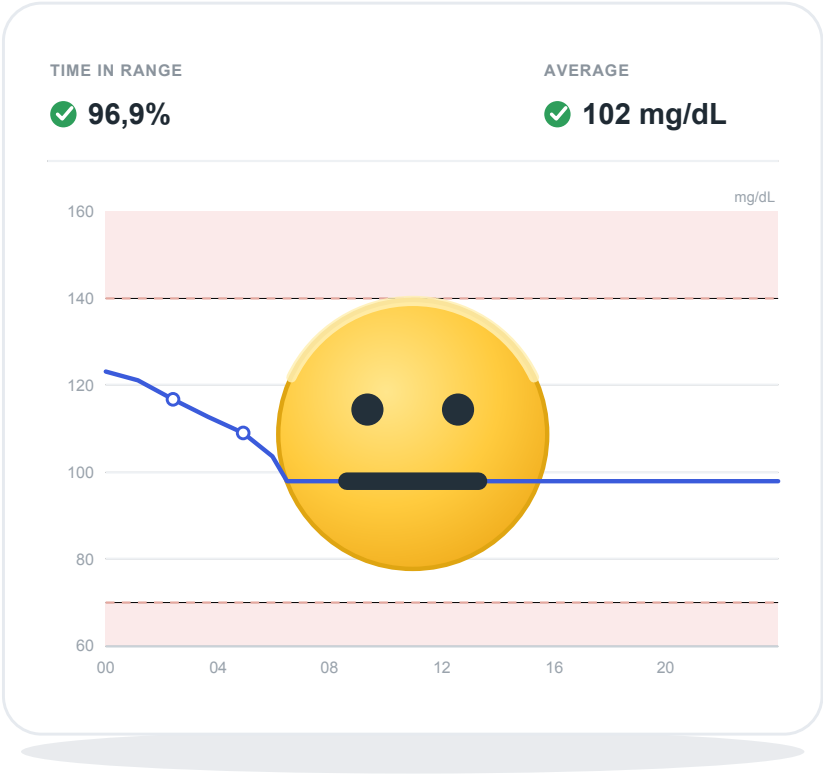
BEYOND THE NUMBERS

Understanding the Mental Health Needs of Teens & Young Adults Living with Diabetes



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This book is intended for general educational and informational purposes only. It is not a substitute for professional medical, psychological, or psychiatric advice, diagnosis, or treatment. Always seek the guidance of your child's diabetes care team and a qualified mental-health professional regarding any questions or concerns. If your child may be in danger of self-harm, seek emergency help immediately.

The case narratives in this book are illustrative. Names and identifying details have been changed, and some cases are composites or fictionalized, to protect the privacy of the individuals and families involved. Any resemblance to specific persons is coincidental.

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Introduction — A Note to Parents

If your teenager or young-adult child lives with diabetes, you have almost certainly learned to think in numbers. Blood glucose readings. Grams of carbohydrate. Units of insulin. Time in range. And, hovering over all of it, the hemoglobin A1c — the quarterly lab value that summarizes roughly ninety days of blood sugar into a single percentage. You have probably watched that number rise and fall, felt your stomach tighten before an endocrinology appointment, and celebrated or worried depending on where it landed. This is not a failing on your part. It is exactly what the medical system has trained families to do.

Diabetes care has, for decades, been organized around biomedical markers, medications, and the pursuit of tighter glycemic control (American Diabetes Association [ADA], 2024). The A1c became the central measure of success because it is objective, reproducible, and strongly linked to the risk of long-term physical complications. It genuinely matters. But here is the quiet truth that this book is written to make loud: the A1c tells you how your child's *body* is coping. It says almost nothing about how your child — the whole person, with a mind, an identity, friendships, fears, and a future — is coping. As one guiding principle of modern behavioral diabetes care puts it: “The A1c tells us how the body is coping; psychotherapy helps us understand how the person is coping.”

When care narrows to the number alone — a kind of tunnel vision, or *myopic focus*, on glycemic control — something important slips out of view. Diabetes is not only a metabolic condition. It is a chronic psychological load — one that presses on how a young person sees themselves, how they relate to the people around them, what drives them, how much they value themselves, and how the whole family functions day to day. A child can have an excellent A1c and be quietly

drowning. A child can have a stubborn, “bad” A1c not because they are careless, but because they are anxious, exhausted, depressed, traumatized by a past emergency, struggling with an eating disorder, or wrestling with attention difficulties that make daily management genuinely hard. When we treat the number as the whole story, we can miss all of that — and sometimes we make it worse by responding with pressure and disappointment when what the child needed was understanding and support.

The one idea to carry through this book

A good A1c does not guarantee a well child, and a difficult A1c does not mean a careless one. Blood sugar is a window into the body. It is not a window into the mind. Both need attention, and the two are deeply connected — mental-health struggles very often show up first as “numbers that won't cooperate.”

This book is for you — the parent or caregiver of a teen or young adult with diabetes, most often Type 1, though much of what follows applies to Type 2 as well. It is not a manual for managing insulin; your child's medical team handles that. Instead, it is a guide to the emotional and psychological side of the illness: how to recognize when your child's struggle is about more than blood sugar, what specific mental-health concerns are most common in young people with diabetes, and how the right kind of mental-health care can genuinely help. The goal is not to alarm you. Most young people with diabetes grow into healthy, capable adults. The goal is to give you a wider lens, so that if your child is one of the many who also carries an emotional burden, you will see it early and know what to do.

Each chapter opens with a story from clinical practice — a young person or family whose experience puts a human face on the concern that follows — and then turns to what the research shows and, most importantly, what helps. The six chapters walk through the areas

behavioral-health specialists in diabetes now consider essential: diabetic distress, identity and meaning, trauma after a medical crisis, attention and executive function, disordered eating and diabulimia, and the strain diabetes places on the whole family.

Each chapter ends with reading recommendations for further study. Some suggestions are diabetes specific, while other purposely are not.

Throughout, one theme returns again and again: psychotherapy and behavioral-health care are not luxuries layered on top of “real” diabetes treatment. For a great many young people, they *are* part of the treatment. Your child's endocrinologist keeps the body running. But whether your child is merely surviving diabetes or actually *living* well alongside it is a question that good mental-health care is often best equipped to answer.

Diabetic Distress: Exhaustion Is Not the Same as Depression

A Story from Practice

The referral said depression. Ava's pediatrician had noticed it first — the flatness, the irritability, the sense that a once-bright seventeen-year-old had gone somewhere dim — and had started her on an antidepressant about six weeks before she came to me. It had not helped. That, as much as anything, was why she was now in my office: the medication that was supposed to lift her had done nothing, and the adults around her had run out of ideas. I have learned to grow curious when an antidepressant "doesn't work," because sometimes it means we have named the wrong problem. Ava was diagnosed with Type 1 diabetes at nine. She is seventeen now — eight years of it, nearly all of her remembered life. On paper she is the kind of patient a care team loves: she wears her pump, she checks, she counts, she tries. Her A1c was marginally respectable. And that, it turned out, was part of the agony. Because Ava was doing everything right, and it still wasn't enough, and no one seemed to grasp why that was quietly breaking her.

When I asked how she'd been feeling, she gave me the word everyone else had given her. "Depressed, I guess." But as we talked, the shape of it did not quite fit. She still loved her friends and lit up talking about them. She still cared about her art, her music, her plans for after graduation. She was not joyless across her whole life. The flatness, the dread, the bone-tiredness — all of it clustered around one thing. Around diabetes. When I asked her to tell me not about depression but about what carrying diabetes every day was actually like, the dam broke.

“I never get a day off,” she said. And then it poured out — the sheer relentlessness of it. Every meal a calculation. A slice of pizza at a friend's house turned into a math problem about carbohydrates and fat and timing while everyone around her simply ate. The alarm going off at three in the morning, again. The arithmetic that never stops running in the background — at a party, during an exam, in the middle of trying to be a normal teenager for one single hour. “I'm so tired of thinking about it,” she said. “And I can never stop thinking about it.”

But the thing that had truly ground her down was subtler, and crueler. “I can do everything perfect,” she told me, “and still get a terrible number. So what's even the point?” This is the particular torment of diabetes that outsiders miss entirely. A sleepover, a growth spurt, a stressful week, a hot day, her period, a bad night's sleep — any of them can send her glucose somewhere she never chose, no matter how flawlessly she plays her part. She is held responsible for an outcome she cannot fully control. Imagine studying hard for every exam and still receiving grades pulled at random from a hat — and then being told the grades are your fault. That contradiction, lived out every day for eight years, does not produce a chemical mood disorder. It produces a specific, grinding kind of helplessness.

Why it isn't depression — or isn't only depression

What Ava was describing has a name, and it is not depression. It is diabetic distress — the emotional weight of the never-ending demands of a chronic illness, distinct from both ordinary burnout and clinical depression. It is not a character flaw and it is not a mood disorder. It is the natural, expected human response to a disease that never takes a day off, and it is common: something on the order of a third of adolescents with Type 1 carry it at clinically significant levels

(ADA, 2024). It showed up in Ava exactly as the literature describes it — decision fatigue, resentment toward the disease, guilt over numbers she could not command, and exhaustion from a vigilance that has no off switch.

This is where Ava's care had quietly gone wrong. Her flatness and fatigue looked so much like depression that the response was a mood medication — a reasonable first guess, and one that may help when depression is truly the driver. But Ava's suffering was not, at its root, a problem of brain chemistry. It was the crushing weight of an illness-management burden, and no antidepressant can lift a weight; at best it can help a person carry one. Handing her a pill for the tiredness of an impossible job was never going to make the job smaller. That is not a failure of the medication. It is a failure of the diagnosis. I hold this carefully — depression and diabetic distress can and do coexist, and where real depression is present, treating it matters — but unless the distress is recognized as its own thing, we go on treating the wrong problem.

What Ava actually needed

The most powerful moment of our first session was not a technique. It was a question. I did not ask Ava whether she was depressed; she had been asked that a dozen times. I asked her how exhausted she was from carrying this every single day. She began to cry — not from sadness, she said, but from relief. Someone had finally named the real thing. Diabetic distress does not respond to symptom-chasing. It responds, first, to being genuinely heard: to validation, to having the exhaustion acknowledged as real and reasonable rather than recast as an attitude or a deficiency.

From there, the work becomes practical. Not “try harder” — the cruelest words you can hand an already-exhausted teenager — but the opposite: finding the parts of management that drain her most

and deliberately lightening them. Together we will look at what can be automated, simplified, or handed off. And I will bring her parents in, because some of the most healing changes cost nothing. They can name the distress out loud instead of pushing against it. They can take over the invisible labor so it does not all fall on their daughter. And they can learn to separate their reaction to her numbers from their relationship with her, so that a high reading becomes a problem to solve together rather than a verdict on her worth.

Ava did not come to me broken by a mood disorder. She came to me worn down by an illness that asks more of her, every hour, than most adults are asked in a week — and by the slow accumulation of being told, in a hundred small ways, that her exhaustion was a symptom to be medicated or a weakness to be overcome. It is neither. It is the reasonable cost of doing something extraordinarily hard, without rest, for years. The work ahead is not to make Ava feel better about diabetes. It is to help her, at last, put some of that weight down.

One of the most important advances in diabetes psychology over the past two decades has been the recognition of *diabetic distress* as something distinct from both ordinary burnout and clinical depression (ADA, 2024). If you learn only one new concept from this book, let it be this one, because it explains so much of what parents observe but struggle to name.

Diabetic distress is the emotional weight that comes from the relentless, never-ending demands of managing a chronic disease. It is not a character flaw and it is not necessarily a mood disorder. It is the natural human response to an illness that never takes a day off. It shows up as decision fatigue, frustration with glucose numbers that refuse to cooperate, resentment toward the disease itself, guilt over perceived failures, and a bone-deep exhaustion from constant vigilance. Roughly a third of children and adolescents with Type 1

diabetes report clinically significant levels of it (ADA, 2024). In other words, this is not rare. It is closer to the norm than the exception.

Why diabetes is so uniquely exhausting

It helps to step back and appreciate what your child is actually asked to do. People without diabetes rarely think about the mechanics of staying alive. Your child, by contrast, must think about it constantly. Meals are not spontaneous; they are calculations. A slice of pizza at a friend's house is a math problem about carbohydrates, fat, timing, and insulin. Travel requires advance planning for supplies, backup pumps, and refrigeration. A sleepover, a sports practice, an exam, an illness, a growth spurt, a hot day, a stressful week — each one can send glucose numbers in unexpected directions. And here is the cruelest part: even when your child does everything "right," the numbers may still misbehave. Diabetes offers no guarantee that effort produces reward.

That unpredictability is what wears a young person down. Imagine studying hard for every test and still receiving random grades. Imagine being told the outcome is your responsibility while also being told the outcome is not fully in your control. That contradiction is the daily emotional reality of diabetes, and it produces a particular kind of helplessness. It is exhausting in a way that is easy for outsiders — and even loving parents — to underestimate, because from the outside all you see is a device on the arm and a number on a screen.

