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“Diabetes Makes You Feel Lonely When You’re the Only One”: A Qualitative Study of Identity Development among Young People Living at a Residential Care Facility for People with Diabetes

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Abstract: Young people with poorly regulated diabetes often experience recurrent hospitalization, behavioral problems, higher incidence of psychiatric disorders, as well as family dysfunction. It is crucial that young people with diabetes learn to manage their diabetes effectively. Some young people with diabetes cannot manage their diabetes at home and have to live at a residential care unit for young people with diabetes. In this study we highlight the identity development of these young people. The data consist of semi-structured interviews with current and former residents of a care facility for young people with diabetes. The analysis revealed three themes: (1) the young people report a high level of personal growth and maturity after moving to the care home; (2) the importance of identifying with others and how forming relations plays a significant role in the young people’s personal development; and (3) the young people have a constant fear of being different. Being able to define and shape one’s identity against a background that includes a meaningful perception of diabetes is key to understanding why life at the care home is so identity-changing for the young residents.

Keywords: identity; diabetes; residential care; chronic illness; self-understanding; authenticity



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1. Introduction

Constructing a sense of meaning and understanding yourself is fundamental for all people. Noble-Carr and Woodman [1] described how vulnerable young people who have experienced multiple adverse life events constructed identities that were significantly influenced by an entrenched sense of autonomy, a longing to be the opposite of what they had experienced, and the expectation of living up to their own constructions of an ideal self. Hartog et al. [2] demonstrated that illness is often experienced as a life event that conflicts with a person’s ultimate life goals, resulting in an experience of contingency and low levels of quality of life. They also showed how people make meaning of illness events by creating narratives and narrative identities that lead to a kind of narrative integration, which then reduces the experience of contingency and increases quality of life.

Type 1 diabetes is one of the most common chronic illnesses among young people. Effective therapies are available but require adherence to a daily treatment regimen that demands constant self-management. Nonadherence and suboptimal glycaemic control are significant concerns for adolescents and young adults. While self-management constraints can be difficult to adhere to at all ages, glycaemic control is the poorest during adolescence, and many adolescents do not regain satisfactory glycaemic control until they reach their thirties [3–5]. Patient education and care provision for young people with chronic somatic illnesses, including diabetes, have been known for being rather inattentive to the complex set of challenges related to the multitude of physiological, social, and emotional changes that characterize the transition into adulthood [6].

Young people with poorly regulated diabetes often experience recurrent hospitalization, behavioral problems, negatively affected school performance, higher incidence of psychiatric disorders, diabetes-specific stress, as well as family dysfunction and conflicts [7–10]. Moreover, dealing with a psychiatric diagnosis influences living with diabetes as well as achieving satisfactory medical outcomes and psychological wellbeing [11]. Given the plethora of short- and long-term health difficulties related to diabetes, it is crucial that young people with diabetes learn to manage their diabetes effectively [12].

Residential care for children and young people who cannot live with their families is an ambivalent institutional system that has continuously been viewed as both a “positive choice” and a “last resort” [13]. Research has indicated that residential care often has unintended consequences, for instance, not sufficiently protecting children against violence, bullying, and abuse, while also causing them to experience increased stigma and being viewed as “troublemakers” [14]. Further, young people living in residential care often experience challenging familial relationships and relationships that are not a source of constant positive emotional and physical comfort [15,16]. Moreover, leaving residential care and having to adapt to new conditions can present yet another burden and additional risks for the children [17]. Nevertheless, research has shown that some of these children are able to prosper [17].

In a literature review, Sapiro and Ward [18] explored facilitators of and barriers to forming connections with others among marginalized young people. They discussed (among other things) the potentially marginalizing effects of young people’s involvement in public systems of care, concluding that the transition to adulthood is a complex period for this target group and that the developmental need for autonomy and the need to connect with others require balance. Munford and Sanders [19] explored the role of social work, focusing on helping young people negotiate and construct identities. They identified three key themes as significantly contributing factors: seeking safe and secure connections; finding opportunities to test out identities; and building a sense of agency.

