

# **Diabetes and the Student Body**

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## Abstract

In this study I examine young peoples' experiences of managing their diabetes in university. Previous studies of students with diabetes have highlighted the problematic effects that the transition from home to university can have for these young people. Young people with diabetes are thought to be at risk of experiencing peer pressure, drinking too much alcohol and eating unhealthy foods. Such practices are often figured to be representative of a 'student lifestyle', one governed by self-indulgence, and are seen to be in conflict with the lifestyle that a well controlled young person with diabetes should maintain. Earlier studies are themselves problematic in several respects, however. First of all they typically see the young person's 'student identity' as being an *a priori* risk to their diabetes care. Secondly these studies often ignore young people's own understandings of risk, or fail to recognize the socially embedded nature of risk for young people with diabetes. Thirdly they often see the transition from home to university as an undifferentiated, uni-directional phenomenon whose effect is the same for all young people with diabetes. Once these students make the transition to university, their diabetes control is thought to take second place to more 'pressing', risky concerns. In this study I argue otherwise. By attending to young people's own narratives of practice in relation to their food, alcohol and technological consumption, I show that young people with diabetes are often extremely concerned about their diabetes control at university, though the meaning of control for these students is mediated by their positions within and dispositions towards discourses of gender and health, the stages they are at in their university careers, and what they consider to be 'normal' behaviours. Overall, my findings challenge the received wisdom of much medical research on young people with diabetes who have been characterised as leading 'hedonistic' lifestyles, taking undue risks with little apparent concern for the future. By attending to students' own narrative accounts of living with diabetes a very different picture emerges where risks are embedded within specific social contexts. This more relational view of respondents' experience has implications for how health professionals care for young people with diabetes.

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**INTRODUCTION**



## 1.1. Introduction

On a trans-national, even trans-continental, scale, concern about diabetes has increased rapidly in the recent past. The reasons for this aren't hard to detect. The world is experiencing what Time Magazine has recently referred to as a 'diabetes epidemic'.

“In 1985, around 30 million people worldwide had the disease. But today in Europe alone, 48 million people- 7.8% of the population- are living with it” (Gorman and Noble 2004: 45).

The impact of this increase has been immense. Diabetes UK<sup>1</sup> estimates that diabetes and its related complications account for nine percent of the annual NHS budget, a figure which amounts to over £5.2 billion pounds a year<sup>2</sup>. In the US, Williams and Pickup (1999) estimate that diabetes costs the US health care system over 90 billion dollars a year, and is associated with a 25% reduction in expected lifespan. In the future diabetes is expected to have a particularly profound effect on non-Western nations.

These figures are striking, and sedentary lifestyles, too much food, too little exercise and genetic predispositions are thought to underlie them. What is particularly interesting and emotive about these statistics, though, is that they represent an increasing amount of children and young people who are developing diabetes. While traditionally diabetes has been associated with middle aged and older people, this is no longer the case. As the incidence rate of obese and overweight children rises, so does the rate of young people contracting diabetes<sup>3</sup>. Because of this a number of 'moral panics'<sup>4</sup> have arisen about children and young people's lifestyles, about what young people do, what they consume, how they place themselves at risk and in what ways. Children's consumption has become a problem. As evinced by **Figure 1**, which shows an image of an young

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<sup>1</sup> The leading charity in the UK for people with diabetes.

<sup>2</sup> <http://www.diabetes.org.uk/infocentre/fact/fact3.htm>

<sup>3</sup> The correspondence between obesity and diabetes is not direct. Not everyone who is obese has diabetes and in the US, 85% of young people diagnosed as having type 2 diabetes are overweight or obese (American Diabetes Association 2000)

<sup>4</sup> Moral panics are large scale movements constructed around the belief that a particular group is deviant or poses a threat to society by undermining the social norms upon which society is based. They involve a disproportionate response, fuelled by society's moral entrepreneurs. The classic study of moral panics is Cohens's (1972) study of the Mods and Rockers in Brighton.



overweight girl with diabetes, diabetes amongst children is currently framed in terms of a discourse that could be called 'the destruction of innocence'. Western lifestyles, characterised by too much chemicals and sugars, are commonly represented as harming young people's bodies, bodies that are 'naturally' considered to be pure, able and unburdened by chronic illness.

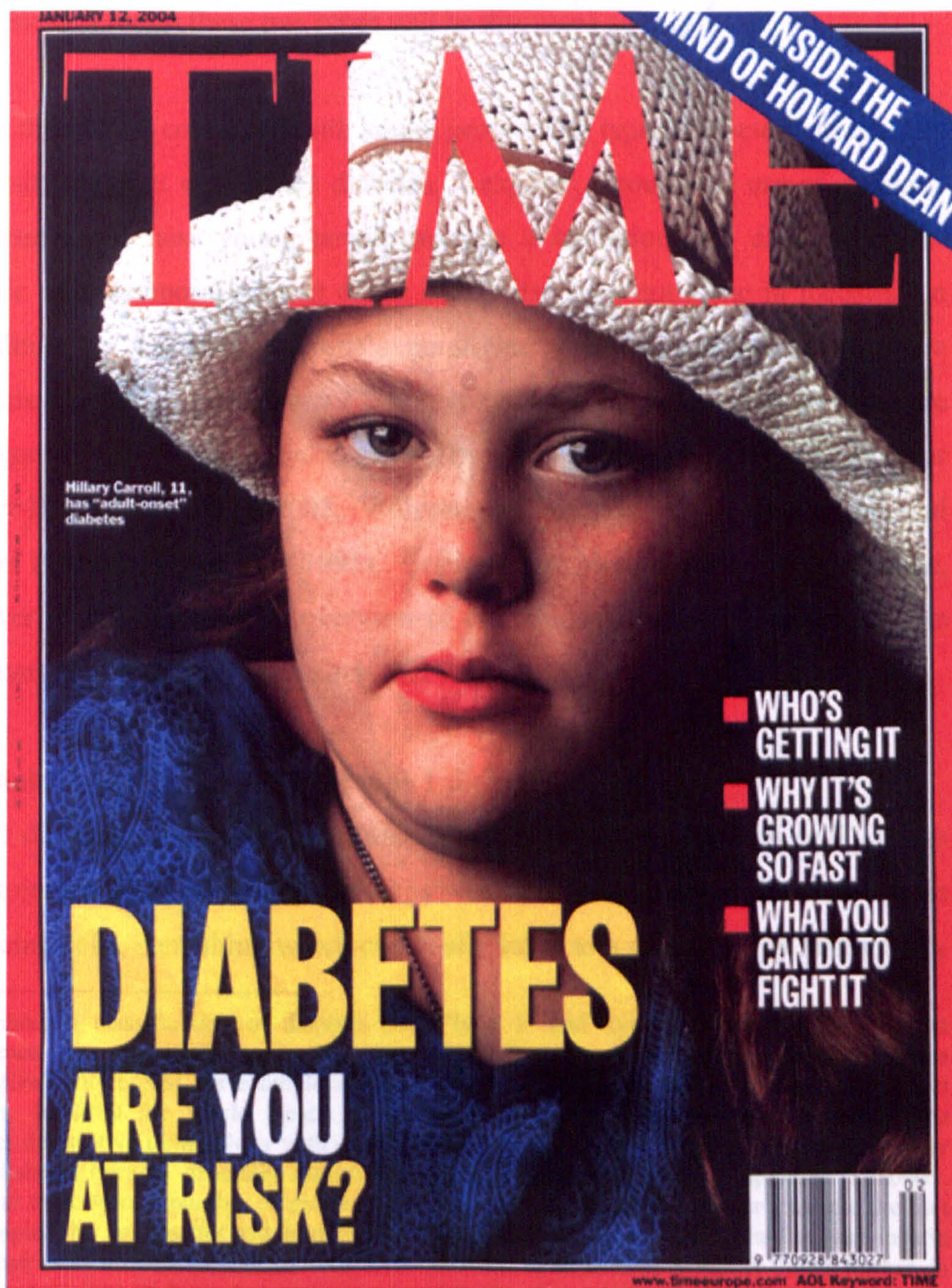


Figure 1. 'Diabetes: Are You at Risk'. Source: Time Magazine, Jan 12<sup>th</sup> 2004.



Recent debates and panics about diabetes in general, and young people with diabetes in particular, are themselves particular, however. They are concerned with young people with a precise kind of diabetes: type 2 diabetes (formerly described as ‘adult onset’ diabetes). Type 2 diabetes is a disease where the body has difficulty using the insulin it produces. There are, however, other forms of the condition, which young people can also develop. Indeed, before the growth in media interest in young people with type 2 diabetes, it was *type 1*, not type 2, diabetes that was mainly associated with children and adolescents (the biological differences between these two types will be discussed shortly)<sup>5</sup>.

In this thesis I am concerned with young people with type 1 diabetes; specifically, university students with type 1 diabetes. I explore, through the use of students’ own narratives, how young people manage a condition like diabetes in the specific spatiotemporal context of the university. I am not alone in focusing on spatialities, or on young people’s narratives; medical practitioners too are recognising the importance of geography and personal accounts in the management of chronic illness generally, and in diabetes care in particular (Miller-Hagan and Janas 2002, Wolpert and Anderson 2001, Anderson and Robins 1998, Anderson et al 1995). Before going on to discuss my thesis aims, however, I will first give an overview of the biology of type 1 diabetes, as this information informs the discussions that follow.

## 1.2. Biological characteristics of type 1 diabetes

Type 1 diabetes, also known as Insulin Dependent Diabetes Mellitus or IDDM, is an autoimmune condition that develops when the body destroys its own insulin producing cells, something which eventually leads to a complete (or functionally

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<sup>5</sup> The modern classification of diabetes (into ‘type 1’ and ‘type 2’) is a relatively recent occurrence. Krentz (2000) notes that prior to 1980 the various forms of diabetes were descriptively interpreted, for example as juvenile or young person’s diabetes and maturity onset diabetes. In 1980 the World Health Organization reclassified diabetes and exchanged the previous descriptive terminology with one based on therapy, meaning that juvenile and maturity onset diabetes became officially recognised as Insulin and Non-Insulin Dependent Diabetes. However there were a number of problems with this classification as well, for example the fact that people who supposedly had Non-Insulin dependent diabetes sometimes had to take insulin when their diabetes became more severe. Consequently, in an attempt to clarify things further, in 1997 the American Diabetic Association replaced the Insulin and Non-Insulin dependent diabetes with a classification based on aetiology rather than treatment, hence the now universal use of Type 1 and Type 2 diabetes.

complete) lack of insulin in the body (type 1 therefore differs from type 2, which is a condition where the body still produces insulin, it just cannot use it(effectively)). Type 1 diabetes is a condition:

“Characterized by autoimmune, cell-mediated, selective destruction of the insulin producing B-cells of the pancreatic islets in genetically predisposed individuals. As a consequence patients are completely reliant upon exogeneous insulin to prevent ketosis and thereby preserve life” (Krentz 2000: 11).

Insulin is a hormone produced by *islets of langerhans* in the pancreas. Insulin enables glucose to be moved from the bloodstream into the body's cells where it can be used as energy. Ordinarily in a person with a fully functioning pancreas, blood sugar levels rises after eating. The pancreas then releases insulin so that glucose can be transported from the bloodstream and into the cells where it can be used or stored. In people with type 1 diabetes, however, the destruction of the insulin producing cells means that glucose cannot be transported out of the blood stream. As a result, it circulates there until it is eventually passed in individuals' urine. Because energy doesn't reach the cells, the body breaks its fat and protein stores down so that they can be used for energy. However, because of the absence of insulin, even this energy cannot be used. Individuals with uncontrolled type 1 diabetes (individuals who are not using exogeneous insulin) may pass up to ten pints of urine a day, and lose 4000 calories a day in this way (Sonken et al 2001). This leads to the person developing a host of other symptoms including lethargy, weight loss, hyperglycaemia, diabetic ketoacidosis and infection, which are commonly referred to as the classic symptoms of diabetes.

The precise causal factors of type 1 diabetes are currently unknown but there are a number of plausible possibilities. For example, it is now believed that environmental and genetic factors contribute to people developing the condition. An important theory is that the immune system responds to a virus that has attacked the body. After defending itself against this virus, the body then proceeds to destroy its own insulin-producing cells in the pancreas, which bear a similar protein structure to the virus.



Once insulin treatment begins recovery is rapid<sup>6</sup>. Indeed, subsequent to initial insulin treatment a period of very good control often develops. This is known as the honeymoon period and can last from anywhere from several days to several years (Krentz 2000). However with time this revival fades away and insulin requirements increase. Either way, the person is left with having to self-administer injections of insulin several times a day in order to stay alive and avoid regressing into the state they were in before starting insulin therapy. This regime is permanent and lifelong. Type 1 diabetes is a disease that currently cannot be cured.

Five million people worldwide have type 1 diabetes (Gorman and Noble 2004). Type 1 diabetes is a geographically weighted condition. It changes from an incidence rate of less than 1 per 100,000 person years in Venezuela and China to over 35 per 100,000 person years in Finland and Sardinia (Kyvik et al 2004, Williams and Pickup 1999). The incidence rate of type 1 diabetes in children (0-14 years) in the UK is approximately 13.5 per 100,000, which is a rate of 1 child in every 1200 (Raine et al 2001). Both sexes are equally affected with twin studies showing an agreement of about 35% with respect to the chance of developing type 1 diabetes (Shillitoe 1994). There is a family history of type 1 diabetes in about 10% of young people who develop the condition. The chance of a mother with type 1 diabetes having a child who also develops the condition is approx 1 in 40, compared with close to 1 in 20 if the father has type 1 diabetes (Hunt 1996)

### 1.3. Complications of diabetes

Before insulin was created (see Appendix 1), people who developed type 1 diabetes died (from losing so many calories, and from the toxic byproducts, called ketones, of the break down of fats and proteins). With the creation of insulin, however, individuals with diabetes can live long and full lives. As people with the condition have lived longer, however, people have come to realise that

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<sup>6</sup> There are many types of insulin. The first insulins were animal insulins and were taken from pigs. In the late 1970s human insulin was introduced. In this insulin the genes of single celled micro-organisms are altered to make. Insulin is rendered inactive if consumed by mouth so must be injected into the body.

type 1 diabetes is a chronic, progressive and life-threatening condition, with potentially devastating consequences for people's health.

Diabetes is associated with a number of complications. In the short term, it is linked to *hypoglycaemia*. Hypoglycaemia means low blood sugar. For people with type 1 diabetes, in situations where sufficient glucose cannot be produced, either because food has not been eaten, too much activity has been undertaken or because there is too much insulin in the body, blood sugar levels can become depressed. If this happens a number of physiological reactions will develop in the body. Firstly the body will release adrenaline and glucagons to counter low blood sugars. These responses, while intended to increase glucose production, can also result in "sweating, tremor, pounding heart, shivering, blurred vision, weakness, dizziness, nausea, [and] headaches" (Rajaram 1997: 282). The second set of effects, neuroglycopenic responses, refers to a set of effects low blood sugars have on the brain once it becomes starved of glucose (falls below 3.5 mmol/l). When the brain is deprived of glucose people often become confused, more susceptible to rage, personality changes, drowsiness and may become unable to think logically and rationally, amongst many other symptoms (which are often particular to individuals) (Fox and Pickering 1995). People might not believe that they are hypoglycaemic, and insist that everything is fine and forcibly resist other people's attempts to help them. Blood sugar levels can be brought back up again if carbohydrates are eaten. If hypoglycaemia is not taken care of quickly there is a risk that sufferers could become unconscious and slip into a diabetic coma.

In the long term, people who have type 1 diabetes have a higher rate and risk of developing numerous co-morbid macro vascular complications such as heart disease and stroke (Williams and Pickup 1999). In women the typical protective effect afforded by women's bodies is ameliorated and coronary heart disease tends to develop at a younger age. By the age of 55 35% of people who have type 1 diabetes will have suffered, or died from, a heart attack (Gorman and Noble 2004). Diabetes is also linked with a number of specific diabetic microvascular complications, in particular nephropathy (kidney damage caused by leaking proteins), neuropathy (damage to nerve tissues) and retinopathy (damage to the



micro blood vessels in the eye). This damage emerges from the long term effect of raised blood sugar levels on the body's micro blood vessels. More than 90% of people with type 1 diabetes will eventually develop some sort of diabetic retinopathy, which is the main cause of blindness in people of working age in the Western world (Raine et al 2001, Williams and Pickup 1999). The incidence rate of nephropathy, which may result in kidney transplantation or dialysis is at least 40% after 40 years (Raine et al 2001). The severity of these complications, and risk of developing them at all, is associated with the length of time the individual has had diabetes (Nathan 2003). The Diabetes and Complications and Control Trial (or DCCT) (1993) demonstrated a conclusive link between hyperglycaemia (high blood sugars) and microvascular complications. It also revealed that excellent control of diabetes (characterised by consuming a "specified diet at appropriate times to attain and maintain appropriate body weight, taking medication at the correct doses and at the correct times, taking exercise and self-monitoring" (Shillitoe 1994: 16)) is associated with a reduction of an individual's risk of developing long term diabetic complications.

#### **1.4. Setting diabetes in context**

Currently, the purpose of the management regimes of type 1 diabetes is to "be free of diabetic symptoms, to have normalized blood sugar levels and to be able to live as normal a life as possible" (Hjelm et al 2003: 426). Continual self-care actions, routine planning and decision making are important practices if these objectives are to be fulfilled (Tolijama and Hentinen 2001). Research studies have demonstrated, however, that people with diabetes, especially young adults, often have, or are thought to have, poor blood sugar control, or do not engage in the 'correct' self-care practices (Wills et al 2003). They might not test their blood sugars regularly, might eat the wrong foods, or might engage in the wrong activities. The reasons for this are complex. However, it is clear that merely possessing knowledge about diabetes does not automatically mean that good diabetic control will develop; other issues are important (Anderson et al 1995).

So what are some of these other issues? Williams (C.) (2000) demonstrated that individuals' gender was an important factor influencing their responses to diabetes' management regimes. She interviewed male and female secondary

school students. She found that the young men she interviewed were willing to inject twice a day in order to minimize the impact of diabetes on their social identities, and trade the beneficial impact this had for their masculine identities off against the higher risk that came with not injecting more intensively (more than or equal to three times a day). These findings demonstrate that there can be conflicting understandings of what good control means for people with diabetes. Good control means not only keeping blood sugars within the normo-glycaemic range, it also means being controlled enough so that diabetes won't unduly affect everyday practices and performances. Many studies of people with diabetes have demonstrated that a recurring element in people's narratives is that individuals do not want their condition to hinder or restrict them in any way (Callaghan and Williams 1994: 136). At the same time they do want to control their blood sugar levels, both because this is often considered to be a moral practice for people with diabetes (Broom and Whittaker 2004), and also because they want to maintain a good quality of life in the future. Balancing competing priorities is therefore a key theme in living with diabetes. This isn't easy, though; and if it develops, takes time to achieve. These issues of maintaining good control and balancing competing priorities are key themes throughout this thesis, which examines students' experiences of living with diabetes at university, and will be discussed throughout. I will do this by using a narrative approach, by seeking to understand students' practices in context and in their own words.

### **1.5. Students with diabetes**

In this study I take a subject-centred approach to university students with diabetes. Little is known about young adults with diabetes (Wolpert and Anderson 2001) and an even smaller amount about students with type 1 diabetes (Eaton et al 2001). In many of the existing accounts dealing that deal with students with diabetes, the university is constructed as a hazardous environment, a place where there is a high risk that students will go out of control and engage in hedonistic thrill-seeking behaviours, to the detriment of their diabetes care. Strachan et al (2000: 70) for example note:

“The move away from the parental home to become a student at a university or college in another town or city may pose problems. The loss



of parental supervision and support, the initial social isolation until friends are made, and the ready access to alcohol and recreational drugs all have the potential to affect glycaemic control adversely in the student with diabetes”.

This study examines the validity of this representation. It explores how students manage their diabetes when they are in university, and how their diabetes influences their experiences of university. As such it seeks to explore how young people with diabetes manage their condition within a specific context, and examine the issues that they consider to be important in this context for their diabetes care.

There are several reasons why it is important to study students with diabetes. Firstly, diabetes is one of the most common chronic conditions of childhood and young adulthood. Secondly, because of the government's current drive to get more and more young people into higher education, going to university is and will be an important experience for an increasing amount of young people, including young people with diabetes. For many of these students, this will be the first time they will be away from home. They will also be in an environment that many medical researchers have identified as being potentially problematic for their diabetes care. The information provided by a study such as this one could be used by clinicians to better inform their practices and understandings of young people with diabetes. This is important because there are likely to be a substantial number of students with diabetes in university at any one time. As I will discuss in **Chapter 3**, my research is based on fieldwork at 4 universities in the midlands of England. 3 of these universities had a student population of 15000. 50 students were registered in each as having diabetes (the other university had only 2 students registered, but was located in a city where most students went to the local hospital for their primary care). If one assumes that there are roughly one and a half million students in the UK at present (Chatterton 1999), and if for every 15000 students there were 50 with diabetes, then there would be currently 5000 students with diabetes currently in university. Even if this figured is an overestimate, it is still likely to be large. The lack of research into this population is therefore striking. And finally, and on a more general level, more research is needed to understand the effect the transition from

home to university can have for individuals' health (Litva et al 2001). Research of this kind is lacking in relation to the student body in general, let alone in relation to specific subgroups within it such as students with diabetes (Farrow and Arnold 2003).

### 1.6. Theoretical Perspectives

In this thesis I examine how young people control themselves, how they conceptualize control, how they feel about being in control, and how they negotiate different forms of control. I am especially interested in the roles that spatialities and temporalities play in the construction and understanding of control: what being in control means for a person will change according to where one is, and the time scale at which one's practices are looked at. Young people (especially students) with diabetes are an important and illustrative group in this regard. They have a condition which means that, in order to reduce their risk of developing long term complications, they need to be regulated and controlled now, in the present. The paradox of living with diabetes is that the more one controls oneself, the freer one is. But because all risk is probabilistic, the regulation of practices might be needless. Individuals *might not* develop complications in the future. Some people therefore might choose to not be controlled, to 'live for the day rather than plan for tomorrow'. Some young people might also choose to control their condition by going out of control, by purposely engaging practices that are risky for their diabetic control. I am also interested to see if there are any common patterns that underlie different individuals conceptualizations of, and dispositions towards, control.

As I discussed above, I am concerned about exploring these issues through individuals' narratives. As such, in this study I use a series of in-depth interviews to examine young people with diabetes' practices (the legitimacy of this approach has been recognized by previous studies of student diabetics- see Miller-Hagan and Janas (2002)). Medical practitioners themselves are beginning to recognize the importance of narratives when seeking to understand people with diabetes' practices. Callaghan and Williams (1994) for example note that people's feelings about living with diabetes have to be placed at the centre of medical discourses. They contrast this subject-centred perspective with what they

refer to as a biomedical approach to diabetes, where care is constructed around the disease, rather than the person. They note that biology is not irrelevant, but that:

“Rather, we want to emphasize that understanding ‘disease’ also means understandings what is often regarded as subordinate to medical knowledge, namely the concerns of those people who live with it” (ibid: 137).

This is not tangential to the treatment of diabetes. To prevent complications and help people successfully treat themselves it is necessary to understand people’s feelings about their diabetes, and how it affects their lives (Hjelm et al 2003)<sup>7</sup>. To quote a widely used medical maxim, the use of narratives symbolize an approach where the person, rather than the numbers, is the one who is being treated.

The need to investigate narratives has also been recognized within medical geography (Dyck 1999, Kearns 1997) (this point will be discussed further in section 2.2. in **Chapter 2**, and also **Chapter 3**). Narrative approaches emphasize that ‘lay’ people have a host of often opposing information, knowledges and feelings about health and illness, which influences their practices and care of the self. Narrative theories can also be used to investigate the multiple and ambiguous meanings of practices. Furthermore, they are important for investigating how individuals’ practices relate to, interact with and emerge from their self-identities, which themselves exist in dialectic with broader social discourses. Indeed, self-identity can itself be recognized as a narrative, a story that one tells about oneself (Valentine 2000, Giddens 1991).

The primary focus of this study is on students’ narratives of practice as they relate to particular forms of consumption, of which alcohol, food and technologies are the most important. As I discuss in **Chapter 2**, the theoretical

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<sup>7</sup> While this is not a representative comment, on the whole it seems to me that many of the medical studies I have read on diabetes that have been authored by doctors do not fit a stereotypically ‘medical model’. This seems right to me because most experienced MD’s would be practicing clinicians and used to hearing and focusing on individuals’ narratives (see Kleinman 1988). Studies which have I have read which I would argue adhere (too) strongly medical model to a medical model seem to be often authored by behavioural psychologists.



significance of consumption is now widely recognized within medical geography (Kearns and Barnett 2000, 1997). Jackson (1999: 27) drawing on Giddens (1991), notes that:

“Identity is a reflexive project, shaped by late modern institutions through narratives of the self that are constantly revised. Consumption can play a vital role in the constitution of such narratives”.

By focusing on consumption it is possible to explore the ways in which young people construct identities through the use (or not) of particular objects, to see how they identify with, resist and/or negotiate dominant discourses. In the context of diabetes, consumption practices also provide a useful focus for analyzing how young people conceptualize risk and discipline. Furthermore, young people’s practices and narratives are useful for situating grand theories of risk (such as those constructed by Beck (1992) and Giddens (1991) (discussed in detail in **Chapter 4**), and discipline (Foucault 1977) (discussed in **Chapter 5**), to see how these are worked out in particular places by particular individuals.

### **1.7. Research Aims**

This thesis has several aims. The first is to examine **how young people with type 1 diabetes negotiate different forms of consumption, especially alcohol, food and technology** while they are at university. As I will discuss in Chapter 2, research on students’ practices, particularly from a consumption-orientated perspective, is currently lacking. This is ironic given that, as I discuss in section 2.3.2., representations of students in popular discourses often focus on the student body as a hedonistically consuming body. Focusing on students’ consumption practices would therefore not only contribute to this gap, it would also address some of the gaps medical geographers have noted in the medical geography literature with regards to research on consumption, and provide useful information about students’ practices that could be used by clinicians to inform their practice. At the same time, such information could be used to challenge medical discourses’ representations of the university as an *a priori* hazardous, dangerous environment for students with diabetes, a place where practices have to be carefully regulated. In many respects the students I talked to found taking risks in university *via* their consumption practices (for example, by binge



drinking) to be a positive experience, a way of negotiating the transition to adulthood, being normal and demonstrating to themselves and to others that diabetes didn't control them.

My second aim is to examine **the role spatialities and temporalities play in the consumption practices of students with type 1 diabetes.** Students' consumption practices, such as the use of alcohol, are often important for constructing student *habitus*, student bodies. However, consumption practices are not negotiated in abstract, empty spaces. They are engaged in particular, concrete, emotionally important spaces where consumption has profound implications for individuals' identities. For example, for many first year university students, drinking alcohol in student bars and clubs is an important activity used to construct identities as normal young people. For students with diabetes however, because alcohol affects blood sugar levels (the reasons for which are discussed in Chapter 4), alcohol consumption is a potentially risky practice, which must be regulated. While alcohol consumption may be used as a way of being like other students, too much alcohol runs the risk of a hypoglycaemic attack developing and spoiling students' presentation of the self as 'normal' individuals. And indeed, the consequences of losing control over the body are potentially greater for these students' in public spaces, because other people would be around to see them lose control over themselves; but at the same time these spaces are precisely those where it is important to be normal, to engage in risky consumption.

Temporalities, perceptions of time, are also important to analyze because they can influence how young people perceive their current practices. As I will discuss in Chapter 5, one of the most important reasons some of my interviewees exercised and regulated their food consumption was so that they could 'preserve' themselves for the future. On the other hand, as I will discuss in Chapter 4, for other students who wanted to be normal students, risky practices such as binge drinking could be used to distance themselves from their past selves, or to reconnect with their past selves. Practices often had multiple meanings, the meaning of which changed according to which time scale it was looked through.

The third research theme I am concerned with examining is **how bodies affect perceptions of space, risk and the negotiation of practice for young people with diabetes**. This builds on the calls in medical geography for more work to be done into this matter (Parr 2002a). While my theoretical perspective is informed by the work of Michel Foucault, Foucault's work, like that of many poststructuralists, has been criticized for being excessively idealistic and disembodied. Foucault talked about how discourses discipline and regulate the body. Some of his adherents took up his work and extended it to the regulation of bodies, for example with regards to food consumption, in contemporary consumer cultures. In many respects though this work was (and still is in many cases) concerned with the regulation of desire, with the will. There is not often a focus on the body's agency, on how the body affects the construction of its own docility. With regards diabetes, the agency of the body cannot be ignored. For example, while many of the women I interviewed were concerned about losing weight in order to make their bodies correspond to normative gender ideals, their diabetes often made it difficult to lose weight. Too much exercise ran the risk of hypoglycaemia developing. As such many interviewees argued that it was important to reach a balance between their bodies, desires and practices, to regulate their desire to regulate themselves.

My fourth research aim builds on aim three, and focuses on **how my interviewees' regulation of their diabetes and consumption is influenced by their gender identities**. Gender has emerged as a key theme in other studies of student diabetics (Williams (C.) 2000- though Williams focused on school age students with type 1 diabetes). In this study, gender was an important theme in relation to my interviewees' consumption practices. Some (female) interviewees, for example, didn't want to become hypoglycaemic in public space in case other people thought they were a 'tart'. Minimizing the risks of hypoglycaemia was therefore important in order to identify with a respectable, 'classy' form of femininity. Similarly, some of the male interviewees drank excessively so that they could act like 'lads' in front of their friends and show that they were strong and resilient, that diabetes didn't affect them.

The fifth and final theme relates to and is threaded through all of the above themes. As such, it is the most general of all. It is concerned with **how students with diabetes negotiate differing forms of control while they are at university, and how they reach a balance between competing imperatives.** In effect, this theme is concerned with how interviewees manage their diabetes. This theme will be developed through an investigation of the others.

### **1.9. Thesis Outline**

This thesis is structured as follows. **Chapter 2** contains my literature review. This is based on an analysis of three main bodies of work: medical geographies, representations of young people, and studies that have examined young people with diabetes. Here I discuss the qualitative turn in medical geography, and highlight absences in the existing medical geography literature that are relevant to this thesis. In particular, I discuss the relative lack of research that has been completed on consumption, on young people, and on risk within medical geography. I then look at representations of young people, and particularly university students, as out of control hedonists, representations that inform medical constructions of the student body and young people with diabetes. I argue that what is missing in this material is young people's personal narratives, accounts that could be used to better inform theorists' constructions of young people's practices. In **Chapter 3** I discuss the methodologies that I used to implement my thesis aims. **Chapter 4** contains a discussion of the theories of risk I use in this thesis (a conceptualization informed by Giddens's (1991) and Beck's (1992) work), which I compare to the model of risk constructed by the DCCT. After this I provide an in-depth exploration of how my respondents managed and conceptualized the risks of their alcohol consumption. Differences between first year and older students' practices will be highlighted, as will be the importance of relationalities and discourses of gender. **Chapter 5** focuses on another important aspect of my students' consumption practices, namely food consumption and exercise. The material in this chapter is informed by Foucault's work on disciplining the body. I discuss the role discipline plays in young people with diabetes' practices, the important place routines have for young people with diabetes, and gender differences in respondents' accounts of exercising and dieting. In **Chapter 6** I discuss how my interviewees used and conceptualized



diabetic management technologies at university. Different forms of technology will be discussed. In particular, I discuss the role spatialities, emotionalities and relationalities played in my respondents' use of technologies. In the **Conclusion** I will summarize the arguments made in all of these chapters, and consider the relevance of my work to health policy and for future academic research.



**Literature Review**

## **2.1. Introduction**

As implied by the title of this thesis, my research draws upon two primary bodies of literature: geographies of health, illness and medicine (diabetes) and literatures on young people (students). While, as I will discuss shortly, there aren't the overlaps between these two literatures that one might expect, there are important absences that both have in common. For example, in both of these bodies of work there are gaps relating to how young adults with chronic illnesses manage and conceptualize their condition in particular spaces. Risk and identity will be key themes looked at throughout this chapter.

I have structured this chapter as follows. Firstly I discuss the cultural turn in medical geography, and the important place the concept of embodiment has come to occupy in this. I then look at some of the absences in health geography relating to consumption and identity, risk and young people. Following this I examine some of the work that has been completed outside of health geographies on young people. Here I will explore the ways in which young people have been represented in popular and academic discourses. I will highlight here the lack of research investigating the lives of 'older' young people, especially students. Finally, I will critique some of the medical work that has been done on young adults with type 1 diabetes, and students with type 1 diabetes in particular. Within geography itself, there has been almost no work completed which has looked at diabetes. That which has tended to have a quantitative focus, such as Green et al's (2003) work on mapping the spread of type 2 diabetes, or Rytönen et al's (2003) work on the epidemiology of children with type 1 diabetes in Finland. In contrast to this work, my research is focused much more on exploring young people's narratives, on attempting to see young people's worlds from their own point of view. In the conclusion of this chapter I will show how my thesis seeks to address and remedy the identified absences.

## **2.2. The cultural turn in medical geography**

Geographical research looking at the relationship between health and place has a long history. Kearns (1993) for example notes that work in this area goes back at least to the ancient Greeks, and in all likelihood beyond. In the more recent past (in the 1960s and '70s), geographical work examining the connections between space and health tended to do so from a quantitative perspective, with the main concern

being with mapping the spread of disease and health care systems in space. There were several reasons why this approach was taken. Prior to the 'quantitative revolution' geography had become, for many geographers, a discipline that was overly descriptive and had abandoned attempts to develop nomothetic laws that could be used to explain human behaviour. Quantitative approaches were seen as a way of addressing these deficiencies, and enabling geographical research to have scientific credibility and validity. While quantitative mapping approaches were useful in many respects, they also had their limitations. As they became orthodoxy, they contributed to a tendency for conditions, such as diabetes, to be abstracted from people's lived experiences and represented only as "dots on the map" (Kearns and Gesler 1998: 3). Consequently, individuals' feelings and opinions about health and illness were often glossed over; and if they were addressed, they were done so only in such a way that they could be statistically quantified and aggregated (Brown 1995). Identities therefore became categories that were often seen as unproblematic, and the complexity of what it is like to live with chronic illness on a day to day basis neglected (Dyck and Kearns 1995, Brown 1995). This was something which undermined medical geography's reasons for using quantitative methodologies in the first place; it is difficult to construct universal laws explaining the meanings of disease and illness if people's voices are absent from the picture.

In the early to mid 80's, the agenda of cultural geography, the focus on 'mapping meaning' (Jackson 1989) began to influence research directions within all geographical sub-disciplines. This 'cultural turn' was directed by postmodern, poststructuralist and feminist ideals, and was a reaction to both the hegemony of quantitative approaches and the absence of 'Others' within geographical work. As a sub-discipline, medical geography was relatively slow to address the implications of the cultural turn, though some important studies were done in the 80s, such as Cornwell's (1984) ethnographies of East London (see also Donovan (1986) for other studies of this nature). In 1993 a series of exchanges in the *Professional Geographer*, started by Robin Kearns sought to set out an agenda for medical geography based on the cultural turn. Kearns argued for the importance of incorporating the positive aspects of the cultural turn into geographical research on health and illness. He (1993: 147) argued that medical geography research, primarily concerned with tracking the diffusion of disease and health in space, was an "unnecessarily placeless endeavour"



and contested that a “replaced geography of health [would] be more easily gendered and inclusive of all maps of meaning”. Laying out his vision for a “cultural geography of wellness” (Kearns and Moon 2002: 608), Kearns noted that there were two predominant strands within medical geography: a geography of disease, and a geography of health care systems. Neither of these streams, Kearns argued, paid sufficient attention to understanding place and health as they were experienced by people, as something that *meant* something to people. Kearns argued that by not doing so, medical geographers were missing out, and that:

“Only a continuing engagement with elements of social theory such as the structure/agency question will provide geographers interested in health with a coherent epistemology that recognizes both the enabling and constraining elements to health experience” (Kearns 1993: 145).

Kearns called for a different twin tracked approach to be developed within medical geography to replace the one he identified: a cultural geography of health, and a geography of medicine. He felt that a cultural geography of health would enable geographers interested in health to identify with and draw upon the more useful aspects of postmodern theory, such as a focus on the different meanings practices and discourses could have for people in different places.

Those geographers who responded to Kearns clarified his arguments and kick started a new research stream within medical geography. A field that until the early ‘90s was built largely around applied work (though as noted above, there were some important qualitative studies done in the 1980s) was very quickly refashioned around “the theory laden terms of society and space” (Kearns and Gesler 1998: 2, see also Butler and Parr 1999). Researchers in this new stream, who often referred to themselves as health rather than medical geographers, argued that geographical research on health should be concerned with investigating people’s practices and feelings, rather than focusing on scientific and biomedical conceptualizations of the body, and mapping diseases (Dyck and Kearns 1995). They argued that medical geography “must be social, given that diseases and health...are socially produced, constructed and transmitted” (Kearns and Gesler 1998: 5). While the biological dimensions of illness were not rejected by these geographers, they argued that health and illness were experienced in very social ways (Kearns and Gesler 1998).



Health geographers were therefore responsible for developing a “narrative turn in inquiry” in the sub-discipline (Dyck 1999: 244, see also Kearns 1997). Narrative approaches explicitly recognize that ‘lay’ people have a wealth of often contradictory information, experiences and feelings about health and illness which directs their practices. These approaches are therefore concerned with the body as it relates to “wholeness and personhood”, and not just as a “system or object” (Dyck and Kearns 1995: 139, see also Dyck 1999). Geographers were not alone in recognizing the validity of narratives and subjective experiences. As I noted in the introduction, in the 90s narratives were increasingly acknowledged both by the medical profession itself (who were having to deal with an increasing amount of people presenting with chronic rather than acute illnesses) (Brown and Duncan 2000), and by health managers and purchasers in neo-liberal health care systems (MacKian 2000), who were concerned as much with recognizing and responding to people as consumers as they were people as patients.

The cultural turn had the effect of (re)stressing the importance of place in the experience and management of health and illness (Kearns and Moon 2002, Dyck 1995). Dyck (1995) for example noted that the understandings people have about their health and their bodies, and the practices individuals undertake in relation to these understandings, “are interpreted in the specificity of place” (ibid: 249). At the same time, she argued that individuals’ everyday, routinized understandings and practices help to construct and negotiate the meanings place have for them. Place, practice and identities are therefore seen as mutually constitutive and recursively linked. This does not mean, though, that identities and meanings are completely fluid (though a lot of geographical work could be criticized for over-emphasizing the fluidity of identities). People will often try to fix and position themselves in light of their self-understandings of who they ‘really’ are, and discourses in particular situations will define what is considered to be ‘normal’. But it does highlight that identities are not essentially unchanging. The benefits of understanding the meaning of health and illness as spatially dynamic are clear. Dyck (1995: 308) notes:

“This renewed sensitivity to place and space as integral dimensions of the situated experience of health, illness and health care has opened up an avenue

of analysis with the potential to link subjective experience and wider sets of relations”.

The focus on the constructed, interactive nature of place also led to a productive reconceptualization of what ‘the field’ meant for health geographers. Kearns and Moon (2002: 615) note that “in the roots of the research tradition, tropical disease ecology, the field was a place that was there rather than here”. As such medical geographers tended to go to other countries to study the spread of diseases such as malaria. While this was useful, it came at the expense of neglecting research looking at more everyday spaces that were ‘closer to home’. More recent cultural studies of health within geography have been less likely to be “outsider accounts of the exotic, and more often critical interpretations of the conditions of our own experience” (Kearns and Moon 2002: 615). I would place my thesis as part of this movement, given that it is a study of students, a community of young people of which I am currently a part of.

Despite the interesting movements within medical geography, though, there still remain areas to be developed. In particular, there has been little health geography research that has attempted to draw upon literatures on the body, meaning that health geography, as a whole continues to be a fairly disembodied endeavour (Kearns and Moon 2002, Hall 2000). It is significant that most of the research conducted on the body within health geography seems to be done by women geographers with feminist commitments (for example see Parr 2002a, Moss and Dyck 1999, Moss 1997, Dyck 1995).

### **2.2.1. Embodiment**

The absence of research on the body within medical geography was noted early on. Dorn and Laws (1994) for example, responding to Kearns’s (1993) call for a new cultural geography of health, argued that one of the weaknesses of Kearns’s argument was that it did not explicitly address the socially constructed nature of the body. They argued (1994: 109) that:

“it is ironic that medical geography, which draws its *raison d’être* from a profession that is obsessed with exploring the differences between the normal



and the abnormal body, is itself so resistant to the treatment of the body as a problematic concept” (Dorn and Laws 1994: 109).

Medical geography was and is not alone, though, in neglecting the body as a significant location (Valentine 1999a, Nettleton and Watson 1998, Longhurst 1995). Valentine (1999a: 329) argues until the 1990s the body was an “absent presence” within most geographical research, implicitly present, though not explicitly so, in that its importance was ceded to other concerns. The consequence of this absence was that individuals were often constructed as cognitive actors, their emotions and habits, pains and pleasures neglected in research agendas (Longhurst 1995, Saltonstall 1993).

The work that has been done on the body within health geography research, however, has made it clear that bodies do matter, and that people’s identities and experiences, their constructions of place, are mediated by their bodies (Nast and Pile 1998a,b, Dyck 1998). ‘Embodiment’ has been a crucial concept here. Embodiment refers to a way of treating the body “as an inherently historical phenomenon, and examining [it] in multi-dimensional terms” (Shilling 1997: 81). It means seeing the body as a “social phenomenon” (Turner 1992: 94), as open and interactive. It means seeing bodies as always in the process of becoming, though understanding this process to be mediated by material, spatial, discursive and contextual factors.

Michel Foucault’s work has been especially influential amongst geographers interested in embodiment. As I will discuss in extensive detail in Chapter 5, Foucault saw the body as a nexus of disciplinary power, constructed through particular practices (Dyck 1998). For Foucault:

“the body is usefully understood as a surface of inscription marked by discourses that mediate our experiences of the body. The body may be inscribed in different ways, affording a multiplicity of scripts to draw on in interaction” (Dyck 1998: 105).

Despite Foucault’s effect on human geography as a whole, though, Brown and Duncan (2002) note that one of the noticeable things about research in health geography is the lack of attention paid to Foucault, despite the potential his work

provides (though see Parr 2002b and Dyck 1998 for exceptions. Also see Parr, Philo and Burns (2004) work on Foucauldian geographies of mental health).

The lack of engagement with Foucault is particularly surprising given that health geography can productively contribute to, contextualize and extend Foucault's work. For Foucault, the materiality of the body was of little interest (Hall 2000); the importance of the body lay in the way it was constructed within discourse and through practice. Foucault had an idealistic perspective of what bodies were (Hall 2000, Turner 1992).

As researchers on health and illness have demonstrated, however, the body is not only "a matter of symbols and signs" (Ussher 1997: 1). The body has edges. It is often impossible for it to be "simply altered or transformed to converge with particular versions of the self" (Budgeon 2003: 35). It can have a complicating effect on the ability to engage in performative practices (Butler 1993). For example, while students with diabetes might want to engage in the 'correct' practices so that they can be 'normal', fluctuating blood sugar levels can disrupt these practices and interfere with individuals' attempts to construct desired identities.

Moss and Dyck (1999: 372) are two health geographers who are concerned with how the material body interacts with inscriptive discourse, with "how the body, particularly the chronically ill body, fits into and forms part of the mundane stuff that makes up everyday life". They argue that instead of taking turns elevating body and mind over one another, it is important to "concentrate on the synchronous embodiment of discursive and material bodies" (ibid: 373). Drawing on the works of feminist theorists of embodiment such as Grosz (1995) and Butler (1993) they note that the body (or what they refer to as 'corporeal space'):

"consists of context, discursive inscriptions, material, economic and matter - based inscriptions, the biological, and the physiological. These spaces are fluid, congealing from time to time around the body, only to be destabilized with new boundaries forming when any part of the context, the discourse, or the materiality shifts" (Moss and Dyck 1999: 389).



While I broadly agree with the spirit of what Moss and Dyck are attempting to capture here, I believe that there are some limitations to their description. In particular, I believe Moss and Dyck place too much emphasis on the mutability of bodies and identities at the expense of emphasizing what stays constant. Corporeal space is a space in flux, not a firm space. Giddens (1991) notes that even when people move across space, their self-identities, their reflexive understandings of who they are as individuals, does not necessarily change in a profound way. Indeed, “the everyday use of identity strongly suggests at least some self-awareness over time, something that remains identical” (Brubaker and Cooper 2000: 11). Identities can change through space and time, but they can also be stable (*ibid*). In fact, if identity changed too much, if they only congealed from ‘time to time’, it would be difficult to speak of identity as a concept at all.

One particularly important benefit research on embodiment has had is in stressing that “our universals, the body spaces, are particular” (Nast and Pile 1998: 1), or, to put it another way, that “there is no one body, only bodies” (Longhurst 1995: 98). Dyck (1999) notes that the recursive relationship of bodies, spaces and identities is experienced differently by different people according to their age, class, gender. Despite this, however, there continues to be comparatively little research done on particular kinds of bodies within health geography. Dyck (1995) examined how first generation Asian-Canadian women with diabetes appropriated Western medical knowledge into their everyday management practices<sup>8</sup>, have addressed the relationship between gender and health, health geographers as a whole have been slow to adopt gender as a category of investigation (Parr 2004, Rosenberg 1998). In particular, research that has been done on gender within health geography has almost exclusively focused on women. Consequently, there is currently a lack of research addressing (un)healthy masculinities (Parr 2004).

### **2.2.2. Consumption and identity**

One reason why research on the body is so in vogue at the moment is because of the importance consumption plays in contemporary Western societies (Brown and Duncan 2000). Parr (2002b: 77) for example notes that:

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<sup>8</sup> Dyck omits to specify anywhere in her paper what type of diabetes her respondents have, though it seems to be type 2.

“in this age of individual health consumerism, bodies comprise significant geographies”.

Research on consumption has assumed a position of importance within academic research for a number of reasons. Consumption usefully highlights the different ways in which consumers construct meaning through use (Slater 2003: 148, see also Du Gay et al 1997). Recent research for example has demonstrated that consumption is an active process (Slater 2003), one which “leaves neither the people engaged in it, the objects involved, nor the spheres of production untouched” (Du Gay et al 1997: 103). A consumption oriented perspective therefore shows that the utilization of artefacts is an act of production as much as it is anything else, a way of constructing meaning through appropriation. Consumption stresses human agency (Du Gay et al 1997), and demonstrates that meaning is not ‘fixed’ by producers. Randolph (1998) for example studied the significance Barbie had for young girls, to see if the ways in which her respondents’ played with Barbie differed from how the toy company suggested they should. She found that rather than attempting to marry Barbie off to Ken, and doing Barbie’s hair, some of the girls Randolph interviewed shaved Barbie’s head, carved the word ‘sex’ into her chest and played a game called ‘naked jet-propelled Barbie’. Randolph argued that the meanings Barbie had for these girls was not only shaped by the wishes of the toy company; the meanings that the toy company fashioned for Barbie were changed by the girls. While consumption is constitutive, though, it is also important to stress that the meaning objects have is not completely free floating. What an act of consumption will signify for a particular individual will be influenced by his or her position within broader social structures, such as their gender or sexual identity, and his, her and other people’s definition of what is normal use (Jackson 1999). Furthermore, not all individuals will be able to obtain the same product (Kearns and Barnett 1997). It is therefore important to avoid “overdrawn optimism” in relation to consumption, one which associates “consumerism with a post-modern politics of difference” (Jackson 1999: 27).

Consumption provides a centrally important concept for studying the construction and maintenance of identities in the modern West. Contemporary theories of identity recognize that identities are relational, constructed with and against others (Jackson



1999). One of the most important ways in which identities are established is through the use of particular objects, in particular ways, in particular spaces (Woodward 1997). Consuming alcohol in university, for example, because it is a normal practice that many other students are perceived to engage in, can be a way for young people to construct identities as normal young people and to feel normal, to feel in place. Consumption therefore is an act that positions subjectivity in particular spaces (Woodward 1997), and “reflects, communicates and is instrumental in the reproduction of cosmologies” (Slater 2003: 153).

Despite the obviously fruitful implications a consumption orientated perspective could have for the study of identity within health geography, consumption is an area, which, like research on masculinities, has not been significantly addressed by the sub-discipline (Brown and Duncan 2000) (though Dyck (1999), Kearns (1997) and Dyck and Kearns (1995) argue that it needs to be placed at the centre of medical geographies’ research agenda).

Kearns and Barnett (1997: 172) note that historically, medical geographers who have dealt with consumption have approached it “in terms of utilization behaviour”. They argue that such models, in contrast to the models of consumption discussed in the preceding paragraphs, have approached consumption in “sterile, asocial and ahistorical ways” (ibid: 179). They note that medical geographers who have looked at consumption have done so in terms of analyzing what kinds of individuals consume what kinds of services. Kearns and Barnett argue that more has to be done if the connections between health, consumption and place are to be fully appreciated (see also Brown and Duncan 2000).

Some geographers have responded to this call. Doel and Segrott (2003) for example examined the ways in which individuals consume Complementary and Alternative Medicines (CAM), and found that CAMs were used by people to help them to take charge of their lives and empower themselves.

Kearns and Barnett (2000, 1997) themselves completed a series of studies investigating the ways in which people consumed health care settings in New Zealand. With regards the earlier of these studies (1997), Kearns and Barnett

investigated how and why people consumed private health care facilities in New Zealand's urban landscapes. They found that for those of their respondents who used the new 'medical malls' that had been cropping up in the country, the relatively cheaper cost of these, at least compared to the cost of going to see the doctor, was less significant than the researchers had anticipated. Only 31% of respondents, for example, said that cost was a significant factor in influencing their decision to attend a clinic. Kearns and Barnett argued that this, at least on first appearance, would appear to undermine the argument that their respondents were 'consumers' in the traditional sense of the word, individuals engaged in rational cost-benefit analysis. What they did find, however, was that:

“for a substantial proportion of the user population, the significance of these clinics as places of health care delivery extends well beyond their status as medical clinics per se. For these users, the clinics are contrived milieu in which the form appears to rival the function in importance” (Kearns and Barnett 1997: 178).

For Kearns and Barnett's respondents, consumption was an aesthetic, emotional practice. Their respondents appropriated the form and place in which their health care occurred as much as they did anything else. The clean, well-lighted space of the clinic was perceived to be a healthy space; by consuming their health care within these 'healthy' spaces, individuals felt that they were being healthy. Consumption in the 'right' places therefore had a positive effect on these authors' respondents. Brown and Duncan (2000) argue that the attitudes of Kearns and Barnett's respondents are common. They argue (*ibid*: 365) that:

“Many products [and, as Kearns and Barnett have demonstrated, places] are now sold and consumed not for their use value but for their identity value: they come to be as associated with certain healthy lifestyles and body images” (Brown and Duncan 2000: 365).

While the works of Kearns and Barnett (2000) have been important for bringing consumption to the research agenda in the new cultural geography of health, as noted above there remain absences in the literature. Specifically, while health geographers have focused on consuming places, there has been far less work done on how individuals, especially those with chronic conditions like diabetes, negotiate and consume ingested substances such as food and alcohol *in* particular places. Even



Brown and Duncan (2000), whose paper focused on the consumption of cigars, didn't address how consumers themselves negotiated the consumption of cigars. Instead, their article concentrated on deconstructing representations of smoking. Absences outside of health/medical geography in relation to the consumption of food and alcohol will be discussed in Chapters 4 and 5. However, I will note here the importance of studying the consumption of ingested substances, because such practices are "inherently social and revealing of cultural processes, concerns and symbols... [one that] permits exploration of user behaviour and social identity in a very broad context" (Hunt and Baker 2001: 178).

### 2.2.3. Health and risk

A related absence in the literature concerns geographies of risk. Kearns and Moon (2002: 613) note that the studies that have been done on risk so far in health geography "are limited applications in comparison to the nascent study potential"<sup>9</sup>, though there have been some interesting studies of risk done recently on HIV-AIDS in Malawi by Susan Craddock (2000), and risk and mental health (Moon 2000).

Much of the existing research in health geography that has concentrated on risk has focused on environmental risk (Coyle 2004). Gregory et al (1996) for example looked at people's perceptions of risk as they related to environmental stigma. These authors found that large differences existed between how risk was perceived by technical experts and lay members of the public. Dangers that experts thought were particularly serious, such as bacterial contamination in food and air, were rated less seriously by lay members of the public. Likewise, some technologies that experts felt were relatively safe were avoided by the public, meaning that the cost of implementing them, a cost measured both economically and socially, was higher than would have been assumed on the basis of a technical risk assessment study alone. Gregory et al argued that people's perceptions of risk are often ambivalent, and that technical knowledge alone doesn't necessarily determine how people will react to them. There is much that is useful here. There are gaps in Gregory et al's paper, though, including a lack of concern with small scale everyday risks; Gregory et al were very much interested in large scale environmental risks, a focus shared by other

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<sup>9</sup> In this section I am discussing the absences of studies dealing with risk in health geography. A full discussion of risk is contained in section 4.2.

studies in health geography that have examined environmental risk (Wakefield and Elliott 2000, Baxter and Eyles 1997).

Coyle (2004) is an interesting exception. Her work focused on how women with Environmental Illness (or EI) constructed safe space within their homes to protect themselves from the debilitating aspects of their condition. She argued that by regulating space through the detection and removal of environmental pollutants, these women empowered themselves by taking control over their spatial situation and minimizing their risk of losing control over their bodies. While not focusing on environmental risk per se, Dyck's (1999) research highlighted that for women with multiple sclerosis the workplace can often be a risky space. For example, not being able to work was a risk to Dyck's respondents' livelihoods. Continuing to work, though, posed a series of subtle identity risks, for example in relation to the danger that these women might be regarded as 'different' or 'abnormal' by others. Dyck's work, like Coyle's, shows that it is important to take the body into account when analyzing risk. Addressing the absence of work in health geography on Foucault, Parr (2002b: 245) notes that much more work needs to be done of the kind completed by Coyle and Dyck on the body as a "complex site of risk assessment". Furthermore, much productive work remains in particular to be done here in relation to risks, bodies and consumption. Brown and Duncan (2000) for example note that in late modern societies individuals are expected to constantly make assessment about the healthy or risky virtues of the items they consume and the practices they engage in, assessments which have profound implications for individuals' identities as moral subjects (whether they have been 'good' or 'bad'). To fully understand how people engage in these evaluations, it is also important to examine the place pleasure and fun have in people's consumption. For example, while consuming alcohol may be risky for young people with diabetes, it can also be a fun thing to do, the positive nature of the practice bound up with its risky nature.

#### **2.2.4. Young people in health geography**

A final strand in health geography I am interested in is how health geography deals with young people. Young people have a presence within health geography research. Robson (2000) for example examined how Zimbabwean young carers (between 15 and 17) looked after impaired or disabled relatives, and Hoy (2001) how young



Chinese people's sexuality was constructed and regulated by the Chinese government.

Collins and Kearns (2001) completed a thought provoking study exploring attempts to improve children's road safety going to and from New Zealand's largest primary school. These authors research was based on a questionnaire survey (n=426), completed by both young people and their parents. Collins and Kearns's study is useful in several respects. Firstly, like Gilroy et al's (1996) work noted above, it highlighted the ambivalent nature of risk. For instance, the authors noted that while children walking to school may be at risk of being hit by a car, there may also be risks for them if they were prevented from walking.

“Children's social development may be impeded if they are denied opportunities to explore stimulating environments and negotiate a variety of public contexts” (Collins and Kearns 2001: 295).

Collins and Kearns also demonstrated that traditional attempts to increase safety and reduce risk on the roads have often viewed children, not motorists, as the problem. Children are seen as “an irrational and unreliable presence in urban public space in need of (re)education” (ibid: 296). This point about how young people are represented as problems is important, and will be discussed in detail shortly.

Several studies have examined the relationship between young people and consumption. Forsyth and Barnard (2000) looked at young people's (mean age 14.5) alcohol consumption practices in Scotland and Kearns and Barnett (2000) study examined the effect the introduction of a McDonald's restaurant into New Zealand's leading children's hospital had.

Finally, several studies have examined young people's health in relation to their place in educational institutions. Holt (2003) explored teachers' conceptualization of inclusion/exclusion and disability, and Litva et al (2001) examined how young women conceptualized health during the transition to university. Litva et al's work is particularly relevant for the concerns of this study. These authors found that the inner health of the body wasn't a concern for their respondents (none of whom was mentioned as having a chronic condition). It was bodily appearance, looking good

and healthy, which was crucial. Their “outer body was the form of physical capital upon which they were evaluated” (Litva et al 2001: 258). Litva et al also found that the university itself was interpreted as an unhealthy landscape by their interviewees and that a student lifestyle, characterised by drinking and eating ‘bad’ foods, was seen to complicate attempts to be healthy. Interviewees thought that once they had transitioned out of university they would be much healthier. Litva et al’s work is useful because it concentrates on the relationship between consumption and identity. However, it doesn’t discuss what time of the year students were interviewed (important when dealing with students) and it also doesn’t discuss the multiple transitions that students make within university.

Despite the important work that has been done on young people in health geography, there remain significant absences; there are also weaknesses in the work that has already been done. Firstly, young people’s voices are absent from much of this research (Collins and Kearns’s, Litva et al’s and Robson’s work being notable exceptions). For example, Hoy doesn’t provide any interview or ethnographic material examining how adolescents in China responded to sexual education, and Holt didn’t interview young people about their attitudes towards disability and exclusion. These absences are not particularly surprising. Kearns and Moon (2002: 613) argue that “in general, people- in the sense of acknowledged, autonomous, sentient beings- remain generally absent from the narratives of health geography”.

Furthermore, what all of the studies mentioned here share in common is that none of them deal with young people who have chronic conditions or acute illnesses. Similar absences are to be found outside of health geography. Furlong and Cartmel (1997: 67) note that young people with illnesses are often an invisible presence for medical researchers. Gabe et al (2002) note the vast majority of research done on chronic illness has concentrated on people who are middle aged or older, with the effect that young people with chronic conditions have been relatively neglected. In part, this absence emerges from the common representation of youth as a period where young people are at a peak of their physical strength and fitness (Furlong and Cartmel 1997). Recently, though, there has been a movement within sociological and medical disciplines to address this portrayal. A recent report by the British Medical Association (2003: 1) has found that “up to 1 in 5 adolescents may experience some



form of psychological problem, including depression, eating disorders, self-harm and neurosis". Commonly girls are represented as suffering from these problems (Frost 2005), though it is important to be aware that they can affect young men as well.

To summarize, then, this review of the recent literature in medical geography has demonstrated that more attention needs to be paid to the voices of young people, especially those with chronic conditions. In particular, the literature has shown that there is room for a study investigating how young people conceptualize risk in relation to consumption, and the implications these risks have for individuals' identities. The literature also demonstrates the importance for theorizing and investigating the ways in which the body affects young people's negotiation of consumption and risk.

In the next section I am going to discuss how young people are represented within popular and academic discourses outside of health geography.

### 2.3. Representations of Young People

**Jessica:** You're *bad*, Bart Simpson.

**Bart:** No I'm not! I'm really-

**Jessica:** Yes you are. You're *bad*...and I like it.

**Bart:** I'm *bad* to the bone, honey.

Outside of medical and health geography, there is a now well-established body of geographical research on young people (see Valentine 2003, Aitkens 2001 and Valentine et al 1998 for overviews).

One aspect of this literature which I would like to briefly focus on here is the way in which young people are represented within academic and popular discourses (though not so much in relation to the geographical literature on youth); namely, as out of control, hedonistic 'deviants'.

From Hall (1904) onwards, youth has been portrayed as a troubling stage in the life cycle in contemporary society (Furstenberg 2000). Academic research hasn't problematized this portrayal as much as one would expect. In a review of the

psychological literature published on adolescence and youth between 1985 and 1995, Ayman-Nolley and Taira (2000: 43) found that most of the published research concentrated on the “dark side” of adolescent practices. They found that young people were overwhelmingly represented in a negative fashion, in a way that emphasized the chaos, drama and abnormality of teenage life. Ayman-Nolley and Taira (2000: 43) came to the conclusion that “from this review...a typical adolescent can only be described as a psychologically abnormal individual who takes risks and is trying to figure out their identity and not much more”.

Such representations are common, particularly in relation to young people aged between 16 and 25 (Valentine et al 1998). In scientific discourses, the storm and stress model of adolescence, characterised by “emotional instability and hormonal imbalances” (Frost 2005: 75), is definitive. Even in sociological literatures, most of the studies that have looked at youth and young people have concentrated on the multiple problems that young people present to modern societies, rather than on the positive practices that young people engage in (Furstenberg 2000). The roots of this obsession with the ‘dark side’ run deep. Valentine et al (1998) note that academic interest in young people emerged from criminology, a field which was concerned with the difficulties and pains adolescents caused to adults in urban landscapes. It was “the...challenge to the established order that caught the imagination of contemporary social scientists” (Furlong 2000: 130).

Malbon (1999) notes that representations of youth continue to concentrate on young people as urban, as ‘unusual’ in comparison to adults, and as the cause of trouble. Representations of young people also continue to focus on the spectacular nature of youth sub-cultures, on situations where and when young people go wildly out of control. These images are gendered, classed and racialised. Traditionally the youth as problem model has concentrated on young black men, though now it is increasingly focused on young Muslim men. Malbon argues that these kinds of images commonly occlude points where young people can be conservative or moderate. Indeed, Osgerby (1998: 90), commenting upon research completed on young people in the 1960s, noted that most studies in that period continually pointed to the “conventionality” of young people. In relation to research on health, youth has typically been represented as a risky stage in the life course, a point where young



people engage in practices of investigation and experimentation that involve the reckless negotiation of hazards that can negatively affect young people's bodies and minds (Furlong and Cartmel 1997). Situations where young people are represented as engaging in thoughtful, risk-controlling practices are much less common.

### **2.3.1. Absences in research on youth**

Soares (2000) argues that focusing on resistance is not what researchers should be doing. He argues that this focus has contributed to many weaknesses in the existing literature on youth. The concentration on spectacular resistance, for example, has come at the expense of sustained research into the lives of young people who attempt to adhere to social expectations (Valentine et al 1998). Valentine et al (ibid) argue that currently academics do not have a sufficient understanding of young people who get on with their lives and do well, young people who go to university for example. Secondly, research which considers young people's practices to be fundamentally problematic often fails to take account of young people's "imaginative and practical construction of their own experience" (Malbon 1999: 18). A reading is made of young people's practices, but is rarely checked with them. Thirdly, research into the lives of young people who could be considered deviant and spectacular has often been research into the lives of working class young men. The relative absence of girls and young women here is striking (McRobbie 2000, Valentine et al 1998).

