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On researching a health condition that the researcher has also experienced

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Abstract

This paper aims to explicate the particular aspects of reflexivity that arise in a research project when the researcher has personally experienced the condition that is the topic of the research. These issues are illustrated in the context of one specific study, in which the researcher was conducting qualitative research on an intervention for type 2 diabetes, when she herself had had type 1 diabetes since early childhood. The first set of issues concerns the advantages and disadvantages of the researcher's experiential knowledge of the topic. These include the possibility for greater empathy with participants, the concomitant problem of false assumed similarity, the need to bracket one's expectations, and the dilemma of whether or not to disclose one's condition to participants. The second set concerns the researcher's emotional reactions to the content of the research: becoming aware of the potential harmful consequences of one's condition, feeling a sense of connectedness with the participants, learning from their struggles, and potentially benefitting personally from conducting the research. These issues are particularly salient in qualitative research, but may also apply to quantitative approaches. They are important to examine, not only because they may affect the trustworthiness of the findings, but also because of the ethical imperative to evaluate the potential impact of the research on both the participants and the researcher.

Keywords: reflection, reflexivity, experiential knowledge, insider research, researcher disclosure

On researching a health condition that the researcher has also experienced

In qualitative research, what issues arise when a researcher is studying a health condition that the researcher has also experienced? In what ways does the researcher's having a similar condition to the participants influence the research process? What is the personal impact on the researcher of conducting research on conditions that she or he also shares? This paper attempts to address these questions by reflexively exploring one researcher's experience.

Central to qualitative research is the understanding that there is a reciprocal interaction between the knower and the known, and that the research setting is a two-way human encounter (Finlay, 2002, 2003; Gough & Madill, 2012; Josselson, 2013). Thus qualitative researchers (and arguably quantitative researchers as well) need to attend to the bidirectional influence between the researcher and the researched: how the researcher influences the participants and the findings, and how the participants and findings influence the researcher.

The key concept of the reflexivity of qualitative research addresses this notion of a bidirectional influence. The concept of reflexivity is used in various ways by various authors from different qualitative traditions (Finlay, 2002) and it is not always explicitly defined. The present paper follows Finlay (2003), regarding reflexivity as "the project of examining how the researcher and intersubjective elements impact on and transform research" (Finlay, 2003, p.4) or, as Schwandt (2015) defines it, "[reflexivity] can point to the fact that the inquirer is part of the social setting, context, and social phenomenon that he or she seeks to understand" (Schwandt, 2015, p.268). In this study, we worked within a phenomenological approach, in which the goal of research is to understand the participants' individual life-worlds; reflexivity can both help and hinder that process of understanding, which has implications for the richness and trustworthiness

of the findings. Furthermore, we were concerned with how reflexivity impacts upon the researcher, and the personal and ethical issues that this may give rise to.

Although some authors (e.g., Alvesson & Sköldberg, 2000) use the terms reflection and reflexivity almost synonymously, there is a useful distinction to be made between them. Reflection, as we are using it here, refers to sustained self-exploration of one's own role in the research. Such self-reflection is a necessary part of reflexivity, but the concept of reflexivity is much broader and more far-reaching, in that there is a critical, self-aware evaluation of the impact of the researcher on the research and vice versa (Etherington, 2004; Finlay, 2002, 2003; McLeod, 2011). It is useful to distinguish between *personal reflexivity*, concerning the researcher's own thoughts, feelings, values, experiences, etc., and *epistemological reflexivity*, concerning the research question and methods (Willig, 2013). It is the personal aspect of reflexivity that we are concerned with in this paper.

