



Minimizing T1D-Related Family Conflict and Improving Communication

INTRODUCTION

Persons with type 1 diabetes (T1D) must engage in a number of complex daily tasks related to diabetes management, including monitoring glucose levels, insulin administration, attention to carbohydrate intake and physical activity, and treatment of high and low blood glucose levels. Diabetes management is demanding, and family members are important sources of support for individuals living with diabetes. However, working with parents or partners on diabetes management brings its own challenges, particularly when family members may have their own expectations for diabetes care.

Family conflict around diabetes-related tasks is fairly common and is a normal response to the relentless demands and worry associated with diabetes management. However, conflict can also hinder optimal diabetes management. In fact, family conflict is associated with multiple negative health and social outcomes for individuals with type 1 diabetes (T1D), including¹⁻⁵:

- Less frequent blood glucose monitoring
- Higher glycated hemoglobin (HbA1c) levels
- Avoidance of diabetes-related tasks, such as carrying supplies for treatment of high or low blood glucose levels
- Higher diabetes-related distress
- Lower health-related quality of life
- Less frequent engagement in collaborative problem solving

Thus, increasing positive interactions around diabetes care and decreasing conflict can help improve relationships, diabetes management, and glycemic control. This handout discusses potential areas of family conflict and practical interventions to address conflict. It will also provide context for this information in a case scenario.

WHAT ARE SIGNS OF FAMILY CONFLICT?

During a clinic visit, you may see several behaviors that point to family conflict:

- Negative communication by the parent or partner (eg, critical, coercive, or hostile language such as, “I can’t believe your HbA1c level is 9% again. I’m done helping you.”)
- Silence from the person with T1D and conversation dominance from the parent or partner
- Use of blaming or shaming language (eg, “bad” HbA1c or glucose levels, “failing” to attain health goals, “cheating” on carbohydrate intake, “sneaking” food or snacks)
- Overt disagreement about diabetes tasks/responsibilities
- Disengaged behavior from the parent or partner of the person with T1D
- Tearfulness or irritability in the patient, parent, or partner

It can help to directly ask the person with diabetes about their support team, including who helps out with diabetes management and how loved ones help or hinder diabetes management. This can provide important information about the role of parents and partners in diabetes care and potential areas of conflict.

POTENTIAL CAUSES OF CONFLICT

T1D Life Stages

Different life stages tend to bring different types of challenges and conflict related to diabetes management.

Adolescence. Adolescence is a uniquely challenging developmental period, and adolescents and parents must negotiate roles and responsibilities for diabetes care. As adolescents become more independent, they may challenge parental authority while turning their focus to socializing with peers, forming new relationships, and experimenting with alcohol, tobacco, and other drugs.⁶ Some family conflict at this life stage is a given, but persistent or high levels of family conflict have a negative impact on diabetes management and health.⁷ Ineffective parental involvement (eg, nagging, scolding, giving orders, blaming) is associated with poorer health-related quality of life and suboptimal adherence to care and treatment plans and glycemic control.⁷