All of the above key points regarding adolescent diabetes, residential care, illness and identity construction, and the importance of forming connections are in play in the unique research setting used in the present study. The residential care home under study is a Danish long-term care unit for children and young people with diabetes. A diagnosis of diabetes is a prerequisite for living at the unit. However, to be granted a place there, residents must be particularly exposed or vulnerable, and many of them have a psychiatric diagnosis. Therefore, the residents are severely at great risk for developing the serious complications associated with diabetes. They are referred to the residential home to reduce the negative influences that exist in their daily environment and to improve their glycemic control and psychosocial wellbeing. Daily care is provided by social workers under the close supervision of the local pediatric diabetes clinic.

Based on all of the aspects mentioned above and the theoretical background described below, the objective of the present article is to study how living in a residential care home for young people with diabetes affects residents’ sense of identity.

This current paper is not an evaluation of the residential care home under study. A broader analysis of the data focusing on care practices and institutional everyday life has previously been published [20]. Both analyses were planned before initiating the study, and the data collection was planned so as to inform both papers.

2. Theory and Methods

2.1. Theory

According to Richard Jenkins [21], all human identities are social identities because interaction with other people is always part of an individual’s own identification. Jenkins called this the internal and external moments of the dialectic of identification [21]. Thus, according to Jenkins, we have two highly interrelated modes of identification: we have the internally oriented self or group identification and externally oriented categorization of others, and all actors are subject to both [22]. For this reason, as regards social identification,

what people think about us is just as important as what we think about ourselves. All people are entangled in a constant process of identifying ourselves and identifying others, while these others are simultaneously identifying themselves and us. Moreover, all of these interdependent identifications are processes marked by the internal–external dialectic of self and public image [22].

Waterman defined identity as: “a clearly delineated self-definition comprised of the goals, values, and beliefs to which the person is unequivocally committed. These commitments evolve over time and are made because the chosen goals, values, and beliefs are judged worthy of giving a direction, purpose, and meaning to life” [23]. Using this definition, Waterman was able to draw attention to the importance of having meaningful goals, values, and beliefs, which enable individuals to build a positive and constructive identity. This value-based identity, combined with Jenkins’ internal–external dialectic, makes the identity-constructing process of identification and categorization interesting as a perpetual process of making sense and ascribing value-based meaning to the observed environment, while at the same time trying to fit into that environment.

James Marcia provided the following short definition: “Identity refers to a sense of oneself as having continuity with the past, active direction in the present, and a future trajectory” [24]. Like Waterman, Marcia was describing the importance of focusing on meaning making by underlining that the past and the future also have to make sense if the individual identity is to make sense in the present.

Charles Taylor linked identity to authenticity, stating: “I can define my identity only against the background of things that matter” [25]. This quote can be used to describe why some people are able to define their identity against the background of disease- or health-related issues, and why some cannot relate to these issues at all. What matters to some does not matter to others, and what is deemed meaningful in some contexts is irrelevant in others. Taylor talked about these things that matter in the context of authenticity in contemporary cultures and societies, in this way essentially describing the interplay between individuals and the social contexts in which they are trying to understand themselves and fit in. Taylor went on to talk about what it takes for people to be able to define themselves and distinguish themselves from other people. It is not enough to simply be different from others. One needs to be different in areas that matter and make sense to other people. If disease matters within a certain social context, then being different within that particular horizon of meaning will have significance, because it will be within the domains of recognizable self-definitions [25]. In relation to identity formation, the domains of recognizable and therefore possible self-definitions are important, as these limit the scope of acceptable and meaningful identities for both the individual and the social context. In a school or in a residential home, these recognizable self-definitions will at all times determine what issues are important enough to form the basis of self-definitions—and therefore also what issues are important enough to be different from others in relation to. As such, horizons of significance are also directly connected to individual choice, in the sense that choices are, in reality, restricted to fit within the horizons. If self-choice is not really self-choice, then the choice to act positively based on diabetes knowledge or any knowledge is not in reality an open choice either.