Furthermore, while many studies have looked at young people as risky actors, in the sense of their being a risk both to themselves and to others, there has been little work that has looked at the connections between risk and pleasure in young people's lives (France 2000). This is perhaps surprising, given that risk, pleasure and self-actualization are often linked in people's narratives. Taking risks is often seen as a necessary practice if life is to be lived to the full. The consequences of not engaging with the pleasurable consequences of risk, and imaginative and emotional dimensions risks have for young people, has meant that young people's consumption practices are often "disembodied, decontextualised and bereft of emotions" (Malbon 1993: 23).

In part, I would argue that the decontextualised nature of research that has examined young people's practices has stemmed from the lack of attention paid to the spaces in

which young people's negotiate risk. Malbon (1999: 19) notes that the insufficient understandings researchers have of young people stem in part from the lack of research into "the practices, spacings, and timings of the ways young people live their lives". This absence is regrettable because a focus on space would clearly be helpful in contextualizing both representations and assumptions. Geographical research has been noteworthy here in addressing context more than other disciplines. Palmqvist et al (2000) for example note that developmental research has more often than not cut the individual young person out of his or her environment. Likewise, surprisingly few studies of young people's alcohol consumption practices have discussed the spaces in which young people consume alcohol, or attempted to view practices from the point of view of young people themselves, though a few have recognized the necessity for this (Harnett et al 2000, Hussong 2000). More research, then, needs to be done on the relationship between young people, risk, consumption and their spatial situations if young people's practices are to be fully understood (Wood 2003, France 2000, Palmqvist et al 2000) (as I discussed earlier, Forsyth and Barnard's (2003) work on the spaces of teenager alcohol consumption in Scotland is a good example of how geography can be used to address these gaps).

One final absence concerns older young people in sociological, geographical and psychological literatures on youth and adolescence. McDowell (2002: 43) notes that "few studies of teenagers are undertaken by geographers", and Valentine (2003: 39) that:

"While the age range 7-14 has received considerable attention from geographers, the discipline has been slower to consider young people on the cusp to adulthood: those aged 16-25" (Valentine 2003a: 39) (though there are some exceptions here: see Leigh and Krenske's (2000) work on heavy metal clubbers).

### **2.3.2. Students**

Furstenberg (2000, see also Christie et al 2002), in a review of the sociological literature published on youth in Western countries in the 1990s argues that there have been few studies of white, middle-class students who go to college. The lack of attention paid to the transitions young people make to university is reflective of the general lack of attention given to the more general transition from adolescence to



young adulthood, which has been studied far less than transitions that occur earlier in adolescence (Waldinger et al 2002). This is surprising, given that in the recent past there has been explosion in the numbers of young people in the UK continuing on in further and higher education. McDowell (2002) notes that in the 1970s over 66% of teenagers went straight into work after school; currently, less than one in ten do. Indeed, straight transitions from school to work have become extremely difficult for most young people in Europe; individuals aged 25 and under have double the rate of unemployment of older people (Egris 2001). Many of the young people who stay on in education go to university. Currently, just over 30% of 18 year olds in the UK are in higher education, with the government seeking to increase this figure to 50% in the near future (McDowell 2002). Translated into numbers, this means that over 1.4 million people are currently classified as students in the UK (Chatterton 1999). This is a massive sum, especially when one considers that prior to World War II the number of students in higher education in the UK was less than 50000.

There have been several effects of this increase in the student population. Firstly, many UK cities now contain large numbers of students (Chatterton 1999). Secondly, groups which have traditionally been excluded from higher education, such as students from non-white and working class backgrounds, increasingly have a presence on the university landscape. Thirdly, there is a growing divide between 'new' (former polytechnics) and 'old' (Oxford, Cambridge and the 'redbrick') universities, with the presence of non-traditional students being largely concentrated in the 'new', less culturally prestigious universities. Most of the positive benefits the expansion in student numbers has brought have been accumulated by the middle classes (McDowell 2002). This trend will no doubt continue with the introduction of top-up fees. Fourthly, while class continues to be a divisive factor, there has been, from a historical perspective, a marked reduction in gender inequality in relation to the types of individuals who attend university (Egerton and Halsley 1993). Men and women are equally represented (at least, once they are middle class). And finally, as researchers have noted, the effects of having further education for all has resulted in the transition from youth to young adulthood becoming increasingly complex (Thomson et al 2002). What was once a relatively set trajectory is breaking down into a number of fragmented transitions (Valentine 2000, Furstenburg 2000). Gill Valentine puts this nicely when she writes:

“Instead of pursuing a linear pathway young people are plotting more complex paths to adulthood riddled with inconsistencies and contradictions (Valentine 2000: 258).

For many young people the university is a transitional space, a space where a ‘kind-of’ adult identity is constructed. What is interesting, however, “despite the material and symbolic importance of students in the life of a higher educational college” (Cowley and Waller 1935: 132), is how little research has addressed students’ identities and practices (Chatterton and Hollands 2003, Chatterton 1999, Silver and Silver 1997). Much of the work that seems to be about students is not really about them at all. It is:

“About statistics, totals, percentages, based on race or sex or age or social class. It is, with one important exception, not concerned with students themselves. The exception is the strong tradition of research into academic success and failure, with the distribution of classes of degree” (Silver and Silver 1997: 1).

Institutional actors in higher education are mainly interested in one aspect of students’ lives, and that is their role, and their success in this role, as learners (Haselgrove 1994). As such, few studies have looked at students as “real people” (ibid: 2, see also Christie et al 2002, Haselgrove 1994). Though there are some interesting exceptions. Henle and Hubble (1938) for example hid under students’ beds to record instances of egocentricity in students’ conversations. In general though the lack of research on students is striking, despite the fact that, for the social scientist, “the campus furnishes an experimental laboratory comparable to that of the biologist with his white rats, guinea pigs, and drosophila flies” (Cowley and Waller 1935: 133). Research on student night lives has been especially neglected (Chatterton and Hollands 2003). Christie et al (2002: 209) argue that “perhaps implicitly, quality of life as a student has been considered to be unproblematic”.

In popular discourses representations of students, in line with the images of young people discussed in the previous section, often focus on students as out of control deviants, as devils rather than angels (Valentine 2001). Silver and Silver (1997: 14) argue that historically (by which they mean since the middle ages), the images that



have clustered around students have to do with them “whoring...and enjoying the privileges of the interval between school and life”. Writing in 1935, Cowley and Waller (:134) note the troubling practices students engage in after winning competitions.

“The tearing down of goal posts after football victories and the wiggles of snake dancers<sup>10</sup> have also a manifest relationship to the victory dances of warlike tribes”.

In the contemporary period, popular representations of student practices tend to centre on students’ hedonistic consumption practices: the student body is often implicitly and explicitly referred to as a consuming body. **Figure 2** is an image taken from the *Sheffield Steel Press*, the University of Sheffield’s student newspaper. It provides the rules for a game which will transform you from a “mummy’s boy into an alcohol worshipping, casual sex loving degenerate student” (no author: 9). A paper board is provided, on which a trail has been marked out. Like snakes and ladders, the aim of the game is to reach the end of the trail by engaging in the consumption practices described in **Figure 2**. The student body then is constructed through consumption practices and excess.

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<sup>10</sup> It’s not absolutely clear what snake dancers are, but it seems to me that they are cheer-leaders.





**Figure 2.** 'The Freshometer'. Source: Sheffield Steel Press. 21<sup>st</sup> September 2002.

These kinds of representations of student consumption practices have occasionally led to moral panics about students actual practices. Interestingly, these panics often emerge from the liminal nature of students' identities, their in-between state, their identities as people who are not quite adolescents but not quite adults. For example,



because of what was perceived to be the excessive and hedonistic nature of student drinking, in 2001 the UK's National Union of Students, in conjunction with the Portman Group (a drinks industry group set up to promote safe drinking), launched the tongue-twistingly entitled 'If You Drink, Do not Do Drunk' campaign<sup>11</sup>. This was a programme aimed at university students and other young people and designed to challenge the attitudes of the 'more than a million 18-24 year olds [who] consume alcohol purely to get drunk every week' (Williams 2002). Harvey Atkinson, the spokesperson for the Portman Group, noted that this scheme was necessary because "there is a problem with binge drinking in Unions and this problem needs to be sorted out. There is a culture whereby freshers think they have to get hammered. Unions need to promote sensible drinking so that when students go out they won't have to put up with peer pressure" (Talbot 2002: 5). The initiative sought to reduce what it saw as the massive preponderance of binge and problem drinking occurring amongst young people on a discomfortingly frequent basis. The NUS and the Portman Group wanted to replace 'delinquent' drinking with more socially responsible, 'grown-up' attitudes towards alcohol.

There were a range of responses to the NUS' drive. These were often predicated upon particular ideas of what students and young people are, and how they should behave. Zoe Williams in *The Guardian* argued that although students "might be young... they are adults" (Williams 2002<sup>12</sup>), and therefore able to make rational decisions about their own behaviours, whether these are viewed by other people as 'problematic' or not. For Williams, adult status, at least in relation to this matter, is attained when the age of eighteen is reached and young people become legally permitted to drink. Furthermore, and in marked contrast to the NUS, Williams' argued that the years between the ages 18 and 21 are in fact "the optimum time in life to over-drink" (ibid) because this is the period when people are at the peak of their physical health (she draws here on the representations of young people as healthy and strong that I discussed and critiqued above). They will suffer few ill effects from alcohol as their bodies can readily deal with the toxins produced by overindulgence.

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<sup>11</sup> I also find it ironic that the two groups who constantly push young students to drink, the students union and the drinks industry, are placing the blame on students themselves for engaging in these practices.

<sup>12</sup> <http://www.guardian.co.uk/comment/story/0,,781040,00.html>

In contrast with Williams, Henrietta Talbot, the editor of the University of Sheffield's student newspaper argued that the problem for the NUS is that "an 18 year old fresher straight out of school cannot be expected to have a responsible attitude towards drinking" (Talbot 2002: 5). From Talbot's point of view young (first year) students are almost, but not quite, adults. Though they are legally old enough to drink they are still as much children as 'grown-ups', and therefore cannot be expected to have developed mature relationships with alcohol. The foundation of Talbot's argument, that young people do not yet possess the intellectual and emotional capacities to control their drinking patterns (and implicitly, their selves) rests on two assumptions. The first of these is that the ability to control the self can be read in a linear fashion off of chronological age. From this perspective eighteen year olds are just too close to the irrationality and irresponsibility of childhood to be able to moderate and mediate their behaviours in an acceptably 'adult way'. The second of these is her focus on 'freshers', young people who Talbot considers to have too recently made a transition from the relatively more disciplined institution of the secondary school and parental home to the relatively freer and less constrained space of the university. In the UK, universities are often constructed as places where young people can go 'out of control'. In Talbot's schema fresher students, because they are new to the game of university life and chron(olog)ically naive, do not yet possess the abilities and experiences necessary to resist the prevailing discourses and peer pressures encouraging them to drink.

From one point of view, then, eighteen year olds are considered to be fully grown up, able to make (some) legally sanctioned decisions; but from the other they do not yet possess the maturity of mind to make the right decisions, or resist the decisions of others. They occupy a liminal, ambivalent position. It is interesting to note that neither Williams nor Talbot challenge the accuracy of representing student practices as out of control or hedonistic. They accept that students engage in risky drinking.

What is noticeably absent in these debates are the narratives of young students themselves, how students conceive, perceive and manage their risky drinking. In fact, a substantial number of students do not drink at all (something which will be discussed in **Chapter 4**), and students that do drink often vary in how much they do



so, a fact that is ignored in these kinds of debates. This point was recognized in a classic episode of the Simpsons where Homer went to college. Homer was shocked when he found out that students didn't drink as much as he thought they would. Because of this, he proceeded to spike the non-alcoholic punch in the party he was attending. The results this action had, however, weren't the ones that Homer intended.

**Homer:** [*spiking the punch*] Heh heh, I'll be a campus hero.

[*Another student tastes the punch and spits it out*]

**Student:** Attention, everyone: the punch has been spiked.

[*Everyone gasps*]

Do not worry. Your parents have been called and will be here to  
pick you up shortly!

[*Everyone cheers*]

Finally, it is interesting to point out that some of the most important work that has been investigated student practices has been completed by a geographer, Paul Chatterton (Chatterton and Hollands 2003, Chatterton 1999). Drawing on Pierre Bourdieu's work, Chatterton sought to examine the lifestyles of what he referred to as 'traditional students', white middle and upper class students aged between 18 and 21 who leave home to go to university in another city (see Christie et al 2002 for a study of student accommodation transitions). These students have high levels of income and are concerned with the practices and representations of youth culture (Chatterton 1999). There are a number of points to commend in Chatterton's work. He emphasizes the complex and divided nature of the student community (Chatterton and Hollands 2003). He highlights the ways in which student identities are acquired and embodied within spaces of student sociability and through media representations (such as in **Figure 2**). He also explores how students acquire particular dispositions by taking part in rituals, such as drinking in Fresher's week. And he notes that part of the process of maturing as a student is distancing oneself from the practices of a typical (white, adolescent undergraduate) student. If Chatterton's work has a weakness, however, it is a tendency to homogenize students from similar class backgrounds. He argues for example that going to university cannot be called very much of a learning experience if the only individuals encountered are those that are similar to you. In this way, he puts class as the determining factor in student identity.

He doesn't reflect on how white middle class students can be further differentiated, for example, into groups with conditions like diabetes and those without. He also, I believe, doesn't engage fully with the complexity of student consumption practices, arguing that "the majority of students have become rather uncritical and passive in their roles as consumers" (Chatterton and Hollands 2003: 135).

In the next, and final section, I am going to look at one differentiating category, which further divides the traditional student body: the presence of a chronic condition.

#### **2.4. Young people with diabetes**

Furstenburg (2000: 905) argues that one point upon which sociology, geography and other social science disciplines can all be criticized for is their neglect of biology, and pretending that individual bodily differences "do not matter". As Judith Butler (1993) has shown, and as the research I have previously discussed on embodiment has argued, bodies *do* matter. And they matter especially so for young people with diabetes.

Like much of the research on young people, the existing research on young people with type 1 diabetes has generally concentrated on the 'dark side' of young people's practices. Raine et al (2001) argue that adolescence is an especially problematic, risky stage in the life course for individuals with type 1 diabetes. It is a period where blood sugar control often declines and the risk of developing long term complications increases (Bryden et al 2001). Biological and cultural factors are thought to underlie this process (Bryden et al 2001, Wolfsdorf 1999).

From a biological point of view, the increased amounts of growth hormone released during adolescence are thought to increase resistance to insulin. More importantly though in explaining adolescent 'noncompliance' with the management regimes of diabetes, are "social and cultural" factors (Raine et al 2001: 18), particularly young people's desire to be 'normal', which is thought to lead them to engage in irrational, needlessly risky practices. Adolescents' psychological states (their inability to engage in counter-factual reasoning) are also figured to negatively impact upon their ability to manage their diabetes. Silverstein et al (2005: 205, see also Wolpert and



Anderson 2001) argue that one of the reasons that young people with diabetes engage in risky driving practices is because:

“Their sense of invulnerability may make it less likely that they will assess hypoglycaemia regularly before driving”.

Dabadghao et al (2001: 890) refer to “the maladaptive lifestyle practices of adolescence” (adaptive here refers to practices that improve blood sugar control). These authors argue that “adolescents who do not respond to supportive strategies and are unable to regain metabolic control often pay the price of early diabetic complications” (ibid). From this perspective, the most important practice that young people can engage in is regulating their diabetes. From the way managing diabetes is described by Dabadghao et al it is clear that this is a moral practice. If young people do not engage in the right practices they will suffer the consequences, which as the phrase ‘pay the price’ seems to me to imply, is their own fault for being irrational.

Because of these complicating developmental factors, many researchers feel that even if young people want to achieve good control, they will find it difficult. Tamborlane et al (2001: 865) notes that adolescents in the DCCT had to receive a “disproportionately large share of the care from the diabetic treatment team and were less successful in meeting treatment goals”. Specifically, young people aged 13 to 19, even with intensive treatment and support, were able to obtain a HBA1C score only “only at a level of around 1% higher than that achieved by adults” (Silverstein et al 2005). While Tamborlane et al interpret these results negatively, it is important to note that they can be interpreted in other ways, ways that stress the good control that adolescents can develop. Silverstein et al (2005) argue that the fact that teenagers were able to achieve such good control in the DCCT before modern insulins and technologies indicates that at least some teenagers can achieve good control. Such positive interpretations are rarely made of young people with diabetes’ practices, however.

It is also important not to homogenize young people’s experiences of living with diabetes or risk. Williams (C.) (2000) found that the young men and women she interviewed (all of whom were in school) managed their diabetes and attempted to fit

it into their social identities in different ways. She found that, compared to the boys, girls adjusted to diabetes better and were able to make diabetes and its management regimes part of their identities with little difficulty. The boys she talked to were much more likely to suppress the presence of diabetes in their lives, and engage in passing practices such as injecting at home so that their social identities wouldn't be spoiled by injecting in public. Williams argued that compared to her female respondents, the boys she talked to had less of a range of legitimate practices they could engage in if they wanted to preserve their gender identities. Girls and young women are considered to be more likely to engage in certain kinds of risky practices, however. For example, Betts et al (2002) argue that insulin omission is often used by young women to lose weight, and that girls with diabetes have more of a chance of developing eating disorders than girls without. Neither of these statements is completely uncontentious, and I will explore them in detail in section 5.8. Information about how boys and young men cope with dietary factors in diabetes is currently lacking (Weinger et al 2001).

What is generally missing in all of these studies, with the exception of Williams (2000), is an attempt to engage with young people with diabetes' personal narratives, to see risk and practice from their own perspective (Frey et al 1997). Because of the absence of young people's voices, risk is seen in terms of negative, irrational non-compliance with medical regimes. Rarely are attempts made to situate, to understand risk, to step into young people's shoes. Furthermore, most of the studies deal with younger children. Findings relating to older adolescents and young adults are missing from them.

#### **2.4.1. Young adults and diabetes**

This absence isn't limited to these studies. Jacobson et al (1997) note that only a small number of studies have examined the effect the transition to adulthood has on young people with diabetes, and Wolpert and Anderson (2001: 1513, see also Kungas et al 2000, Orr et al 1996) argue that "young adults with diabetes are a forgotten group". Several studies have, however, looked at the impact the transition to adulthood has for young people with diabetes.



Bryden et al (2001) completed a study examining the effect the transition to adulthood had on the clinical and psychological course of diabetes. They did baseline interviews with 76 young people aged 11-18, and followed these people up ten years later. They found generally poor outcomes. There was a high incidence of binge drinking and smoking, a problem with weight gain and a high incidence of diabetic complications.

In another study Bryden et al (2003) followed up 113 young people, again at a 10 year interval. As before, they found generally poor outcomes for young people with type 1 diabetes when they were in their late 20s and early 30s.

“Although self-care behaviour improved over the period of follow up, this was overshadowed by the development of psychiatric morbidity in about one-quarter of patients and serious diabetic complications in over one third” (Bryden et al 2003: 1055).

In particular, they found that psychiatric problems, psychological distress and behavioural difficulties were common during the transition to young adulthood, especially in women (ibid: 1052). They noted that unless these problems were identified early on, there was a high chance that they would persist into adulthood.

Wills et al (2003) reviewed the clinical notes of patients aged 16 to 25 at some of the UK's biggest diabetic clinics. For the 397 patients' records they examined, the average HBA1C level was 9.5%<sup>13</sup>. They found this number troubling, given that each decrease of 1% in HBA1C levels is associated with a decrease of 30% in the attendant risk of developing micro vascular complications. Generally, they argued that diabetic control was poor for most young people, and the chance of people of this age showing up to their clinical appointments low.

Other studies have, though, shown more positive (or at least, not completely negative) outcomes for young adults with diabetes (Jacobson et al 1997). In general, however, young adulthood is considered by most of the studies to be a problematic, risky phase in development for people with diabetes.

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<sup>13</sup> HBA1C is a test that measures how good an individual's blood sugar control has been over a period of weeks or months. The lower the number, the better.

This is particularly so for students with diabetes.

#### **2.4.2. University students with diabetes**

Research addressing students with diabetes is “sparse” (Eaton et al 2001). Little “is known about their beliefs...attitudes” (Wdowik et al 2001: 17) or practices (Miller-Hagan and Janas 2002, Rachmandani et al 2000).

What is often assumed, though, is that they are the wrong people at the wrong place at the wrong time of life. They have a condition that is predicated upon being in control and being disciplined, but are in an environment that is perceived (at least by many outsiders) to be completely out of control. It is therefore thought that there is a tension between “two lifestyles” (Eaton et al 2001: 940), between “taking care of health and being normal” (Wdowik et al 2000: 96). Wdowik et al (2001) notes that “college life raises concerns” for students with diabetes.

Several studies in the US have examined how students manage their diabetes while they are at university. Miller-Hagan and Janas (2002) explored students with diabetes’ drinking practices. They interviewed 15 students, and found that their interviewees often felt pressure from other students to drink. The positive element of Miller-Hagan and Janas’ work was that it identified multiple drinking practices that students engage in, practices that were related to students’ personal histories and stages at university. As such, Miller-Hagan and Janas treated students with diabetes as a heterogeneous population. They noted, though, that because of the tentativeness of their findings, more work needs to be done on student drinking practices. They argued that:

“Qualitative studies may best identify key strategies...Studies that expand on the drinking practices here would be invaluable, especially those that clarify the drinking practices of those students who refer to themselves as non-drinkers” (Miller-Hagan and Janas 2002: 243).

Rachmandani et al (2000) sent 164 questionnaires to students with diabetes at several universities. They sought to obtain information about the factors that influence diabetic control in university. 51 questionnaires were returned, giving a response rate



of 31%. One of the positive aspects of this study was that it sought to examine both positive and negative factors that influenced diabetes control. In relation to the negatives, Rachandani et al's respondents indicated that lack of parental support, the presence of alcohol, lack of routine, peer pressure and dieting all deleteriously influenced their diabetic control. Factors that improved control included an increased sense of maturity that came with living away from parents, exercising and the anxiety of becoming hyperglycaemic. Overall, the authors found that despite increased levels of stress that came from living independently, no major changes in HBA1C levels were found, though 71% of respondents felt that it was more difficult to control their diabetes in university. Generally, though, most students had excellent control (Rachmandani et al 2000).

Some studies have also examined how students manage their diabetes when they in university in the UK. In Schur et al's case (1999), the fact that their respondents were students was incidental. Schur et al interviewed eight students with diabetes in Sheffield. Again, they found that blood sugar control was generally good. However, they also found that it was important for their interviewees to have a balanced relationship with their diabetes given the perceived impossibilities of being in control of diabetes all of the time. Schur et al (1999: 226) found that:

“Diabetes was threatening to participants, both on a practical level with respect to the time and hassle of self-care tasks, and with respect to a fear of being overwhelmed by...vulnerability and distressing emotions”.

There are weaknesses to Schur et al's study, however. Firstly, while they interviewed students, they didn't focus on students' practices, or even consumption practices at all. They were primarily interested in the differing ways in which their interviewees' conceptualized control since the time that they were diagnosed. As such, no mention is made of the spaces in which their respondents' practices took place and assumed meaning. Relatedly, Schur et al do not mention whether their interviewees were living away from home or not.

The last study I wish to mention here is a letter written to the editors of medical journals by student doctors in Leeds, stressing the importance of taking the transition from home to university seriously for students with diabetes. Eaton et al (2001)

interviewed several students with diabetes, investigating how diabetes affected students' university lives, and vice versa. They found that diabetes didn't cause any particular problems for their students.

“In general, most of the time it seemed that having diabetes for these students was most of the time just an added complication that could be dealt with and treated correctly or ignored. It may be this attitude towards having diabetes that needs to be changed in some way to try and improve control. The relatively poor response to requests to take part in studies like this is perhaps an indication of the low priority that students give to diabetes management” (Eaton et al 2001: 940).

Of all the studies mentioned here, I believe Eaton et al's is the weakest. It didn't seek to explore the *reasons* why students felt their practices were unproblematic, something which perhaps would have led to an exploration of their interviewees' embodied practices. I believe this lack stems from the way risk is constructed in diabetes discourses; namely as negative. Eaton et al found nothing because they were looking for problems. They weren't looking for how young people engaged in complex risk assessment practices in order to control and minimize the negative aspects of risk. Eaton et al also adhere unnecessarily close to medical conceptualizations of compliance when they argue that students' attitudes would have to be changed, and that there are right and wrong ways to manage diabetes. There is no acknowledgement of competing rationalities, or that students' practices might make sense in their own terms.

## 2.5. Conclusion

It is clear, based on this literature review, that there are a number of gaps in the existing research dealing with young people, and, specifically, young people with diabetes. Perhaps what is most striking overall is the lack of research that has been done to date, both within health geography and outside of it, on the lives of older young people. Only a few studies have addressed young adults within health geography, the wider geographical literatures that have dealt with young people, and the literatures on adolescents and youths with type 1 diabetes.

In particular, what is lacking in the research on young adults with type 1 diabetes is research that investigates practices, and the meanings that practices have for these



young people. Fruitful areas of investigation that have been identified in this chapter include young adults with diabetes' consumption practices. While Rachandani et al (2000) have highlighted a number of positive and negative practices that young people with diabetes engage in, their research was based on a questionnaire survey. Qualitative research of the sort that this study is based would be useful for exploring situations where positive factors become negative, and negative positive (Miller-Hagan and Janas 2002).

Based on this literature review, it is also clearly important to investigate young people with diabetes' consumption practices in terms of risk. Risk is the dominant lens through which young people's practices are viewed in both sociology and geography, and also in the medical literatures. Risk is also a concept that is growing in importance within medical geography, though as I used Parr's work to illustrate, far more work needs to be done on the body as a space of risk assessment. In relation to the work on risk that has been done so far, Vitellone (2003: 39) notes that "what is missing from grand theory approaches to risk are understandings of risk that are more empirically grounded and operate at the level of situated experience". These kinds of situated experiences would be provided by an analysis of the ways in which young people with diabetes negotiate risk *vis-à-vis* their consumption practices while they are at university. Such negotiations would say much about their reflexive self-understandings, their identities and how they conceive space.

As Malbon (1999) makes clear, though, it is important, when studying risk, not just to focus on the dark side, but also on the positive effects taking risks can have. This is not always understood by medical practitioners and psychologists, who generally see risk as a negative, something that must be suppressed or minimized. As such, an in-depth, sensitive exploration of risk in relation to young people with diabetes would be useful for challenging, or at least contextualising, dominant representations of students and young adults with diabetes as an out of control, risky group, a hazard to themselves. It would also be useful for challenging representations of university as a threatening space for young people with diabetes. Furthermore, it would serve to address the sketchy literature we currently have of students' practices, and the arguments that students do not think about the future, heedlessly engage in consumption practices, or that they do not reflect upon their practices.

Finally, the focus on embodiment and place that the risk-consumption nexus implies addresses an area that is increasing in importance within medical geography. As such it will help advance some of the current debates within the discipline.

Taken as a whole, this literature review justifies the existence of a study of this sort, based as it is on examining young people with diabetes' narratives of practice at university, and the interaction between these narratives, consumption, spatialities, understandings of risk and self-identities.

In the next chapter I am going to discuss my methodology, which was based on a number of qualitative, in-depth interviews with students with diabetes. One of the most important reasons I chose to use narrative methods in this study is that they answer Miller-Hagan and Janas's (2002) call for more research to be completed on the narratives of young people with diabetes. Indeed, one of the most interesting points to note about the studies done of students with diabetes to date is that medical practitioners clearly acknowledge the legitimacy of narrative methods in order to investigate student practices (though as Eaton et al's (2001) study demonstrates, clinicians sometimes do not seem to appreciate the complexity of narratives). In the next Chapter I will discuss in further detail how I designed my study, how I obtained my respondents' accounts, and how I analysed them.



**Methodology**

### **3.1. Introduction**

In the previous chapter I demonstrated that my Ph.D. is embedded within, and draws upon, two different bodies of geographical literature, geographies of health and geographies of young people. I also highlighted absences in these literatures that are important for my thesis.

In this chapter I am going to discuss the methodologies I used to implement my project. In particular, in this chapter I am going to discuss:

- Methodologies in geographies of health and illness.
- My research design.
- How I recruited my respondents.
- Research in practice. The specific methodologies I used for my research, in-depth semi-structured interviews and research diaries, and a consideration of why some of these methodologies didn't entirely fulfil their expectations.
- With the help of specific examples, I am going to discuss questions of positionality as they related to my project.
- A discussion of research ethics.
- How I analysed my interviews.

### **3.2. Qualitative methodologies and geographies of health and illness**

With the paradigmatic changes in medical geography discussed in the previous chapter have come concomitant shift in the types of methodologies geographers use (Dyck and Kearns 1995). Rosenberg (1998: 219) notes that "on one level [these changes] are almost about methodology as epistemology". Traditionally, medical geography has been quantitatively based, embedded within a statistical paradigm, and has sought to map the distribution of disease through space (Wilton 1999). However, the cultural turn within the subdiscipline has been characterised by an acceleration in the number of health studies in geography using qualitative methodologies (Wilton 1999, Curtis et al 2000, Dyck 1999, Parr 1998, Kearns 1997). Interviews, diaries, life-histories, story-telling practices, are now commonly used.



There have been several reasons for the growth in the methodological importance of these schedules and tools. Firstly, the narrative turn within health geographies noted by Kearns (1997) has problematized abstract, disembodied knowledge, and emphasized the need for research grounded in people's everyday lives and practices (Wilton 1999, Dyck 1999). Qualitative methodologies are suitable for this task. They can be used to highlight the multiple, embedded ways in which meaning is made, socially constructed, while providing "the flexibility and varied strategies necessary for exploring different dimensions of a phenomenon" (Dyck 1999: 246). Qualitative methodologies can enable in-depth explorations of people's feelings and subjectivities to be made, something which (theoretically) can allow for "new understandings of the body/mind relationship and associated constructions of health and illness" (Parr 1998: 348). Dyck (1999) argues that qualitative methodologies are particularly useful for enabling health geographers to closely examine and breakdown the often complex relationships between spaces, bodies and identities, and so explore the recursive ways in which places and discourses, understandings and practices, are embedded within and fold back upon each other. In diabetes research, the "importance of qualitative methodologies for understanding diabetes" is increasingly being recognised (Anderson and Robins 1998: 1387). Anderson and Robbins argue that it is necessary for researchers to explore people with diabetes' feelings if their practices are to be understood (and changed). They also note that qualitative methodologies allow the traditional focus on compliance to be displaced in diabetes research, as they emphasize that:

"The choices that patients make appear to be quite sensible if one understands the demand characteristics of their environment" (Anderson and Robins 1998: 1387).

The use of such an approach when dealing with a group such as students with diabetes, who are often considered to act 'irrationally, is clear.

Secondly, on the macro-scale, the concern that much of the research in 'new' geographies of health and illness displays with examining subjects' narratives can be read as a way of challenging "the authority of the 'grand' narratives of science and medicine in the ordering of everyday experiences, and especially in response to illness" (Bury 2001: 265). Dyck (1999: 245) for example notes that recent

geographical research on health has been characterised by increased attention being paid to 'consumer' voices and a deconstruction of hegemonic "medical categories". In this sense qualitative methodologies, at least as many geographers use them, are underlain by political motivations, in that they are intended to challenge dominant biomedical understandings of health while seeking to increase the power of research participants. Qualitative methodologies multiply singular narratives and emphasise diverse experiences of health and illness. They are thus often used by researchers who have sympathies for difference and social justice. Furthermore, by using qualitative methods geographers can attempt to acknowledge and make explicit their own power and ability to represent 'others' (Wilton 1999). These issues will be discussed later.

### **3.3. Research design**

Given that my thesis is concerned with young students with diabetes' narratives of practice, I felt qualitative methodologies would be the most suitable to use. They would let me obtain the accounts that I needed to address my thesis' aims.

Once I decided on my methodological approach, several issues then presented themselves: firstly, how the research would be designed, secondly, what qualitative methodologies would be best to use, and thirdly, how I accessed a group of students with diabetes.

With regards research design, I felt that a combination of interviews and research diaries would enable me to best fulfil my research aims. In conjunction, they would allow me to attempt to capture "what people say...and what people say they do" (Bell 1998: 77, see also Jackson 2001). Theoretically, multiple methods enable successful triangulation, the confirmation of results through multiple sources, which can increase the credibility and validity of research findings (Baxter and Eyles 1997, Valentine 1997). I initially envisaged using participant observation as well, but this proved problematic. As I will discuss in Chapters 4, 5 and 6, interviewees, especially first years, often wanted to be perceived as normal. While first years did not mind talking to me, they were often far more wary about having me around them all of the time, especially when they went clubbing with their friends. I mentioned the possibility of doing participant observation with my respondents, and left the choice



with them. None ever brought the matter up after I mentioned it. Older interviewees were mainly medical and law students and were studying intensively. They were willing to do interviews with me, but were not willing to talk to me to the extent that it interfered with their work.

Interviews are the most commonly used qualitative technique (Kitchin and Tate 2000). Sandelowski (2002) in fact notes that much of the research that has been done in health sciences has used *only* interviews, and the same could be said for much of the research in social and cultural geography. An interview is a “complex social interaction in which you are trying to learn about a person’s experiences or thoughts on a specific topic” (Kitchin and Tate 2000: 215). There are different types of interviews, ranging from those that are completely open-ended (having no pre-defined questions) to those which have a highly prescriptive structure. I decided in this study to use semi-structured interviews, interviews which are guided by a general topic list. Semi-structured interviews allow an in-depth investigation to be made of people’s thoughts, opinions, practices, and beliefs as they relate to a particular matter. Feelings can therefore be explored more closely than allowed by more closed schedules (Smith 2001, Kitchin and Tate 2000, Valentine 1997, Arendell 1997), but in a more focused way than completely open-ended interviews. This is important in situations when respondents may not have a lot of time to talk.

Interviews, whether open ended or semi-structured enable researchers to explore ambiguity within respondents’ accounts, and allow questions to be asked in alternative ways; consequently they can allow for a thorough exploration of the meanings of narratives (Valentine 1997). Valentine (*ibid*: 111) notes that interviews also allow individuals to highlight issues which they feel are relevant to them, but which researchers may not have considered. For example, in my interview with Naoimh she noted that her house mate did her injections for her, a subject which I would never have considered asking about in a questionnaire study.

Well, we got back to the house about 3 am. I found Andy in his room so I went up and spoke to him for a bit. He walked me upstairs to my room and gave me my nighttime injection and put me to bed. For some reason he likes doing my injections and to be honest, he’s very good at it as it doesn’t hurt one bit. I let him do it all this time including squirting a bit out to start,

pinching the fat and putting it in...I won't be allowed to miss any injections if he has his way.

Successful interviews are characterised by the construction of a successful rapport between research participant and researcher. This enables trust to be built (Kitchin and Tate 2000). Valentine (1997) argues that it is often easier for individuals who feel that they have something in common, or share similar interests, to construct a rapport. In my case, the fact that my father has type 1 diabetes and I was a student often seemed to legitimate my presence in my interviewees' lives.

Based on a review of the literature, I drew up a topic guide of material I was interested in covering. This guide was piloted with two former students of the University of Sheffield who had diabetes. These people were identified from an internet support group. Based on this pilot I revised the topic guide to the interview schedule displayed in **Figure 3**.

The second principal methodological technique I used was open ended research diaries. Diaries were piloted with the same two informants I piloted the interviews with. Research diaries are intended to obtain narrative information about a specific topic by asking respondents to record their feelings and thoughts, as they pertain to this topic. The rate of completion of diaries is dependant on the ability of the researcher to chase respondents up. Verbrugge (1980: 91) argues that "when respondents are monitored and given active encouragement throughout the diary period, they produce diaries with few missing responses". Time is an important factor; asking a respondent to keep a diary for any longer than 2 or 3 weeks and the reporting burden would likely be excessive (Corti 1993, Verbrugge 1980). Based upon my initial piloting of research diaries, I decided a week was the maximum I could ask a respondent to keep a diary for.

The advantage of research diaries, compared to interviews, is that they get participants to reflect upon and record their everyday activities and practices, practices which may have been glossed over or forgotten during the course of an interview (Elliott 1997, Corti 1993, Verbrugge 1980). Research diaries are also useful for discovering information about not only the practices interviewees did or



did not engage in, but the practices that they would have liked to engage in, and the reasons why they did not do so (Elliott 1997).

Unlike other forms of diary, such as the intimate journal, it is important to be aware that the research diary is a semi-public document, written with a particular audience in mind (this was made very clear when my respondents addressed me in their diaries i.e. 'Hi Myles, how are you?'). The information provided in these diaries, then, will not be the 'truth', but a contextual understanding of the meaning practices and events have for diary keepers at a particular time (Elliott 1997).

Health research diaries compliment interviews well, providing researchers with knowledge about how respondents construct meaning across time and media (Elliott 1997). In this study I envisaged research diaries, as well as being a useful methodological tool in themselves, as achieving their power through synergy, through being part of an interview-diary-interview methodology, where interviewees would be asked in their second interview about the material they had discussed in their research diaries and first interviews. Corti (1993) argues that this '1-2-1' approach is an effective and reliable way of collecting information.

<u>INTERVIEW</u>
<u>DIABETES</u>
INTRODUCTION
DIFFERENCE FROM HOME > ROUTINE
BEST/WORST THINGS ABOUT BEING A STUDENT
WHAT KINDS OF THINGS CHANGE WHEN YOU COME TO UNI. > DIABETES
ISSUES YOU THINK ARE IMPORTANT
ACCOMMODATION (HALLS/ SELF-CATERING/ HOUSEMATES) EFFECT ON
DIABETES/ VICE VERSA
SOCIALISING (GOOD NIGHT OUT/ WHERE/ WHAT DO YOU DO)
ALCOHOL. DO YOU DRINK >
RELAXATION > REASONS
NEEDLES / TESTING EQUIP > DO YOU LIKE CARRYING AROUND? >
WORK
DIFFICULTIES OF UNI.
GAP YEAR > WHAT DID YOU DO/ WHERE DID YOU GO > DIABETES
CAN YOU TELL ME ABOUT > SCHOOL/ TEENAGE YEARS
PREPARATION TO MOVE AWAY FROM HOME?
DIET
CONTROL
NUMBERS COMFORTABLE/ HAPPY WITH UNHAPPY >
WEIGHT GAIN/ LOSS
DIFFICULTIES IN DIETING
TIMES/ PLACES MORE WILLING TO LET GO OF CONTROL?
TIMES OF DAY HARD TO CONTROL?
THOUGHTS ABOUT THE FUTURE
FEARS > SCARIEST THING ABOUT DIABETES
HOW WOULD YOU DESCRIBE YOUR ATTITUDES TOWARDS
MANAGEMENT REGIMES NOW > FATALISM/ ENTHUSIASM
HYPOS OR HYPERS
MORE LEEWAY WITH CONTROL NOW (IN UNI.)?
THOUGHTS ABOUT MEDICAL ESTBL.
WHAT KINDS OF ADVICE WERE YOU GIVEN AS A STUDENT?
DRAWBACKS/ BEST THING ABOUT HAVING DIABETES
ANYTHING ELSE?

**Figure 3. Interview Topic Guide**

When designing the research diaries I gave to my respondents, I used Corti's (1993) useful item breakdown. She argues that diaries should have a list of hints and tips for completion at the start (see Figure 4), an example, and a debriefing list of questions at the end.



HINTS AND TIPS FOR COMPLETION OF DIARIES

1. Please use this diary to describe what you did on a particular day and how diabetes affected your experiences.
2. Each entry should cover a period of one day. One A4 page is provided for each entry (if you want to write more than this you can use the back of the sheet).
  - a) Diary entries should be recorded daily for a period of 7-10 days.
3. Entries in this diary are to enable you to record feelings, thoughts or comments concerning your day-to-day experience of being a student and living with diabetes.
4. Diary entries could describe:
  - a) Your everyday life: what you did, where you went, who you met and what happened, whether or not you went out, went to lectures, took the day off, what you did in the evening and so on.
  - b) Your day to day thoughts about being a student, and what 'student life' means for you.
  - c) How your diabetes interacts with your everyday activities (whether studying, clubbing, travelling, etc.).
5. A final section is also enclosed where you can give your thoughts on keeping the diary.

**Figure 4.** List of instructions for completing research diary.

### 3.4. Recruitment

Upon deciding the general topics I wanted to cover in interviews, and the structure of my research diaries, the next stage in the project was concerned with finding students who had diabetes. I contacted six university health services in the Midlands and asked to arrange a meeting with a university doctor. Four universities agreed that this would be possible. I asked these universities to pass on a letter from me to their students, in which I asked for research participants. All four said that this would be possible, though three universities subsequently asked me to submit a formal letter to them outlining my project, so that it could be discussed by all relevant members of staff (see **Figure 5**).

All of the medical professionals/gatekeepers I talked to were extremely enthusiastic about the project. As I have previously discussed, increased attention is being paid by

medical professionals to the relationship between meaning and health in order to improve patient adherence rates. One doctor I interviewed noted that while she was, in general, happy with the control of her diabetic patients, she would like to improve their control still further, and felt that a study of this sort could be one way of doing so. Another felt that respondents would talk to me about things that they wouldn't talk to doctors about. So while in one way a study of this sort can challenge medical discourses, the information in it can be used by medical professionals to link people into these discourses ever more tightly. This is not, however, necessarily a bad thing.





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12/09/2003.

Dear Sir/Madam,

My name is Myles Balfe. I am a researcher at the Dept. of Geography. Currently I am completing a project on university students who have diabetes. My research is based on in-depth qualitative interviews with students (please see the attached sheet for the kinds of areas/topics that are normally covered during interviews). This research has been ethically approved by an academic panel in my dept., as well as by my supervisory panel.

I am writing to inquire if it would be possible for you to pass on a letter requesting participants for this project to students registered at your surgery as having diabetes.

By agreeing to forward my details to your students I will have no contact with your registry, and people who are interested in this project can contact me of their own volition.

If it is not too much trouble, could you think about whether you would be willing to pass this on, whether as e-mail or letter, sometime in the near future? If you need any further information about this project (or would like to arrange a face to face meeting), please do not hesitate to contact me, or alternatively either of my supervisors, Professor Peter Jackson (0114 XXX XXXX) and Professor Gill Valentine (0114 XXX XXXX)

Yours Sincerely,

Myles Balfe.

**Figure 5.** Letter to university health services.

All of my respondents, for example, appreciated the benefits of science for people with type 1 diabetes, and many identified very strongly with scientific discourses.

Three of the universities I contacted had 50 to 55 students with Type 1 diabetes registered on their databases. The remaining university had 2 students registered. Roughly 160 letters requesting participants for my project were sent out to students at these universities with type 1 diabetes. These letters were often posted with respondents' repeat prescriptions for insulin, and accompanied by reminders from the university health service about the need for students to come and have a blood sugar check up in the near future. While this may have biased the response rate (for example, by positioning my project as a study sponsored by medical professionals), sending out my letter in this way seemed to me to be a necessary decision in order to keep gatekeepers' good will. Gatekeepers were quite firm in sending all three things (insulin/reminder/my letter) at once in order to keep costs down.

19 students with Type 1 diabetes responded to my study, which is an 11% response rate. The number of people who responded was therefore quite low, though similar response rates have been found in studies similar to mine (Eaton et al 2001). However, I was looking for an "illustrative rather than representative sample" (Valentine 1997: 112), for meaning rather than representativeness. I was therefore happy with the sample of people who responded because there was a good spread both in terms of age and the stage respondents were in their university careers. It is important to note that when I say sample here I am not referring to a sample of a group representative or typical of all young people with diabetes, or even all students with diabetes. A sample here refers to a group of people whose practices are illuminating. Mitchell (1983: 206) notes "the positive role of exceptions to generalisation as a means of deepening our understanding of social processes". As he points out, the advantages of studies such as this one is that the respondents who take part often *are* exceptional; their attitudes, practices and narratives can productively challenge the 'universality' of the findings of more 'representative' studies by highlighting the differences that exists between members of a particular group or category.

Several further points can be made. Firstly, all of the students who responded were white. Secondly, while I did not give interviewees a questionnaire soliciting socio-economic information, all of my respondents, with the exception of Kirk and Sylvia, attended red-brick universities, which often have a high proportion of middle-class



students. It is likely therefore that my study continued a trend in research on young people with diabetes to focus on middle-class young people and young people from the majority ethnic group (Schur et al 1999).

A list of respondents, their ages, how long they had diabetes and the courses they studied are listed in **Figure 6**.

#### **List of Respondents**

**Alexander:** 20 years old. 2<sup>nd</sup> Year engineering student. Had diabetes for 10 years. Did 2 interviews.

**Alice:** 19 years old. 1<sup>st</sup> year biomedical student. Had diabetes 8 years. Did 2 interviews.

**Christina:** 20 years old. 2<sup>nd</sup> year language student. Had diabetes 6 years. Did 2 interviews. Diary completed.

**Elayne:** 23 years old. Postgraduate student. Had diabetes 10 years. Did 2 interviews.

**Erin:** 18 years old. 1<sup>st</sup> year arts student. Had diabetes 7 years. Did 2 interviews.

**James:** 21 years old. 3<sup>rd</sup> year med student. Had diabetes 8 years. Did 3 interviews. Diary completed.

**Jason:** 19 years old. 2<sup>nd</sup> year engineering student. Had diabetes 8 years. Did 2 interviews.

**Kirk:** 18 years old. 1<sup>st</sup> year engineering student. Had diabetes 1 year. Did 2 interviews.

**Lars:** 24 years old. 4<sup>th</sup> year med student. Had diabetes 10 years. Did 2 interviews.

**Laura:** 18 years old. 1<sup>st</sup> year arts student. Had diabetes 6 years. Did 1 interview.

**Lilya:** 19 years old. 2<sup>nd</sup> year psychology student. Had diabetes 4 years. Did 2 interviews.

**Lorna:** 24 years old. Postgraduate student. Had diabetes 7 years. Did 2 interviews.

**Maria:** 23 years old. Postgraduate student. Had diabetes 9 years. Did 2 interviews.

**Michelle:** 19 years old. 2<sup>nd</sup> year law student. Had diabetes 5 years. Did 1 interview.

**Naoimh:** 20 years old. 2<sup>nd</sup> year med student. Had diabetes 5 years. Did 2 interviews. Diary completed.

**Sylvia:** 24 years old. 2<sup>nd</sup> year Fashion design student. Had diabetes 4 years. Did 1 interview.

**Vincent:** 23 years old. 2<sup>nd</sup> year biosciences student. Had diabetes 9 years. Did 2 interviews.

**Figure 6.** List of respondents.

In the material I have discussed so far, then, I have explored both my research design, and the reasons why I chose to use particular methodologies. In this section I am going to discuss how my methodological techniques operated in practice.

### **3.5. Research in practice**

Firstly, research diaries proved to be a relative failure. Only 3 interviewees completed them. There appeared to have been several reasons for this. Firstly some of the interviewees (Alex and Jason) said that they didn't know how to write diaries. They felt that the two examples given at the front of the research diary weren't sufficient for enabling them to 'grasp' how to write in a diary format.

Secondly, many of the interviewees just never got around to completing their diaries, for one reason or another. While Verbrugge (1980) notes that diaries have good response rates for researchers prepared to put some effort into 'chasing up' participants, I found chasing up hard to do in practice. If an individual hadn't completed the diary by the time they said they would, I felt there were only a certain amount of time I could email them asking how things were before I felt like I was hassling, rather than encouraging, them. While not all of the interviewees discussed specific reasons for non-completion of diaries, those who did said there was either too much going on in university to think about, or get around to writing, diaries. Erin noted that she didn't like having to sit down and engage in unwanted practice, which she felt the diary was, when she could watch T.V. or do something more important or relaxing. In the end, I decided that I would interview respondents again without the aid of a completed diary, and follow up on things they said in their first interview. In place of getting them to keep a diary I asked interviewees if they could describe what they did for the week before our interview. I accepted the loss of information that abandonment of diary form would bring.

Those 3 respondents who completed diaries (Christina, James and Naoimh) did, however, provide some very interesting and useful information.

For example, Christina's diary highlighted a number of concerns that were important for this thesis. Firstly, it emphasised the events she considered to be important (at



least, given her perception of my research concerns) on any particular day with regards her diabetes, the most obvious of which was her need to, and the difficulty of, continually balancing blood sugars. Her diary also articulated the emotional importance good control and being independent had for her, and the way her need to maintain good control in one dimension of practice (having good diabetes control) could conflict with her need to have good control in another (controlling weight). The diary therefore showed that Christina negotiated competing moralities of practice. It also demonstrated the difference space makes to diabetes control. Being in a different place placed her in a different state of mind, a different emotional state, which influenced her blood sugar control. Mind, body and spatialities are all revealed as being linked in her diary account.

**Christina- diary- 22<sup>nd</sup> April 2003**

First day of lectures so up at the crack of dawn in order to leave the house at 8.30 am. Always hard settling back in as sugars go mad because I am emotional and homesick which makes my sugars jump around and also totally different lifestyle up here compared to at home

Woken up at 5pm when housemates came home so did a test, was 6 and headed down to cook some tea. Not hungry as had to pick all day and really fed up with amount of calories consumed so sulked but gave in and decided really needed to be sensible so ate pasta and salad

Went to bed at 11pm and sugars were ok plus had lost headache and felt so much better – happier as soon as settled and sugars ok

**Christina- diary- 23<sup>rd</sup> April**

Headed home with my friend at 5pm and began to feel a little low yet again so had yet more lucozade and cooked tea when got in

Told my friends about this diary and they thought it was really cool and a good idea as I tend to be quite independent and will not discuss diabetes with them really, which makes them worry even more! I guess I just hate being dependent on people so like to deal and control with it myself

Ok, did yet another test and injection and headed to bed as all ok at 3am.

The interview-diary methodology could have a number of positive, if unexpected, effects for interviewees as well. As I will show later on in this thesis, one of the main problems James had with his diabetes when he was in university was testing his

blood sugars regularly. These difficulties had both gendered and spatial components. With regards the latter point, the lack of structure in university life meant it was difficult for him to order his practices in way he considered ideal. Secondly, because of his experience of the ‘dawn phenomenon’ (whereby his body produced cortisol in the morning, increasing his blood sugar levels), he felt that there was no point testing as his blood sugar levels were consistently elevated. As such he felt he was losing a battle against his diabetes, which reduced his desire to test. However, at the same time he also felt anxious and guilty about his ‘bad’ practices. While his guilt was later resolved by going on the DAFNE programme (something which will be discussed in detail later in section 6.3.), the interview-diary-interview I did with James enabled him to clarify and crystallize a lot of the reasons why he had stopped testing in the first place. The methodologies made him reflect on the adequacy of his own practices, and led him to resolve to change himself for the better. These methodologies therefore acted as what Foucault would call ‘technologies of the self’ (technologies of the self are discussed in more detail in section 5.2.1.). This is a somewhat common occurrence in the use of health diaries. Verbrugge (1980: 87) for example notes that “because of participating in the study, respondents’ perceptions of symptoms and their health behaviours may change”. What perhaps intensified the impact of these methodologies upon James was the fact that I first interviewed him two days after he had engaged in intensive binge drinking practices. At the time of our interview he had been experiencing intense cognitive dissonance about his binge drinking, principally because he was aware that such practices would negatively affect his diabetes control; they also conflicted with his sense of who he was as a person, namely a well controlled diabetic. As I will discuss in section 4.5., James’ drunkenness seemed to have led him to develop what Giddens (1991) would call a fateful moment, a moment where practices are fundamentally reflected upon, and resolved to be changed for the better. Keeping a diary seemed to have clarified this moment/process because it made him meditate even more closely upon his practices and for a more sustained period of time than he otherwise would have done. Keeping a diary also increased James’ anxiety about the effect his practices could have on him in the future, which further intensified his self-regulatory activities. At the start of our second interview James noted:



James: After the interview as you probably know, I found it [interview/diary] really interesting. Really looking at myself...which was useful and...I have done considerably more bloodtests so it has worked, just talking about it. But I've not been recording them. But it felt good, yeah. I didn't...the interview didn't upset me, keeping a diary didn't upset me. It's only ten minutes at the end of the day so.

Myles: And did you find...I thought it was very interesting at the end of the diary where you said you almost found yourself becoming a hypochondriac.

James: Oh I did write that didn't I! Cause I was just focusing on everything quite a lot and...and also, it's weird doing medicine...you pick out on things and think 'oh, I've got that at the moment'. I've got pins and needles, or neuropathy or something! And yeah, you do feel sort of a hypochondriac.

Myles: You just seemed to say that since you started writing it you were like hyper-aware of everything.

James: Yeah, absolutely. That's exactly how it was. Yeah. Which was quite a good thing. And I have become more aware about thinking about...my diabetes a lot more. This is just something I've been thinking about for the last couple of weeks, I could be blind by the time I'm sixty five, what with diabetes in my family and its history. And that's not a very positive thing. But it's stuff like that I use to keep me testing and things like that. So that's how I'm making myself test more frequently. Whereas before I wasn't.

Interviews proved to be a more successful methodology than research diaries. Even those respondents who did not complete a research diary were usually willing to do a follow up interview. An important reason for this is that respondents felt that interviews were less hassle to do than research diaries, as they could be completed in just over an hour.

As the interviews progressed, material brought up in earlier interviews was incorporated into interviews done with later respondents. As such, the topic guide continually evolved. For example, the liberating effect technologies had for my interviewees' practices and identities proved to be an important theme, something which I hadn't anticipated before my fieldwork started.

### **3.6. Positionality**

Questions about positionality were important in 'the doing' of the interviews. Hertz (1995: 432) notes that interviews, from the moment researcher and research participant come into contact, "become a socially constructed matrix of multiple

identities- both the researchers and the respondents”. There is now an extensive body of evidence showing that identity differences and power differentials affect social interactions in complex ways (Valentine 2001, Dyck 1999, England 1994, McDowell 1992). The researcher is very much part of the research. This literature has also demonstrated the importance of researchers at least trying to think about the positionalities and motivations of the individuals involved in the research process, and attempting to take these understandings into account in the writing up of research findings (Dyck 1999, McDowell 1992). England (1994, see also Valentine 2001) deems this process of taking into account ‘reflexivity’, which she defines as a “self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher”. Reflexivity involves the researcher taking a critical step back from the research in order to look at his or her own practices more objectively (Guillemin and Gilliam 2004).

Reflexivity isn’t necessarily easy, however. Rose (1997) wrote about the feelings of failure that stemmed from her difficulties achieving reflexive awareness of her own practices. She argued that the idea of being objectively able to know the self through “transparent reflexivity” is impossible (ibid: 309). Because identities are so complex, gendered, classed, sexualised and so on, and because, from her psychoanalytic perspective, they are influenced by unconscious processing, she argues that it is impossible for individuals to know themselves or their situation completely. What she thinks reflexivity does is enable the researcher to access a (distorted) representation of the self. She argues that individuals who say that they are engaging in ‘self-conscious analytical scrutiny’ of the sort described by England are engaging in a ‘god-trick’, pretending to see things clearly when in actuality things are too complex to be definitively discerned. Her argument stems from the fact that she (1997: 314) sees the self as not:

“coherent but a decentred site of differences...un-centred, un-certain, not entirely present, not fully representable: this is not a self that can be revealed by a process of self-reflection”.

Rose’s position is useful for being a cautionary call “to inscribe into our research practices some absences and fallibilities while recognizing that the significance of this does not rest entirely in our own hands” (ibid: 319).



Her argument can be criticized in several ways, though. While Rose contests that one is engaging in a ‘god-trick’ when one attempts to justify, explain and analyse one’s practices, as Giddens (1991: 32) notes “agents are normally able, if asked, to provide discursive interpretations of the nature of, and the reasons for, the behaviour in which they engage”. While it could be argued that such discursive interpretations are themselves ‘god-trick’ distortions produced by the unconscious or through performance, if this is true, then we would never be able to know anything about ourselves, because everything we thought could/would be deceptive, or we would be fooling ourselves (though I am sure the latter happens much more than people would like to admit). Individuals do not (all of the time) experience this process of accounting as being problematic.

Nielson (1999: 350) notes, and I agree with her here, that Rose’s feelings stem from the fact that she is “hostile to *any* notion smacking of conscious awareness/action”. Rose (1997) argues that:

“There is no clear landscape of social positions to be charted by an all-seeing analyst; neither is there a conscious agent, whether researcher or researched, simply waiting to be reflected in a research process” (ibid: 316).

Drawing on Butler’s (1993) arguments, Rose sees subjectivities as being constructed through process. She sees reflexivity bringing the self that one is attempting to analyse into being. From this perspective, reflexivity is circular; it creates the self it seeks to analyse. But the question must be asked: just because there is a transparent self does not exist, why does this mean that one cannot reflect upon one’s practices and motivations successfully, and theorize about those of others (with suitable caveats)? For Rose, the reason seems to lie in the way she conceives of agency only in stereotypical terms: that one can know the self completely, or one cannot know it at all (Nielson 1999). I believe that this approach is flawed for two reasons. Firstly I believe that you can know parts of yourself, motivations, desires and that on many occasions you can discern some of the effects your practices and presence have on other people. Secondly, by drawing on Butler’s (1993) work, Rose argues that it is impossible to know the self because it does not actually exist, except as process or in the becoming. This ignores both the elements of constancy in the self (for example, people have a sense of themselves existing *as* individuals across space and time with

semi-constant desires and motivations). In fact, experiencing the self as fragmented is not something that I would imagine most people would consider to be a positive experience. Because Rose's approach is so all or nothing, I think that, in the end, her critique of positionality amounts to a straw-man attack on existing approaches; it seeks semantic rather than radical change. Her argument is one:

“which understands the imperative to situate less in terms of surveying positions in a landscape of power and more in terms of seeing a view of power as punctured by gaps precariously bridged” (ibid: 315).

Her conclusion is that “all I'm suggesting in this article is that feminist geographers should keep...worries, and work with them” (ibid). But they do (or at least should do) this anyway. Guillemin and Gilliam (2004) note that researchers think about their positionality not to provide a 'true', definitive, accounting, but rather to promote reflection about how they develop and interpret knowledge during and after the course of the research process, for example what kinds of things influenced the kinds of questions asked and how they believe this affected the information gathered, and, ultimately, representations constructed from the research (Guillemin and Gilliam 2004).

With all of these points and provisos about reflexivity in mind then (I believe that one cannot know everything, but contra Rose I believe that that should not stop you trying, and I also believe in an 'I' that stays at least partly constant across time and space), I will briefly examine issues about positionality in my interviews. I will discuss my own feelings and reactions to what my interviewees were saying, and discuss how I believe this affected the course of the interviews and the narratives that were constructed in the interviews. I will also examine how my interviewees positioned me within the interviews, using evidence from the transcripts. At points I make reference to what I believe my interviewees thought or believed. Following what I believe to be the positive aspects of Rose's paper I phrase these statements hesitantly (in terms of 'I think' and 'I believe'), and highlight points where my respondents noted something but I did not know how to interpret it.

Elwood and Martin (2000: 649) note that it is important that interviewers think about how the spatial location in which an interview takes place influences the interview



itself, as different interview sites have different implications “for the power and positionality of our research participants”. Spatialities, where the interviews were actually done, proved to be important, a finding shared by previous research (Elwood and Martin 2000, Kitchin and Tate 2000, Parr 1998, Valentine 1997). In all cases I let respondents choose the place where they wanted to do their interview. In general, most of the interviews were completed either in student bars or clubs, with three being done in interviewees’ houses. Valentine (1997) notes that university is often a good place to have an interview as it is quiet, but listening back over the tapes, it was sometimes difficult to distinguish interviewees’ comments from Beyonce singing ‘Crazy in Love’ somewhere in the background. Furthermore, it was often difficult to find a room that had not been booked. While these spaces of student sociability were often not the most convenient to do a tape recorded interview, I did not suggest to my respondents to do the interviews anywhere else, especially with female interviewees, because I was conscious that women are often aware of sexual risk around strange men (Koskela 1997). In terms of putting my respondents at ease over safety/sexual risks, I felt that doing the interviews in public spaces was important.

There were several instances where I felt spatial location influenced the course of my interviews. For example, I did my first interview with Erin in the student coffee shop in her university library. About half way through the interview, three male students came in and started playing rugby, pushing and throwing rugby balls to each other. This was ok until they crashed in to the table next to the one where we were doing our interview, and then decided to sit down at it. Because they were so close and could hear everything we were talking about, I asked Erin if she wanted to go somewhere else, but she said staying where we were was fine. Realistically, there was no where else we could go to do the interview, except back to her place, as Erin lived in a hall of residence on a campus university, and it was raining heavily outside. Everything else was closed, and it was 30 minutes into town by bus. While the male students didn’t seem too concerned about the tape recorder next to them, I was much more conscious of the kinds of questions I was asking Erin. Consequently, I decided not to follow up on one point which she had raised earlier in the interview, which I thought was interesting, namely that she had started on the pill since she had come to university several weeks beforehand, but had since found out she was at a higher risk of suffering complications from it because of her diabetes. However, I was

uncomfortable about asking these kinds of intimate questions when other people were so close.

Many of the topics I covered with my respondents could be described as sensitive. Corbin and Morse (2003) note that while any topic has the potential to be regarded as sensitive, some are likely to be more sensitive than others. These are topics that relate to individuals' personal lives. Several of my respondents considered diabetes to be part of their personal, rather than social identities, and didn't like other students knowing that they had the condition. Parr (1998) notes that an advantage of in-depth interviewing lies in the way it allows researchers to explore individuals' feelings about a particular matter. However, what may be good in terms of research could be complex to deal with when sitting at a table with an interviewee. Because "open-ended interviews are open-ended" (Swain et al 1998: 28), they can often take on a life of their own and bring up topics which participants may not have been expecting to be brought up. As such these kinds of interviews may be difficult to deal with by researcher and research participant. How one deals with them, though, can be important to the success of the interview.

In some interviews my respondents' feelings about their alcohol consumption practices was clearly a sensitive area. For example, in my interview with Kirk alcohol emerged as a key form of consumption through which his identity as a normal young person was constructed. However, alcohol consumption was also something that Kirk felt guilty about. He was anxious that alcohol consumption could deleteriously affect his ability to perform valued forms of masculinity in the future. What intensified Kirk's anxieties here was his opinion that he should be more in control of himself, and that by not being sufficiently well controlled he was letting himself down. At the same time though, he needed to go out clubbing, to 'have a laugh', because this enabled him to demonstrate to himself and to others that diabetes didn't control him. Alcohol consumption was an emotionally ambiguous practice for him.

