality is an existential state rather than a passing phase. People experience liminality but also actively negotiate illness to assert some control over illness uncertainty. Saunders et al (2018) found that people with sciatica rejected their diagnosis as representing ‘the real me’, sometimes leading to proactive illness management to assert control over symptoms. Similarly, dementia could lead individuals to move into a post-liminal state as either active or passive citizens in the way they respond to the illness (Birt et al. 2017).

Type 1 diabetes, young adults and chronic illness

Management of type 1 diabetes in young adults particularly during the transition from paediatric to adult care is challenging and often results in poor clinical outcomes (Barnard et al 2014). This is a long-term condition often diagnosed in childhood or adolescence. The effective control of blood glucose is critical to avoid long term complications such as blindness, limb amputations, and kidney failure (Knight et al 2005). Consequently, the challenge is to attain good control of blood glucose, which is problematic in young adults transitioning from paediatric to adult services. As they move to adult diabetes care they are eventually expected to assume greater independence over disease management, away from
reliance on parents. This process can present a tension in the way they adjust to their illness, assuming more responsibility and navigating the healthcare system. Type 1 diabetes places almost unique demands on the individual. Long term conditions such as HIV or stroke in older people or even malignant disease which is often slowly progressive is essentially a passive process in terms of minimal self-management. In contrast, type 1 diabetes places huge demands on the individual both in terms of skills (calculating insulin dose, measuring blood glucose etc). If they get it wrong, either their glucose falls below normal and they experience hypoglycaemia which can lead to confusion or coma, or their glucose runs high and, over time, there is a risk of long-term complications. During childhood, it is the parents who bear the responsibility (usually the mother). But during adolescence they need to learn and implement these complex self-management skills. Thus, in the short-term if they get it wrong they risk hospital admission, death, significant hypoglycaemia, impaired cognitive function, loss of consciousness, and embarrassment in front of friends. This means acquiring many skills that non-diabetic friends are not burdened with. Self-management is not as simple as using an inhaler when feeling breathless. They need to do this every day even in the absence of symptoms. Symptoms of breathlessness, pain, decreased mobility as in some cancer diagnoses usually drive people do something proactive. A sub-normal glucose level (asymptomatic) does not.

Much of the literature on young adults with type 1 diabetes presents illness experiences as characterised by a desire to lead a normal life. The reality of daily living, however, is influenced by ongoing interference of diabetes. In relation to the concept of biographical disruption, young adults’ attempts at detachment from the disease are met by constant reminders that life with diabetes is anything but ‘normal’ (Schur et al 1999). The negotiation of diabetes alongside the pressures of youth is conducted with various degrees of success. The co-existence of normal and disrupted biographies in the context of older age are equally evident in relation to young people with type 1 diabetes. Research shows that parents and young adults with Type 1 diabetes engage in a trade-off between leading a normal life and
enforcing self-discipline to control the disease, by injecting insulin at the right time and avoiding certain foods; a price thought to be worth paying for the benefit of reduced relapse and therefore disruption to family life (Marshall et al 2009). A finding echoed in Miller’s (1999) study where self-discipline around glucose control appeared important and a sacrifice worth making for keeping symptoms under control. In one sense the family context seems to provide stability and protection from the disruption caused by diabetes. In another, it reinforces glucose control regimes which may in themselves cause disruption to young adults but offer a sense of stability and reassurance to parents that the disease is being properly managed. In a study by Hatton et al (1995) the stress of living with the condition required ongoing control and inflicted long-term disruption to both parents and young people. Whilst for Dovey-Pearce et al (2007) the daily disruption of diabetes symptom control was tempered by the safe base of the family, which had a protective effect for young people providing safety and security in the face of relapse. It is of note to distinguish between disruption caused by the disease and the effort surrounding symptom control. Peer support has also been shown to buffer the negative experiences of diabetes such as improved control of illness disclosure in public. Integration into a larger peer group may render the disease less visible perhaps. Others yet show how the tension between diabetes control regimes and conformity to expected student norms at university inevitably led to trade offs. The typical student experience was characterised by a varied blend of living life both as normal and disrupted. Depending on the circumstances the tension was resolved in different ways; at times in favour of glucose control where adherence to a regular dietary programme outweighed the need to conform to university culture (drinking, socialising), at other times the converse. Here biographical disruption could be described as ‘ever present’ though to different degrees, negotiated according to the immediate circumstances the young person finds themselves in. All of this is viewed as an attempt to construct or maintain a ‘moral self’. Balfe (2007) found that university students with type 1 diabetes engaged in ‘body projects’ to establish control over illness by presenting a moral narrative; that is for instance, the goal of eating appropriate food and well measured quantities in order to reduce weight and conform
to societal body image stereotypes, not to protect themselves from future health complications. The context of the university had a major impact on how participants negotiated their identity body project, and the constant pressure to balance both. This literature suggests that the management of potential future or immediate disruption was a proactive exercise, not passive as sometimes depicted in relation to older people with chronic illness (Pound et al 1998). Balfe (2007) found gendered repertoires of subject positions, where males were more disciplined in their glucose control regimes as these fitted with their moral narrative of the ideal masculine identity, since dietary discipline aligned more comfortably with participation in sports and physical activity leading to an ideal body shape. Females’ subject positions (of a thin body image, for example) were less well aligned with the glucose control regimes that demanded a disciplined dietary routine (eating certain foods, right quantities, at the right times). Previous literature has also shown that in addition to the desire to ‘fit in’ a social context and achieve the required trade off with maintaining optimal glucose control, other social processes such as stigma may come into play, where young people become stigmatised and socially isolated as a result of their condition (Dovey-Pearce 2007; Schur et al. 1999).