Recognizing distress: what it actually looks like

Because diabetic distress hides so easily behind ordinary teenage behavior, it helps to know the specific shapes it tends to take. It rarely announces itself as "I am distressed." Instead, you may notice

your child going quiet or defensive whenever numbers come up, snapping at a CGM alarm, or "forgetting" to bolus after a run of stubborn highs. You may see them avoid looking at the glucose graph altogether, dread an upcoming endocrinology appointment for days, or quietly hand back responsibilities they used to manage on their own. Some teens become tearful or furious specifically around diabetes tasks while remaining otherwise engaged with friends and life. Others simply go flat and say some version of "what's the point." The single most useful clue is the pattern. Diabetic distress clusters around the disease rather than spreading across your child's whole life. A teen who is withdrawn about everything may be depressed; a teen who is worn down and reactive specifically about diabetes, yet still lights up with friends and interests, is more likely carrying distress. Clinicians can measure this directly. The Problem Areas in Diabetes–Teen scale (PAID-T) was developed precisely because adult questionnaires miss the concerns that matter most to adolescents, and it gives families and providers a concrete way to see distress rather than guess at it (Weissberg-Benchell & Antisdel-Lomaglio, 2011).

It isn't one feeling: the sources of distress

One reason distress is so easy to misread is that it is not a single emotion but a cluster arising from several distinct sources, and different children are worn down by different things (Fisher et al., 2015; Weissberg-Benchell & Antisdel-Lomaglio, 2011). Naming which source is loudest for your child points directly toward what will help. The most common sources are:

- **Regimen distress** — the sheer, relentless workload of counting, dosing, checking, and timing, with no days off. This is the exhaustion of the job itself.

- **Emotional burden** — fear of complications, guilt over "bad" numbers, and the defeated sense of never doing well enough no matter how hard one tries.

- **Interpersonal distress** — feeling nagged, judged, monitored, or unsupported by the very people trying to help, including parents and friends.

- **Healthcare distress** — feeling unheard by the care team, and dreading appointments and the A1c "verdict" that can feel like a report card on one's worth.

When you can identify which of these is heaviest — is your child drowning in the workload, or bruised by feeling judged, or frightened of the future? — the response can be targeted rather than generic.

The danger of calling it depression

Here is where families and even clinicians can go wrong. Because diabetic distress looks like sadness, fatigue, and low motivation, it is frequently mistaken for major depression. A well-meaning primary-care doctor may respond by prescribing an antidepressant. Sometimes depression genuinely is present and medication genuinely helps. But when the true source of a child's suffering is the crushing management burden of the illness, an antidepressant alone often fails — because the problem was never primarily a chemical mood disorder. It was chronic disease fatigue. Treating exhaustion as if it were depression is like giving someone a mood pill for the tiredness of working three jobs. The medication does not lighten the load.

This distinction matters for you as a parent because it changes how you respond. If you interpret your child's frustration, withdrawal, or "attitude" as depression, laziness, or defiance, you may push in ways that add to the burden. If you recognize it as diabetic distress — a

legitimate, expected response to an exhausting illness — you can respond with validation and practical help instead of pressure.

> **A better question to ask your child**
>
> The most useful question is not "Are you depressed?" It is: "How exhausted are you from carrying this every single day?"
>
> A young person can score perfectly normally on a depression screening and still be completely overwhelmed by diabetes. Distress and depression can look alike from the outside but call for different kinds of help.

Distress, depression, and burnout: three different things

It is worth adding a third figure to this picture: burnout. These three are related but distinct. Distress is the emotional weight of living with the disease. Depression is a clinical mood disorder with its own biology and criteria. Burnout is what distress can harden into when it goes unrelieved for too long — a kind of "I give up" disengagement in which a teen stops trying because trying has stopped seeming to matter. Telling them apart matters because they call for different responses, and because the tools clinicians use to detect them differ: distress is assessed with instruments such as the Diabetes Distress Scale (Polonsky et al., 2005) or the teen-specific measures above, while depression is screened with separate, validated depression tools.

Researchers have specifically warned that everyday diabetes distress is frequently mislabeled as clinical depression, which leads to over-diagnosis and to treatment aimed at the wrong target (Gonzalez, Fisher, & Polonsky, 2011). This is not an argument against ever treating depression — it is an argument for accuracy. You can ask your child's care team to screen for distress specifically, not just

depression; leading guidelines now recommend routine psychosocial screening as a standard part of diabetes care (ADA, 2024).

Why adolescence pours fuel on the fire

Diabetic distress is not spread evenly across a lifetime; the teenage years concentrate it, and for reasons worth understanding. Adolescence is exactly when the responsibility for daily management is transferring from parent to child, so the full weight of the disease is landing on shoulders that are still developing the executive skills to carry it. It is also the age when belonging matters most, and diabetes makes a young person different at the very moment they most want to blend in. On top of this, the hormonal surges of puberty make glucose genuinely more erratic, so effort and outcome drift even further apart. The result is a kind of perfect storm.
The numbers bear this out. Around a third of adolescents with Type 1 diabetes experience elevated distress, and in this age group it is closely tied to lower self-efficacy, reduced self-care, and higher (worse) glucose levels (Hagger et al., 2016). In other words, the teenage years are precisely when distress is most likely to appear and most likely to affect health — which is exactly why catching it early in adolescence is so important.

The double edge of diabetes technology

Insulin pumps and continuous glucose monitors are genuine advances, and for many families they reduce both danger and mental load. But they carry a modern, specific cost that deserves naming. Devices turn every glucose value into a notification, so the disease never fully goes quiet — not at dinner, not at a party, not at three in the morning. Over time this produces what researchers call alarm fatigue: so many alerts that a person becomes less able to respond to any of them. One combined pump-and-CGM system can sound

alarms for as many as 47 different reasons (Shivers et al., 2013). For a teenager, that can mean a constant, low-grade hum of interruption and worry, layered on top of everything else.

The technology also invites comparison — to yesterday's graph, to an idealized “flat line,” to other people's posts in online diabetes communities. None of this means the devices are the problem; they save lives. But it does mean the mental load can be actively managed. Adjusting alarm thresholds with the care team, deciding together who watches the data and when, and taking planned breaks from scrolling through reports are all legitimate ways to turn the volume down without compromising safety.

The distress cycle — and how it feeds the numbers

It helps to picture distress not as a static mood but as a loop. Distress leads to disengagement — skipping a check here, avoiding the graph there. Disengagement worsens the numbers. Worse numbers bring shame and a sense of failure. And that shame feeds still more distress, which drives still more disengagement (Hagger et al., 2016). Once you can see the cycle, two things become obvious. First, pressure and criticism accelerate it rather than reversing it, because they add shame to a system already saturated with it. Second, the way to break the loop is almost always to lighten the load somewhere — to reduce the burden or the blame — so that re-engagement becomes possible again.

What actually helps

Diabetic distress responds not to symptom-chasing but to a combination of being genuinely heard and being given practical relief. The building blocks include validation (acknowledging that the exhaustion is real and reasonable), collaborative problem-solving

(finding small ways to reduce the daily load), and behavioral support from professionals who understand the disease. A behavioral-health provider experienced in diabetes can help your child identify which parts of management are most draining and build realistic strategies to lighten them, rather than simply telling the child to "try harder" — advice that, to an already-exhausted teen, lands like a weight rather than a lifeline.

As a parent, some of the most powerful things you can do cost nothing. You can name the distress out loud: "This disease asks so much of you, and it's okay to be tired of it." You can look for concrete ways to share the mental load — taking over supply reordering, insurance calls, or appointment scheduling so those tasks do not fall entirely on your child. And you can consciously separate your reaction to the numbers from your relationship with your child, so that a high reading becomes a shared problem to solve rather than a verdict on their worth.

Beyond validation, several specific approaches have real evidence behind them, and most can begin at home.

Structured problem-solving. Rather than trying to fix everything, pick the single most draining task and address only that — the 3 a.m. alarms, the lunchtime dosing at school, the Sunday supply scramble. Interventions built on goal-setting and problem-solving have been shown to reduce distress in adolescents specifically (Hagger et al., 2016), and small, concrete wins rebuild the sense of agency that distress erodes.

Planned relief and shared management. Deliberate "diabetes breaks," in which a parent or another trusted adult takes the wheel for an evening or a weekend, are not indulgent; they are maintenance. Consciously dividing the invisible labor — the

reorders, the insurance calls, the appointment scheduling — keeps the whole burden from resting on one young person.

Self-compassion. Distress feeds on guilt and perfectionism, and self-compassion is a direct antidote. In a randomized trial, a structured mindful self-compassion program significantly reduced diabetes distress and depression and produced a clinically meaningful drop in A1c of nearly one percent (Friis et al., 2016). Helping a teen speak to themselves the way they would speak to a struggling friend is not soft; it measurably helps.

Peer connection. Isolation intensifies distress, and other young people with diabetes can offer what even the most loving parent cannot — the relief of not having to explain. Diabetes camps, peer-support groups, and moderated online communities can reduce that isolation meaningfully.

What professional help looks like. When distress is entrenched, diabetes-focused psychotherapy can help. Cognitive behavioral therapy has been shown to improve both glucose control and mood in people with diabetes (Uchendu & Blake, 2017), and acceptance and commitment therapy — which teaches people to relate differently to painful diabetes-related thoughts rather than fight them — has improved self-care in clinical trials (Gregg et al., 2007). Increasingly, care teams also use collaborative-care models that embed a behavioral-health provider directly in the diabetes clinic (ADA, 2024).

Red flags that call for more than reassurance

Distress and depression can coexist, and sometimes distress tips into something that needs urgent attention. Seek help promptly if you notice hopelessness that spreads across your child's whole life rather than clustering around diabetes, loss of interest in things they once loved, marked changes in sleep or appetite, deliberate omission of insulin, or any talk of self-harm or not wanting to be alive.

If your child expresses thoughts of suicide or self-harm, treat it as an emergency. In the U.S. you can call or text 988, contact your child's care team, or go to the nearest emergency department.

Parents feel it too

Finally, a word for you. Diabetes distress is not confined to the person with diabetes. Systematic reviews document high rates of stress, worry, guilt, and sleep disruption among parents of children with Type 1, particularly the primary caregiver (Whittemore et al., 2012). This matters for two reasons. Your own distress is real and deserves care in its own right. And distress is contagious across a household — a depleted, frightened parent inevitably transmits some of that tension to the child. Tending to your own exhaustion, whether through your own support, respite, or professional help, is therefore not a distraction from caring for your child. It is part of it.

Suggested Reading

William H. Polonsky, *Diabetes Burnout: What to Do When You Can't Take It Anymore* — the classic on the emotional exhaustion of diabetes, written for patients and families

Adam Brown, *Bright Spots & Landmines: The Diabetes Guide I Wish Someone Had Handed Me* — practical and encouraging, aimed squarely at lightening the daily load

Emily Nagoski & Amelia Nagoski, *Burnout: The Secret to Unlocking the Stress Cycle* — excellent on chronic stress and recovery, for exhausted teens and parents alike

Kristin Neff, *Self-Compassion: The Proven Power of Being Kind to Yourself* — an antidote to the guilt and perfectionism that fuel distress

Identity and Meaning: Who Is My Child Beyond the Diagnosis?

A Story from Practice

Sam was seventeen when we first met, a high school senior-rising, and by almost every outward measure a young man who had done everything right. He had lived with Type 1 diabetes since he was twelve, and after a single hospitalization for diabetic ketoacidosis at the time of his diagnosis, he and his mother had built a management routine most clinicians would envy: an insulin pump, steady numbers, the occasional low. In the language of the clinic, his body was coping beautifully. It was the person inside that body who had come undone. His mother — a bank manager who had raised him largely alone since a divorce that preceded his diagnosis by eight years — did not call it depression. She called it his “despair.” It was the right word.

Existential despair is not ordinary sadness. It is what settles in when a person can no longer see a future worth walking toward — when the story that gave life its shape suddenly reads as impossible. Sam's collapse even had a date. He had been a near-perfect student, straight A's through the fall, until the spring term of his junior year, when his grades fell away almost overnight. He had never cared for sports. He had dated the same girl since his sophomore year. From the outside his life was intact. What had broken was not a relationship or a habit but a narrative — the single story he had quietly organized his entire sense of self around.

That story was about his father. Sam's father was a military officer stationed in California, a man Sam had seen only a handful of times and not once since the eighth grade. Distance and silence had not diminished him; they had done what absence so often does to a

parent — polished him into an ideal. Sam did not know his father well enough to be disappointed by him. What he had instead was an image — service, discipline, the uniform, honor — and a plan to become it. He would attend the state university a short drive from home, join ROTC, and commission as an officer. He would, in the most literal sense, follow in his father's footsteps, and in doing so become worthy of a man who had never quite been present to confer that worth.