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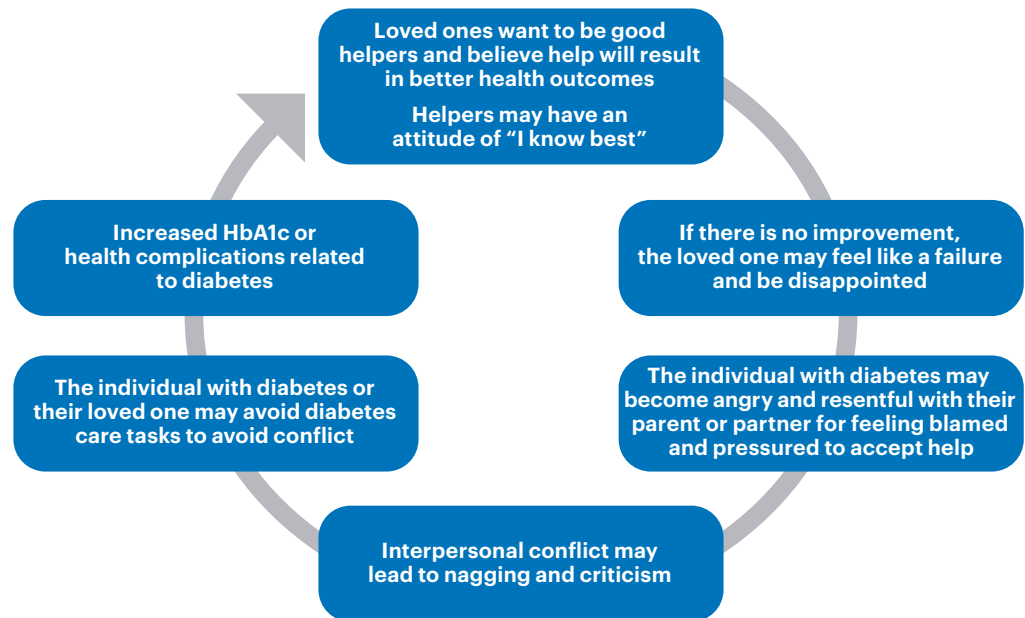
Young adulthood. This can be an unstable developmental period characterized by numerous transitions in employment, living situations, healthcare, and relationships with family members, friends, and romantic partners.⁸ Young adults must assume increasing responsibility for their diabetes self-management and general health, yet it may be difficult to prioritize diabetes care in the context of other responsibilities.⁸

Adulthood. Adults with T1D must maintain a rigorous regimen of diabetes-related activities while balancing the competing demands of a career, marriage or partnership, and children. In middle age, individuals with T1D may also have to cope with advancing diabetes-related complications.⁹ Conflict with partners can arise over diabetes self-management and the social and economic effects of having a chronic disease.⁹

“Miscarried Helping”

In the context of diabetes management, “miscarried helping” occurs when a family member or partner makes well-intentioned attempts to help a loved one with T1D, but the person receiving the help perceives the attempts as unhelpful, inappropriate, or excessive (Figure 1).¹⁰

FIGURE 1. MISCARRIED HELPING



Reprinted with permission from JDRF, based on data in Anderson BJ, Coyne JC. “Miscarried helping” in the families of children and adolescents with chronic diseases. In: Johnson JH, Johnson SB, eds. *Advances in Child Health Psychology*. Gainesville, FL: University of Florida Press; 1991.

Diabetes management works well when parents and partners are able to match their level of involvement to the needs of the individual with diabetes. Ideally, as a child with T1D matures, the parental role evolves from management to monitoring to coaching. When it doesn’t, family conflict may occur.¹¹ For example, parents may give too much responsibility to adolescents before they are ready. Or they may fail to recognize that their role should change as their child with T1D becomes more independent, and they may use ineffective or unhelpful parenting tactics, such as strictness, overprotection, and harshness.¹¹ Such approaches can cause teens to become resentful of parental intrusion in their diabetes management and may hinder their development of diabetes management skills and related confidence.¹¹

Among adults with T1D, parents or partners often want to help but may not know how to get involved in an appropriate manner. Common examples of miscarried helping among couples include partners who nag or criticize (“You really should be checking your blood glucose more often.”) or who feel responsible for the individual’s self-care (“I do everything I can to make sure you’re eating right!”) or get upset when the individual’s health does not improve (“It makes me angry that you don’t seem to care that your HbA1c is getting worse!”).

STRATEGIES TO ADDRESS FAMILY CONFLICT

Supportive Communication for People with T1D

The way in which family members or caregivers communicate with their loved ones with T1D is crucial, as is the communication style that healthcare providers use during patient interactions.¹² The following patient case illustrates critical and supportive communication approaches. It may be helpful to share these examples with your patients’ family members/caregivers as well as apply these strategies to your own patient care.



CASE SCENARIO

Cameron is a 15-year-old teenager who was diagnosed with T1D when he was 3 years old. His HbA1c level has been steadily rising for the past 3 years, and his most recent level was 11.2%. He does well in school, plays on the varsity soccer team, and regularly spends time with friends. He reports a positive relationship with his parents, but shares that they frequently argue with him about diabetes tasks.



He recently stopped wearing his continuous glucose monitor (CGM) because he felt that his parents were always “nagging him” about diabetes management and interrupting his time with friends. At today’s clinic visit, Cameron avoids eye contact and gives 1-word answers to most of your questions. His mother reports that she is “fed up” with asking him about his diabetes management and that Cameron is often not truthful about what he eats at school or when out with friends.