**Youth transition**

It is important to appreciate how individuals move from childhood to adulthood as a basis for explaining illness experiences. Traditionally, adult transitions have been studied by academics interested in youth ‘geographies’, but much of this work has applied a static conceptualisation of transition based on linear temporal phases and movements across time (Butcher and Wilton, 2008; Valentine, 2003). Allport (1955) and Grosz (1999) showed how the concept of ‘becoming’ can be used to consider the inherent complexities of contemporary youth transitions. Arnett’s theory of ‘emerging adulthood’ describes a distinct stage of the life course where young people have left the dependency of childhood but not yet assumed the responsibilities of adulthood (Arnett, 2000). Giddens’ (1991) ontological security can help to conceptualise how young adults negotiate chronic illness in the context
of youth transition, a time often characterised by pressure to normalise illness and find ways
of integrating a disrupted biography into a ‘practical consciousness’; everyday routines to
reinstate a normal sense of self.

Methods

Setting and participants

The qualitative study was conducted in the context of a structured education programme
(Working with Insulin, Carbohydrates, Ketones and Exercise to Manage Diabetes –
‘WICKED’) delivered at two different sites: a village hall (Site A) and a seminar room at a
hospital (Site B) designed to facilitate shared learning and self-management among young
adults (16 to 24 years old) with type 1 diabetes. The aim of the study was to explore the
acceptability of the course, reported in a separate paper (see Sanders et al 2018). We
explored the individual and collective experiences of young adults towards managing their
diabetes and the key obstacles to effective self-management at a key point in their transition
towards adulthood. Interviews were conducted twelve weeks following each course in the
homes of the study participants, whilst focus groups were conducted at two course sites.
Focus groups were convened on the final day of the course. A total of 17 participants
attended Site A and 15 attended Site B, yielding a total of 32 attendees (all attended focus
groups). We therefore recruited a total of 15 young people to an interview, approximately
50% of all attendees. Average time since diagnosis was 9 years in all interview participants.
Eight girls/women and seven boys/men were interviewed, and the average age was 18.

Interviews and focus groups

We conducted 7 focus groups immediately after each WICKED course with the participants,
and 15 interviews twelve weeks following the course. Interview participants were sampled
purposively based on maximum variation to ensure broadly equal proportions. All
participants were invited to participate in focus groups following each 5-day course, thus the
focus group data is representative of all participants attending the WICKED course. The
interview and focus groups were audio recorded and transcribed. The data were coded and
analysed thematically using a combination of N-vivo 10 and manual coding techniques. The
data were coded independently by two members of the study team (a senior medical
sociologist and a research health psychologist). Regular meetings were held to discuss and
compare the coding and the emerging findings. Interviews and focus groups explored similar
topics including the experiences of attending the course and attitudes towards diabetes self-
management before and after completion of the course.