Then, that spring, Sam learned that his diabetes would almost certainly bar him from military service. It had never once occurred to him — not for a single minute — that the future he had staked himself on had been closed since he was twelve. The knowledge did not land as a disappointment. It landed as an annihilation. “If I can't serve my country,” he told me, “then anything else I ever do will never be good enough. I'm a failure before I even got to start my life.”

The future as identity

Listen closely to that sentence, because it does more than voice grief; it reveals a piece of existential architecture. Sam had fused three things into one load-bearing beam: his identity, his worth, and a single imagined future. Remove the future, and by his own logic the other two fall with it. That is what makes his despair existential rather than merely situational. He was not mourning a career. He was mourning a self — the self he was supposed to become, the only version of himself he had ever found acceptable.

Adolescence is the natural season for this kind of fusion. It is the age at which we first ask in earnest, who am I, and who will I be — and Sam had answered early and absolutely: I am the boy who will become the officer his father is. Diabetes, arriving in the middle of that project, had already opened a quieter existential wound — the body's betrayal, the loss of the taken-for-granted trust that one's own

body will simply cooperate. On the surface Sam had managed that wound well. But the diagnosis had lodged a hard limit in him at exactly the age his identity was forming, and now, five years later, that limit had reached up and claimed the one future he had built himself upon.

What the existential work offers

The existential givens Sam was colliding with are the ones we all eventually meet — he simply met them at seventeen and all at once: that freedom is not limitless; that the body is finite and imposes constraints we never chose; that no external authority — not a father, not a uniform — can hand us our worth; and that meaning is not found lying ready-made along a single approved path, but must sometimes be made from the wreckage of the path we lost.

The temptation in a case like this is to argue Sam out of his conclusion — to reassure him that there are other careers, that plenty of good lives never involve the military. This misses the point entirely, and he would rightly feel unseen by it. The work is not to swap his lost future for a substitute. It is, first, to let him grieve it honestly — to treat the death of an imagined self as the genuine loss it is, rather than a problem to be argued away. Only once that grief is witnessed can the deeper question be opened: not what else can you do, but who decided that this one path was the sole measure of a worthy life?

For beneath the ROTC dream lies something more tender — a boy reaching for an absent father, trying to become recognizable to him, hoping to earn through service the closeness he was never simply given. The military was never really the point. Connection was. Worth was. And neither of those is gated by an insulin pump.

The freedom that remains

There is a well-worn existential idea, drawn from Viktor Frankl, that when we can no longer change our situation, we are challenged instead to change ourselves — that the last of the human freedoms is the freedom to choose our response to what cannot be undone. Sam cannot undo his diabetes, and he cannot enlist. But every other freedom remains his: to decide for himself what service and contribution mean, to find forms of discipline and even honor his body does not forbid, and — most of all — to stop outsourcing his worth to a future he did not fully choose and a father who was never there to grant it.

Sam came to me certain he was a failure before his life had begun. The truer statement is that one particular story of his life ended before it began, and he mistook that story for the whole of himself. The task ahead is not to find him a new career. It is to help him discover that he is not, and never was, identical to a single imagined future — that the person is always larger than the plan, and that a life can hold meaning in ways he has not yet let himself imagine. His body has been coping all along. Now the work is to help the person do the same.

Adolescence and young adulthood are, developmentally, the years devoted to a single enormous question: Who am I? Young people are busy figuring out what they believe, who they love, what they want to become, and how they fit into the world. A diagnosis of diabetes lands directly in the middle of that project — and it can quietly hijack it.

Chronic illness inevitably raises deep questions about identity, autonomy, mortality, and meaning. For many young people, diabetes threatens not only physical health but their fundamental sense of self. Over time, “I am a person who has diabetes” can slide into “I am

a diabetic" — a label that starts to feel more central than being a musician, an athlete, a friend, a sibling, a student, or a future professional. When the illness becomes the loudest part of a young person's self-definition, everything else they are can begin to feel small by comparison.

Four ways diabetes can settle into identity

Researchers have given us a useful map of exactly how an illness weaves itself into a young person's sense of self. Studying hundreds of adolescents and young adults with Type 1 diabetes, they identified four distinct ways the condition can be integrated into identity, measured by what they called the Illness Identity Questionnaire (Oris et al., 2016). Understanding these four can help you recognize where your own child sits — and where you would hope to help them move.

- **Engulfment** — diabetes swallows the self. The condition dominates how the young person thinks and talks about who they are; it becomes the whole fabric rather than one thread. Engulfment is linked to more depression, anxiety, and diabetes distress.
- **Rejection** — the young person refuses to let diabetes be part of them at all, dismissing or ignoring it. This can feel like freedom, but it tends to go hand in hand with poorer self-management and worse glucose control.
- **Acceptance** — diabetes is acknowledged as a real part of life without being allowed to define the whole person. Acceptance is associated with better psychological and medical outcomes.
- **Enrichment** — the young person finds that living with diabetes has, in some ways, made them stronger, more disciplined, more empathic, or clearer about what matters. Enrichment is linked to the best adjustment of all.

The goal, in other words, is not to make diabetes disappear from your child's identity — that is rejection, and it backfires — but to help it settle into acceptance, and where possible, enrichment. A young person can carry diabetes as one meaningful part of a large and interesting self, rather than as the thing that has eaten the rest.

The grief that hides behind irritability

One of the least recognized aspects of a diabetes diagnosis is that it involves genuine loss, and genuine loss brings genuine grief. Your child may be mourning the loss of spontaneity — the freedom to eat, sleep, travel, and move through the day without calculation. They may be grieving the loss of bodily trust, the taken-for-granted assumption that their body will simply work. They may be mourning the future they had quietly imagined before diagnosis, a future that did not include needles, alarms, and constant monitoring.

Here is the crucial point for parents: this grief rarely announces itself as sadness or tears. In teenagers especially, it tends to wear a disguise. It shows up as irritability, anger, avoidance, sullen withdrawal, or what looks like a bad attitude about diabetes tasks. A parent who sees only the surface may respond to the behavior — "Why are you being so difficult about checking your sugar?" — and miss the mourning underneath. Recognizing that anger and avoidance can be the *face* of grief allows you to respond with compassion rather than conflict.

It also helps to understand that this grief is not a single event that resolves and disappears. Because diabetes is lifelong, the losses can be re-grieved at every new stage — the first sleepover, learning to drive, leaving for college, starting to date, imagining a career. Each milestone that other families celebrate without a second thought can quietly reopen the question, "Why is this harder for me?" This

recurring, milestone-linked sorrow is normal and expected. Naming it as grief, rather than misreading it as regression or drama, is itself a form of care.

What meaning-making sounds like

Beneath the surface, many young people with diabetes are quietly wrestling with questions like these:

- Who am I now that I have this condition?
- What kind of life is still possible for me?
- How do I keep my independence and dignity when so much of my day is monitored?
- Will anyone see me as more than my disease?

These are not just philosophical musings. Young people who find meaning and identity beyond disease management tend to adapt better over the long run — emotionally and, often, medically as well.

Stigma and the pressure to hide

Part of what pushes a young person toward engulfment or rejection is the social experience of feeling different. Diabetes is a visible-yet-invisible condition: a pump clipped to a waistband, a sensor on the arm, an insulin injection before lunch, a low that requires stopping everything to eat. Adolescents, who want more than anything to belong, can feel marked by these moments. Some respond by hiding — dosing in bathrooms, skipping checks in front of friends, downplaying the condition — and hiding, while understandable, quietly reinforces the message that diabetes is something shameful to conceal.

As a parent, you cannot remove the social awkwardness of adolescence, but you can shape the story your child tells about their condition. When diabetes is treated at home as an ordinary, unremarkable fact — neither a tragedy to be pitied nor a secret to be buried — a young person is freer to be matter-of-fact about it in the

world. Connecting them with peers who have diabetes helps enormously here, because nothing dissolves the sense of being uniquely burdened like meeting someone who simply gets it.

Meaning, resilience, and better outcomes

There is a hopeful thread running through all of this research: identity and meaning are not soft extras but genuine drivers of how well a young person does, medically and emotionally. Diabetes researchers have described a model of *diabetes resilience* — the observation that although management often falters in adolescence, many young people manage well, protected not by the absence of stress but by the presence of strengths: problem-solving skills, supportive relationships, a sense of competence, and the ability to find meaning (Hilliard, Harris, & Weissberg-Benchell, 2012).

Resilience is not a personality trait some kids happen to have. It is a set of protective processes that can be deliberately cultivated. This is where a style of therapy focused on *resilience* becomes valuable. Rather than aiming only to reduce symptoms, resilience-oriented psychotherapy works on a different set of muscles: strengthening a young person's confidence in their own abilities, steadying their emotions, sharpening how they solve problems, and loosening rigid, all-or-nothing thinking into something more flexible. Researchers describe resilience as the capacity to adapt, recover, and even grow in the face of adversity (Southwick et al., 2014). Applied to diabetes, this kind of care helps a young person move from merely surviving the illness toward engaging meaningfully with life despite of diabetes — pursuing goals, relationships, and identities that are theirs, not the disease's.

Engulfment and rejection, up close

Because engulfment and rejection are the two most worrying places a young person's identity can settle, it is worth learning to recognize them in everyday life. Engulfment sounds like a teenager for whom diabetes has become the main character of their story. It shows up in constant talk of numbers and failure, in social withdrawal (“I can't, because of my diabetes”), in a flattened sense of the future, and in a self-image organized almost entirely around being sick. Rejection sounds and looks like the opposite: a shrug, a refusal to check in front of others, skipped doses not out of forgetfulness but out of a wish to pretend the condition does not exist, and irritation at any reminder that it does. It can masquerade as confidence — “I've got this, stop worrying” — while the actual management quietly falls apart.

It helps to remember that both are attempts to cope with the same unbearable fact: that something serious and permanent has happened to a young body and a young life. Engulfment tries to manage the threat by surrendering to it; rejection tries to manage it by denying it. Neither is willful bad behavior, and neither responds well to argument. What moves a young person toward the healthier middle — acceptance, and eventually enrichment — is rarely a lecture. It is repeated experiences of being seen as a whole person, of succeeding at things that have nothing to do with diabetes, and of meeting others who carry the condition without being consumed or destroyed by it (Oris et al., 2016).

The transition years: leaving home and owning the diagnosis

Identity questions come to a head in the transition to adulthood — the stretch from the late teens into the twenties when a young person

leaves home, takes over their own medical care, and consolidates a sense of who they are. This is a genuinely high-risk period for diabetes, because the scaffolding of parental oversight falls away at exactly the moment when independence, new freedoms, and the desire to be "normal" are strongest. A young adult who has not yet integrated diabetes into an accepted identity may drift toward rejection once no one is watching — skipping appointments, letting supplies lapse, drinking like their peers without accounting for it — with real medical consequences.

The transfer from pediatric to adult diabetes care is a particularly vulnerable handoff, and young people can fall through the cracks between systems designed for children and those designed for adults. As a parent, your role shifts here from manager to consultant: staying available and interested without taking back the wheel, helping your child build the practical and identity-level skills to carry the condition into an independent life. The goal of all the identity work of adolescence is precisely this — a young adult who can say, in effect, "Diabetes is mine to manage, it is part of me, and it is not all of me," and mean it.

When identity struggles cross into depression

Much of what this chapter describes — grief, irritability, a narrowed sense of self — is a normal, if painful, part of adapting to a lifelong condition. But sometimes it deepens into something that needs more than time and understanding. Watch for signs that the struggle has crossed into clinical depression: a persistent low mood that colors everything rather than clustering around diabetes, loss of interest in friends and activities once loved, hopelessness about the future, changes in sleep or appetite beyond the diabetes routine, and especially any expression of worthlessness or of not wanting to be alive. Engulfment in particular travels closely with depression and

anxiety (Oris et al., 2016), so a young person whose whole identity has been swallowed by the disease deserves a careful look. If these signs appear, it is time to involve a mental-health professional, and any talk of self-harm should be treated as an emergency.

What actually helps

As a parent, you reinforce this every time you relate to your child as a whole person rather than as a patient. Ask about their music, their friendships, their opinions, their dreams — the parts of them that have nothing to do with glucose. Resist the pull, understandable as it is, to let diabetes become the main topic of every conversation. When the dinner table is not a daily diabetes debrief, you send a quiet but powerful message: you are so much more than this condition, and we see all of you.

Beyond that, there are specific ways to nudge a young person from engulfment or rejection toward acceptance and enrichment. Give them room to try on identities that have nothing to do with illness — a sport, an art, a job, a cause. Help them notice, without forcing it, the ways the discipline of diabetes may have grown real strengths in them: self-awareness, resourcefulness, empathy for others who struggle. Introduce role models and mentors who live full lives with diabetes, so the future feels expansive rather than foreclosed. And when a young person seems truly stuck — when diabetes has swallowed their self-image, or when grief has curdled into depression — a therapist skilled in existential, meaning-centered, or resilience-based work can help them author a self in which the disease is a chapter, not the whole book.