Kirk: I know I've got to be sensible about things so, um, I just want to go out and have fun all the time and have a laugh. I'm not too concerned about how it might affect me when I'm older. I know you can go blind or lose body parts or feet. I'm not too bothered about it really. It might be considered to be a bad



attitude but I do not think it is really. You cannot drink alcohol all the time. I mean, it's not like I'm an alcoholic...it's just hand in hand with going out.

Myles: In fairness, a lot of university culture in every university in England and Ireland does revolve around the consumption of alcohol.

Kirk: Yeah, unfortunately. I think it did worry my Mum a bit. She used to get really, really worried about me when I did go out. But she's used to it now, she just treats it as normal. She knows I look after myself and do my injections and eat the right things. She's a mum though and keeps banging on about things.

Several important things are happening in this narrative. In the first instance Kirk is attempting to position himself as someone who is unconcerned about his diabetes, someone for whom diabetes is 'no big thing'. This kind of virtuous approach to suffering was a theme that came up, at some point, in all of the interviews. Respondents would say that diabetes didn't affect them, or that it wasn't the worst thing to have in the world, or something similar. Research on illness narratives has demonstrated that telling stories about the self is a performative act (Bury 2001). Identities are constructed within narratives, in "shows that persuade" (Radley and Billig 1996: 221). Frank (2000) argues that illness narratives enable individuals to demonstrate that they have, or can, overcome the disruptions their condition causes to their lives, to show that it doesn't affect them. They are narratives in which desired, moral versions of the self are enacted. Consequently, illness narratives often cannot be said to reveal an essential self as much as "a preferred one, selected from the multiplicity of selves or persona that we all switch between as we go about our lives" (ibid: 7).

Kirk, however, had difficulties sustaining his preferred performance of an unconcerned self in this narrative. His narrative oscillates; while he is trying to construct a 'virtuous self', he is clearly aware of, and feels guilty about, his bad practices. By noting that everyone in university drinks alcohol, then, I attempted to help Kirk deflect some of his guilty feelings, to solidify his performance of a moral self. I positioned his practices not as matters of personal irresponsibility, but as the common, if unfortunate, practices of the student body. Jenkins (2004: 72) notes that in inter-subjective interaction an emphasis is often placed on "interpersonal trust, tact and collusion, interactional damage limitation and repair". This kind of interpersonal

support is a practice that was, I believe, necessary to the success of my interview with Kirk. Because I was exploring material in our interview which Kirk felt uncomfortable and embarrassed about, I felt it was necessary to help mend any damage, anxiety or guilt the interview caused. This was not a conscious decision, but more of a pressure I felt from inside of myself to say something to make him feel better. I would have felt uncomfortable letting Kirk's ambivalence go unremarked upon. I believe it is in this, often unarticulated, way, that trust and rapport were constructed within the space of the interview.

On other occasions, though, 'supporting practices' felt flat. For example when I interviewed Alice the second time she noted that she felt that she was overweight. I said this wasn't the case, that I thought she was slim. She didn't agree with this at all, leading to a slightly awkward moment in the conversation. From my perspective, the difference between the success of supporting practices in my interview with Kirk, and failure with Alice, was that with Alice I directly contradicted Alice's preferred definition of the situation, whereas I supported Kirks. Alice appeared to take my pronouncement as pointless flattery. She became a little annoyed, I think, at my attempt to redefine what she saw as the obvious truth. It's also possible that she felt I was coming on to her.

Myles: I think you're thin.

Alice:...I'm not thin; I'm overweight. The hospital have told me I need to lose weight. And like my friends have told me I do not look overweight, but I do not like myself the way I am when I try clothes on or whatever. So. It's just because I'm the same build as my mum. Like me and her have the same sort of genetic...that's what it is (laughs). So. That's...that.

How my interviewees positioned me was also important, because it meant some topics were or weren't covered. Early feminist research often argued that female researchers had insider status with the women they studied, because they shared a history of relative powerlessness at the hands of patriarchal structures. All women were in a sense 'sisters' (Stachel and Lawson 1994). Extending this argument to my study, it could be argued that because, like my interviewees, I was a student, I too had a shared background with my interviewees, which would have facilitated my easy development of an insider status, someone with a more direct access to



information and a more intimate attachment to respondents than 'outsiders' (Valentine 2003b). This is not, however, completely true. While my experiences were often not completely different from those of my interviewees, they were not exactly similar either. Also my respondents' perceptions and reactions to me could have been influenced by things I did not know about. I cannot address such perceptions. At times, however, my respondents articulated clear differences between us that can be interpreted. Kirk for example told me that he was surprised that I could remember what it was like to be 18 (because I had a beard), and Alice indicated that she had some 'women's problems' that she didn't want to talk about. My physical body here influenced my position in relation to that of my interviewees. For some other students, the fact that I was a student appeared to help them talk freely about doctors/health care, as they said that I wasn't going to judge them. The fact that I was a *Ph.D* student was important to other interviewees (especially the ones studying medicine or law) who felt that *Ph.D* students were serious researchers, like themselves. For other interviewees my status as an Irish citizen was important. Two of my respondents came to Ireland from England when they were children and so seemed surprised and enthusiastic to find out that I was Irish. Some interviewees also saw me as a vehicle for communicating important information about their lives and practices to the medical establishment. I agree with Rose (1997) in the sense that in many cases I didn't know what the significance that these positionings had for my respondents, but it is clear that I had no one identity across all of the interviews; who I was, and what I was, changed for each interviewee.

Interviewees often seemed to find doing the interview to be beneficial. Elayne noted that one of the reasons she agreed to do the interview was because she felt that the material covered in my *Ph.D* was something that should have been covered by her medical doctors when she came to university. I was someone who could use her descriptions of the practices she engaged in at university to better inform the medical establishment about what it was like to be a student and live with diabetes. England (1994: 85) and Garvin and Wilson's (1999: 303) statements, that "fieldwork is inherently confrontational" and an "imposition upon respondents 'valuable leisure time'", these arguments are not really applicable here, where the interview had benefits for both people involved (though it could perhaps be applicable for the failure of the diary methodologies discussed above).

Myles: Were you ever given any specific medical advice when you came to university?

Elayne: Nothing. At all. No. Complete lack of. Notable by its absence I would say. Yeah. Nothing at all. Which I thought...some of those questions you [asked] you know, they're things that should have been...even if somebody had just, said please bear in mind that you'll be living with people who do not know you're diabetic, do not understand the symptoms, most of them will never have encountered a diabetic who injects before. There was none of that. I mean, it was something I was very aware of anyway. And maybe they thought 'oh, she understands'. But there should have been something there. Cause it's a big thing you know, going from...you know, living with your parents for ten years and being diabetic and then...living with a whole set of to her people who do not know anything about it.

Sylvia saw me as someone with whom she could talk to about the difficulties of living with diabetes.

Myles: Well, when you go to see them, do you ever go into meetings [with doctors] with an idea of what outcome you want?

Sylvia: I don't know. I want to talk it through more. But I suppose doctors do not have time, which is why I saw the counsellor, someone's who's just there, who you talk it through with them and they just listen. I suppose something like that. But I suppose they do not really have the time or patience for that. But sometimes you just want someone to sit down so you can just sort of rant on, a bit like now. Someone listening.

Bury (2001) argues that before the 19<sup>th</sup> century the primary focus of health practitioners was on listening to their patients' narratives (usually because of the ineffectiveness of most of the other things they did). In the 19<sup>th</sup> and 20<sup>th</sup> centuries, however, with the rise of scientific biomedicine, doctors became much more focused on normalisation, on connecting patients' narratives to particular diseases, and curing them of these diseases. The importance of patients' narratives was therefore attenuated in this paradigm. Bury notes, however, that with the growth in the number of people with chronic illnesses, narratives have become more important. Kleinman (1988) in fact argues that in face of chronic illness, the physician may best act as a witness to suffering and as a practical informant. Sylvia, however, didn't feel that doctors had the time to talk to her, to see things from her point of view, to explore the meanings of her practices in context. The interview was a situation, then, in



which she could talk, relieve (di)stress. She noted that it would be nice sometimes to be able to talk to someone if she wasn't testing, "having a lapse", someone who wouldn't judge her, someone who would "hug, not push". The interview was also a situation, I believe, in which identity work could be done, a space in which a moral self could be constructed. By contextualising practice, it could be justified. It was important to her that other people, especially doctors, be aware that the reason she had stopped engaging in the 'right' practices was not from personal failure, but because of her spatio-temporal situation.

### **3.7. Ethics**

Ethical considerations were an important part of both the research design and the research process. With regards the initial design of the project, my project was approved by both my supervisory panel, and also by a Ph.D. upgrade panel in the Dept. of Geography, who acted as an ethics approval panel.

Each of the university health services where my research took place set up a meeting to discuss the ethics of the project, and the risk of harm the study posed to their patients. In all cases, doctors decided the research design was sound and the risk to participants low, so the study could go ahead.

Before each interview, respondents were given information about the research (see **Figure 7**), including the preliminary list of topics I wanted to cover during the course of our conversation. Respondents were all asked to sign a consent form to show that they understood these issues. To reduce the possibility of harm to my respondents (many of whom felt that their diabetes was part of their personal rather than social identities) I chose to anonymize all of my respondents' names. I also chose not to name the universities where I did my research, and changed the names of the courses that my interviewees' studied.

Dept. of Geography

***The University of Sheffield***

CONSENT FORM

Thank you for deciding to take part in this study on students with diabetes. This research seeks to explore students with diabetes own understandings of their diabetes, and also their understandings of the university environment in which they work and live.

This work is interview and diary based. You should be aware that extracts from interviews/ diaries in which you take part may be used in support of my Ph.D thesis, for conference presentations or alternatively for academic publications. Your name and identity will remain confidential in any publications or discussions, and will not appear on any tapes or transcripts resulting from the interview. I will not allow anyone other than my research supervisor to review a transcript of the interviews. All materials generated from your interview will stay in my direct physical possession. Pseudonyms will be used for all quotations.

Taking part in this study is entirely voluntary. You do not have to answer any questions that you do not wish to. If you have any further questions please do not hesitate to ask me.

Myles Balfe.

-----  
By choosing to take part in this research I recognize that extracts from any interviews/ diaries in which I take part may be used in support of the Ph.D thesis on 'University Students with Diabetes', or alternatively may be used in conference presentations or academic publications. I recognize that my name and identity will remain confidential in any publications or discussions, and will not appear on any tapes or transcripts resulting from the interview.

Figure 7. Consent form.

In general I tried to approach each interview as a supplicant (England 1994), someone who acknowledged that my interviewees knew more about the topic in question than I did. I also tried to be as sensitive as I could in how I asked questions, and informed respondents that if there was any topic they did not want to answer then they did not have to. After each interview I spent up to two hours talking to interviewees about doing the interview, and general life stuff.

Ethical issues arose both within and outside of the interviews. For example, while I noted previously that I tried to approach each interview as a supplicant, at times this



strategy could backfire. After one of my first interviews my respondent asked me what I thought about his practices. I said that I wasn't qualified to judge him. He in turn said that my attitude was a 'cop out', and asked me what I really thought about him. I said that I thought what he was doing seemed a bit crazy and that he seemed to be lying to himself when he said that diabetes had no effect on him. Parr (1988) described similar situations in her fieldwork, where she was asked by a respondent what she thought about her respondents' practices. Parr notes that these situations are tricky. She described her own horror at being asked this question, as she didn't want to position herself as someone who could pass normalizing judgements. In contrast to Parr, I didn't become emotionally upset giving my opinion, even if I was passing judgement. In fact, I felt more uncomfortable saying that I wasn't qualified to comment on my respondent's practices. I felt that by saying this I wasn't acting like a normal human being, but trying to position myself as someone trying to pretend to an objectivity that I didn't really possess. My respondent picked up on this. And he seemed to respect that I told him my opinion straight out. He said that he agreed with it. And in fact, saying what I did seemed to relax him. We got on well after that. In contrast to England's (1994) comment about the negative confrontationality of fieldwork, confrontation here was appreciated, and I would say, sought.

Ethical issues arose within the interviews themselves. One area where this was especially pertinent related to my need to ask questions to obtain the information I sought, and balance this with the need to avoid causing my interviewees undue harm or upset (this didn't necessarily mean avoiding sensitive topics, however. As I used Sylvia's narrative to argue above, interviewees often found it a positive experience to talk freely about matters that they found troubling). An example is useful. As I interviewed my respondents I became interested in the effects that their diabetes technologies could have on their appearances and self-identities. This was a theme that came up in several of the early interviews. When I interviewed Lorna towards the end of our conversation I asked her if there was anything else that she wanted to talk about. She mentioned that she didn't like carrying around insulin pens. In previous interviews, other female students had discussed similar feelings. These were generally related to the effects that pens had on their outfits, and their appearances as 'normal' young women. Lorna mentioned that she didn't like carrying technologies for practical reasons. However, she framed this statement within the context of a

discussion regarding her 'superficiality'. She became embarrassed at what she had said. She felt that she was coming across to me as someone who was vain and self-indulgent ('superficial'). I said that I did not think that she was superficial at all. By saying this I was trying to both help her do identity work (as with Kirk above), but also encouraging her to talk more about her feelings as I felt that they were interesting. She became uncomfortable, making a comment about the door, shifting the topic of the conversation away from her 'superficiality', which was marked off as an 'off-topic' area. I followed this shift by switching the questions I was asking away from insulin pens and on to chocolate bars. This again, though, was an awkward area. As with insulin pens, she felt that what we were talking about, food, appearance and weight, was 'shallow'. She adopted an ironic tone. At this point I myself started to become slightly uncomfortable because I did not want her to become upset, and I felt that she was, if not upset, becoming acutely conscious of how she was presenting herself. At the same time I was also becoming more interested in her feelings of 'superficiality', especially as she herself was the one who had brought them up. I decided to probe the matter from another direction. In previous interviews I did, on occasions some interviewees said diabetes technologies didn't affect them in any way, or indicated at first that this wasn't an area they wanted to talk about. However, when the issue was questioned further, respondents often 'opened up', and revealed much more ambiguous feelings about the matter than they initially presented. For example, when I interviewed Kirk he said throughout our interview that he was unconcerned about his diabetes, but often when I followed up on such statements he proved to be much more uncertain and anxious about his practices.

**Myles:** And when did you last do your HBA1C?

**Kirk:** Um...presumably I did it...I go to see a senior doctor every six months at the hospital. But I missed my last appointment because it was at home and I couldn't make it. So it was about last August. So I do not really remember what it was, but I'm not really concerned about that stuff really. It doesn't really concern me. Maybe that's naïve.

**Myles:** Are there times when you think it's naïve?

**Kirk:**...Yeah. Cause I'm not stupid. Because I know it is serious. But....yeah...but...if I think about it too much, if I think about it too much then it might get to me and I do not like that.



In Lorna's case, I mentioned that other diabetic students engaged in similar practices, and had similar feelings, to her. Lorna became interested by this (one question which my interviewees often asked me was how other students dealt with their diabetes, because most of them had never met another student with the condition). I made a general comment about my other female interviewees' reasons for wanting smaller insulin pens (because of what they felt was the negative relationship between appearance and technology). Rather than following up on the matter, though, Lorna again said that appearance was of no concern to her. This time her tone was definitive. Since the interview had been going on for over an hour by that point, I decided to stop it there. I felt that if pressing and probing further would be counter-productive to the construction of a successful rapport. There was an ethically complex process going on in this interview. I was attempting to avoid upsetting Lorna and disrupting her presentation of the self through the indirect way I addressed topics that were of interest to me and important to the success of the project. Looking back with hindsight now, though, I believe that it would have been better to directly address the issue of why she was uncomfortable rather than trying to skirt around it (as I did with Kirk when I asked him if he felt that he was being naive). While I was trying not to cause distress, I think that I was going about it the wrong way (in part I believe this stemmed from my own lack of confidence doing interviews at this time). In later interviews, when similar situations came up I tried to address them directly, though not in a confrontational way. Being direct with people seemed to be appreciated (as my respondent above who asked me what I thought about him seemed to appreciate). My interview with Lorna demonstrates that there is often some uncertainty in knowing just how, how much and how far to probe an account if one believes that there is more to a narrative than is being initially provided by a respondent, to balance respondents' need to do identity work with ones' need to acquire important information.

Myles: Um, I think that's about everything. Anything else?

Lorna: Um, I don't think so. No, because all the stuff I say just sounds so superficial and vain it's just incredible.

Myles: No it doesn't.

Lorna: No, wait for it. When you go out in the evening, you should have insulin pens that are really, really small. Small enough to fit in a handbag, and not big ones. I don't know have you ever noticed girls handbags. Probably not.

Myles: I was actually looking at the handbags of the girls across the road, very small.

Lorna: Very small. Insulin pens and blood testing equipment will not fit in them. So I have like a big...not too big for an evening out, but one where you just want your purse in it, or key. If you have six cereal bars it would be nice to have shrunken insulin pens.

Myles: As in the aesthetics or...

Lorna: Ok, a man just goes out with his wallet. So if he is diabetic he has his pen in his pocket. Whereas women don't tend to have pockets on their skirts or whatever. So if you have a big heavy bag with all of your stuff in it then it's a pain. But if you've got a little bag then it's much easier.

Myles: Ok, that makes sense.

Lorna: Like if it's raining you take your umbrella. That's more the same kind of thing. So we can stop it raining or we can get shrunken insulin pens. Do you see what I mean. So.

Myles: Ok, I get that.

Lorna: That sounds so superficial.

Myles: That's not superficial. Not at all.

Lorna: I can't think of anything else.

Myles: Like it's things like that which the whole world is made up of, all of these small things and people's feelings and what they want...

Lorna: I suppose I come across as someone quite confident about it. [looks away]. Tell you what they could sort that door out.

Myles: So cereal bars are your first choice over chocolate?

Lorna: Yeah, I remember they told me when I was first diagnosed that when you have cereal bars you have the caramel and the chocolate, the short acting sugar, and then the oats, so it's a mixture of the long acting and short acting. So chocolate will bring you up really high, and this will put you on an even keel. That's how I understand it. And also you feel that they're vaguely, possibly good for you. God I sound as if I'm obsessed with food!

Myles: No, not at all.



Lorna: But not the pure roasted nut ones. Got to have some chocolate [ironic tone].

Myles: Yeah, I suppose...they do kind of give the impression that they're healthier than chocolate. You know chocolate's just an indulgence, but cereal bars...are healthy!

Lorna: Crisps are healthy too you know. Crisps are really healthy.

Myles: It's true, it's true.

Lorna: I think that everything you enjoy is good for you in moderation. Can you imagine if you had a diet full of porridge or sprouts. I like sprouts, but most people don't like sprouts. So imagine that they're good for you, and your diabetes. Everything in moderation, and you enjoy it. It's just balance. You need to have, you need everything that you eat. Cause, is your dad vegetarian?

Myles: No.

Lorna: Cause I think that would be quite hard for a diabetic, just cause it limits what you eat to quite an extent. Like my diabetes would be a lot more boring if I didn't eat fish and meat. Do you eat cheese and eggs as well?

Myles: Cheese is my mortal enemy.

Lorna: Because you don't like it or...

Myles: I hate cheese so much it's unbelievable. Really.

Lorna: Because without cheese, eggs, yogurt...do you eat yogurt?

Myles: I love yogurt, but I hate cheese. So...

Lorna: Like... It's useless being vegetarian. But yeah, I think it would be quite restrictive if you were a vegetarian or a vegan.

Myles: Yeah, yeah, I think so. Some of the people I've talked to are vegetarian.

Lorna: Oh really?

Myles: If I had to go by statistics, I'd say half are law students, half are medical students, and the other half are vegetarian.

Lorna: So do people generally have the same kind of attitude as me or...

Myles: Um, yep. Smaller insulin pens, all the women do.

Lorna: Really? (laughs).

Myles: Well, you can kind of see why, there's so much emphasis put on appearance and...looking good and....

Lorna: Well I don't care what I look like, just my handbag, it's practical and convenient to have a small one.

In general like Gilbert (1994), after I did my interviews with my respondents I walked away. This is not to say that we were not in contact by email and so on, it's just that we did not see each other socially. A few days after doing my interview with Sylvia, though, I got an email from her asking if I would like to meet up.

I thought since you seemed a bit of a film buff (like me!) you would fancy checking out a film... like Irreversible (spelt wrong I suspect).

You seem like a nice guy and I hate to think of you at the cinema on your own, plus I have no-one to go with either!

Let me know what you think and if you fancy it we will have to meet up one weekend.

Hope you didn't think I'm a nutter after the interview.....I would honestly like to have a mate who's as interested in films as me.

Look forward to hearing from you.

I was initially uncertain about what to do when I got this email. I had the ethical guidelines of the British Sociological Associations' codes of ethical practice in front of me, codes which reminded researchers that they "have a responsibility to ensure that the physical, social and psychological well-being of research participants is not adversely affected by the research". I tried to work out what I wanted to do, and knew that, myself, I would like to meet her socially. I was uncertain though of what the ethics of such a practice would be. While I may have seemed like a nice person to Sylvia, she was responding to me in terms of how I presented myself in the interview, where I was a sympathetic person who listened to her, and supported her, in an exposed situation, a situation where she was vulnerable. In these circumstances people would, I believe, be inclined to trust and react positively towards others. Perhaps too much so. But then, on the other hand, would it be ethical to interview



someone and then not be available for them if they wanted to talk to you? I asked my supervisors what they thought, and both urged caution. There was a line to be crossed, and I should only cross it if I was sure that this is what I wanted. I thought about the matter for a while, and decided to meet her. Looking back now, with hindsight, I think that this was a mistake, that I did cross a line I wasn't completely comfortable with crossing. I understood the emotional context of the research, and was aware of power differentials (Wilkins 1993). I knew that researchers using qualitative methodologies have long argued that these techniques might potentially be as threatening for respondents than more "traditional methods" (England 1994, see also McDowell 1992). But I was excited about meeting Sylvia again outside of an interview situation. I was attracted to her (see Cupples 2002 for the field as a place of desire). She looked, and talked very much like a woman I had been going out with for years before hand, and who I missed a lot. I found out, though, on meeting Sylvia again that she was engaged, and living away from her partner, which is, perhaps, one of the reasons she wanted to talk to me in the first place. We talked for a few hours, but I think she became uncomfortable as time went on because she mentioned her boyfriend every so often. I didn't want to call her after that night, but felt I should a few days later, but it was awkward. I didn't call her again. In the end, then, I lost an important informant. It was the first and last time this happened. It made me emotionally, rather than just intellectually, conscious, though, of the multiple ways individuals interact in an interview situation.

In this section I have discussed how ethical and positional issues in relation to doing the interviews. In the next section I am going to explore how I analysed my interviews.

### **3.8. Data analysis**

From my fieldwork I was left with 35 interviews, each of which was about 2 hours in length. I also had 3 research diaries. Once the interviews were transcribed, I had over 850 pages of material to analyse. In this section I will discuss how I did this.

First, though, I believe that it is important to discuss the status I gave to my fieldwork material (Sandelowski 2002). My fieldwork left me a series of in-depth narratives, respondents' "verbal representations of their practices (what they say

rather than what they do)” (Jackson 2001: 211). Information about what respondents actually did, for example in the private sphere, was not present (Garvin and Wilson 1999). Furthermore, because of the relative failure of the diary methodology, participants’ narratives of their everyday “transient, low impact” (Verbrugge 1980: 93) practices were also, to some extent, absent. However the absence of diary information was compensated by the depth of information I received in interviews, obtained for example by asking respondents to describe what they did during the previous week.

There are a number of potential weaknesses to relying on narratives to the extent that I did. Sandelowski (2002) for example notes that:

“Feelings of mistreatment expressed in talk might be symptomatic of these individuals’ condition...[and] talk might be a narrative strategy designed to present themselves in a certain way or to cope with their disorder” (Sandelowski 2002: 106)

However, here it can be seen that the dangers of relying on narratives stems from naively believing them to be accounts of “authentic experience” (Sandelowski 2002: 106), and not taking into consideration the motivations people might have for telling stories about themselves in a particular way. As I have shown above, though, with my discussion of the linkages between illness narratives and identity work, I have tried to avoid simplistic readings of narratives, and instead tried to take into account my respondents’ narratives in all of their complexity. I have treated the interview as both topic and resource. To investigate meaning in interview situations I always tried to follow up on what respondents said, to probe their narratives for instances of ambiguity.

While there are some weaknesses to my fieldwork, which could be addressed by a follow up ethnographic study using participant observation, on the whole I believe that the narrative material I collected was suitable for addressing my research aims of exploring young students with diabetes’ subjective experiences of risk, control, discipline and balance while they are at university. Furthermore, the fact that people could be using interviews to do identity work is important in itself, and is certainly not, I believe a weakness.



### 3.9. Coding

I analysed each interview as I collected it. The first step in analysing the data was coding it. Coffey and Atkinson (1996) describe coding as a way of breaking data down into discrete units so that it can subsequently be rebuilt and used to inform, critique, construct and develop theory. Coding involves carefully examining the data, “marking up the transcripts with a series of ‘codes’ that label particular words and phrases for subsequent analysis” (Jackson 2001: 201). It is a practice that allows researchers to be thorough and rigorous in their analysis. It thereby helps to mitigate ‘cherry picking’, a process where researchers use selective, but non-representative quotes to support their initial assumptions (Jackson 2001, Coffey and Atkinson 1996). In my case, my initial hypothesis was that students with diabetes would go ‘out of control’ once they got to university, a state which would have had deleterious consequences for their blood sugar control. My research findings supported this assumption somewhat, especially with regards first year students, but overall demonstrated that the student diabetics I talked to often had very good blood sugar control.

Each interview was read through at least twice before I coded it. I generally coded my transcripts using words that were similar to those that my interviewees used. Sometimes the codes I used were at higher levels of abstraction, and sometimes they were descriptive. After I coded an interview, I grouped all of those codes that were thematically similar together, and labelled these groupings with a summary code, which I called a category. A category is located at a higher degree of abstraction to a code. It brings “fragments of data together...that have a common property so these fragments can be further linked together or differentiated” (Coffey and Atkinson 1996: 27). By grouping codes together as parts of a category it is possible to engage in what Crang (1997), drawing on Glaser and Strauss (1967), calls axial coding, seeing how different codes in the same category relate to each other. As an example of this process I have placed two category summaries from Lilya’s transcripts on the next two pages. In Lilya’s transcript summary 1 it can be seen that I have grouped a series of coded interview extracts together and labelled them as instances of ‘technological stigma’. The original codes with which I marked these extracts are highlighted by the bold lettering positioned above each quote. Grouped in this way

the codes in Lilya's transcript summary can be seen to be about more than the relationship between technology and stigma; they are about the relationship between technology, stigma and space. I am aware, though, that other researchers may have coded this differently, but I also agree with Charmaz (1990: 1164) here that "one researcher's conceptual framework may resemble another researcher's theory"; I believe my codings here make sense of this material. The second transcript summary describes some of the codes I identified in the transcripts that relate to Lilya's alcohol consumption practices, in particular those practices that Lilya used to minimize the risks of alcohol consumption for her diabetes when she was out clubbing.

### **Stigma- technology**

#### **Stigma- visibility- spatial management**

Lilya: Like some people won't do injections in front of everyone else and go off to the toilets to do it. Um, and I'm like, why should I do that? I'm perfectly comfortable with it. If anyone else is particularly needle-phobics, then it's going to be quite an interesting experience for them. If they have a problem with it then it's their problem and not mine.

#### **Stigma of technology**

Lilya: Like I do not like needles and injections and the associated stigma, but then if you're inhaling something it might be lung function and cannot breath properly, and I think that might be worse. The side effects of it.

#### **How would feel if brought the pen out in public space**

Lilya: Conspicuous.

#### **Pen not cool**

Lilya: Um, I guess it's probably it connects me with something and that association. Whereas if it's inconspicuous or looks cool, like a kind of fashion accessory you do not mind having it with you, it makes it in a really abstract way cool to be diabetic. Whereas that just makes it worse. Which is a bit convoluted but...

#### **Awareness of stigma- spatial**

Lilya: Yeah, I think the main time I wouldn't want them to know is when I'm queuing up to get into a nightclub. Because there's a big stigma about needles and especially with the drugs in nightclubs and things like that. So if there was ever a time not to shout about it that would be it. Which is ridiculous because you couldn't inject heroin with something like this as it's specifically for insulin but I was carrying around syringes for a while because it broke and that that was worse. Because people see the syringes and become a bit suspicious.

**Lilya: transcript summary 1.**



## **Alcohol- risk minimization practices**

### **Alcohol- balances over time- relationalities**

Lilya: Well (laughs). Well, to be honest I'm probably supposed to, and I'm probably supposed to follow all of the sensible guidelines more than a normal person would be expected to, even though a normal person should follow them anyway. But the way I've discovered with my blood sugar is that, um, usually when I drink I'll go very very high the evening I'm drinking, and then come back down to normal the next morning and wake up about eight. Um, which is great, you know, it's perfect.

### **Energy bars- hassle/ risk minimization (compare to Alice)**

Lilya: I always take my...the energy bars with me just because it's silly not to really, in case you need them. It does turn out to be an annoyance with the type of handbags I can take with you though, because you have to have quite a substantial handbag with you to fit all your stuff in it. But that's not too much of a bother though. (inaudible).

### **Telling people (risk minimization) (compare to Sylvia)**

Lilya: God yeah. You have to. Otherwise...you cannot disappear off to a toilet every time you have to have insulin or try to do a blood test on a table and you're machines beeping and your fingers are bleeding everywhere. It's just not practical. And plus from a safety point of view, if you've passed out somewhere because you're low they might think she's just drunk or whatever.

### **Keeping high when drinking (risk minimization)**

Lilya: Yes. Particularly if I'm drinking, cause I'm always aware of the alcohol thing. Because if I start of slightly higher then I won't be slightly lower the next morning.

## **Lilya: transcript summary 2.**

Several points can be elaborated at this juncture. The first relates to how I identified categories. I differ in the way I did this from grounded theorists, who try not to bring a "set of finely-honed preconceived concepts and categories to apply automatically" (Charmaz 1990: 1170). I agree with Jackson (2001) who argued that it is impossible to come to a series of transcripts without thinking about how the information contained within them relates to prior knowledge known by the researcher about a particular topic. For example, much of the recent literature on young people, and young diabetics in particular, looks at their narratives and practices in terms of risk, and so based on my literature review I came to my fieldwork with an interest in how students negotiated and conceptualised risk. This awareness was not suspended when I analysed the transcripts, as can be seen from the way I coded several extracts from

transcript summary 2 in terms of their risk minimization effect. However, neither did my awareness of theory determine my analysis. The empirical material informed and shaped my understandings of risk.

Once I had summarised the transcripts, I started comparing categories and codes across transcripts. This is one of the most important steps in developing a comprehensive analysis (Jackson 2001). Reading across the transcripts is a practice that is intended to explore “similarities and differences, connections and contradictions” amongst respondents accounts (Jackson 2001: 210, see also Corbin and Strauss 2003 and Coffey and Atkinson 1996). As can be seen in transcript summary 2, I highlighted instances where the codes in Lilya’s transcript could be productively compared with those of other interviewees. For example Alice wouldn’t take her energy bars out with her because she felt it would interfere with her ability to dance and be completely ‘normal’. She didn’t mind leaving energy bars at home, because it would only be a few hours, and so wouldn’t be too much of a risk. In contrast Lilya brought hers out because she felt that leaving them at home would be risky. Risk, therefore, was a shared discourse, but negotiated differently by both interviewees. Comparison helped develop complex categories, as I had to figure out why there was difference between interviewees’ accounts, and whether such differences emerged from a pattern or individual proclivity.

Based on this process of comparative categorization I developed 9 broad categories which I thought made sense of the material contained in the interviews. However, in many respects these categories weren’t exhaustive, *contra* the advice of Kitchin and Tate (2000). Specifically, I developed categories around the concepts of stigma, exercise, food (eating healthily and weight management), alcohol, emotions, perceptions of time, feelings of anxiety and fear, routines, risk. Codes that I put under the category of food, though, could also come under exercise. By re-reading the transcripts I eventually decided that all of these categories, broad in themselves, could be subsumed under even broader categories related to three narratives of practice: namely, alcohol consumption practices, disciplinary (food and exercise practices) practices and practices related to the use of diabetes’ technologies. These three themes were exhaustive, made sense of the material I was analysing, and were grounded in the theoretical literature. Many of the 9 themes I developed then became



sub-categories of these three meta-themes. In effect, these three themes became my three main empirical chapters, with categories such as stigma making up sections of these chapters. Structuring my material in this way also had the advantage of enabling me to explore concepts of balance and control, vital for people with diabetes, in multiple dimensions of practice.

Practice, therefore, emerged as an important stone upon which the project was built. Foucault argues that “the self...is constituted in real practices” (Foucault 1984: 369). Identities are not disembodied and anchorless, but are located by and materialized through particular, concrete practices (Moss and Dyck 1999, Mehta and Bondi 1999, Malson 1997). Saltonstall (1993) argues that if the theoretical work on health is to be considered valid, it must take into account the practices and processes through which the body is constrained and known as personal, particular and concrete. He argues that activities taken in relation to health can be seen as “a form of practice which constructs the subject in the same way that other social and cultural activities do” (ibid: 12). As I noted above, though, what I had were narratives of practice, rather than observations of them. This, however, is not a weakness, as it allowed me to explore interviewees’ ambiguous feelings about particular practices, something that has not often been done in relation to the practices of students with diabetes (Miller-Hagan and Janas 2002, Eaton et al 2001).

Finally, validity and rigour were important considerations in analysis (Baxter and Eyles 1997). Baxter and Eyles note that the most common way of ensuring the rigour of research findings is by discussing the suitability of the research methodology, using several different methodological techniques, giving information on respondent selection and giving verbatim quotations (ibid: 506). In the material I have discussed in this chapter until now I have demonstrated that my research methodology was suitable for my aims, and highlighted the suitability of my sample. In the main empirical chapters I give verbatim quotations in support of all of my arguments. As discussed above, though, I had difficulties with mixed methods; however I tried to compensate for this through a focus on everyday, micro-practices in the interviews. Baxter and Eyles also note several other strategies for ensuring rigour, including getting respondents to verify the research findings, and going back to respondents to check previous findings. In relation to respondent verification I sent

all of my interviewees copies of the three main empirical chapters, saying that if they agreed or disagreed with anything then to contact me. Two respondents wrote back saying that the findings were interesting. These respondents appeared to find the research findings credible, credible being defined as “a description of human experience such that those having the experience would immediately recognize it” (Baxter and Eyles 1997: 512). Most, however, didn’t respond. There could be several reasons for this. These students may have dropped out of university or graduated since we did our interviews. They may also have found my arguments embarrassing; it is, after all, one thing to do an interview talking about the difficulties of living with diabetes, another for a person you talked to coming back several years later with an in-depth analysis of your conversation. However, I believe giving my interviewees copies of my empirical material in full, rather than in summary form, was an ethically justified practice. Firstly, because all of my interviewees asked for a copy of the full Ph.D when it was done. Secondly, because if I was going to be representing my informants in a particular way, I wanted them to be aware of how they were being represented.

### **3.10. Conclusion**

In this chapter I have discussed the methodologies I used to implement and design my research project. I have also discussed the theoretical perspective underlying my methodological approach. In the first section of this chapter I looked at how I went about finding my sample of respondents, and the techniques and schedules, semi-structured interviews and open-ended research diaries, I used. I showed that interviews worked successfully but open-ended research diaries were more problematic. I have also discussed issues surrounding positionality and reflexivity in the interviews. In the final section I discussed how my interviews were analysed, and how I ensured my findings were both rigorous and credible. Taken together, I have shown that my research methodology was suitable for addressing my thesis aims, namely exploring the meaning practices had for my interviewees when they were at university.

There are a number of general points to be noted here. The first relates to the difficulties I experienced using research diaries. In general, I found it much harder to get my respondents to keep diaries than is normally indicated in the literature. In



retrospect, they are probably not the best methodology to do with young students who have recently left home and just wish to get on with things and be 'normal'. All the interviewees who did complete dairies were in their third or fourth year of university. This would indicate that in future research it might be best to use different methodologies for different students at different stages in their university career. On reflection, though, I do not believe that I lost too much information with the relative failure of the dairies. Like with interviews, research dairies provide researchers with a narrative of practice. In theory, the idea is that diary keepers write down in the evening information all of the relevant practices they engaged in during the day, and so record an assemblage of micro-practices. However in practice, what seemed to happen even for diary keepers who do record is that practices are recorded days after they are engaged in, when the diary keeper feels like writing. In this case, the information is much like that obtained in an interview.

Secondly, there are issues raised in this research about being a student interviewing students. Most of the current research literature on interviewing concentrates on the process of gaining access to and interviewing elites (see Desmond 2004 for an example of such research, and a list of references). Less work has been done in the recent past on interviewing peers. I didn't find interviewing people of my age with an often similar background to be a problem. However, it did raise its own set of issues. For example, as my interview with Sylvia showed, if two people are of the same age and have similar interests, and one (that being me) is attracted to the other person who is looking for someone to go to the cinema with and the boundaries are fuzzy, what an interview actually means can be difficult to ascertain. It can mean both more or less than is sometimes wanted. I am sure that Sylvia wouldn't have sent me the email that she did if I was twenty years older and from a non-student background. A further point here that is worth mentioning is the lack of formal guidelines within academic geography about what to do when you are attracted to someone and met your respondents socially. Is this best practice? There is evidence here of a need for clearer guidelines, even so you can be sure of what line you are crossing over. At present the line seems to be highly mobile.

And a final point relates to meaning- specifically what meaning practices are granted. It seems obvious to me that my interviewees felt their practices had meaning, even

when this meaning wasn't consciously articulated by them. They could all provide discursive accounts of their own actions. This being the case, while coding the interviews I tried as far as possible to keep the analytic codes close to the words interviewees themselves used, to preserve their meanings in the analysis. I also acknowledge that at many points that I inferred meaning from my interviewees' practices. While I believe it is legitimate to interpret meaning into others actions (indeed, it is impossible not to) I tried to ensure that my interpretations weren't radically different from my respondents' by checking them with my respondents. Unfortunately, not many of them replied. Where my interpretations of practice differ from my interviewees, I wouldn't necessarily say that they are wrong, however; in fact, because they are different they could theoretically be used by interviewees as a device to reflect upon their own practices, creating a double hermeneutic.

In this chapter then I have explained how I collected and analysed my respondents narratives in practice. In the next chapter I am going to provide an analysis of these narratives as they related to my interviewees' alcohol consumption practices.



**Young People, Diabetes and Alcohol Consumption**

**“To alcohol. The cause of- and solution to- all life’s problems”**

**-Homer Simpson**

#### **4.1. Introduction**

This chapter explores my interviewees’ alcohol consumption practices. Alcohol consumption plays an important place in representations of student life and everyday student practices, often providing a way for young people in university to build a sense of community and construct themselves as a student body. For many young people at university, alcohol consumption provides a way of becoming and being like everybody else, of being ‘normal’.

For students with diabetes, however, alcohol consumption can be risky. Frey et al (1997: 38) argue that for young people with diabetes:

“Alcohol and other drug use...unfortunately these risky behaviours often pose a greater threat to health status than does the illness. Use and misuse of alcohol and other drugs, smoking and unprotected intercourse increases the morbidity and mortality associated with homicides, suicides, accidents and sexually transmitted diseases ”.

What is often ignored in studies of young people’s alcohol consumption practices, however, is the context in which these practices take place. As I used Miller-Hagan and Janas’s (2002) work to demonstrate in the literature review, only a small amount is known about young diabetics alcohol consumption practices at university. This absence is not only limited to students with diabetes. Palmqvist (2003: 196, see also Harnett et al 2000) notes that “research on young people’s attitudes towards drugs in the past has tended to separate the individual from his or her environment”. This chapter hopes to remedy this gap by highlighting the place of space and identity in young people’s consumption practices, and exploring the meanings and contexts that underlie students with diabetes’ alcohol consumption practices.

I open this chapter with a discussion of risk, where Beck’s (1992) work on the Risk Society will be compared to the model of risk put forward by the Diabetic Control and Complications Trial (DCCT). I will argue that while the DCCT model is useful



for providing people with diabetes with information about the risks particular practices have for their long term health, Beck's (and the work of people who have followed in his wake) is more useful for analysing how people take up knowledges and negotiate competing risk/ rationality claims in the context of their everyday lives. Following this, the remainder of the chapter will provide an in-depth exploration of both my interviewees' understandings of, and the practices they engaged in relation to, alcohol consumption and risk, and highlight how these practices relate to the construction and articulation of desired identities. In particular, in this chapter I will discuss:

- The positive and negative meanings that the risks of alcohol consumption had for my interviewees' diabetes and identities. Differences between first year and older students' attitudes towards alcohol consumption will be discussed.
- The place of peers in my respondents' accounts.
- How and why my interviewees managed the interaction between hypoglycaemia and alcohol consumption. I will focus here on the practices my respondents used, following Miller-Hagan and Janas' (2002) call for more work to be done students with diabetes risk management practices. However, I extend Miller-Hagan and Janas' study by focusing on the ambivalent experiences of practice.
- 'Alternative' consumption practices, and why some of respondents engaged in such activities.

#### **4.2. Risk society**

The concept of risk has assumed an increasingly important place in people's everyday experiences and ways of understanding the world. The Bush Doctrine of pre-emptive strike, for example, is premised upon what it views as the irredeemably risky state of the modern world.

This is still a dangerous world. It's a world of madmen and uncertainty and potential mental losses.

George Bush isn't the only individual to engage in risk assessments. Giddens argues that risk is "fundamental to the way both lay actors and technical specialists organise

the social world” (Giddens 1991: 3). But what is meant here by risk? Ulrich Beck (1992) argues that risk is a “systematic way of dealing with the hazards and insecurities induced and introduced by modernization itself” (Beck 1992: 33). Beck argues that modern Western industrial societies (‘late Modern societies’) are risk societies. By this he means that they are societies that are involved in a continual interrogation of the nature and consequences of their very modernity.

In historical terms, Beck argues that risk societies are relatively recent occurrences. It has only been with a temporal shift from early to late modernity that there has been an attendant epistemological shift away from a world governed by religious belief, acceptance, and luck, and towards a society increasingly concerned with probability, scientific estimation, counter-factual reasoning and control (Green et al 2000).

Beck argues that the modern world is not inherently any more dangerous or risky than earlier societies (though the nature of these risks has changed. The possibility of a nuclear Holocaust, for example, did not exist in the past); however, in late modern societies Beck argues that it is people, rather than god, nature or some other external force who are considered to be responsible for their own actions and who are aware that the repercussions of their practices, whether positive or negative, are of their own making. This view is somewhat different from views on risk that may have been found in the past. Lupton notes for example that in the middle ages risks “signified the possibilities of objective danger, act of god, a tempest that could not be imputed to a wrongful action” (Lupton 1999: 7). These were things that were outside of human control and whose effects couldn’t, by a then contemporary stretch of the imagination, be attributed to human practices. In contrast, in the modern period, risks are more intimately bound up with the consequences of human decisions. As a model risk presupposes human reactions to the world, an awareness that the course of things are not inalienable and can be altered for the better or worse through human (in)action (Lupton 1999).

Discourses both emanating from, and constructing, these dominant understandings of risk encourage individuals to develop relevant practices and behaviours. Giddens (1991: 28) argues that one of the most important qualities individuals are advised to develop in risk societies is “a calculative attitude to the open possibilities of action,



positive and negative, with which, as individuals and globally, we are confronted in a continuous way". People with diabetes, for example, are encouraged to continually engage in reflexive monitoring practices is to reduce their risk of developing diabetic complications.

Several points can be noted here. The first of these refers to the statistical nature of risks; risks are often viewed as something that can be evaluated against "some external and fixed criteria" (Lawy 2002: 407). Secondly, and relatedly, risks are most often interpreted in scientific terms. Rational individuals are presumed to make informed choices based on the best available scientific information. Thirdly, risks are often viewed negatively. They are things to be avoided, linked to chaos and lack of control, associated with and fuelling "anxiety created by disorder, the loss of control over our bodies, our relationships with others and the extent to which we can exert autonomy in our every day lives" (Lupton 1999: 3).

#### 4.2.1. Risks and identities

Negotiation and awareness of risks is bound up with the constitution and practice of subjectivities (Lupton 1999). Beck (1992: 23) argues that "in class and stratification being determines consciousness, while in risk positions consciousness determines being" (1992: 23). Avoiding risk is often considered to be a "moral enterprise related to self-control, self-knowledge and self-improvement" (Lupton 1999: 91). In Foucault's terminology, the practices and texts that circulate around and emerge from discourses of risk can be interpreted as technologies of the self, ways of allowing individuals ways to constitute ideal subjectivities and practices (Green et al 2000)<sup>14</sup>.

Beck (1992) argues that the relationship between risk and identity is associated with a process of individualization. Individualization refers to the ways in which "biographies are removed from traditional precepts and certainties, from external control and general moral laws, becoming more open and dependent on decision making, and are assigned as a task for each individual" (Beck and Beck-Gernsheim 1995: 131). Individualization "means freedom to choose" (Beck and Beck-

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<sup>14</sup> Foucault's concept of technologies of the self is discussed in extensive detail in section 5.2.1.

Gernsheim 1995: 5). As “biographies become reflexive” (Beck 1992: 131) though, people face an increasing amount of decisions and options. Individuals are expected to choose amongst different alternatives to find the outcome that rationally and best suits them (which ironically, Beck argues will often be what conforms to the dominant imaginary). This freedom frequently goes hand in hand with anxiety and doubt because while people are expected to create and choose amongst an existing array of possibilities, there is often no completely right or wrong action to take. For example, what may seem to be a good choice in the long term may be bad in the short term, and vice versa.

#### 4.2.2. Criticisms of Beck and Giddens

Before I discuss medical conceptualizations of risk and compare them with the critiques of risk put forward by Beck (1992) and other social theorists, there are in the first instance a number of points to make about Beck and Giddens’ own work on risk. The first of these relates to the nature of the risks studied by Beck himself. Beck is interested in how people deal with global risks, primarily the threat of nuclear meltdown or holocaust; “by risks I mean above all radioactivity” (Beck 1992: 22), “the ecological and high-tech risks that have upset the public for some years now, which will be the focus of what follows” (Beck 1992: 22). His focus on large scale risks can therefore be productively contextualised through an in-depth exploration of how individuals negotiate risks in particular settings.

Other criticisms can also be noted. Elliott for example argues that Beck does not take sufficient account of “interpersonal, emotional and cultural factors as these influence and shape risk-monitoring in contemporary society” (2002: 312). Lupton (1999) also argues that the risky actor interpolated by Beck and Giddens is primarily rational, someone presumed to reflexively negotiate risks at the level of conscious awareness. She contests that people may not necessarily consciously respond to risks, but may in fact take account of them through unarticulated practices and routines<sup>15</sup>. I believe she is right and wrong on this point. Giddens for example argues that “to be human is to know all of the time...both what one is doing and why one is doing it” (1991: 35).

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<sup>15</sup> Though as mentioned in the methodology section of this thesis, given the difficulty non-interview methodologies had in this project, the risk reflexive practices discussed in this chapter taken are from narrative accounts where interviewees consciously reflect on their own practices.



However at the same time he makes clear that “many of the elements to ‘go on’ are carried at the level of practical consciousness” (ibid 1991: 35). Lupton (1999: 114) is more accurate when she argues that “the self-reflexive individual as presented by Giddens and Beck is a socially and economically privileged person who has the cultural and material resources to engage in self-introspection”, noting that people who correspond to this model of the self are rare. Arguably, though, the interviewees in this study could be considered to be in relatively privileged positions given that they overwhelmingly attended old, red-brick, prestigious middle class universities and subscribed to prestigious, knowledge driven courses such as medicine and law (although they lack the privilege of age and experience). A third criticism made by Lupton and Tulloch (2002) notes that the model of the risky actor described in Beck and Giddens’s work is one who generally sees risk as something bad (which is perhaps a reasonable way in light of something like the risks of nuclear catastrophe discussed by Beck), a view which was challenged by their interviewees who often saw risk taking in their everyday lives as a positive, productive activity. Lupton and Tulloch (2002) furthermore note that Beck has been criticized for not paying sufficient attention to gender, age or other social characteristics of individuals in how they interpret and deal with different risks. This is an important gap because young people’s perceptions of risk are often grounded in these categories (Green et al 2000). Finally, both Beck and Giddens do not sufficiently address the spatialities of risk (Furlong and Cartmel 1997).

#### **4.2.3. Medical conceptualizations of diabetic risks**

So how does risk relate to diabetes? Diabetes is a condition where medical management is geared towards the rational minimization and reduction of statistically significant risks. As I noted in the introduction, the Diabetes Control and Complications Trial (1993), or the DCCT, is the study most relevant here, as it confirmed that excellent control of diabetes correlates with a diminution in the risk of developing long term complications.

The DCCT was a multicentre, randomised clinical trial that was created for the purpose of contrasting intensive insulin therapy with conventional therapy, and examining the subsequent impact these two therapy regimens had on the genesis and evolution of diabetic complications. Intensive therapy in the DCCT was designed to

bring blood glucose levels as near to normo-glycaemic levels as possible through multiple daily injections (MDI) or through the use of an insulin pump (Continuous Subcutaneous Insulin Infusion, or CSII). Individuals' on the intensive therapy regime had their insulin dosage adjusted daily to take account of the results of blood glucose tests (of which at least four had to be made per day), food consumption, and exercise. Conventional therapy on the other hand consisted of only one or two injections a day and insulin dosages were not normally adjusted. 1441 people with diabetes were followed for an average of six and a half years with the purpose of answering two questions: "Will intensive therapy prevent the development of diabetic retinopathy in patients with no retinopathy (primary prevention), and will intensive therapy affect the progression of early retinopathy (secondary intervention)?" (DCCT 1993<sup>16</sup>).

The DCCT found that after five years, the incidence of retinopathy amongst the people treated with intensive therapy was around half that of the group treated with conventional therapy. After six years intensive therapy reduced the risk of developing retinopathy by 76%. Intensive therapy also reduced the risk of individuals developing macrovascular disease by 41%.

At the same time, however, the DCCT also established that the risks of developing certain other diabetes' complications actually increased with intensive therapy. For example, the risk of developing severe hypoglycaemia was approximately three times higher amongst the intensively treated group.

Based on their findings, the DCCT group argued that the majority of insulin dependent diabetics should be treated with intensive therapy, with the goal of bringing blood glucose levels as close to the normo-glycaemic range as possible. While the DCCT noted that, because of the increased risk of developing severe hypoglycaemia, intensive therapy may not be suitable for everyone, on balance the risk cost-benefit analysis was clear.

"Given the catastrophic nature of end stage renal disease to the patient, and the huge cost to society, it is imperative that physicians recommend the most

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<sup>16</sup> <http://gateway.uk.ovid.com/gw2/ovidweb.cgi>



effective current therapy aimed at the lowest HBA1C that can be safely achieved” (DCCT Research Group 1996).

The concept of risk constructed by the DCCT has a number of characteristics. While the nature of the risk described is somewhat ambivalent (given that positive outcomes are also associated with the negative effect of severe hypoglycaemia), risk in the DCCT’s analysis is primarily related to harmful and deleterious outcomes. Risk is seen as a technically analysable activity that can be compared to some outside standard, and reduced by engaging in relevant preventative measures. The DCCT also figured that risk avoiding behaviour was a rational activity and that people with diabetes consciously think (or, at least should think) about and engage in cost-benefit analysis when figuring out which risks bring the most benefit and which are best avoided.

The ideal human actor emerging from the DCCT’s study therefore is a risk-avoiding, risk- knowledgeable individual who takes personal liability for his or her own lifestyle and diabetic control, in particular the management of their blood sugar levels and consumption practices. Risk is connected to technical education, and is decontextualised in the sense that its ultimate meaning rests with its effect on HBA1C levels, and with the onset or not of complications.

It is important to note, though, that the people in the DCCT trial were risk aware, knowledgeable actors only to the extent that each had a large number of resources and the support of a diabetic team behind them. In most everyday situations, people often do not have all the information on which to construct objective techno-science risk assessments. For example in this study one interviewee, Laura, noted that she didn’t know what effect particular practices would affect her control.

I used to get up and have breakfast. But now sometimes I'll just skip breakfast and go straight to lunchtime, and only have like three meals a day, three injections instead. Which I'm not sure if I'm supposed to do that. I do not know, cause I'm not eating and not having injections. I do not think that it makes any difference really. Because the insulin is so short acting...I'm confused (laughs).

#### 4.2.4. Competing rationality claims

And indeed, not all people can make, or indeed want to make, their practices correspond to those recommended by medical discourses. Many people with diabetes in fact engage in practices that actively contravene those recommended by the DCCT, as I noted in the introduction. Adolescents and young adults are often felt to be the most problematic in this regard (Bryden et al 2001). It will be remembered that Dabadgo et al (2001) argued that adolescence is associated with a number of ‘maladaptive’ lifestyle practices in relation to diabetes care, and that often adolescents do not understand the need to engage in risk reducing behaviours.

But is this interpretation of young people’s experiences and understandings of the risks of living with diabetes valid? Are young people unaware of diabetic risks, or unconcerned by them? Are their practices fundamentally irrational, or is there something else going on? Why do people engage in what could be potentially harmful practices when the medical evidence of the hazard of this is as clear as anything of this nature can be?

An important first step to resolving these questions is to move away from a view that sees actions taken in relation to risk as being either essentially good or bad. Often, risky practices can have both positive and negative implications for the people who engage in them. For example, choosing to be well controlled for the future could mean having to sacrifice or moderate a practice that is important to the individual in the present, which they may not want to do. Also, as Lupton and Tulloch (2002) note engaging in risky practices can be a positive activity. Indeed, Campbell et al (2003: 678) found that for their diabetic interviewees’ ‘strategic cheating’, or “departing from medical advice in a thoughtful and balanced way” was associated with greater diabetic control.

It is important, therefore, when seeking to understand how young people with diabetes negotiate and understand risks to situate their practices and understandings in the framework of their everyday lives, to contextually explore the “localized and individualized” characteristics of practice (Lupton and Tulloch 2002: 319). This is an



important realisation because when you are dealing with a condition that is medicalized to the same extent as diabetes traditionally has been, risk is often looked at in terms of compliance, whether or not young people ascribe to the correct lifestyles and behaviours or the wrong ones. Compliance is linked to acquiescing to the authority of medical discourses. Donovan and Blake (1992: 507) note that in medical discourses “non-compliance is deviant. Patients who do not comply are rebellious, ignorant or forgetful”. I am not denying here that engaging in practices of the sort discussed in this chapter may have deleterious effects on people’s lives and bodies in the future. Indeed Beck himself notes the profound reality of risks, “the tangibility of need suppresses the perception of risks, but only the perception, not their reality or their effects; risks denied grow especially quickly and well” (Beck 1992: 45). Neither am I denying the importance scientific understandings and discourses play in young people with diabetes’ negotiation of risk and practice. However, I believe it is more productive to reject the outright distinctions some discourses make between the falseness of young people’s beliefs and the truth of reality. The ‘reality’ is that people act towards ‘objective’ risks in a way that is influenced by imaginative beliefs that people hold about these risks; risks awareness and negotiation is influenced by other factors than purely rational cost-benefit analysis. Practices which may seem irrational in a clinical setting may seem entirely rational in some other spatiotemporal context. This view, has in fact, as I noted in both my methodology and introduction, been recognized by some in the medical profession itself.

Instead of the compliance-non-compliance dualism, therefore, I believe it is better to look at how people deal with risks in terms of negotiating competing rationality claims. Beck makes clear that “the growing awareness of risks must be reconstructed as a struggle amongst rationality claims, some competing and some overlapping...” (Beck 1992: 59). The danger, as Beck notes, when dealing with risk “is to include human beings only as organic material” (Beck 1992: 30). From this point of view

“the population is composed of nothing but would-be engineers, who do not yet possess sufficient knowledge. They only need to be stuffed full of technical details, and then they will share the experts’ viewpoint and assessment of the technical manageability of risks, and thus their lack of risks...this perception is wrong. Even in their highly mathematical or

technical garb, statements on risks contain statements of the type that is how we want to live” (Beck 1992: 58).

I will look now at my interviewees’ alcohol consumption practices in light of the material and conceptualizations I have discussed so far. Rather than assuming that young people engage in harmful and illogical risk taking practices at university, I will contextually investigate my interviewees’ consumption practices, where they do them, why they do them, and how they do them. In doing so I will argue, in line with what I have discussed so far, that risk is not something disembodied but something that is negotiated and meaningfully understood in particular spaces. Hopefully the rest of this chapter will help to both simultaneously complexify and elucidate young people with diabetes’ risk taking practices while they are at university.

### 4.3. Alcohol consumption amongst students

The first thing to note is that alcohol consumption amongst university students is an important practice, particularly for young, white, middle class students at traditional universities (Chatterton 1999). It is also an entrenched practice. Silver and Silver (1997: 112) note that “drinking as part of the undergraduate rite of passage has an enormous international history, across, for example, the European universities of the middle ages to the twentieth century”. For many young people alcohol consumption plays a crucial element in their university experiences (Farrow and Arnold 2003). Farrow and Arnold (ibid: 342) argue that alcohol consumption is *the* most important form of consumption that young people engage in while they are at university, and is “the accepted norm and even expected of both male and female students in many Western countries”.

In a comprehensive study of the inter-faculty drug taking and alcohol consumption practices of university students, Webb et al (1997: 147) found that the average alcohol consumption for all the faculties they studied exceeded “the low risk level of 21 units/week recommended by the Royal College of Physicians”. They discovered that “10% or more of students reported drinking in the ‘hazardous’ range (over 50 units/week, men; over 35 units/week for women)” (ibid). Their findings have been supported by other studies. Pickard et al (2000) found that second year medical students at the University of Leeds regularly drank large amounts of alcohol, with



binge drinking<sup>17</sup> being described by almost two thirds of male students and three quarters of women. In their study of the drinking practices of second year med students Webb et al (1998) reported that just under half of men and two fifths of women exceeded the safe levels of consumption recommended by the medical establishment. Farrow and Arnold (2003) argue that, overall, 90% of women at university are likely to drink alcohol. When they do, women students are “three times as likely to exceed recommended drinking limits as the general population” (Gill 2002: 119). As I noted in the literature review, because of the sheer scale of student drinking the National Union of Students recently decided to launch it’s ‘If You Drink, Do not Do Drunk’ campaign. Some media commentators were doubtful about its efficacy, though, given what they saw as the inherent institutional alcoholism of student culture:

“It looks like Mission Impossible. But the National Union of Students has set itself what is probably its greatest ever challenge: stopping its members from getting drunk...mass drunkenness is as much a part of student life as exams and lectures...” (Wazir 2002<sup>18</sup>).

What is often overlooked in these studies, though, are the reasons why students drink alcohol.

For my respondents, alcohol consumption was often described as a way of helping them to feel ‘in place’. Especially for my first year respondents, who had recently made the transition to university, and were uncertain about the rules of the student

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<sup>17</sup> Several qualifications need to be noted about the term ‘binge drinking’. Firstly binge drinking is an ambiguous term with no single agreed upon definition, though it is most usually taken to refer to intermittent consumption of large amounts of alcohol (Kuntsche et al 2004, Institute for Alcohol Studies 2003). Specifically it describes two forms of drinking practice, one denoting a short period of time during which a particular amount of alcohol is consumed with the intention that this consumption will result in intoxication, and the other referring to heavy alcohol consumption over a more extended period of time (Kuntsche et al 2004). Kuntsche et al note that for young people binge drinking is often equated with their consumption practices in general, and so differentiating binge drinking from young people’s ‘normal’ or ‘safe’ consumption practices can be a problematic activity. Binge drinking *is* a normal drinking practice for most young people between the ages of 18 and 24. In a report on adolescent health, for example, the British Medical Association noted that that “amongst 16 to 24 year olds in 1997, 33% of young men were estimated to be drinking more than 21 units per week, and 9% more than 50 units a week. 22% percent of women were estimated to be drinking more than the recommended levels, and 5% more than 35 units a week” (BMA 2003: 15). Because of the difficulties in defining binge drinking, the consumption practices referred to in this section draw upon interview extracts where the interviewees themselves label their consumption practices as excessive or binge like.

<sup>18</sup> <http://education.guardian.co.uk/higher/news/story/0,9830,780527,00.html>

game (Chatterton 1999), drinking was an important way of negotiating differences. It was a form of consumption which, because everyone else was engaging in it, allowed interviewees to construct identities as 'normal' students. It was a way of demonstrating social competence. The visibility of alcohol practice was important in this process. It was important for respondents to be seen to engage in the same consumption practices as everyone else was. As Litva et al (2001) have noted, the outer body is the most important part of the student body when it is in public. It is the "form of physical capital upon which they are evaluated" (ibid: 259). It was also clear from my interviewees' accounts that there was a spatial aspect to the construction of physical capital; being seen to drink was particularly important in popular, student spaces, spaces in which the student body is most directly constituted and a student identity embodied (Chatterton 1999).

Alcohol could also be experienced by first years a way of releasing inhibitions, of helping ease nerves (which were often raised by feeling 'on show'). Lupton (1995: 152) notes that alcohol "provides a way to pass off embarrassing practices and temporary instances of loss of control as the fault of the alcohol rather than the person herself". This benefit was especially important for first years, and who were often especially anxious about how they presented themselves to others. Erin for example noted:

I do not remember that much [about the first few weeks] as I had a little too much to drink. It was just nice. Because the whole thing that alcohol releases inhibitions, you do get to talk to people and...kind of talk to them if you'd met them in the day as a complete stranger.

First years often found that organized activities in the first few weeks revolved around alcohol.

Christina: Um...people in halls in the first couple of weeks drunk sooo much that I couldn't begin to imagine it. And it was encouraged...by the union, by the week one reps whose job it was to introduce everyone. It was kind of forced, I would say. People would drink half to three quarters of a bottle of vodka before going out. Whereas I would have four or five vodkas in an evening and then I'd be drunk. So. It was eye-opening from a social point of view and from a health point of view.