The concept of social imaginaries adds a relational aspect to the case of acquiring and acting on the basis of identity. It also elaborates on the connections between expectations and common understandings of how we make choices and act in society and in relational contexts: “... the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative images that underlie these expectations” [26]. This theoretical element can be used to further elaborate on how difficult it is to make changes in disease management behavior—on an individual level as well as within a group or societal level. There will always be an element of having to fit in with a certain group and an ensuing element of imagining how that group might interpret any behavior or

behavior change. On the other hand, it is equally difficult to choose not to change, if a certain change becomes the norm and thereby the expected behavior.

Combining these theoretical elements, we obtain a theoretically informed analytical strategy focusing on the internal–external dialectic of identification and categorization, delineated value-based self-definitions, the sense of experiencing continuity across past, present, and future, horizons of significance, and social imaginaries.

2.2. Methods

The target groups for our study were current and former residents. The residential care social workers informed the 11 residents who lived at the care home (and their parents) about the study at the time of the interviews. The current residents were then recruited by one researcher (L.B.J.) directly during visits to the care home. Former residents were recruited by the same researcher at an annual event for former residents.

At the time of recruitment, 11 adolescents lived at the care home and 21 former residents participated in the annual event. Nine residents (6 girls and 3 boys) with a mean age of 17 years (range 15 to 20) agreed to be interviewed. The mean length of their stay at the care home at the time of the interviews was two years, ranging from three months to four years. The average time since diagnosis with diabetes was eight years, ranging from one year to 17 years. We interviewed eight former residents with a mean age of 26 years (range 19 to 32). The average length of time residing at the care home was three years (range 1 to 6). The average length of time since leaving the care home was eight years (range 2 months to 15 years). We decided not to interview former residents if more than 15 years had passed since they had lived at the care home.

The average time for the interviews was 36 min for current residents and 39 min for former residents. The interviews were semi-structured and included a range of open-ended questions designed to inform both this specific identity analysis and the previously published broader analysis focusing on care practices and institutional everyday life (blinded ref). The interviews included the following themes: (1) institutional everyday life: with questions focusing on the individual and collective everyday life at the care home; (2) diagnosis and self-understanding: with questions focusing on the individual experience of living with diabetes and other diagnoses in and outside the institutional context; (3) social workers' practice: with questions focusing on the role of the social workers' actions and relationships; and (4) residents' practice: with questions focusing on the positioning and relationships among residents.

All interviews were facilitated by L.B.J. between August and October 2019. The first interview with each target group was considered a pilot-test and therefore evaluated and discussed by the researchers. No changes were made to the interview guides, and therefore all interviews were included. The interviews with current residents were conducted so as to fit into daily life at the care home. The interviews with former residents were conducted in their homes or in a nearby café.

After collecting each dataset, the recordings of the interviews were transcribed verbatim and transferred to NVivo software, where they were iteratively analyzed in Danish and then categorized using radical hermeneutics. All three authors participated in the analysis and interpretation of the data. All three authors are experienced diabetes researchers and none of them had any prior involvement with the residential home or any of the interviewees.

Radical hermeneutics is a set of guidelines for content analysis that, as a combination of hermeneutics and constructivism, manages to simultaneously be empirically grounded and theoretically complex [27]. Radical hermeneutics focuses on keeping a perpetual balance between theory, method and data by acknowledging how all of these elements influence each other in an interconnected process. The use of radical hermeneutics also entails constant alternation between analyzing and interpreting. Radical hermeneutics is a validated methodology consisting of three steps of data analysis. The first step involves reading the data with a view to observing specifically selected differences in them. This

observation in itself constitutes an interpretation rather than a description, and its task is to reduce the complexity of the data. Elements within the scope of the differences selected by the interpreter are extracted from the data. The second step involves making these elements the subject of interpretation as an observation of the differences employed. The third step involves interpreting the sum of these differences [27].