Suggested Reading

Viktor E. Frankl, *Man's Search for Meaning* — the short, foundational book on finding meaning amid suffering
Lisa Damour, *Untangled* and *Under Pressure* — clear, compassionate guides to adolescent identity, pressure, and anxiety. *(general)*

Toni Bernhard, *How to Be Sick* — a warm, practical guide to living a meaningful life alongside chronic illness

Kerri Sparling, *Balancing Diabetes: Conversations About Finding Happiness and Living Well* — on building an identity and a full life beyond the disease

Trauma After a Medical Crisis: When a Scary Low Becomes a Lasting Fear

A Story from Practice

Haylee was twenty when we first met, a junior at the state university in her hometown, a premed major with the kind of transcript that opens doors. When I asked which field of medicine drew her, she looked at me as though I had asked something absurd.

"Endocrinology," she said — obviously. She had chosen it at ten years old, not long after her own Type 1 diagnosis, and she had never once wavered. Her first endocrinologist had been a woman who wore an insulin pump. "She was so pretty and confident. I didn't have any real idea how serious diabetes was — I was just a kid — but she made me feel I was going to be okay. I want to do that same thing for other kids going through this horrible disease." Ten years later, that sentence was still the engine of Haylee's whole life.

It had shaped how she managed her illness. My sense, early on, was that Haylee had made herself a master of doing hard things with diabetes — not merely to stay healthy, but because she was rehearsing a role. Every difficult task done well was a small down payment on the physician she intended to become: the calm, capable woman who would one day sit across from a frightened ten-year-old and make her believe she was going to be okay. Her diabetes and her vocation were not two separate things. They were a single identity, braided together since childhood.

That identity had carried her a long way. Premed is punishing — near-perfect grades are only the beginning, layered over with volunteer hours and the quiet performance of dedication. Haylee spent her summers at a community health clinic. She was especially

proud of a fifteen-hundred-dollar grant she had won the previous summer, which she used to help several local churches build a website organizing contact information for providers offering care to the community's indigent. She was, in every visible way, thriving — a young woman becoming exactly who she had set out to be.

Then came this summer, and the trip that brought her to me. Haylee had enrolled in a study-abroad course in medical anthropology; she and eleven classmates would travel to Northern Ireland to study its healthcare system and the cultural currents beneath it. She had been overseas before, but always with her parents. This would be the first time she went alone. She told her professor about her diabetes. The professor did not carry the same easy confidence as that first endocrinologist, but she did not try to talk Haylee out of going, and Haylee was not especially worried. Ireland was not part of the developing world. It had doctors, hospitals, pharmacies; insulin could be replaced in an emergency; the hotel had refrigeration. Her insulin sat sealed in a cool thermos, her supplies packed with care. She had done everything right. She always did.

“The nightmare” — her word — began at the airport. The dozen students inched through a long, slow security line. Because her insulin pump could not go through the scanner, Haylee requested a pat-down. A female agent performed it, which was correct procedure, but it happened in full view of her classmates, several who were male, who waited and watched as the agent's hands moved between and beneath her breasts. “I was so embarrassed,” she told me. Then she corrected herself. “No. I was mortified.” What should have been a private medical accommodation had become a public exhibition of her body, witnessed by the very peers among whom she had always been the competent one.

It got worse. Their connecting flight was delayed, and they reached the Belfast hotel late. Haylee planned to unpack and find a meal if the restaurant was still open. Then her pump alarmed. Her roommate, unpacking nearby, noticed something off — a little brain fog — and asked if she was all right. Haylee said she would be fine; she just needed to eat something soon. She knew exactly what to do; she had done it a thousand times. But the roommate bolted from the room to the professor, who called EMS — without first checking on Haylee at all. “I thought getting groped by a TSA agent in front of the class was embarrassing,” Haylee said, “but having paramedics walk into the hotel restaurant was humiliating. I was fine. I'd found my applesauce before I even left the room.” She traveled with applesauce packets, each exactly fifteen grams of carbohydrate. She had corrected the low herself, competently, before anyone else had even understood what was happening. “The rest of the trip,” she said, “I felt like a leper.”

The wound was not to the body

It is worth pausing on that word — leper. For centuries it has named the person a community casts out: the untouchable, the unclean, the one others recoil from and keep at a distance for fear of contagion. That is very close to what had happened to her. Twice in a matter of hours, Haylee's diabetes had been dragged out of the private, competent sphere she had spent a decade building and put on public display — and each time, the people around her responded less to Haylee than to her disease, handling her, alarmed by her, treating her as something to be managed and held at arm's length. And here is the clinical heart of the matter: neither event was a medical crisis. Her body was fine. Her glucose was handled. She had both situations under control. The injury was not to the body at all. It was to her dignity, her privacy, and her identity — and those are exactly the injuries that become traumatic.

In trauma-informed terms, an event becomes traumatic not because of its medical severity but because of the helplessness, exposure, and loss of control it imposes. Haylee had not been endangered; she had been overpowered — her body handled by a stranger in front of an audience, her competence overridden by people whose fear of her disease moved faster than their willingness to simply ask her a question. The professor who called EMS without checking, the roommate who ran for help instead of handing over the applesauce three feet away: these were not acts of cruelty. They were acts of fear — other people's fear of diabetes — and that fear turned Haylee from a capable young woman into a patient, a spectacle, a problem to be managed. It is the same dynamic that plays out, in gentler forms, whenever well-meaning vigilance overrides a person's autonomy. Here it happened publicly, twice, far from home, and it left a mark.

A dream and a fear pointing in opposite directions

The aftermath took the familiar shape of a trauma response. For the first time in her life, Haylee felt intense fear about leaving home for medical school. She had two panic attacks in the weeks before we met — one about a month earlier, the second just two days before our first session. And notice the particular cruelty of it: the future she had organized her entire self around — becoming an independent physician — requires precisely the independence that had just wounded her. The dream and the fear now pointed in opposite directions. To become the confident endocrinologist who reassures frightened children, she must leave home, travel, live alone, and place her diabetic body, again and again, in public and unpredictable spaces. The trip did not merely frighten her. It threatened the very identity she had been building since she was ten. It would be a mistake to read Haylee's panic as evidence that she is not cut out for medicine — and an equal mistake to reassure her breezily that “it wasn't that bad.” Both responses miss what actually

happened. Her fear is neither irrational nor weak; it is the residue of two genuine violations of dignity, arriving at once, in a stranger's country, in front of the people she most wanted to impress. Panic attacks are a recognizable consequence of trauma, not a character flaw and not a verdict on her future.

The way back to herself

The work, then, is not to talk Haylee into medical school or out of her fear. It is trauma-informed at its core: to ask not *what is wrong with you ?*, but *what happened to you?* — and to let the answer be taken seriously. That means giving the two events their real weight rather than minimizing them; reconstructing the story so that the shame settles where it belongs — on the exposure and the overreach, not on Haylee's body or her competence and normalizing the panic as a predictable response to being overpowered. It means, gradually, rebuilding her sense of agency: distinguishing realistic preparation — knowing her rights at security, rehearsing how she will disclose her diabetes and set boundaries, deciding in advance who may intervene and how — from trauma-driven avoidance, the quiet surrender in which she simply never travels, never leaves home, and lets the dream go. The aim is to help her reclaim the competence that was always hers.

There is a deeper opportunity here, too, and it lives inside Haylee's own reason for choosing this path. She wanted to become the doctor who makes frightened patients feel they are going to be okay. This summer, she learned in her own body what it feels like to be stripped of dignity by a medical moment — to be watched, handled, and managed rather than asked. Most physicians never learn that lesson so viscerally. Metabolized well, the very experience that traumatized her could become one of the truest sources of her gift as a clinician: she will know, from the inside, the difference between caring for a

patient and turning that patient into a spectacle. That is not a reason to be grateful for what happened. But it is a reason to believe the dream can survive it.

Haylee came to me afraid that the fear meant the end of everything she had planned. The more accurate reading is that something real was done to her, and it has not yet been worked through — that her body coped, as it always has, while the person was left alone with the humiliation. The task ahead is to tend to that person: to let her grieve the ease she lost, to restore her trust that she can move through the world in her own capable body, and to help her see that she is not, and never was, the leper she felt herself become — that she is instead the young woman who is going to become, in the end, exactly the physician she set out to be.

Some of the most powerful — and most overlooked — mental-health effects of diabetes come from frightening medical events. A rapidly growing area of research now recognizes *diabetes-related posttraumatic stress symptoms* (PTSS): trauma reactions that develop after severe low blood sugars, episodes of diabetic ketoacidosis (DKA), terrifying high-glucose crises, intensive-care admissions, a frightening diagnosis experience, or the repeated dread of future emergencies (Hosoda-Urban & O'Donnell, 2024; Lunkenheimer et al., 2023).

It is easy for adults to file a severe hypoglycemic episode under "medical event, now resolved." But for the young person who lived through it, a bad low is often experienced as something much closer to a brush with death. A seizure, a blackout, an ambulance ride, terrified parents, a hospital bed — these leave marks that do not disappear when the glucose returns to normal. Long after physical recovery, a young person may carry intrusive memories, hypervigilance, disturbed sleep, panic symptoms, and avoidance

behaviors. As specialists in this area emphasize, a severe low is not always filed away as a routine medical episode — for some young people it lodges in the mind as a lasting wound.

A framework: medical events as trauma

It helps to have a name and a shape for what is happening. Researchers describe *pediatric medical traumatic stress* — the set of psychological and physical responses that children and their families can have to pain, injury, serious illness, frightening medical procedures, and invasive or scary treatment (Kazak et al., 2006). The framework makes three points that matter enormously for diabetes families. First, it is the child's subjective experience of threat, not the medical severity, that drives trauma; an event that looks routine on a chart can be terrifying from the inside. Second, traumatic stress unfolds in phases — the event itself, the early days and weeks of reactions, and, for some, a longer-term pattern that persists. Third, and crucially, medical trauma is not confined to the patient; it radiates to parents and siblings, who may be just as haunted by what they witnessed.

Naming your child's experience as medical traumatic stress, rather than as overreaction or drama, does two things at once. It normalizes what they are feeling — trauma responses are the mind's ordinary reaction to extraordinary threat — and it points toward the right kind of help, which is trauma care rather than lectures about targets and numbers.

How common is it?

More common than most families realize. In a study of adolescents and young adults with Type 1 diabetes, roughly a quarter showed clinically significant posttraumatic stress symptoms, and a

substantial share identified their most distressing trauma as specifically diabetes-related (Hosoda-Urban & O'Donnell, 2024). The more emergency-room visits a young person had experienced, the higher their risk, and PTSS was tightly interwoven with depression, anxiety, and emotional distress. The researchers' conclusion was striking and worth sitting with: diabetes itself can act as a traumatic stressor. Related work has found that when full posttraumatic stress disorder is present, it is associated with worse A1c, more DKA episodes, and poorer diabetes outcomes overall — evidence of a two-way street in which trauma worsens diabetes and diabetes worsens trauma (Lunkenheimer et al., 2023).

How trauma shows up in a young person

Trauma reactions tend to cluster into a few recognizable patterns, though in teenagers they are easily mistaken for something else. There may be *intrusion* — nightmares, replaying the event, sudden waves of fear seemingly out of nowhere, or panic when a number or symptom recalls the crisis. There may be *avoidance* — reluctance to check, to be alone, to sleep, to return to the place it happened, or to talk about it at all. There may be *hyperarousal* — jumpiness, irritability, trouble sleeping, difficulty concentrating, or obsessive, anxious over-checking that never feels like enough. And there may be *negative shifts in mood and thinking* — guilt, a sense of doom, or a bleak conviction that it will happen again.

From the outside, these can look like anxiety, defiance, clinginess, or a bad attitude. A teen who refuses to sleep in their own room, snaps at every alarm, or won't go on the school trip may not be being difficult; they may be carrying an untreated traumatic memory. The pattern to watch for is a change that dates from a specific frightening event and clusters around reminders of it.

The high blood sugar that is actually fear

There is one pattern here that every parent should understand, because it is so easily misread. After a single terrifying low, some young people begin to deliberately run their blood sugar *high*. They under-treat, over-correct in the safe direction, or avoid the insulin doses that might risk another low. To the medical team — and to a worried parent — this looks like poor control, carelessness, or noncompliance. In reality, it is often *trauma avoidance*. The young person has learned, in the deepest and most instinctive part of the brain, that a low nearly killed them, and they are choosing the terror they can see (long-term complications, which feel abstract and distant) over the terror they have already survived (a low, which feels immediate and real). This is sometimes informally called fear of hypoglycemia, or "hypotrauma."

This fear is well documented, and it lives in parents as much as in children. A systematic review of families of young children with Type 1 found that fear of hypoglycemia is common among parents, disrupts their sleep, and drives specific counter-behaviors: keeping glucose deliberately high, pushing extra carbohydrates, giving less insulin than prescribed, and avoiding exercise — all to prevent another low (Barnard et al., 2010). In other words, the very pattern that frustrates the medical team is often a rational response to remembered terror, and it can run in the whole family at once. A household organized around never having another low will, understandably, drift toward chronically higher numbers — and the answer is not more pressure about the A1c but addressing the fear underneath it.