While alcohol consumption is a popular and pleasurable practice amongst young people at university, though, it is also a risky one. Amongst women students, for example, alcohol is often associated with an increased risk of having unsafe sex and/or becoming pregnant (Farrow and Arnold 2003, Lorente et al 2003). Student drinking practices such as binge drinking are also commonly considered to be problematic for young people's health. And more specifically, and importantly for the concerns of this thesis, alcohol consumption is risky for students with diabetes (one of the most important reasons why the studies on students with diabetes that I discussed in the literature review identified the university as an especially hazardous landscape for young people with diabetes). Gallagher et al (2001) note that high levels of alcohol consumption of the sort engaged in by the students in the studies above may increase young people's risk of developing hypoglycaemia in the short term, and also their risk of developing long term complications. As such these authors recommend that people with diabetes limit their consumption of alcohol to two units a day. From the perspective of medical practitioners and researchers, alcohol consumption is an obstacle to good care of the self (Miller-Hagan and Janas 2002). However despite this, young people with diabetes at university "may be as likely as students without diabetes to drink alcohol as not" (ibid).

#### **4.4. First years and risk**

One reason for this is that the risks alcohol consumption poses for students with diabetes are not always negative. Risk, in fact, especially for the first years, often had a positive place in my respondents' narratives. Engaging in risky drinking practices could be a way for first year interviewees to demonstrate to others and confirm to themselves that diabetes didn't control them, that they were just as capable, free and independent as anyone else. In a study looking at young people in higher education's experiences of managing diabetes in Sheffield, Schur et al (1999: 226) found that their sample of young people were most worried about being controlled by their condition.

My first year interviewees often expressed similar anxieties, for example that their diabetes would dictate the shape and intensity of their consumption practices. They

were worried that they would be forced to adjust their practices to fit the needs and demands of their condition, rather than adjust the condition to fit the needs and demands of their lifestyles.

Erin: I do not really let it take control of my life. That's not the way it should be.

Lilya noted that when she was in first year and met people for the first time she would often drink more alcohol than she otherwise would have on her own (and perhaps would have been comfortable with when by her self) in order to prove to other people that her diabetes didn't restrict her.

I make sure I kind of show them that it doesn't limit me or that I do not change anything because of it. Um, which is what I'd say anyway, I just make an extra point of it. Because it was our first meeting... it doesn't affect me because of my diabetes at all. I guess I kind of get looks of astonishment as I down pints from people who haven't spent long with me.

Lilya's risky consumption practices can be interpreted in terms of what Foucault calls 'technologies of the self', practices "offering possibilities both for self-liberation and...self-construction" (Green et al 2000: 111). Risk is not experienced as a negative here, it is a way of "achieving self-actualization" (Lupton 1999: 171), constructing an ideal self, a self not bound by diabetes. Breton (2004: 2) notes that when young people engage in risky practices their risk of suffering damage is linked to the spectacular demonstration of "an adolescent's active resistance and his attempts to become a part of his world again" (ibid: 2004). Indeed, Breton argues that the risk of physical damage to the physical self, such as the risk to the body in the long term from binge drinking, often goes hand in hand with positive benefits for the emotional self in the way these practices can enable feelings of independence. Risk taking from this perspective is not a practice aimed at cancellation but constitution, a way of walking the edge and coming back, a way of binding the self to others through normative consumption practices and thereby showing that the self is free.

For some interviewees, these kinds of risky practices could be used to construct normal *gendered* identities, and to recapture past selves. Kirk for example noted:



I'm ok with it [diabetes] now. I just feel like everyone else. I do not feel like a...I just feel normal, I do not feel like a...I've got an illness or anything. I have but it's not...it is fairly serious, but I think it's something which affects you more when you're older, so that's why I'm a bit more...live fast, die young kind of thing. Maybe that's a bit more selfish but that's the way...I feel now. I just like having fun all the time. ...It might be considered to be a bad attitude but I do not think it is really. If I had something else even more serious I'd still want to go out all the time.

For Kirk, alcohol consumption was a practice that enabled him to identify with a laddish form of masculinity. This identification allowed him to create an account of the self as someone who was strong, normal, unconcerned about the future, able to treat his body as an instrument, able to go out and have fun and have a laugh. This was an identity that Kirk clearly felt conflicted with the demands of self-regulation imposed by diabetes' management regimes. However, the emotional importance of this identity for Kirk rested precisely upon the fact it obviously conflicted with medical ideals of good diabetic control. By engaging in the practices of a 'normal' lad he could control his fears of *being* controlled, of being abnormal, of being different from other. These fears circulate throughout his narrative, in spite of his repressive efforts, in the ways the words describing indifference have to be searched for, if they come at all, in the ways the narrative repeatedly contradicts itself.

One way of understanding why the construction of an identity as a normal lad was so important to Kirk is through Bury's (1982) concept of the experience of chronic illness as a form of biographical disruption. Bury argues that the development of a chronic illness cannot be seen only as an attack on the body of an individual. It also assaults their sense of self, who they believe themselves to be and where they believe themselves to be going in life. This is an important realization in light of the understanding that Kirk was the interviewee who had most recently found out that he had diabetes, receiving a medical diagnosis just slightly over a year before we did our interview. He was clearly still struggling to come to terms with his diabetes when we met. Engaging in risky practices allowed him to "demonstrate courage" (Lupton 1999: 159) and stoicism in the face of his diabetes, and to resist the identity of the 'ill diabetic'. They provided him with a way of (re)connecting and (re)constructing the normal identity that Kirk felt was threatened by his diabetes.

Importantly, the consumption practices that Kirk engaged in at university were actually far more intense than the practices he engaged in before developing diabetes. He described going out as an addiction, noting “I want to, I really need to go out almost every night”. In a study examining the effects chronic illness had on men in America, Gerschick and Miller (1993) found that men could have a variety of responses to the onset of chronic condition. For Gerschick and Miller’s interviewees, chronic illness called into question their sense of who they were as men. Subsequently, individuals engaged in a variety of different practices to reconstruct their masculine identities. One of these practices was to intensify activities that could establish a (re)identification with hegemonic notions of masculinity, for example by trying to sexually wear out partners in order to confirm personal stamina and performative competence. Kirk’s practices here, like some of Gerschick and Miller’s respondents, were intended not only to construct and enforce a heterosexual masculine identity, they were intended to create a ‘super-self’, a self more normal than the one he had been before being diagnosed. This is the reason why going out for Kirk felt like an addiction. His way of repairing the damage diabetes caused to his biography was by drinking heavily.

As with Lilya’s account above, it’s important as well to note the relational nature of this process (this point challenges Maharaj et al’s (2004) assertion that relationalities are far more important for the construction of identities for young diabetic women than for young diabetic men).

Like I do get quite a lot of respect off my friends because of the way I’ve dealt with it. People...people...like friends of friends, I’ve been out with them and they’ve seen me do an injection and they like cannot believe I would go out and drink so much and do the things that I do and have diabetes as well. I do not know if that’s a good thing. I just try and be normal.

Charmaz (1983: 170) notes that for an individual to maintain the legitimacy of their self-identities means receiving “empirical validation in daily life”. She argues that people with chronic illnesses (especially those who are recently diagnosed) sometimes experience their selves as brittle and vulnerable, open to fragmentation and collapse, and as such often analyse their interactions with others for signs that



their self is lacking in some way or failing to meet the perceived normal standards of performative competence. In these circumstances, interactions with peers can be used to “maintain continuity” (ibid: 193) with ideal versions of the self. Peers can positively comment upon and reinforce the validity of interviewees’ practices. Kirk’s friends here, for example, serve to normalize and legitimate his risky alcohol consumption practices, and justify the practices he engages in. They act as a form of peer review. Their respect enables him to feel that he is the equal of anyone else and that his condition doesn’t make him any less than his friends are. They acknowledge, and allow Kirk to feel, that he is ‘dealing with it’.

However, while the laddish practices and live fast, die young philosophy Kirk described above were “to some extent...vital to self-realization and improvement” (Lupton 1999: 154), in other ways they threatened Kirk’s ability to embody a desired forms masculine identity.

Kirk: I do get a conscience about when I’m older sometimes. But I try not to think about it because it might get me down...

Myles: When do you think about it?

Kirk: The only times I think about...if I take the piss now and abuse my body now. So say when I’m older...I hope to have kids when I’m older where...I could get really ill and might not see my kids grow up, that worries me.

As this extract indicates, the meaning of risks for Kirk are temporally contingent. The positive nature risk had in Kirk’s narrative was connected to the way it enabled him to construct an identity as a normal young person now, in the present. However, these same practices also had the negative potential to have a serious, deleterious effect on his life in the future. They could undermine Kirk’s future identity as a husband and provider for his family. Risk, masculinity and time are ambivalently linked; the actualization of one form of masculinity, constructed through a rejection of diabetes, is felt to come at the expense of risk to another.

Different temporalities are therefore at play in Kirk’s narrative, and the meanings of alcohol consumption practices change according to whether they are viewed in the long term or the short term. What is good in the short term is damaging in the long.

There is also a strong sense in Kirk's narrative that diabetes has upset a trajectory which Kirk feels he would (or should) otherwise have followed, one where he could move from the identity of young laddish (and invulnerable) youth to that of a responsible man. Consequently, Kirk's feelings about the future are confused; he could die tomorrow, he die twenty years from now. His ability to imagine a self continuing through time has been disrupted. His feelings about the future differ from those of the young people in Lawton's (2002: 720) study. Lawton found that for her respondents:

“The possibilities of imagining a self in sickness, and in death...appeared to be absent...importantly, the ways in which they described their futures precluded any references to ill-health, let alone death...in all cases, their comments revealed an implicit assumption that they would retain the corporeal and mental capabilities to pursue these goals”.

In contrast, Kirk's future self is represented as being extremely vulnerable to risks, and he is aware that the intensification of practices designed to ensure the performance of a normal identity, someone whose fate rests is in his hands, only serves to increase the threat to this identity in the long term, and ultimately increase his risk of being controlled by, rather than in control of, his diabetes.

#### **4.4.1. Controlling anxiety**

While first year students were likely to binge drink the most out of all of my respondents, then, they were also often worried about the effects their drinking practices, pleasurable and necessary in the present, could have on their future selves. As such, they often attempted to justify and balance their practices in order to diminish and control the anxieties and guilt that were raised by their drinking. Such accounts enabled interviewees to feel like 'normal' students while maintaining their sense of themselves as well controlled people with diabetes, to act without becoming paralysed by contradiction.

For example, one of the ways Kirk attempted to control the anxieties and guilt raised by his lack of control in relation to his alcohol consumption was by being relatively disciplined in relation to his food consumption practices. He felt that by regulating the qualitative and quantitative nature of his food intake he could at least modify



some of the harmful effects of his alcohol consumption, and therefore minimize the disruption his consumption could cause to his future self. He contextualised these two forms of consumption, alcohol and food, as balancing each other, and in this way allowing the body to be brought back into a state of equilibrium. Importantly, regulation of what he ate was more important for Kirk than what he drank. Williams (C.) (2000, 1999) notes that young men are often worried about the stigmatizing effects diabetes can have on their social identities. For Kirk, alcohol was the most social form of consumption he engaged in. It was therefore important for him to be 'normal' while he was out drinking because he felt that the success of his social identity would be judged by and against other 'normal' young people. Food consumption was a more private affair, and its regulation wouldn't impact upon his social identity. Also, food consumption may have been considered a more fundamental form of consumption than alcohol, and therefore subject to greater control.

Female interviewees engaged in similar balancing practices. For example Erin noted:

I do occasionally not drink. This Wednesday I went out and didn't drink. I had a couple. I have been quite bad for the past few weeks. But then over the exams I probably won't drink at all. It's again...just one of those things...it's your choice that you have to make. I can just go and ignore drink, but to be honest since you're there you might as well just have a couple and do not go to extremes. Like...it's a risk, everything as a risk. But you have to take it and live with it. They're probably not risks at all, it's probably just a media thing. It's my choice, my health.

As with Kirk, the concept of balancing risk is crucial here. In contrast to Kirk, though, Erin moderates the risks of consumption by contextualising her practices: while she may have drunk intensely in the recent past, in the overall scheme of things, she hasn't drunk very much at all. Her comment about the risks of drinking alcohol being a media representation is also interesting. Beck (1992) argues that risks are bound up with probabilities, with things that might happen; they are trans-temporal in character. He notes that "in the risk society the past loses the power to determine the present. Its place is taken by the future, thus, something non-existent, invented, fictive as the cause of current experience and action" (Beck 1992: 34). The trans temporal nature of risks, combined with their often intangible, potential presence,

means that risks “have something unreal about them” (Beck 1992: 33). Because they are probabilistic, so unreal, people can deny them, as Erin attempts to do here.

When I interviewed Erin for the second time, her practices hadn’t changed (she said that she was still drinking a lot) but she felt more ambivalent about them than she had done previously.

I know it’s terrible, but I think it’s only three years and after that I’ll be finished binge drinking. And it is kind of a student thing. It’s probably not the best thing ever. And the hospital is always telling you you’re drinking too much but at the same time they expect you’re nineteen and a student so that’s what you’re going to do. So as long as you’re sensible about it...Um...I suppose I look at as at the moment I’m quite young, quite healthy. Can probably deal with it. But in the long term, you always have to think of the long term effects of these...in the long term to drink. It probably isn’t even too good for me now, but...I’m only a student for three years, but I’m sure it’ll die down anyway.

Several important points can be noted. Firstly, Erin argues that binge drinking is a student practice, something done by all young people at university; she effaces the multiple differences that exist between students and other young people with regards their practices (Chatterton and Hollands 2003, Valentine 1999). Valentine notes that the assumptions at work in discourses of this kind “can universalize or oversimplify...complexity” (ibid: 257). While Valentine’s work here was a critique of widespread beliefs that young people will act in a certain way because they are a certain age it can also be seen that Erin’s emotional security rests on a denial of the multi-strandedness of individuals’ identities, and also of the differential nature and possibilities of personal practices. The anxieties raised by risk come about in large part because risk is linked to personal responsibility for decisions made in the face of competing imperatives and choices. Binge drinking, when understood as one potential practice amongst many, can challenge the moral self and generate anxieties by highlighting the role of choice in the actualization of potentially harmful and damaging practices. In the modern period a refusal to engage in risk management practices signifies an unwillingness or inability to take care of the self, which is a sign of an irrational subjectivity (Lupton 1999). It signifies a person who is uncontrolled, who hasn’t internalized the dominant values of late modernity (Warr and Pyett 1999). By interpreting binge drinking as a routine practice that all students



do because they are students, however, the anxieties raised by binge drinking can be suppressed by deflecting moral and practical responsibility onto the student body.

This is not the only strategy revealed in Erin's account, though; other tactics are also described here. Erin for example also reduces some of the emotional anxieties through the invocation of temporalities. Giddens (1991: 130) notes that "deferment in time and remoteness in space are other factors that can reduce the disquiet that awareness of risks as risk might otherwise produce". It can be seen here, though, that rather than deflecting the outcomes of her practices on to the future, she brackets off her current practices from the future. The student body is in a sense closed off from the wider life course.

What is perhaps most striking at this juncture, taking both of Erin's narratives together, is the amount of justificatory accounts she has to articulate and balancing practices she has to engage in, in order to binge drink. Binge drinking, while important, is also an emotionally and morally problematic practice.

Finally, Erin's awareness of time differs in some respects here from Kirk's. Kirk didn't, or couldn't, bracket his current practices from his future self in the same way Erin does in her narrative. For Kirk, diabetes signified a loss of self, and the collapse of the future into the present. He was concerned about the things he felt he had lost because of his condition (he said he was 'devastated' when he was diagnosed). In contrast, Erin's primary concerns lay with differentiating her current student practices from the far more controlled practices of her younger self. Her practices are articulated in order to enable her "to 'do' ...identities differently" (Valentine 1999: 259), and thereby negotiate the transition to young adulthood and identify with the student body. She noted that when she was younger she was obsessed by control, to the point that she stopped feeling normal and started feeling controlled by her condition. Erin's narrative points to is an understanding that diabetes is not just something that is integrated into an individual's identity once and that's it. Rather, it is something that must be continually (re)negotiated via consumption practice; its meanings are continually changing according to different contexts, and to the individual's reflexive understanding of her own self-identity (Lawton 2003)

The thing is, I was a perfectionist about everything. And since I was in sixth form, I've become less conscientious, and more and more relaxed if it's not perfect. So it has been a gradual thing. I didn't find it hard when I came here; I decided I'm a student now, so...I cannot let this influence my life, my student life...I'm going to look after myself but I'm not going to let my diabetes stop me doing anything.

#### 4.5. Older interviewees and risk

The older interviewees' attitudes towards diabetes and drinking differed from those of the younger students. Often, rather than attempting to show that they were in control of themselves by drinking riskily, they tried to achieve control by not drinking too riskily. Several previous studies have looked at the notion of a drinking transition within student cultures. Pickard et al (2000: 149) note that alcohol consumption is likely to be more intense at the start of the year for students than at the end because they would have more work later on, and Hannay (1998) found that while young people living in halls demonstrated high levels of drinking in the first few years at university, this levelled off again with the stresses and demands of studying and work. In Bourdieu's (1990: 67) terms, younger and older, my respondents seemed to have had a different "feel for the game" of university life. Because the field, the space of the university, was largely unknown to them upon their first encountering it, first years often adjusted their practices to fit the perceived demands of the field. To identify with the 'normal' student body, they often drank a lot because they felt that that was what students did, and because their drinking was encouraged by embedded institutional actors. The older students, though, were more habituated to university life. They were conscious that they weren't going to be students forever. As such, these respondents tended to regulate, to modify, their alcohol consumption. They considered control of their alcohol consumption to be a fundamentally important, risk reducing practice, not a stricture imposed upon them. They also tended to disidentify from 'normal', unhealthy student identities and practices. Mainstream student life and the student body itself were regularly perceived by these interviewees to be institutionally infantile, a culture to be cast off if the self was eventually to 'grow up', deal with diabetes properly and develop an adult identity. This did not by any means mean that these interviewees stopped drinking alcohol; but their consumption didn't have the same intensity and frequency as their younger counterparts. Lilya noted:



Everyone is like oh you're teetotal, why? And I'm like my health. And they're like oh you're going to miss out on the university experience. But the way I figure I've had the university experience, my first year was madness. But I'm in my third year now and I think I've got to concentrate more on my studies. Um, so now I cannot get half-cut because I've got self-control.

Older interviewees also considered controlling their alcohol consumption to be a necessary practice in order to maintain their identities as normal young students. Alex for example noted that "if you control it [diabetes], you're no different from a normal person". Not being well controlled before drinking, or going out of control while drinking, often led these interviewees to experience strong anxieties about their practices, anxieties that could in fact negatively affect their nights out.

Jason: That's always a worry, going low [from drinking] at night, when you're out at night. Just because of the situations you're in, when you're in a night club. I do not go to those sorts of places often but you know...it's just not the kind of feelings you want to be having, worrying about your sugar levels.

Relationalities continued to be important in how older interviewees conceptualized their drinking. For example, Lorna noted that since starting her M.A. degree she had largely stopped drinking alcohol, and the form of alcohol she had continued to drink had changed. Now she drank wine more than beer. She experienced guilt from drinking, though. To minimize and control this feeling, a feeling which resulted from the way her practices contravened her sense of what a 'good' diabetic should be and do, Lorna compared her practices to those of younger students, who she felt consumed far more than her. This helped her to maintain her sense of herself as a moral subject.

I do not drink a lot by any stretch of the imagination but I do like wine. When I got to America I'll go to a vineyard because I really enjoy wine. So I'll have a few glasses of wine and sometimes I'll think 'oh, maybe I shouldn't be doing this' but then I think 'compared to other students I probably do not drink that much at all' And some nights I won't drink at all.

The forms of masculinity or femininity that were identified with by the older interviewees were also important factors in explaining why their practices differed

from their younger counterparts. For example, whereas Kirk practiced a form of laddishness based on excessive consumption, the other male interviewees' priorities lay with constructing strong, fit, healthy bodies. They felt that 'excess' alcohol consumption could undermine their fitness, and increase the risks that the body would be out of shape in the future.

James' account is illustrative. James was one of the older male students I interviewed. Like most of the older male interviewees, he was someone who had a strong ethic of responsibility towards his diabetes. In contrast to Kirk, he was not (or at least was no longer) concerned about fitting his diabetes into 'the' student lifestyle. Being in control of his diabetes and being healthy were more important considerations for him, and he often engaged in disciplinary practices such as exercising regularly and eating healthily in order to construct a strong, powerful body which stood a good chance of weathering the effects of diabetic complications in the future. The idea of living a stereotypical student lifestyle, characterised by indulgence and inebriation, was alien to James' understandings of what university life was (which, given that he was a 3<sup>rd</sup> year med student, was a lifestyle mainly characterised by work and care for his diabetes). A 'student lifestyle' was in fact seen as 'other', as harmful to the ethic of care which he felt a person with diabetes should have. As far as possible his practices embodied the understandings of risk promulgated by the DCCT<sup>19</sup>.

I behave exactly how a diabetic should behave I think. And I accept it is expected of me to behave in a way that a diabetic person should. And that's simply for my own benefit...I see things as positive and negative towards my body. Alcohol is a negative.

While he didn't drink heavily, or often, because he felt it would affect his diabetes, James noted that on special occasions he would binge drink. This was usually after particular rites of passage, such as passing exams, celebrating the end of his training

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<sup>19</sup> Interestingly, James' status as a medical student was important here as well. While Beck notes that risks are often perceived as immaterial, because he worked in a hospital James often came across other people who didn't control their diabetes. This ability to visualize the effect of current practices in light of potential outcomes helped him to reflect on his own practices. "I saw somebody whose liver no longer functioned because of alcohol in their life. And you know, it just shocks you into thinking this is what happens if you drink too much alcohol. And I'm learning what happens when you binge drink, you're pancreas...not that mine functions perfectly anyway, but that rest of it stops working if you binge drink".



year, or when he went to university balls with his girlfriend. While alcohol was generally perceived as a negative by him, on these occasions James felt that the positive effects of consumption outweighed the deleterious effects, especially given that the consequences of binge drinking would be temporally balanced, and would not affect his long term health care or current management regime.

I do battle in my mind with that sort of thing, but not with alcohol. Because I just think to myself I just binge five times a year. Then five times a year's not really going to affect me very much.

The night before we did our first interview James engaged in an intense bout of binge drinking, consuming 28 units of alcohol in a few hours. Consequently he became extremely drunk and finished the night engaging in practices that he felt were embarrassing, and also posed a risk to his long term care of his diabetes.

I've always been able to take my drink well. And I just enjoy it. But I haven't drunk for quite a while now because of the exams. So the last time I've drunk was before Christmas. So to go out and do that last night was just barmy, just stupid. So it sort of shocked me into thinking 'stop this, you're just a pain and it will put your diabetes in jeopardy'.

James' interprets his binge drinking practices here in a profoundly negative way, because they are a risk to his diabetic control. James' binge drinking also contravenes the identity that he most strongly relates to, that of a moral subject concerned about his diabetes, whose main priority is engaging in the 'correct' regulatory practices. Furthermore, his drinking negatively impacted upon his ability to engage in sporting practice, and made his girlfriend extremely angry at him. The lack of fit between his practices and his understanding of who he was as a person, combined with his strong shame anxiety, led him to fundamentally reassess both his practices and the reasons why he engaged in them. Shame appeared to have a stronger effect on James than on Erin because James dis-identified, rather than identified, with the student body, and so couldn't deflect moral responsibility on to it. In Giddens (1991: 113) terms, James' practices led him to experience a fateful moment. Giddens argues that fateful moments take place when individuals reach some intersection in their lives that forces them to reflexively examine the practices which brought them to that point in the first place. Fateful moments can therefore

become “transition points which have major implications not just for the circumstances of an individual’s future conduct, but for self-identity” (ibid: 143). After his heavy drinking episode, James decided to stop binge drinking and intensify his efforts to make himself healthy, to take even more moral responsibility for his body and practices.

#### **4.6. Presence of other young people**

As indicated by the narratives I have discussed so far, peers (both imaginatively and materially) often had a strong influence on interviewees’ consumption practices. Previous work (Miller-Hagan and Janas 2002) has found that the pressure on young people with diabetes to consume alcohol, pressure emanating from both from themselves and other young people, can be strong. There are several reasons for this. Alcohol “is a prominent part of the college culture, present at most social functions and part of many peer interactions” (Borsari and Carey 2001: 392). Borsari and Carey list a number of ways in which peers directly influence individuals’ drinking practices, including encouraging other young people to drink large amounts of alcohol, influencing the ways in which other young people perceive their drinking situations and helping make heavy alcohol consumption appear to be the ‘normal’ form of consumption practice in particular contexts.

On several occasions some of my respondents, all women, admitted to feeling pressure to drink. Naoimh for example noted that she felt that if she went out and didn’t drink that people would see her as boring. She felt that she didn’t have the confidence to get up on the dancefloor without alcohol, and didn’t want to be stuck in the corner, different from others. She noted that while people could say no when other students asked them to drink, individuals rarely did so because “it’s just sort of the done thing”. Spatialities were important when interviewees talked about peer pressure, with those experiencing peer pressure linking it to the experience of drinking and clubbing with groups of other young people in student spaces. As Chatterton (1999) notes, the student body, as an imagined community, is constructed through clustered group consumption practices in emotionally important places such as the students’ union club and student bars. For the interviewees in this study it appears that not drinking in these spaces ran the greatest risk of overt group pressure



being exerted upon them by other young people, as other people either became uncomfortable that someone in the group was not drinking, or wanted the person to drink so they could have as much fun as everyone else. Elayne noted:

I've been out when I've been the only sober person and they're all completely pissed and I've been quite happy to be the only sober person and they're pushing you and pushing you to drink.

On occasions interviewees used their diabetes as an excuse not to drink.

Elayne: That's probably helped because (laughs) you feel as if you've got an ally, you do not feel as such a leper (laughs). For not going to the bar. And they will push it and push it and push it. Um, I have been known to resort to the 'I cannot, my sugars are a bit high'.

While peer pressure could be resisted by using diabetes as a justification for not engaging in normative practices, the choice not to drink on a night out, whether because of diabetes or because the individual just didn't want to drink on that particular night, could lead to feelings of difference from others. For example, both Elayne and Laura used the word 'leper' in relation to their feelings about not drinking. Not engaging in alcohol consumption was explicitly recognized as a stigmatising activity by them.

While used somewhat ironically by Elayne, leper was a word that was used more seriously by Laura, who was a first year student.

Myles: I don't drink myself.

Laura: Oh don't you? Not at all?

Myles: No, I worked in a bar sometimes since I was twelve. In fairness, it does feel quite awkward sometimes when I'm out...

Laura: Yeah, do not you ever feel like pressured to have a drink?

Myles: Um, yeah.

Laura: It's like a social thing, isn't it?

Myles: Do you feel that pressure yourself sometimes?

Laura: Yeah sometimes. But I do not want to say no, and I don't want to feel like a leper, like 'oh no, I cannot have that, or...'. Especially if I'm out with people I do not know very well, I sort of go along with it because I do not want to cause a fuss.

In their study of young adolescent diabetics, Kyngas and Hentinen (1995) found that the young people they talked to sometimes consumed items they perceived to be harmful to their diabetic control so as not to appear different from their peer group. Diabetic management strategies that were interpreted as constructing difference were viewed negatively. Macleod and Austin's (2003) work on young people with epilepsy found that young people were often alive to the possibility of connection between their condition and difference. Macleod and Austin argued that for young people the presence of a chronic condition could result in the loss, or fear of loss, of status in relation to peers because of the possession of a characteristic deemed to be different or undesirable. They note that young people are often worried about not only overt discrimination, but also disapproval and rejection from others. As a consequence adolescents with chronic conditions are often highly sensitive to peer group norms and may limit disclosures about their condition in order to feel less different and to minimize the possibility of personal refutation.

In this study, anxiety about difference and stigma, as it related to alcohol consumption, was most consistently articulated by the first year interviewees, especially in the first few months of university. In a context where other individuals knew nothing about them, the only aspect upon which they could be judged 'normal or 'abnormal' was their consumption. Neither Laura nor any of the other first year interviewees described experiencing prejudiced reactions from other young people; in fact, when they did tell other young people about their diabetes more often than not the reactions of other students was enthusiastic and favourable. Diabetes was cool. However, Laura and the other first years, at least in the first few months of university, were apprehensive about the risk that they could experience an unfavourable reaction; they felt that disclosing information about their condition could risk their identities as normal young people. In Scambler and Hopkins (1986) terms, it was felt stigma, fear of an undesirable reaction from others, rather than enacted stigma, the experience of active discrimination by other people, that Laura experienced in relation to her alcohol consumption practices. Like Scambler and



Hopkins interviewees, she had a strong sense of what was ‘normal’ (in this case drinking lots of alcohol), and regulated her actions and practices so that they would fall in line with what she felt other young people would expect. From this perspective, Laura’s alcohol consumption practices can be seen as active strategy in the construction of an ideal self, and in the management of identity risk (Adams et al 1997). This is not to efface the anxieties and negative feelings she experienced when she compared her self to ideal norms and find herself lacking; it is, however, to recognize that Laura herself is actively involved in the construction of her own identity, a reconceptualization that brings her practices in line with Foucault’s view of power as a productive force (discussed more detail in the next chapter).

It is also important to note though that while peer groups are often seen in a deleterious light, they do not have to have a negative presence in relation to the drinking practices of individuals; “in relation to drinking alcohol, peers can help support individuals’ choices not to drink as much as they can encourage them to do so” (Lupton 1995: 149). Lupton’s arguments were supported from the evidence here, where James and Alice’s friends often encouraged them , or supported their decision, not to drink. However, it is noticeable that only two interviewees indicated that their friends encouraged them *not* to drink.

Alice: The people I've made friends with do not [drink] as much because they're people with a lot of work to do. And when they've finished their work they'll watch a film or something. I know quite a few people who are out every night. I couldn't do that anyway; it's too tiring.

In the material I have looked at so far in this chapter, then, I have discussed my interviewees alcohol consumption practices largely in relation to the long term risks of diabetes. In the next several sections of this chapter I am going to explore how interviewees’ negotiated the risks of hypoglycaemia in relation to their drinking practices. Hypoglycaemia was one of the complications of diabetes that interviewees were most worried when out drinking.

#### **4.7. Alcohol and hypoglycaemic risk**

Alcohol induced hypoglycaemia is an especially risky complication of diabetes. Turner et al (2001) note that up to 20% of all incidents of severe hypoglycaemia

amongst people with diabetes involve alcohol in some form or another. There are several risk factors which make alcohol induced hypoglycaemia problematic. Firstly the onset of hypoglycaemia after drinking is uncertain both the length of time it takes to occur, and also in its intensity. It can for example, happen any where between 6 and 36 hours after drinking (depending on how much alcohol is consumed), and can even occur if alcohol concentrations in the blood stream indicate that the individual is only slightly inebriated (Frey et al 1997).

**Naoimh:** It usually affects me the next day. So I'll be fine right through the night and the next morning. But about now I'll usually go really low. For some reason it takes that long to get through my system. It's usually the day after lower rather than higher. If I drunk the bottle though, then it's just high forever. It's a bit weird.

Secondly the intoxicatory effect of alcohol can make it difficult for people to deal with a hypo once it has begun (Cryer et al 2003). Thirdly, the similarity between intoxication and hypoglycaemia can make it difficult for other people to distinguish between the two of conditions, meaning that there is a chance a person with low blood sugars will be considered by others to be drunk.

**Michelle:** You're not supposed to go out and get massively drunk. You might be left in a corner and go into a coma. Because I know people who've had experiences who are diabetic and that happened. So I personally am quite conscious of...I mean, I'm not saying that I do not drink, because I do drink. But I'm very conscious of going out and being careful about what I drink and stuff. Whereas people who aren't diabetic do not really give that a thought.

One final factor that makes alcohol consumption risky for young people with diabetes is the fact that alcohol consumption at university also often goes hand in hand with other risk factors such as vigorous exercise, for example dancing. Combined with the forms of alcohol consumption prevalent at many universities (namely binge drinking) it is easy to see how alcohol consumption poses a number of problems for students with diabetes. In fact in a letter to *Diabetes Care* outlining some of the potential difficulties that American students with diabetes would face on going to university, Mellinger (2003) identified alcohol induced hypoglycaemia as being the most problematic.



Rajaram (1997: 293) notes that hypoglycaemia is disruptive in a number of dimensions for people with diabetes. Reasons include its volatility, its often rapid onset, the disorientation it causes, and the chance of physical injury that emerge from it. Interviewees in this study noted several additional reasons why they were concerned about hypoglycaemia. When I asked Lilya what the worst thing about going low was, she noted:

The worst thing about going low? You need to be looked after. Which is nice sometimes, but when it's forced it's not...desirable. I've also got the whole emotional thing. I get very very depressed and start crying because of the stupidest of things...So yeah, I hate that. So under five...I try to keep between five and ten, ideally between five and eight... I'd like to be between five and ten. Because I do not like going low, it's just a horrible experience. If I go severely low I often find...you just cannot think and you cannot make a decision.

Loss of control is key here. Hypoglycaemia forces dependence. In a study examining the reasons underlying young people's fears of hypoglycaemia, Ritzholz and Jacobson (1998: 802) found that their respondents' often had strong anxieties "that others might perceive them as less capable and more impaired than they saw themselves or wanted to be seen". Hypoglycaemia therefore interfered with the process of "self enactment through which individuals' with diabetes attempt to project a positive image of themselves in 'the world of health'" (Rajaram 1997: 282). These kinds of disruptions were difficult as well for my respondents, especially when they were out clubbing and going to bars. Strong panoptic pressures to be 'normal' were usually present in these spaces. Schur et al (1999) argue that:

"If a person, has a chronic illness that is invisible to others then by giving public accounts that reinforce his or her identity as a person who can participate in the healthy world, that person can maintain his or her identity as a well person" (Schur et al 1999: 230).

Hypoglycaemia disrupted these presentations and constructions of a well self. It revealed that something was 'abnormal' about the person, in front of witnesses. As such, it was often upsetting and embarrassing. Frost (2005) notes that individuals who cannot maintain a social identity as a normal person risk being discredited. She argues that being unable to pass as normal poses a fundamental threat to the person, their identity as a 'normal' individual.

In Lilya's account, hypoglycaemia can also be seen to swamp rationality, which leads to a temporary loss of self (Charmaz 1983). Lupton notes that in Western industrialized societies control of the body (with the emotions generally being placed on the side of the body) by the mind has traditionally been considered to be something which all people should at least attempt to achieve, with the body being represented as continually "threatening to overcome the processes of the mind" (Lupton 1998: 3). The emotions are identified with the body in these discourses, as disorderly and existing outside the self (Lupton 1998: 85). Uncontrolled emotionality of the sort induced by hypoglycaemia therefore represents a profound erosion of personal control, an infringement of borders "between inside and outside" (Lupton 1998: 87).

#### 4.8. Risk minimization practices

To maintain their care of their selves and stay in control of their bodies, interviewees engaged in several forms of practice to reduce their risk of developing hypoglycaemia when they were out drinking. The practices were: self-surveillance, carrying around carbohydrates, drinking alcopops, telling other people about the interviewee's diabetes in order to build a support network, and eating something before going out. These practices will be discussed now, as will interviewees ambivalent responses towards them<sup>20, 21</sup>. It is important to note as well that these practices were used by interviewees to increase and maintain their feelings of emotional/existential security in the face of the sometimes uncertainties, both of diabetes and of their spatial situation.

All of the interviewees engaged in **self-surveillance practices**, with self-surveillance itself being typically composed of several discrete micro-practices. These included stopping every now and again in order to see how blood sugars 'felt', checking the label of bottles in order to see how much sugar or caffeine was contained in each, and making sure that certain kinds of alcohol or forms of drinking practice (such as

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<sup>20</sup> One important note: technological surveillance played an important role in the minimization of risk. This will be discussed in detail in the section 6.4.

<sup>21</sup> While the list of practices that follow is extensive, Miller-Hagan and Janas (2002) have demonstrated the necessity for analysing students with diabetes' drinking practices. Issues and ambiguities thrown up and into relief by these practices will be discussed.



binge drinking- more of which will be discussed below) were avoided if they were perceived to be too risky. Interviewees usually didn't bring their testing equipment out with them when they went drinking (the reasons for this will be explored in more detail in section 6.5.), and primarily relied upon phenomenological scrutiny of their bodies to tell if they were high or low. Naoimh provides an account of how surveillance practices are put into action here. In Naoimh's narrative surveillance can be seen to be first of all based upon examination of the body and its consumption practices. She notes that she looks at bottles of alcohol in order to see how much glucose each contains, and adjusts the qualitative and quantitative nature of her consumption in line with the potential effect she perceives these drinks could or could not have on her control. Secondly, her surveillance is based on how she feels, with technological monitoring used as a secondary, back-up mechanism serving to confirm or deny her primary, 'funny' sensations. Self-surveillance here is also constructed as a habitual practice, something that is unarticulated, something that has been internalized over time. However, the narrative is also clear that self-surveillance does not necessarily mean that the 'correct' practices will be engaged in; achieving a kind of 'fuzzy balance' seems to be satisfactory. Self-surveillance works once it ensures that the body will be in a state where it is likely that things will be ok. The notion of a risk/hassle trade off is important here; there is a law of diminishing returns with self-surveillance practices. Once it is likely that things are fine, focusing any further on diabetes is a hassle and disruption. For example, running off to the toilet to test ever half an hour is disruptive when all of her friends are dancing around their handbags on the dance floor. The point of a night out is to have fun, not continually monitor one's practices. This adds ambiguity to Foucault's notion of discipline and docility. As I will discuss in section 5.2., Foucault saw disciplinary activity as a practice which was executed, or not. Here it is clear that the important thing is being good enough, with what good enough means often changing according to where one is.

I've probably annoyed a fair few bar people by going 'is that diet coke' and they're like 'yes'. So I always make sure they give me diet coke. And if I feel funny I'll go and test my blood sugar and stuff, but I usually just forget about it to be honest...I think it's sort of inbuilt now.

Attempting to figure out how blood sugars ‘feel’ in a crowded nightclub can be a difficult practice, though. Christina didn’t trust herself to be able to do this. As such she noted that “part of the compromise” she had to make with her diabetes was that if she left her testing equipment at home then she would limit the type of alcohol she drank (no alcopops), and the amount of it. In this way she would know “what kind of sugar I’m consuming” and the effect it would have on her.

Indeed, Naoimh herself didn’t entirely trust herself to be able to sense what her blood sugar levels were. To minimize this risk of being “left in a gutter” Naoimh wore a bracelet saying that she was a diabetic when she went out clubbing.

Naoimh: Like I always wear a sort of identity bracelet thing when I go out, which I get asked about every time by my parents. When I say I’m going out their ‘wear your bracelet’. So when I get the photos back I prove it to them so their quite happy with that. I just wear it. I do not know if anyone will notice it or see it if I collapse or whatever but most of my friends know. And it’s ugly as hell. When I go out. Sort of when you’ve been drinking. It’s like another watch basically. Cause it’s an unscrewable thing.

Myles: Do you always wear it?

Naoimh: Well, we had the rugby ball last Friday and...I cannot remember what I did. I think I wore it but I tucked it under my watch, cause you can kind of do that. But then by the end of the night I do not care at all. Whatever. Or I might tie it around the handle of my bad. Yeah, I do not like...it is clunky and horrible. It's just like if sat at a table with short sleeves someone might notice. My dad had a go at me for not wearing it on the train on the way home. But I do not see that as a particularly threatening situation. But then again he’s right, cause like if I collapsed on the train then no one in the world would know that I was diabetic. So. I saw his point. I do not know if I would do it though... I just...it’s a train. Nothing’s going to happen on a train. It’s not like you’re out on a night out, not knowing what you’re up to or...people around you or...you’re just sitting there. Nothing should be happening. So. I can understand why he says wear your bracelet on the train. I do not know. I might do in future. Maybe. We’ll see.

Several points can be noted here. Firstly, the identity bracelet, while a risk reducing technology, is also experienced by Naoimh as a threat to her identity. It disrupts her attempts, and desires, to construct a normal appearance. As is clear here, taking care of her appearances was an important concern for Naoimh. Featherstone (1991: 71) notes that “women are trapped far more in the world of images than men” and Entwistle (2000: 8) argues that clothes are often viewed by women in moral terms,



and that “what women wear can be of...moral concern”. Entwistle notes that having the right outfit is often so important that even individuals who are not particularly worried about their appearances will dress correctly in order to avoid making a negative impression. Bodies that wear inappropriate clothes are at risk of being discredited, of experiencing stigmatising reactions from others. This was something that Naoimh was worried about, as evinced by her attempts to hide her bracelet and pretend that it was a watch. The bracelet also made her feel different; it was a constant, irremovable reminder that she was diabetic, that there is something ‘wrong’ with her. The concept of trade-off is important. Naoimh wore the bracelet in student spaces of sociability because, due to the presence of alcohol in these spaces, she considered the risk of going low to be plausible. Spaces like trains, though, were not perceived by Naoimh to be risky because she was not intentionally placing herself in harm’s way. She would be sitting passively rather than being actively in motion, actively consuming. The danger of anything happening here is perceived to be low. Consequently, the risk to her identity, which was constant, is too high. There was a clear cost-benefit process to the wearing of the bracelet, one that was connected to her spatial situation.

Most of the interviewees carried some form of chocolate or glucose tablets with them when they went out drinking. Female interviewees were most likely to encounter difficulties or hassle in relation to this though when they were wearing tight fitting jeans with no pockets, or very short skirts, they didn’t have many places left to store chocolate away in. Putting handbags into a cloakroom and keeping money could also be risky, because handbags could be lost.

Erin: Like some people might put their bags in a cloak room. I think when I first started going out at home, it was a strange sort of club where you had to put all your bags in the cloakroom. So I always had the issue of where do I put my sugar. So I put my sugar down my socks, and got away with it like that. But now I just carry it around in my bag.

However, while carrying around chocolate was a way for interviewees to minimize the risk of alcohol induced hypoglycaemia and thereby stay in control of their bodies, having to carry around chocolate could be experienced as a form of constraint, a limit placed by diabetes upon the freedom of the self.

Naoimh: One thing that I hate is that you always have to carry something round with you. Like you can never go to the pub with just your wallet. There's always got to be sugar, or maybe the injection if you're going to eat. That sort of really irritates me. But apart from that it's...do not mind it.

In general, feelings of constraint were most clearly articulated by the female interviewees in relation to the practice of dancing. Having to carry around a handbag was often felt to interfere with female interviewees' ability to dance with their friends. Malbon (1999: 142) argues that the clubbing experience for women is largely based around dancing. He argues that through dancing, feelings of belonging and identification with other young people are created, feelings "central to the clubbing experience" (ibid: 37). Deciding not to carry around diabetic management technologies (such as glucose tablets) could be seen then as an acceptable practice if these technologies are felt to interfere with the ability to dance wherever, however and with whoever the self wants, in spatio-temporal, bounded situations where being like, and *feeling* like, everyone else is important.

Risk could also be controlled by drinking non-risky forms of alcohol, such as whiskey or vodka and diet cokes. Interviewees were much more ambivalent about drinking alcopops. Alcopops are a form of alcoholic soft drink that contain 4-5% alcohol, have very high levels of sugar, and are primarily drunk by, and marketed towards, a young female audience. On the one hand alcopops were seen by some of the interviewees as a vital way of minimizing the risks of hypoglycaemia when they were out, allowing them to keep their blood sugar levels high and enabling them to engage fully with the carnivalesque spaces and oceanic experiences of the night out (Malbon 2000). On the other, alcopops were seen by some interviewees as being an especially risky type of drink precisely because of their high sugar content.

There were strong gender differences with regards to alcopop consumption and perceptions of its attendant risks. For example, none of the male interviewees indicated that they would be willing to drink alcopops because they felt the drinks would increase their risk of developing long term complications. Drinking alcopops was a 'bad' practice, one that disrupted attempts to construct a moral self.



Kirk: I mean I stay away like alcopops because they're just full of sugar. Like some of them carry warnings on the back saying not recommended for people with diabetes. Um, and I've been told the best drink is vodka and diet coke so that's...that tends to be one of me favourites<sup>22</sup>.

On the other hand, the female interviewees were as likely to drink them as they were not, and view them as a way of managing, rather than increasing, risks. If and when alcopops were seen by the female interviewees as a means of *both* increasing and decreasing risks, then their short term benefits, particularly the way they enabled control of the body in uncertain spaces, were usually seen to outweigh their long term effects. Spatialities were implicated in interviewees' attempts to stabilise and control the consequences of alcopop related risks here, in the sense that while alcopops were used to control blood sugars in risky spaces, the risky effects they themselves engendered were usually disciplined and managed in the controlled space of the home after a night out. Alice noted:

Normally like I like Bacardi, so normally I'll have like Bacardi and coke and stuff. And then because that sends you low I'll normally have some alcopops when I get there. So if you have alcopops and spirits it sort of balances out. I'd rather get a bottle where I can put my finger in and look after than get a bacardi and coke which is in a glass and whatever and is much easier to hold and dance with than it is.

There are a number of important points in Alice's narrative. Alcopop consumption is firstly associated with the management of risks. For example it is linked with the management of sexual risk in the way the very shape of the bottle disbars strangers from easy access to it, and by implication, the vulnerable body holding it. Indeed, the pleasurescape in which alcohol consumption takes place can be read as implicitly hostile spaces from Alice's perspective. Numerous geographical works, focusing on groups as diverse as female undergrads in Edinburgh (Mehta and Bondi 1999) and metal clubbers in Australia (Krenske and May: 2000) have clearly demonstrated that women are conscious that they could be attacked in public places, and in particular of the risk that they could be sexually assaulted by strange man, something which "is perceived to be both very serious and relatively likely" (Koskela 1997: 304). From this perspective, the use of alcopops allows the risks raised by the presence of what is

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<sup>22</sup> Kirk noted here that one of the ways he tried to keep himself 'sensible' in the face of his excessive drinking practices was to avoid certain forms of alcohol. He felt this would balance up the risky nature of his consumption and allow him to maintain some control over his practices.

felt to be a vulnerable body in public spaces to be managed. So while their consumption may be risky from a medical point of view, this same consumption consequently helps manage the risks created by encountering unknown others in uncertain spaces. There was also an important gender reason why Alice consumed alcopops: she noted that “girls drink them”. Consumption here was a way of constructing a normative feminine identity. Indeed, it appeared that one of the reasons why the male interviewees could easily reject alcopops as a hazardous form of alcohol was because consumption of the drinks weren’t important for constructing a normal *gendered* identity.

Secondly, alcopop consumption was seen as a necessary practice by Alice given that she didn’t carry around (like many of the female interviewees) chocolate bars or glucose tablets, as they would interfere with her ability to dance. Anxieties raised by drinking alcopops were controlled by Alice by contextualising her practices, and by temporally bracketing them. She noted that she went out relatively few times in a week, for example.

I do not know because I do not really go out that often; I do not really go out that much. Because basically I do spend all night dancing that’s the only thing to keep my blood sugar up because I do not have anything with me. And I’m only out like for four hours at the most. The sugar content of the drink minimizes the spectre of hypoglycaemia, which may be raised by the presence of the body actively moving around a dance floor.

Balance was also a key theme in Laura’s description of her alcopop consumption practices. Laura noted that she didn’t feel guilty drinking alcopops, but she did about “stuffing crisps”, because there was there was no moderating factor in crisps to balance the rise they would cause to her blood sugar levels.

Myles: But you would you feel more comfortable having a drink, or eating a bag of crisps?

Laura: Having a drink.

Myles: For what reason?

Laura: Because then I wouldn’t worry about my sugars being high.

Myles: Even if it was an alcopop?



Laura: Yeah...I'd probably have that than the packet of crisps.

Myles: So would the crisps send you blood sugars higher than the alcopops would?

Laura: I do not know actually...I do not know. The alcohol in the alcopops might bring it down so it'd stay about the same.

Myles: That's...

Laura: It's so complicated. People do not realize.

Finally, some interviewees didn't like alcopops because they were perceived to have negative effects on their weight. Again, this was mainly a concern of the women I interviewed. Naoimh for example noted that the downfall of every student in university as "getting a beer gut". Lilya decided to cut alcopops out of her diet not because they could have a negative effect on her blood sugar control but because her BMI score had gone up from drinking them.

Lilya: I started to go down to the gym and managed to lose, like, a stone. Ish. Over the summer. Which was good. Then I had another conversation with my team who gently pointed out how many calories there were in a bottle of alcopops. And I worked out that I'd have to spend about 20 minutes on the cross trainer to burn off one bottle. And I thought that's ridiculous when I could be eating that much chocolate or doing less exercise. So I cut that out. Though I'm still going to be drinking on special occasions like Christmas or the New Year, so it's not like a diet at all. It's better for my health and my finances anyway.

As a group, interviewees had ambivalent attitudes about the third of the risk minimization practices, telling other students about their diabetes. Generally, most of them argued that they were willing to inform their peers about their condition, letting them know what to do in case anything went wrong. By doing so some of the emotional pressures, the fears, worries and anxieties of self-surveillance could be distributed through a network of actors, rather than being the sole responsibility of one person.

Lilya: You have to [tell people]. Otherwise...you cannot disappear off to a toilet every time you have to have insulin or try to do a blood test on a table and you're machines beeping and your fingers are bleeding everywhere. It's

just not practical. And plus from a safety point of view, if you've passed out somewhere because you're low they might think she's just drunk or whatever.

Most of the older, non-first year students relied on their friends to act as a risk reducing support network operating *in addition* to other risk reducing strategies practiced by the interviewee herself, such as self-surveillance and keeping blood sugars high. First years respondents, however, were more likely to elide and ignore (at least in the first several months of their first year at university) the usual intensity of their other risk reducing practices if they felt their friends were there to take care of them. They not only brought their friends into an economy of collaborative surveillance, they were also more likely to rely on their friends to intervene and take care of them *before* anything went wrong. Feelings of responsibility were therefore diffused, as well as the practices upon which this responsibility was based. Consequently, first year students were more likely to engage in binge drinking and other risky practices when they went out because they felt that their friends would take care of, and be accountable for, them.

Erin: I have a lot of good friends here and they'll look after me and generally there'll be someone who's less drunk than you and saying have you done this or done that.

A reliance on other young people to *too* great an extent, however, could itself be perceived as a risky practice, particularly if it was felt that too much personal control and personal responsibility was surrendered to the network. For example Erin noted that she was also worried about giving up control to other people, even if this was only temporarily and even if this was only while she was out, because she felt it could increase her risk of something happening to her and the possibility that she would do something foolish like have sex when she was drunk. The surrender of responsibility in this way could also be read as a challenge to an identity narrative based around "themes of individual responsibility for self-care and risk management" (Brown and Duncan 2000: 365) which run through medical discourses of diabetes .

Myles: What's the worst thing about drinking?



Erin: The worst thing? Um...I guess, if it's been a big night out, then the next day. Um, yeah...and also if you do go a little too far not really being able to function and get home and having to rely on other people. And I suppose also not remembering things is not a good way to go. Whether it's things like not doing my injection, or whether it's things like where you went and who you were with.

Trust was a crucial issue in interviewees' decision about whether to tell other people about their diabetes or not. Giddens (1991: 19) notes that trust is something that "presumes a leap to commitment, a quality of faith which is irreducible", and "attitudes of trust...are directly connected to the psychological security of individuals and groups". He argues that "in situations of uncertainty trust has a particular application. Trust is basic to a protective cocoon which stands guard over the self in its dealings with everyday life. It brackets out potential occurrences which if they were to be contemplated would produce a feeling of paralysis or engulfment" (Giddens 1991: 3). While most of the students trusted their peers (to greater or lesser extents) and for differing reasons, some of the interviewees argued that they did not trust other students to intervene to help them if anything went wrong. Sylvia for example noted that she didn't have faith in anyone else's ability to look after her (apart from her boyfriend) when she was out.

I do not know if I trust myself to do that...I do not know if I could trust anyone else to get me home or look after me or...you know, that's the diabetes as well, in the sense that although the people around me know, I'd maybe a bit cautious that they'd know what to do if I get into a state. So I'm probably aware of that. I'd never get myself absolutely...you know have too much to drink in case here comes the diabetes and they wouldn't know what to do.

In their study of student practices, Rachmandani et al (2000: 665) found that 38% of their respondents "did not have any arrangements of supports in case of hypoglycaemia". They noted that the reasons for this were unknown. Sylvia's narrative is useful for addressing this gap in knowledge. In part, it can be seen that the lack of confidence Sylvia feels in others stems from the liminal presence of diabetes in her account; diabetes is constructed as existing outside the self ('here comes'). It is represented almost as a force of nature. As such, it has something that

even she has trouble predicting and dealing with. It can sneak up, but when it does appear, its presence cannot be stopped. It is therefore important to always have control over it if it is to be successfully regulated. Control cannot be allowed to slip away, or surrendered to another person. Furthermore, another reason why Sylvia didn't tell other people about her diabetes was because she felt that diabetes was part of her private, rather than her social, identity.

You know like if you told your friend and they told someone else...you do not mind your friend knowing because they're close to you, but...you do not like other people talking about it because it makes you feel uncomfortable.

Sylvia balanced an absence of trust in others by intensifying the practices she used to control herself, for example by regulating the amount of alcohol consumed on a typical night out (which wasn't very much, and a typical night out wasn't very often, given Sylvia's desire to regulate herself).

Maria's narrative forms an interesting counterpoint to Sylvia's. Like Sylvia, Maria too didn't trust people to look after her on a night out, and for much the same reasons. However unlike Sylvia Maria sometimes fantasised about hypoing just so that she could finally know who she *could* trust. Lupton (1995b: 108) notes that ambivalence often underlies situations where individuals must rely on the trust of others because trust develops only *in* situations where there is a lack of knowledge. This ambivalence sometimes ate away at Maria. While she considered control of her diabetes to be her responsibility, she wanted to know, for definite, if she could rely on other people if she really had to.

Sometimes I'd love to have a hypo just to see what happened if I left it, and see what people do just because I'm not sure if anybody really knows. I just wondered if they thought about it, because sometimes I wonder if...I'm the only person who thinks about my diabetes. But then at the end of the day it is my illness.

The fifth and final risk management strategy my interviewees engaged in was making sure that their blood sugars were high when they were going out. Risk awareness in relation to this practice operated on several temporal levels



simultaneously. On the most immediate, high blood sugars, though they were not good in terms of long term control, could minimize the risk of blood sugars collapsing when alcohol was consumed (and the potentially harmful effects of high blood sugars here could be ameliorated by the fact that blood sugar levels would only be high for a few hours, and would in all likelihood be eroded by exercise and activity). Elevated blood sugar levels also reduced the possibility of a hypo occurring in the medium term, such as during the night after interviewees came home from clubbing, or the next morning. Interviewees were especially anxious about hypoing during the night, especially if they lived in halls, because it could be difficult to get someone to assist them if anything went wrong. Alex noted that:

If I go out I try to make more but not that much. I try to keep it higher than lower. Because if I am kind of tipsy I could also be low blood sugar. This is a really, really dangerous thing. I cannot...it's a huge risk you know.

Importantly, though, being high could come with its own set of issues. Alex for example noted that being high, while providing a means for him to feel in control of his body while out, rendered him out of control in another, fundamentally important way: namely his ability to exert control over his emotional self. Control of the emotions was an important dimension of the control of the self for the interviewees in this study. However, hyperglycaemia had the potential to make the body uncontrollably emotional, even if it was actualised in order to prevent hypoglycaemia. Alex noted that he often felt very angry when he became hyperglycaemic. While anger is an acceptable emotion (to some extent) for men to feel and display (in the sense that it is often associated with the desire to engage in violent, powerful actions, behaviours approximately corresponding to those valorised by hegemonic masculine discourses), anger is also associated with erosion of personal control. Indeed Lupton (1998: 89) notes that “to ‘lose your temper’ is to relinquish control, to unleash unacceptable feelings from within the body and to let them loose upon external world”. This would appear to be especially relevant when, as in this case, the emotion is forced. The emotion does not arise through interpersonal interaction but through rising blood sugar levels. It is the body affecting the mind, not the mind controlling the body, and therefore something that must be regulated. So whereas some studies such as the one done by Rajaram (1997: 286) found that people “find it easier to be medically out of control in order to be more in control of their personal

and social identities and to decrease the probability of biographical disruption” (Rajaram 1997: 286), here both hypo- and hyper-glycaemia lead to some sort of disruption of the self.

The thing for example, if I have low or high blood sugar...high blood sugar makes you angry. Sometimes I feel it directly influences my psychological situation; directly. I feel that, you know. I really became much more angry than usual. And that's one of the other things why I want to keep my blood sugar levels under control.

#### 4.9. Alternative consumption practices

While the emphasis in research into the alcohol consumption practices of young people is often placed on the risky nature of the consumption practices themselves, many young people do not drink alcohol or do not (always) engage in ‘spectacular’ drinking practices such as binge drinking. For example for young people who ascribe to a straight edge lifestyle<sup>23</sup>, drinking is often seen as a something practiced by people who have no control over themselves (Wood 2003). Miller-Hagan and Janas (2002: 237) note that, with regards to the drinking practices of students with diabetes, students are as likely to abstain or regulate their drinking to maintain their control. Indeed, Gill (2002: 113), in a wideranging review of student drinking practices, noted that in general “average results from all studies would suggest an abstention rate for males of 14% and 12% for females”<sup>24</sup>.

As I discussed earlier, out of the whole group of respondents, the ones who drank most regularly and heavily were the first years, and even then their drinking was most intense in the first few months of university life. First years also simultaneously engaged in more relaxed drinking practices, though, for example by having wine with meals during the week and then going binge drinking at the weekend. In this way they felt that some degree of balance could be maintained over their practices. As interviewees made their transitions within the university system, their drinking practices often changed. While older interviewees still sometimes engaged in binge

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<sup>23</sup> A youth movement that grew out of the punk scene, where an emphasis is placed on personal purity, a state achieved by not drinking or doing drugs, not eating meat, and being sexually pure.

<sup>24</sup> Gill notes that abstention in most of the studies he looked at was a practice where an individual would usually not drink alcohol in a typical week. Overall, Leifman et al (1995: 113) notes that “in alcohol research, abstainers have received only limited attention” (Leifman et al 1995: 113).



drinking practices, the frequency of this practice became more sporadic, if not the intensity of the practice once it was engaged in.

Maria, Lars, Elayne and Sylvia were different. These students largely abstained from drinking throughout their university careers. Abstention here is a tricky word to define. Lars, for example, was the only interviewee who had never drunk alcohol. The three women who I classified as abstainers did drink alcohol sometimes, but did so only very rarely, even when they were in their first year of university. Spatialities were important. These interviewees were much more likely to enjoy drinking in moderation in the space of the home, rather than in public space, because they perceived drinking in the latter places to be too risky. The chance of losing control was perceived to be too great. However, they did drink some alcohol. Nevertheless, the steady moderation of their practices is different from those of the other interviewees, for whom a regulatory attitude towards consumption often developed as these students transitioned within the university. So while Maria et al are not quite abstainers in the sense, for example, that I am (I have never drunk alcohol), they do form a unique group in the sample of respondents as a whole.

There appeared to be several reasons why these interviewees differed from the other students in their attitudes towards alcohol. Elayne noted that she had internalized the values of public health discourses, which emphasized the negatively risky relationship between risk and alcohol, and moderated her practices in light of this.

I've never really drank, certainly not heavily...because ever since I was diagnosed...you're bombarded in a way with all these cautions and all these cautionary tales of what will happen if you do, if you drink, if you smoke, if you do drugs, you know.

For Lars his identity as a diabetic was more important to him than his identity as a student. For Erin above for example, the ability to drink was something that she didn't want to be limited. She considered alcohol consumption to be a necessary practice in order to construct an identity as a normal young student. Lars had a stronger sense of himself as a diabetic than he had of himself as 'a student', and had a firm idea of the correct moral practices that a diabetic should engage in. Binge drinking wasn't one of these practices. Independence was also a key theme in Lars'

narrative. He didn't like the idea of conforming to the norm, especially when he thought that it was based around a juvenile, bravado and alcohol fuelled form of masculinity. Independence for Lars meant being able to take responsibility for his own actions (Connell 1995), staying in control, having a Clint Eastwood rather than Rambo styled approach to consumption.

It's just something [drinking alcohol]...I've never really felt compelled to do. As I've grown up I've seen how people are just...get sucked in by drinking and it's this thing that people do when they get drunk and get silly and I think what's...what's the attraction in that? I mean, I've always been quite a strong willed person, and I'll never be swayed by somebody. And obviously it can affect your diabetes.

For some respondents anxieties about alcohol losing control were intense.

Elayne: You know if I wasn't diabetic, take that out of the equation completely, um, I wouldn't drink excessively simply because I'd be feeling awful the next day. It's why I do not drink. I mean even if I wasn't a diabetic, just having to take that out of the equation completely, um, I wouldn't drink excessively. Simply because I hate feeling awful the next day. I cannot stand it. I hate the lack of control you feel when you're drunk.

Importantly, Elayne's anxieties were spatialised. Elayne noted that when she was out drinking, she often felt she had to be in control of everything around her in order for her to feel secure.

Elayne: My biggest fear generally is going low in a situation where I cannot control it. Around people that I do not know. Which is why I do not like drinking in clubs. I'll go to the pub and we'll have a few drinks because I do not want to go low there. Or high. That's probably my biggest fear. It's never happened cause I won't let it happen cause I won't drink so much that I cannot sort of control what's going on.

What is most striking about Elayne's account is that she is describing events that haven't yet happened but *could* happen. Elayne for example hasn't gone low in public but she is worried that there is a risk of this happening, and adjusts her practices in light of this understanding. Giddens (1991: 202) argues that thinking in terms of possibilities and risks is a "means to stabilise outcomes, a mode of colonising the future" (Giddens 1991: 133-134). Giddens argues people often



reflexively interpret their practices in light of the effect they could have on their care of the self. In doing so an individual can exert a degree of control over situations he or she finds him or her self in, and, as can be seen here, increase emotional security in threatening spaces.

However, while Elayne hated drinking alcohol in public spaces because it increased her risk of going out of control, drinking in private, and in moderation, could be a way of managing risk. As I will discuss in more detail later on in this thesis, during her final year in college Elayne's diabetes started to go out of control because the continual stress of revision and exams. This resulted in her experiencing consistently elevated blood sugar levels. While there was nothing that she could do about this, she found that drinking alcohol could be used to control her blood sugar levels by brining them down and counter-acting the effects of stress on her body. In this way alcohol consumption provided Elayne with a way of staying in control, rather than losing control, over herself.

Alcohol helps. If my boyfriend are at home having dinner we'll have a bottle of wine, and it's fantastic because the next morning my sugars are always perfect as it lowers my sugars. It certainly doesn't send me high. Having a bottle of wine with dinner, when I wake up the next morning my sugars are brilliant, always the low side of good.