In the present analysis, this approach meant that the analytical process was developed in several steps as we delved deeper into the data. The first step focused on extracting issues of direct relevance to identity and self-understanding. In this phase, each researcher conducted the coding independently and discussed the identification of themes. The second step involved analyzing and interpreting the extracted data, and this step revealed the three main themes presented in the Results section. Theme developments were discussed and agreed on. The final step was then a separate interpretation of the data within each category, materializing as the findings presented for each of the three themes.

The study was approved by the Danish Data Protection Agency (P-2019-199) and carried out in accordance with the Declaration of Helsinki. According to Danish legislation, interview studies require no approval from an ethics committee. All participants gave their informed consent based on a thorough explanation of the purpose of the study. All participants were told that they had the right to abstain from answering any question and that they could stop the interview at any time if they were uncomfortable with the situation. Furthermore, they were given details concerning whom to contact for answers to questions about the research and the rights of research subjects.

3. Results

The three themes presented below are highly interwoven and even interdependent. The various aspects of identity theory that we have presented in the theory section and that have been essential to the analytical process have informed all of the findings across the three themes.

3.1. *“I’ve Changed So So Much—In a Positive Way”*: The Young People Report a High Level of Personal Growth and Maturity after Moving to the Care Home

Adolescence and early adulthood are phases characterized by personal development and growth in self-understanding and identity. However, even when this is taken into account, it is striking how these young people describe the fact that living at the residential home has significantly changed who they are and how they see themselves.

“Well, I’m not that little insecure girl anymore. Now I dare to show myself to other people and to stand up against other people and say: ‘Hey, I don’t want to do this.’ I couldn’t do that before. I’m no longer together with all the people who dragged me down and turned me into the person who couldn’t do anything . . . I think that’s made all the difference” (current resident #4, female).

This girl clearly sees herself as someone who has grown and maybe even as a different person. In the quote, she draws attention to two relational aspects of the changes in identity. She ascribes the actual growth to the changes in her relational context (her move to the residential home), and she also measures the changes in her ability to interact positively with these relations. The ability to stand up to people and not being afraid to be noticed by her surroundings are clearly important competences for her and are perfect examples of the interdependent internal–external dialectic of her self-differentiations, based on how she expects her surroundings are simultaneously categorizing her.

“I’ve learned so much. Of course about diabetes but also about myself. I’ve found out that that if I really want it I can do it. I’m just so goddamn lazy . . . When I lived at home, I just never did anything. I just sat there in my room all day long—and now I’ve found out that there is so much more out there . . . So I’m out more and I’m more open and I’ve just accepted more responsibility as well . . . It’s changed me” (ex-resident #1, female).

This ex-resident highlights the significance of changing relational contexts. She now identifies herself as someone who can get things done and who knows there are possibilities out there. In doing so, she implicitly links identity development to knowledge and action, and perhaps most importantly, she links it to individual choice. Her horizons of possible self-definitions have been greatly expanded and therefore her horizons of possible choice have been expanded as well.

"I've matured a lot. I deal with stuff in a totally different way than I used to back home. I think I used to take a lot of things for granted . . . I'm taking responsibility now. When I do something wrong, I own up to it and face the consequences—and I just wouldn't have done that two years ago." (current resident #5, female).

The (dis)connection between what and who they used to be and what and who they are now is straightforward for all of them. The residential home has caused a clear disruption in identity and self-understanding, which makes it easier to attribute all changes to this one major event. However, it also presents them with an easy cornerstone on which to rebuild their identity.

Self-understandings using descriptions like "being more mature", "taking responsibility", and "facing consequences" run through all of the interviews with both current and former residents. These are all central aspects of the pedagogical approach employed at the residential care facility, and for most of the interviewees, these descriptions were things that were in no way connected to their diabetes before they moved to the care home. In many of the interviews, it becomes clear that experiencing being able to form meaningful relationships with adults, and as a consequence seeing yourself as someone who can ask for help, has been a key aspect of how these self-descriptions have become part of both how they now see themselves and their social imaginaries.