Our approach to analysis was informed by the principles of grounded theory, particularly the
constant comparative methodology (Strauss & Corbyn 1994). This included immersion in the
data to identify the major themes, following which we compared data extracts in search of
similarities and differences. Themes were developed using thematic coding, where both
researchers assessed the most highly recurring views to explore in more detail. Although we
used semi structured methods, we tested earlier findings in subsequent interviews. The
themes were also examined using theoretical concepts such as biographical disruption and
to what extent and in what way did the experiences of participants reflect some of the key
constructs relating to this theory. We eventually arrived at three dominant themes, which
forms the basis of our paper, and analysed these in further depth to explore how public
spaces, attendance at clinics and assimilation of complex knowledge about diabetes led to
illness disruption. We examined negative cases such as the absence of biographical
disruption in the data.

As each researcher came from a different discipline (sociology and psychology), the findings
were interpreted using slightly different conceptual frameworks, although through discussion
the interpretations converged. This prompted critical reflection on the early interpretations
with a view to examining the data in search of examples in the interviews which supported or
refuted them. Reflection was also facilitated by the lead researcher’s (sociologist)
attendance at the courses, which informed interpretation of the interview and focus group
findings. Much of the discussion during the course offered insights with which to interpret the
analysis. Data saturation was reached when no new ideas or insights were found in the data
analysis. We analysed the focus groups first, which is why we reached data saturation after
fifteen interviews. The key themes were identified early on from the focus groups, which we
explored further in the interviews, and decided to stop data collection at this point when no
new insights emerged.

Results
The findings present the negotiation of normal and disrupted biographies by young adults
with diabetes. We use the notion of liminality to illustrate the fluctuation of illness
experiences between disruption and normality depending on the context.

‘Nobody knows what it’s like to be me’
As type 1 diabetes affects just 10% of all cases of diabetes, with type 2 the most common,
participants struggled to place their experiences in a broader context, leading to feelings of
isolation. A major frustration was the view that young adults are often labelled as different or
perceive that they are different. This seemed to be an important obstacle to their transition
into adulthood as they tried to present a ‘normal’ self in public. It required ongoing
awareness and anticipation of when they may experience a sudden deterioration in glucose
levels that could risk exposing their illness to others.

Yeah. There’s a quote I found on the internet ‘A lion will not understand a zebra until
a lion becomes a zebra for a day’. Which kind of means you can talk to someone as
much as you like but if they don’t understand or they don’t have what you’ve got they
won’t understand at all. So the best person to talk to is someone who actually has it
(Interview, 008, male, 16, Site B)
If you were like oh yeah I didn’t do my insulin purposely because I didn’t want to be well. That ... like you would feel judged. Like somebody outside would be why the hell are you doing that, that’s like somebody with a broken foot going oh I’m going to go and play football though even though my foot’s broken. Like it doesn’t make sense to people that whilst you’re sat in a group with other diabetics they get that. They’re like oh yeah I’ve felt that way. (Interview, 003, female, 21, Site A)

Young adults reported the less tangible benefits including listening to others' experiences and challenges of living with the condition, to help find their own 'level' within the group.

Lawton and Rankin (2010) showed that patients ‘recalibrated’ their risk thermostats based on the insulin dose adjustment experiences of others. The literature shows that social networks can provide emotional and practical aid as well as facilitating a means to mobilise, negotiate, mediate and access further assistance (Reidy et al 2018; Kennedy et al 2016; Hempler et al 2016). A supportive social network is known to have a “buffering” effect in situations eliciting stress, such as the introduction of a complex new technology (Blickem et al 2013; Harrison et al 2014). This seemed to help them normalise their glucose management behaviour and acknowledge it as acceptable, rather than something to be ashamed of. Not being understood by others who were unaffected by diabetes led to feelings of isolation and detachment. It also led to concealment of the condition from others in anticipation of the negative public assumptions surrounding diabetes.