There could be consequences, though, for not drinking. Not drinking in public so as to stay in control and manage risk could also place interviewees at the edges of their peer groups. Maria for example noted that after she returned to university after being diagnosed, her need to be in control of her surroundings increased.

I think that my control that I had from my diabetes spread to everything around me. So like my whole surroundings. So I think I was a lot more...I might have put people off and stuff because I was a lot more like...this has to be done, just because this is how my thought processes were, having diabetes at the same time. And that sort of pushed me out of the crowd sort of thing.

Control of the self via the regulation of consumption practices is not a practice that allows one to easily become part of the student body here. Chatterton (1999) notes that experience of consumption practices in the traditional spaces of student life, such as bars and clubs "allow students to embed and reinforce their identity as students"

(ibid: 120). He argues that these spaces “act as sites of social centrality within student life in which rituals of studenthood are undertaken and the rules of student life are learnt” (ibid: 120). Consumption of alcohol therefore enables interviewees to experience feelings of community and collective effervescence with other students, to become and feel part of peer groups; inebriation and identification go hand in hand. The intense controlling practices that Maria describes here in a sense dislocate her from these central spaces of student identity, spaces that are predicated upon hedonistic consumption and loss of control over the self. However, Maria does not describe the same feelings of anxiety about difference as Erin and Laura do. One reason for this is that Maria was an older, postgraduate student, and so considered herself different from the study body in the first place. Secondly, she also felt that being in control of themselves was much more important than engaging in ‘student practices’. Indeed, Maria’s practices in particular were rigidly routinized and characterised by an attempt to construct what Giddens (1991) refers to as compulsive mastery (at least until she went on the DAFNE project, which will be discussed in more detail in the technology chapter). The need to be safe and to minimize the vulnerability she experienced during hypos were much more important concerns.

#### 4.9.1. Respectability

Constructing a respectable self by limiting alcohol consumption was a central theme in Sylvia’ narrative. Regulating consumption was a practice that was intended to minimize the risks of appearing drunk or hypoglycaemic in public, states which Sylvia felt would be a challenge to her self-identity as a ‘classy’ woman.

One time I was having a mild hypo and we went to see a band. And I’d come back on the train and I was feeling a little bit woozy and I had to have something to eat. And my friend told me that I was sitting on a chair in McDonalds, and it was like I was drunk. It was like I was slurring my words...I couldn’t walk straight...and I couldn’t bear if that happened again...I couldn’t bear people thinking I was drunk. I didn’t want them thinking I was like drunk or lost control...you know, having a look...I think that even if it wasn’t for the diabetes I do not particularly like being drunk. There’s nothing worse than a classy girl looking a state. And it might just be because of my background, it looks just terrible if someone’s drunk, you know, in the sense of tarty drunk. It’s just horrible, I wouldn’t want to be seen like that (laughs). Just...I just think I’d feel a mess, and then in the morning I’d be like...oh, what was I doing. It’s just not my thing.



Myles: So are you quite conscious of how people perceive you?

Sylvia: Yeah. Yeah. Very, in fact. Yeah. (laughs).

Rajaram (1997) notes that often:

“An illness episode such as an insulin reaction upsets patients’ biographies and self-worth...hypoglycaemia can be seen as a marker of loss of control over one’s body and one’s situation- a failed performance” (Rajaram 1997: 285).

In Sylvia’s case this disruption is of a moral identity, one whose validity rests upon being controlled and composed in public space.

Skeggs (1997) argues that the concept of respectability is a central element in the formation of working class women’s identities. Respectability is a relational concept, constructed in opposition to those deemed not to possess it. For example in the 19<sup>th</sup> century women who were considered to be respectable (mainly bourgeois or upper class women) were defined against working class women, who were deemed to lack all respectability. Where bourgeois women were thought to embody the respectable virtues of modesty and chasteness, virtues considered conducive to the formation of family values, working class women were often seen to embody profligate excess and sexual abnormality. Like most binaries, this was an unequal relationship; respectable women were considered to have greater moral power and authority than those figured to lack respect. Skeggs argues that in the contemporary period, for women who identify with a discourse of respectability, a large amount of time is taken up with controlling the presentation of the self so that others won’t think that the individual is, or won’t be able to position the individual as, someone uncontrolled, someone excessively sexual. It’s important to note that while students are often represented as being sexually promiscuous, female students are often concerned about their sexual reputations, about “portraying an image of sexual innocence and not promiscuousness” (Farrow and Arnold 2003: 353).

Sylvia’s desire to control her drinking stems from a desire to identify with an emotionally resonant, classy, feminine subjectivity. For Sylvia a ‘classy’ feminine subject is one who is not drunk, who is in control of her actions in spaces where

other people can make moral judgments about her. It is a subjectivity that is not 'tarty', a characteristic which Skeggs (1997: 4) argues is often taken to be a signifier of working class women's identities. It is a subjectivity attuned to style, control and refinement. Drinking alcohol 'excessively' on the other hand is an identity risk for Sylvia because it threatens to make her disrespectable.

The management of hypoglycaemia is therefore itself a crucial practice for ensuring successful disidentification from a tarty, working class identity. Sylvia was aware that from the perspective of other people, it would be impossible to work out if her behaviour, when she was low, resulted from either a severe hypo or from uncontrolled drunkenness; most people would just assume she was drunk. She was conscious that, despite her best efforts to dissimulate herself from a disrespectable self, her diabetes constantly threatened to make her body 'other', to make her seem like a 'tart'. As her narrative indicates, when it did occur, hypoglycaemia made her look 'a state', which she was ashamed about. Giddens (1991) notes that that shame is central to the integrity of individuals' identities in late modernity. It is something that brings into question the very validity of individuals' sense of themselves as competent agents. Shame emerges in situations where people feel their behaviour does not correspond to the "self as I want to be" (ibid: 68). In Sylvia's case, shame results from the uncontrolled practices she engages in when she is low, the complete loss of control she experiences over her body. Her body becomes loud and visible in public space, the body of a working class woman (Skeggs 1997), not the body of someone who is respectable and regulated.

Shame is a profoundly relational emotion. Bartky (1990: 86) notes that shame requires "if not an actual audience before which deficiencies are paraded, then an internalized audience with the capacity to judge". It needs an acknowledgment that conclusions and opinions of other people on the practices of the self are valid (Skeggs 1997). And indeed the presence of other people is a central discourse in Sylvia's narrative. She is ashamed about hypoing in front of an audience of strangers. Spatialities are important here; developing hypoglycaemia in private spaces wasn't experienced by Sylvia as being as shameful or as disruptive to her identity because there would be no witnesses around to see her lose control over herself. One point to mention here, which will be discussed in more detail in the technology chapter, is



that Sylvia's anxieties were intensified by the fact that in many respects she wasn't controlling her diabetes. She didn't want diabetes, and often wouldn't inject nor test intensively because she felt these practices would disrupt her ability to be a normal young woman. However, by not engaging in these practices, she increased her risk of losing control over herself.

It is also important to note that while Sylvia wanted to maintain a respectable identity via regulation of her diabetes and her consumption practices, at points her narrative indicated certain ambivalences about both. For example, while she wanted to minimize hypoglycaemia, when it did occur Sylvia indicated a wish that the experience was more disruptive than it was, so that her embarrassment, anxiety and subsequent attempts to discipline her body would be all the more intense in the future. So while drunkenness/hypos challenge the respectable self here, in some respects they not do so enough. Indeed, they can never do so enough. It is always possible to be more ashamed. Intensive regulatory practices, fuelled by the branded memory of shame at her lapse into disrespectability, would therefore have a twofold purpose; they would increase her ability to identify with a desired discourse of feminine respectability while simultaneously suppressing the presence of diabetes in her life.

It's a horrible feeling 'losing control', but what makes it worse is that when you have a turn you can feel awful at the time but then half an hour later everything's fine and there is no lasting effect. So you can forget it quicker. And I think...that if there was something there that made you remember you'd be a lot more cautious about letting it happen again. Yeah, definitely (laughs).

Furthermore, despite her desire to be in control of her body, Sylvia also sometimes had a wish to abandon all control, and let her moral self slip away in the happy haze of a drunken hour, to be taken out, tonight, because she wanted to see music and wanted to see lights. Hubbard (1997: 58) notes that images of 'out of control', sexualized women in public spaces are often viewed with feelings of both desire and disgust. While desire in this context is more often than not associated with men, it can be seen here that Sylvia herself, at least partly, desired this 'other' identity. It's also interesting to note the way management of risk is represented here as an all or nothing activity. If she goes out, she doesn't eat or do her injection. She hasn't

achieved a balance, a flexibility with her control that could come from making her diabetes part of her *habitus* in the way the way some of the other students did.

You know like you just want to let your hair down and not worry about it. Sometimes I just want to be able to say yeah, let's go out and not go home. And although I do that occasionally I'd like to be able to do it more often without having to worry. Like I'd still do it, I'd just be worried about not eating or not having my injection or...you know. I'd just like to be able to do it, and not worry about it.

#### 4.10. Conclusion

Few previous studies have provided an in depth exploration of young people with diabetes' negotiations of risky practices (Seiffge-Krenke and Stemmler 2003). Those that have looked at young people with diabetes' practices often concentrate on the "maladaptive lifestyle practices of adolescence" (Dabadghao et al 2001: 890). Eaton et al (2001: 942) for example argued that:

"Most of the time [diabetes appears to be] just an added complication that could be dealt with and treated correctly or ignored [by students]. It may be this attitude towards having diabetes that needs to be changed in some way to try and improve control. The relatively poor response to requests to take part in studies like this is perhaps an indication of the low priority that students give to diabetes management".

In contrast to the findings of these studies, the young people in my study had anything but an unconcerned attitude about their consumption practices and their diabetes. Interviewees were intimately concerned about the risks of their alcohol consumption, both in the short term and the long term. Risk, whether negotiated consciously or habitually, was an important part of their every day/night lives. It was clear that students' understandings of the risks of their consumption drew on understandings of risk constructed by the DCCT (seen in their desire to minimize risk), but it also clear that their understanding of risk was influenced by the stage they interviewees were in their university careers, their personal background, the length of time they had been living with diabetes, and what they defined as 'normal' behaviour, a definition influenced by the gendered identities they identified with and so on. What it could not be argued was that my interviewees had an irrational approach to risk. They interpreted medical discourses in light of their own experiences and spatial situation.



Control emerged as a key, if ambivalent, theme in interviewees' narratives. First years were often worried about the risk that their diabetes could render them 'abnormal' by dictating the qualitative and quantitative nature of their alcohol consumption practices. Risky consumption practices could therefore be used by respondents as a way of demonstrating to themselves and others that they had control over their diabetes, and that it didn't have control over them. 'Having' control by 'going out' of control in this way was closely linked by interviewees with the performance of identities as 'normal' students. There was evidence that as interviewees transitioned within the time-space of the university, their attitudes towards alcohol and risk changed. Engaging in risky alcohol consumption on a regular basis was generally felt by the older interviewees to be a negative practice, one which was likely to be associated with a loss of control. This did not mean that these interviewees stopped binge drinking altogether; but it did mean that binge drinking practices often became more irregular, and, as James indicated, when binge drinking did occur, it could challenge the discourses of responsible care that interviewees identified with. In the process it could lead to what Giddens (1991) refers to as fateful moments. Furthermore, a substantial amount of the older interviewees didn't drink alcohol at all because of what they saw as the hazardous nature of consumption for their social and personal identities.

Temporalities occupied an important place in interviewees' consumption narratives. Interviewees were often worried about the effects their practices could have on their bodies and identities in the future. Valentine et al (1998) have noted that in contemporary consumer culture young people are often considered to be hedonistic deviants who rarely, if ever, think beyond the present. Pais (2000: 220), for example, contests that young people "often take the 'good bishop' approach [to life], and seek mobility and attack, even at the risk of losing the bishop". However, the arguments of authors like Pais do not fit the findings of this chapter. Interviewees were often anxious about engaging in precisely those practices that they used to identify with the 'normal' student body. Their practices, then, had multiple temporal connotations; what was a positive practice for them in the short term could be a negative activity in the long term. Balancing practices was therefore an important activity. This balancing could be done in multiple ways. For older interviewees, it could be done

by regulating the frequency of alcohol consumption. For first years who went out drinking four or five times a week, it could be done by contextualising current practices within the set of all the practices the individual would engage in over the entire life course.

Spatialities also had important presences in interviewees' accounts, particularly in relation to the short term risks of diabetes. The focus on space in this chapter develops Beck's account of risk, for whom the risk conscious individual is primarily a temporally orientated subject. The meaning of alcohol related risks often changed according to whether or not these risks were negotiated in public or private spaces. With Sylvia's narrative I demonstrated that anxieties about engaging in shameful and degrading practices were linked to the risk of hypoglycaemia and drinking in public. In contrast, hypoglycaemia in private wasn't experienced as as disruptive an event because no one else would be around to witness her loss of control. To regulate themselves while they were in public, interviewees engaged in a variety of risk minimization practices, which often, in terms of scientific models of risk, were risky themselves. A good example of this is female interviewees' alcopop consumption. However, these were practices that made sense in context. Interviewees who carried alcopops around didn't have to carry any extra chocolate which would interfere with their attempts to engage in normative practices like drinking. Drinking alcopops was also something that "girls do" (Alice). Alcopop consumption here both serves to minimize the disruptive potential of hypoglycaemia while reinforcing a desired account of femininity.

Gender therefore also emerged as an important category in understanding my interviewee's alcohol consumption practices. Interviewees' alcohol consumption practices were influenced by the discourses of masculinity and femininity they identified with. For example, Kirk's consumption was designed to construct a laddish form of masculinity, while Sylvia's refusal to consume was intended to enact a respectable feminine subjectivity. However, it was also clear that there was no one unified form of masculinity or femininity which my respondents identified with; rather, there were different forms of masculinities and femininities present.



Overall, then, alcohol occupied an important, and often ambiguous position in my interviewees' university lives. In Homer Simpson's words, it often seemed to be both the cause of, and the solution to, all life's problems. And in the terminology of the 'new medical geography, it clearly lighted important linkages between risk, the body, identity and consumption.

In the next chapter I am going to examine some of the themes addressed in this chapter, such as control, balance and the spatialization and temporalization of risk, in relation to another important form of interviewee consumption: food.

**Diabetes, Diet and Disciplinary Practices**



### 5.1. Introduction

There are many assumptions about student identities and practices. One of the most common is that ‘students’ eat ‘student’ diets, which more often than not are thought to consist of spaghetti, beans on toast, fish and chips, and bars of chocolate. For extra effect, these foods will usually be consumed from rusty tin pots left on the sideboard for several weeks. This is, of course, a stereotype. Even authors who seek to challenge the stereotypes about student practices, though, often end up reconfirming them. For example, while Platt (2001)<sup>25</sup> notes that there is no such thing as a ‘typical student’, he rests his argument on the difficulty of distinguishing students from the “millions of other kebab-chomping drunkards who spill onto the streets every weekend”, which is an ambiguous differentiation at best.

People with diabetes are often considered to have their own identifiable consumption regimes as well as well. In contrast to ‘student’ body projects, though, those of people with diabetes are usually felt to be much healthier. They are based on sensible, balanced diets and regular exercise. However, “studies of dietary compliance in diabetes indicate that the majority of people do not rigorously follow the recommended diet” (Maclean 1991: 689). Young people with diabetes are often considered to be the most non-compliant, and consequently the most ‘problematic’, in this regard.

Consequently, many researchers see students and young adults with diabetes as an especially risky group. They have a condition which means that they have to (or at least, should) regulate their consumption and exercise practices, but they are at a stage in their life, and in a place, where healthy consumption isn’t a priority. Researchers often feel that there is a greater chance that these young people will be uncontrolled rather than controlled.

In this chapter I will examine the ways in which my interviewees’ diabetes intersected with their fitness and food consumption practices (also known here as their disciplinary practices). I am going to demonstrate that my interviewees were

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<sup>25</sup> <http://education.guardian.co.uk/students/story/0,9860,547779,00.html>

often extremely concerned about their health, and the practices that they could use to control and increase it. My interviewees were often aware of the effects their current practices could have on their future selves, and engaged in practices to colonize the future (Giddens 1991), to shape it towards their desired outcomes.

The chapter is divided into several sections. The first of these is concerned with exploring Foucault's concepts of discipline, self-surveillance and self-technologies. The discussion in this section will provide the conceptual apparatus through which the empirical material that follows will be examined.

Following the section on Foucault, I will explore the relationship between interviewees' diabetes and their disciplinary regimes in four key areas.

- Male and female interviewees' conceptualisation of control and discipline as moral practices. The role of pleasure in interviewees' disciplinary practices will be discussed here.
- The presence of temporalities and risk in interviewees' accounts, with emphasis placed on the ways in which disciplinary practices were used by interviewees to diminish the long terms risks of diabetes and minimize biographical disruption (Giddens 1991).
- The place of routines in interviewees' accounts.
- How interviewees' control of their diabetes intersected with their other body control practices, such as weight management activities.

## 5.2. Disciplinary practices

Michel Foucault's work provides a useful theoretical starting point for exploring the reasons why, and the ways in which, individuals engage in disciplinary practices.

In *Discipline and Punish* (1977) Foucault argued that individuals use disciplinary practices to control themselves, their bodies and their desires. He argued that by engaging in these practices individuals construct themselves *as* individuals, as regulated subjects, subjects that are "not born in sin and subject to punishment, but [are] born rather out of methods of punishment, supervision and constraint" (Foucault 1984a: 177). By repeatedly engaging in disciplinary practices over time,



Foucault argued that the norms underlying these practices become internalized and emotionally important aspects of the self (in Bourdieu's terms, part of the individuals' *habitus*), and thereby imprint the body "with the stamp of prevailing historical forms of selfhood" (Bordo 1993: 166). Foucault argued against the view that human beings possess essential identities. Rather, he argued that individuals create their identities and selves in process, through power laden activities (Willems 2000, West 1996, Shildrick 1999, 1997, Sawicki 1994).

From Foucault's perspective disciplinary activities are productive (in the sense that they create identities) rather than repressive (often considered to be the primary modality of power). They are:

"not simply negative mechanisms that make it possible to repress, prevent, to exclude, to eliminate; but...they are linked to a whole series of positive and useful effects which it is their task to support" (Foucault 1984a: 172).

Foucault argued that people engage in disciplinary activity because these activities help to develop "norms and competencies" (Sawicki 1994: 291). However, it is important to note that productive here does not necessarily mean something completely affirmative. It means something has been, or can be, constructed (Lupton 1995).

While discipline creates individuals, it is important to recognize that it creates particular kinds of individuals. These are what Foucault called docile subjects, subjects "that may be used, subjected, transformed and improved" (Foucault 1984b: 180). The docile body for Foucault is one that is open to:

"endlessly more intensified self-regulation, self-management and self-control. It is no longer a body docile with respect to power, but more a body docile to will, desire and mind" (Grosz 1995: 2).

Foucault argued that this docility is maintained via constant surveillance of practice, so that "the whole indefinite domain of the non-conforming [becomes] punishable" (Foucault 1984c: 194). The concept of surveillance in (and in relation to) Foucault's work and people who draw upon him here is often linked to the idea of panoptic technologies, which refers to a hierarchical arrangement of bodies in space in such a

way that the self is never sure if it is being observed or not; as such, practices attempt to conform to a normative ideal because the self presumes it is being watched and judged at all times (Johnston 1996, Bordo 1993).

As I will show shortly, this idea of intense self-regulation and management of the body and mind had a central presence for interviewees in this study, being closely associated with the construction and maintenance of ideal identities as normal young people. More generally, the vision of docility articulated by Grosz (1995) above can be closely mapped on to medical constructions of the ideal diabetic body. Stein notes for example:

“In the treatment of diabetes, the goal is to replace the pancreas with the ego” (Stein 1985: 116, in Broom and Whittaker 2004: 2376).

Finally, it is important to note that disciplinary practices are:

“not something that the individual invents by himself. They are patterns that he finds in his culture and which are proposed, suggested, imposed on him by his culture, his society and his social group” (Foucault 1987a: 122, in Smart 1999: 94).

Practices are only meaningful, and assume their power, when they are actualizing, or resisting, powerful social discourses, shared ways of understanding and interpreting the world. Foucault had a different view of discourse to that commonly employed by geographers. Whereas discourses for geographers often refer to the shared schema of a group or set of texts of groups, and often operate on a micro-level, discourses for Foucault are macro-constructs; so for example, where a geographer may refer to a dynamic discourse of diabetes that is composed of the interaction between texts and practices of all individuals involved in this field (acknowledging that some actors and texts have more power within this arena than others), Foucault would be more interested in a broader medical discourse that had developed over several hundred years. And his main focus of interest might be in how one macro-discourse gives way to another, rather than seeing how individuals negotiate, resist and internalize discourses in the context of their everyday practices, which is the focus of this chapter.



### 5.2.1. Technologies of the self

In his later work Foucault realised that, in some respects, his early work on docile bodies and disciplinary practices was lacking. An interpretation of the individual as someone who had an ability to generatively act him or herself as a constitutive agent, in whatever limited capacity, was not either not present, or if it was, then not sufficiently emphasised (Smart 2002). Consequently Foucault moved more fully towards the question of addressing subjectivity, which until the first volume of the history of sexuality was only represented, largely, as an “effect of social practices of subjection” (ibid: 92). His later work focused on how the self could engage in practices of “self-constitution, of self-stylization” and actively tack between different discourses (ibid: 92). Foucault looked at these practices of constitution through the lens of what he called technologies of the self, practices:

“Which permit individuals to effect by their own means or with the help of other people a certain number of operations on their own bodies and souls, thoughts and ways of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality” (Foucault 1988: 18).

These technologies of the self appeared to be distinguished somewhat from his earlier work on disciplinary practices which could be classified as technologies of power, technologies “which determine the conduct of individuals and submit them to certain ends of domination” (ibid). The difference between the two positions was sketched out by Rose (2001), who noted that if disciplinary practices are concerned with the regulation of the subject, then practices which could be called technologies of the self are those that allow people to create ideal versions of their selves, (though ironically, these ideal versions are often normative in nature). Technologies of the self are culturally meaningful, moral practices that are articulated by subjects seeking to make themselves better than they are (Monaghan 2001). They imply some degree of agency. In Giddens’ terms, they are practices that allow the individual to “cultivate bodily regimes as a means of reflexively influencing the project of the self” (Giddens 1991: 105). Foucault himself differentiated between practices that he saw as resulting in domination and those practices articulated in a project of self-construction.

“What may be regarded, at first sight, as a more pronounced severity, an increased austerity, stricter requirements, should not in fact be interpreted as a tightening of interdictions...the change had more to do with the manner in which the individual needed to form himself as an ethical subject” (Foucault 1986: 67).

Differentiating between practices which could be described as technologies of the self, and those that are disciplinary, though, can be difficult. At the least, practices have to be looked at in their context in order to examine the meaning behind them and the particular effect they have on the individual, and even then particular practices may be experienced as both a positive and negative. Bordo (1993) notes that while bodies may be docile and normalized with respect to and through power, this docility may also have positive consequences for individuals. Indeed, Foucault himself didn't address the question of under what circumstances “forms of self-discipline or self-surveillance can with any justification be seen as exercises of autonomy or self-creation” (Grimshaw 1993: 66). In all probability, both of Foucault's conceptualizations of discipline, as normative and constructive, are necessary in order to understand how people engage with, understand and choose to engage in disciplinary practices (Bordo 1993). The concept of technologies of the self, therefore, is useful for drawing attention to the subjective meaning of disciplinary practices, something which is in some respects absent in Foucault's earlier work on surveillance and discipline.

### 5.2.2. Criticisms of Foucault

It is important to be aware of some gaps in Foucault's concept of disciplinary practices. Firstly, in Foucault's later work it often appears that practices that could be referred to as technologies of the self are disembedded, with no reference made as to how they are worked out in particular, material spaces and contexts, and how the presence of other people can affect these practices (Smart 2002).

Secondly, the gendered body is to some degree absent in Foucault's account. He doesn't sufficiently address how disciplinary practices are differentially worked out by men and women (Soper 1993). Disciplinary practices are also exerted on an abstract, unemotional body in Foucault's work (Smart 2002, Sawicki 1994). This is an important absence because at the level of their everyday practices people may not



be able to engage fully in disciplinary practices and construct docile bodies because “of a conscious sense of frustration, resentment or anger, or because they experience an unconscious imperative that directs them to take up alternative subject positions and bodily practices” (Lupton 1995: 133).

The ability of the material body to itself act, whether to upset or reinforce disciplinary practices, is also not discussed. In diabetes, hypoglycaemia or hyperglycaemia can often upset the articulation and implementation of practices of the sort discussed by Foucault (and as will be discussed later, often require their own disciplinary practices to deal with them).

And as Foucault himself (1979) noted, disciplinary practices are often not completely disciplined practices. People might fail in their ability to articulate the practices of one discourse because they are equally committed to the practices and ideals of another. Consumption practices often have to be consciously disciplined precisely because achieving disciplined self-control in relation to them *is* so difficult, both practically and emotionally. Even where and when self-control is achieved, for example by limiting food consumption in order to lose weight, paradoxically it is often accompanied by an intensification of desire, which can further increase and intensify the need to be self-controlled.

### **5.3. Introduction to the interview material**

The rest of this chapter will explore the disciplinary practices that my interviewees used to regulate their bodies and selves, and the reasons why they did so. While there hasn't been much research completed on students with diabetes in general, there has been even less done on the food and fitness practices of these students than on their alcohol consumption. In particular, few studies have investigated the reasons why young people with diabetes engage in risky disciplinary practices (Neumark-Sztainer et al 2002).

I should make a point about the structure of this chapter here. Slightly more of the material that follows concentrates on the accounts of my male interviewees than the female respondents. This is a deliberate decision, as there has been relatively little work done on the disciplinary practices of young men with diabetes compared to the

work completed on young women (Weinger et al 2001). I do not wish to imply that my female interviewees were less important than the men.

And finally, one point needs to be made concerning the differences between Beck and Foucault's approach to risk. Because Foucault concentrated primarily on discourses, sets of mutually related texts and practices that construct the meanings of objects, authors (see Lupton 1999 for an overview) have argued that his perspective on risk differs from Beck, from whom risks, while bound up with probabilities, are 'real' things, and have material consequences. In keeping with the aims of this thesis, I think it is best to ground these sorts of arguments in the narratives of the people one is studying. From this point of view, I think that my interviewees' perceptions of risk would side with Beck's model. While the risks of diabetes for them were probabilistic (and hence might not often), most of them treated risks as something real; current practices in the present could have material effects in the future. Risks didn't just refer to social constructs for them, even if their meaning was socially constructed. This is a weak constructivist view of risk.

#### 5.4. Moral control

There were a number of reasons why my interviewees engaged in disciplinary activities. One of the most important of these was that interviewees considered disciplining themselves to be a moral practice.

James for example regulated his consumption in accordance with how good or bad he perceived particular foods to be, and the positive or negative effect he felt that consumption of these foods would have on his body. Foods that were considered to be healthy and non-sugary, helped reduce risk and provided long-lasting stable blood sugars, such as vegetables and pasta, were more likely to be eaten more regularly<sup>26</sup>.

I'll eat the right amount of whatever is available at the time. I do not eat huge sweets and um, I like lots of mash. I like good decent food, wholegrain rice and everything. Sometimes I like to snack more than I do but I get around that by having things that aren't carbohydrates. I have a huge jar of pickled onions. You're more at risk of coronary heart disease, so it's important to

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<sup>26</sup> It's interesting to note that the 'good' foods that are being described here are all carbohydrates, but not refined carbohydrates.



have a low fat diet. In terms of my physical performance it's good to have a good diet.

James' practices here reflect his understanding that the management of consumption is crucial for efficiently controlling his diabetes. Modern management of diabetes is not just based on avoiding sugar and injecting insulin. It is based on a sensible, healthy diet and regular exercise (Williams and Pickup 1999, Watkins et al 1996).

Eating healthy food is not only a practice that is good for the body, though. Lupton (1996) notes that moral meanings are regularly embedded within foods, and that when these foods are incorporated into the body their meanings are also transferred. Eating healthily, therefore, is a way of constructing a moral self (Saltonstall 1993). The relationship between consumption and virtue is particularly clear with diabetes, where control is often described as being 'good' or 'bad'. When people engage in 'bad' practices they are often blamed, both by themselves and others, for doing so. Bad practices explicitly call the integrity of the self into question, because they are a matter of personal irresponsibility in a condition where you're supposed to be responsible. Control, therefore, is not simply "a biomedical statement about the management of blood sugar levels... [but is] tied to moral understandings of the body" (Broom and Whittaker 2004).

For many of my interviewees, the positive nature of disciplinary practice emerged from the ways in which it enabled identification with desired subject positions. For example all of my male respondents, with the exception of Lars, were concerned about being 'sportsmen'. Sport is one of the quintessential arenas in consumer culture in which masculinity is defined (Robertson 2003, Connell 1995, Hargreaves 1987). It is a realm where men can test their strength and skill. By eating healthily and working out my interviewees' increased their strength and fitness, and thereby maximized their performative capacity and ability to compete against other men. Sport was good because it allowed interviewees to construct desired forms of masculinity. Team sports were especially important for my interviewees. Vincent's account illustrates some of the common benefits male interviewees took from sport:

I just find personally that I like feeling fit and healthy. Like, it's good to feel that, when you're walking up and down the road or whatever. I love playing

sport. I love playing with a team, like football and hockey and stuff. I just really enjoy being active. In my own mind I want to fit my diabetes around my sport, rather than fit my lifestyle around my diabetes. And at the end of it all if you're feeling healthy, then that's great, and if it's helping to regulate your diabetes, then that's even better.

Several points can be noted here. Firstly, the positive morality of sport is clear. Sport is intimately linked to good health, wellbeing and pleasure. It provides a way of effectively managing the risk of diabetes. Vincent noted that without exercising his blood sugars would become chaotic, go "haywire". Sport is also bound up with the 'vibrant physicality' of action (Monaghan 2001). Monaghan (ibid: 351) notes that "within today's fitness-orientated cultural context, the active/sporting/disciplined/self-controlled body...has become a central site for sensual embodied pleasure". Pleasure in this context, as can be seen in Vincent's narrative, comes as much from disciplining the body as it does from 'giving in' to it.

A second point refers to the relational nature of the sporting body in Vincent's account. One of the reasons sport is fun and pleasurable is because it allows Vincent to interact with other students, and through this interaction construct an identity as a normal young person. Sport is bound up with a process of collective effervescence, with the construction, through routinised, interactive fitness practices of an emotionally positive identity as someone who is part of the group. Vincent argued that one of the most important reasons he wanted to exercise was to ensure the maintenance of this identity as a normal young person, someone who was the same as, and not different, from others. The moralities of control that are present in Vincent's account emerge from the fact that his disciplinary activity, while individualized is also strongly relational, in the sense that the effects of practice are intended to regulate him self by making him more like others (Foucault 1979).

I want to try and keep my sugars well balanced, to try and keep my diabetes under control. But not let it interfere with my life. It's something I have to deal with and think about, but I do not want it to ever stop me doing stuff or...make me different to everyone else.

It can be seen here that Vincent's desire to engage in disciplinary activity stemmed at least in part from the potential threat he felt diabetes could pose to his health and identity/ies if these practices *weren't* engaged in. Diabetes could render him



'abnormal'. Discipline, then, is connected to the minimization of risk to his identity, as well as to the positive production of ideal bodies and identities. Alex noted:

I do not want to get bad. If you control it you're no different from a normal person. It's like if you eat too much...if you eat too much then you're going to get fat and die earlier than usual. If I do not get control of my diabetes, I know I'm going to die earlier. It's completely under my control. It's nothing to do with a long life. It's my control. I make the insulin. It's not something like AIDS or things like that, it's something I control.

Alex here is concerned about engaging in practices that he could use to control himself and prevent himself from going 'bad', becoming unable to identify with hegemonic notions of masculinity. Few studies have examined the interaction between sport, masculinity and health (Robertson 2003). Robertson (*ibid*) found that sport could be used by men with chronic conditions to assert control over their lives, to minimize the risks to their identity that their condition may have posed (Charmaz 1995). Similar findings have been reported for young men with diabetes (Williams (C.) 2000). In my study, there was often an anxiety underlying interviewees' accounts about what could happen to them if they weren't successful in actualizing their fitness practices, for example that they could become impaired, disabled, weak, undesirable, a burden on others. Interviewees were worried that if their bodies became incapacitated by diabetes they would be unable to engage in disciplinary activities at all, practices which for my interviewees were a source of moral pleasure, a way of constructing a 'good', powerful self. Sport then provided them with a way of keeping a desired biography intact.

In general, the attitudes of my male interviewees towards the role of health risks in the construction of masculinity differed from other studies that have looked at this relationship. For example, Cameron and Bernardes (1998: 674) argue that men are more likely than women to engage in "damaging or risky behaviour" in a bid to identify with and embody hegemonic gender representations (see also Courtenay 2000, Lupton 1995). Courtenay (*ibid*: 1388) notes that men often attempt to construct masculine identities by "embracing risk...displaying the behaviours like badges of honour", a process which can afford men the opportunity to deny "weakness or vulnerability" (*ibid*: 1385), and create feelings of "emotional and physical control". In the context of diabetes management Silverstein et al (2005) note

that young men are far more likely to engage in risky practices than young women, for much of the same reasons. However my interviewees engaged in practices of risk minimization in order to maintain bodily independence, emotional wellbeing, and the continual identification with emotionally resonant discourses of masculinity. They often defined their disciplinary practices against those of other students, who they usually saw as being unhealthy.

An interesting exception was Jason. While I will discuss his narrative in more detail later in this chapter, I will give a brief summary here. Jason engaged in disciplinary practices that he considered were bad for his blood sugar control. However, in contrast to the risky practices discussed by Silverstein et al and Courtenay, risk for Jason did not emerge from the hazardous nature of the practices he engaged in; it emerged from the intensity with which he engaged in healthy, moral practices. Because he felt that his exercise practices were beneficial for him, in that they provided him with a way of controlling himself, of being strong, Jason gradually began exercising more and more. Eventually he was exercising for up to forty hours a week. At this point, his control of his diabetes began to suffer. However, because his disciplinary practices were so successful in enabling feelings of strength, it was difficult for him to stop. An interesting tension emerged; practices intended to achieve ever greater control over the body in actuality sent his body out of control, at least in some dimensions. When I described the kinds of practices Jason engaged in to some of the other male interviewees (James and Lars) and asked them if they would be willing to engage in similar regimes of practice, they said they would like to be able to, but such a regime would be too risky. While exercise and sport were considered to be beneficial practices for the male interviewees, then, their benefits emerged from the balanced way in which they were engaged in. When they were this intense, exercise regimes had a deleterious effect on blood sugar control, and indeed risked interviewees' ability to identify with different forms of masculinity in the future. However, it is important to recognize that balance does not imply a stalled identification with hegemonic masculinity for my interviewees. Jackson (1992) notes that balance is a concept that is associated with hegemonic masculinity generally, for example with men being pressurised to be strong and brave but not to the point of violence.



The accounts of the female interviewees revealed similar concerns to those of the men. They too felt a strong need to engage in disciplinary practices so as to minimize the risks of diabetes to their bodies and identities. Taken as a whole, though, the accounts of the female interviewees showed a more heterogeneous range of reactions to disciplinary practice than the men. The male respondents were generally ate very healthily and exercised regularly. However, when they did in engage in risky practices these were likely to be riskier than similar practices engaged in by the women. In contrast, the female interviewees were more likely to engage in less healthy practices, than the men, but were less likely to engage in very risky practices. There were a number of reasons why this was so. Firstly, female interviewees seemed to have found it practically more difficult to eat healthily on a continual basis while they were in university. They were also far more likely to eat chocolate and sugary foods on a regular basis when they were bored or lonely. A greater proportion of the female respondents were first years as well. The first year students I interviewed were the most concerned about not letting the consumption regimes of diabetes interfere with their attempts to be 'normal'.

#### **5.4.1. Balancing consumption**

The narratives of the female interviewees indicate that achieving a balance, however, even for individuals who want to achieve one, isn't easy. One reason for this is that individual practices often have multiple, and diverging, meanings, with diverse moral and practical implications that cannot easily be integrated. For example Maria noted:

When I go into a restaurant I'll have to have some kind of starch. I could not have no starch. I'd have to have a decent amount. And then I'm always conscious about my weight as well. Are they creamy based sauces or are they tomatoes based or...or sometimes I'll just eat what I want. But then when I've eaten it I'm just like, well...I've just had something, how could I have eaten it?

The ambivalence which Maria experienced emerged from the fact that she was engaged in multiple body projects, each of which was intended to control her body in a slightly different, if often intersecting, way, and each of which was articulated through sometimes conflicting moral practices. Firstly, as with the male interviewees, carbohydrate consumption is 'decent' because it provides Maria with a way to regulate her diabetes, construct a virtuous self and engage in the right practice. However, while this consumption is good in terms of blood sugar control, it is bad in

terms of Maria's weight management practices, which themselves are strongly linked to self-discipline and moral control of the self, especially for women (Valentine 1999, Grogan and Wainwright 1997, Bell and Valentine 1997, Lupton 1994, Bordo 1993). Lupton (1996: 138) notes that in Western consumer cultures women's identities are often judged, both by themselves and others, according to how well women embody the values of the 'food/health/beauty' triplex, and under the sign of this triplex "the most important role played by food is its caloric value". Food consumption of any sort in this context can undermine the performance of an ideal, virtuous, slim self and lead to feelings of shame and self-recrimination. There is therefore a lack of fit between the two moralities of practice in Maria's account, something which makes it difficult to balance them, though in an abstract sense both regimes consider it "morally good to exercise rational control over one's diet, suppressing urges for 'bad' foods and eating only 'good' foods in the name of health and physique" (Lupton 1996: 151).

Furthermore, both regimes are complicated by a third form of morality that is present in Maria's narrative, and this is one that sees the morality of consumption as being located in its pleasureable nature. Maria noted that she sometimes ate food when she was high because hyperglycaemia made her feel cold and lonely.

Sometimes you feel hungry...if you're sugars go between twelve and fourteen, then you start going cold and you start going hungry. And you shouldn't be eating anymore because your sugars are too high. But you're hungry and cold and want to eat something to keep you warm. But that for me, between twelve and fifteen, that's when I start feeling cold and hungry. If I eat anything else they'll get even higher. So you have to stop yourself from eating anything else. If they get higher, then you start feeling sick. Which is good in a way because then you cannot eat anything else.

Eating while high is described as a way of comforting a self that is in pain. The hand that heals, though, is also the hand that hurts in this narrative; this consumption simultaneously alleviates and intensifies feelings of emotional stress and alienation. It is used by Maria as a form of comfort, yet also produces anxiety because it has a deleterious effect on her weight and on her control of her diabetes. Lupton (1994: 42) notes that this kind of positive/negative relationship with food is one commonly experienced by many women, that "the role of food as comfort in times of depression, boredom or stress also results in food having ambiguous meanings of both a relief



and a cause of anxiety and unhappiness”. Interestingly, the body itself acts as a final moral defence of the ‘weak’ self in this account. Hyperglycaemic effects on the body eventually become so severe that it becomes impossible to eat food at all. This is experienced as a ‘positive’ effect because it enforces control in a situation where Maria feels she isn’t strong enough to achieve it. As such it limits the damage that her consumption could have both on her weight and her ability to manage long term risks. Sometimes it’s good to feel sick.

#### 5.4.2. Guilt

As indicated by Maria’s narrative, guilt was an emotion commonly expressed by many of the interviewees when they felt they had lost control over their practices. Christina noted:

I feel guilty like most people do when I snack or when I eat is, you know, potentially is not great for my diabetes and not great for my weight.

Broom and Whitaker (2004) argue that people with diabetes often understand their blood sugar levels to indicate their degree of correspondence with the ‘correct’ management regimes of their conditions. When their practices bring their blood sugars close to the ideal, they are usually felt to be good. Being insufficiently well controlled on the other hand has more negative connotations, and can lead to guilt and anxiety. These emotions are connected to individuals’ awareness that their activities contravene normative standards of practice and violate “codes of ‘proper behaviour’ in respect of the body” (Giddens 1991: 64). Such failings do not only have negative implications for individuals’ health, though, they also detrimentally impact upon the moral status of the self. They transgress the codes of proper practice upon which good diabetic control is constructed, and consequently call the adequacy of the individual’s performance of and as an ideal (normal, regulated) self into question.

One brief point to make about interviewees’ feelings of guilt, which will be discussed in more detail in section 6.4., is that guilt was often related to technological measurement. Any deviation from normal practice could be measured and quantified through short term blood testing or HBA1C tests which summarised the adequacy of

an individual's care over the long term. The tools to assess adherence to the codes of proper behaviours were always at hand, and so the moral status of the body could be continually assessed (if so desired).

Guilt could have positive effects, though. Erin for example noted:

I swim a couple of times a week. I'm not fanatical in any sense about sports, but I do it because I know it's good for me. But just generally my friends and I are making each other go, and going together. It's one of those things. If one person is going you feel guilty. Which is good. It's good as well because after half an hour you cannot give up.

Several points can be noted here. Firstly, discipline is bound up with the construction of a moral self (though the medium in which moral practices were articulated, sport, was not as central to Erin's self-identity as to some of the male interviewees). Secondly, guilt can be seen to develop in a relational context. Guilt is created when the individual compares her practices to those of other young people and finds them wanting. Thirdly, guilt in Erin's account does not have a completely negative presence; in fact it has positive moral implications. Guilt makes the person change themselves for the better in order to reduce the moral dissonance caused by relational comparison of practice. It leads to the intensification of discipline, of activities designed to ensure that the successful performance of a normal, ideal self. And fourthly, it is important to be aware that the primary focus of Erin's intensified disciplinary practice was control of her weight, rather than regulation of her diabetes (though exercise undertaken in order to manage weight also had beneficial implications for her diabetes' control). Many of the other female interviewees noted similar orientations of practice.

Myles: So do you exercise because of your diabetes or...

Lilya: What, you mean diabetes? I think it's more a vain thing. I mean I get the benefits, and I feel good because I'm getting the benefits...but it's triggered by the wanting to lose weight.

Saltonstall (1993) notes that for women the process of eating well and constructing a moral subjectivity is often bound up with dieting, and that healthiness and slimming are often linked in women's accounts. From this perspective, rather than a purely



'vain' practice women's weight loss practices in this study can also be read as a way of constructing a virtuous, healthy subjectivity.

Finally, I mentioned above that interviewees were often worried about the effects not engaging in practices could have on their bodies and identities in the future. In the next section I am going to explore this assertion in more detail.

### 5.5. Temporalities

As I have shown, risk was a key discourse in interviewees' disciplinary practices. Temporalities were particularly important in interviewees' awareness of risk. As I noted in the literature review, medical research on teenagers with diabetes has often argued that young people with diabetes are relatively unconcerned about risks and the future, a nonchalance perceived to stem from the 'fact' that "developmentally, older teenagers have a sense of 'invulnerability' and tend to discount risks to their future health and the need for medical care" (Wolpert and Anderson 2001: 1513). The conclusions of these authors, however, do not fit the findings of this study. My interviewees were often very concerned about the risks their current practices could have in them in the future if they weren't sufficiently well controlled now.

Erin noted:

You hear about things like, um...diabetics get things like kidney failure and that kind of thing. It's pretty scary. Eye damage as well. I always go to the hospital and it's like oh, we'll just do some blood tests and we'll do this and do that just to make sure. Which they wouldn't ordinarily do for another twenty years. Excellent, thanks, just take all of my blood. It just become normal, really. But I do not like hospital and stuff and I suppose that's one of the scariest things about long term complications. (laughs).

Erin's awareness of the future here differs from that articulated by Wolpert and Anderson above, and from individuals in other studies that have looked at young people's perceptions of time. Lawton (2002: 719) found that a large number of her interviewees "appeared to take basic good health for granted, an experience that was most common amongst younger participants" and Segal et al (2001) found that the young people they interviewed "were extremely confident about their futures, perhaps to an unrealistic degree".

Why is there a difference here?

Giddens (1991) notes that in contemporary consumer societies death “is associated with anxiety of an utterly fundamental sort”. It is the point where individualized control of the self completely collapses. As such, it is something which people often bracket out of conscious thought or reflection in their daily lives. However, with chronic conditions people do often have to confront the possibility that they will die, and possibly sooner than they otherwise might expect to (Bury 1991, Charmaz 1983). For example, as Erin indicates, the complications of diabetes, and the requisite management regimes of the condition, bring the future body into the present, leading to a ‘premature’ aging of biography and the disruption of the ‘protective cocoon’ which individuals with non-chronic conditions may use to screen out these anxieties.

While this point will be discussed in more detail in the section 6.5.4., it’s important to note that anxieties about loss of control over the body here in this narrative are linked to fears about the forced medicalisation of the body, the traumatic ‘invasion’ and penetration of the body by machinery. While people like Haraway (1986) have celebrated the construction of cyborg bodies, bodies that are not built around dualisms corporeal spaces where body and world can flow into one another, in Erin’s case it can be seen that emotional wellbeing is dependent upon the rejection of medical technologies and the separation of technology from her body. Increased medicalisation is represented as coming at the expense of the individual’s control over her life.

### **5.5.1. Maintaining a desired narrative of the self**

One of the most important reasons interviewees engaged in moral disciplinary practices was to minimize diabetes’ ability to affect their identities in the future. For James, this referred to the potential of diabetes’ to upset his ability to successfully work. Hegelson (1995) notes that work is a central way for men to construct a masculine identity, to articulate “power, control and achievement”. He argues that the thought that they may be forced to stop working by their bodies may be extremely difficult for men with chronic illnesses to deal with. This was the case for James. He noted that one of the reasons he regulated his consumption practices was



to ensure he could successfully maintain a work based identity in the future, and so keep a desired narrative of the self going (Giddens 1991).

For some reason if you're diagnosed with diabetes at the age of thirteen your life expectancy is fifty. That's something which makes you plan for the future. Can you imagine, at fifty? I wouldn't even be close to retiring then. And that's the age, on average, when you're going to die.

Giddens notes that while "thinking in terms of risk certainly has its unsettling aspects... it is also a means of seeking to stabilise outcomes, a mode of colonising the future" (1991: 133). Conceptualizing the future allows action to be taken to control it, the right (healthy) consumption practices to be engaged in now to shape and colonise it, and orientate it towards the desired outcome.

Lars: I think that's the things really with avoiding complications. You're trying to make a better life for yourself in the future really. You're trying to preserve yourself for the future.

Thinking in terms of risk, though, can lead to feelings of engulfment, the stripping away of the individual's sense of autonomy over his or her agentive ability (Giddens 1991). This can threaten the self-identities of individuals who identify with discourses (for example, discourses of masculinity) that construct the agent as an independent, powerful actor (Connell 1995).

To maintain the integrity of the self and prevent paralysis, anxieties about the future have to be regulated. This can be done in multiple ways (see section 4.8. in the for strategies interviewees used in relation to their alcohol consumption practices). For example, returning to Alex's comment above<sup>27</sup> it can be seen that agentive ability here is continually stressed. Alex notes that unless he is completely controlled he is going to "die earlier". This statement is quickly qualified though by one saying that his control has nothing to do with time, but is valuable only in itself; the fundamental insecurities that are raised by his initial statement are foreclosed. Furthermore, Alex engages in a 'downward comparison' (Schur et al 1999) of his diabetes with more

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<sup>27</sup> It's like if you eat too much...if you eat too much then you're going to get fat and die earlier than usual. If I do not get control of my diabetes, I know I'm going to die earlier. It's completely under my control. It's nothing to do with a long life. It's my control. I make the insulin. It's not something like aids or things like that, it's something I control.

terminal conditions, and this, combined with his insistence that he has personal control over his condition, can be read as a strategy enabling him to feel he has power over his own fate. The account therefore acts as a way of controlling risk orientated anxieties by rejecting an identity associated with passive vulnerability and engulfment. It constructs a representation of the self as someone involved in shaping his own life, someone whose destiny rests in his own hands; it is a way of asserting a powerful, independent form of masculinity in the face of threat to this identity.

A second coping mechanism some interviewees described was the development of a fatalistic ethos. Vincent noted:

So long as you're doing as much as you can to control yourself at the time there's not a lot you can do about it. So as long as you're doing as much as you can to make sure you're eating healthy and well, hopefully long term you'll be alright. And if not, then there's not a lot more you can do about it anyway so...you know, just make sure you're as well as possible and keeping as good control as possible. And fingers crossed it'll all turn out alright in the end.

It can be seen in Vincent's account that fatalism didn't so much refer to an ethic where individuals decided to give up their management practices because they felt there was nothing they could do about the future. Rather, it pointed towards a feeling that once regulatory practices were engaged in to the best of one's ability, there was not much one could do about the consequences afterwards. This attitude seemed to be a way of controlling the anxieties raised by the management regimes of diabetes and by the continual future orientated reflexive practice of the interviewees (Giddens 1991). It provided interviewees with a coping mechanism, a way to emotionally disengage from practices that could easily become dominated by hyper-regulation and hyper-anxiety.

### **5.5.2. Changing attitudes towards risk**

Finally, it is important to note that interviewees' attitudes towards consumption and the future could also change as they moved through university.

For example, when I first interviewed Alice she noted that if she was hungry she would just eat something:



Well, if I'm hungry I'll just eat it and you just have to sort it out later. If I want to eat...if I injected and then I go there [hall canteen] and there's something I want to eat, like the main course and the pudding, and I'm hungry, I'm just going to eat it anyway. I've basically just said to everyone...some of my friends have asked if I should be eating that stuff and I'm like, you only live once, so what's the point of letting it restrict you, it shouldn't control you. You could die tomorrow. So if you want a piece of chocolate cake when you're a bit high now, it's not going to have any lasting effect when you're older. It's only if you're high for a long period of time.

Food is linked in this account to pleasure, the satisfaction of immediate desire<sup>28</sup>. Lupton (1996: 151) notes that there is a paradox in consumer cultures. On the one hand desire has to be regulated in order to produce a desired account of the self. However, a counter-discourse is also present encouraging “oneself to ‘give in’ to one’s impulses [to] express one’s feeling- to be ‘true’ to oneself” (Lupton 1996: 151). In this narrative, engaging in risky consumption enables Alice to feel, and to show others, that she is a normal young person in control of, rather than controlled by, her condition. Refusal to discipline her body provides her with a means to actualize a desired, normative identity. Eating pudding, while an everyday activity, is also a technology of the self, a moral practice that is used to make oneself better.

Spatialities are implicated in this process of self-actualization. Alice’s narrative is describing food consumption in a hall of residence, a place where she would be eating with many other students, all of whom would be eating approximately the same thing; this is a space where normalizing, regulatory, panoptic pressures would be present. Alice didn’t want to feel or act different from the perceived group norm in this context. She was anxious about what other people would think about her (being in halls was described as like being “back at square one” with regards her diabetes), which is one of the reasons she injected in her room before going down to eat. Jenkins (2004: 74) notes that “others do not just perceive our social identity, they actively constitute it. And they do so not only in terms of naming or categorising, but in terms of how they respond to or treat us”. As I have highlighted previously, Litva et al (2001: 258) argue that the “outer, social body” is central to female

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<sup>28</sup> Alice was the only female interviewee I talked to who initially said she was happy with her weight. Her feelings changed in the time between our first and second interview. By the time we talked again she felt that she was overweight and had started on a diet.

undergraduates' identities, the central "form of physical capital upon which they are evaluated". While these authors were discussing female undergraduates bodies in relation to the construction of beautiful appearances, their argument has relevance here. Alice was clearly aware that, in a context where other individuals knew nothing about her, the only aspect upon which she could be judged 'abnormal' was her consumption. Hence she regulated her consumption practices in order to ensure the successful management of a desired social body. Having to match her food to her insulin was the last thing she wanted. Her most important consideration was preserving her ability to engage in flexible consumption, and thereby being able to feel, and demonstrate to others, that diabetes wasn't a limitation on her autonomy. The consequences of excess consumption, if any, could be regulated in private back in her bedroom, away from the gaze of other young people (the spatialities of the technological management of diabetes will be discussed in more detail in section 6.5.).

Temporalities also have a critical presence in the conceptualisation and management of risks in this narrative. Alice felt that any potential hazardous side effects resulting from her risky consumption practices would be bracketed by their short-term duration. She didn't feel they would detrimentally impact upon her long term care of the self. This awareness of risk contrasts with that of the DCCT, which found that the risk of developing complications is associated with cumulative exposure to high HBA1C levels over the lifetime.

Alice's feelings regarding risk and her consumption practices changed markedly, though, between our first and second interviews. Our second meeting took place one year after our first. On this occasion Alice noted that she had altered her diet, cutting out chocolate completely and had started eating healthily.

It's just that basically that now, this year on my course we're doing a lot more about the body and we're doing dissecting and stuff. So you can see what happens to people's bodies if they do not look after themselves. And if I do not look after myself then I'm going to end up in hospital a lot sooner than...a lot of things occur because of diabetes, you get a lot of side effects more than other diseases. Basically. Cause now I know how it could actually affect you. So if you keep control when you're younger then it's less likely



that it's going to be bad when you're older. And that's the main thing why I've changed my diet.

An important reason Alice's practices changed is that the risks of diabetes became real for her. As Beck (1992) notes, there is often something phantasmagoric about risks, something about their potential effects that makes people believe that they won't affect them. The "dangers they present, in other words, are thought to be too far removed from a person's own practical involvements for that individual to seriously contemplate them as possibilities" (Giddens 1991: 130). While most of the students in this study didn't deny the risks of diabetes (often because they had firsthand experience of them), denial was an important consideration for Alice in the first interview. Because of her status as a bio/medical student, though, she was beginning to come across information about the consequences of chronic illnesses. As such, the long term risks of diabetes stopped being 'unreal presences' for her and became the visible, encountered, material consequences of bad control. This ability to visualize the consequences of risk in turn ameliorated her ability to deny "personal vulnerability" (Kavanagh and Broom 1998: 441). While science is often associated with hegemonic discourses of masculinity (Connell 1995, Seidler 1989), here it can be seen to empower Alice, to provide her with the information she can use to control herself.

Alice's shifting perspective on risk therefore supports the perspective that risk and risk consciousness "is not static and objective but negotiated as part of a network of social interaction and formation of meaning" (Lupton 1999: 29). Awareness of risk can change over time according to changing contexts that have implications for individuals' identities<sup>29</sup>.

### **5.6. The role of routines**

So far, I have shown that for the interviewees in this study, eating healthily and exercising were moral practices orientated towards the management of risk and colonization of the future.

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<sup>29</sup> Though it is interesting that this shift is conceptualized here as a move from a flawed, erroneous understanding of risk, orientated towards the short-term, to a true, scientific understanding, directed towards managing long-term complications.

It is crucial to recognize, though, that the success of these practices for people with diabetes is bound up with the abilities of individuals to continually actualize them across time and space. The DCCT has shown that in order to control diabetes (at least from a medical perspective), it is not enough to eat healthily on an occasional basis, or to sometimes exercise. Rather, control is dependent upon the constant practice of disciplinary activity, on the linking together of individual micro-practices to form part of a wider routine. It is as a sequence that practices acquire their true disciplinary power. Docility requires “an uninterrupted, constant coercion” (Foucault 1977: 137). Docility does not equal passivity; it requires active management.

The actualization of stable routines had a number of positive emotional and identity implications for the interviewees.

Firstly, eating healthily and exercising on a continual basis were activities connected by all of my interviewees’ with an increased capacity to engage in successful practices of temporal colonization. Interviewees felt that the future could only be orientated towards the desired outcome if disciplinary pressure was habitually exercised upon their bodies. Constructing a routine in this sense was a moral practice, as it was linked to a feeling of being in control of, rather than controlled by, diabetes, and bound up with ensuring the continual performance of a normal self through time.

Secondly, routines helped enforce interviewees’ feelings of emotional security in the face of the sometimes threatening uncertainties of diabetes (this was especially important in relation to diabetes’ short-term risks). Erin for example noted:

It helps [having a routine]. But...it just makes me a little bit surer of myself, that I’m not going to go low or whatever. Um...so yeah, it is good.

Giddens (1991: 39) notes that routine practices are never just “carried out in an automatic way...[rather] maintaining...habits and routines is a crucial bulwark against threatening anxieties”. In a study looking at young adults with diabetes’ experiences of hypoglycaemia, Ritzholz and Jacobson (1998) found that their respondents (aged between 21 and 30, white and middle class) were especially anxious about hypoglycaemia disrupting their sense of self as normal, controlled



individuals. In Erin's case, it can be seen that routines help to minimize the risks of such disruptions by increasing the regulatory capacity of the self. Routines in this sense act as matrices that help lock the ideal self into place. Again, it can be seen in Erin's narrative that this process is expressed through highly moralistic language.

Thirdly, routines could also be used by interviewees' to resolve ambivalence about the presence of diabetes in their lives. For example Sylvia noted:

It's [diabetes] at the back of your mind; it's not like oh my god I cannot do this, I cannot do that. I know I cannot do certain things like eat the wrong things, but I'm not going to let it take over. It's incredibly easy to just think about it when you've got to and then just forget about it. I've just got to try and...focus, you know. I do not have to think about it every single day, but as long as I get into a routine and a pattern where I do not have to think about it, eating the right things, not drinking too much, just making sure my blood sugar's not going haywire, then once I get in the pattern, the routine, then I won't have to think about it.

Several points can be noted. Firstly there is a clear undercurrent of fear present in this account that diabetes could take over Sylvia's life. Diabetes is represented as a threat to her self-identity, and therefore has to be managed if this threat is to be successfully contained. However, the disciplinary practices that could be used most successfully to manage this risk, such as eating healthily, are the very ones Sylvia perceives to be threatening.

Secondly, anxiety also emerges from Sylvia's inability to engage in these practices. As I have shown, eating healthily and exercising were practices that were important for all of the interviewees because they provided them with the ability to construct normal identities that could exist through time. Not being able to engage in these practices is therefore not a positive but a negative, because it challenges the moral status of the self. Sylvia is also conscious that unless she is able to discipline herself, in the end the chances are that diabetes will come to dominate her in one respect or another.

The solution to these tensions in this narrative is perceived to lie in the routinization of practice. In Bourdieu's terminology, Sylvia is trying to make the body rather than the mind the centre of practical consciousness, to regulate herself through "numb

imperatives" (1990: 72). It is in the sequential organization of care that Sylvia perceives the emotional and biographical disruptions of diabetes will be resolved. However, without first intensifying, acknowledging and consciously managing her diabetes, it was impossible for her to routinize her care of the self. Her ambivalence about this is clear.

### **5.6.1. Difficulty of constructing routines**

The university environment itself could deleteriously impact upon interviewees' abilities to construct disciplinary regimes, even for those who wanted to do so. Elayne noted:

A lot of diabetes is about routine. It's about getting up in the morning at the same time, having your insulin at the same time having lunch at the same time. And as a student your sense of routine is out the window.

The reasons for this were twofold. On the one hand, the protean structure of the official university systems, in particular the changing timetables of lectures, could influence interviewees' abilities to adjust their care of the self to the temporal demands of the university, or what Bourdieu (1990) would call the university field. Similarly, the social aspects of university life could, as I have shown in the last chapter, also have their own complexifying impacts. As such, when these two poles of university life were combined, it seemed to many interviewees that there was no fixity in university life, nothing solid upon which to build disciplinary practices around.

The attitudes of the first year interviewees towards this lack of fit could best be characterised as one of ambivalence. They had constructed a diabetic habitus through years of living with the condition, but this habitus had been embedded within, and for the first semester at university at least, continued to be orientated primarily towards the fields of school and home. The university field was felt by all of the first years to have less structure than they were used to. As such it was difficult to achieve the standards of control they desired because of a lack of fit between habitus and field. Erin noted:



I think that this is the first time of my life where I've had a real lack of routine, and also there's no one really checking up on you. Whereas school has a routine and they're always actually like making sure you stick to it. Whereas here...there's nothing and no one's going to care for me. And that is a bit of a problem. I think you just have to do it for yourself really.

First year students, though, were also the most likely to accept this lack of fit as both natural and, in some respects, desired. The same routines which contributed to a relative loss of control in terms of diabetes were also the same routines that enabled the construction of identities as normal, and on occasions popular, students. Alice noted:

We're normally up until half one talking to everyone. You know so many people that everyone wants to talk to you and stuff, and you just want to go to bed, but you do not want to seem rude to everyone so you just end up talking to them until half one in the morning.

Older students were different. They generally felt a lack of routine to be a negative absence. Alex was a second year living in halls who showed a strong antipathy towards the idea of being a 'typical student' and strictly regulated his consumption.

In between the meals I do not eat sweets at all because it has a very bad influence if I eat something extra between the meals. If somebody serves something at four o'clock or something, I do not eat it if I feel it affects my blood sugar. If it gets out of control it takes three or four hours to get it under control again. If it goes too much up then you have to make too much insulin. Measure it again, and it goes too much down. Stability is the most important thing.

The moral, qualitative meaning food consumption has in Alex's narrative is clear, and is dependent on the point at which it is eaten. Bad food is not only food that has too much sugar but is food that is not eaten at the right time, whose consumption disjoints the temporal sequence upon which good control is built. Once this good control is dislocated, routines that have been constructed to manage the body and ensure the performance of a healthy, virtuous self become disrupted in a bid to re-regulate the body. Schur et al (1999) identified these kinds of disruptions as being particularly onerous for young people with diabetes, as they are likely to lead young people to feel that they are being controlled by, rather than in control of, their diabetes. Additionally, practices intended to bring the body back under control

themselves carry short and long term risks. For example, taking too much insulin could result in hypoglycaemia, which could itself result in loss of control over the ‘good’ (regulated) body in the short term. On the other hand, taking too much sugar could swing blood sugars the other way, and lead to the feelings of guilt and anxiety. Furthermore, hypoglycaemia and hyperglycaemia, by rendering the body vulnerable could challenge masculine identities predicated upon the suppression of vulnerability and control of the emotions.

Older interviewees were more likely to blame themselves if they weren’t able to successfully routinize their disciplinary practice. They often felt that by their second or third year they should have a feel for the university game. Because of this, when interviewees experienced difficulties constructing routines, their ability or willingness to displace guilt and anxiety onto situational naivety or the ‘naturalness’ of particular student practices was eroded. Importantly, though, while their desire to construct routines often increased, older interviewees still continued to have difficulties regimenting their disciplinary activities.