Reframe before you react

If your child seems to be “letting their sugar run high” after a bad low, pause before assuming carelessness. Ask gently whether they are scared of going low again. A persistently high A1c that appeared after a frightening episode is frequently a trauma symptom, not a discipline problem — and criticizing the numbers can deepen both the fear and the shame.

Trauma travels through the whole family

If you watched your child seize, lose consciousness, or be rushed to an emergency room, you may be carrying trauma of your own — and it deserves acknowledgment, not just for your sake but for your child's. Parents who are themselves frightened tend, without meaning to, to become hypervigilant: checking constantly, hovering, waking through the night, communicating a low hum of alarm that a child absorbs. A household's nervous system is shared. When a parent's fear goes unaddressed, it can quietly amplify the child's, and the two can feed each other. Recognizing your own medical trauma, and getting support for it, is part of helping your child heal.

Not only the big events: the slow drip of vigilance

Trauma in diabetes does not always come from a single dramatic crisis. For some young people it accumulates, drop by drop, from years of small distressing experiences: thousands of finger sticks and site changes, needle fear, the discomfort of a low in public, the dread before every A1c result, the sense of a body under constant inspection. This is sometimes described as cumulative or complex stress, and it can leave a young person just as depleted and reactive as a single big event, even though no one moment stands out as “the trauma.” Procedure-related distress in particular — real fear of needles, insertions, and blood — can build into avoidance that

undermines management. The pediatric medical traumatic stress framework reminds us that it is the accumulated experience of threat, not just headline events, that shapes a child's response (Kazak et al., 2006). If your child seems worn thin by the ordinary machinery of diabetes, that reaction is legitimate and worth addressing, not dismissing.

How trauma looks at different ages

Traumatic stress wears different clothes at different developmental stages, and knowing this helps you read your child accurately. Younger children may regress — becoming clingy, having new nighttime fears, returning to behaviors they had outgrown, or replaying the scary event in their play. School-age children may complain of stomachaches and headaches, become preoccupied with danger, or resist anything that reminds them of the hospital. Teenagers more often show it as irritability, anger, withdrawal, risk-taking, or a flat refusal to talk about what happened; some throw themselves into distraction, others into avoidance. Because these look so different from the classic picture of a frightened, tearful trauma survivor, they are easily misread as misbehavior, moodiness, or defiance. The clue, across all ages, is timing and theme: a change that began after a frightening medical event and orbits around reminders of it.

Rebuilding trust in the body, one step at a time

A central task of recovery is helping a young person feel safe in their own body again — and that is done gradually, not by force. The trauma-informed principle is to move at a pace that expands the comfort zone without flooding it. In practice, that can mean a stepwise plan built with a therapist and the diabetes team: naming the fear out loud, learning calming and grounding skills first, and

then approaching feared situations in small, tolerable increments — checking a slightly lower number, spending a bit more time in range, returning to the activity or place that got avoided — each success rebuilding the belief that a low can be caught and handled rather than being a catastrophe waiting to happen. Technology can be a genuine ally here: continuous monitors with predictive alerts that warn *before* a low, and automated systems that reduce the frequency of severe lows, can give a frightened young person concrete evidence that the ground is safer than it feels, which is often what allows the nervous system to settle.

What actually helps: trauma-informed care

Trauma responses call for trauma-informed care. The shift at the heart of this approach is captured in a simple change of question: instead of asking "What is wrong with you?", trauma-informed care asks "What happened to you?" (Knight, 2015). That reframe moves everyone — clinician, parent, and child — from judgment toward understanding. Treatment typically involves establishing emotional safety, gently helping the young person put words to and make sense of what happened, normalizing the trauma response so they stop feeling "crazy" for being afraid, and slowly rebuilding confidence in their ability to handle future situations. Resilience-oriented therapy supports the same goal, helping a young person re-establish trust that they can manage a crisis if one arises again.

Beyond these principles, specific therapies help. Trauma-focused cognitive behavioral approaches gently and gradually help a young person face what they have been avoiding — a feared number, a feared situation, the memory itself — at a pace that rebuilds a sense of safety rather than overwhelming it. For fear of hypoglycemia specifically, this often means working *with* the diabetes team to loosen glucose targets temporarily, so the young person can rebuild

trust in their body without being pushed into the exact territory that terrifies them; safety first, tighter control later. And because trauma is a family matter, the most effective plans include support for parents' own fear, so the household can settle rather than stay braced. When trauma symptoms are significant — nightmares, panic, avoidance that shapes daily life — a therapist trained in trauma and familiar with diabetes can help far more than repeated conversations about the numbers ever will.

For you as a parent, the most healing stance is patience paired with validation. A young person who is afraid of going low is not being dramatic; they are responding to something real that happened to them. Acknowledging the fear — “That was genuinely terrifying, and it makes sense that part of you never wants to feel it again” — does more good than any lecture about target ranges.

Suggested Reading

Bruce D. Perry & Oprah Winfrey, *What Happened to You?* — accessible, and built around the exact "what happened to you" lens this chapter uses

Peter A. Levine & Maggie Kline, *Trauma-Proofing Your Kids* — a parent-friendly guide to helping children recover from frightening and medical experiences

Tamar Chansky, *Freeing Your Child from Anxiety* — practical tools for fears and panic, including after a scary event

“I Know What to Do and Still Can't Make Myself Do It”: Attention and Executive Function

A Story from Practice

The word arrived before she did. It was there in the referral, tucked into the notes from her diabetes team like a diagnosis of its own: “noncompliant.” By the time a fourteen-year-old is labeled that way, the label has usually already done its work — it has shaped how every adult in the room sees her and, more quietly, how she has begun to see herself. So when Zoe settled into the chair across from me for our first session, arms crossed, eyes on her shoes, I made a decision before either of us had said a word: I would try to meet the girl, not the chart.

The facts, on paper, were not flattering. Zoe was diagnosed with Type 1 diabetes at seven; she is fourteen now, which means she has carried the disease for half her life. Her A1c had been climbing. She missed insulin boluses. She forgot to change her infusion sites. Her logging was erratic when it happened at all, and she had missed two endocrinology appointments in the past year. Her care team, understandably weary, had arrived at the conclusion that Zoe simply would not do what she knew she needed to do. The chart called it noncompliance. Her parents, exhausted and frightened, had started using the same word.

But when I asked Zoe about it directly — gently, without the edge of accusation she was so clearly braced for — something in her face shifted. “I know what I'm supposed to do,” she said. “I just… don't do it. And then everyone acts like I did it on purpose.” I asked whether “not doing it” was only a diabetes thing. She almost laughed. It was, she told me, the story of her whole life. She forgets her homework in

her backpack — finished, done, never turned in. She loses her phone, her keys, her retainer. She starts things and never ends them. She sits down to do one task and looks up an hour later having done four others and not the one that mattered. Time, she said, "just kind of disappears." Her room is chaos. Her teachers write "not working to potential" on everything. None of this was about diabetes. Diabetes was simply the arena where the stakes were highest.

What the label missed

What I was hearing was not defiance. It was executive dysfunction — the whole familiar constellation of it. Trouble initiating tasks. Trouble holding a multi-step routine in mind. Trouble sustaining attention through something tedious. Time blindness. A working memory that drops things without warning. And the crucial detail, the one her diabetes team had no way to see from inside the clinic: the pattern was everywhere. It was in her schoolwork, her chores, her belongings, her sense of time. Diabetes management is, at bottom, one of the most executive-function-demanding jobs we ask of anyone — a relentless sequence of remembering, calculating, timing, and initiating, forever, with no days off. For a brain that struggles with exactly those functions, it is almost engineered to expose the weakness.

By the end of our hour, my working impression was that Zoe meets criteria for attention deficit hyperactivity disorder (ADHD) — most likely the inattentive presentation, the kind that so often goes unrecognized in girls. She is not hyperactive. She does not disrupt the classroom. She is, by every account, a sweet and cooperative kid who simply "spaces out," "doesn't apply herself," and "is careless." That description is precisely why so many girls with ADHD are missed for years, sometimes well into adulthood: they do not match the picture of the restless boy bouncing off the walls. They slip under

the radar, quietly absorbing the message that their struggles are a matter of character rather than neurology.

The cost of the word

And here is what worried me most — more than the A1c. Zoe had been living under that word, noncompliant, during the exact years she is building her sense of who she is. Adolescence is when identity sets, and Zoe was assembling hers out of the material the adults around her kept handing her: careless, lazy, difficult, the girl who wasn't "living up to potential." She had begun to believe it. When I asked what kind of person she thought she was, she shrugged and said, "A screwup, I guess. A bad diabetic." That sentence is the real injury. A missed bolus can be corrected in an afternoon. A fourteen-year-old's belief that she is fundamentally a failure, "a screw up," can shape the next decade.

This is the quiet violence of the moral interpretation. When a neurological difficulty is read as a character flaw, the young person is left with nowhere to put the struggle except shame — and shame does not improve executive function. It corrodes it, feeding the very avoidance and hopelessness that make everything harder. Zoe was not refusing to manage her diabetes. She was drowning in a task her brain was not equipped to carry unassisted, and then being blamed for the drowning.

A different question

The most useful thing I can do for Zoe is to change the question everyone has been asking. The team has been asking, "Why won't she comply?" The better question — the only one that leads anywhere — is, "What supports does this brain need to make this possible?" That reframe turns a moral dead end into a practical plan. My recommendations, which I will begin to build with her and her

parents, start with a formal evaluation for ADHD; if it is present and treated, the benefits often reach well beyond school, because improved executive function can translate directly into steadier diabetes management and even into fewer of the impulsive food decisions that drive her glucose swings.

Beyond assessment, the work is scaffolding — not more willpower. Zoe has been told to try harder for years, and it has only made her feel worse. What she needs are external systems that do not depend on a struggling memory: alarms tied to things she already does, radically simplified routines, supplies positioned where they cannot be forgotten, the administrative burden lifted off her narrow shoulders, and her parents repositioned from enforcers into partners who help engineer the environment rather than police the behavior. And, just as importantly, I want to get into her chart and her family's vocabulary and retire the word noncompliant altogether. Language is not cosmetic. The story we tell a fourteen-year-old about why she struggles becomes the story she tells herself.

Zoe came into my office braced to be scolded by one more adult who had already decided she was the problem. What I hope she left with — even in that first hour — was the smallest and most radical possibility: that she is not lazy, not careless, not a bad kid or a bad diabetic, but a girl whose brain works in a particular way that no one has yet accounted for. Her diabetes team was not wrong that something is getting in the way. They were only wrong about what it is. The task now is not to make Zoe comply. It is to build the world around her so that the hard, endless work of this disease finally becomes something her brain can actually do — and to give her back a self that is not defined by a word she never deserved.

Perhaps no area is more prone to unfair judgment than the overlap between diabetes and difficulties with attention and executive

function. Executive functions are the brain's management systems: the abilities to get started on a task, hold information in mind, sustain attention, plan ahead, and keep track of time. When these systems work imperfectly — as they do in ADHD, and to some degree in every adolescent, whose executive brain is still under construction — the intensive daily demands of diabetes become genuinely, neurologically hard.

A young person with executive-function challenges may forget to reorder insulin until they run out, miss endocrinology appointments, put off prior authorizations, delay lab work, eat inconsistently, or fail to correct a high glucose promptly. From the outside, this can look exactly like not caring. Adults — parents and clinicians alike — often reach for a moral explanation: “He knows what to do; he just won't do it.” But listen to how young people with ADHD frequently describe their own experience, and you hear something entirely different: “I know exactly what to do, and I still cannot make myself do it.”

Two very different explanations for the same behavior

- The moral read: “She's irresponsible, lazy, careless — she just needs to try harder and want it more.”
- The accurate read: “Her brain struggles with task initiation, memory, and follow-through. The knowledge is there; the executive machinery to act on it consistently is not.”

The first explanation produces shame, conflict, and often worsening avoidance. The second opens the door to actual solutions.

What executive function actually is

It is worth slowing down on what these skills really are, because diabetes management leans on every one of them. *Task initiation* is the ability to get started — the difference between knowing you

should change your infusion set and actually doing it now. *Working memory* holds several things in mind at once, exactly what is required to count carbs, remember your last dose, and track when insulin will peak. *Sustained attention* keeps you with a boring, repetitive task; *planning and organization* let you make sure supplies, prescriptions, and appointments line up before you run out; *time management* estimates how long things take and keeps you on schedule; and *emotional regulation* and *self-monitoring* let you notice a drifting number and respond without being hijacked by frustration. Diabetes is, in effect, a full-time executive-function job layered on top of school, friendships, and growing up. When the executive systems are weak, it is not the caring that is missing — it is the machinery for turning caring into consistent action.

