The psychological impact of a diagnosis of diabetes: why the moment matters

JAMIE ROSS,[1] SHOBA PODUVAL,[1] KATE HARDENBERG[2]

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The personal account by a fourth-year medical student,[1] published alongside this editorial, offers a compelling reminder that a diagnosis of diabetes is not simply a biomedical event. It is also a psychological one, with immediate and enduring implications for one's identity, emotional wellbeing and engagement with care. While the narrative reflects a single experience, the themes it raises will resonate with clinicians working across diabetes services and people living with diabetes.

Diabetes is a lifelong condition that requires sustained self-management. From the moment of diagnosis, individuals are asked to assimilate complex information, make daily decisions and incorporate treatment into the fabric of everyday life. The way in which diagnosis is experienced often sets the tone for how people come to understand their condition, relate to healthcare professionals and engage emotionally with ongoing care.[2]

Diagnosis as a psychological event

Diagnosis commonly evokes an understandable emotional response to learning that one is living with a long-term condition. Feelings of distress, shock or overwhelm at this stage are normal aspects of adjustment rather than signs of pathology. As people begin to live with diabetes, this initial response gives way to the continuing psychological demands of managing a condition that is frequently experienced as relentless. These demands unfold within family, social and healthcare contexts that are often poorly aligned with the realities of managing a 24-hour condition.

Diagnosis therefore represents a critical transition point. Evidence consistently shows that communication at diagnosis shapes patients' understanding of their condition, engagement with treatment, and ongoing relationship with healthcare services.[3] Although patients may not recall all clinical details, they often strongly remember emotionally charged information, particularly negative messages about risks or prognosis. This highlights the need for careful early communication to support understanding while minimising unnecessary distress.

Different diagnoses, different experiences

Diabetes is not a single condition, and differences in aetiology, treatment and care pathways between Type 1 and Type 2 diabetes (T1DM and T2DM) shape how diagnosis is experienced. T2DM, a metabolic condition with typically gradual onset, accounts for the majority of diagnoses. It is often identified through routine blood testing, may initially be asymptomatic, and may be framed as a risk state rather than a definitive illness. Diagnosis may therefore be experienced as incremental or low-key, particularly when individuals have anticipated the possibility of diabetes because of symptoms, family history or prior risk factors. In such circumstances, emotional responses may be characterised by acceptance or relief rather than shock. Conversely, diagnosis through routine testing in the absence of symptoms can be unexpected and emotionally disruptive. For some individuals, later transitions in treatment – particularly the initiation of insulin – represent a more psychologically salient moment, symbolising disease progression or loss of control.[4]

In contrast, T1DM often has rapid onset and may present as a medical emergency, including diabetic ketoacidosis. Diagnosis commonly takes place in secondary care and may involve hospital admission, particularly for children and young people. Such presentations can be physically and emotionally overwhelming.[5] In addition, diagnosis following acute illness and hospitalisation has been associated with elevated parental distress, underscoring how sudden routes to diagnosis can intensify emotional impact not just on the person living with diabetes, but on family members and carers also.[6]

1. Wolfson Institute of Population Health, Barts and The London School of Medicine and Dentistry, Queen Mary University of London
2. Diabetes Psychotherapy Service, Royal United Hospitals Bath NHS Foundation Trust

Address for correspondence: Dr Jamie Ross
Senior Lecturer in Primary Care Science, Wolfson Institute of Population Health, Barts and The London School of Medicine and Dentistry, Queen Mary University of London
E-mail: Jamie.Ross@qmul.ac.uk

Systems, settings and pressures at diagnosis

The setting in which diagnosis occurs also shapes the experience. Most people with T2DM are managed in primary care, where time-limited consultations and population-level targets prioritise achieving stable clinical markers and treatment initiation, often leaving little space to explore emotional impact. People with T1DM are usually managed within specialist secondary care teams, where access to multidisciplinary input has improved, although provision remains variable. Paediatric services are generally better resourced than adult services, creating a recognised transition gap for those diagnosed in late adolescence or early adulthood.

Across settings, the clinical emphasis on biomedical outcomes can sit uneasily alongside the emotional experience of diagnosis. Whether identified during emergency admission or routine testing, individuals are confronted with the reality of a lifelong condition that requires sustained emotional and cognitive work without necessarily being equipped to do this.

Diabetes distress is common — and easily missed

Diabetes distress – the emotional burden of living with and managing diabetes – is common and understandable. Severe diabetes distress affects one in four people with T1DM, one in five people with insulin-treated T2DM and one in six people with non-insulin treated T2DM.[7]

Distress fluctuates over time and tends to peak at key pressure points, including soon after diagnosis, during treatment escalation, with the onset or progression of complications or during periods of wider life stress. It is also heterogeneous. Certain groups face heightened or qualitatively different challenges, including adolescents negotiating increasing independence, people diagnosed with T1DM in later adulthood, individuals with established complications, neurodiversity or learning difficulties, and those who develop diabetes secondary to other serious illness or treatment.