For example, Naoimh noted:

I've got lots of different variables. Because now I'm doing more exercise and probably going out more. So I do not know. It could be any one. Like on Monday morning when I say 'right, I'll have a good week'...like I know the causes of why I'm maybe high or low. It's just remembering like how much to take and stuff. So. I have tried to sit down, but not long and hard. If I had a week where I didn't go out and had some sport and had lectures from maybe nine to five, then I'd probably be fine, I'd sort it out. But the next week once I started going out again I'd just...screw up.

There is a strong feeling of self-recrimination present in this narrative. Naoimh both disparages her own knowledge (‘like I know the causes...’) and she represents her self as not being sufficiently committed to control of her diabetes (‘not long and hard’). Her inability to develop control of, and mastery over, her diabetes by balancing her practices leads her to feel shame about the adequacy of her current practices (‘I’d just...screw up’). As I discussed in section 4.9.1, shame is important for self-identity “because it is essentially anxiety about the adequacy of the narrative by which the individual sustains a coherent biography” (Giddens 1991: 65). Shame



results from feelings of “personal insufficiency” that in turn deleteriously impact upon “integrity of the self” (ibid). In Naoimh’s case here one of the ways in which the adequacy of self-identity can be re-confirmed is through the routinization of practice. However, this would mean not going out, and not engaging in the social practices of the sort looked at in the last chapter, which, as I demonstrated, were emotionally important for interviewees, not least because they enabled interviewees to construct identities as normal young people, and feel that they were in control of their diabetes. On the other hand, not being able to develop routinized disciplinary practices challenges the moral status of the self and leads to guilt, shame and anxiety about the future. Naoimh felt that the tensions between her lack of structure and her desire for control couldn’t be successfully resolved while she was at university. She imagined that after her exams, once she was in a nine to five job, then she would be able to develop control over her self. One strategy that she used to control her feelings of guilt and self-recrimination that stemmed from this understanding, was giving up her “diabeticness” to her friend for a week. For one week she let her friend tell her what she could eat, what she could inject and when she could do so. In doing so she wanted to prove to her friend that controlling diabetes was more difficult than he knew, to somehow convey to him what it was like to live Type 1 diabetes. A lack of confidence in her own capacities underlay her decision. When I asked the male interviewees if they would ever do something like this, be willing to give up their control over themselves in this way, I received a generally confused, and sometimes incredulous reaction. However, this strategy was important for Naoimh because it justified the lack of control she had over herself; if someone else had similar difficulties in controlling her blood sugar levels and routinizing her practices, then her failure would not be her fault, but a fault that anyone would experience. Guilt about the perceived inadequacy of her practices could be deflected, and in this way managed.

### **5.6.2. Flexible routines**

Finally, while routines were central aspects of disciplinary practice for my interviewees, it was also important that these routines didn’t become too strict. Extreme rigidity was perceived to be not only a threat to personal autonomy, but also something that could undermine interviewees’ ability to discipline their bodies. Balance was important.

For example, when he went on a gap year Vincent noted that he had to (and wanted to) be more flexible with his blood sugar control than he would have been at home, given that there were so many unforeseen variables to take account of while he was moving around, and also because he didn't want his diabetes to interfere with the freedom and excitement of seeing new places. One way he dealt with the worries raised by this flexible control was by bracketing the trip temporally, saying that his control was only going to be relaxed for several weeks, and that this relaxation wasn't long enough to do any damage to his body. When asked why he was he more flexible with his control while travelling he noted:

You have to be. Because you do not know specific carbohydrates all the time and, it's a bit of a guessing game, and you have to rely on a general knowledge of what foods work and things like that. And, um, you just need to be a little bit more flexible and note how your body feel. A couple of weeks bad control isn't so critical as when you're away for three months and it's bad control. It just depends on the time scale.

Control here is both spatialised and temporalised. Flexibility was an important theme in Vincent's narrative. While it was important for him to engage in regulatory practices that enabled the management of risk, it was also important that these practices did not solidify into rigid routines, not only because extreme rigidity was perceived to be a threat to his personal autonomy and independence, but also because he felt that these kinds of 'compulsive' routines could detrimentally impact upon his ability to exert control over his body in the context of everyday practice. Control of his diabetes was not only predicated upon routinised regulation, therefore, but also on a degree of pragmatic, improvisatory, creative adaptation to changing spatial circumstances. The further away Vincent went from home the more flexible he was willing to be with his control, unless he was in a new place for an extended period of time, in which case he would develop more extensive management routines.

Sylvia is interesting in this respect. As I noted above, Sylvia desired to be in a routine so she could minimize the biographical disruption diabetes caused to her. However, in relation to certain aspects of her food consumption she had developed a



routine<sup>30</sup>, albeit in an unwanted way. This related to her regular pattern of food consumption going to bed, something which was intended to regulate her fears of becoming hypoglycaemic while she was sleeping. She was worried that if something happened to her while she was asleep there would be nothing she could do about it; she would have no control over the situation. Eating food therefore provided her with some sense of security by increasing her ability to control her self when she was unconscious. In Giddens' (1991: 3) terminology, consumption here was a practice that reinforced Sylvia's "protective cocoon...[something that] 'brackets out' potential occurrences which, were the individual seriously to contemplate them, would produce...feelings of engulfment". These same practices, however, while constructing security in one dimension, undermined her ability to construct a moral account of the self through the regulation of her food consumption practices, and therefore sent her out of control, in another dimension of practice.

After you first had your funny turn, you think every time before you go to bed that I've got to have something extra to eat. You think I've got to have something, because I'm not going to have a repeat of what happened before. Because you get into the habit of having food when I do not need it or when I'm not hungry. I just think I'll eat because I've got to have it to stop me having a hypo. And that happens quite a lot, because you know it's a habit. And I still eat, I still eat things I really shouldn't eat, and I have them all the time.

### 5.7. Men's weight management practices

In the final section of this chapter I am going to explore a theme that was important for all of my interviewees, and that was using disciplinary regimes to manage weight. Bordo (1993) notes that in contemporary Western consumer cultures a toned, disciplined body has become *the* signifier of a valued, and valuable, self.

I have divided the discussion of interviewees' weight loss practices in this section along a gender axis. While the practices of the male and female interviewees were not diametrically opposed (for example, tone, shape and control were important virtues to both), they often differed in degrees of intensity and intentionality, and the ways these practices constructed and referred to bodies and identities that reflected

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<sup>30</sup> Though she referred to it as a habit, something which distanced it from a routine- which she wanted to be in- and suggesting links to what could be considered bad habits like smoking

interviewees' understandings of what it meant for them to be men and women and in control of their bodies (Cameron and Bernardes 1998).

Men's practices will be discussed first. The segment on male interviewees' weight control practices is structured on a comparative basis. Jason and Lars' practices will be examined. Jason's weight control practices were actualized exclusively through fitness and exercise practices, orientated towards the sensual experience of a strong body and as I mentioned earlier had the effect of decreasing his diabetic control. Lars were actualized through food restriction practices, orientated towards the scientific management of the body and were linked to the minimization of risks. Similarities and dissimilarities between these accounts will be discussed afterwards.

### 5.7.1. The virtues of practice

Weight was a key concern for Jason. When he first came to university he stopped exercising and began eating unhealthily. He put on over a stone in weight during his first few months at college. This weight gain was experienced negatively by him.

I came to university and I stopped playing [football] until this time last year and that was a six month gap. And that wasn't really much exercise. I'd come from a situation where I'd be doing exercise five, six, seven times a week. And I actually put on a stone of weight. And felt like a lot worse. And looked like a lot worse. It knocked my confidence and stuff. Because I suddenly realized when I went home for the weekend and my brother said what is that, looking at my stomach as I came out of the shower. And I was like, yeah, that is a bit of a beer gut developing. Which is not nice when you consider yourself a sportsman to be on that side of the fence. To be like that. You do not want to be like that.

Myles: How'd it feel gaining that weight?

Jason: Not good. It wasn't the weight that was the issue for me, just the feeling of being healthy. Like you just feel it; you think I'm twenty years old, there's no way I should be feeling like this after running for five minutes. I should be able to do this a lot better. You just enjoy everything a lot more if you're healthy, and that is quite important to me. You do not want to be like that...the general student at university is not really concerned with health. Most people are quite lazy to be honest. I do not consider myself to be a lazy person.

Several points can be noted. Firstly, the pleasureable consumption engaged in by Jason at university is constructed as a form of duplicitous gratification. While, as I



demonstrated in section 4.4., going out drinking was often an important activity for my interviewees, it can be seen here that pleasureable consumption is also something that is seen to undermine and harm the male body.

Secondly, Jason notes that the weight he gained during his first year wasn't itself the problem. Rather, it was the type of weight gained; this was weight as undisciplined flab, rather than muscle. Watson (2000: 71) notes that fitness is often desired by men because it is "an indicator of how efficient one's body is". Efficiency is linked to other desired characteristics of hegemonic masculinity, such as performance, strength, capacity, health. Flab is problematic because it interferes with the individuals' attempts to embody, experience and articulate desired practices of the self.

Thirdly, there is an important connection between identity, appearance and relationalities here. Jason notes that he became aware of his weight in front of his brother, when his body in a sense 'failed' a performative display of competence by being out of shape and not being strong and fit enough. Baumann and May (2001) note that in modern consumer cultures, the fitness of people's bodies is a core trait upon which individuals are judged. They argue though that within this milieu, "it is not enough for the body to be fit, it must be seen to be fit" (ibid: 101). As such, an important emphasis is placed on individuals to construct bodies that are "strong looking, fat-free ...which [signify] health" (Monaghan 2001: 338). When the body fails the standards of performative normalcy in question, as Jason felt his did, it can lead to feelings of embarrassment and shame, to a sense that the person isn't good enough because they aren't sufficiently disciplined and controlled.

A fourth point relates to Jason's comment that he 'should be able to do this a lot better'. As we have seen at the beginning of this chapter, Foucault argues that people use disciplinary practices in order to improve and enhance themselves. In a very real sense, fitness practices make people better. However, there is a flipside to this as well. Because in consumer cultures individuals are considered to be responsible for, and indebted to maintain, their own care of the self, if this care is lax in any way feelings of anxiety can develop (Baumann and May 2001).

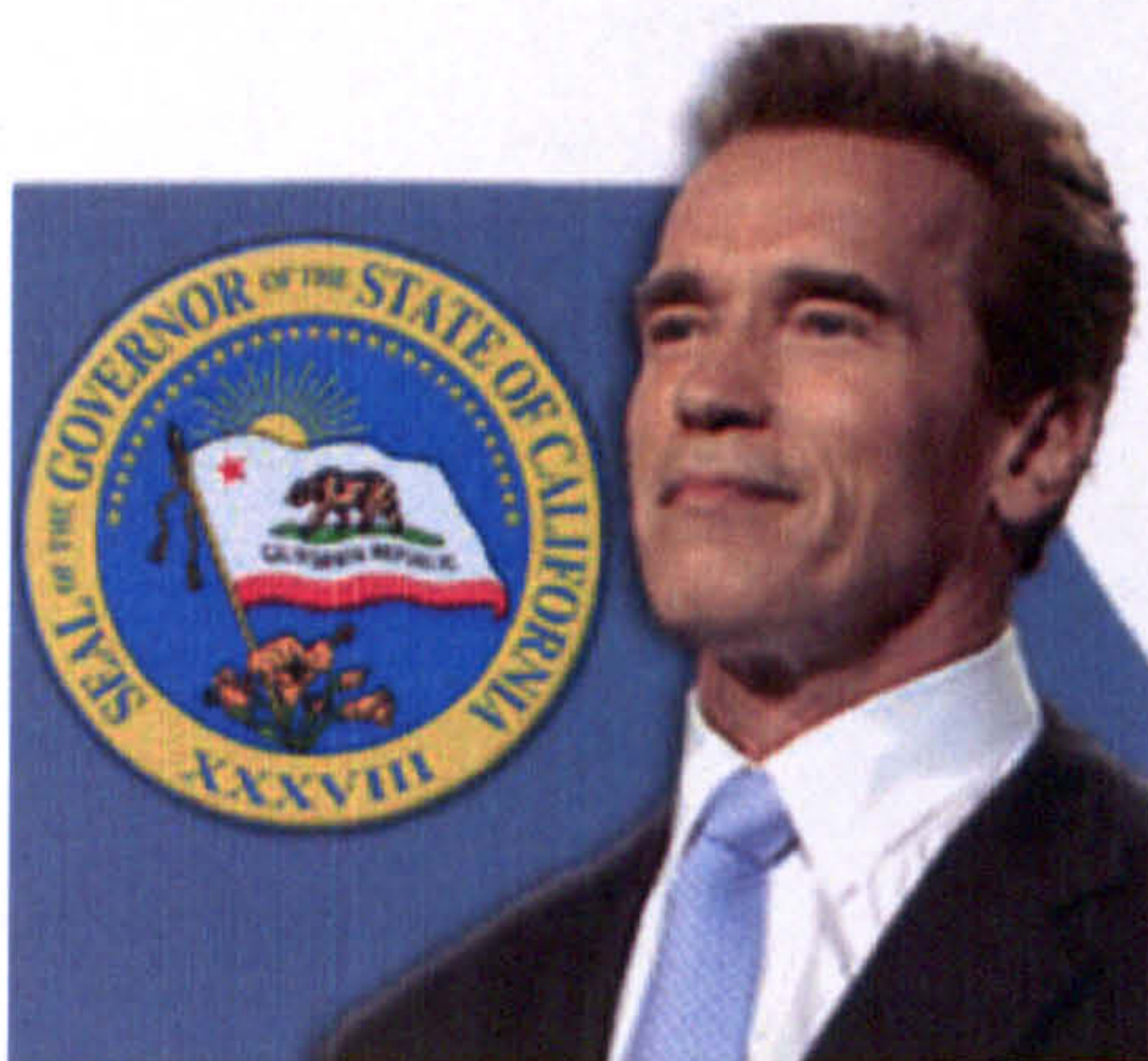


Finally, it can be seen that Jason defines himself against what he considers to be a normal student. His lack of fitness is experienced as challenging because it positions him closer to this out of shape identity, while simultaneously contravening his ability to identify with an ideal subject-position as a strong, youthful sportsman.

Because he experienced his weight gain as a threat to his identity in multiple dimensions, Jason engaged in a period of intensified discipline designed to re-assert control over his body and to re-regulate, change and modify himself for the better. He engaged in these practices when he went home from university for the Summer. The primary intentions of these practices, though, weren't to lose weight:

My fitness goals aren't to lose weight. They're to gain stamina and to gain strength. Basically. It's not to lose weight.

Jason wanted to move from being someone who was out of shape to someone who embodied a mesomorphic ideal ("moderately muscular and typically fairly lean" (Monaghan 1999: 281)). He didn't want to lose weight indefinitely, because doing so could challenge his attempt to construct a gendered body project built around identification with, and embodiment of, the virtues of power and fitness<sup>31</sup>.



<sup>31</sup> One interesting point to note here about the male interviewees' weight loss practices is that they were often ambivalent about the idea of losing weight. Frost (2003, Labre 2002) notes that young men are increasingly coming to articulate their identities through body projects based around their appearances in the same way women historically have. She argues that young men's increased concern with their visual presentation is part of "the mass changes relating to appearance, consumption and identification under conditions of consumer capitalism" where the "display of identity" is of central importance (Frost 2003: 54). While taking care of themselves was important for young men such as Jason, there was a definite feeling that taking too much care of themselves could run the risk of them appearing to be what Arnold Schwarzenegger has previously referred to as a



### 5.7.2. Intensification of discipline

The exercise routines Jason used to discipline his body became so intense though that his blood sugar control began to suffer. He found himself regularly becoming hyper- and hypoglycaemic.

My control's gone a bit... it seems to have got worse in terms of the hba1c. My result actually went up, to about 9.1 or something. I think a lot of that...my control during the summer went a bit haywire because I undertook a ridiculous exercise regime. I was cycling ten miles to work, which is about twenty miles cycling a day. I went to the gym six times a week and played tennis twice a week. Um...so the effect was...and the work I was doing, I was working in a food factory so that was heavy lifting work all day. So I was exercising basically for the vast majority of the week. My sugars were going right down. So I had a bit of trouble stabilising that. So that provides most of the explanation for why my control went a bit out.

While achieving excellent control was important for Jason (he noted that diabetes was 'a zero sum game'), he also noted that he had difficulties cutting down on his exercise despite the fact it was negatively affecting his diabetic control<sup>32</sup>.

So what accounts for the fact that Jason was prepared to engage in practices that were risky for his diabetic control in order to improve his fitness (especially given that control of his diabetes was so important for him)?

There appeared to be several reasons. Firstly, health for Jason seemed to have been interpreted in terms of fitness. By exercising so much he felt he was being healthy, though at the same time his blood sugar levels became more difficult to control.

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'girlie man' (Schwarzenegger 2004), a feminine narcissistic obsessive. Watson (2000) argues that active dieting is often perceived to be inappropriate for men, something they should not be seen or acknowledge doing, unless it is for instrumental purposes. Indeed it can be seen that Jason deflects the potential identity of a girlie man by emphasising the goal orientated nature of his practices. The morality of weight loss is not embedded within the process itself but in the strong identity it can help him achieve.

Baumann and May (2001: 101) note that while the idea of health assumes that there is a norm that a human body should meet, with deviations from this norm being viewed in terms of imbalance, disease or danger:

“The idea of fitness is another story. There may be a bottom line but the sky is the limit. The question is what is the body ultimately capable of doing. The ideal of fitness takes the body as an instrument for reaching the kind of experience that makes life enjoyable, entertaining and exciting” (Baumann and May 2001: 101).

There have been criticisms of this position. For example, Watson’s (2000) male respondents felt that there was an ideal balance to exercise. While exercise was important in terms of increasing the body’s performance, too much exercise could lead to the body ‘breaking down’. However, Jason clearly differed from Watson’s respondents, and his practices sided more with the version of fitness put forward by Baumann and May. He felt that it was always possible to be better, that he could never be too fit, or discipline his body too much. His fitness practices were technologies of the self with no defined limits.

Secondly, his intensive practices enabled him to construct a moral self. When I asked Jason if he was willing to stop exercising to improve his control he said:

No. No, because it’s something I enjoy and something that it’s...I’m being really...it’s a real part of me...what I perceive as a virtuous activity...to sacrifice a virtue seems illogical really. If someone said to me you have to cut out drinking entirely, because I stopped drinking for four months; I’ve only started drinking since I’ve been back at uni. You’re in a social environment a lot more. But I could make a sacrifice like that but not makes any changes to exercise.

What is most striking about this narrative is the strongly didactic language present in it. Morality emerges from the feelings of mastery that Jason’s disciplinary practices provide. Control via exercise creates a feeling of moral empowerment, which is experienced primarily in terms of strength and stamina. Exercising is considered to be a part of him, a way of articulating a desired attitude of the self (Lester 1997). For most of the male interviewees, the moralities of practice were connected with the minimization of risk. Exercising was good because it reduced their chances of



developing long term complications. In Jason's account, though, morality and risk are disassociated concepts. The morality of practice serves to increase risk.

Interestingly, Jason was only worried about the morality of practice as it related to exercise. Eating good or bad food wasn't an issue for him.

The amounts of bad food I eat to the weight I've got is ridiculous. I eat a lot more bad food. Maybe it's because of the amount of exercise I do, I just burn it off, and it might be because I've got a high metabolism. But it's not really a problem.

The notion of burning food was crucial in Jason's narrative. Food was interpreted in terms of its quantitative, rather than its qualitative impact upon the body. As such, the kinds of food he ate were almost irrelevant. It was just energy to keep him going. The key words that the female interviewee's used in relation to the practice of eating during or after exercise, such as futility or pointlessness, are absent here because eating is not interpreted as a loss of control. Rather, it was seen as a way of keeping the body firmly under control by minimizing the risk of hypoglycaemia, and enabling Jason to keep exercising and build strength. It was not a contravention of the aesthetically based slimming body-projects upon which the identities of the female interviewees were built.

Finally, I believe there are some interesting connections between the practices Jason engaged in, and those engaged in by people who have eating disorders like anorexia nervosa, at least in the intensities of practice. Jason was the only male interviewee to exercise to such an extent that his diabetic control became risked. Indeed, the other male interviewees saw Jason's level of practice as unbalanced, in practice if not in theory. Like in anorexia the body regimes Jason engaged in were extreme, and emerged from a profound threat to his self-identity. The weight he gained disrupted his sense of himself as a powerful masculine agent, and his ability to identify with discourses of hegemonic masculinity Giddens (1991: 107) notes that in anorexia intensive disciplinary practices "bring about a sense of achievement, rather than simply despair, and one can clearly see in them important aspects of empowerment". A similar sense of achievement is clear in Jason's account. Jason noted that after his summer of 'crazy' exercising he had never been fitter, stronger, more powerful, more

able to embody a desired form of masculinity so well. His practices not only allowed him to reconstruct a desired narrative of the self that had been disrupted by his weight gain, they created a self that had never been better.

However, there are differences between anorexic practices (at least as practiced by some women), and those engaged in by Jason. Firstly, Jason's practices weren't designed to disassociate himself from his body; they were designed to embody himself ever more fully within it. He wanted to *feel* powerful, *feel* in control. Indeed the reason he disliked hypoglycaemia was because it made his mind feel different from his body, when ideally he felt they should be working in harmony with each other. Secondly, Jason didn't feel himself taken over by his practices, something which many individuals with full-blown anorexia describe. He continually stressed his sense of agency and control over his practices/destiny, traits themselves associated with hegemonic constructions of masculinity. Thirdly, the spatialities of practice were important. While Jason exercised to an extent that his practices became risky for his blood sugar control, he did this during the Summer. He had a strong sense that even though he couldn't stop exercising while he was at home, that he was, in a sense addicted to exercise, that things would change once he got to university, where it was only possible to be "so fit". In this way he felt that he could balance and manage his practices. As I noted in section 5.4. balance itself is associated with dominant forms of masculinity in the contemporary period.

### 5.7.3. Scientific dieting

At the time I carried out my fieldwork, Lars was the only male interviewee to use restrictive consumption practices in order to control his weight. He noted that he would have liked to have had the time to exercise and start running, but because of the stresses and pressures of being a fourth year medical student, he didn't have much time to work on his body. Lars was slightly embarrassed about the form his weight loss practice took, something intensified by the fact that he admitted his dieting practices weren't only directed towards maximizing the health or functionality of his body (though he still wanted to be strong and fit).

It sounds really vain, but just to have a better looking body, but that's not useful is it?



Lars' account is interesting, not only because he was the only male interviewee to engage in weight loss practices that were exclusively based on the management of consumption, but also because he was the only interviewee who lost weight by going on the Atkins diet<sup>33</sup>, and because in some important respects his account differed from those of the female interviewees who engaged in similar weight loss practices.

Dieting in order to lose weight was closely connected in Lars' narrative to the DAFNE (Dose Adjustment for Normal Eating) project (discussed in extensive detail in the section 6.3.). Lars noted that before going on DAFNE he generally tried to maintain very good control over his consumption practices because he wanted to minimize the long term risks associated with diabetes. The question of what could happen to him in the future if he ate a particular chocolate bar or cake was never far from his mind. In many respects his concentrated control was linked to a general uncertainty about the specific effects the consumption of x amount food would have on his blood sugar levels, or how much units of insulin would be needed to properly regulate post-consumption blood sugar spikes.

Lars felt that the DAFNE course gave him the tools he needed to evaluate his diabetes and consumption in scientific terms, to figure out how his diabetes worked technically. Consequently, he felt it gave him more freedom to eat whatever he wanted. This new-found autonomy, however, proved to be as problematic as it was pleasurable. Lupton notes that "there is a paradox implicit in the dualism of control and release: discipline intensifies desire" (Lupton 1995: 142). Because he had been living with the regulatory regimes of diabetes for so long and with management practices supported and sharpened by habitual and deep rooted anxieties, when these were relaxed he began to eat uncontrollably.

I think that for so many years I wasn't allowed to eat what I wanted to eat. Suddenly I could do so I went wild.

It became apparent that the pleasurable lack of stricture and autonomy Lars experienced in relation to his blood sugar control led to a troubling loss of control in

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<sup>33</sup> The Atkins diet recommends adherents cut out, or severely cut down, on carbohydrate consumption, which is tricky for most people with diabetes.

other dimensions. Namely, because he felt that he now had the independence to eat what he wanted, he quickly began to put on weight.

In order to re-exert control over his body, Lars decided to go on the Atkins diet, because he felt its scientific nature would best help him lose weight.

It speaks very scientifically. That's the great thing about Atkins; it's very scientific. It's all in facts and you can read about it and make it work for you. And I mean, I have to say that DAFNE makes it very easy to put on weight, but it also makes it very easy to lose weight because at least you can control things when you're losing the weight. You haven't got to think about carbohydrates and it's ok not to eat carbohydrates with DAFNE so it's fine to lose weight too. Whereas before if I was trying to lose weight it would have been a lot more complex and I'd have had to have spoken to the diabetic nurses and things, whereas now I have a lot more autonomy. I can do it myself. It's fantastic.

The common connection between Atkins and DAFNE here for Lars was the systematic and technocratic nature of both systems. Both encouraged the development of control through exact, methodical, logical interpretation. It's interesting to note here that it seems to have been because of the scientific nature of these systems that Lars's narrative didn't contain the same kinds of negative descriptions of dieting that the female interviewees did. Whereas the female interviewees were routinely injecting x amounts of insulin and then exercising and going low, Lars just completely cut carbohydrates out of his diet and scaled his insulin dosages down accordingly.

There is something to say about the relationship between science, masculinity, rationality and control here as well. Traditionally men have been identified with science and technology (Connell 1995, Seidler 1989). Hildebrand (1998) argues that this traditional identification of men with science and rationality has been at the expense of a disidentification with the emotions, the body, the intuitive. As such she argues that powerful versions of masculinity are based upon the setting up of mutually exclusive dualisms. Jackson and Scott (1997: 553) note though that in many respects this representation of a dualistic masculinity is a bit of a straw man. They argue that while rationality and autonomy may be characteristics that men find important to identify with, these traits exist in continually alternating relationships



with their antitheses within the same person. In Lars' account, it can be seen that his identification with and appropriation of scientific practices enables him to increase feelings of happiness and wellbeing by intensifying his ability to control himself. The place of emotions are not denied here in the identification with science; rather, science allows the place of the emotions usually present in Lars' relationship with his diabetes (anxiety, guilt) to be managed. It's important to note that Atkins and DAFNE also allow him to diet in such a way that the virtues of masculinity (autonomy, control) were maintained, something which itself contributed to Lars' 'fantastic' feelings about his dieting practices.

Finally, risk also had a presence in Lars' account of his dieting practices. He noted for example that the Atkins diet is often seen as being a problematic diet for people with diabetes because of its perceived deleterious effect on health. Jarvis and Rubin (2001) argue that people with diabetes have a greater risk of developing higher blood pressure and developing problems with their kidneys. As such, these authors argue that it is important for diabetics to control their fat intake as fat increases the risk of developing both of these complications. They argue that people with diabetes should avoid diets like the Atkins because such a diet is likely to be higher in fat than diets where carbohydrates are included. However, Lars argued that the risks associated with Atkins for people with diabetes could be regulated if they were temporally bracketed, if they weren't engaged in for too long, if they were balanced.

If you've been on Atkins, Atkins induces a state of ketoacidosis, and I do not know if you know all about this, but it's basically just kind of starving yourself in a way, Atkins is. Um, but it's like a healthy way of doing it. I think the Atkins diet is fine if it's a short term diet. If it's long term then sure, be careful and think about the long term implications such as bone density and kidney problems. But I was on it probably for a month, strictly on the Atkins diet. But yeah, I think that people are careful to worry about those side effects. But I think that's only if you do it long term.

Lars' and Jason's narratives, then, both indicate the important of weight control practices in the narratives of the male interviewees. In both of their accounts, control of weight *via* the use of disciplinary practice was linked to the construction of a desired subjectivity that had been threatened by previous weight gain. Weight control therefore provided a way of reconstructing a damaged narrative by enabling Lars and

James to identify with powerful, normative representations of masculinity. Risk was a theme/technology of the self in both, and was closely linked to the construction of these ideal selves.

### **5.8. Female interviewees' weight control practices**

As has been indicated at various points throughout this chapter, weight control was a, if not the, central, emotionally important activity for the female interviewees in this study (at least in relation to their food consumption). The moralities of consumption, the negotiations of risk, the regulation of anxieties: none of these can be fully understood in relation to the practices of the female respondents without acknowledging and exploring the ways in which these practices intersected with, and often emerged from, their weight loss practices.

This section explores these practices. It is structured as followed. First it explores the reasons why the female interviewees engaged in weight loss practices. The emphasis will be placed here, following Foucault, on the regulation of food consumption and exercise as disciplinary technologies of the self that the women used to make themselves better subjects. Relationalities and temporalities will be emphasised. I will then examine the difficulties female interviewees experienced while trying to lose weight while managing the risks of diabetes. The emotional dimensions of practice will be highlighted.

Before going on to look at the practices of the interviewees in this study, though, I feel it is important to note the way in which young women's weight loss practices are often considered in medical discourses; namely, problematic. Silverstein et al (2005) for example note that young women are more likely to 'mismanage' their diabetes than young men. The most important arena in which this mismanagement is commonly thought to occur is control of food consumption.

Many of the studies in the medical literature that have focused on weight control practices amongst young women with diabetes have explored the connection between diabetes and 'disturbed' eating, particularly as this relates to clinical eating disorders. Young female diabetics are often considered to be, as a group, at a higher risk for developing eating disorders than their non-diabetic peers, in a similar way to



athletes and ballerinas (Grylli et al 2005, Maharaj et al 2003, Rodin et al 2002, Hunt 1996). In the largest epidemiological study done to date on the relationship between women with type 1 diabetes and EDs, Jones et al (2000) argue that young women with type 1 diabetes are twice as likely to develop an eating disorder as other young people of their age, and that 'milder disturbances' in food consumption practices are much more common amongst young women with diabetes. In particular, certain types of eating disorders are thought to be more common, specifically bulimia, but not anorexia (Rodin et al 2002).

When these conditions do develop they can undoubtedly have severe consequences; Jones et al (2000: 1563) note that eating disorders are associated with "impaired metabolic control and an earlier than expected onset of diabetes related complications".

However, two points can be noted.

Firstly, the research literature does not, at present, definitively support an assertion that there is a higher rate of eating disorders amongst type 1 diabetics. The evidence for a higher rate of eating disorders amongst women with type 1 diabetes is inconsistent (Peveler et al 2005, Neumark-Sztainer et al 2002, Herpertz et al 2001, Bryden et al 1999, Eveler et al 1992), though on balance I would say that the rates of eating disorders are at least as high in young women with diabetes as young women without the condition, and probably higher.

Secondly, and more importantly for the overall concerns of my thesis, I have concerns with the dominant 'order/disorder' paradigm through which young women with diabetes' consumption practices are often viewed by the medical literature. Firstly, exploring consumption practices through a paradigm of disorder effaces the fact that "meanings are not simply sent by producers and received by consumers but are always made in usage" (Du Gay et al 1997: 85). Secondly, I also have some problems with the terminological definitions in some of these studies. Maharaj et al (2004: 711) define a 'mild disturbance' in eating as "engaging in one or more of the

above disordered eating<sup>34</sup> and/or weight loss behaviours at a frequency of < or = to one times a month over the preceding three months”. According to the exclusionary criteria of this definition, it would be difficult to find women who are engaged in ‘ordinary’ food consumption practices at all. Furthermore, what may be a disturbance in eating from a medical perspective may, as I will show shortly, be an emotionally positive practice from the young person’s perspective. It is vital that the young person’s perspective be considered as quality of life cannot be measured by hba1c levels alone. Maclean (1991: 694) notes, and I agree with him, that:

“Self-care actions may result in behaviour that health professionals consider detrimental to health. When such actions result from deliberate autonomous choice, the decision must be respected”.

And finally, the flipside of disturbed consumption perspective is that in the absence of a clinical eating disorder, consumption is viewed as non-problematic. Grylli et al (2005: 199) note for example defined ‘no eating problems’ as the category that:

“Included patients who reported no problems in eating attitudes and behaviours, as reflected by the absence of a clinical eating disorder and of subthreshold eating and shape problems”.

However, as I will show now, not having an eating disorder does not mean consumption is experienced unproblematically by young women with diabetes; in fact, it is often difficult and trying.

In general, I believe that this focus on eating disorders comes at the expense of an exploration of the practices most women with diabetes have to negotiate in the context of their everyday disciplinary activities. None of the studies mentioned in this section engaged in phenomenological exploration of what it is like for women with diabetes to engage in weight loss practices. Also, none of the women in this study said that they had an eating disorder (though they may not have told me if they had had one).

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<sup>34</sup> Binge eating, self-induced vomiting, laxative/diuretic use, insulin omission or complete food avoidance



### 5.8.1. Weight loss as a technology of the self

One of the most striking things about the reasons female interviewees in this study gave for wanting to be slim was the similarity between their accounts. Naoimh and Erin noted:

Naoimh: You live longer. Feel more confident. Makes you feel good after you've been for a run and gone swimming and all that sort of stuff. Um...I think confidence is the biggest thing. Yeah. Cause like if you're thin and nice then you can walk down the street with your head held high.

Erin: Just the whole normal, stereotypical...looking good in clothes or whatever. And I suppose it's just about feeling better in yourself. Um...the whole self-confidence thing...everyone would want to be thinner because it's perceived to be better or feel better about yourself.

Four important points can be noted.

Firstly, the relationship between weight loss and identity is clear in both of these narratives. Weight loss is connected to pride in the adequacy of personal practice, something that serves to confirm “the integrity and value of the narrative of self-identity” (Giddens 1991: 66). Brumberg (1997: 97) notes that the slim body has become “the ultimate expression of the self” for women in Western consumer cultures<sup>35</sup> (Brumberg 1997: 97). Questions of personal validity and self-worth are typically answered by women with reference to their bodies, and by implication, the level of control and discipline they can exert over themselves via the regulation of their consumption and exercise practices. A slim body is viewed as a “healthy, normal body, [that displays] tangible evidence of rigid self-discipline” (Lupton 1996: 137), a body that has internalized the values of late capitalism (McDowell 1999). Slimness represents a person:

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<sup>35</sup> Historically, this has been a relatively recent association. Young women today base their identities around their bodies in a way that young people of a similar age did not in the past (Brumberg 1997). Grogan (1999) notes that a plump body was considered the ideal weight for women even until relatively recently. Until the beginning of the last century girls did not build identities around the aesthetic body-projects (Brumberg 1997). In fact slimness as an idealised a state of being only developed widespread acceptance in the 1920s, and it wasn't even until the 1950s that “there was a significant move towards slimness as it came to exemplify unconventionality, freedom, youthfulness and a ticket to the jet set life in 1960s Britain” (ibid: 15).

“Who is smarter, better, more together and less vulnerable. Slenderness communicates competence, self-control and intelligence. It reflects a self that can rise above a need to eat.” (Lester 1997: 486).

In this respect, Erin and Naoimh’s weight loss practices are technologies of the self, disciplinary operations that individuals use upon themselves to achieve a state of happiness or perfection, or otherwise make themselves better than they are.

Weight loss can secondly be seen to be a moral practice, linked to the construction of a virtuous subjectivity. In Naoimh’s account, for example, being thin and being a good person are equated.

Thirdly, as indicated by Erin’s comment that ‘everyone would like to be thinner’, weight loss is a normative practice. Charles and Kerr (1986: 53) note “practices centred around resisting food are often enduring features of women’s personal landscapes”, something that women engage in routinely and habitually. Dieting to lose weight is a “prescriptively normal” (Malson 1997: 224) state of affairs for women.

And fourthly, while not explicitly highlighted in these narratives, temporalities were an important aspect of the female interviewees’ slimming regimes. Interviewees were concerned about using their practices to maintain the integrity of their identities through time. Most commonly, this translated into concerns about ‘letting themselves go’ in the future. As such interviewees wanted to be sufficiently controlled with regards their disciplinary practice now so that they decreased their risks of losing control over themselves and becoming fat, rather than fit, in the future. Interviewees’ temporal awareness could also extend in the other direction as well, however.

Myles: How come you want to be slim?



Sylvia: What, apart from the obvious like...looking better and...? Well, I do not know, that's the obvious thing, but for me...because I know I was thinner, I wasn't thin, I was thinner to start with, and then over the past three or four years I put on the weight...it's almost like annoyance that it's come to this. You blame the diabetes, although really, it's not the diabetes' fault, but still push the blame onto that.

In research looking at gender differences in adolescent management of diabetes, Williams (C.) (1999: 1162) found that the young women in her study were less likely to attempt to reconstruct a past self through their current practice than men were, and that "all of the girls interviewed incorporated diabetes into their identities to a greater or lesser degree". Sylvia, though, had not incorporated diabetes fully into her identity. Her slimming practices were orientated towards uncovering the "fit and lean individual hiding beneath the layers of flesh" (Lupton 1995: 143) that she felt had been lost through the years of living with diabetes. However, while diabetes may have been the reason behind her weight gain<sup>36</sup>, Sylvia blamed herself, not her condition, for the increase in her weight. She felt she should have controlled her self from the beginning. She felt ashamed about the adequacy of her personal practices, her inability to successfully discipline her body. Weight gain was seen as a failure of willpower. Her use of disciplinary practice to regulate her weight, therefore, was connected to a desire to resolve these feelings of personal insufficiency by reconstructing an ideal, past self, one that she felt had been disrupted by the presence of her diabetes and loss of control over her disciplinary practices. It can also be seen here that these practices of the self are temporally dynamic; Sylvia's current practices were designed to ensure the integrity of her future self by recapturing a self that she felt she had lost in the past.

### 5.8.2 The difficulties of practice

Lester (1997) notes that technologies of the self are made up of two principal components: theoretical and practical. The material I have discussed so far in this section falls under the category of theory. It describes the ethos, the 'desired attitude of the self' that these women embodied, or were trying to embody.

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<sup>36</sup> In a study examining the clinical course of diabetes from adolescence to young adulthood, Bryden et al (2001) found that the percentage of young women who were medically overweight in their sample increased from 21% to 54% over nine years.

Practice is as important an element of disciplinary regimes, though, as theory. The two main practices that the female interviewees used to control their weight in this study were exercise and controlling their food consumption.

Diabetes could complicate female interviewees' weight loss practices in a number of ways. Firstly, diabetes management was associated with weight gain by a lot of the female interviewees. Weight gain appears to be a relatively common problem for young women with diabetes. For example in a study that examined the longitudinal course of diabetes over ten years amongst a sample of young people, Bryden et al (2001: 1538) found that their female respondents were "significantly overweight at both assessments", both baseline and follow-up. The DCCT (1993) also found that weight gain was a problematic complication of intensive therapy, with intensive therapy being linked to a 33% increase in the risk of trial participants becoming medically overweight. In fact at the five year follow up in the DCCT people who were on insulin therapy weighed on average 4.6 kg more than people who ascribed to the conventional therapy.

This kind of weight gain often came as a surprise to the interviewees. For example, when she was first diagnosed Sylvia thought that one of the benefits of having diabetes would be that she would continue losing weight in the same manner she had been before starting insulin therapy. In actuality, she gained three stone in four years. This was hard to deal with in itself.

However, diabetes could also affect interviewees' abilities to successfully actualize their slimming practices.

For example, Alice noted:

If you do exercise then there's more chance of you having a hypo and then you...eating or drinking or having extra stuff because you're hypoing. So why do the exercise in the first place? If you hypo you're going to have to have some extra orange juice or...some digestive biscuits or whatever. And then you just did that exercise for no reason, in a way.



Exercise was a risky form of discipline for the female interviewees. Like with the male interviewees, the female interviewees argued that diabetes had to be managed if the risk of suffering a hypoglycaemic episode while engaging in vigorous activity was to be minimized. However, the principal form this management often took, namely eating sugary foods before or after working out, could be problematic for the women because it contravened female interviewees' weight loss activities, practices which were deemed necessary for the actualization of valued body projects and the production of desired accounts of the self. If sufficient food wasn't eaten prior to exercising, though, it could result in a hypo, and the uncontrolled consumption of a large amount, or the wrong kinds, of food after hypoing in order to get blood sugars back up. The results then would be the same, or worse, as not exercising at all (though at the same time, interviewees occasionally commented that hypoglycaemia provided them with an excuse to eat chocolate). Furthermore, trying to lose weight by restricting food consumption could have a deleterious effect on the ability to regulate blood sugar levels because insulin requirements changed with changing body weight.

Weight loss, therefore, was a balancing act. The desire to regulate the body had to be tempered by the need to manage the risks of diabetes; the wish to be disciplined had to be disciplined itself. Most interviewees accepted balancing as a necessary aspect of having diabetes. Indeed, the difficulties interviewees experienced with balancing could have productive effects. Erin for example noted that the need to balance blood sugar levels with the wish to lose weight intensified her 'willpower', because she felt that if these practices failed too much effort would be required to find a new balance. She felt this kind of effort to be threatening because diabetes would have to be consciously, rather than routinely, regulated, at least until her blood sugars and practices stabilized again. Diabetes would therefore come much more to the foreground in her everyday practices, rather than being, in Bourdieu's terms, an unarticulated component of her *habitus*. This in turn could be difficult for her attempts to construct an identity as a 'normal' first year student.

For interviewees who hadn't accepted diabetes as part of themselves, however, particularly Sylvia and Maria, balancing could have much more negative connotations (and it wasn't completely positive in Maria's narrative, more a case of

pragmatic acceptance). For example, for Sylvia balancing diabetes with the desire to lose weight (which, as I showed above, was important for Sylvia in recapturing a past identity that she felt had been disrupted by diabetes) was a threatening practice, because it was in the first instance predicated upon accepting diabetes as part of the self. In practical terms, assimilating diabetes in this way would mean ascribing to intensive management regimes and injecting multiple times a day. However, Sylvia only injected twice a day (the least out of all of the interviewees) because she wanted to minimize the presence of diabetes in her life, not make it a part of herself. Without the refined control over her diabetes that intensive therapy provided, though, including the ability to continually adjust insulin dosages to contextual requirements, it was impossible for her to control her weight to the degree she wanted and so (re)construct a desired self-identity.

I just...I suppose, I can lose weight, it is possible to do it when you're diabetic, it's just a damned sight harder. I suppose you've got to tell your self you've got to be more regulated, you've got to have more regular meals, you've got to have...or maybe go on a different plan where you know you have four injections. It's more controlled. To lose the weight you've got to be completely controlled about what you're doing. Especially like if you exercise as well. You're trying to balance it all.

### **5.8.3. Emotional aspects of dieting**

The kinds of difficulties described here, and the accommodations female interviewees had to make to their disciplinary practices because of them, often had negative emotional effects, even for interviewees who accepted that balancing competing priorities was part of living with diabetes. In a culture where the successful self is slim, deviation from this ideal can have deleterious implications. This is particularly the case for women, who are more likely to be castigated, both by themselves and others, for being overweight than their male peers (Valentine 1999). The emotional stresses of body management can be especially intense in the teenage years when worries about body weight often become intensified by physical changes, and the ways in which these changes intersect with increasing social pressures to lose weight (Brumberg 1997, Grogan and Wainwright 1996).

During her second year of university Elayne developed a pattern of regular and severe hypos. She began to eat more and more food in order to control her blood



sugar levels. Because of this, she began putting on weight. She used exercise in an attempt to control her weight gain, but this resulted in hypos of its own, which led to the consumption of more food, which intensified the negative circularity that had quickly come to characterise her care of the self.

The constant lows and the constant eating; that...really got me down. You kind of think 'I'm fighting a battle I cannot win here'. Yeah. Cause if I try and exercise and try and do something about this...then I'm going to go low in the middle of the night. Which was happening at two o'clock in the morning. I was downstairs, drinking lucozade and eating toast. So you think, what's the point. It's actually counter-productive. You know, I'm getting less out of it; I'm putting on weight by doing this.

Kovacs et al (1997) note that amongst young people “depression has traditionally been considered the most frequent mood disorder of IDDM”, and is related to “the pressures of living with a chronic condition, the constant need to be, and actual difficulties of being, in control, and the possibility that future complications will develop” (Kovacs et al 1997). In Elayne’s case it emerged from her feeling that she had lost control over her body, and was unable to actualize “the virtues of thinness and self-regulation” (Turner 1992: 47). Diabetes had become something that threatened the integrity of her self by preventing her from engaging in desired practices of the self while simultaneously forcing her to engage in undesired, defensive practices whose purpose was to limit the negative control diabetes had over her. These practices in turn carried their own risks, often making her hyper- rather than normo-glycaemic. Diabetes became separated from her self, something heavy and uncontrolled, a continual, unmanageable risk. Having to eat was an assault, rather than a pleasurable activity, because it was her diabetes that was forcing her to eat.

Elayne resolved these tensions and exerted control over her body by using an insulin pump; the use of technology to enable the successful actualization of gendered based body projects and control of the self will be discussed in more detail in section 6.3.2.

Anger was also a commonly reported feeling, and was directed both at diabetes and at the self for not being disciplined enough.

Myles: Like how does it feel if, you know, to be healthy you cannot really lose weight. How does that feel if you want to...?

Christina: Frustrating. It's frustrating but...I do not really think it matters to a really great extent. I do not think...I think the problem with women is...they put all their insecurities into one thing...so...I do not...it was frustrating, but you do kind of get past it and you do just think, like having the diabetes thing, that 'this is the way it is'. You can really stress yourself about it and make yourself ill and then potentially give yourself complications. And risk your life. Or you can do the best you can do, and be healthy. And get on with it.

Several points can be noted. Firstly, weight loss practices are constructed as ambivalent techniques in this narrative; they do not radically transform the self. Instead, they are represented as problematic responses to women's material problems. There is an understanding here that "women are more likely to be *trapped* [emphasis added] in narcissistic body management and presentation since they have been more exposed to the discourse of health and the glorification of the slim body" (Litva et al 2001: 254).

Secondly, there is a distinction made in this narrative between the desire to engage in disciplinary activity in order to lose weight, and to increase health. Where these two regimes have trouble fitting together, managing health is considered more important, more fundamental, than managing appearance. Christina's ambivalent attitude differs here from the female student interviewees in Litva et al's (2001) study. The undergraduates in that research were asked what health meant to them. They described healthiness primarily in terms of appearance, referring to health as being made up of having "clear skin, shiny hair, nice teeth, being average weight, not too skinny and not too fat, and 'fit' or toned" (ibid: 256).

"The interviewees felt that there is a 'look' of health since women with particular 'desired' features are 'looking' healthy while women with other 'undesired' features, such as being overweight, tend to 'look' unhealthy...having the look is what is important" (ibid: 257).

Healthiness for Litva et al's respondents was therefore primarily representational in nature, in contrast to Christina for whom healthiness was also representational, but was also made up of other elements, such as ensuring good control of blood sugar levels.



What is common to both of the points I have made about Christina's narrative is that they construct weight loss practices as less important than, or flawed responses to, more important concerns. As such, they attempt to minimize the centrality of these practices to Christina's self-identity (and they were important- Christina noted she was 'always on 'yo'yo' diets). In the process they serve to balance, within the narrative, the emotional frustrations that result from the diabetes' often deleterious effects upon the successful actualization of disciplinary regimes. They change Christina's difficulties in actualizing a slim self into the necessary, virtuous practices of a rational self concerned with maximizing personal health. It's important to note, though, the intensity of the emotion being expressed here; anger is represented as not only consuming the self, but also harming it ('stress about it and make yourself ill').

#### 5.8.4. Health diets

Christina's narrative is not only a way of constructing a virtuous self within an illness narrative, however. It also describes an attitude that many of the female interviewees articulated, namely a desire to walk a reasonable 'middle ground' between the desire to stay healthy and the desire to engage in slimming practices- to make sensible adjustments to consumption practices that were proportional to the risks of diabetes, to be 'good enough' rather than go to 'extremes'. Alice for example noted that she accepted that with diabetes it was only possible to be so slim, and that slimming beyond this point would be something that was risky for her health.

Quite a lot of my friends in the corridor that I had last year were really thin. Like skinny girls sort of thing. But I'm never going to be that anyway. I just want to be a bit thinner. I do not want to be thin; I just want to be the right weight for me...I'm not trying to get thin, I'm just trying to get to a reasonable weight, that's all.

The desire to be healthy by balancing practice was reflected in the way female interviewees would engage in some weight control practices they considered to be healthy, but usually not others they felt to be inherently unhealthy.

Neumark-Sztainer et al (2002) et al provide an interesting typology of the different weight loss activities engaged in by young people with diabetes, based on a

questionnaire survey completed with 143 youth aged 12 to 21, and broken down into healthy, unhealthy and very unhealthy categories:

“Healthy: exercise, more fruit and veg, less high-fat foods, less sweets.  
Unhealthy: fasted, ate very little, skipped meals, increased smoking.  
Very unhealthy behaviours: diet pills, vomited, skipped insulin, used less insulin, laxatives, diuretics” (Neumark-Sztainer et al 2002: 1291)<sup>37</sup>.

Out of all the practices mentioned this list, interviewees in this study most commonly engaged in those described by Neumark-Sztainer et al as healthy, with ‘unhealthy’ practices being less commonly described.

None of the women I interviewed said that they never omitted taking their insulin injections in order to lose weight, principally because they felt this was a ‘bad’ practice, and one that could have risky effects on their bodies in the future. Omission of insulin is a weight loss practice specific to diabetes. If insulin isn’t taken blood sugar levels rise rapidly, until these sugars are passed in the individual’s urine. Omission therefore leads to ketoacidosis, and provides a quick and efficient way of losing weight. Some studies have also found that omitting insulin is a common practice amongst young women with diabetes. Jones et al (2000) study of the dietary practices of young female diabetics “insulin omission was the most common weight loss method after dieting”. However, the findings here support those in Neumark-Sztainer et al’s (2002) study which found that young women are most likely to attempt to control their weight through healthy practices.

Similarly, none of the interviewees described going on the Atkins diet, or a related diet. When I did my first interview with Lilya she had recently completed the DAFNE programme. One of the things DAFNE taught her to do was carry around a diary with her to record her carbohydrate consumption on a regular basis. Her friends thought she was on the Atkins diet when they saw her checking the labels of different food stuffs. Her reaction to being associated with Atkins, though, were strong. Her

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<sup>37</sup> Some criticisms can be made of Neumark-Sztainer’s argument in light of the findings of this study, however. The perspective these authors take on disciplinary practice is “highly instrumental...relating habits and preferences to anatomical functioning” (Lupton 1996: 6). Healthy practices are those that seem likely to best ensure normoglycaemia. Health in Neumark-Sztainer’s account is a normative concept, and practices either correspond or deviate from it.



general response to her friends when they asked her if she was on Atkins was “I’m not that stupid, thank you very much”. It made her angry having to carry around a little carbohydrate book but only because other people mistook it for a little calorie counting book. The strength of her feelings in this regard stemmed from the fact that she felt that Atkins put people into the same state as an undiagnosed diabetic. Atkins wasn’t interpreted as a way of constructing an ideal self, but of risking this ideal.

Because you do not have carbohydrates and you produce ketones because...I do not know quite how it works, it seems to be a by product of processing everything. And you burn your fat stores and get ketones and they’re the ones that kill you off. Plus they’ve got all these nasty side effects. I mean why would you do that to yourself? I do not want to be ill. I remember what it was like to be an undiagnosed diabetic. It was just the worst week of my life.

It is important to note as well, though, that interviewees were alert to the possibility that that they could use the concept of balance as an excuse not to engage in slimming activities at all. Interviewees generally felt that while having to balance competing regimes of practice, such as the desire to lose weight while maintaining good quality of health, could take some of the pressures to lose weight away, it did not provide a justification for not trying to be slim.

Myles: And at the same time then, does having diabetes take away some of the bad feelings? Can you say I have diabetes, I can give myself some slack?

Alice: Yeah, you can do that, but then, like I probably have done that in the past, but then it’s not the way about it really is it? It’s not the right thing to say. You cannot blame it on things. You can a bit but otherwise you’re never going to keep at it and you’ll just spiral out of...(laughs). You’ll just get lazier and not like do anything.

#### **5.8.5. Relational aspects of practice**

Finally, as with the male interviewees, female interviewees’ feelings about their weight often developed relationally, through comparison of their personal practices with those of other young students, discursive ideals and parental attitudes.

This comparison of practice could have productive (or at least ambivalent) effects in the way it encouraged interviewees to change their practices in ways they considered to be for the better. Naoimh for example noted that her three male housemates, by

constantly making comments about other women, made her reflect upon her own body, which she gradually began to feel was lacking. As such she intensified her disciplinary regimes to ensure the successful performance of a normal, ideal self.

Naoimh: I think living with the people I'm living with this year has made me quite self-conscious. Because they're very...they always point things out. Like 'look at her, she's fat'. And then you go...and then you're comparing yourself to her all the time. So. And look, she's really fit, so you compare yourself to her. And then...you sort of realize, I'm more aware of what other people might think, which is probably a bad thing, but it sort of kicked me into gear and said just go out and get fitter. So I'd probably say it's all due to the people I live with this year...I'm glad...that I've lived with them and it made me more self-aware.

Myles: More aware of...

Naoimh: How you are compared to other people, I think.

Myles: Really? That's good?

Naoimh: Yeah, because it spurred me into changing things...I think it's beneficial for me.

The self Naoimh is representing in her narrative is one that is intimately attuned to self-improvement and instances where personal practices deviate from the ideal. It is a self that, where it feels itself to be insufficiently well controlled or engaged in the incorrect disciplinary practices, can reflexively intensify its regimes of control to bring the actual practices in line with the ideal. Bordo (1993: 27) notes, following Foucault, that these kinds of practices are attractive because they are "experienced in terms of power and control" while simultaneously making the practices of the self, and the self these practices produce, correspond to cultural ideals.

However, while these practices enable a feeling of power, Bordo argues that when women engage in them women they:

"Continue to memorize...the feel and conviction of lack, of insufficiency, of never being good enough" (Bordo 1993: 166).

A feeling of insufficiency similar to that described by Bordo is clearly present in Naoimh's narrative. Naoimh changed her practices because she felt that they weren't



good enough, though at the same time, she felt that changing them was ‘probably a bad thing’. Lester’s (1997: 487) argument, that on a cultural level “the slender female body communicates almost the opposite of its significance on the psychological level- conformity to sexual stereotypes, vanity, superficiality, vulnerability, delicacy”, has relevance here. Naoimh felt she was lacking something either way, in the first case discipline, in the second, an ability to resist normative social pressures. There was no answer to these tensions in Naoimh’s narrative, though by themselves they are important for highlighting the relational nature of identity, and the point that “identities are not unified. There may be contradictions within them which have to be negotiated” (Woodward 1997: 12).

Parents had an influence on interviewees’ practices as well; in contrast to the influence of peers, though, parents’ pressure was more likely to be experienced by interviewees as a negative. For example, after going on the DAFNE course Lilya felt, like Lars, that she had the knowledge to successfully lose weight. In large part Lilya felt happy about this. She felt that DAFNE had given her the ability to produce a desired account of the self. However, a part of her also felt angry about her happiness at being able to lose weight. Like Naoimh, Lilya’s anger stemmed to a certain extent from the fact that she felt she was conforming to normative social pressures. However, her emotional ambivalence about dieting emerged most strongly out of a much more specific context: her father’s feelings about her mother’s weight. She noted her father had always been worried about her mother’s body, even going so far as to put her mother on a diet on their honeymoon. When Lilya herself began to lose weight after going on DAFNE, her father told her mother that she should be more like Lilya. After this, Lilya often became upset whenever her father told Lilya that she looked good; Lilya said that she had nearly attacked her father once over the dinner table when he made a positive comment about her weight. There was a clear difference in her account between the positive emotions she experienced whenever her friends told her that she looked good, and the negative ones she felt when her father did (though at the same time her father’s endorsement of the success of her practices was clearly important to her as well). Her friends didn’t have an agenda. Lilya’s narrative here indicates that the meaning of disciplinary practice does not emerge from a single relational context, but can often develop in multiple, sometimes conflicting, contexts simultaneously.

The anger Lilya felt towards her father emerged in another context as well, and this related to her father's feelings that people with diabetes should and shouldn't eat certain kinds of foods such as chocolate.

Lilya: They often make an assumption that I won't want to eat pudding. I'd like to be asked if I want some pudding. And like my dad has two pieces of cadburies chocolate after lunch on a Saturday and he'd give some to my Gran and some to my mum, although he doesn't always do that, [as he thinks] she shouldn't be eating chocolate. But he doesn't ask me. And I'm like can you ask me please? And he's like why, you cannot have it. Excuse me?!

In a study of parent-child conflict in diabetes management, Weinger et al (2001) noted that girls were often most worried about the need to be normal and would adjust and ameliorate their diabetes management practices in order to feel so. However, their parents were more likely to be worried about the effects consumption practices in the present could have on their children's long term control. The young people in Weinger et al's study were less likely to be worried about the future (possibly because they were several years younger than the interviewees in this project), and were more worried about the possibility of developing hypoglycaemia. Weinger et al's interviewees reported frustration when they felt their parents weren't able to differentiate between them and their diabetes, when they felt that they were being equated with their condition. Similar feelings can be seen in this narrative, though Lilya also felt angry at herself when she ate chocolate in order to demonstrate to her parents that she was as normal and in control of her own body as anyone else. She felt that her father forced her to engage in practices that she may not have wanted to (because they symbolized a loss of control over her diabetes and weight) just to show she was in control. As Elayne noted in another interview, necessity destroys pleasure.

### **5.9. Conclusion**

In this chapter I have explored the disciplinary practices that my interviewees engaged in with reference to four principle themes: exercising and eating healthily as moral practices, the presence of temporalities in interviewees' perceptions of risk, the importance of routines in the actualization of disciplinary practices, and the importance weight control had in interviewees' accounts. These points build on



Neumark-Sztainer et al's (2002: 1294) call "for further research to explore the reasons why adolescents with type 1 diabetes engage in unhealthy weight control practices" (Neumark-Sztainer et al 2002: 1294). To this I would add the need to examine why young people engage in healthy practices. I have highlighted the multiple ways in which my respondent's diabetes intersected with their disciplinary activities. With regards all of these themes, I have both explicitly and implicitly drawn upon the work of Michel Foucault in a constant attempt to understand why my respondents engaged in the practices that they did. In this conclusion, I will draw out more fully the implications my interviewees' practices have for Foucault's work.

Gender emerged as an important underlying theme in this chapter. One of the criticisms made of Foucault's work is that he doesn't adequately address how disciplinary practices are differentially worked out by men and women. In this chapter I have shown that similar practices, such as eating healthily and exercising, had different implications for my male and female interviewees. My male interviewees for example used disciplinary activities to control their blood sugar levels and increase the performative capacity of their bodies. In contrast to men without diabetes, my interviewees were highly conscious of what they could lose if they didn't engage in these practices, such as an ability to identify with hegemonic notions of masculinity. Indeed, one of the things that interviewees were most worried about was the possibility that they wouldn't be able to engage in fitness activities if they didn't exercise. This indicates that exercise wasn't recognised by the male interviewees as a 'disciplinary' activity at all; it was pleasure, an affirmation rather than a restriction. This supports Foucault's argument that people only engage in disciplinary activities because they produce positive effects. Occasionally, though, the feeling of power disciplinary activities provided for my male interviewees proved so attractive that interviewees were willing to engage in regimes that became unbalanced, and negatively affected their blood sugar levels. Balance was important; it was necessary to manage the extremes to ensure the middle.

In the literature review I noted that in a study exploring the longitudinal effects diabetes has on young people as they transition into young adulthood, Bryden et al (2001) found generally poor outcomes, with blood sugar levels being generally high for their respondents. This elevated HBA1C was thought to result from 'bad'

practices, such as excess alcohol consumption. However, as I demonstrated with Jason's narrative in this chapter, elevated blood sugar levels could also be the outcome of intensive moral practices used to develop a desired account of the self. Jason noted that when he told his doctor that the reason his blood sugar levels, his doctor didn't understand his perspective and reasons for engaging in these practices. From his doctor's point of view, the meaning of Jason's practices rested with the numbers, the elevated blood sugar levels. However it seems to me that without attempting to understand the context in which such practices occur, it will be difficult for medical practitioners to truly help people with diabetes develop the type of control recommended by the DCCT. Developing an empathetic understanding of why young people want to identify with particular discourses of masculinity is important for understanding the they sometimes engage in practices that can be risky for their blood sugar control. In general, though, for the most part my male interviewees engaged in all of the 'correct' practices that they felt 'good' diabetics should. Similar findings have been reported in other studies. Williams (1999) for example found that for the most part her male interviewees had very good control. She argued the reason this was so was because her respondents had a limited repertoire of subject positions to draw from, and were unwilling to let diabetes deleteriously affect their accomplishments.

Gender was also an important concern for the disciplinary practices of the female interviewees. My female interviewees used exercise and healthy eating to manage risk and produce moral accounts of the self. As I discussed, the female interviewees generally didn't engage in healthy practices with the same level of drive as displayed by the male interviewees, though at the same time they were less likely to engage in practices that could be considered medically risky, such as going on Atkins or exercising for up to 40 hours a week. Weight loss was an important concern for all of the female interviewees, and as a group they generally seemed to have more difficulties losing weight than the men. This was because weight loss for my female interviewees was an indefinite, continual activity. The male interviewees wanted to lose just enough weight so they could get rid of fat and begin building muscle. In contrast, the identities of my female interviewees were bound up (to a greater or less extent) with a process of constantly losing weight. However, their diabetes often complicated this process, when it didn't actively contravene it. For example, most of



the female respondents experienced difficulties managing hypoglycaemia when they were exercising, and would often end up having to eat to bring their blood sugar levels up after exercising. This had negative emotional effects. In contrast to the male interviewees, for whom disciplinary activities were a source of pleasure, disciplinary practices were viewed more ambivalently by the female interviewees. Looking back over the transcripts, there is something sad about the extent the female interviewees felt they had to discipline their bodies. Erin for example switched from eating chocolate to eating dextrose tablets to manage hypos after coming to university, as the tablets were less fattening. Even in a situation where she had lost 'complete' control, such as during a hypo, she was actively attempting to regulate herself and manage her weight.