Issues of reflexivity become even more acute in the particular situation that we are addressing here, where the researcher has experienced the same condition that is the topic of the study in question. Barker, Pistrang, and Elliott (2016), advising researchers about how to select their research topic area, briefly touch on one of the central issues of insider research:

Sometimes researchers are drawn to topics that touch them personally, as with someone who has experienced anorexia doing research on eating disorders. There are pros and cons to this. The advantage of researching an issue in which you are personally involved is that it gives you the benefit of *experiential knowledge* (Borkman, 1990) that an outside researcher cannot possess. However, there is a danger that your own experiences may lead you to overidentify with the participants. If you are going to conduct research on a topic that is close to home, it is important to have some emotional distance in order to

attain the necessary critical detachment. If you're in the middle of a divorce, you probably want to avoid doing research on marital satisfaction. (Barker et al., 2016, p.31). These issues of striking the balance between detachment and involvement, and between empathy and over-identification, prefigure many of the dilemmas discussed in the present paper.

Borkman's (1990) concept of *experiential knowledge* was coined in the context of her research on self-help groups, to denote the knowledge that members of such groups – often described as "experts by experience" – have gained through living with their conditions and interacting with the health care system. It contrasts with the professional knowledge possessed by healthcare professionals, which is derived from instruction and professional practice. In the healthcare context, both professional and experiential knowledge have their characteristic strengths and weakness (Borkman, 1990). In the research context, the analogous terms of outsider (professional) and insider (experiential) knowledge are often used.

Numerous authors have picked up these themes of engaging in insider research. One example of the researcher belonging to the population studied is Bolger's (1999) qualitative study of what constitutes emotional pain. Participants were members of a therapy group for the adult children of alcoholics, and the researcher herself was an adult child of an alcoholic. Bolger describes how she attended all sessions of the therapy group, and disclosed her condition in the course of the research, and how so doing helped build rapport with the group members whom she was interviewing. However, she also established credibility checks with an independent research collaborator, in order to ensure that her interpretations were not overly biased by her own experiences, thereby increasing the trustworthiness of her findings.

In a second example, Tillmann-Healy and Kiesinger (2001) give an extended account of a dyadic auto-ethnographic study of disordered eating. The two researchers, who had both

struggled with bulimia, interviewed each other in depth, over several months, about their separate experiences. Throughout the evolving interview process, each of them read and reacted to the other's narrative account. Their report raises complex issues, which they reflexively explore, about mutual disclosure, mutual trust, and ethics in terms of the emotional impact of research on both interviewee and interviewer.

A third example is Berger's (2015) study of the experience of immigrants to the USA when she herself was one such (we are not of course that implying that immigration is a problematic condition per se, in the way that bulimia is). Berger gives an insightful account of the advantages and disadvantages of positioning herself as an insider rather than an outsider. She succinctly lists the main advantages of the insider position as "easier entrée, a head start in knowing about the topic, and understanding nuanced reactions of participants" (Berger, 2015, p.223), and the disadvantages as "risks of blurring boundaries; imposing own values, beliefs, and perceptions by a researcher; projection of biases" (p.224).

The present paper aims to further explore the role of the researcher's experiential knowledge in the context of one specific study in the field of clinical health psychology (Hofmann, Dack, Barker, & Murray, 2016), which aimed to evaluate the impact of using a newly developed internet-based UK self-management intervention called HeLP-Diabetes on the psychological well-being of adults with type 2 diabetes. Users could obtain online information and advice about a broad range of topics, such as diet, exercise, and emotion management. The study used a mixed-methods approach, with qualitative and quantitative components; its qualitative arm – the focus here – used semi-structured interviews with 19 participants, conducted both before the intervention began and six weeks later. The study used a qualitative,

phenomenologically-oriented thematic analysis approach (Braun & Clarke, 2005) to examine the expectations, benefits, and barriers of using the HeLP-Diabetes website.

The researcher herself, the first author of the present paper, has lived with type 1 diabetes since early childhood. This paper reflects on her experience of conducting the study, in order to explicate some issues and dilemmas that may arise when a researcher is researching a condition similar to one that she or he also experiences. The central question is: What role does the researcher's own experiential knowledge of the research topic play in the research process?