That’s what most people are like though. Most of them just go ‘oh so you can’t have sugar’ and then I just sort of... well I bank my head against a wall. The worst thing is when someone says ‘is that the one for fat people Type 1 or is that Type 2?’ I’m sat there thinking oh my god that’s not very politically correct is it (Interviews, 004, female, 18, Site A)
So if we normalised it and it isn’t our fault it’d be a lot easier and people wouldn’t get misconceptions about it which if a lot of people have the same misconception can be really frustrating and annoying for us to have to deal with and to have to explain every single time (FG, male, Site B)

Some expressed a desire to hide their diabetes by refusing to inject in public. Valentine’s (2003) ‘performativity’ alludes to how young people ‘act out’ their ‘subjectivity’ in public, in this case to be perceived as a ‘normal’ young person.

It helps you feel more like... I don’t like to use the word normal person, but everyone with a sort of disability or disease or anything like that, I don’t want to say it in a bad way but they don’t want to feel they’ve got it... everyone wants to sort of, kind of, yeah not be like they’ve got something wrong with them and talk about things freely (FG, male, Site B)

Whereas Type 1 it’s not our fault at all. We don’t know what causes it but its not due to being overweight or anything like that and that stigma that’s attached itself to Type 1 because people don’t know the difference it can be quite... it’s really negative and it can impact on you like psychologically and the perception of yourself cos of everybody else’s misconception (FG, female, Site B)

Blame featured strongly in our participants’ accounts and led to concealment of behaviours that could reveal the illness, signifying a disruption to self and identity. Self-medication in public spaces was perceived as socially undesirable leading to stigmatisation.

A. But it might be because we go into private places to inject so that’s why people aren’t as accepting.
B. I just feel because there’s less cases of Type 1 diabetes than Type 2 and even with Type 2 there’s very few that are actually on insulin injections for Type 2 so it’s a lot less common than... Maybe people carry round inhalers just for the... just like as a safeguard but they never actually seem to use it but everybody knows that an inhaler is safe and that its normal whereas again injections aren’t, whatever equipment that nobody else seems to have that you might have if you’ve got a pump, they don’t understand why that is. And other people, when they go out to town, they barely have anything with them. You always have to have a bag and they don’t... it’s just those little things (FG, female, Site B)

I used to hold back and put a guard up and like ‘no I don’t want to hear the word diabetes, I don’t like diabetes’. I was embarrassed about what I had and even if someone mentioned diabetes I was like no stop mentioning this, change the subject. (FG, male, Site A)

Young adults experienced biographical disruption (Bury 1988) which they attempted to manage through hiding their condition in public by not injecting insulin and thus making the visible invisible. Disruption posed a threat to self and identity and was clearly present but accommodated through ‘concealment’; a necessary precaution to ‘fit into’ public spaces and normalise the illness. A dialectic relationship is evident in the struggle to maintain a ‘normal externally facing self’. There is disruption to biography, but that is carefully and sometimes haphazardly managed to maintain a normal self in public. The young people are ever conscious of their diabetes but push towards a normal self-presentation (Goffman 1959). They do not reach a state of complete normality in this context since the diabetes is ever present and requires constant planning to avoid outwardly manifestation. A state of liminality is evident; neither is their illness normal or disruptive. Disruption is controlled through concealment. Normality is maintained only in public view; in private such concealment may be unnecessary, and therefore only must be managed in social situations. To our young
adults, disruption is always present, either safely tucked away in the background or 
threatening to reappear at the most embarrassing moments. Similarly, Balfe (2007) reported 
the trade-off students make between tight control of glucose regimes and the desire to 
participate in student culture, with the latter often winning the day. For our young people 
participation in social life meant a similar trade off had to be made.