As with their alcohol consumption, relationalities emerged as an important theme in my respondents accounts here. Male interviewees identified with discourses of masculinity that stressed independence; they often took pride in not being like other students, in being fitter and stronger, in eating healthier foods. In contrast, the first year female students were often anxious about the possibility that their consumption could make them different from other young people. They often stressed that what they ate was the same as everyone else, that their consumption was part of a normal healthy diet that everyone, not just diabetics, should be eating. Interviewees such as Laura and Alice compared their consumption practices with the more restrictive ones that their celiac friends had to engage in. Spatialities had an important presence here. Both of these interviewees noted that they only became aware of the relation between their consumption and the idea of being 'normal' when they had made the transition from home to university. Alice described being at university like being back at square one. Especially in halls, interviewees were often conscious of the possibility that other young people could find them different, which was the last thing they wanted. Being accepted was an important concern. Spatialities also had an important presence in the accounts of the older interviewees as well. For example, Christina noted that even in second year the difficult thing about being university was that it was a space where no one would be around to prevent her from eating foods if she wanted to. It was a space where it was important to regulate consumption, but a space that almost seemed to militate against the development of self-control. Some of the male interviewees noted similar points. Jason for example described university as

an unhealthy space where it was only possible to be so fit, as there was always pressure to eat unhealthily

My interviewees' accounts therefore build on and inform Foucault's account of disciplinary practices in a number of ways. However, they support his general assertion; that engaging in disciplinary activity results from an appetite for construction, rather than destruction.

In the next chapter I examine how my interviewees' used their diabetes technologies to manage the risks of their alcohol and food consumption and construct desired accounts of the self.



**Diabetes and Technologies of the Self**

## 6.1. Introduction

In previous chapters I have explored the ways in which my interviewees negotiated risk, and disciplined their bodies, with respect to their food and alcohol consumption.

As I have shown, *control* and *balance* were recurring themes in interviewees' narratives. These themes were articulated through temporal, emotional, relational and habitual dimensions of practice. In this chapter I will investigate these themes in relation to another important form of consumption: that of symbolic and material technologies.

Technologies play a fundamentally important role in contemporary management of type 1 diabetes. 'Good' practice is predicated upon the regular testing of short term blood sugar levels with blood testing machines. Test results can be recorded on computers or in notebooks to help the reflexive monitoring of the self. Insulin is administered *via* injection technologies (often referred to as MDI, or Multiple Daily Injections) or insulin pumps (referred to in this chapter as Continuous Subcutaneous Insulin Infusion, or CSII).

There are numerous gaps in the existing geographical and sociological literatures on technologies. Timmermans and Berg (2003) for example note that research on medical technologies has often focused on cutting-edge, socially controversial technologies such as reproductive or genetic technologies. In contrast, they note that the "ubiquitous, small, home-care technologies such as insulin pens [which] might have far-reaching impacts" are likely to be ignored by social scientists, especially in relation to how these technologies are used in practice (ibid: 108). Even in diabetes research relatively "little is known about current patterns and barriers associated with SMBG [self-monitoring of blood glucose]" (Karter et al 2000: 477). Lupton and Seymour (2000) note that for the most part studies of medical technologies have not concentrated on how people with bodily impairments consume technologies. In most studies, they argue that the technological body is able bodied and does not possess a chronic illness. Balsamo (1995: 216, in Lupton and Seymour 2000: 1851) argues that:

"technobodies are healthy, enhanced and fully functional".



To this I would add research on technologies often doesn't address the spaces in which technologies are used, and their meanings negotiated.

In this chapter I will therefore examine how my interviewees used, conceptualised, and felt about their everyday technologies when they were in university. In particular I will focus on the ways in which their technological consumption intersected with discourses of bodily discipline and risk minimization operating at other points in interviewees' narratives. Importantly, I will demonstrate that while my interviewees often used technologies to regulate themselves while they were in university, technologies came with their own risks as well.

The chapter is divided broadly into three sections. The first looks at how interviewees consumed intensive<sup>38</sup> technologies, especially CSII, and the tools of the DAFNE programme (Dose Adjustment for Normal Eating). In Foucault's terminology, I will argue that these artefacts were used by interviewees as particular technologies of the self, technologies that interviewees used to make themselves better (freer, more independent) by increasing their capacity to control their bodies. The second section examines surveillance technologies and practices. In the final section I will explore the theme of stigma in relation to my interviewees' technological consumption.

## **6.2. Consuming Technologies**

Before going on to examine the material in this chapter, I feel that it is important to explore first how I am going to use the term 'technology'. As indicated above by my use of the phrase 'symbolic technologies', and my inclusion of the DAFNE project in this chapter, I am using a relatively broad concept of technology. Indeed, because of the difficulty in defining technology (Lupton and Seymour 2000), I use the phrase 'technologies' in this chapter to refer to those artefacts and programmes interviewees themselves referred to, or understood, as technologies. While DAFNE is not a material artefact in the same way an insulin pen is, interviewees referred to DAFNE as a technological system. James for example referred to "the tools of the DAFNE system".

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<sup>38</sup> Intensive here refers to the frequency with which technologies are used. Intensive generally indicates a particular technology is used three or more times a day.

In this chapter I take a primarily consumption orientated perspective on technologies in order to investigate the “meanings that objects have when consumed” (Du Gay et al 1997: 90).

There are a number of advantages to this perspective. Firstly, it allows a path to be negotiated between social and technologically deterministic models of technology. Valentine and Holloway (2002) argue that both models of human-technology interaction are predicated upon a synthetic dualism, when in actuality different technologies are embedded to different degrees in humans’ lives, and vice versa. A focus on consumption therefore highlights how the meanings of technologies are created in and through practice (Timmermans and Berg 2003: 97). Technological artefacts are not seen as static, and individuals’ reactions to them, and the effects technologies in turn can have on individuals, are not interpreted as frozen; rather, they are spatially and temporally dynamic. Technologies, in Tiles and Oberdick’s (1995: 60) words, are revealed as being “multi-valenced...their embedded values show fluidity” (see also Silverstone et al 1992). Furthermore by locating the meaning of technology in use, “the user of technology...can come into view as an important actor in its shaping” (Berg 1994: 96). My primary concern lies with “the way technology enters into our...identity” (Cockburn 1992: 39).

Secondly, it is important to note that the meanings of technologies are shaped in particular social contexts, which will impact upon how people will consume technologies, and the meanings this consumption will have. For example, Umble (1992) found that cultural discourses, social position and historical location influenced the ways in which individuals in the Amish community used and conceptualized telephones in the early 20<sup>th</sup> century. While the telephone was seen by many Amish people as a technology that allowed communication with the outside world, something which was useful in the event of an emergency, the telephone was also experienced problematically by many Amish people, for example in the way it was thought to accentuate personal pride and intensify feelings of individualism. Technologies, therefore, “far from being merely technical, are at once both material and symbolic” (Bingham et al 1999: 656). Umble (1992: 183) argues:



“Historical and cultural orientations shape...meaning...for particular social groups. [Technology] has little universal meaning apart from that which is constructed or negotiated by those social groups who make use of it. Its meaning is transformed as social and cultural boundaries are crossed”.

My focus on exploring the meanings of technologies in context leads to an “un-black-boxing” of technology (Lehoux et al 2004: 620), highlighting the multiple narratives in which technologies are located and positioned, both by individuals and broader cultural groups. It is important, when seeking to understand how young people negotiate and consume technologies, to explicate these multiple narratives. For example, in a study of the history of cochlear implantation, Blume (1999) found two dominant accounts at work. One was focused on the success of medical technology, where medical knowledge enabled the overcoming of a natural disability. The other account was centred around society not being able to accept deaf people for who they are. Blume argued that it was impossible to say which one of these was true; he argued that both were true, but there were power differentials between them. The meaning of the implant varied according to which narrative it was embedded within.

Using the consumption orientated perspective on technology discussed here, and drawing on the material on consumption I have discussed elsewhere in this thesis, the rest of this chapter will now explore how and why interviewees used the technologies of diabetes, and the different narratives within which these technologies were embedded and experienced by interviewees. The approach I take to the consumption of technologies draws on Jackson’s (1999: 29) perspective on consumption, who, in describing a study completed with other researchers on individuals’ experiences of shopping in malls argued:

“We attempt to follow our respondents as they moved between different subject positions in the dynamic play of identity, interested as much in the association between people and place as between people and goods. Here we approach identity as multiple and contested, though subject to a regulatory framework of cultural norms and social expectations”.

### **6.3. Intensive technologies**

In this section I will explore the ways in which, and the reasons why, interviewees used intensive technologies such as MDI, CSII and DAFNE.

Insulin pens were the main form of therapeutic technology used by interviewees. Insulin has been available for sale in the UK since 1923 (DaCosta et al 2002). Until the 1970s, people took insulin primarily via glass syringes and re-usable needles; for reasons of safety and hygiene, “these instruments had to be boiled and sharpened respectively” (ibid: 55). It was only in the 1980s that plastic syringes became widely available on prescription through the NHS (DaCosta et al 2002). However, while syringe technology had developed between 1920 and 1980, many of the problems associated with syringes, such as the length of time it took to make an injection, and the hassle of carrying around separate insulin and injections, remained. Injections were often painful. Additionally, users frequently felt syringes to be stigmatised devices.

In the 1980s Nova Nordisk Pharmaceuticals brought out the first insulin pens. These were injection technologies that combined “the insulin container and syringe into a single unit that accurately meters the insulin dose, thus eliminating the need for a separate syringe and vial” (DaCosta et al 2002: 54). Insulin pens marked a leap forward in design compared to previous injection technologies (ibid). Insulin pens, once they are stoppered, resemble fountain pens more than anything else. Pens are not as ‘medicalised’ as syringes, and therefore, in theory, do not carry the same stigma (though I will challenge this idea later on in section 6.5.). Pens are intended to be flexible, durable and unobtrusive, allowing diabetes to be discreetly managed in public spaces. In a study of 1310 people with diabetes’ feelings about pens compared to syringes, Graff and McManahon (1998) found that the majority of their respondents found pens to be markedly superior to syringes in all categories analysed, including flexibility and impact on lifestyle.

Insulin pumps are the second technology explored in this section. At the time of my field work Elayne was the only interviewee to use an insulin pump. She was also, with the exception of Lars, the interviewee who had had the most positive feelings about CSII, for reasons that will be explored. Other interviewees had more negative responses. Female interviewees felt that pumps were stigmatised devices, and the male interviewees were worried that pumps would either constrain their ability to exercise or could break if interviewees’ exercised too vigorously. How interviewees



felt about pumps, therefore, was influenced by the discourses of femininity and masculinity they identified with. The attitudes of these interviewees will be discussed later in section 6.5.4.

Insulin pumps first received sustained research interest in the 1970s, and **Figure 8** shows how drastically insulin pumps have changed in shape and size since then. Early versions of CSII were the size of back packs and were connected to the body via a multiplicity of tubes. Contemporary versions are much smaller and connected to the body via one thin tube. Pumps that are currently on the market are about the size of a mobile phone and have “electronic memory, multiple basal rates, several bolus options, a safety lockout feature, and a remote control” (Bode et al 2002<sup>39</sup>).

Insulin pumps are widely used in clinical practice, though not as much as insulin pens. Torrance et al (2003) note that more than 200,000 individuals worldwide are thought to use CSII, more than 130,000 of whom live in the US. In the UK, however, only a few hundred people use insulin pumps, primarily because current policy is influenced by early concerns about CSII, and because the cost of supplying the pumps through the NHS is more expensive than MDI. Irrespective of what country it has been used in, CSII generally hasn't been used very often in the context of adolescents' care of the self (Boland et al 1999).

CSII operate on a basal bolus system of insulin. Unlike multiple injection regimes, which work by combining one long acting injection of insulin with several short acting ones, all of the insulin given via a CSII is short acting. Individuals programme the pump to administer a continuous stream of short acting insulin into the body, which is the basal element. Before eating, the pump is programmed to administer a higher dosage of insulin to take account of raised blood sugars, which is called the bolus.

Numerous benefits have been associated with CSII. Wessberg-Benchell et al's (2003) metanalysis (of 52 studies) found that CSII use was linked to greater blood sugar control than MDI, especially if CSII is used for more than one year. CSII was also

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<sup>39</sup> [http://www.postgradmed.com/issues/2002/05\\_02/bode3.html](http://www.postgradmed.com/issues/2002/05_02/bode3.html)

found to increase flexibility and the “ease of scheduling and timing of meals” (Weissberg-Benchell et al 2003: 1063). From the perspective of people with diabetes themselves, the greatest benefit of CSII often lies in the way it enables people to have a more ‘normal’ lifestyle (Bode et al 2002). Because insulin dosages can be finely tailored to situational requirements (such as decreasing the amount of insulin administered by the pump while the wearer is exercising), it can enable greater feelings of control of, and freedom from, both diabetes itself and the condition’s management regimes.

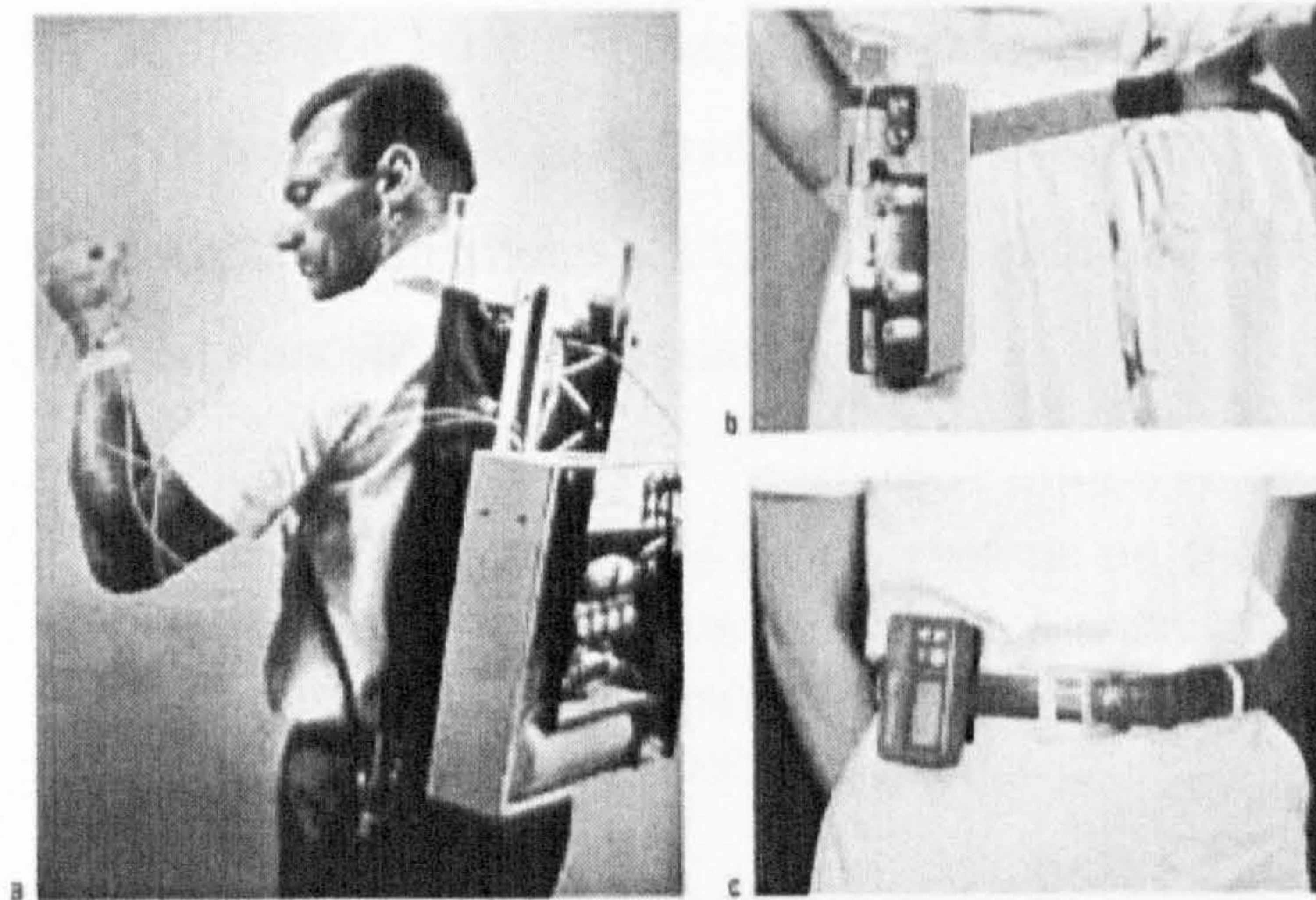
A number of limitations are associated with CSII, though. Pumps are complex to use and require technical skill to operate correctly. They also require a high degree of motivation and personal investment in their use. Other impacts include potentially adverse effects upon body image and sexual relationships (Weissberg-Benchell et al 2003). Amongst young people:

“Obstacles to the use of pump therapy in youths with diabetes have included the size and technical limitations of early pump models, [and] psychosocial issues regarding continuously wearing an external device” (Boland et al 1999: 1779).

However, little research has been completed upon the psychosocial impacts on individuals’ use of CSII (Weissberg-Benchell et al 2003) and Boland et al (1999) in fact argue that CSII improves coping skills amongst adolescents with diabetes:

“The flexibility and effectiveness of CSII appear to have compensated for potential problems in feeling “different” from peers by wearing an external device” (ibid: 1783).





**Figure 8.** Evolution of CSII. Source Bode et al 2002, [http://www.postgradmed.com/issues/2002/05\\_02/bode3.html](http://www.postgradmed.com/issues/2002/05_02/bode3.html). It's interesting to note the gradual feminisation of the device, from section a to c.

The third technology looked at in this section is DAFNE. Five interviewees went on the DAFNE programme, with three others indicating a desire to go on it. DAFNE stands for Dose Adjustment for Normal Eating. It is an educational programme that has recently introduced into the UK, and is based on a model that has been operating in Germany for over 20 years.

DAFNE works on the principle that “type 1 diabetes is an insulin deficient disorder, best managed by insulin replacement as needed, and not by dietary management to match prescribed insulin” (DAFNE study group 2002<sup>40</sup>). As a system, DAFNE’s philosophy is “eat what you like, and like what you eat”<sup>41</sup>. DAFNE aims to give individuals the tools to lift the dietary restrictions that often accompany traditional regimes.

The DAFNE course takes place over several days and focuses on different elements of diabetes care. As with CSII and MDI, the central discourse operating in DAFNE is freedom through control; “DAFNE teaches you how to adjust your insulin during the

<sup>40</sup> <http://bmj.bmjournals.com/cgi/reprint/325/7367/746>

<sup>41</sup> <http://www.diabetes.org.uk/infocentre/inform/dafne.htm>



day so that you have the freedom to eat what you want”<sup>42</sup>. Individuals who go on DAFNE learn how to carbohydrate count effectively and adjust their insulin levels to match their requirements. Situational flexibility, rather than adherence to a code, is the most important consideration.

On DAFNE there are no restrictions on the quantity of carbohydrate foods you choose to eat. You are taught to calculate the amount of insulin you will need to match that amount of carbohydrate so that your blood glucose levels remain more controlled (ibid).

DAFNE, therefore, is a highly scientific model of consumption. In Foucault’s terminology it aims to produce, by directing conduct and encouraging individuals to develop a logical, technocratic orientation towards consumption, a particular kind of person, one who is “self-reflective, self-regulating...with the correct concern for themselves” (Coveney 1998: 464). Coveney notes that public health discourses often govern individuals by linking them “into the language of expertise at the moment of their freedom and autonomy” (ibid: 466). Parr (2002a: 86) argues that this is “a rather depressing” idea, as it leaves individuals ever more subject to powerful medical discourses that construct what a normal, healthy person should look like and what kinds of things he or she should consume. However, as Foucault’s work itself indicates, increased scientification is not necessarily experienced by individuals as negative. For example, the DAFNE study group (2002) published results on the multi-dimensional impacts of DAFNE and argued that 12 months after training individuals’ HBA1C levels improved, and stayed improved. The study group noted that:

“The training [...] produced sustained positive effects on quality of life, satisfaction with treatment, and psychological wellbeing, despite an increase in the number of insulin injections and encouragement to increase blood sugar monitoring” (<http://bmj.bmjournals.com/cgi/reprint/325/7367/746>).

### 6.3.1. Flexibility

As can be seen then, MDI, DAFNE and CSII are not only intensive technologies, they are also liberation technologies. They are tools designed to help individuals maximize their freedom and independence from their diabetes. Lupton (1995b) notes

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<sup>42</sup> <http://www.diabetes.org.uk/infocentre/inform/dafne.htm>



that freedom is a recurring theme in technological discourses. For example, computer systems are often figured as a way of allowing humans to escape from the real world into a world where everything is fluid, and normative identities can be abandoned (Valentine and Holloway 2002, Lupton 1995b). The technologies discussed so far, though, are not intended to help people escape their bodies; they are intended to help individuals control them<sup>43</sup>. They are designed to help people construct identities as ‘normal’ people, rather than assist them in abandoning these identities. Like many medical technologies, in design at least, these tools and systems embody “the ethic of the normal social person, which is intrinsically an ethic of the healthy body” (Rose 1994: 67). Indeed, while utopian discourses often stress the increasing plasticity of the body, a plasticity often considered to be accentuated by technologies, Williams (1997) notes that in many respects medical technologies are used by people to develop, rather than attenuate, ‘rational’ control over their selves and their bodies. Diabetes technologies in this sense are part of a modernist, rather than postmodernist project and “are to be judged in terms of a logic of health and recognized in terms of a quest for normality” (Rose 1994: 67).

The flexibility that these technologies engendered was commonly linked by interviewees with the construction of normal identities. Most of my respondents noted that when they were first diagnosed (which was usually as children) they were put onto a regime of two injections a day. While this was generally accepted by them when they were younger, as they grew older two injections a day was experienced as more of a constraint. Taking two injections a day was described by several respondents as like being on a ‘military regime’. For most of them, it meant having to constrain activities. Practices had to be tailored to best fit the requirements of the management regimes of diabetes, rather than the young person’s own desires and wishes. Furthermore, it was difficult to achieve the degree of control recommended by the DCCT on two injections a day. Injecting more often, on the other hand, opened up possibilities, while simultaneously enabling greater control. It meant being able to live a normal life. Alex noted:

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<sup>43</sup> There is one important additional caveat to the use of intensive therapeutic technologies by people with diabetes, however: intensive control increases the risk of developing severe hypoglycaemia (Wolfsdorf 1999). This increased risk doesn’t seem to be as severe for people using CSII and DAFNE.

I used to make a long period in the morning, but this could cause some problems. So if I make this I do not inject in the lunch time. But I find this very useless. Why shouldn't I inject in the lunch as well? Because I had four shots I am better controlled. Whereas if I had the long-term one, I couldn't control it as well.

Sylvia and Michelle were the only interviewees to take two injections a day at the time of my fieldwork; as Alex indicates, most of my respondents took between four and five a day. However, for Sylvia and Michelle, taking fewer injections, while decreasing flexibility, was also a way of constructing an independent, normal identity. I noted in section 5.8.3. that Sylvia hadn't integrated her diabetes into her identity. She wanted to suppress her diabetes, not intensify its presence, so she limited the number of injections she took. She felt that taking more than two injections would be too upsetting, though she was aware of the paradox that it was only going to be by intensifying her management practices that she would ultimately be able to control her diabetes in a way that she considered ideal. Spatialities were also important in Sylvia's use of technologies. By taking a long-acting injection before leaving the house in the morning, and one again after coming back at night, she didn't have to inject in university. She could therefore regulate her diabetes in private and prevent it from negatively impacting upon her social identity. Normalisation for Sylvia meant trying to maintain her pre-diabetes identity and re-capture her pre-diabetes body, rather than integrating the technologies of diabetes into her lifestyle (Bury 2001). It is important to note, though, that injecting twice a day came with its own costs. For example, if her friends spontaneously decided to go to a club, Sylvia couldn't just go with them. She often had to go home to inject first. She didn't like having to do this, however, because she felt that it was another way in which diabetes impinged upon her flexibility and independence. Secondly, she often felt guilty about her 'bad' practice, and anxious about the effect not injecting more often would have on her in the future.

I've looked at some programmes where every time you eat you have to inject, but what put me off that was that every single time you eat you have to inject. That would drive me crackers. Two is enough as far as I'm concerned. Two is more than enough, I wouldn't want to do it anymore. Cause in a situation like this...like, say you're out at maybe a restaurant or something, you just want to sit down and maybe be normal and have your food without running off doing injections.



Technologies could also be used to free respondents from the structures, compulsions and routines that they sometimes developed from living with diabetes. These compulsions were often developed in the first place in order to protect interviewees, both emotionally and physically from their diabetes by giving them rigid control over it. There was a risk that these compulsions could come to define respondents however, take them over. Like Sylvia, Maria too hadn't yet assimilated her diabetes into her identity. She saw diabetes as a "big thing", an unwanted disease that she was ultimately going to die from. To stay in control, she ate at the same times, and often the same things, everyday. Her routines came to be defined by her attempt to construct what Giddens (1991: 107) refers to as 'compulsive mastery'; like the women with anorexia that Giddens uses this term to refer to, Maria "frequently felt herself 'taken over by the very regime to which she submitted her body'". She ate the same foods, and the same amount of them, at the same times everyday. Like Sylvia, she often felt guilty and anxious about her practices, especially when they deviated from her habitual routines, and what she considered to be 'good' care. When this happened she would intensify her attempts to regulate and routinize herself. For example after eating a bar of chocolate, she would run around the block several times in order to bring her blood sugars down. However, at the same time she often couldn't stop herself from eating things like chocolate. Chocolate was used as a way of coping with the depression that had developed from having to be in control of herself all the time, and from her difficulties accepting her diabetes. She compared herself negatively to other people; she felt they could do what they wanted and never had to worry about what they were doing or the effect their practices could have on them in the future. In contrast, Maria couldn't stop thinking about the future, which she felt was closing in around her.

DAFNE changed this pattern of negativity. It gave Maria back a feeling of control over herself and her practices by teaching her how to view her consumption scientifically; 10 grams of carbohydrate was one unit of humalog. By learning how to logically adjust the amount of insulin she injected to the amount of food she ate, rather than matching her food to her insulin, she didn't have to eat at all. Consumption could be as much about desire as about necessity. Temporalities were important here. I noted in section 5.6. that for the interviewees, bad food was not only food that had too much sugar, but food that was not eaten at the right time,

whose consumption disjointed the temporal sequence upon which good control was built. Once this good control was dislocated, routines that were constructed to manage the body and ensure the performance of a healthy, virtuous self became disrupted in a bid to re-regulate the body. However, with DAFNE there was no right time to eat; practices became detemporalized, flexibly dislocated from clock time. Maria felt she could eat whenever she wanted. She stopped feeling dominated by her routines, by the impulse to stay in control all of the time.

Myles: So, what kinds of differences did it [DAFNE] make to your lifestyle?

Maria: You can eat, right, whatever you want and do not have to worry about it and think 'oh god, I've got to eat in two hours'. You can just eat what you want, when you want. And not only can you eat whatever you want, you can eat whenever you want. Because you're not at risk of having a hypo because you haven't eaten.

It is important to note, though, that the way I have described technologies here in relation to Maria's account is in terms of a narrative of liberation. She had a problem with routines, and technologies freed her from herself. And this is an accurate description, based on her account. However, it is important to note that this freedom could itself become problematic in different situations. For example, as I noted in section 5.7.3., after going on DAFNE Lars too felt liberated from the strict routines he had imposed upon himself. This freedom however led him to lose control over his consumption practices and engage in uncontrolled consumption, which he also didn't want. There is a fine balance, therefore, in the use of intensive technologies. Freedom itself must be controlled if it is not to become problematic.

### **6.3.2. Being (in) Control/led of/with/by Technologies**

Furthermore, in certain circumstances, technologies used to increase flexibility and independence can themselves assume an unwanted position of dominance.

During her second year in university Elayne developed severe difficulties with her diabetes. No matter how hard she tried to regulate her blood sugar levels, she often found herself becoming either hypo- or hyper-glycaemic. This pattern of highs and lows proved disruptive in a number of dimensions. Firstly, it undermined her capacity to engage in disciplinary practices and thereby identify with emotionally



resonant discourses of femininity. Secondly, as I have shown in section 4.9., Elayne was one of the interviewees who was most worried about the risk of hypoglycaemia when she was out drinking and clubbing. Because of the amplified risk that came with her uncontrollable diabetes, Elayne's anxiety about going out increased. She was scared that she wouldn't be able to control herself if anything went wrong, and she felt that no one else would be able to help her. She stopped socialising with her friends in order to control her anxiety, but this only made her feel different from them, which she didn't want. Thirdly, the chaotic nature of her diabetes undermined her sense of self as a well controlled, 'good' diabetic, and so damaged her capacity to construct a moral identity through practice. And fourthly, her diabetes made her increasingly anxious about the future. This anxiety was intensified by her sense that no matter what she did, she couldn't balance her blood sugar levels; the longer her blood sugars remained uncontrolled and unstable, the more her anxiety increased. Unfortunately, the more anxious she felt, the more stressed she became, which in turn increased her blood sugar levels and made it more difficult to control them.

I thought that if this goes on for very long I'm going to have serious problems. The last time I went to my optician I had white spots behind my eyes. Which is the sign of a build up of sugar...Um...but yeah, I was beginning to worry about it. Because I was thinking if it keeps going like this I'm going to have serious complications, all kinds of problems.

Elayne became depressed in the face of these multiple disruptions; diabetes had become something that controlled her, rather than something that she controlled. Her doctors recommended taking extra injections. Intensifying her management regimes in this way proved to be problematic, though. While taking more insulin provided her with a degree of extra control over her condition, it did not provide complete control; it gave her an extra kick that helped her to keep her head above water for a little while longer. However, this came at the expense of altering, for the worse, the relationship between her self and the technologies of diabetes. Technology came to assume a position of dominance in her life. Her day centred around injections and dealing with their consequences. Practices designed to achieve control over her body in actuality, served to undermine her sense of agency and mastery.

I mean I was on anything up to six or seven injections a day by then. And this was due to taking insulin at night-time, you know bed-time, long-lasting

insulin, and it obviously having its peak at about two o'clock in the morning. Whereas your body is on the other end of the scale at two o'clock in the morning and you need the least amount of insulin at that time in the morning. Having three or four hypos a week where you're having to drag yourself out of bed at three o'clock in the morning and eat something when you're *not* hungry and you *do not* want to eat, and then going back to bed and then waking up with the most god-awful, what felt like a hangover...cause your sugars are all over the place. You know, cause it affects...your feeling that awful when your blood sugars are up and down that much. I suppose it must be like taking drugs on a frequent basis. And then trying to go cold turkey for a bit, and then trying to go...you know what I mean? Your emotions, everything, are up and down all of the time.

The disruptions emerging from the interaction between Elayne's uncontrollable diabetes and her excessively controlling management regimes are explicit in this narrative. Her body is temporally unbalanced; blood sugars, insulin and the 'natural' rhythms of the body are all operating on different wave lengths, at different times, rather than being integrated with each other. By taking insulin before going to bed Elayne minimized her risk of hyperglycaemia but increased her risk of hypoglycaemia. When she became hypoglycaemic she was forced to engage in unwanted practices at unwanted times in order to bring her self back under control. These practices served to make her body something 'other' to her self, something heavy and chaotic that bent her desires and wishes to its wishes. Notions of choice, independence and freedom had to be abandoned in the face of this dictatorial necessity; as implied by her image of drug taking, she was completely dependent upon food consumption to control her self, though this consumption itself was responsible for her loss of control. Lester (1997: 481) notes that in Western cultures, and especially for women, this kind of ambivalence (though not to this extreme) is common, and the body is often:

"Constructed as animal, appetite, deceiver, and jailer of the self, undermining the best strivings of the self. The self [in contrast] is the soul, the spirit, the mind, the noble strivings" (Lester 1997: 481).

Lester (ibid: 484) argues that for many women the body is an "enemy, to be controlled, punished, 'starved out'" if the "true self that transcends the physical" (ibid: 485) is to be released. This reading clearly has resonance with Elayne's account, especially when control in relation to diabetes is understood as a victory of a rational self over an irrational body (Broom and Whittaker 2004).



The problem for Elayne was that achieving a balance with, let alone control over, her diabetes was proving to be impossible. Diabetes had become something that was completely outside of her ability to effect, but it, in turn, was very capable of affecting and threatening her. There was no traction here, nothing to build control upon. She was trying to hold things together while her body tilted in multiple directions at once. It's important to note the emotional dimension of this loss of control. Changes in blood sugar levels not only led to depression in the long term, but directly affected Elayne's emotional state in the present. Shifting blood sugar levels resulted in mood swings. She could be talking to a friend and suddenly feel like crying. Lupton (1998: 85) notes that in Western cultures emotions are often experienced in terms of a loss of control over the self, as "disruptive and somehow external to the self". They are often experienced as drowning rational thought, and, as such, are regularly interpreted negatively. They are "associated with chaos, with excess, disorder, unpredictability and irrationality" (Lupton 1998: 96). When experienced as the artificial creations of fluctuating blood sugar levels, rather than the result of engagement with the world, they are an especial challenge to, and an undermining of, a self that is predicated upon control; especially so for a person like Elayne who calls herself a "control freak".

Eventually Elayne had enough. She felt that if things continued in this way she couldn't deal with it anymore. Her diabetes controlled how she felt, it controlled how she interacted with other people. From a studying perspective, it controlled whether she was capable of sitting down for three hours with a book. Around this time Channel 4 ran a series about young people with diabetes' care of the self. On one programme she saw that a young person was wearing an insulin pump. Intrigued by this, she talked to her doctor about the possibility of getting a pump on the NHS. He said no, because they were too risky; they could lead to ketoacidosis if they stopped working. Feeling that she had nothing left to lose, Elayne decided to buy one anyway with her own money. The effect this technology made to her life was marked.

It's fantastic that this thing, you know, works so well. It has changed my life. It really has. Cause I do not have the highs and lows I used to have.

In some respects, though, the pump worked a little too well. Because it was so effective in helping her to obtain ‘perfect’ control, Elayne started to become obsessive about her blood sugar levels. Particularly for the first month, Elayne kept a diary recording what her blood sugars were every few hours. When her levels finally deviated from what Elayne considered to be the ideal, she became extremely angry at herself for having engaged in the ‘wrong’ practices; whereas before starting CSII therapy, she felt that going ‘all over the place’ was completely normal. Grosz (1995: 5) notes that the docile body, in certain situations at least, is one that is subject to “endlessly more intensified self-regulation, self-management and self-control”. In Elayne’s case, it can be seen that therapeutic technologies, by increasing her capacity to engage in practices of self-colonization, also increased her desire to engage in these practices. Elayne’s practical orientations here mirror those of Lars in section 5.7.3. There, I noted that Lars had been so used to intensively controlling himself that when DAFNE finally allowed him to relax this control, he went “wild”. In contrast, Elayne had so much difficulties achieving control that when she finally was able to do so, she *really* controlled herself. In retrospect she felt that her control swung from one extreme to another, when it, and the practices and desires underlying this control, should have been more regulated.

However, overall, the changes CSII produced in Elayne’s life were positive. Firstly, she didn’t have to inject anymore.

When I got the pump...my first reaction...[was] I thought that I wouldn’t have to inject seven times a day you know. I’m not going to be a human pin cushion anymore.[...] Food had started to become...it was about eating a certain amount to compensate for the insulin. Not eating a certain amount because my body needed that amount...eating a certain amount because the injection told me I had to eat that much.

Elayne’s image of being a ‘human pin cushion’ is striking, and sums up her relationship with her diabetes and its technologies before CSII. It is an image of a passive, helpless, self, manipulated and controlled by an outside force. It is the technology that has agency in this image, not the person whom the technology acts upon. What Elayne is describing here is a relationship of dominance, where injection and condition are linked together in a configuration that is actualized at the expense of an alienated self. The pump, however, reinserts the self back into the network. It



breaks the link between constant injections and constant lows and makes technology an extension of the self that can be used to discipline the body effectively. The ideal relationship therefore between technology and self is one where the self used technology to effectively control diabetes. The idea that self and technology would be on an equal level, or that technology would have more agency than her, was something that she found emotionally and existentially threatening.

Secondly, the pump, by giving her the freedom to eat whenever she wanted, also gave her the ability to successfully lose weight, and thereby construct a desired account of the self based around the production of a body that corresponded closely to normative feminine ideals. By being able to adjust her insulin dosage to fit her situational requirements she could exercise without worrying about going low. The catch-22 relationship she had previously 'enjoyed' with regards to her disciplinary practices was altered. She felt that going to the gym was now something that she could successfully do, rather than it being a self-defeating exercise.

It's been dead easy [losing weight with the pump]. Um, it was a lot to do with the pump actually and not having to eat all the time. The thing with injecting insulin is that you're constantly playing a game of catch up in the sense that you've got the insulin and you're having to eat to match the insulin. Whereas with the pump it's the other way around, you're eating but you're injecting to match what you're eating.

Elayne's mother had an interesting, if complicating, effect on Elayne's weight loss practices. Her mother wasn't happy with the way the pump allowed Elayne to eat whatever she wanted. She wanted Elayne to stop engaging in pleasurable consumption, and use CSII technology to intensify her dieting practices. However, rather than her mother's attitudes encouraging her to intensify her disciplinary practices, they turned Elayne in the opposite direction. For example, Elayne noted that she sometimes intentionally ate high calorie foods just to provoke her mother. However, she generally regretted this consumption as she felt that it was unbalanced, and that by eating in this way she was ceding control to her mother, or her own irrational reactions to her mother feelings. Maharaj et al (2003) found that that mothers who had weight and shape concerns increased the risks of their daughters developing a problematic relationship with food, particularly given the higher body mass index rating that young women with diabetes generally have anyway compared

to their non-diabetic peers. In Elayne's case, though, her mother's feelings led her to reject, rather than embrace, an identification with a normative feminine subjectivity. While she could now successfully lose weight with the pump, her mother's attitudes increased her desire to have a 'normal', balanced relationship with consumption precisely so that she wouldn't be like her mother.

It's sort of pushed me the way sort of 'she's mad'. Watch her (laughs), I'll listen to her and she'll phone and we'll be talking and she'll be like 'oh I did really well today, I had a banana for breakfast, I haven't eaten anything since then'. At two o'clock in the afternoon I'll be thinking 'freak'. I had a really nice breakfast, I've gone out to lunch with my friends, and we had a really nice time sitting in a restaurant having lunch. Really enjoyed it. But yeah, I think it's mum's extremism which has pushed me the other way. And there have been times when I've said 'oh sod it'...I mean I've sat with my mother in a restaurant and had desert not because I wanted it but to spite her. And that's not right either. That's going too far the other way.

### 6.3.3. Technologies and the future

Finally, one particularly important effect the use of intensive technologies had for my respondents was changing their practical orientations towards the future. As I noted in section 5.5., my respondents' attitudes about the future differed to a great extent from the young people in Lawton's (2002) study. Lawton argued that the young people in her research often had difficulties imagining a 'sick' future self, let alone the possibility that they would die. In contrast, my interviewees were often worried about the effect risky practices could have on them, for example in the way consumption and disciplinary practices could threaten interviewees' abilities to embody valued masculine and feminine identities.

Worries about the future, however, didn't always translate directly into future orientated risk minimization practices. Everyday priorities could take precedence. For example, I noted in section 4.4. that when Lilya went drinking with her friends, she would sometimes drink more alcohol than other people in order to demonstrate to them that diabetes wasn't a limiting factor for her. This was a practice that, while arguably irrational from a medical perspective, was quite rational in context. However, Lilya herself often felt ambiguous about the consequences of her practices 'the morning after'; she was profoundly aware that they increased her risk of



developing long term complications. When I asked her if she was worried about the future, she noted:

I think I've got some sort of defence mechanism that makes me not quite believe it [that could suffer from complications]. But um, no, I'm aware that there is a big risk of very nasty complications when I'm older. But whether it has that much influence on my day to day actions I cannot really be sure.

What Lilya is describing here is what Giddens (1991: 129) refers to as a protective cocoon. Giddens argues that a "psychologically crucial part of the protective cocoon is the deflection of the hazardous consequences that thinking in terms of risk presumes". The interesting thing about Lilya's narrative here is that she is clearly aware of the presence of this protective cocoon. However, while the rationality of engaging in practices of risk minimization wasn't in doubt (like all of the other interviewees, she accepted the validity of techno-scientific constructions of diabetes' risks), the practicalities were. She noted that if her diabetes care was marked like a university essay, she would be happy with a 2.2. result, at least while she was in college. She felt that developing greater control beyond this point would deleteriously affect her status as a normal young student. The meaning of her practices as they related to identity in the present were at least as, if not more so, important as the effect they could have on her in the future.

Between our first and second interviews Lilya decided to go on the DAFNE programme. During our second interview, I again asked her what result she would be happy with in terms of her diabetes care. This time she noted:

I think that's changed [previous attitude]. Because I can now see that in the future if I get a 2.2. now I will be getting a third in fifteen years. And even though I'll have had a life and all those memories to look back on, I'd prefer to get a 2.1 or a 1<sup>st</sup>. And that's probably the DAFNE course that's changed that, increasing my awareness.

Going on DAFNE led her to reflect on her practices, and the effect they could have on her in the future. In Giddens' (1991) terminology, it ruptured her protective cocoon, and led her to experience a fateful moment. It is important to note though that Lilya herself actively cultivated this fateful moment. She went on DAFNE because she wanted to change; she wanted to achieve better control over herself.

Indeed, in some respects Lilya's 'fateful moment' started long before going on DAFNE. During her second year of university she started to realise that she wasn't going to be student forever. She felt that she was going to have to grow up and develop control over herself at some point. She began to reflexively examine, and alter, her practices in light of this changing self-understanding, of what it meant for her to be an adult. DAFNE was a tool that she purposely incorporated into her lifestyle at a general moment of transition in her life, and was used to both intensify and clarify these changes.

While DAFNE therefore had a number of positive effects for Lilya, it did have some unexpected ones. For example, it brought diabetes much more to the forefront of her personal identity. Prior to DAFNE, Lilya had been diabetic for so long that diabetes had become part of her, something habitual, rather than something that was consciously managed. DAFNE, however, transformed a body that was docile to habitual control into a body where diabetes had to be consciously acknowledged, and practices intentionally articulated in order to control it (though after time these new practices themselves became dispositional in nature).

Another reason I didn't like it to start with is that it makes you think about the fact that you are diabetic every time, all the way through a meal. Whereas before I might have injected before or with the starter, and just thought I'll probably have this much and then completely forget about it...when you're on DAFNE you have to count the starter, the main course and the pudding and after you've counted you have to do your injection afterwards. So...it makes you think about it much more.

#### **6.4. Surveillance technologies**

I have so far discussed the ways in which my interviewees used intensive therapeutic technologies to discipline their bodies and manage the long and short term risks of diabetes. For technologies such as CSII and DAFNE to operate effectively, however, they require individuals to have a constant stream of information about the effects consumption and disciplinary practices are having on their bodies. In diabetes, this information is provided in a number of ways. One of the most important of these is through the use of surveillance technologies to monitor blood sugar levels.



Blood tests come in several primary forms: HBA1C tests, which are administered by medical professionals and give an individual's average blood sugar result for the past few months, and self-monitoring of blood glucose, which is done daily. SMBG will be form of blood testing that will be discussed in more detail in this section as it was the form of monitoring that interviewees used most regularly while they were at university.

In SMBG people use a device to prick their skin (most often their finger tips). This brings up a few droplets of blood, which are then used to coat a testing strip. This strip is inserted into a glucometer, which summaries blood glucose levels as a number, such as 6 or 7 (Mol 2000). The numbers given by these tests can then be recorded in electronic or paper blood sugar diaries, which individuals can use to analyse the (in)adequacy of their practices, to see where and by how much personal practices deviate or correspond to 'good' practices.

Blood testing is now considered to be "the sine qua non of a successful intensified treatment regimen" (Wolfsdorf 1999: 1767). In a recent statement about self-monitoring of blood glucose the American Diabetes Association (2002: S97) noted:

"It is recommended that most individuals with diabetes should attempt to achieve and maintain blood glucose levels as close to normal as is safely possible. Because most patients with type 1 diabetes can achieve this goal only through SMBG, all treatment programs should encourage SMBG for routine daily monitoring...three or more times daily".

In current understandings of best practice in diabetes care, only the regular, intensive use of SMBG is considered adequate for individuals with Type 1 diabetes. Anything less and people will have difficulties maintaining their control within the "normal limits" (Schur et al 1999). Single tests aren't really useful from a medical point of view, with the exception of serving either to confirm or deny the presence of hypoglycaemia when a person's warning signals, her ability to tell whether she is high or low, are blurred (for example from drinking alcohol) or not working (Krentz 2000).

In Foucault's terminology, SMBG operates on an ethical as well as therapeutic level. It encourages people to regulate their desires and practices through normalizing, reflexive practice. It promotes the development of an attitude whereby "the body becomes an object of intense vigilance and control" (Balsalmo 1995: 217). SMBG enables practices to be "assessed and measured, and...conformity induced by way of correction" (Nettleton 1994: 81). Mol (2000: 13) notes that SMBG has changed the meaning of 'normality' in the context of diabetes management. Prior to SMBG, blood sugar levels could only be monitored and corrected at a doctor's surgery. Now, because blood sugars can be continually monitored, adjusted and tightened, 'normality' has become ever more defined. Normal blood sugars 40 years ago would be considered abnormal and risky blood sugars now.

There is a moral dimension as well to the monitoring of blood sugar levels. If an individual's blood test indicates that her blood sugar levels fall outside the normal range it means that he or she must have done something wrong somewhere along the lines, engaged in incorrect practices, and should now engage in the right ones to bring blood sugar levels back in line with the norm, if risks are to be reduced and the body is to be disciplined effectively. To appropriate Foucault's phrasing, with SMBG:

"The whole indefinite domain of the non-conforming is punishable: the [diabetic] commits an offence whenever he does not reach the level required" (Foucault 1984: 194).

SMBG is not (or at least is not just) a negative, repressive practice, though. It has productive functions. It evaluates the effects current consumption and disciplinary practices have on blood sugar levels. It allows insulin dosages to be adjusted to situational requirements. And it helps individuals decide what changes should be made to these practices, if any, and in this way can assist in the construction of a moral self.

#### **6.4.1. Managing risk**

One of the most important functions SMBG had for my interviewees was enabling the effective management of risk, particularly those risks that emerged from consumption practices.



For example, I noted in section 4.8. that my interviewees engaged in a number of risk minimization practices (trusting others, making sure blood sugars were high before going out etc.) when they drank alcohol. One practice that was not explored in that section, but which was important for my interviewees, was using of blood tests to monitor blood sugar levels before, during and/or after drinking alcohol. SMBG was, in fact, a practice that was especially important in those situations where interviewees consumed alcohol. Interviewees sometimes found it difficult to monitor themselves through 'intro-sensing' (through 'feeling' their blood sugars) when they were drinking. In these kinds of circumstances, testing could be relied upon to give a valid reading of blood sugar levels and provide a 'true', scientific account of the body.

Testing, though, was a highly spatialised activity for my respondents. Most of my interviewees tested their blood sugar levels when they were at home, which meant before and after going out drinking. Only a small number of my interviewees (Erin and Elayne) brought their blood testing equipment with them when went clubbing. There were several reasons for this. Firstly, carrying blood testing equipment around was often considered to be a hassle, especially if my interviewees wanted to go dancing. As I noted in section 4.8., dancing is a central practice that students use to create feelings of community, to construct themselves as a student body. Anything that interferes with the ability to dance wherever, however and with whomever the person wants, in situations where being like, and *feeling* like, everyone else is important, is something that is, and often was, likely to felt to be unacceptable. Secondly, interviewees were often worried that if they left their testing equipment in a cloakroom when they went dancing there was a risk that the equipment itself could be damaged. Interviewees generally didn't trust other people to look after such important technology. And thirdly, and most importantly (especially for the female interviewees), carrying around technologies was often felt to be a stigmatising practice, an activity that would prevent interviewees from passing as normal. It medicalised identity. This point will be discussed in detail in the next section.

For interviewees who tested before going out but didn't bring their equipment with them when they went clubbing, SMBG was often an indicative practice, one that suggested to them how much and what types of alcohol interviewees should drink on

a particular night, and what kinds of activities, and at what levels of intensity, they should engage in. It was a practice that, by providing information about the state of the body in the present, enabled them to map the night out in advance (Giddens 1991). This was often emotionally reassuring. Interviewees generally said they felt good, secure, when they went out knowing their blood sugar levels were normal and that they were going to be ok while they were out. Testing after coming home provided interviewees with a way of regaining control over their bodies, and therefore of becoming 'normal' again.

It is important to note, though, that while my interviewees sometimes drank 'excessively' when they were out clubbing in the knowledge that they could regulate themselves once they got home, this generally didn't appear to happen as often, or to the extent, that some medical researchers have feared. In fact, even in the periods between tests, when interviewees were out drinking, they were often conscious of the need to maintain some kind of control over themselves precisely because they couldn't engage in SMBG. Interviewees were often worried about the possibility that they would drink too much alcohol to be able to do a test when they got back home, and therefore might end up over-injecting insulin. Interviewees who didn't bring their testing equipment with them when they went drinking often felt the need to balance their consumption in another way.

Erin was one of the few interviewees to bring her testing equipment with her when she went drinking. In section 4.4.1., I noted that Erin was also one of the respondents who most clearly used alcohol consumption as a way of constructing an identity as a 'normal' student. Erin's concerns lay with differentiating her current student practices from the practices and feelings of her younger self. When she was younger she was treated for depression because of the extra stress "not being completely normal" diabetes brought. Since sixth form, though, she was "gradually becoming less conscientious" about her diabetes care. She made a decision before coming to university that she wouldn't let diabetes influence her life and prevent her from doing anything. However, as evinced by her regular testing (up to six times a night) when she went drinking, she still was very conscious, and anxious, about the possibility of losing control. Indeed, she was testing more in university than she was living at home.



As with the other interviewees, testing for Erin was an emotionally reassuring practice. This fact was especially important for her given that when I first interviewed her she had only been in university for five weeks. As such she still considered student spaces to be unknown risky spaces. Secondly, testing was an ingrained habit, a disciplinary activity that Erin had internalized as part of her *habitus*.

It's one of those things that's ingrained that I must do I think. Along with drinking water before you go to bed. It is so ingrained now that I've been doing it every day for so many years. I just think I should do a blood test.

Testing, though, was a habitual practice for many of the interviewees. This by itself does not account for the reason Erin was willing to bring her equipment with her when other first years weren't.

Several specific factors appear to be important. Firstly, anxiety appears to have been an important factor. Bryden et al (2001) note that in diabetes there is a tendency for young adults with diabetes who have anxiety or depression to have good glycaemic control. They argue that anxious young people "may be more diligent in monitoring and may take more effective care in response to signs of poor glucose control" (ibid: 1540). In Erin's case, her anxieties were concentrated more on the fear of being rendered abnormal in public by hypoing, than by testing. Testing in fact wasn't seen as "too much of a bother" because her glucometer and testing strips were so "discrete". Erin also drank more alcohol than any other student I interviewed (eight or nine pints on a night out). Other interviewees could go without testing for longer because they drank far less. Testing provided Erin with a way of feeling she had some control over herself when she was drinking. Hypos would make her dependent on other people, and lead to a breakdown in her presentation of herself as a normal young person, something which she didn't want. Furthermore, while she trusted others to look after her, she was also worried about this. There was a risk of sexual exploitation. Erin also noted that several months before coming to university she had nearly had a massive hypo when she came home drunk and forgot whether she had taken her insulin or not. As such she nearly injected twice, and sent herself into a coma. This incident was still very much in the forefront of her mind (in Giddens

(1991) terms, since it led to a re-evaluation of practices, it could be deemed a ‘fateful moment’) and she interpreted her current practices in the light of this event.

And finally, when she was younger one way she rebelled against her diabetes was by not testing at all. A way of becoming ‘normal’, therefore, was accepting her diabetes, making its management regimes a part of her. Here, the transition from home to university and the possibility of constructing a ‘new’ identity brings with it an increase in a willingness to engage in risky practices, but also brings a concomitant increase in the desire to engage in monitoring practices to balance risk.

#### 6.4.2. Stress

As Chatterton and Hollands (2003) note, drinking alcohol and having fun are only part of the equation for students at university. Stress and pressure are also commonly experienced feelings. Anxieties can be especially intense around exam time and/or when coursework has to be handed in. Stress, though, can have deleterious impacts on blood sugar levels for people with diabetes. Blood sugars are likely to be higher when individuals are stressed compared to periods when they are relaxed (Aikens et al 1994). For interviewees who experienced stress, technologies could be used to discipline the stressed body, and manage the risks of raised blood sugar levels. However, it was also important to respondents that these technologies be used in a balanced fashion.

Stress was an important theme in Elayne’s account. I demonstrated earlier, using material from my first interview with Elayne, how the switch from MDI to CSII led to positive changes in her life because they increased her flexibility and ability to engage in desired practices. My second interview with Elayne took place one year after our first (the material above is taken from my first interview with Elayne). At the time of our second meeting (which occurred in early December) Elayne was in her final year of studying law. Things had changed a lot between our interviews.

The most important change was that her blood sugar control had gotten a lot worse, in spite of the pump. Between September and December her blood sugars had steadily risen. On the 1<sup>st</sup> of December Elayne started to feel sick and dizzy. She told her friend that she was feeling nauseous. Her friend called emergency services and



explained to them that Elayne was diabetic. An ambulance was sent and Elayne was taken to hospital. Once she got there she was put on an insulin drip. A blood test by her doctors found that her blood sugar levels were 33.3 (rather than her ideal of 4-5). She was diagnosed as suffering from stress induced hyperglycaemia.

Stress emerged from the pressure of having to complete dissertations and essays, as well as preparing for exams, while in the meantime being involved with numerous extra-curricular activities. Having to fit all of these activities into a limited amount of time was “too much”, and resulted in consistently elevated blood sugar levels. This made it difficult to concentrate for sustained periods of time. Because her sugars were generally high, she would often have to stop studying every few hours in order to regain her control. The stress of this loss of study time sent her blood sugar levels up further. Her problems were intensified by the fact that as a student she felt that she had no weekend, no breathing space in which she could relax and calm herself down, balance herself out. She noted that at the weekend she had just as much work to do, if not more, than on the weekdays, especially if there were deadlines on Monday. There was no cut off point. A nurse in the hospital told her to do yoga, but she started panicking at the thought of losing another hour of work.

She left hospital once the medical staff had brought her blood sugars down. Before they discharged her, however, they informed her that her blood sugars would in all likelihood go up again as long as she remained in a stressful situation. The only thing guaranteed to bring her blood sugars down was taking insulin directly into her vein.

Because this wasn't a practical option, the only thing which she felt that she could do was take more and more insulin. This, however, was a problematic and troubling practice for Elayne in a number of respects:

I hate taking more insulin. Because they tell you from when you're diagnosed that basically you should and try and...what they're always trying to do is get you on the least amount of insulin you need. In terms of fluctuating blood sugars obviously, and highs and lows, and weight gain. So they always try to keep you on the lower end of what you need. So now being told to start taking more and more, you're thinking this goes against everything I've been told for the past fifteen years. I do not like doing it. Particularly because I'm always worried I'm going to crash down.

Taking insulin, then, while a practice that was necessary to control stress induced hyperglycaemia, was also risky in a number of dimensions. Firstly, it contravened her feelings about what good practice was in the context of diabetes management. Secondly, taking extra insulin increased her risk of regaining all of the weight which she had been able to lose with the pump. This was something she didn't want as she felt it would mean that diabetes was reasserting its control over her, when she had struggled so much to control it. Her anxieties about hypoing were also intensified by her spatial situation. Because she was living on her own in a flat she was acutely aware that if she hypoed from taking extra insulin no one would be able to do anything about it, and she could slip into a coma. This was something that she described as being "very, very scary".

In these circumstances, diabetes' technologies provided the only means of limiting the damage stress was doing to her body. She accepted that while she was in university her blood sugars would remain high. She was too much of a "stresshead" for them to be otherwise. However, technologies could be used to "make some sense out of the chaos", to find "the middle ground". In particular, SMBG enabled some of the risks and anxieties of taking more and more insulin to be managed. The most important thing it allowed her to do was continue studying; Elayne had a strong sense of herself as someone who was a successful student. If diabetes ever interfered with her career or work, she "couldn't bear it". Technologies therefore enabled her to engage in emotionally important practices, through which she could maintain a desired self-identity. However, as during the period in her second year when she was injecting seven times a day, she felt that there was a risk in intensively using surveillance technologies; namely that they could come to dominate her when she had put so much effort into freeing herself from them.

**Myles:** So how often do you test now?

**Elayne:** Anything up to...ten times a day. Yeah, over the last couple of days. So I'm testing and I'm seventeen and I'm taking some insulin and I'm testing an hour later and maybe they've gone up a bit so I have to take some insulin and I test them half an hour later to check were they going up or on a curve down. And then testing in the middle of the night if I wake up, making sure I test then. But I'm trying to bring that down. Because it's very easy to get into



a state where you're constantly testing. I've had to stop and say testing isn't going to make a difference.

### 6.4.3. Disruptions

Despite the role surveillance technologies played in the management of risk and the development of good blood sugar control for my interviewees, SMBG was also a practice that many of my respondents either felt ambivalent about, or had difficulties with. There were several reasons for this, which mostly related to the disruptive effect SMBG had on interviewees' everyday practices. In the remainder of this section I am going to explore some of the reasons behind these disruptions. Firstly, I am going to show with James' narrative that the practice of (not) testing could be influenced by the gendered discourses interviewees identified with, and also their spatial circumstances. Secondly, I am going to discuss, with the aid of Sylvia's narrative, how for interviewees who hadn't assimilated diabetes into their self-identities testing could be a biographically disruptive practice.

I noted in section 4.5. that achieving good control of his diabetes was an important practice for James. He considered disciplining himself to be a moral activity, something which enabled him to identify with resonant discourses of masculinity while helping him to minimize the long term risks of his diabetes. He felt that he engaged in all of the practices that a "good diabetic should", for example eating healthily and exercising on a regular basis. However, in one very important respect James was not engaging in the practices that medical discourses recommend people with diabetes should: he wasn't testing.

You would have thought for somebody who is so anal about taking paracetamol [he refused to take drugs in case they affected his control] they'd have been testing their blood sugar all the time. But I do not. And I have a real sort of...I have real cognitive dissonance about that.

Testing was described as a hassle by many of my interviewees. It disrupted the flow of their everyday routines. This was a point that was both explicitly and explicitly articulated in James' narrative. For example, when James described testing, he represented it as a laborious, time-consuming process rather than a fluid integrated practice. To test he had to take his equipment out of his bag, and then take the equipment out of its leather case. The glucometer had to be switched on, blood had to

be taken, time had to pass before a result was given. And to repeat this four or five times a day?

And yet not testing had its own impacts as well. When he thought about it (which he tried not to, because he noted “when I do not think about it it doesn’t piss me off”), he was acutely conscious that his current practices, his lack of testing, conflicted with his sense of who he was as a person, his self-identity, and the practices he felt a good diabetic should engage in. He was aware, from having completed courses on endocrinology, of the increased risks to his body that came with not testing.

Why testing had become a hassle was something that he asked of himself constantly.

How can I motivate myself? How can I motivate myself? And I do not know. I do not know. Because I really do try. It’s like everything else in my life I can motivate myself fine. I can work like crazy... I mean, for some people, they say you do not need to [test], but you do. You definitely do. Because the amount of insulin you need can change on a weekly basis anyway.

Like many of my interviewees, James experienced difficulties routinizing his practices in university. The success of SMBG is dependent upon the ability of individuals to engage in it habitually. However, having to constantly move around between different lecture theatres and home and social spaces drained the motivation from him. After a while he either couldn’t be bothered to test, or he felt that there was never enough time in which to do so. The longer he went without testing, the more worried he became about seeing the results, which increased the likelihood that he wouldn’t test next time. He was ashamed about his practices, and didn’t want to be confronted by his inadequacy. He became both apathetic and anxious, paralysed.

Furthermore, James continued to have problems with the Dawn phenomenon. Because of the stress his course placed upon his body, he produced high levels of cortisol when he was sleep. Cortisol is an anti-insulin, which works against insulin. Because of the effect cortisol had on his body, he would wake up high, between 12 and 15. The doctors said that they couldn’t do anything about it because “it just happens”. The body was an unknown ‘Other’. He would spend the rest of his day “battling” against his body in order to bring his blood sugars back down. Despite his



best efforts, his constant engagement in disciplinary activity, his body continued to exceed his rational control. Testing wasn't able to pick up on any underlying patterns that he could use to decipher or improve on his current situation. Indeed, after a while the only thing testing produced with any regularity was frustration.

Both of these elements, his experience of the dawn phenomenon and his difficulty in routinizing his practice, led him to feel that he was losing a fight with his diabetes. In our third interview, James said that he had stopped testing:

Because I felt as if I was losing. So I didn't test as much so I didn't know I was losing.

Shortly after our first interview James came across information about the DAFNE programme. He was initially dubious about DAFNE because he wasn't sure what the programme could teach him that he didn't already know. He was also wary that DAFNE would turn out to be a self-help group for people complaining how terrible diabetes was. However, he decided to go on the course anyway in case it could help in some way, help him to motivate himself. The changes DAFNE engendered in his practices were marked:

Since the DAFNE course it's given me a reason to do my blood testing. It's made it quite scientific actually...because it's made it so scientific it's really interesting. I'm a scientist. I like to know what to do. Before it was just guesswork and it was very inaccurate guesswork, whereas now it's pretty good stuff. So it allows me control and I am far more at ease.

The strength of James' identification with science in this narrative is important, and, of all of the interviewees who went on DAFNE, is shared only by Lars; none of the female interviewees talked about the rationalities of the DAFNE system in relation to the construction of identity, though they valued the systematizing, scientific nature of the programme in enabling intensified control. As I discussed in section 5.7.3., rationality and science are both concepts that have historically been associated with hegemonic forms of masculinity (Connell 1995, Seidler 1989). Reason has traditionally been defined against its opposites, against irrationality, chaos, emotions, feelings, desires, all of which are states of being primarily associated with the body (Johnston 1996, Massey 1995, Longhurst 1995). In contrast, reason itself is generally

considered to be transcendent, disembodied, associated with the mind, with control. Prior to going on DAFNE, James' diabetes had in some respects become an 'Other' to his rational mind. It was an unknown, outside of his control. As such, he developed a fatalistic attitude towards it. He couldn't understand it, so why test if it made no difference? The only thing it confirmed was his powerlessness. DAFNE provided him with a system that he could use to regulate his body. It enabled James to act upon his diabetes, to control it, to make it docile, to transform his care of the self from an unsatisfactory regime built upon improvised regulation and personal experience into a system predicated upon protocols and clear knowledge of cause and effect. It provided him with the rules of the game. Testing became a rational activity. The positive effects this engendered are clear. One of the most important of these was that DAFNE enabled James to effectively compete against his diabetes, to win rather than lose. Connell (1995) notes that competition is a central tenet of hegemonic discourses of masculinity in Western consumer cultures. Competition enables men to test their force and skill, in whatever domain, against an opponent. Being able to compete, and win, was a process that provided James with the positive reinforcement he needed to continue testing. Being able to win against his diabetes gave him a sense of mastery, and confirmed the legitimacy of a self-identity that had been undermined by the previous shame he experienced over the adequacy of his practices.