A note on pronoun usage: The more conceptual parts of the paper – this introduction, and the discussion – were written by both authors (researcher and supervisor) and use the first person plural pronoun ("we") or an impersonal voice. The experiential part of the paper, in the following sections, was principally drafted by the first author using her voice and perspective and employs the first person singular pronoun ("I"). We hope that this transition of voices will not jar; the movement backwards and forwards from a more detached to a more personal viewpoint in many ways characterizes the theme of the paper and embodies the reflexive process.

Authors' Backgrounds

I am a White British woman in my thirties, currently working as a clinical health psychologist in the United Kingdom (UK). The research in question was conducted as the thesis for my doctorate in clinical psychology (Cockburn, 2014). The study was jointly supervised by my co-author, in collaboration with two other colleagues.

I was diagnosed with type 1 diabetes in 1990, at the age of six. Since then, there have been many significant advances in understanding diabetes and providing care (Nyenwe, Jerkins, Umpierrez, & Kitabchi, 2011). For example, my own self-management regime has advanced

from using insulin vials with hypodermic needles, to using pre-loaded insulin 'pens', to wearing a continuous subcutaneous insulin infusion pump. These advances have certainly made aspects of the physical management of diabetes easier. However, an area which I have long felt to be less advanced in diabetes care is the provision of psychological or emotional support, and I therefore welcomed the opportunity to conduct research aimed at improving provision in this area. I also welcomed the opportunity to carry out the qualitative component of this study as a way of gaining a deeper understanding of the emotional support needs of my fellow diabetes patients. My general approach to qualitative research is best characterized as constructivist.

My co-author's personal background is as follows: "I'm a White British male professor of clinical psychology, in my sixties. My main research area is on psychological helping and support generally, but I have also published on research methodology, particularly on methodological pluralism (e.g., Barker & Pistrang, 2005). My approach to qualitative research draws from several sources, but I work principally within a humanistic-phenomenological standpoint, having been influenced by Rogers' (1975) ideas of the centrality of empathy in human relationships. My epistemological position is best described as critical realist. I do not have diabetes myself, and, prior to this study, had not had much personal contact with anyone with diabetes."

Researcher's Experience

Conducting this study brought to the fore several personal and methodological issues raised by my researching a condition (type 2 diabetes) that was very similar to the one I lived with (type 1 diabetes). These are divided into two overarching domains – 'Experiential Knowledge' and 'Emotional Reaction'– each containing a number of different themes (see Table 1 for an overview).

Domain 1: Experiential Knowledge

  1.1 Participant can speak more freely with less need for clarification. Having experiential knowledge of a research topic can offer both advantages and disadvantages to the research process (Berger, 2015). One advantage of my knowledge of diabetes was that it gave me a good understanding of the self-management challenges described by the participants. This meant that I rarely needed to interrupt them for clarification, and my impression was that they could speak freely during the interviews, with less need to elaborate.

  1.2 Empathizing by drawing on experiential knowledge. My experiences of living with type 1 diabetes better enabled me to empathize with the participants. I could relate to many of the difficulties they described in relation to their condition, including emotional responses to the challenges of diabetes self-management: in one participant's words "… I'm not a depressing type of person, but it can make you feel down sometimes." Given the complexity and high level of personal demand involved in diabetes self-management, it may be a particularly challenging condition to understand without personal experience.

  1.3 Less judgmental of participant compromises to cope with condition. Feeling misunderstood was a theme that was included in the findings of the study, where the participants described having to balance their diabetes self-management with wanting to lead a normal life. Whilst family, friends, and medical professionals may view a person with diabetes as not doing everything they can to look after themselves, another perspective could be that they are doing all they can whilst maintaining their quality of life. Having been through a similar balancing act myself, I was able to empathize with the difficult nature of this dilemma and be accepting of participants' life choices, rather than negatively judging any inabilities of participants to meet the demands of their self-management regime. As another participant expressed it: "That's part of

wanting to feel as normal as possible and to feel as normal as possible could involve a degree of pushing to one side what actually one needs to do to remain stable and to manage one's condition."