Young adults make choices to manage embarrassing or difficult social situations that carry 
future health risks, in an attempt at ‘colonising the future’ (Giddens 1991). These decisions 
however are not ‘passive’, miscalculated or misunderstood, but based on an evaluation of 
risks and decisions that have meaning, and help preserve their public (image) identity as 
‘normal’ young adults (Valentine 2003). In this situation disruption is defined by exploration 
of possible futures (Arnett 2000) and a desire to lead a normal life, and careful consideration 
of what they want to ‘become’ (Arnett 2000). The need however for safe(r) glucose control 
will manifest eventually and demand a response, fuelling the cycle of disruption and the 
presentation of a ‘normal’ self in everyday life. In this public presentation of self, we can 
define the illness experiences of young adults as managing the cycle of biographical threat. 
They were more concerned about identity than the risk to health. As Giddens (1991) might 
concede, colonising the future is about managing the self in everyday life, or as Balfe (2007) 
contends in relation to the maintenance of ‘subject positions’ by people to help construct a 
moral narrative. The subject position constructed by our young people involved presenting a 
‘normal self’ in public spaces, helping to counteract illness disruption. Biographical disruption 
here is neither dominant or latent, but ever present, and characterised by ‘liminality’; 
‘backgrounded’ in public spaces at least for the time being, only to resurface in the relative 
safety of home. Diabetes was never described as overwhelming (total disruption) or normal 
(undisruptive) but occupied a middle ground.

‘It’s me against the (medical) system’
Target driven glycaemic control reinforced by the medical system was viewed as a major
disruption preventing young adults from leading a normal life. The following narratives refer
extensively to the medical pressure to maintain optimal glucose control and concur with the
demands of the (medical) system driven by targets. Young adults reflected on the
discordance of target driven medical care with their own self-identity as autonomous and
independent agents of change (Giddens 1991). Many claimed that the medical system was
preventing them from living a ‘normal’ life; encouraging short term sacrifice for long term
clinical benefit.

I don’t know it’s just maybe the everyday things like how people are always asking
questions or they stare whenever I check my blood sugar or something. I don’t know
just being able to, if not relate, then just tell someone about it who will understand a
little bit that... I don’t know. (Interview, 007, female, 17, Site B)

They (clinicians) do personalise like different numbers according to how well you’re
doing like my HbA1c is always above what the government sets but it’s still better
than what it could be and they know that like life kind of does happen and things...
aren’t always able to do everything that they ask you to and would like you to do in
an ideal world where you didn’t have work, school, days out things like that that can
affect different things, stress, illness or anything like that. But sometimes it can be
difficult talking about your problems to clinicians (FG, female, Site B)

The structured education programme had implications for patient self-management and
interactions with the healthcare system. The findings revealed a contradiction between
young adults’ interactions with the healthcare system and maintaining their own sense of
autonomy.
Most endocrinologists I feel they don’t understand the emotional side of the disease but all the nurses they seem to have more of a relationship with all of us and have more of an understanding of what we go through emotionally and every day (Interview, 007, female, 17, Site A)

I want to do it my own way. I don’t want to be forced to look at a graph, see what’s good, what’s bad and keep doing that like (Interview, 008, male, 16, Site B)

if I’m having a difficult time in my life I’ll get worse control. But just going to clinic I don’t feel like that’s... I don’t get the sort of message that that’s normal so it feels like I’m doing bad (FG, male, Site B)

Similarly, they distinguished between diabetes as both a physical and a ‘lived’ experience.

I suppose the importance of keeping it in... your blood sugars in the target range and the effects of not keeping it in your target range and I suppose the importance of that was explained which makes it more... rather than just the consultant saying you need to keep it in the target range, this is....., you need to do this. There’s a reason behind it and sort of like you’ve got an understanding of why it needs to be like that. You understand almost the consequences of what’s happening behind that. (Interview, 002, female, 22, Site A)

I think sometimes if you find it hard like to do something... like with my blood sugar readings they’ve always been a problem and every clinic appointment it’s the same thing and the way its presented to me sometimes it’s kind of like ‘do you not get this yet?’ Sort of situation where you’re just sort of sat there thinking I know exactly what you’re going to say, there’s no point in saying it but you’re going to say it to me anyway and I’m going to feel really bad about it and you’re going to look at me with
that expression on your face of ‘are you an idiot?’ Because you don’t do it already.

That’s what it’s like. (Interview, 004, 18, female, Site A)

Interactions with the medical system imposed a set of expectations to optimise glucose control. This conflicted with other central tenets of their adult transition; autonomy, choice and independence. These values were constrained by a target driven medical culture, concerned with outcomes and less with young people’s personal and social challenges.