Every teenage brain is still under construction

Before assuming a diagnosis, it helps to remember that adolescence is, by design, a period of unfinished executive development. The prefrontal cortex — the seat of planning, impulse control, and follow-through — keeps maturing into the mid-twenties. This means that even teenagers without ADHD are being asked to run an executive-heavy medical regimen with a brain that is not yet fully wired for it. This is not an excuse; it is a design constraint. It explains why management so often wobbles precisely in the teen years, and why the answer is rarely more pressure and usually more support and structure. For some young people, though, the difficulty goes well beyond ordinary adolescence — and that is where ADHD comes in.

When it is ADHD: the evidence and the stakes

The link between attention difficulties and diabetes outcomes is not speculative. In one large study, executive-functioning skills predicted how well children managed their diabetes, and that management, in

turn, predicted their glucose control — meaning executive function shapes A1c largely by way of the daily follow-through it makes possible (McNally et al., 2010). The stakes are real: a registry study of more than 56,000 children and adolescents found that those with both Type 1 diabetes and ADHD experienced diabetic ketoacidosis — a dangerous, sometimes life-threatening breakdown of control — about twice as often as peers without ADHD (Hilgard et al., 2017). And ADHD is badly under-recognized in this population. In a study of adults with Type 1 diabetes, nearly a third — 31.9% — screened positive for ADHD symptoms, yet only 15.4% had ever been formally diagnosed or treated (Zhang-James et al., 2025). Roughly half of those whose brains were struggling had no name for it and no support, and ADHD symptoms were strongly linked to worse glycemic control and higher rates of depression. Under-recognition is worst of all in girls, whose ADHD more often takes the quiet, inattentive form — spacey, disorganized, forgetful — that gets read as carelessness rather than a treatable condition. If this is the picture in adults who have had years to build coping systems, the challenge for a teenager with an even less mature executive brain is at least as significant.

Why treating it matters for diabetes

This is not merely a matter of getting a label. When ADHD is present and treated, the benefits can extend into diabetes itself: better executive functioning tends to mean more consistent management, and studies suggest treated ADHD is associated with better glucose control and fewer hospitalizations than untreated ADHD (Zhang-James et al., 2025; Hilgard et al., 2017). Treatment can also reduce the impulsive eating that drives glucose swings. If the pattern of forgetting, procrastinating, and struggling to start is pervasive — showing up in schoolwork and chores, not just diabetes — it is worth asking your child's doctor whether an evaluation for ADHD is

warranted. What looks like a diabetes problem may be an untreated attention problem wearing a diabetes costume.

The quiet ADHD that gets missed

It is worth dwelling on why so many young people with attention difficulties go unrecognized for years — because the ones who are missed are often the ones diabetes hits hardest. The stereotype of ADHD is a young boy who cannot sit still, interrupts, and bounces off the walls. But a great many people with ADHD, and girls especially, have the *inattentive* presentation: they are not disruptive at all. They are the daydreamers, the disorganized, the ones who lose things, run late, and "aren't working to their potential." Because they cause no trouble in a classroom, they slip through screening again and again, absorbing a lifetime of feedback that they are lazy, careless, or not trying — when the truth is that their brains are wired to struggle with exactly the skills school and diabetes both demand. For a young person with Type 1, this means a quiet, treatable condition may be silently sabotaging both their grades and their glucose, while everyone around them reaches for the language of character instead of neurology.

Getting an evaluation: what it involves

If the pattern fits, an evaluation is a concrete, low-risk next step, and it helps to know what it involves so it feels less daunting. An ADHD assessment is not a single test but a picture built from several sources: a careful history of how your child functions across settings (not just at home, and not just around diabetes), standardized rating scales completed by parents and teachers, and a clinician's judgment about whether the difficulties are pervasive, long-standing, and impairing. It can be done by a pediatrician, a psychiatrist, or other licensed behavioral health professional. Moreover, a good evaluation

also looks for the conditions that often travel with ADHD or mimic it — anxiety, depression, learning differences, sleep problems, and, importantly, the effects of diabetes itself, since both very high and very low glucose can cloud attention. The point is not to pin a label on a struggling teen but to understand the mechanism behind the struggle so the right supports can follow.

Questions parents ask about treatment

When ADHD is confirmed, families understandably have questions about treatment, and this book is not the place for medical advice — those decisions belong to you and your child's clinicians. But a few points help frame the conversation. Treatment for ADHD is usually a combination of approaches: behavioral strategies and environmental structure (the scaffolding described below), often alongside medication, which for many young people meaningfully improves focus, follow-through, and impulse control. In the context of diabetes, effective ADHD treatment is not a distraction from medical care; because attention and follow-through drive daily management, treating ADHD can be part of what finally makes diabetes management workable, and treated ADHD has been associated with better outcomes than untreated ADHD in this population (Zhang-James et al., 2025). Any medication decision deserves a full conversation with the prescribing clinician about benefits, side effects, and how it fits with your child's overall health. The larger message is simply that this is a treatable condition, and that treatment can lift a burden your child has been carrying, often in shame, for a long time.

What actually helps: change the question, then build the scaffolding

The single most useful move a family or clinician can make is to change the guiding question from “Why won't this young person comply?” to “What executive supports does this young person need?” That reframe turns a dead end into a to-do list. Instead of demanding more willpower — which is precisely the resource in short supply — the goal is to build external structure that does the work the brain finds hardest.

In practice, that means *externalizing memory and initiation* rather than relying on them. Tie insulin and medication reminders to alarms and to things the young person already does every day. Let technology carry the load where it can: pumps and apps with dose reminders, automated refills, a shared family calendar for appointments. *Reduce the number of steps* in any routine, and store supplies where they physically cannot be missed. Post simple checklists where the task actually happens. Consider “body-doubling” — doing a dreaded task alongside someone — to get past the initiation hurdle. And crucially, reposition yourself as a parent from *enforcer* to *engineer*: instead of nagging about a task your child keeps “forgetting,” help design an environment in which the task happens almost automatically, without depending on memory or motivation.

The Post-it Note Game

Write daily tasks out separately on post-it notes, posting them in a common area (i.e. on the refrigerator). For example: “Walk the dog;” “Change out CGM.” At the end of the day, remove those post-it notes where the task was completed. Crumple them into a ball and shoot for the trash can. Each basket equals a point. Track points. Siblings may compete with each other, keeping in mind that as the rate of daily tasks increase, so do the opportunity for points.

Two more supports matter. At school, a formal plan (such as a 504 plan) can secure accommodations — permission to check and treat,

extra time, a place to manage lows — that reduce the executive burden of a diabetes day. And because years of being called lazy or careless leave a residue of shame, self-compassion is part of the treatment: a young person who believes they are simply a failure will not be rescued by trying harder. Pairing real ADHD treatment with a kinder story about why things have been hard is what finally lets the scaffolding hold.

Suggested Reading

Peg Dawson & Richard Guare, *Smart but Scattered Teens* — the go-to parent guide for building executive-function skills

Sharon Saline, *What Your ADHD Child Wishes You Knew* — warm and practical, aimed at breaking the shame-and-blame cycle

Edward Hallowell & John Ratey, *Driven to Distraction* — the classic, hopeful introduction to ADHD

Russell A. Barkley, *Taking Charge of ADHD* — an authoritative but readable parent handbook

Disordered Eating and Diabulimia: The Most Dangerous Overlap

A Story from Practice

Psychotherapists are not instruments. We do not hold ourselves at a clean clinical distance; we empathize with our patients, sometimes too much, and that overflow is one of the quiet occupational hazards of the work. For me the hazard has two edges. I live with Type 1 diabetes myself, and it is a genuine gift in the consulting room: my diabetic patients never have to explain to me what life with the disease is like — only what their diabetes is like for them. But the same knowledge can betray me. I can wander into the weeds of the science — the numbers, the mechanisms — and let the biology blind me to the person sitting in front of me. Both edges were waiting the morning I logged in to meet Allan. I took a slow breath and let it out before I clicked to join out Zoom meeting. I knew this one was going to cost me something.

We never made it past the introductions. “Hi, I'm David.” “Hi, I'm Allan.” His eyes were red and swollen from hours — from days — of crying. His nineteen-year-old son, Ryan, had died of diabetic ketoacidosis a few days earlier. So I did the only thing worth doing: I let him be. I gave him permission to say anything, or to say nothing at all, and for most of that first hour he said very little. He mostly wept. What I gathered came in fragments. He had divorced a few years back. His ex-wife was, in his phrase, “in the wind.” He had been left to raise their two sons — identical twins — on his own.

It was in our second session, two days later, that the facts began to come, and I recognized them for what they were: a place to stand. Allan had handed the funeral arrangements to his sister, and he needed somewhere to put his attention that was not the raw center of

his grief. The details were that somewhere. Grief often works this way — the facts become a railing to grip while the floor gives way beneath you. I let him grip it. Ryan, he told me, had been diagnosed with Type 1 at twelve.

Then Allan began holding photographs up to the camera — his boys, his family, a few that still included his ex-wife. In each one he pointed carefully to Ryan, so I would not confuse him with his brother. But I could already tell them apart. Ryan was the heavier of the two. Not by much — a few extra pounds — but enough to see. I had to ask. “Was his brother diabetic too?” “No,” Allan said, getting lost in the science too for just a moment. “You'd think if they were twins, they'd both have gotten it.” It is a reasonable thing to think. The truth is that an identical twin of someone with Type 1 does carry a substantially elevated risk — yet the odds still favor the second twin never developing it. One brother diagnosed, one untouched, from the very same genetic blueprint. It makes you wonder about everything else that goes into the soup: the triggers, the timing, the thousand unseen factors that decide whether the disease ever surfaces at all.

More of Ryan's life came out in pieces. He had rented an apartment with two friends. College had never interested him; he was working two jobs, retail and waiting tables. And there had been a girl — his girlfriend since high school — who had broken it off. She had gone away to college and met someone new. Ryan had not gotten over it. In the way of this era, he could not stop following her online, studying the photographs she posted, studying the new man beside her. And then Allan said something that lodged in me. Ryan had recently decided he was ready to date again. He had started going to the gym. He had lost “that pooch on his belly.” He was spending too much money on new clothes.

As Allan offered these details — evidence, to him, that his son had been turning a corner — my own suspicion quietly grew, and I had to work to keep it off my face, because this was a father's hour, not a place for my clinical theorizing. But I could not un-hear it. A young man with Type 1, heavier than his twin, always seeing what a leaner, more muscular version of himself would look like, wounded by a breakup, measuring himself against a rival's flatter stomach, newly devoted to the gym, wanting to remake his body — and then dead of DKA. I have seen the shape of this before. Restricting insulin is a brutally effective way to lose weight; deprived of the hormone it needs, the body sheds pounds through its own slow chemical unraveling. To a young man desperate to change how he looks, it can seem like a secret working in his favor: eat, drink, skip the insulin, watch the weight fall away. It is also among the most lethal things a person with diabetes can do.

We do not tend to picture men when we picture eating disorders. That picture is out of date. Over the past several decades the rates among men have climbed until they run far closer to women's than most people — most clinicians, even — assume. Diabulimia in particular hides easily in a young man, because it does not announce itself the way we expect an eating disorder to. It arrives disguised as ambition: the gym membership, the new discipline, the better clothes, the visible progress everyone around him applauds. A father watching his son finally “get it together” has no reason to read a death sentence in it. Neither, most likely, did the son.

I do not know that Ryan died of diabulimia, and I want to be honest about the limits of what I can claim. I never met him. I have only a grieving father's photographs and a scattering of details, filtered through my own trained pattern-recognition — and pattern-recognition, as I said at the start, is exactly the edge of the sword that can cut the wrong way. It is possible I am seeing a story that fits my

expertise a little too neatly. But I suspect. And the suspicion matters less for what it might explain than for what it can never give back. Because here is what I had to hold, sitting with Allan: even if I am right, it changes nothing for him now, and it might wound him terribly to hear it. My work in that room was not to solve the mystery of how Ryan died. It was to accompany a father through the unbearable fact that he did. Allan will most likely never know for certain what took his son, and part of the work ahead is helping him live inside that not-knowing without letting it curdle into self-blame — the endless, cruel rehearsal of what he might have noticed, might have asked, might have prevented. There was nothing obvious to notice. That is precisely the tragedy of this disease when it turns inward: right up to the end, it can look like a young man getting better.

When the session ended, I sat for a while before I opened the next chart. Being someone living with diabetes and a psychotherapist gave me a way into Allan's grief that I would not otherwise have had; it also meant I could not keep a safe distance from it. I saw my own body in his son's story, and my own mortality, and the thin, quiet margin that every person with this disease walks every single day. Both edges of the sword, in the same hour. I let out the breath I had been holding since “Hi, I'm David,” and I allowed myself, for a moment, to grieve a young man I never met.

This chapter addresses the most life-threatening behavioral-health concern in this book, and for that reason it asks for your close attention. The intersection of diabetes and eating disorders is uniquely dangerous, and it is far more common than most parents have ever been told.