1.4 Danger of false assumed similarity. A disadvantage of my experiential knowledge was the risk of "false assumed similarity" (a term coined by G. Goodman, personal communication, 1975) with the participants, i.e. wrongly believing that we had more in common than we actually did. Despite being aware of the great variations in how people can experience their diabetes and self-management, my personal knowledge of diabetes placed me in a position where I might have over-identified or over-empathized with the participants. This issue was managed through reflecting on and bracketing my assumptions throughout my research and in dialogue with my supervisors, in order to remain mindful of potential differences from the participants.

1.5 Need to bracket assumptions. A researcher's prior assumptions and beliefs will inevitably shape the interpretations and meanings that are formed (Fischer, 2009; Willig, 2013). Through self-reflection, often aided by interaction with colleagues or supervisors, researchers can gain greater awareness of their preconceptions about the research topic. They can then attempt to 'bracket' them or set them to one side (Ahern, 1999; Fischer, 2009; Gearing, 2004). Bracketing is central to the phenomenological tradition, from Husserl onwards (Finlay, 2008; Gearing, 2004). Husserl's original concept arose as part of what he called "phenomenological reduction", which involves radical self-meditative processes to reduce (temporarily) the field which commands one's attention, in order to better see the phenomenon in its essence. In practice, it means holding previous knowledge in brackets though still in awareness (Ahern, 1999; Fischer, 2009; Gearing, 2004). It is not just accomplished at the outset of the research:

bracketing is a continuing process that occurs throughout the data collection and analysis, involving the researcher interrogating their own taken-for-granted assumptions behind the questions they ask in an interview, and the interpretations they make from the material. Instead of being a process engaged to eliminate researcher subjectivity, it involves a reflexive concentrated focus on both that subjectivity and the phenomenon being researched (Finlay, 2008).

During the study process, I used discussion with my supervisors to reflect on and bracket my own assumptions about diabetes. I needed to recognize the possibility of divergence of experience as well as commonality. For example, one such assumption was that most participants would have experienced or would currently be experiencing some level of emotional distress with regards to their diabetes. This belief was based on my own experiences, the experiences of friends with diabetes who had reported feeling similarly, and my reading of studies of the impact of health conditions. By bringing this view into my awareness through discussion at the outset of the research and following each interview, I could attempt to bracket it and remain open-minded to other possibilities, e.g. that the emotional impact of living with diabetes may be positive as well as negative. This process of reflection was made easier by my supervisor's outsider status, which allowed him to question my possible taken-for-granted understandings, enabling me to step back and examine them.

Another salient personal characteristic that was aided by bracketing was that I was a trainee clinical psychologist when I carried out the study. During the interviews, it was necessary to reflect upon the distinction between my role as a researcher versus my role as a clinical psychologist (cf. Colbourne, & Sque, 2004; Josselson, 2013). I was conscious of my tendency to want to intervene, in order to help people gain greater understanding of their difficulties and to

challenge unhelpful cognitions and patterns of behavior. I was also aware of hypotheses that formed in my mind about the possibility that some patients might avoid expressing or being in touch with difficult emotions about their diabetes. This again seemed to relate to my preconceptions about the emotional experience of people with diabetes. I recognized the value of stepping away from being a psychologist and reinforcing my researcher role geared to witnessing their experience rather than attempting to effect change.

To bracket my role as a trainee clinical psychologist, I tried to listen and reflect without offering interpretation or suggestions. My semi-structured interview approach allowed me to be flexible and move on to another question if I felt that we were getting to a point where I might be tempted to intervene. However, for two participants, speaking about their diabetes opened up some challenging emotional material which was not entirely relevant to the study but which they felt compelled to share with me. In these moments I felt that the researcher and trainee clinical psychologist roles were conflicted. Rather than moving to the next question, I tried to find a compromise of allowing participants to off-load a little before steering them back to the topic. I also recommended to these participants that they speak to their family doctor about opportunities for counseling. This way of handling the situation also had an ethical dimension of respecting and safeguarding the participants. It also seemed to aid the rapport and trust that I was able to establish with them.