Clinicians’ technical knowledge of diabetes control stands in contrast with young adults’ lived experiences. The consequence of life with diabetes is that targets must be met, and the medical system is a constant reminder of ‘disease’ and ‘difference’. Young adults did not escape this reality. However, espoused resistance to the target driven medical system offered some protection, helping to assert their independence as emerging adults able to make their own decisions whether to follow targets. Such defiance might be viewed in terms of an emergent ‘resistance’ narrative in contrast to the language of acceptance, accommodation and stoicism reported in previous research on biographical disruption in the context of old age (Pound 1998).

There is clear indication of liminality at play. First, resistance to medically driven targets enabled young adults to assert their independence. Clinic appointments and targets are a disruption. Note, it is not simply the disease per se but the social relations around it that cause disruption. Participants did not display resistance directly with clinicians in clinics, but ‘quietly’ in the way they attempted to live life as normal despite the medical advice. Living a normal life as a young person outweighed the need to meet targets. These were not completely disregarded, but glucose control was deprioritised in the context of socialising or drinking alcohol. Acting as a normal young adult meant exercising choice and autonomy; independence was the ‘new’ normality. Second, the clinical setting was perhaps easier to negotiate than public space since young adults could ignore targets as these only became relevant at specific times and relatively infrequently, hence at clinic appointments. For the
large part targets were ‘out of sight and out of mind’; they could be followed flexibly or not at all. This created space for the resumption of normality and the ‘backgrounding’ of illness.

Disruption moved in and out of view, manifesting during clinics and disappearing thereafter. Disruption was liminal, though only occurred at certain time points, less frequently compared to the disruption experienced in public spaces where young people spent most of their time. Away from the clinic diabetes became a normal illness, ‘ignored’ or moved to the background. They could after all depend on the safety net of the family as a last resort if the condition got out of hand (Govey et al. 2010).

‘Daring to learn the complexity’

A major difficulty of transitioning to adult life with type 1 diabetes was having the confidence and courage to learn the complexity of disease self-management and letting go of the dependency on parents to monitor glucose control. The WICKED course seemed to facilitate such confidence. The adult transition is not a simple matter of a knowledge shift but also an identity change, influenced by social and peer pressure, as well as balancing diabetes control, school, and social life in a way that opens the way for future ‘becoming’ (Grosz 1999). The medical expectation to accomplish a radical shift in disease control was countered by young adults’ desire for tempered change to adjust to the complexity of living with diabetes.

We learned that you can’t be perfect all the time you are going to have these ups and downs and I think a lot of us its either got to be good or its got to be bad, they can’t be an in between (Interview, 005, female, 21 Site A)

They sort of like taught us that it’s normal to have blips and don’t worry about it. As in blips as in unlevel sugars. (FG, male, Site A)
Young adults were taught to view glucose control as an imperfect task with inevitable fluctuations. The disruptive elements of glucose control could in fact be viewed as ‘normal’ after all. Others felt that diabetes was greater than the sum of its parts, again illness could be accommodated into ‘normal’ everyday life. What seemed to matter was the totality of the illness experience which was more significant than the individual elements of disease management.

You can have like the tiniest little thing in your head, to somebody else even without diabetes doesn’t seem as big cos it’s in your head sort of thing but when you’ve got diabetes and you’re high or you’re low its bigger than your own head do you know what I mean? It’s gone out of the box. You’re all over the place and everybody else is just saying you’ve got to clean up that mess that you’ve caused and to be honest you’re not in the right state of mind to be touching any of that yet. Do you know what I mean? And they try to push you towards it and people need to understand that it is pressure. A hell of a lot of pressure on all of us. (FG, female, Site A)

Here treating diabetes as a ‘normal illness’ is viewed as inevitable. Acknowledging the complexity of living with and managing diabetes seemed to be a critical point, which signalled the beginning of a new phase, and one which the following participant stressed had to be recognised by the medical system. The complexity meant that targets could not always be followed.