" . . . and before I came here, I wasn't that good at talking to adults or asking for help. I just never did that . . . I just did everything myself because I wanted to do everything myself . . . But now I've started to ask for help if I need help—and that's one of the things that has changed with me since I lived at home" (current resident #2, female).

Observing and understanding yourself as a changed individual often happens when you suddenly find yourself in a new role due to changes in how other people see you. This was something the young people referred to quite a lot, as they slowly became diabetes experts after having lived a while at the care home and even after leaving.

"There's actually one of the others who always calls me, when there is anything with his blood glucose or something concerning foods or insulin. And then I tell him 'Ok, if you've done this or that then you'll have to do this now.; I remember my parents laughing about them calling me instead of calling the social workers . . . And the people at (care home) thought it was funny too." (ex-resident #4, male).

This quote illustrates how this ex-resident has been observed or externally categorized as an expert on diabetes and how he confirms this new internal identification by referring to how the parents and the social workers also see him in a new light. This is good example of how a person is able to build his identity against a background of things that really matter. Diabetes now matters so much in his life that he is actively constructing his identity around it in a way that would have been unthinkable for him before and perhaps even during his stay.

Most of the ex-residents reflect on where or who they would be today had they not stayed at the care home. Their stay marks a very solid point of disruption in their life narratives, with extremely distinct differences between before and after. Several of them went to the extreme of speculating on whether or not they would be alive today if they had not stayed at the care home.

"After (care home) I did feel that 'OK, I'm more grown up now,' and to be honest, it's (care home) that has made me who I am today—and I have thanked them for that . . .

And as my boyfriend puts it: 'If it hadn't been for them, you wouldn't be alive today' (ex-resident #3, female).

3.2. *"It Has Really Helped a Lot That It's That Big Thing We Have in Common": The Importance of Identifying with Others and How Forming Relations Plays a Significant Role in the Young People's Personal Development*

The very straightforward identification experience of suddenly being surrounded by other young people with diabetes, after having been very much alone with the disease, is one event that has made quite an impression on all of the young people we interviewed.

"and sometimes you just need people around you who understand you—and people understand you here, 'cause they're in the exact same situation as you are. It's really helped a lot that it's that big thing we have in common" (current resident #2, female).

Even though the young people are actually there for very different specific reasons, the fact that they all have diabetes and are all living there instead of at home is more than enough to establish that they are in almost identical situations. This then creates rather unique grounds for the dialectic of internal identifications and external categorizations to be played out intensely and in a small identity bubble, where the diabetes is actually not mentioned explicitly that often. Rather than being the single kid in school who is categorized as abnormal because of the diabetes, the disease now takes on the role as the common denominator that they are identified by as a group.

Regarding diabetes, the most important outcome of identifying as a group and establishing close group relations is the significantly different role played by the disease in daily interactions.

"When I'm here, I'm totally fine with it. Because I mean, we all have diabetes. It's a completely different situation . . . And that's really the reason I'm so happy to have come here. Because you're not alone with the things. People understand you here" (current resident #3, female).

Sharing the same diabetes issues is not only a matter of not having to worry about being categorized as abnormal. It is also one of diabetes suddenly being something that matters for everyone. Even though they say they do not really talk that much about diabetes, it is simply always there and that is just fine. When something matters, it can automatically be positively integrated into your sense of who you are and your identity—both internally and externally.

"Before I came here it was very difficult for me to inject insulin when I was with friends . . . But after coming here and seeing everyone else doing it, I've started to be more OK with it" (current resident #7, male).

Another reason for the high degree of identification is that not only does everyone have diabetes; everyone also has a history of difficulty managing it properly. The young man above told of his encounters with other young people with diabetes prior to his stay at the care home.