1.6 Dilemma of whether to self-disclose own condition. The most difficult role to bracket was that of being a fellow diabetic. As well as attempting to set aside any false assumed similarities, I also had to restrain my temptation to offer practical advice about difficulties described by the participants that I too had experienced (e.g. managing blood glucose levels in social situations). In anticipation of this, I made the decision prior to the interviews that I would

not disclose my diabetes to the participants. Not only did this help me to gain some emotional distance, but I felt that disclosure would have interfered with the interview process and possibly the themes that the participants felt willing to talk about. It might, for example, have engendered social comparison processes, where participants might have imagined me as being a 'better diabetic' than they were. It might also have resulted in my feeling drawn in to offering advice or suggestions. Instead of offering advice, if there was a specific aspect of their diabetes self-management that they were finding difficult, I would direct participants to a relevant section on the HeLP-Diabetes website or advise them to speak to their family doctor.

Domain 2: Emotional Reaction

　　2.1 Knowing more about negative consequences of own condition may be disturbing. A possible disadvantage of having experiential knowledge of the research area was my potential emotional reactions to the study. When deciding whether to undertake this piece of research, one major consideration was that the subject matter might be too close to home. I contemplated whether being continually exposed to information regarding difficulties associated with diabetes, especially health complications, might be disturbing.

　　Undertaking this research had a considerable impact on my own conceptualization of diabetes. From my initial reading of the diabetes literature, I realized how little I knew about the potential serious consequences of poor glycemic control. Reading the facts about long term health complications and reduced life expectancy did cause some initial shock. In my history of diabetes care, health professionals had always spoken of the 'risk of complications' as a way of highlighting the importance of good diabetes self-management. The finer details of such complications were not, however, discussed, presumably to prevent generating too much anxiety or psychological distress. This meant that on starting this study, I was exposed to new

information that caused me concern. I dealt with this by thinking further about how I might improve my own self-management.

2.2 Anger at deficiencies in participants' healthcare. I found the interviews and interactions with participants to be enjoyable but also sobering and evocative. I was moved by the manner in which they coped with their diabetes and the daily challenges it presented them with. I also felt, and communicated to the participants, anger that more wasn't being done to support these individuals with their diabetes-related distress, but I needed to take care at this point not to impose my own anger onto participants, and to stay open to their experience.

Participants acknowledged the overloaded nature of the National Health Service in the United Kingdom and the limited time and resources it could offer to the ever growing number of people with type 2 diabetes. Most also spoke in a complimentary manner of the nurse or family doctor who conducted their annual diabetes reviews. However, my overall sense was that they were largely fighting the diabetes battle alone, and often felt that they were losing. I believe that this created emotional challenges that they predominantly dealt with by downplaying their diabetes, at a detriment to their health.

This was one point where my own experiences differed from my participants', in that UK services for people with type 1 diabetes are generally better than those for people with type 2 diabetes, and over the years I have been offered appointments with a diabetes consultant every 3 to 6 months. In hearing about the limited care offered to the participants, I felt grateful for the level of support I received in comparison. I also felt some guilt about receiving better care than them and thought that they deserved better.

2.3 Sense of connectedness with participants (but also feelings of difference when conditions do not correspond). One of the benefits of HeLP-Diabetes described by participants

was the sense of social support and connectedness with other people with type 2 diabetes. This benefit is commonly reported in the mutual support group literature (e.g. Borkman, 1999; Yalom & Leszcz, 2005). My experience of the research process also reflected this. By meeting people with diabetes my own struggles with diabetes were normalized and thereby became easier to manage. However, I was also mindful that my experience of living with type 1 diabetes differed in some significant ways from their experiences of type 2 diabetes. One factor that differentiates type 2 diabetes is that it is often caused by lifestyle and obesity. The participants spoke of a sense of self-blame and guilt associated with this, which I could understand, but had not personally experienced. Also, as type 2 diabetes is most frequently controlled with oral medication, many of the participants spoke of their strong fear of having to start insulin injections – which I have been using since the age of six. Despite these differences, I strongly empathized with the participants, without, I hope, over-identifying with them. My clinical training enabled me to separate my own and my participants' experiences while still attempting to enter deeply into their worlds. I appreciated the need to maintain my personal and professional boundaries.