Life events. I feel like life events need to be discussed. Things like festivals. Things like travelling. We’re dealing with young people that are deciding what they want to do with their lives and you don’t really realise how much having this illness affects you in say the workplace or wanting to go travelling. The health insurance, the... every little thing. Like if I was a normal person I would be like I’m just off to France for the weekend whatever like I’m just going to book the flights and go. You have no
idea that you’ve got to like... nobody takes actually on board that oh crap I’ve got to take insulin, oh better get health insurance because you never really know what’s going to happen. (Interview, 003, female 21, Site A)

The transition to life as an adult with diabetes seemed to require not only awareness of diabetes management but a recognition of its complexity in the context of young adulthood. The complexity was shaped both by the need for technical knowledge and tacit knowledge, the latter was more about understanding each young adult’s unique experiences and personal responses to living and managing diabetes.

Yeah. So my confidence has been built up from my just being confident with dealing with diabetes day to day. (Interview, 005, male 21, Site A)

Similarly, young adults valued listening to the experiences of their counterparts and the way others managed their diabetes, helping to better understand their unique struggles.

Just it opened, like other people’s experiences opened my mind to like just a bigger world I guess cos I’ve never really had problems with discrimination like a couple of people in the course have and I’ve never really had problems with drinking and drugs and things like that. So, it just made me realise that there are other things that could influence me and that I could run into later on in life. (Interview, 007, female, 17, Site A)

If you’ve got the same sort of views you feel like something probably could be done to change what we see as not right about social issues to do with diabetes and you don’t feel as alone really in terms of how you feel sometimes if you are the only one that you know with diabetes you don’t feel like you can do anything about it, you’ve just got to accept it. Whereas now, meeting other people with diabetes that feel
similar or the same way something could be done about it if we met with even more diabetics not just the ones that attended the class (FG, female, Site B)

The ‘complexity’ discussed here not only relates to the challenge of learning the clinical knowledge for glucose control, but balancing this with everyday knowledge, activities and distractions. The narratives stress the importance of acknowledging that living with, self-managing and applying new learning about type 1 diabetes is difficult sense-making work and not just a matter of telling yourself the simplified version (“eat your greens, inject your insulin, all will be well and parents will watch over you”-authors’ own words). In this way this sense making work involves owning the knowledge rather than applying someone else’s.

This is facilitated through the peer group of young people with diabetes. It needs to be their knowledge, or knowledge which comes from their ‘tribe’ to have meaning. Facing up to the complexity of diabetes self-management might be interpreted using a social capital perspective (Bourdieu 1986). Knowledge acquisition must be turned into knowledge ownership. ‘Their knowledge’ must become ‘my knowledge’, achieved through complex sense making work and the active production of social capital (Helve and Bynner, 2007).

“Transition is not just what others do to us, but what we can do to help ourselves” (authors’ own words). In this vein they embodied clinical knowledge to make it their own, and in the process moved gradually from biographical disruption to a life with a ‘normal illness’. They achieved this through self-reflection of how far diabetes could be readjusted to fit in with their lives, not the other way around. The choice was no longer ‘either’ diabetes control ‘or’ living life to the full as ‘normal’ (Babler and Strictland 2015). A compromise was reached and suggests a movement from childhood dependency on ‘others’ to living independently with complexity. Liminality in this context (compared to the public and clinical contexts) is characteristic of a more radical shift towards a ‘normal illness’ narrative. Diabetes is still disruptive, but it is ‘foregrounded’, brought into line with everyday routines.
Disruption co-exists with life as ‘normal’; one does not replace the other. One way of conceptualising this theme is as ‘narrative restitution’; the integration of technically complex knowledge and an appreciation of the imperfect nature of type 1 diabetes self-management within a new biographical narrative. Everyone is fallible and will get things wrong. Narrative restitution is a work in progress for the young people in this study. It is however a key step in the transition to a life as a young adult with diabetes (Babler and Strictland 2015).

**Discussion**

Biographical disruption operated in three contexts; public spaces, clinics, and the knowledge context (promoted by the WICKED study which helped to realign realistic expectations of managing a complex illness). The implications of these findings are as follows. First, ‘Nobody knows what it’s like to be me’ depicts the social pressures of living with, and struggling against the cultural (mis) representations, of type 1 diabetes. This had profound impact on our participants, leading to a mixed cocktail of feelings prompting a range of responses. The most striking was hiding the condition by refusing to inject insulin in public spaces, and perhaps putting themselves in danger. Frustration with others’ misunderstanding of type 1 diabetes and its aetiology was another common reaction. We interpret these findings as the ‘maintenance of a public self’. Disruption in this case requires planning to minimise the risk of relapse at the ‘wrong time’ and illness exposure in public.