Higher levels of diabetes distress are consistently associated with poorer self-management, higher HbA_{1c}, increased risk of severe hypoglycaemia and reduced quality of life; they may develop into clinical depression if left unmanaged.[8,9] Despite this, distress often goes unrecognised in routine care, particularly among individuals who appear clinically stable or well engaged.[10]

Why psychological care struggles to embed

Psychological care in diabetes is rarely absent by intent. More often, it struggles to embed because it is not consistently defined as core clinical work, nor routinely supported within existing care pathways. Time pressures, competing priorities and uncertainty about (or lack of) referral options can make clinicians understandably hesitant to raise emotional concerns, particularly when pathways for psychological support are fragmented, limited or poorly understood. This hesitation reflects real gaps in current care, where many people experiencing diabetes-related distress do not meet thresholds for specialist mental health services, leaving clinicians uncertain how best to respond.[10]

Implications for practice

A pragmatic approach is therefore required. Addressing diabetes distress does not mean exploring emotional wellbeing in depth at every appointment, nor resolving distress in a single consultation. Rather, it involves legitimising emotional burden, recognising key transition points where distress is likely to intensify, and responding proportionately when concerns arise.

Diagnosis should be recognised as both a medical and psychological intervention point. How the diagnosis is communicated, the space given for emotional response and the pacing of information all matter. Anticipating and normalising emotional reactions at diagnosis, offering reassurance and clear next steps, and planning opportunities for follow-up can help to prevent distress from becoming embedded at an early stage. Routine but proportionate enquiry about emotional wellbeing should be embedded across diabetes pathways, with an emphasis on simple, consistent questions rather than formal assessment, for example asking, "*How have you been feeling lately?*"[11]

Even when access to specialist psychological services is limited, brief and repeated acknowledgement that emotional responses are expected and understandable can reduce isolation and legitimise future disclosure of distress. In this way, psychological care becomes part of how diabetes is managed over time, without placing unrealistic demands on clinicians or services.

Conclusion

The personal account[1] published alongside this editorial reminds us that diabetes care extends far beyond diagnosis, targets and treatment algorithms. Emotional wellbeing is inseparable from self-management and long-term outcomes. Integrating psychological care into everyday diabetes practice is essential if we are to support people not only to live longer, but to live well.

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References

1. Thorpe G. Both a person with type 1 diabetes and a doctor: what I have learnt. *Br J Diabetes* 2026**;26**(1)29-30. https://doi.org/10.15277/bjd.2026.504
2. Polonsky WH, Capehorn M, Belton A, *et al.* Physician–patient communication at diagnosis of type 2 diabetes and its links to patient outcomes: new results from the global IntroDia® study. Diabetes *Res Clinical Pract* 2017;**127**:265-74. https://doi.org/10.1016/j.diabres.2017.03.016
3. Barry E, Blane D, Ross J, Freeman J. Conversations matter: improving the diagnosis experience for people with type 2 diabetes. *Br J Gen Pract* 2024;**74**(748):489-90. https://doi.org/10.3399/bjgp24X739713
4. Peel E, Parry O, Douglas M, Lawton J. Diagnosis of type 2 diabetes:

a qualitative analysis of patients' emotional reactions and views about information provision. *Patient Education Counseling* 2004;**53**(3):269-75. https://doi.org/10.1016/j.pec.2003.07.010
5. DeCosta P, Grabowski D, Skinner TC. The psychosocial experience and needs of children newly diagnosed with type 1 diabetes from their own perspective: a systematic and narrative review. *Diabetic Medicine* 2020;**37**(10):1640-52. https://doi.org/10.1111/dme.14354
6. Landolt MA, Ribi K, Laimbacher J, Vollrath M, Gnehm HE, Sennhauser FH. Brief report: posttraumatic stress disorder in parents of children with newly diagnosed type 1 diabetes. *Journal Pediatric Psychology* 2002;**27**(7):647-52. https://doi.org/10.1093/jpepsy/27.7.647
7. Diabetes UK. What is diabetes distress and burnout? https://www.diabetes.org.uk/living-with-diabetes/emotional-wellbeing/diabetes-burnout accessed June 2026
8. Hessler D, Fisher L, Glasgow RE, *et al*. Reductions in regimen distress are associated with improved management and glycemic control over time. *Diabetes Care* 2014;**37**(3):617-24. https://doi.org/10.2337/dc13-0762
9. Hessler DM, Fisher L, Polonsky WH, *et al*. Diabetes distress is linked with worsening diabetes management over time in adults with Type 1 diabetes. *Diabet Med* 2017;**34**(9):1228-34. https://doi.org/10.1111/dme.13381
10. Flury R, Solomons L. Too often missing: making emotional and psychological support routine in diabetes care. London: Diabetes UK, 2019.
11. Hendrieckx C, Halliday JA, Beeney LJ, Speight J. Diabetes and emotional health: a practical guide for healthcare professionals supporting adults with Type 1 and Type 2 diabetes. London: Diabetes UK, 2019, 2nd Edition (UK)