Start with a sobering fact: girls and women with Type 1 diabetes are roughly 2.4 times more likely to develop an eating disorder than

their peers without diabetes (Jones et al., 2000). Disordered-eating behaviors of some kind affect a large share of young people with Type 1 — by various estimates, somewhere around a third of adolescent girls and a meaningful minority of boys (ADA, 2024; Jones et al., 2000). Diabetes, in a cruel twist, creates the very conditions in which eating disorders flourish: relentless attention to food, carbohydrate counting, numbers, weight, and constant bodily surveillance. A young person is asked, every day, to police what they eat and to watch how their body responds. For someone vulnerable to an eating disorder, that is fuel.

What diabulimia is

In Type 1 diabetes, there is a specific and especially deadly behavior with an informal name: *diabulimia*. It refers to the deliberate restriction or omission of insulin as a means of controlling weight. It is not an official diagnosis in the psychiatric manual, but clinicians consider it among the most lethal behavioral-health problems in all of diabetes care.

The mechanism is what makes it so seductive and so dangerous. Insulin allows the body to use glucose, and adequate insulin supports normal weight. When a person skips insulin, glucose cannot be used and instead spills out in the urine, carrying calories with it — producing rapid weight loss through a process of slow metabolic self-destruction. A young person discovers that they can eat and still lose weight simply by taking less insulin. That discovery can launch a powerful, self-reinforcing cycle wrapped up in body-image concerns, perfectionism, shame, secrecy, and a distorted sense of control.

How dangerous it really is

It is worth being direct about the stakes, because the danger is easy to underestimate when a young person looks, on the surface, like they are simply "watching their weight." In a landmark eleven-year study of women with Type 1 diabetes, those who reported restricting insulin had roughly a *threefold* higher risk of death, and they developed diabetes complications — kidney disease, nerve damage, and foot problems — at higher rates and earlier ages than women who did not restrict (Goebel-Fabbri et al., 2008). Insulin restriction accelerates the very complications that diabetes care exists to prevent: retinopathy that threatens vision, neuropathy, kidney failure, and repeated, dangerous episodes of diabetic ketoacidosis. This is not vanity with a medical footnote. It is one of the most lethal patterns in all of chronic illness, and it can hide behind a body that looks perfectly healthy.

Who is at risk — and why it is not only girls

Adolescent and young-adult women are the highest-risk group, and much of the research has focused on them. But it is a serious and dangerous mistake to assume boys and young men are exempt. Eating disorders in males have long been under-recognized and under-diagnosed, in part because the cultural image of an eating disorder is a teenage girl — and that blind spot means a struggling young man is even less likely to be identified before he is in crisis. In young men, the drive may express itself through the pursuit of leanness or muscularity, through gym culture, or through a sudden, praised "getting healthy" that is actually something far more dangerous. Diabetes adds its own risk on top of ordinary body-image pressures: the disease trains every young person, regardless of gender, to fixate on food, numbers, and the body, and it hands them

a uniquely effective and hidden tool for weight loss. Any young person with Type 1 can be vulnerable.

The psychology underneath

The drivers are rarely about vanity alone. Diabetes trains a young person to attach meaning — even moral meaning — to numbers and to the body. It becomes dangerously easy for them to tie their sense of worth to a reading on a meter or a number on a scale.

Perfectionistic thinking turns corrosive: a single out-of-range value becomes proof of total failure, and a young person who feels they can never be “good enough” at diabetes may seize on insulin restriction as one area where they finally feel in control. Understanding this is essential, because it explains why the behavior cannot be corrected by medical stabilization alone. If you fix the body but never address the emotional function the behavior was serving, the behavior comes back.

Warning signs — and a tool that can help

Because diabulimia hides, parents are often the first line of detection. Signs worth taking seriously include a persistently high A1c that does not match your child's reported efforts, repeated episodes of DKA, unexplained weight loss, secrecy around insulin and glucose data, skipped doses, unused insulin accumulating in the house, extreme concern about weight or body shape, avoidance of eating in front of others, and frequent trips to the bathroom after meals. Any one of these deserves a conversation; several together deserve prompt professional evaluation.

You do not have to rely on intuition alone. Care teams can use a brief, validated screening questionnaire designed specifically for this

population — the Diabetes Eating Problem Survey–Revised — which was created to catch disordered eating in young people with Type 1 diabetes early, before it becomes a crisis (Markowitz et al., 2010). If you are worried, you can ask your child's diabetes team directly whether they screen for disordered eating, and request it if they do not. Leading guidelines now recommend routine screening for disordered eating as part of diabetes care (ADA, 2024).

Why diabulimia so often hides in plain sight

Insulin restriction for weight control is not rare. Estimates suggest it occurs in roughly 11–15% of adolescents with Type 1 diabetes and in an even larger share of young adult women (ADA, 2024; Jones et al., 2000).

It is frequently missed because it does not arrive through the usual eating-disorder doors. Instead of dramatic dieting, it often surfaces as a medical mystery: unexplained high A1c, unexpected weight loss, and — the biggest red flag — recurrent episodes of diabetic ketoacidosis.

How it usually begins: the slippery slope

Diabulimia rarely starts as a decision to do something dangerous. It usually begins somewhere ordinary — the diet culture every teenager swims in, a comment about weight, the normal body-consciousness of adolescence — and then collides with a discovery unique to diabetes. A young person notices, sometimes by accident after a period of skipped or forgotten insulin, that letting their sugar run high makes the weight fall off. From there a private, powerful logic can take hold: here, at last, is a way to eat freely and still control the body, and no one has to know. What may have started as a few missed doses becomes a habit, then a compulsion, then an organizing principle. Understanding this gradual, almost accidental onset matters, because it means the young person did not set out to harm themselves, and it means early moments — the first signs of

insulin avoidance, the first unexplained weight change — are exactly when intervention is most possible and most effective.

What recovery looks like

Recovery from diabulimia is real and possible, but it is rarely quick, and it helps parents to have honest expectations. Because the disorder lives at the intersection of body and mind, healing has to happen on both fronts at once. Medically, the first priority is stabilization — safely restoring insulin, which can be physically uncomfortable at first (the body may retain fluid and the person may temporarily gain weight as it rehydrates and heals), a stage that must be handled gently by the medical team because it is precisely the stage a body-anxious young person most fears. Psychologically, the work is slower: untangling the meaning that food, insulin, numbers, and weight have taken on, addressing the perfectionism and shame underneath, and gradually rebuilding a tolerable relationship with a body the young person must monitor for life. Setbacks and relapses are common and are part of the process, not proof of failure. Recovery is measured less in a single perfect A1c than in a young person slowly reclaiming a life that is not ruled by the number on the scale or the meter.

Finding specialized help and levels of care

This is not a problem for a family to solve alone, and it is not one that a general psychotherapist or a general eating-disorder program is always equipped to handle, because so few clinicians are expert in both eating disorders and diabetes. Care is delivered at different levels of intensity depending on medical and psychological risk: standard outpatient care with a coordinated team; more intensive outpatient or day programs for those who need more structure; and residential or inpatient care when someone is medically unstable or

unable to interrupt the behavior on their own. When you seek help, it is worth asking directly whether a provider or program has experience treating disordered eating specifically in people with Type 1 diabetes, because that combined expertise changes outcomes. Diabetes and eating-disorder advocacy organizations maintain referral resources, and your child's endocrinology team is often the fastest route to a specialist who understands both worlds. The essential message is to act early and to insist on expertise: this is a condition where the right, specialized help is genuinely lifesaving.

Why ordinary eating-disorder treatment must be adapted

Treatment works best when several kinds of professionals coordinate closely: the endocrinology team, a psychotherapist, a dietitian, and — very often — a family therapist, all pulling in the same direction. But standard eating-disorder treatment cannot simply be copied over, because it usually asks a patient to stop counting, weighing, and monitoring food — and a person with diabetes cannot safely do that. The vigilance that fuels the disorder is also medically necessary to stay alive. This double bind is exactly why diabulimia is so hard to treat and why it requires clinicians who understand both worlds. Recovery, then, is not about caring *less* about food and glucose — it is about changing the emotional charge those numbers carry, so that necessary awareness no longer tips over into fear, punishment, or a desperate bid for control.

What parents can do — and what to avoid

One point deserves emphasis for parents, because it is easy to get wrong in a moment of fear. Shaming language backfires. Calling a young person reckless, manipulative, or self-destructive drives the behavior further into secrecy, which is exactly where it is most

dangerous. So does turning mealtimes into surveillance: policing every bite and every number tends to intensify the shame and control dynamics that feed disordered eating, not relieve them. As much as you safely can, aim to model a calm, neutral relationship with food and bodies at home, and to keep your own comments about weight — your child's, your own, anyone's — to a minimum. Effective care, and effective parenting, gets curious about the *function* of the behavior: What need is the insulin restriction meeting? Is it about control, fear, self-punishment, body image, identity? A young person in this situation is suffering, not misbehaving. Approaching them with compassion and urgency — rather than anger — keeps the lines of communication open, and open communication can be lifesaving. If you suspect diabulimia, treat it as the emergency it is and involve your child's medical team and a mental-health professional experienced in eating disorders without delay. Early, specialized, coordinated care is what changes the trajectory.

Suggested Reading

James Lock & Daniel Le Grange, *Help Your Teenager Beat an Eating Disorder* — the leading evidence-based parent guide (family-based treatment)

Jennifer L. Gaudiani, *Sick Enough: A Guide to the Medical Complications of Eating Disorders* — accessible, and directly addresses diabetes and insulin restriction

Lauren Muhlheim, *When Your Teen Has an Eating Disorder* — a practical, step-by-step parent playbook

Diabetes Is a Family Disease: Parents, Marriages, and Siblings

A Story from Practice

Mark and Susan met in their first year at community college and married young. Fifteen years later they have built the kind of steady, hardworking life that rarely draws attention to itself. Mark runs a contracting business, framing and finishing single-family homes, often working six or seven days a week. Susan teaches third grade. For years their division of labor felt natural and fair — until two years ago, when their nine-year-old son was diagnosed with Type 1 diabetes. A diagnosis like that does not stay with the child. It moves into the house, rearranges the quiet architecture of a marriage, and asks each parent to become something no one trained them to be.

Since that day, Susan has thrown herself into learning. She has read the books, the clinical guidelines, the online forums; she can recite carbohydrate ratios and correction factors and knows her son's overnight glucose patterns better than anyone. Mark, by his own account, has stepped back from that role. As he put it in one of our sessions, “Susan has a master's degree; I was lucky to make it out of community college with a degree. I trust her; I know she knows what she's doing.” It is a statement of real respect — and, underneath it, a quiet self-doubt that has shaped how this couple carries their son's illness.

This pattern — one parent becomes the expert, the other defers — is among the most common after a childhood diagnosis, and on the surface it looks efficient. Over time, though, it tends to concentrate the emotional and mental load on one person while leaving the other feeling peripheral, or searching for smaller, less visible ways to help. Mark has found his: food. He has appointed himself steward of what

he calls the “family diet,” offering frequent meal suggestions and reviewing the groceries Susan brings home. In his mind this is his lane, a concrete way to protect his son and stand beside his wife. To Susan, it can feel like being audited in her own kitchen.

Susan carries two resentments, and both are worth naming plainly. The first is a bind that would strain anyone. She would like to leave teaching and devote herself fully to caring for their son, but because Mark is self-employed, her job carries the family's health insurance. She is tethered to work by the very illness she wishes she could stay home to manage — unable to step back from her career, and feeling equally unable to step back from diabetes. The second is that Mark's unwillingness to “do a deep dive in the literature” strikes her as unfair, leaving her alone with the intellectual and medical weight of their son's care.

Mark's resentment runs in the opposite direction. He finds candy bars and sweets tucked into their bedroom drawers, and Susan does not deny the private eating — the stops at Dunkin' on the way to and from work, the unhealthy snacks at school. To Mark, who has organized his entire contribution around disciplined family eating, this feels like a contradiction he cannot square: the household holds a firm line on sugar for their son while, quietly, that same line is crossed.

A single system under strain

What looks like two separate grievances is really one system pulling against itself. The “family diabetic diet” and Susan's hidden sweets are not unrelated; they are two ends of the same rope. When food in a home becomes watched — suggested, reviewed, weighed — eating can quietly split into what is permitted and what is hidden. Susan's drawer of candy may be less about appetite than about autonomy: a small private space that is hers, unmonitored, inside a life that has

become intensely monitored. Stress eating is also a well-recognized response to precisely the kind of chronic, high-vigilance load she carries. This is not a character flaw. It is a pressure valve. Seeing it that way does not make the pattern healthy, but it moves the conversation from blame toward understanding.

Mark's focus on food is easy to read as controlling. Through a kinder lens, it is the contribution available to a man who believes he lacks the schooling to handle the “real” medicine. He cannot run the literature review, so he runs the groceries. His attention to the diet is how he loves his son and partners with his wife, expressed in the one domain where he feels genuinely competent. When Susan experiences that attention as scrutiny and Mark intends it as teamwork, both of them are telling the truth.