2.5 Brings own condition into awareness. One personal consequence of this research process was that it brought my own diabetes to the forefront of my consciousness. In common with several of the participants, I have also tended in the past to push my diabetes to one side in trying to keep up with the demands of the rest of my life. However, learning more about complications and meeting with other people with diabetes provided me with the motivation to address my own self-management. I have subsequently managed to achieve much tighter control of my blood sugar levels and am currently healthier than I have been in a very long time.

Discussion

This researcher's account highlights several issues about the interplay between researcher and participant subjectivities and the reflexive impact of the research on the researcher. We will discuss three central ones: the challenge of insider research, researcher self-disclosure, and the emotional risks to researchers. We will also consider the researcher-supervisor relationship and the overall contribution of this research.

Although under some circumstances a researcher's beliefs or emotions may negatively impact the research process, perhaps even biasing the findings, the present account shows that they can also add insight and value to a study (Etherington, 2004; Finlay 2003; Gilbert, 2001b, Gough & Madill, 2012; McGrath & Johnson, 2003). Although the concept of bias can be understood in realist terms as a problematic deviation from truth, in our phenomenologically-oriented study we were committed to exploring rather than eliminating (inter-)subjectivity: our concern was to represent our participants' varied experiences as faithfully as possible.

In the study in question, the researcher's experiential knowledge of the research topic had both advantages and disadvantages, similar to those described by Berger (2015). The major advantage was greatly increased empathy with participants' experiences, and increased acceptance of the life compromises that they had made. On the other hand, there was an ever-present danger of false assumed similarity – of inaccurately believing that the participants' experiences were similar to the researcher's. As many commentators have noted (e.g. Hammersley, 1993), there are no overwhelming advantages to being either an insider or outside. The advantages and disadvantages take on different weights depending on the particular contexts and type of research involved. These are the questions that need to be reflexively explored.

Navigating the line between empathy and over-identification remains a challenge. The risk of over-identification can, in part, be mitigated by a process of bracketing (Ahern, 1999;

Fischer, 2009; Gearing, 2004), but it does presuppose that the researcher has deeply reflected upon the issues arising out of the research.

One key dilemma for researchers is whether to disclose to participants that they also share a similar condition. The advantages of self-disclosure are that it increases the rapport between researcher and participant, enables the researcher to feel more authentic in the encounter, and leads to a more egalitarian relationship between researcher and participant (Josselson, 2013). Galvin (2005) recognized how her disability allowed her to look upon her research dialogues as a "space in which to share our stories and to reflect on the various ways in which disability had affected our identities" (pp.395-396).

The disadvantage of self-disclosure is that it may influence the participant's narrative, as the participant will present themselves differently to someone who shares part of their experience (although this may not be problematic). It may also reduce the participant's feeling that their experience is unique (Josselson, 2013). If the researcher is disclosing a socially undesirable aspect of their life, such as a mental health condition, it may possibly also result in a diminution of the researcher's standing in the participant's (or the wider community's) view. Reinharz (1992, p.34) notes that "researchers who self-disclose are reformulating the researcher's role in a way that maximizes engagement of the self but also increases the researcher's vulnerability to criticism, both for what is revealed and for the very act of self-disclosure."

Ultimately whether or not to disclose is an individual decision for each researcher to make. The key point being made here is the need to reflexively interrogate the relational and ethical implications of whatever decision is made.