- ▶ What advice can you offer Cameron’s parents about communicating with their son?
- ▶ How can you better communicate with Cameron about his T1D self-management?

FAMILY MEMBER COMMUNICATION		HEALTHCARE PROVIDER COMMUNICATION	
CRITICAL	SUPPORTIVE	CRITICAL	SUPPORTIVE
Your glucose level when you got home was 350! What did you eat?	It looks like your glucose level was 350 after school today. How can I help? Let’s figure this out together.	Your HbA1c has been going up at every visit lately. We need to figure out what you’re doing to cause this.	Before we talk about your HbA1c results, can you tell me what’s been working well for you lately? What’s been the biggest challenge with your diabetes since your last visit?
You forgot to check your glucose level again. How do you expect me to help you when you can’t even take care of yourself?	Diabetes is tough, and I know that you have a lot to do every day in addition to managing your diabetes. What gets in the way of checking your glucose level before school?	You really should wear you CGM if you want to lower your HbA1c level and not have problems later on.	Even though you aren’t using your CGM right now, I can see that you’re still checking your blood glucose regularly. That’s great! Having that information can help me see if we need to adjust your treatment plan.

How Can Clinicians Address or Prevent Family Conflict?

Collaborative family relationships that emphasize shared responsibility for diabetes management are associated with improved emotional functioning and better diabetes self-management.¹³ To that end, you can¹⁴:

- **Recognize strengths** in the diabetes care visit and offer praise for what is working well
- **Work with patients and family members to set goals** that are developmentally appropriate for daily diabetes tasks
- **Encourage shared problem solving and decision making** among family members and individuals with T1D
- **Help patients and family members set up a plan for regular diabetes communication;** patients and family members can identify designated times to discuss diabetes management to identify trends and assess regimen adherence (rather than accosting the individual with T1D)
- **Incorporate technology to facilitate sharing and collaboration of T1D information;** for example, recommend that parents use emojis and other communication “shortcuts” when text messaging their adolescents about diabetes management

Strategies for Individuals with T1D and Their Families

Glucose and HbA1c are just numbers. A common pitfall is assigning judgment—good, bad, or even a letter grade—to glucose and HbA1c levels. Family members can benefit from understanding that¹²:

- A nonjudgmental approach to T1D data sets the stage for a collaborative interaction
- T1D data are best used as information to guide problem solving and decision making in diabetes care

Communicate to de-escalate. Communication that conveys support, caring, and compassion not only defuses conflict but is also associated with better quality of life, glycemic control, and adherence to diabetes regimens.⁷ Suggest that family members:

- Pay attention to tone and nonverbal communication
- Focus on how to help rather than blame the individual with diabetes
- Wait until everyone is calm to discuss diabetes concerns
- Discuss expectations for diabetes management and responsibilities for each person



CASE SCENARIO REVISITED

You acknowledge to Cameron and his parents that daily diabetes management seems to be causing tension between them. To help minimize family conflict:

- ▶ Work with them to develop a communication plan so they can discuss diabetes management in a more productive manner
- ▶ Help Cameron and his mother set clear expectations for diabetes management when he is out with his friends; for example, Cameron can send a text to his mother with a “thumbs up” sign to indicate that he took his rapid-acting insulin when eating with his friends
- ▶ Find out more about what burdens Cameron experienced with CGM and help him and his mother use the communication plan to address how CGM data could be shared and discussed; for example, maybe Cameron’s mother can see his glucose levels on her phone but only texts him directly about glucose levels if he is trending high or low
- ▶ Suggest that Cameron and his parents sit down each Sunday afternoon to review his diabetes self-care and work to solve any challenges together

When Patients and Families Need Extra Help

Consider making a referral to a behavioral health professional for concerns that can’t be addressed in primary care or when other circumstances are negatively affecting a patient’s diabetes management, such as parental job loss or divorce.¹⁵ To locate a mental health professional with expertise in diabetes, visit the American Diabetes Association Mental Health Provider Directory Listing at https://professional.diabetes.org/mhp_listing.

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