The insurance trap and the expertise gap feed each other. Susan cannot ease off at work, and she feels she cannot ease off diabetes either, so the pressure has nowhere to go. Mark, sensing his wife's exhaustion but doubting his own competence, doubles down on the one job he has claimed. The result is a marriage in which two people who love each other and love their son grow more and more alone inside the same crisis.

Why the marriage is part of the care

There is reason to treat this as more than a private matter between spouses. Research in pediatric diabetes has linked the quality of the parents' relationship — including the primary caregiver's marital satisfaction — to children's glycemic outcomes. The distance opening between Mark and Susan is therefore not only a marital concern; indirectly, it is part of their son's medical picture. Strengthening their partnership is a legitimate form of diabetes care, not a luxury set apart from it.

The work ahead is not to settle who is right about the carbs or the candy. It is to redistribute the load so that neither partner is stranded. For Mark, that may mean building real confidence and competence on the medical side — not because Susan is failing, but so that she is no longer alone. For Susan, it may mean loosening her grip enough to let him in, naming the insurance bind out loud, and grieving the full-time-mother life she imagined rather than letting that grief leak out sideways as resentment. And it means treating Susan's private eating not as a betrayal to be policed but as a signal: a sign of a woman running on empty who needs care herself, not another set of eyes on her plate.

Mark and Susan did not drift apart because either of them stopped caring. They drifted because a nine-year-old's diagnosis handed them an impossible job and they divided it the way most couples do — by instinct, along the lines of who felt capable of what. The task now is to come back together, and to see that the expert and the food-watcher, the tethered teacher and the self-doubting builder, are sitting on the same side of the same table. Their son does not need two parents managing diabetes in parallel. He needs two parents managing it together.

Everything in this book so far has focused on your child. This chapter turns the lens toward you — because when a young person has diabetes, the whole family lives with it, and the health of the family system has a real, measurable effect on the child's wellbeing. This is not said to add to your burden. It is said because supporting yourself and your relationships is one of the most effective things you can do for your child.

When a child is diagnosed, mothers and fathers take on a role no one prepared them for: not simply parenting, but jointly running a demanding medical regimen in which the stakes are high and the

watchfulness never fully switches off. That role reshapes a marriage or co-parenting relationship, and it often creates strain. A common pattern emerges: one parent becomes hypervigilant, immersing themselves in the medical details — reading everything, mastering the device data, watching the glucose graphs around the clock — while the other parent, perhaps feeling less expert, steps back and defers. Over time this imbalance can breed resentment on both sides. The engaged parent feels alone with the responsibility; the other feels sidelined or criticized. Instead of drawing the couple together, the diagnosis can drive a wedge of blame, anxiety, and emotional distance.

Family conflict is itself a medical variable

It is not only marital strain that matters; conflict *about diabetes* has its own measurable effect on a child's health. Researchers developed a Diabetes Family Conflict Scale precisely because this kind of conflict — arguments over checks, doses, food, and numbers — turns out to be closely tied to how well a young person manages and to their glucose control (Hood et al., 2007). The mechanism is painfully familiar to most families: a worried parent reminds, monitors, and corrects; the teen experiences this as nagging and control; the reminders trigger conflict; the conflict makes the teen disengage from the very tasks the parent was worried about. Clinicians sometimes call this well-intentioned pattern “miscarried helping” — help that, however loving, ends up making things worse. Seeing the loop is the first step to stepping out of it. The aim is to keep the relationship warm and the conflict low, because a low-conflict home is, quite literally, part of good diabetes care.

The delicate handoff: staying involved without taking over

One of the hardest tasks of these years is calibrating how much to hand over and when. It is tempting, as a child gets older, to step back quickly — they are capable, they want independence, and constant involvement causes friction. But handing full responsibility to a young person before their skills and their still-developing brain are ready is associated with poorer management, not better. The most protective stance is neither rigid control nor hands-off retreat, but *collaborative involvement*: staying genuinely engaged as a partner and a safety net while gradually, deliberately transferring specific responsibilities as your child demonstrates readiness. The message that works is not “It's all on you now,” nor “I'll do it because I don't trust you,” but “We're a team, and I'm handing you the wheel one stretch of road at a time.”

The everyday battlegrounds — and the technology that heightens them

Diabetes gives families new things to argue about: food choices, discipline, how much independence to allow, how to handle school, and how aggressively to use monitoring technology. A young person's completely normal developmental push for autonomy can collide head-on with a parent's completely understandable need to keep them safe. What a teenager experiences as suffocating surveillance, a parent experiences as lifesaving vigilance. Both are right, which is exactly what makes it so hard.

Continuous glucose monitors (CGMs) have been a genuine medical blessing, but they can amplify this tension. Because a parent can now watch a teen's glucose in real time from across town, the temptation to intervene constantly is enormous. Remote monitoring can slide

into remote controlling — and the constant stream of alerts can wear on parents, too, disrupting sleep and keeping the household in a state of low alarm. College students sometimes describe the humiliation of a parent phoning campus staff or a professor in response to a glucose alert. What begins as love can, without anyone intending it, become an overreach that damages trust and independence. It helps to agree together, explicitly, on when and how you will respond to the data — and to renegotiate those rules as your child grows, so the technology serves the relationship rather than straining it.

Siblings carry it too

In the understandable intensity of caring for a child with diabetes, it is easy for brothers and sisters to become the quiet background of family life. Siblings often carry their own mix of feelings: worry for the child who is sick, resentment at the attention that flows toward them, guilt for that resentment, and a sense of being overlooked. Some become anxious little caretakers themselves; others act out to reclaim attention. None of this means anything is wrong with your family — it is a normal response to a genuinely uneven distribution of parental bandwidth. What helps is small and deliberate: protected one-on-one time with each sibling, honest and age-appropriate information about the diabetes so the unknown is less frightening, and explicit acknowledgment that their feelings are allowed. A sibling who feels seen is far less likely to carry that hurt into adulthood.

Why your relationship is a medical variable

Here is a finding that surprises many parents: the quality of the parents' relationship is associated with the child's diabetes outcomes. Research has found that the primary caregiver's

satisfaction in their own marriage is linked to their child's A1c (Loomba et al., 2022), and that young people in two-parent households tend to have healthier glycemic control (Swift et al., 2006). The implication is remarkable — strengthening the parental relationship may actually improve the child's blood sugar. Couple therapy, communication training, shared and clearly divided caregiving responsibilities, and collaborative problem-solving are not indulgences that distract from "real" diabetes care. For many families, they *are* diabetes care.

Practical ways to protect the family system

- Share the load deliberately. Divide diabetes tasks so one parent is not silently carrying all of it. Rotate the night alarms, the appointments, the supply runs.
- Present a united front. Disagree about diabetes decisions privately, not in front of your child, so management does not become a wedge between parents or a source of mixed messages.
- Watch the monitoring creep. Agree together on when and how you will respond to CGM data, and revisit those rules as your child grows toward independence.
- Don't forget the siblings. Brothers and sisters often absorb less attention and may feel overlooked, resentful, or frightened. Make space for them too.
- Get your own support. Caregiver burnout is real. Your steadiness is a resource your child depends on, and protecting it is not selfish.

Single parents and co-parenting across two homes

Not every family managing diabetes has two parents under one roof, and the picture shifts in important ways when it does not. A single parent may be carrying the entire relentless load — the night alarms, the appointments, the supplies, the worry — without anyone to trade off with, and the risk here is not marital conflict but sheer depletion

and isolation. If this is your situation, building a support team outside the household becomes essential: a trusted relative, a friend, a school nurse, an online community of other diabetes parents, anyone who can share even a small piece of the vigilance so it does not rest on one set of shoulders indefinitely.

When a child splits time between two homes after a separation or divorce, diabetes adds a demanding layer to co-parenting. Insulin, supplies, routines, and monitoring have to travel and stay consistent across households that may not agree on much else — and inconsistency between homes is not merely inconvenient; it can directly destabilize a child's control. However difficult the adult relationship, children do best when their parents can build a shared, written diabetes plan, keep each other informed about doses and trends, and present the child with one consistent set of expectations. It is worth remembering the research thread running through this chapter: the child's glucose is genuinely affected by the family's functioning (Loomba et al., 2022; Swift et al., 2006). Cooperating on diabetes, even when little else is cooperative, is a concrete gift to your child's health.

The wider circle: grandparents, schools, and other caregivers

Diabetes also has to be carried, at least part-time, by people beyond the parents — grandparents who babysit, a coach, a school nurse, the parents of friends hosting a sleepover. Each of these hand-offs is an opportunity for either support or anxiety. Grandparents and other relatives sometimes over-worry, sometimes under-appreciate the seriousness, and sometimes undermine routines with well-meaning treats; clear, simple, written instructions and a little patient education go a long way. Schools are a world of their own: a formal plan (such as a 504 plan) can secure your child's right to check and

treat, to have snacks and water, to see the nurse, and to make up missed work, reducing both the medical risk and the daily friction of a diabetes day. The more the wider circle understands, the less the entire weight falls on the immediate family — and the more your child experiences the world as a place that can accommodate them.

Rupture and repair

No family manages a chronic illness without conflict — sharp words over a missed bolus, a slammed door, a parent's fear coming out as anger. What distinguishes families that stay close is not the absence of these ruptures but the presence of repair. Coming back afterward — acknowledging that you were scared and that it came out as criticism, apologizing for the sharpness without abandoning the underlying care, and reconnecting — teaches a young person that the relationship is bigger than any single bad moment, and it keeps conflict from calcifying into distance. This matters medically as well as emotionally, because it is chronic, unrepaired conflict, not the occasional argument, that erodes a young person's engagement with their own care (Hood et al., 2007). Repair is a skill any family can practice, and modeling it may be one of the more lasting things you teach your child.

Help that treats the family, not just the patient

When the strain runs deep, family-focused help works — and there is strong evidence for it. A structured approach called Behavioral Family Systems Therapy for Diabetes, which coaches families in communication, problem-solving, and conflict resolution, has been shown in randomized trials to improve both family relationships and glucose control in adolescents (Wysocki et al., 2007). In other words, working on how a family talks and solves problems together is not a detour from medical care; it can move the A1c. Depending on your

family's situation, the right support might be couple therapy, family therapy, or simply structured coaching in communication.
And do not overlook your own depletion. Systematic reviews document high rates of stress, worry, guilt, and disrupted sleep among parents of children with Type 1, especially the primary caregiver, and this burden is often compounded by fear of hypoglycemia that keeps parents up at night (Whittemore et al., 2012; Barnard et al., 2010). Your steadiness is one of your child's most important resources, and it cannot run on empty. Behavioral-health providers increasingly recognize that diabetes rarely belongs to one person alone. Effective treatment may involve working not only with your child but with the whole relational system around them. If your family is feeling the strain — and most families do at some point — seeking support for the *family*, not just the patient, is a sign of wisdom rather than failure.

Suggested Reading

Moira McCarthy, Raising Teens with Diabetes: A Survival Guide for Parents — exactly this chapter's territory, warm and practical

Leighann Calentine, *Kids First, Diabetes Second* — a parent's guide to family life with Type 1

John M. Gottman & Nan Silver, *The Seven Principles for Making Marriage Work* — strengthens the marriage this chapter shows matters to a child's health

Daniel J. Siegel & Tina Payne Bryson, *The Whole-Brain Child* (or Siegel's *Brainstorm*, on the teen years) — connection-based parenting that lowers conflict

Conclusion — Caring for the Person, Not Just the Numbers

Diabetes care is undergoing a quiet but profound shift — away from a narrow focus on compliance and lab values, toward a fuller understanding of the whole young person living with a chronic illness. The condition reaches far past insulin and glucose. It reshapes identity, can leave traumatic imprints, strains attention and follow-through, becomes tangled up with eating and body image, and sends ripples through the entire household. To see only the A1c is to see only a shadow of what your child is actually carrying.

Each chapter of this book carried a single, freeing idea. Diabetic distress reminds us that exhaustion is not always depression. The work of identity and meaning reminds us that young people need to be more than their diagnosis. Research on trauma shows that a frightening medical crisis can become a lasting wound. The reality of ADHD and executive dysfunction challenges the reflex to read struggle as irresponsibility. The phenomenon of diabulimia shows how the daily work of managing the disease can fuse with shame and self-harm. And family-systems research confirms that diabetes almost never belongs to one person alone.

Woven through all of it is one conviction: mental-health care is not an optional extra bolted onto real diabetes treatment. For a great many young people, it *is* part of the treatment. Your child's A1c can tell you whether their body is surviving. But whether your child is genuinely *living* — finding meaning, holding onto their sense of self, feeling safe, connected, and hopeful — is a question the numbers cannot answer. That is the question this book has invited you to keep asking. Your attention to it may be one of the most important parts of your child's care.

You cannot take diabetes away from your child. But you can make sure they never carry it alone — and you can make sure that the people around them are looking after the whole person, not just the numbers. That is within your power, and it matters more than you may know.

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