The DAFNE course was five days and each day you would put your results up on an acetate. And I had to have the most consistent, between four and seven. So yeah, I'm competing in that. I compete against everything I think. I think I must do because I like to do well so I'm so happy because I am doing well. And when I wasn't doing as well, I didn't test as much.

The hassle of testing was also a key theme in Sylvia's narrative, though for radically different reasons to those found in James'. James stopped testing because testing wasn't able to provide him with the fine degree of control he wanted in order to be able to effectively compete against his diabetes. But he wanted to test. James experienced his lack of testing a disruptive practice because it was a (lack of) activity that directly conflicted with his sense of himself as a 'good' person, a well controlled diabetic. In Sylvia's case, testing itself was the disruptive practice. In fact, out of all the practices of diabetes that she had difficulties with, testing was the most



existentially troubling. I discussed earlier how Sylvia injected twice a day in order to minimize the effects diabetes had on her social identity. However, she often had difficulties forcing herself to do even this many tests; frequently, she did none. With injections she could get up in the morning and do her 'jab', and then get on with her day. She didn't have to think about injecting again until evening. Testing, though, was different; it was a constant reminder to her that she was a diabetic. Every time she opened her bag it seemed that a testing kit was there. Injections were enough to deal with, without having to deal with everything else.

It's something to do with...it was a hard enough disruption when you were first told you had to inject yourself and regulate mealtimes. It's enough disruption having to do that twice a day without the...without the...factor of having to test your blood three times a day. And test it before you go to the gym and test it before you do, like, anything, really. If you're going to do something you do not normally do you're meant to...test. You're meant to test a couple of times a day. And it's something to do with the disruption; I do not like having to do it. Because I feel it's like disruption my daily life.

I discussed the concept of biographical disruption in section 4.4. Several criticisms have been made of the concept over the years. In a review of the literature on biographical disruption, Williams (S.) (2000) argues that research on biographical disruption most often neglects young people. He notes that the concept has also concentrated on biographical disruption as a once-off event, caused for instance by an individual developing a chronic condition. The changes this disruption causes to an individuals' biography is eventually integrated into an individuals' self-identity, their personal narrative. In Sylvia's case, testing was connected to a constant series of mini-disruptions. After four years she had not assimilated diabetes into her identity, accepted it as part of her, and therefore everytime she used diabetes technologies it was troubling; it reminded her again and again of her diabetes, that diabetes could and would interfere with even the most ordinary of everyday practices. She accepted diabetes now more than she did when she was younger, when she actively rebelled against it; but this acceptance was predicated upon not thinking about diabetes, suppressing its presence in her life. She felt bad about her attitude, that she was letting herself down. As I noted in the section 5.8.3., though, the catch-22 she was in was that unless she was prepared to intensively engage with her

diabetes, she wasn't going to be able to habitually, rather than consciously, regulate herself.

In this section, then, I have explored the place self-monitoring technologies had in my interviewees' narratives of practice. In the next, and final, section I am going to explore the theme of stigma in my respondents' accounts.

### **6.5. Technologies and the presentation of the self**

I have noted at various points throughout this thesis the importance that my interviewees placed on being, and being perceived as being, 'normal'. For example, in section 4.4., I demonstrated that Laura was conscious about the effect not drinking alcohol could have on her social identity; and in section 5.5.2. I discussed how Alice (at least in her first year at university) was conscious about the need to regulate her food consumption so that she could construct an identity as a normal young student.

Anxieties about difference therefore circulated through my interviewees' consumption narratives. These anxieties were most intensely articulated in relation to my interviewees' use of diabetes technologies. There were several reasons for this. Firstly, management technologies could disrupt interviewees' abilities to present themselves as 'normal' young people. Interviewees' food and alcohol consumption practices were practically indistinguishable from those of other students, and where they were different, they could easily be altered so as to enable interviewees to pass as normal. For example, interviewees could sip alcohol slowly when out with other students, rather than engage in binge drinking. Diabetes' technologies were more problematic, principally because they were so obviously different and out of place in the spaces my interviewees routinely moved through. Furthermore, technological devices themselves were sometimes interpreted as stigmatised devices by my interviewees. Technologies could also deleteriously impact on interviewees' gendered identities. These points will be explored now in the material that follows.

#### **6.5.1. Spatialities and Stigma**

Much contemporary research on stigma owes a debt to Goffman's (1963) work on the subject. Goffman noted that the ancient Greeks used the word stigma to refer to signs that were "cut or burnt into the body and advertised that the bearer was...a



blemished person, to be avoided, especially in public spaces” (ibid: 1). These marks signified that the person had done something wrong to disgrace herself, and that that she was now different from others; her status as moral subject was void.

In the present day, stigma is a wide-ranging “multidimensional concept which centres on the concept of deviance” (Alonzo and Reynolds 1995: 303). Goffman (1963: 3) argues that stigma refers to an attribute “that is deeply discrediting”. Stigma develops when individuals have a feature that differs in some way from “an ideal or expectation” (Alonzo and Reynolds 1995: 303). When individuals do not meet, or feel that they do not meet a particular normative ideal, their identities are at risk of being discounted or spoiled, “pejoratively regarded” (ibid).

There are positive and negative aspects to Goffman’s argument. In relation to the negatives, Goffman’s (ibid: 14) thesis that during interactions with ‘normals’ the stigmatized person is “likely to feel that he is on [show], having to be self-conscious and calculating about the impression he is making” doesn’t take sufficient account of the habitual or emotional nature of practices and interactions (Jenkins 2004). Often people do things because they are part of their routine, without taking conscious account of them. The strengths of Goffman’s argument outweigh his weaknesses, though. The most important of these strengths is Goffman’s understanding that stigma develops relationally; it is not inherent to people or their attributes. Rather it is something that develops between, in dialectic with.

In this study, interviewees were often aware, and worried, about the risk that their diabetes could make them different from others. Lars for example noted:

I do not really like telling people. Telling people is like, eventually if I get to know them well enough...I do not really like talking about it...I think that if I told people they’d nearly see me as a pariah basically. Diabetes is quite hidden really. No one knows you’ve got it unless you tell people or they see you injecting or something.

Lars’ comments here can be productively interpreted through Goffman’s concepts of discredited and discreditable stigma. Goffman argues that subjects who possess a discredited stigma have an obvious mark of their difference, something that cannot

be easily hidden. People who have a discreditable stigma, however, do not continually display a visible sign of their dissimilarity from 'normals', "those who do not depart negatively from the particular expectations at issue". However the nature of their stigma could be revealed if they do not engage in regulatory practices to efface the presence of their condition. Passing is possible when the signs of the illness may be controlled or downplayed; difference is suppressed so others won't observe abnormal performances.

It is possible to 'pass' with diabetes because, if it is well controlled, diabetes is an invisible condition (Broom and Whittaker 2004). As Lars indicates, though, the use of technologies, especially in public spaces, can disrupt this invisibility, draw attention to the young person, highlight their 'difference'. Some interviewees felt that the type of attention drawn to them through the use of diabetes technologies would be of a particularly negative kind, given that injecting in public is a practice that has "negative connotations" (ibid: 2373). Lilya for example noted that she associated injecting with illness, heroin, drugs. She felt needles had a "negative image" because they were "negative objects".

Diabetes' technologies, therefore, were risky because of the deleterious impacts interviewees perceived these technologies could have on their identities. And yet, not using technologies could also be problematic. For example, not carrying a glucometer around could increase the risk of interviewees' bodies going out of control, which would itself could threaten their presentation of the self as normal, or impact on interviewees' presentation of the self in other ways. I mentioned earlier that Sylvia injected twice a day in order to construct an identity as a normal young woman; she also rarely tested. By not injecting or testing more often, though, she couldn't go out as often as she sometimes wished, and had to regulate her consumption practices more strictly than the other interviewees who used intensive management regimes. This in itself impacted upon her ability to present herself as a 'normal' young woman. She might have to restrict her consumption when others were eating freely, or have to go home when others were going out. When she did go out, her risk of hypoing was increased by the fact that she didn't test regularly. As I discussed in section 4.9.1., hypoing was experienced problematically by Sylvia because it forcibly disidentified her from desired discourses of respectability. It



rendered her body an out of control, unfeminine, disreputable presence. So while not injecting decreased Sylvia's risk of her identity being spoiled through the public use of management technologies, in other ways it increased this risk. Interviewees walked a fine line in deciding when and where to use their technologies; deciding not to inject in public could preserve interviewees' social identity in one way, but risk it in another.

It is important to note as well that while interviewees were often anxious about the possibility that their diabetes and their use of technologies could make them different from others, when they did tell other young people about their condition the reactions were generally positive, and often very much so. For example, walking home from a night club one night Alice had a hypo and had to tell all of her friends that she had diabetes, which she hadn't done until then (having known them for two months). Her friends thought that it was great that Alice had diabetes. Dear et al (1997) note that unlike H.I.V.A.I.D.S, diabetes is a socially accepted condition in Western cultures<sup>44, 45</sup>. Dear et al found several factors contribute to this acceptance. Firstly, Type 1 diabetes is a condition which does not impinge upon the functionality of people who have it. As discussed above, it is a largely invisible condition. It doesn't interfere with established conventions. It doesn't develop because of individual negligence. Other people can readily put themselves in the shoes of people with diabetes (everyone has to control themselves in some way). And it is not contagious. In a book written in the early 1980s for teenagers who had been recently diagnosed with diabetes Farquahar (1982: 115) summarises these arguments neatly:

“No one needs to be any way ashamed of being diabetic. In the first place it is in no way the fault of the individual. It is neither infectious nor messy. The boy or girl with it looks like a healthy person, behaves normally”.

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<sup>44</sup> Or at least Type 1 is. It seems plausible that young people who develop Type 2 diabetes in the future will suffer increased social stigma for having so drastically engaged in the 'wrong', unhealthy practices

<sup>45</sup> One point that my interviewees' continually stressed was that they did not have a disability. Rather, they said that they had an individualized 'condition'; none of them were really interested in meeting other diabetics to talk about what it was like to live with diabetes. As such, the idea that they could construct a political identity around their condition was something interviewees found strange. Stigma, when it was experienced, was not appropriated and reworked into broader social project. No interviewee questioned, in our discussions, why they experienced stigma, and whether it was wrong that they experienced stigma; their primary concern lay with how best to deal with it.

And yet as Lars indicates, my interviewees were often worried about being ‘pariahs’, about being different or having other people perceiving them negatively, despite the fact that none of them had experienced discrimination from other people. Scambler and Hopkins’ (1986) distinction between *felt* and *enacted* stigma is important here. These authors argue that enacted stigma refers to instances of active prejudice made against people who possess a certain attribute or condition, because of either the perceived offensiveness or objectionability of the attribute or characteristic. Felt stigma, on the other hand, is different. It refers to an individual’s worry that they could suffer enacted stigma from others, for example through the use of therapeutic technologies in public. It also refers to individuals’ feelings of shame about their condition, and their awareness of their difference. It encompasses the ways in which individuals compare their bodies and identities against those of other people and perceived norms, and find themselves lacking in some respect. Foucault’s work on docile bodies and self-surveillance is relevant here. In Foucault’s terms, felt stigma is experienced by docile subjects who are engaged in a process/project of continual self-monitoring. These subjects are intimately aware of the extent to which their practices, and indeed their self, do(es) not conform to the norm. Self-surveillance encourages self-regulation, the normalization of practice, in order to ensure the successful construction of an identity as a normal young person. In keeping with Foucault’s reading of discipline as a pleasureable, affirmative activity, my interviewees experienced their management of their technological consumption as positive practices, particularly in the way it was seen to ‘maintain’ their identities as regular students.

My interviewees’ desire to be normal accounts for at least part of the reasons why they often experienced felt stigma with regards to their technological consumption. But what contextual factors were important in this process? Why did my interviewees experience ‘felt stigma’ while they were in university? And did some interviewees experience felt stigma more strongly than others?

The stigmatising effect of public technological consumption was an especially important consideration for my first year respondents. First years didn’t want others to see them as individuals with a ‘disability’. Rather, they wanted to be seen as unique, normal individuals. In many respects, first years’ desire to be normal was



intensified by their recent transition to university. They were conscious that in university they were in a new field where the only aspect of their identity that they could be judged upon was their appearances, their ability to present themselves as normal. Frost (2005) notes that people who cannot present themselves as 'normal', whose performances do not come up to standard, are at risk of being discredited. Frost (*ibid*: 80) argues that "the opinion formed by those making...judgements does not stop at immediate presentation...[rather] the discrediting of the person...takes in the whole identity". This understanding, that their diabetes could discredit their entire identities, often intensified first years' awareness of their diabetes and its management practices. Alice for example noted that before coming to university injecting didn't bother her at all. She didn't think of herself as a diabetic. However, on moving to university she became much more conscious of where and for how long she was injecting, and the fact that she was 'a diabetic'. She was more conscious of the possibility that the management technologies of her condition could forcibly medicalise her, at least if she wasn't careful about where and when she injected. As such, she often spatially regulated her practices by injecting in toilets when she was out, or in her bedrooms in halls when she was at home. Alonzo and Reynolds (1995: 303) note that few studies have attempted to examine at what points in the lifecourse "stigma may be differentially experienced and managed". The transition to university is clearly one here. Alice noted:

The reason why I'm on three [injections a day] is because I do not want to take my injection out [with me when clubbing]. Because normally you have to do one before you go to bed. Cause I think it would bother me. Some people it doesn't bother them, but it would bother me to take me injection out and stuff, just to carry it around. Lunch is sometimes awkward as well because I'll have to inject straight before I eat, for breakfast and for lunch. So if I'm not with anyone then I'll have to get like sandwiches and stuff. So if I have food it's better if I'm with someone so I can go to the toilet. I'm...not really comfortable yet with injecting in public. It depends who I'm with and where I am. And breakfast as well; it depends who I'm with and how many people are in the dining room-whether I'll go to the loo or not, to inject myself.

Spatialities are crucial to this account. By relegating her technological usage to private spaces, it is possible for Alice to preserve her social identity. Similar findings have been found in other studies. Tak-Ying Shiu et al (2003) for example found that for their diabetic interviewees in Hong Kong the relationship between geography and

stigma was a crucial one. Shiu et al's interviewees interpreted injecting in public space as a primarily negative experience because it would highlight their difference from others and reveal that there was something 'wrong' with them. To minimize the social stigma of injecting, and the potential for discreditation, interviewees often withdrew to closeted spaces such as restrooms when they wanted to inject, practices designed to minimize spoiling their identities as normal, healthy people. However, it can be seen in Alice's account here that the meaning of spaces is not uniform, or unchanging. Injecting in public spaces is not automatically risky. For example, the meaning of injecting in a restaurant at quarter to one where there are few unknown others around, and where friends can support Alice's desired definition of the situation (that injecting is a 'normal practice'), is completely different from a situation where Alice would be on her own and there would be hundreds of students queuing for food. In these kinds of situations Alice would have food that she may not necessarily have wanted, and would inject in a toilet in order to preserve her identity as a normal person (Brown 2000) (though she noted that the few times she did inject at a dinner table no one paid her any attention). Moreover, retreating to inject in closeted spaces such as a toilet could itself be a risky practice. Vincent for example felt that other people would find it a lot more dubious if he went to a toilet to inject because "they won't necessarily sit there and go 'oh he might be diabetic', they'll think what's he doing with syringes and stuff". As such he felt it was far less stigmatising to inject where other people were around because the practice of injecting would not be connected to spoiled spaces. The meaning of stigma for Vincent lay in space, whereas for Alice it rested in the technology itself.

Like Alice, Kirk was uncomfortable about doing his injections in front of people because of the "awkwardness" of this practice. However, the pressure of having a full timetable of lectures, having to be in classes in different parts of the city meant that occasionally Kirk might have to inject in public. In situations like this he would engage in spatial information management practices such as positioning his friends in front of him so other people would not see him inject. In this way he could preserve his identity as a normal lad, unfettered by illness. However, to preserve his identity as a normal lad he sometimes had to take his technologies with him when he went out clubbing. For example when he went binge drinking with his friends he was always aware of the possibility that, if he was lucky enough, he might end up having



sex. If this happened, he might end up going back to the girl's place, rather than to his. In these kinds of situations it would be necessary to have his injection on him because otherwise he wouldn't be able to take his insulin. He was also worried that if his blood sugars went too high or low, then his diabetes could interfere with his ability to have sex, which would also interfere with his performance of the self as a normal, heterosexual lad. At no point in Kirk's narrative did he mention the possibility that, if he left his injection at home, he would go home to do his injection, rather than have sex. In this, his attitude differed markedly from the female interviewees, all of whom imagined themselves returning home after a night out, especially if they had to do an injection. The discourses of gender that interviewees identified with were therefore important here; laddishness is based on constantly being up for 'having for a laugh', and being 'on the pull'. Women who engage in similar practices are at risk of being labelled as 'sluts'.

Kirk: I just normally take it [injection] out with me just in case because you never know who you're going to meet.

Older interviewees were also worried about the stigma of injecting. For example, I noted in section 5.5.2. that as Alice had progressed through the university system her feelings about injecting changed. In her second year in university Alice switched from having three injections a day to having four, because she wanted to develop better control over herself.

However, while the amount of injections she took increased, her anxiety about injecting in public still remained. Her mother's feelings about injecting were an important consideration here.

My mum is a bit...she thinks just because other people do not want to see it [Alice injecting]. She doesn't...like if I'm with my mum then sometimes I'll just go to the toilet and do it in the toilet or something. Because she feels that people look at me out of curiosity and stare and stuff. Like most of the time they do not even notice but if they did...but she also thinks like, maybe she also thinks like people shouldn't have to see it or that kind of thing basically. I do not know. She's always a bit...about me doing it in public. So if I'm with my mum then I'll always, probably most of the time unless no one can see me, go to the toilet most of the time.

Scambler and Hopkins (1986: 34) argue that for most of their interviewees (who had epilepsy) “felt stigma and their special view of the world seemed to have been learned within the family of origin”. While I couldn’t make this argument for all of my interviewees, family was an important context for understanding Alice’s feelings about her injection practices and the technologies of diabetes. Her mother’s opinions about injecting were not interpreted entirely favourably by Alice, however. While these practices ostensibly allowed her to pass as normal it is clear that she felt that they also served to position her as different. For example, Alice noted that because of her mother’s feelings she often had to leave the dinner table when she had to inject. Charles and Kerr (1988) have argued that a sense of family identity is constructed through sharing food during proper meals, through inclusive practices of exchanging conversation, through laughing and touching. Having to inject in a closeted space when in the supposedly protective and private space of the home, a space where self-surveillance can supposedly be relaxed and the self accepted, is emotionally upsetting in the way it positions the person as outside the group and constructs difference through exclusionary pressures. It also perhaps serves to legitimize the fear of enacted stigma from others.

Why should I have to leave the table to do an injection, while my dinner’s there, getting cold or whatever? When I could basically just do it here and it wouldn’t be a problem? But then...I know that’s just the way my mum feels about it.

The irony here is that the place where Alice experienced the most overt discrimination with regards her injecting was in the most private and secure space, within the space of the family home. In public, in university, people either didn’t care about her injecting, or thought it was cool. However it was in these spaces that Alice herself felt most uncertain and worried about injecting. Alice’s narrative is important for demonstrating the complexity of interviewees’ feelings and practices with regards the stigma of injecting. The stigma of practices did not necessarily decrease as interviewees transitioned within university, though their definitions of what normal meant may have.



### 6.5.2. Technology, gender and stigma

Finally, gender emerged as an important analytic category in interviewees' experiences of stigma. In a study exploring how young men and women 'do' health and gender, Williams (C.) (2000) found that amongst the young men and women she interviewed (who were aged between 15 and 18), boys who had diabetes attempted to relegate the management of their condition by injecting in private spaces in order to minimize the impact of their diabetes on their social identity. In contrast, the girls Williams talked to were content to inject in public spaces such as schools. Diabetes was integrated into their social identities. Williams' findings, however, do not fit those of my study. In fact, in my study it was the women who were more worried about the association between stigma and the use of technologies than the men. Several factors appear to account for the differences between mine and Williams' study. Firstly, Williams' study does not look at the effects of transitions upon her interviewees' experience of stigma. She interviewed young people who had had the same group of friends for a number of years. In these circumstances, it seems plausible to hypothesize that Williams' female respondents had become habituated to injecting in front of their friends, who formed a network that helped support her respondents' desired definition of injecting as a normal, habitual practice. As I have demonstrated, however, the move to university often disrupts young people's habits; it often made my interviewees more conscious about their injecting practices. Secondly, with the exception of Kirk, none of my male interviewees would countenance injecting less than four times a day. Having less control would be too risky, and threaten their ability to identify with desired discourses of masculinity, both now and in the future. And thirdly, Williams does not differentiate between the types of stigma young people associate with different forms of technology.

In this study, one of the technologies that my female interviewees connected stigma most directly and strongly with was insulin pumps. This is one reason that explains why more of my interviewees did not use CSII, despite the fact that, as Elayne demonstrated, insulin pumps enable a greater degree of blood sugar control compared to MDI.

Maria and Alice both noted this:

Maria: I do not particularly like them [CSII] for the fact that you have a needle in your tummy all the time either. I just do not particularly want to wear it. I just do not like the idea of a needle in your tummy all the time.

Alice: When you're a teenager your control does go out of control a bit. And he [the consultant] said he was going to threaten that the next time I came in [for a check up] and my blood sugar was that high he'd put me on an insulin pump, which is just attached to you with a tube into your stomach sort of thing. I was just like 'no way am I going to have that'. And when I went out I was crying. I must have been about fifteen or something. When I came out of the clinic I was crying (laughs).

Numerous academics have celebrated the construction of 'cyborg' bodies and identities (Klugman 2001, Lupton 1995b, Featherstone and Burrows 1995, Haraway 1991). Haraway (1991)<sup>46</sup> for example argues that cyborgs are creatures that take "pleasure in the confusion of boundaries" and "signal disturbingly and pleasurablely tight couplings" between people and machines. Haraway celebrates cyborgs because she feels that they break down oppressive and restrictive dualistic ways of thinking.

I have sympathy for Haraway's argument. However, its utopian thrust does not fit my interviewees' accounts or feelings, at least with regards CSII.

In Maria and Alice's case, the insulin pump is interpreted as a traumatic device. Alice reacted so strongly to the pump when she was younger because it was a device that would have forcibly medicalized her body. The technology would have been part of her, rather than something separate from her that she could use to control herself. In Alice's case, the construction of a 'normal' identity, and indeed, her emotional wellbeing, is dependent upon the separation of technology from the body, boundaries. Kristeva (1982) argues that reactions like Alice's, "violent, dark revolts of being", are responses to things deemed to be abject, liminal, in-between, things that cross borders and raise the presence of "death infecting life"<sup>47</sup>.

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<sup>46</sup> <http://www.stanford.edu/dept/HPS/Haraway/CyborgManifesto.html>

<sup>47</sup> The idea of technologies as 'infecting life' may seem dramatic; however, it was a theme in several interviewees' narratives. Lilya for example noted that having children was an important consideration for her; in fact it was *the* most important consideration. It was a central aspect of her identity.

It's my life ambition I suppose. It's fundamentally important to me. If I do not have children I won't feel fulfilled. I do not know if that's a biological drive or whatever.



Kristeva herself argues that the main threat to the subject is dependence, or as she phrases it herself, reliance on the maternal body. One does not have to accede to a psychoanalytic perspective, though, in order to see the value of Kristeva's argument. CSII here is an abject device because it undermines distinctions and forces reliance. Lupton notes there is something unsettling about technology, in the way it can penetrate borders (Lupton 1995 b: 106). Indeed, Alice and Maria's feelings support Wilson's (1995: 246) argument that while:

“A machine both sheds parts and acquires new ones easily, the human perspective seems to insist upon organic integrity as the only possible norm”.

This, of course, is not completely true; many people wear insulin pumps with no problems. However, it is an attitude that describes the feelings of many of my interviewees. For my female respondents, the effect of CSII on their appearance was also an important consideration.

Myles: So why wouldn't you wear an insulin pump?

Michelle: You'd have to have it strapped to you all the time wouldn't you? Like how ugly would that look when you're going out to have your monitor thing strapped to you? I wouldn't...I'd rather do the injections.

Featherstone (1991: 71) notes that “women are trapped far more in the world of images than men”. And as I highlighted in section 5.8.1., taking care of their appearances was an important concern for my female interviewees. Entwistle (2000: 8) argues that clothes are often interpreted in moral terms, and that “what women wear can be of greater moral concern to what men wear”. She notes that having the

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Lilya was not using CSII when I talked to her, but she was using an intensive MDI regime. When I asked her what parts of her body she injected into, she said that she injected everywhere, basically, except into her stomach. When I asked her why this was so she said:

Well, the injection thing in my stomach is closer to my heart, if you know what I mean, and that's where you'd have a baby. Injecting into the centre of you.

Lilya was one of my respondents who felt most strongly that insulin pens were stigmatised devices, irrespective of *where* her injections were made. She described her pen as a “sterile device”, an “empty” technology. It was a technology that she felt in some way threatened both life, Lilya's ability to have a baby, and identity, Lilya's ability to become a mother in the future. While I did not discuss this in our interview, it seems possible that one of the drawbacks of CSII was the fact that they would be continually injecting into her stomach, something which she clearly did not want to happen.

right outfit is often so important for women that even individuals who are not particularly worried about their appearances will dress correctly in order to avoid making a negative impression. Bodies wearing inappropriate clothes are at risk of being discredited, of experiencing enacted stigma. Wearing the right clothes is therefore a critical practice. As **Figure 9** indicates (this picture was taken from a nightclub gallery for a club night at the University of Sheffield), at the time of my study the 'right' clubbing fashions for women often included short skirts and crop tops. A CSII device would be clearly visible if these kinds of clothes were worn, and would highlight that there was something wrong with the person wearing it. Interviewees felt that it would ruin their outfits, and run the risk of spoiling identity. Even Elayne, the only interviewee to actually wear a pump, was concerned at times about the effect of the pump on her appearance. However, she felt that its primary function (keeping her alive) was ultimately more important than its effect on her appearance. She accepted the annoyance of having a "big white thing clipped on a black dress" as a fair trade-off for having good blood sugar control.

As I have highlighted with Lars' and Kirk's narratives, stigma was also an important concern for some of the male interviewees (though not as much; Jason for example note that after ten years he had become so habituated to living with diabetes that he didn't care where he injected). However, the men I talked to generally disliked CSII for different reasons to the women. James and Vincent for example noted that they would not like to wear pumps because the devices would interfere with their ability to exercise successfully, and prevent them from tackling when they were playing football and getting really into the game. The effect on their appearance was less important. Lars in fact noted that he would like a pump because it would enable the management of stigma.

I mean it would be more handy just to press a button if I was in a restaurant instead of having to secretly inject under the table.





**Figure 9.** Student Clubbers. Source:

<http://www.shef.ac.uk/union/ents/juice/gallery.php>

By being able to just press a button, Lars wouldn't have to inject in public and fear social censure, or engage in spatial management strategies such as retreating to restrooms to inject. Several points can be noted here. The social and personal meanings of having a 'deviant' appearance are unequally gendered (Valentine 2001), which explains why wearing an insulin pump in and of itself wasn't experienced as a challenge to Lars' self-identity as it was for some of the female interviewees. Contemporary men's fashion, despite the influence of David Beckham, hasn't yet extended to men wearing crop tops. As such if Lars went out with his friends he could easily cover the pump with a long shirt. Stigma for Lars was connected to the practice of injecting, not wearing CSII. Furthermore, as I discussed in the previous chapter, in contrast to the other male interviewees Lars' didn't exercise that much, meaning that the pump wouldn't interfere with sporting performance. And Lars noted that he was extremely interested in science and technology. As such, he didn't



find the idea of wearing a pump scary; it was interesting. He wanted to explore the effect it would have on his body.

### **6.6. Conclusion**

In this chapter I have highlighted some of the ways in which my interviewees interacted with their management technologies of diabetes. In the first section of this chapter I discussed how my interviewees used intensive management technologies to discipline their bodies and manage the risks of diabetes. I explored how technologies increased my interviewees' flexibility, and how technologies could positively influence interviewees' attitudes and practical orientations towards the future. Balance emerged as a key theme here; it was important to my respondents that technologies be used intensively, but that they did not come to dominate them.

In the second section, I discussed the importance self-monitoring of blood glucose played in my respondents' accounts. SMBG was often used as a way of managing risk, especially in relation to some of the other forms of consumption I have discussed in previous chapters. However, SMBG was also often a practice that interviewees had problems with. I explored the theme of disruption in detail.

And in the final section of the chapter, I provided a detailed examination of the theme of stigma in relation to my interviewees' technological consumption. I highlighted the importance the visibility (or not) of technology had in interviewees' construction of identities as normal young people. I also discussed the importance both gender and the stage interviewees' were at in their university career played in respondents' attitudes towards stigma.

Several summary points can be made.

Balance was an important concept. For example, Elayne was willing to wear an insulin pump 24 hours a day, 365 days a year on the understanding that it was going to improve her control. Wearing the pump negatively impacted upon her in some ways, for example when she was socialising or wanted to go scuba diving, but overall she felt that the benefits far outweighed the cost. The insulin pump, though, enabled her to successfully study and regulate her diabetes, and she considered these



practices to be much more important than the impact CSII could have on her appearance. In contrast, the other female interviewees, at least at the time I interviewed them, weren't willing to use CSII, despite the fact it may have enabled them to achieve better control. Fear of dependence, of a liminal connection being created between body and technology and anxiety about the negative effects CSII could have on appearance were important concerns for these interviewees. The female interviewees felt that wearing a CSII device would irretrievably medicalise their identity, and negatively impact upon their ability to pass and feel as normal. They were far happier using MDI. Gender therefore was an important structure underlying how interviewees went about making and conceptualizing 'balance'. But it is also clear, as the differences between Elayne's and the accounts of the other female interviewees show, to talk about femininities, rather than femininity, when exploring how gender affects the use and conceptualization of technologies. As well as/simultaneous with, the importance of gender in interviewees technological narratives of practice, age emerged as an important category. As interviewees transitioned within university, their desires and feelings about what was best practice could change, which would lead to an entirely new set of value judgements upon which to base trade-offs and balances. In Bourdieu's terms, they were playing a slightly different game from their younger counterparts, which influenced their perception of technologies and the various costs and benefits associated with each.

The paradox of achieving freedom through control was also important. Increased scientification of the body (for example through DAFNE), and increased frequency of technological intervention into the body (for example via the use of MDI and SMBG), were associated in most interviewees' minds with liberation from diabetes. Interviewees acknowledged that the more they controlled their diabetes now, the better their long-term control would be. Achieving intensive control via the use of technologies could also, however, have negative meanings for interviewees. For example as I showed with Sylvia's narrative, injecting more than twice a day was perceived to be a threat to her identity because it positioned her as someone who was 'a diabetic'. As such, Sylvia tried to suppress the presence of her diabetes as far as possible. Not injecting in order to preserve an identity as a normal young person could also be a practice that was risky for identity, though. For example she might

not be able to go out with her friends and 'be normal' if she needed to take an injection and it was at home.

As in previous chapters, spatialities and temporalities emerged as important contextual factors in relation to how my interviewees' used and conceptualized diabetes' technologies. With regards temporalities, interviewees' were often concerned with the amount of times a day they needed to inject, how often they had to think about diabetes on a daily basis and about the future. An important reason Sylvia was so angry at her inability to test was because she felt that after four years she should have it controlled by now. Instead she was still struggling to master what she considered to be the basics of diabetes care. Spatialities were most evident in relation to my respondents' attitudes towards technological stigma. The primary method interviewees' used to regulate information about their identities and pass as normal was by injecting in private spaces so as to preserve a public image of themselves. Spatialities could also play an important part in interviewees' trade-offs. As I noted in section 4.8., Naoimh noted that before coming to university her father gave her a bracelet which had the word 'diabetic' engraved upon it. Naoimh hated this bracelet because she felt it was so ugly, and it impacted upon her ability to look good when she was out with friends. However, she wore it because it reduced some of her anxieties about what could happen if she hypoed in public and no one knew she had diabetes. She never wore the bracelet at home or on trains, though, because she felt these weren't risky spaces. In these spaces stigma became more important than risk minimization.

Relationalities proved to as important with reference to interviewees' use of technologies as they were with their food and alcohol consumption. Interviewees, especially first years, were often worried that using technologies would make them different from their peers. They often regulated their injections and their technologies according to who was around, and how they felt about these people. As I used Elayne's narrative to show parents could have a profound influence on how interviewees' interpreted the meanings of their diabetic technologies. In Elayne's case the positive aspects of her insulin pump, namely being able to discipline and regulate her body and give her control over her life, were in some respects attenuated by her mothers feelings that she should use her new ability to control herself to



control her weight. While this was something that Elayne wanted to do anyway, the fact that her mother wanted to make her lose weight made her newfound ability to control her body in some respects pyrrhic. The meanings control and technology had for respondents was therefore relationally constructed.

The final point to make concerns the importance feelings and emotions had in interviewees' technological consumption practices. In the narratives discussed until now it is clear that the ways in which interviewees managed risk and disciplined their bodies via technological consumption, and the ways in which they understood the risks of technologies, were emotionally framed. The processes of taking control of and constructing an ideal self through the use of diabetes technologies was often experienced positively. Lars in section 5.7.3. found that DAFNE was a positive system in the way it enabled him to develop a pleasurable sense of control and autonomy. While there were risks to DAFNE, these were less important than the emotional benefits; risks could be controlled. On the other hand, it was clear with regards Maria and Alice's narratives in section 6.5.2. that interviewees could also have strong, negative reactions to the risks of diabetes technologies as well. With regards Alice's feelings of disgust at having to wear a pump, gender, spatialities and relational awareness of others were important factors influencing her perceptions of CSII. She was worried that wearing a pump would irretrievably separate her from the student body, especially if she was seen to wear one in public space. Another salient example is Erin's bringing of her testing equipment with her when she went clubbing so as to minimize her anxiety that she could suffer a hypoglycaemic attack in public. Most of the other female interviewees, in contrast, left their technologies at home, so as to minimize their anxieties about appearing to be different. While the practices were different, both were used to control fear and uncertainty. Overall, these arguments support Lupton and Tulloch's (2002) arguments that it is necessary, when seeking to understand risks in particular contexts, to investigate the place emotions occupy within individuals' perceptions of risk.

In the next chapter I am going to summarise the arguments I have made throughout this thesis, and make my general conclusions. I will also highlight some of the limitations of this work, and what this suggests for potential future research.

**Conclusion**



## **7.1. Conclusion**

This thesis has examined young people's experiences of managing their diabetes in university. In it I have provided an in depth exploration of my respondents' narratives of practice in relation to three important forms of consumption: alcohol, food and technologies. I have demonstrated links between my respondents' narratives, their identities and their diabetes, connections which centre around the inter-related concepts of risk, control and balance. Overall my findings challenge the received wisdom of much medical research on young people with diabetes, young people who have been characterised as leading 'hedonistic' lifestyles and taking undue risks with little apparent concern for the future. By attending to students' own narrative accounts of living with diabetes a very different picture emerges where risks are embedded within specific social contexts. This more relational view of respondents' experience has implications for how health professionals care for young people with diabetes. In this conclusion I am going to discuss the findings of my three main results chapter and examine how they relate to my thesis aims (discussed in the Introduction). To briefly recount them here, my aims were:

- To examine how young people with type 1 diabetes negotiate different forms of consumption, especially alcohol, food and technology while they are at university.
- To examine the role spatialities and temporalities play in the consumption practices of students with type 1 diabetes.
- To explore how bodies affect perceptions of space, risk and the negotiation of practice for young people with diabetes.
- To see how my interviewees' regulation of their diabetes and consumption is influenced by their gender identities.
- To see how students with diabetes negotiate differing forms of control while they are at university, and how they reach a balance between competing imperatives.

## 7.2. Narrative Themes

Firstly, the links between consumption practices and self-identities proved to be extremely important. Being 'normal' was an important concept for all of my interviewees and 'normality' was often understood in relation to, and constructed through, consumption practice. 'Normality' was also a protean concept. For example, first year students were likely to engage in risky drinking practices in order to appear and feel like other students. In contrast, older respondents were more likely to engage in more moderate drinking practices so as to be normal (indeed, many didn't drink alcohol at all). Older and younger university students seemed to have a different 'feel for the game' (Bourdieu 1990) of university life. This difference was influenced by the dissimilar perceptions of time and space that older and younger students had of the risks of consumption; older students were more acutely conscious than their younger counterparts that they weren't going to be students forever, and so regulated their drinking (compared to first years) so that they would be 'normal' in the future. They also felt that the practices of younger students were 'abnormal'. First years were also likely to be conscious about the future, but they didn't generally want their diabetes to interfere with their performance of normal identities now, in the present. First years' anxieties about difference were articulated especially clearly in relation to alcohol consumption in the 'classic' spaces of student sociability (Chatterton 1999), such as students' union bars or student night clubs. It was in these spaces that first year students were most concerned about being part of the student body, and about the risk of being separated out from it because of their diabetes. Litva et al's (2001) argument that it is the surface body which is central to students' identities is relevant here. I would also extend their argument though so that it applies to male as well as female students. While maintaining a normal bodily surface was important for first years when they were in student spaces, when they were in other spaces where they weren't so obviously on display, the health of their inner bodies was an extremely important concern. This finding differs from Litva et al's, who found that female undergraduates without a chronic condition were rarely concerned about the inner health of their bodies. Indeed, it is important to note that when my first year respondents engaged in 'risky' drinking practices they often felt guilty afterwards, though at the time they may have been caught up in the happy haze of a drunken hour. Interviewees often experienced their drinking practices in moral terms, with



consumption practices being connected by interviewees to the construction of moral selves. This finding supports Broom and Whittaker's (2004) assertion that it is important to investigate morality when looking at how people manage their diabetes.

Secondly, interviewees' gender identities, the discourses of gender that they identified with, were also important. For example there were clear differences between male and female respondents with regards to alcopop consumption. Female students were much more likely to drink alcopops than the men. Alcopops were seen by my female respondents as something that 'girls drank'; female respondents viewed alcopop consumption as a way of performing a normal feminine identity. Alcopop consumption was also seen by female interviewees as a way of managing sexual risk when they were in public spaces, and of allowing them to manage the risk of hypoglycaemia. Female interviewees who consumed alcohops saw the drinks as a way of staying in, rather than losing, control.

Gender was implicated in interviewees' *style* of drinking practice. Kirk for example used 'excessive' consumption of alcohol to construct an identity as a normal lad, and so identify with a valued form of laddish masculinity. He resisted his diabetes by rejecting his doctor's advice, and his own feelings about what good care was. In this way he sought to construct an invulnerable self. In contrast, Sylvia, who also experienced diabetes as a disruption to her identity, tried as far as possible to regulate her alcohol consumption so that she wouldn't become hypoglycaemic in public and run the risk of other young people thinking that she was a 'tart'. In both of these interviewees' cases their practices were influenced by the broader *gendered* social discourses that they identified with. With respect to Kirk's narrative it is also important to note that other male interviewees engaged in alternative drinking practices. A significant reason why these respondents engaged in these 'alternative' practices was because they identified with different forms of masculinity to Kirk. This indicates the importance of recognizing gender as a heterogeneous, rather than homogeneous, category when investigating students' practices.

Whereas the main difference between interviewees with regards their alcohol consumption related to the stage they were at in university (leading to a first year/older student divide), the main difference with regards their disciplinary practice

was based on gender. Both male and female interviewees were concerned about being 'good' or 'bad' in relation to what and how much they ate and exercised. The female interviewees experienced more ambivalence here than their male counterparts, though. The reason for this appeared to be because male and female respondents were involved in different gendered body projects. For the male respondents, the practices upon which good diabetic control was predicated, namely working out and eating healthily, could easily be incorporated into body projects that were aimed at constructing and embodying desired forms of masculinity. The situation was more complex for female respondents. As Brumberg (1997) has noted, in contemporary Western consumer cultures, the ideal female body is a 'disappearing' body, a body where it is hardly possible (on an idealistic level) to be too thin. In diabetes, though, it is important to eat healthily, to not go too far towards the extremes, to be balanced. Consequently, the slimming body projects and the diabetic body projects of the female interviews at times contradicted each other. When their diabetes interfered with their slimming practices it was often emotionally upsetting for the female interviewees. It felt to them that their body was controlling their mind, them, when they felt that they should be controlling it. Most of the female interviewees felt that because of their diabetes, they wouldn't be able to slim in the way their friends did. They acknowledged the importance of achieving a balance between health and weight loss, even if this balance was acknowledged in a somewhat resigned way. Interviewees could use technologies to give them more control over their bodies, though, and so more successfully actualize emotionally important gendered body projects. Technologies had an important part to play in the successful reconciliation of interviewees' slimming practices with their diabetes.

**Spatialities and temporalities** also proved to be important themes in interviewees' accounts. Spatialities were implicated in the ways in which interviewees conceptualised and managed the risks of their diabetes. For example, interviewees were often worried about the risks of suffering a hypoglycaemic attack when they were out drinking in student spaces. In section 4.8. I supplied an extensive list of the practices that interviews used to regulate themselves, and interviewees' ambivalent responses to some of these practices. Interviewees rarely used technologies to manage the effects of alcohol when they were *in* student spaces, however. In section 6.5. I demonstrated that interviewees often left their management technologies at



home when they went clubbing. They felt that carrying their technologies around with them would draw unwanted attention to them and risk their identities being spoiled. Interviewees regulated themselves, made themselves 'normal' again, when they returned home from clubbing, and didn't feel the same pressure to be 'on'. While interviewees were often concerned about managing the risks of high blood sugars, in spaces of student sociability they were willing to trade-off increased risks of hyperglycaemia against the ability to better present the self as they wanted. The irony for some respondents, though, was that by *not* carrying technologies into risky spaces their risk of something like a hypoglycaemic episode developing was in some respects increased. Balancing practice was an ongoing process.

Temporalities had a similarly important place in my respondents' accounts. Interviewees' practices were rarely seen only in terms of the effect they had on interviewees in the present; they were often simultaneously viewed and experienced in terms of the effects they could have in the future, and in relation to other practices that interviewees had engaged in in the past. Time swashed back and forth in interviewees' accounts, something which challenges Wolpert and Anderson's (2001) account that young people with type 1 diabetes either don't think about the future, or perceive themselves to be invulnerable to risk. Time was implicated in both Erin and Kirk's alcohol consumption practices. Erin and Kirk both engaged in intensive alcohol consumption (as defined by themselves). Erin's alcohol consumption practices were used to distance herself from a younger self that she felt had been dominated by the management regimes of diabetes. As such her current practices were meaningful in so far as they related to her past self. In contrast, Kirk's practices, while intended to construct a powerful masculine self *now*, were experienced ambivalently because he was aware that they increased his risk of developing complications in the future. As such, they were perceived to undermine his ability to actualize a responsible masculine self in the future, a time when ideally he would act as a provider for his family. One of the interesting points about interviewees' use of technologies is that they could, by enabling interviewees to develop intensive control over their diabetes, open up the future for interviewees, allow them to colonize it (Giddens 1991), shape it towards a desired outcome, and so make respondents more hopeful and less anxious about it.

Spatialities and temporalities were linked together in respondents' accounts as routines. As I demonstrated in section 5.6.1., one of the main difficulties interviewees experienced in university was successfully routinizing their practices. While medical research has often concentrated on students with diabetes spectacular consumption practices, a focus which draws from the 'youth as trouble' model discussed in section 2.3., some of principle difficulties students' themselves identified as being important in university were more subtle and spatial. The reasons for their difficulties with routines emerged from the fluid, dynamic time-space of the university environment. Lecture timetables constantly changed, and lectures were often situated all over the campus, if not the city. As such it was often difficult to eat similar things, or eat at the same time everyday. This tended to promote snacking, which could destabilize blood sugar control. Changing routines also negatively impacted upon the successful actualization of SMBG (Self-Monitoring of Blood Glucose) regimes; as James indicated, when interviewees had difficulties testing the same amount of times everyday, they sometimes lost the motivation to test altogether. On occasions this could become a downward spiral. Some interviewees were less successful at adapting to changing spatial and temporal routines of university than others. For example, when I first met Maria she had particular difficulties with routinizing her practices in university. The reason for this appeared to be, in Giddens's (1991) terms, that her practices were based on an attempt to develop 'compulsive mastery'. This response (to intensify control in an environment where control was lacking) was understandable, but even she felt it was counter-productive. Technologies could be used to provide interviewees with the flexibility they needed and desired. DAFNE was particularly notable in this regard. It provided interviewees with the tools they needed to successfully adapt to changing spatio-temporal circumstances.

In all of these points the **relationalities** of practice were salient. Other young students, both in a material and imaginative sense, occupied an important place in respondents' accounts. My interviewees had a very clear idea of what was normal practice for students to engage in. They often regulated their own activities so they corresponded to these ideals. The student body, then, was an explicitly social body. The last thing most interviewees wanted was to appear or to feel different from other young people. As mentioned above, what being normal meant in practice often



varied. For example, for the older interviewees, being normal meant *disidentifying* with the student body. Lastly, on occasions the desire to be normal did appear to have negative implications; for example, it is hard to interpret Laura's feelings that if she didn't drink alcohol she would be a leper, or interviewees' feelings about stigma is a positive way. However, in Foucault's terms, it is possible to see these attitudes in a productive way. By engaging in information management practices so as to appear normal interviewees can be seen to be involved in an active attempt to manage and construct ideal identities.

The final point to make concerns the important place **emotions and feelings** had in interviewees' narratives. Saltonstall (1993: 7) has noted that:

“Sociological theory has tended to cast people as cognitive actors and neglecting affective and habitual actions, and for the body as more than simply a surface upon which social and cultural meanings are bestowed”.

In contrast to these approaches, my respondents often interpreted risk, control and balance in affective terms. For example interviewees were often concerned about minimizing hypoglycaemia when they were in public because of the intense fears and anxieties that they associated with this state. Indeed, in section 4.7. Lilya's narrative demonstrates that at least one of the reasons that interviewees disliked hypoing so much was because they felt that it made them uncontrollably emotional. The practices which interviewees engaged in in section 4.8. were not only used by interviewees to control their blood sugar levels, they were intended to regulate anxieties, to reassure them. With regards my female interviewees weight loss practices, described in section 5.8., it is important to note as well that the difficulties their diabetes caused them in practice often led to strong feelings of guilt, anger and frustration. It is important to note, however, the positive nature of emotionality in interviewees narratives. For example, when interviewees were successful in regulating their practices or balancing their diabetes with other concerns they often felt happy, felt good, felt pleasure. As I used Jason's narrative in section 5.7. to demonstrate, however, the pleasures of disciplinary activity, of managing risk, could themselves become risky activities if they were not controlled. As with many things in diabetes care, balance is key.

Based upon these findings, several points can be made. **Control** was an extremely important concept/feeling for my respondents, and one that, as I have shown, was influenced by spatial, relational, emotional and temporal factors. Previous studies of students with diabetes in the UK, such as Eaton et al's (2001), have argued that diabetic control often becomes unimportant for students when they go to university. This study suggests otherwise. Achieving control over their diabetes, bodies and selves was a process that interviewees were continually and actively involved in. The reasons for this have been discussed above, but were bound up with the role control had in interviewees' constructions of normal, moral identities. It is crucial to recognize, however, that students were involved in multiple body projects, each of which recommended the control and regulation of the body in a particular way. As indicated above, some of these body projects conflicted. As such, for their own emotional wellbeing, interviewees often attempted to achieve a **balance** between differing forms of control.

Two points emerge from this. The first is that it is important to situate students 'practices in relation to **broader social discourses and identity categories**. In this study the principal identity categories I have focused on have been health, age and gender. It is likely that respondents' positions within other structures (of race, class, disability etc.) also influenced their conceptions of control and their perceptions of practice, though it cannot be said in what way this was so based on my findings (more on the study's limitations will be discussed shortly). The thesis findings also suggest the importance of seeing how different identity categories intersect in interviewees' constructions and conceptualizations of practice. For example, in this study I have highlighted the simultaneous connections that existed between interviewees' ages, health and gender and their experience of practice. Interviewees did not experience different aspects of their identities independently, but simultaneously, and this had implications for their diabetic control. The second point to note is that it is important to recognize the **legitimacy of the concept of competing rationality claims** when examining students with diabetes' practices. As I discussed in detail in section 2.4., students with diabetes, and young adults with diabetes more generally, are often perceived to be a risky group, a group who engage in hazardous practices that are detrimental to their diabetes care. However, as I have



shown throughout this thesis, young people's practices, when they do conflict with what could be considered medical ideals, often make sense in context. I believe that it is important that clinicians and researchers recognize this. Control cannot be seen merely in terms of HBA1C levels, though they are important. Jason noted that after engaging in the intensive exercise practices described in section 5.7.2. he went to see his clinician. Rather than examining the reasons why Jason engaged in 'risky' exercise practices, the clinician assumed that Jason had engaged in the wrong practices.

What annoyed me more was the way the guy told me I had poor control and I tried to explain how I'd change my level of exercise and there'd been a change of routine. My routine is split when I'm at university and when I'm at home. And there was no attempt to contextualise my problem. There was no attempt to contextualise it within how I was living day to day. There was no real help. There was annoyance at that; that's what I was mainly annoyed at. Obviously I was disappointed with my HBA1C. I wanted to do better than that.

While diabetes is mainly a matter of individual self-discipline, diabetes teams and medical advice plays an important part in the management of the condition. My evidence suggests that it will be hard to improve control if both parties are having what are in effect different conversations.

### 7.3. Theoretical contributions

The broad findings of this thesis support Giddens' (1991) and Beck's (1992) work on risk, and Foucault's (1977) on discipline. However, they also extend them in several ways. Perhaps the most important of these is that, by focusing on a particular group of young people with a chronic condition, this study embodies these authors' work. A criticism of Beck and Foucault is that both authors ignore the material presence of the body in their readings of risk and discipline. This study has shown that for young students with type 1 diabetes, the body cannot be ignored. For example, when the female interviewees attempted to control their bodies through disciplinary practices, this wasn't merely a process of the will regulating an abstract, corporeal space. There was always a risk of the body becoming hypoglycaemic. The body was also implicated in interviewees' accounts of risk in relation to the pleasures of disciplinary practice. One of the reasons why Jason exercised so much was because exercise made him *feel* good; it embodied him ever more, and enabled him to

construct a powerful masculine physique based on the virtues of strength and fitness. Indeed, it was because of the pleasures of practice that Jason was willing to engage in fitness practices to the extent that his diabetes control was risked. Because exercising was so pleasureable, it was difficult for him to stop, even when his diabetic control suffered.

Beck and Giddens have also been criticized for neglecting the spatialities of risk (Furlong and Cartmel 1997). As I have highlighted throughout this thesis, and summarised here, spatialities were extremely important to my interviewees' experiences of risk.

In relation to existing medical geography research, this thesis addresses several gaps that other authors have previously identified. Firstly, it provides a sophisticated and in-depth exploration of the ways in which individuals manage and conceptualize consumption. Kearns and Barnett (2000, 1997) have noted previously that despite the importance the concept of consumption plays within cultural and social geography research, it is an undertheorized area that has not been sufficiently attended to within the sub-discipline of medical geography. Previous studies in medical geography which have addressed consumption have tended to look at how people consume places and spaces. This thesis has extended this focus by concentrating on how people consume particular objects within places. In this, it not only extends existing calls and debates within the sub-discipline, it also addresses calls in related fields such as alcohol and drug research for more work to be done on the spatialities of consumption.

The thesis has also explored the linkages between consumption, health and risk, an area that Parr (2002) and Brown and Duncan (2000) have flagged up as needing more research. I have noted previously that many of the studies completed on risk within medical geography have tended, with a few notable exceptions (section 2.2.3.) to focus on environmental risks. There have been less studies done of the body as both a risky space in itself, and how the body influences individuals' perceptions and constructions of risk in space. This is another area which has been addressed by this thesis.



This point builds on the calls to embody medical geography (Dorn and Laws 1994). The thesis has addressed some of the more recent debates on embodiment and medical geography by exploring the intersections between bodies and gender, particularly as these relate to the relationships between masculinity, health and space. These are areas which Parr (2002a), in a review of medical geography, notes that research is still lacking. Another positive aspect of the thesis is its addressing of the connections between pleasure, risk and gender.

And finally, in relation to the medical geography literature, this thesis has provided a detailed account of young people's practices based upon a narrative methodology. In this it develops several studies in the sub-discipline. It extends the relative absence of studies of young people with chronic conditions and disabilities within medical geography, and addresses Kearns and Moon's (2002: 613) argument that "in general, people- in the sense of acknowledged, autonomous, sentient beings- remain generally absent from the narratives of health geography".

The thesis has made other contributions as well, most particularly in relation to the existing geographical research on young people. Most noticeable in this regard has been its focus on the practices of 'older' young people, a group which hasn't yet been sufficiently addressed by geography (Valentine 2003). Most of the existing research on young people within geography has concentrated on children and younger adolescents. For example, Aitkens's (2001) book on the geographies of young people is, on closer inspection, actually about the geographies of children. Older young people are absent. However, the thesis does build on previous geographical work on young people in the ways it demonstrates the often spatialised nature of the identities and practices of young people. The fact that the thesis has focused on students is particularly important given that even outside geography, students' lives are under researched, and that there are currently almost one and a half million students in the UK (Chatterton 1999). Like Chatterton's work, this study provides evidence that students make multiple transitions within university, rather than just a singular one to it. The thesis also addresses the lack of studies that explore how young people manage chronic conditions within particular spaces (Gabe et al 2002). Finally, Furlong and Cartmel (1997) and Valentine (2000) note that in lay and official discourses youth is often considered to be a period when young people are

viewed as being inherent risk takers, and also have healthy bodies. In this study I have shown that the group young adults with a chronic condition that I worked with were often very much concerned about minimizing risks rather than taking them, and about the health of their bodies, which they often felt was fragile. This finding challenges the notion that adherence tends to decrease when young people move away from home (Frey et al 1997, Jacobson et al 1997, Kungas et al 2000) and that students with diabetes see their condition as just an added complication (Eaton et al 2001).

#### **7.4. Thesis limitations and avenues for future research**

I have noted at various points in this thesis that my findings are limited in several respects. Firstly, they are based on my respondents' narratives of practice: on what my interviewees said they did, rather than what they actually did. Secondly, the population that the study was based on was all white and primarily middle class. This statement, about the class of my respondents, is problematic given that I didn't systematically collect socio-economic information about my respondents. But it seemed to me that most of my respondents were middle class, based on their educational backgrounds, their accents, how they moved, talked, gestured and so on. The majority of them also studied away from home at universities in the midlands of England where a large proportion of students were middle class. They therefore appeared to fit Chatterton's (1999) description of traditional, middle-class students.

These limitations suggest potentially fruitful avenues for future research. Firstly, if another study of this sort is to be carried out, it will be important to collect ethnographic information about students with diabetes' practices. Combining this study and previous studies (discussed in section 2.4.2.), there is now an extensive body of information about the narratives of young people with diabetes. There needs to be a methodological evolution, including participant observation needs to be used. In future studies it will also be important to use multiple methodologies when investigating different groups of students (not, for example, trying to use diaries with first years).

Secondly, I believe that it is important to explore the practices of students with diabetes who aren't white. It would also, I believe, be interesting to study the



practices of students with diabetes in relation to other axes of identity besides those discussed in this study. Religion would be especially interesting here I think, both in relation to how students use it as a coping strategy, but also in terms of its material effects on students' practices. For example, many Muslim students do not drink alcohol. This being the case, these students would have a very different experience of managing diabetes in university compared to some of the traditional students that I have looked at in this study. It would also be interesting to look at students' practices in terms of class. As Sylvia's narrative indicated, interviewees' experiences of diabetes were sometimes phrased in terms of a classed vocabulary.

Finally, while this is not a clinical study, there do appear to be several clinical implications that emerge from it. The first relates to the importance of listening to patients' narratives in a non-judgemental way. Interviewees often indicated that they wished they had more time to talk about their problems with their primary health care providers. Indeed, Kleinman (1988) notes that in chronic illness the most important practice a health care professional can engage in is to bear witness to suffering, to listen.

However, the most important recommendation I could make, based on this study's findings, is to extend the DAFNE programme to all students who want to go on it, or even setting up a tailored version of the DAFNE programme for students with diabetes. This could be run from a university health service. Students are a group who seem to especially benefit from a programme such as DAFNE given that DAFNE increases flexibility and independence in diabetes care, and university often seems to be almost too flexible for students' resources.

As these concluding comments suggest, I have met each of the aims of my thesis, as set out in section 1.7. and recapitulated in this chapter. I have:

- Examined how young people with type 1 diabetes negotiate different forms of consumption, especially alcohol, food and technology while they are at university
- Examined the role spatialities and temporalities play in the consumption practices of students with type 1 diabetes.

- Explored how bodies affect perceptions of space, risk and the negotiation of practice for young people with diabetes.
- Demonstrated how my interviewees' regulation of their diabetes and consumption was influenced by their gender identities.
- Investigated how students with diabetes negotiate differing forms of control while they are at university, and how they reach a balance between competing imperatives.

Taken as a whole, I have demonstrated that, contrary to many previous representations of young people with diabetes, my respondents were intimately concerned about the risks of their practices and about controlling themselves while they were in university. By focusing on students' own narrative accounts of living with diabetes an image emerges of students conceptualizations of risk being embedded and negotiated within specific social contexts. For my respondents, diabetes and the student body were not mutually exclusive concepts, though they were ones that often had to be carefully balanced.



**Appendix: A brief history of diabetes**

People have been aware of the condition that is now referred to as type 1 diabetes for thousands of years, though understandings of what it is, and the subsequent implications these understandings have had for treatment regimes, have changed radically. MacCracken (1997) notes that ancient Hindu records made reference to a fatal and incomprehensible disease that caused an incredible thirst in people who developed it, as well as forced them to constantly urinate. These two symptoms were also associated with the wasting away of the body. The Hindu writings noted that flies, ants and other creatures were often attracted to the urine of the emaciated person because of its sweet and sugary nature. Reference is made to a similar condition in the Egyptian Ebers Papyrus dating from 1550BC, a scroll which itself draws upon a much earlier tradition of care for the body (McGrew 1985). While the ancient Egyptians and Hindus made note of a diabetes like condition, it was Apollonius of Memphis, writing in 250 BC, who was the first person to make reference to the condition *as* diabetes (McGrew 1997). Diabetes was the Greek word for siphon, or passing through, and the name was an explicit acknowledgment of the large amount of urine passed by individuals who developed diabetes. Another Greek, Arateaus of Cappadocia, writing in the 2<sup>nd</sup> century ad, noted that diabetes took both time to form and take hold of the individual, but once it had:

“the melting is rapid, the death speedy, which all in all was for the better given that diabetes is a dreadful affliction not very frequent amongst men, being a melting down of the flesh and the limbs into urine. The patients never stop making water and the flow is incessant, like the opening of aqueducts. Life is short, unpleasant and painful, thirst unquenchable, drinking excessive, and disproportionate to the large quantity of urine for yet more urine is passed. One cannot stop them from drinking or making water. If for a while they abstain from drinking, their mouths become parched and their bodies dry; the viscera seem scorched up and the patients are affected by nausea, restlessness and a burning thirst, and within a short time, they expire” (Williams and Pickup 1999: 1).

Greek physicians recommended frequent and vigorous exercise on horseback to cure diabetes, figuring that excess heat on the body's surface would serve to affect the humours of the body and ultimately bring the body back into balance.

The beginnings of modern scientific understandings of and approaches to diabetes have typically been tracked to Tomas Willis, who was the personal doctor to King Charles the 2<sup>nd</sup> (McGrew 1985). Willis noted that urine from a person who has diabetes is “wonderfully sweet as if it were imbued with honey or sugar”, and as a result of this he added the Latin word *mellitus*, or ‘honey sweet’ to the Greek diabetes to form *diabetes mellitus*, the name by which the condition is known to the present day (ibid: 92). Like the ancient Greeks, Egyptians and Hindus, Willis noted that the “diabetic pissed a great deal more than they drank” and continually suffered from a persistent thirst and a suppressed but consistent fever (ibid). Treatment around this time was centred on the haemorrhaging, drugging and burning model of medical care (ibid). In 1798 John Rollo discovered that there were high levels of sugar in the blood as well as the urine of people who had diabetes, and about 15 years later Claude Bernard linked diabetes to glycogen metabolism. Sir Edward Albert Sharpy-Schafer established that the substance necessary for metabolism of carbohydrates was created in the islets of langerhans in the pancreas (insulin shares its root (*insulia*) with the island of the *islets of langerhans*). However there was still uncertainty about the particular parts of the body diabetes was associated with. Oskar Minkowski and Joseph von Mering found this out accidentally when they tried to discover if a dog could survive, and if so for how long, without its pancreas. As it turned out the dog could survive, but it developed diabetes (McGrew 1985). The discovery and synthesis of clinically safe insulin was made in 1921 and 1922 by Banting and Best, for which they later won the Nobel prize in medicine. One of Banting's patients, Leonard Thompson, was the first person to receive this insulin. He was 14 years old and 64lbs when Banting first treated him. Injected with insulin, or what Banting's colleagues called ‘the thick brown muck’, he showed a dramatic improvement (MacCracken 1997). In fact, such was the qualitative and quantitative improvement caused by insulin to the bodies of people with diabetes that the effect was often interpreted in quasi-religious terms. Banting noted for example that one of his diabetic patients, Elizabeth Hughes, on 16<sup>th</sup> August 1922, and prior to taking insulin, was “45 lbs, height 5’... extremely emaciated, slight oedema of the ankles, skin dry



and scaly, hair brittle and thin, abdomen prominent, shoulders dropped, muscles extremely wasted, subcutaneous tissues almost completely absorbed". After starting insulin treatment Elizabeth wrote 5 weeks later wrote to her mother saying "I look entirely different everybody says, gaining every hour it seems to me in strength and weight...it is truly miraculous" (Watkins et al 1996: 5).

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