Second, ‘It’s me against the (medical) system’ signified a desire by young adults for health care provision to become more person-centred and less target driven. The clinic represented dependency on medical systems, standing in conflict with young people’s transition into adulthood characterised by independence and autonomy. We can interpret this theme as the desire to ‘maintain an independent self’. Normality is only attainable if they can be independent. It can be maintained in the face of clinical target disruption which our young people were able to avoid or follow flexibly. Whenever not in clinic targets could be avoided altogether if so desired. The disruption to self-described here is transient and temporary.

Third, ‘Daring to learn the complexity’, shows how young people step outside into the adult
world navigating and comparing their experiences with those of others in their peer group (Reidy et al. 2018; Kennedy et al. 2016; Hempler 2016). Technical knowledge of diabetes management only becomes relevant when it is ‘owned’. The technical facts must be transformed into practical wisdom to make sense and have long lasting application. The argument we present is to show how young people’s narratives represent a call for ‘pragmatic’ knowledge to facilitate the transition to a pre-illness identity. We coin this theme ‘narrative restitution’ (Frank 1995) where a shift occurs in illness disruption allowing for a more realistic and practical understanding of disease self-management.

Liminality in this context could be conceptualised as representing a dialectic relationship between an independent and pragmatic self, perhaps located at opposite ends of the liminal spectrum. Independence represents the desire to maintain autonomy in the face of disruptive illness, by hiding the disease in public and resisting external interference from those in authority. Disease is an interruption to living a normal life and an unwanted obstacle to biographical continuity. This form of liminality is where disease is ‘backgrounded’ and the quest for a normal life without illness is vigorously sought. Any talk of ill health is replaced with talk of a future free of disease; it is removed from immediate view in the hope and belief that it does not return. The converse appears to be the case in young adults adopting a ‘pragmatic subject position’. Liminality in this case is characterised by the foregrounding of disease in the hope that the pre-disease self can be reintroduced back into the new biography. A process of ‘restitution’ is enacted involving biographical reconstruction and the reintroduction of the former self into a new illness identity (Frank 1995).

Limitations

Although not statistically representative, the findings are likely to reflect experiences of the broader population of young adults with Type 1 diabetes, although the aim was not to generalize beyond the immediate study participants. The interview sample included 15 participants, which may be viewed as a low number, although we did reach ‘data saturation’
and did not require further data collection. In addition, the seven focus groups provided further data which gave us confidence that we captured a broad range of views and experiences in significant depth. As our participants were primarily white British, future studies need to explore the views of a broader range of ethnic groups in search of possible cultural differences in how young people navigate these three illness contexts.

Conclusion

The findings have implications for health services. First, the pressure to maintain a normal self in public requires greater recognition and guidance from health professionals (GPs and diabetes specialists in secondary care) of young people’s everyday challenges to self-manage their diabetes. Particularly specific advice on how best to manage difficult or embarrassing social situations safely. The struggle to lead life as normal despite the illness is indicative of a need for practical guidance to negotiate challenging social situations.

Second, the adoption of an ‘independent subject position’ in relation to glucose targets seems to suggest a need for a person-centred care model during clinic appointments, responsive to young people’s everyday struggles. This calls for more holistic healthcare interactions which recognise the wider social context of glucose control. Finally, health services need to deliver pragmatic education moving away from target driven approaches for optimising glucose control; and towards a more flexible healthcare model to directly respond to the often chaotic and uncertain experience of managing chronic illness during adult transition. Research in educational settings has shown that young people are not only passive recipients of capital from their parents, but creators of capital through their own peer groups (Helve and Bynner, 2007). Peer groups, based on friendships created from structured education programmes such as the one described in this paper, could facilitate the formation of pragmatic self-management strategies through peer engagement and reflection.

References


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