A further set of issues concerns the researcher's own emotional response to the research material. In health research, this partly involves learning more about the negative consequences

of one's own condition, which may be unsettling, or even alarming. In the mental health field, when studying topics linked to trauma, there may also be a risk of re-traumatizating the researcher. These processes raise ethical concerns about the potential impact of research on the researcher (as well as on the participants). We recommend that, before committing to carrying out a project, researchers ask themselves whether the content is likely to be too distressing or disturbing. We also recommend that senior investigators be wary of allowing their more junior research team members to undertake such projects without thorough discussion of potential consequences (Gilbert, 2001a). Further, supervisors need to monitor any potential over-investment by the researcher in the research. As Etherington (2004) states, "ethical principles of 'non-malificence' apply to researchers as well as participants."

On the other hand, there may be positive aspects of the researcher's emotional reaction to the research, and researchers may personally benefit from carrying out the study (Etherington, 2004; Stiles, 1993). One may feel a sense of connection to the participants, and learn from their struggles, for instance, about how better to cope with one's own condition. In the present study, the researcher's own awareness and diabetes self-care improved as a result of her involvement.

One feature of the present research was that the qualitative study was conducted as part of a mixed-methods investigation. Furthermore, each of us would describe our epistemological orientation using somewhat different terms: the first author as constructivist, the second as critical realist. However, we were both comfortable locating ourselves between what Lincoln, Lynham, & Guba (2011) label the post-positivist and constructivist positions. Any epistemological tensions might also have been mitigated (or at least perceived as minimal) because of the second author's methodological pluralistic stance (Barker & Pistrang, 2005), which argues that the demarcations between different epistemological positions may not be as

distinct as they are sometimes painted. Even researchers who might be traditionally seen as holding a realist position are often more reflexive than they might initially appear. As the cognitive scientist Steven Pinker (2014) has remarked in a totally different context "Even scientists ... are a *bit* post-modern. We recognize that ... the world doesn't just reveal itself to us, that we understand the world through our theories and constructs, and that our ways of understanding the world must be constantly scrutinized for hidden biases" (Pinker, 2014, p.37).

The major limitation of the present paper is that it is based on one particular piece of research, which is clearly an insufficient basis from which to draw general conclusions. The extent to which research on other conditions would generate other issues is unclear. It is likely that socially stigmatized conditions might generate additional issues, or increase the valence of some of the issues that we have discussed.

We hope that this account has delineated some of the central concerns, and put on record the account, of one particular case that may resonate with the experiences of other researchers. This paper has aimed to contribute to the already extensive literature around insider research and reflexivity. It would be useful to build a corpus of researchers' accounts of studying a health condition that they share, which could then be subjected to a meta-synthesis (Pope, Mays, & Popay, 2007; Timulak, 2009), in order to draw out common themes. Although issues arising from doing insider research are particularly salient in qualitative research, several of them – particularly those concerning the researcher's emotional reaction – may also apply to quantitative approaches.

To close once more on a personal note, it is worth re-iterating that the transformative impact of the research process on the researcher's own diabetes self-management, and her views on diabetes care in general, was considerable. An unanticipated and fortuitous reflexive aspect of

conducting this research was that it was personally therapeutic for the researcher (cf.,

Etherington, 2004; Stiles, 1993). How much this is generally the case would make a valuable

future study. Whilst issues arising from researching a health condition very similar to one's own

can offer both disadvantages and advantages to the research process, on balance, from a personal

perspective, this research proved a beneficial experience.

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Table 1

Issues Arising in Researching a Similar Health Condition

Domain	Issue
1. Experiential knowledge	1.1 Participant can speak more freely with less need for clarification
	1.2 Empathizing by drawing on experiential knowledge
	1.3 Less judgmental of participant compromises to cope with condition
	1.4 Danger of false assumed similarity
	1.5 Need to bracket assumptions
	1.6 Dilemma of whether to self-disclose own condition
2. Emotional reaction	2.1 Knowing more about negative consequences of own condition may be disturbing
	2.2 Anger at deficiencies in participants' healthcare
	2.3 Sense of connectedness with participants (but also feelings of difference when conditions do not correspond)
	2.4 Brings own condition into awareness