"They were all what I would call perfect diabetics. They all had pretty numbers and were all like 'I don't eat this and don't eat carbs 'cause that's not good for you.' And then I'd just sit there with my blood glucose way too high . . . I couldn't really relate to them properly . . . Here it's more like everyone has kind of a hard time with it and everyone has to learn to accept it. So, you feel you can relate to them better" (ex-resident #1, female).

Thus, in addition to the immediate identification that ensues upon meeting someone else with diabetes, they can also relate to each other's daily struggles with managing it and in many cases they can actually help each other because they have been in similar situations.

" . . . you could just go and talk to someone about it: 'my diabetes just sucks, let me tell you about it' and then they'd go: 'well that same thing happened to me, you just need

to do this and that.' It was really nice to be able to talk about your diabetes with other people who also have it" (ex-resident #3, female).

Many of the interviewees mentioned that diabetes is often a lonely disease, and many of them had very few friends prior to their stay at the care home, meaning that the basic situation of having a significant number of people constantly around you to whom you could actually relate was new to several of them, and it more or less forced them to change how they viewed themselves and their position in the group. The basic operation of socializing meant that their social imaginaries were evolving as they were establishing connections between expectations and common understandings of how people act in relational contexts and in society as a whole. For many of the interviewed young people, the very sense of constructing an actual identity based on social interaction was a new experience.

3.3. "Diabetes Makes You Feel Lonely When You're the Only One": The Young People Have a Constant Fear of Being Different

As illustrated by themes 1 and 2, positive identity processes are definitely integrated into the dynamics taking place among the young people at the care facility. There are, however, also negative aspects associated with this unique relational context.

While all of the young people reported becoming more and more comfortable with doing their diabetes management tasks in each other's company at the care home, they are still reluctant to do so when they leave to attend the local school.

"People from my school don't even know I have diabetes. It's not something I just tell people . . . I mean if they notice that I have the pump in my pocket and they ask me, of course I'll tell them . . . But otherwise it's not something I tell them" (current resident #2, female).

Naturally, this is not necessarily significantly different than it is for any other person with diabetes. Not wanting everybody to know that you have a chronic disease is only natural and very common. However, when this is combined with the fact that a person might not want others to know they are living at a care facility for any combination of reasons, it creates a situation of potentially feeling very different from peers at school.

"Sometimes I just don't want to take my insulin in front of friends in school. Everybody doesn't need to know that I live in a care home and that I have diabetes" (current resident #5, female).

This reaction of not wanting to disclose these two very significant aspects of what actually matters significantly in the lives of the young people living at the care home creates a conflicting identity process. They identify strongly with the other young people at the care home because life with diabetes suddenly matters both in terms of internal identification and external classifications, but as this identification gains strength it becomes more and more of a contrast to the identifications and classifications going on at school. This contrast then creates very different horizons of significance for the young people, which means that prioritizing and making choices across contexts become difficult and potentially confusing with regard to constructing a solid identity that can encompass the expectations of a positive future diabetes trajectory.

One recurring theme in most of the interviews is that, even though they are living in a diabetes care facility and all the other young people therefore have diabetes, diabetes plays an insignificant role in their life when they are there.

"Well, it (diabetes) takes up a lot of space all the time, but much less when I'm here at home where we have more freedom, I guess . . . Even though they remind me to check my blood glucose every second or third hour. But I actually like that" (current resident #1, male).

It is interesting that regular reminders and a perpetual focus on diabetes actually creates a sense of freedom for these young people. By having diabetes all around them, they apparently do not have to worry about the disease, and the negative labelling and

categorizations associated with being a person or group of persons with diabetes are not relevant in a context where everyone has the disease.

“I feel that diabetes is normally a very lonely disease. I know lots of people have it, but you’re rarely together with anyone who has it—only when you’re here. I mean, I don’t go to school with anyone who has it and they just don’t understand what it’s like and they always ask stuff like ‘doesn’t it hurt, when you prick yourself’ and I just can’t do it. I don’t want to talk about it all the time . . . ” (current resident #2, female).

For the same reason that diabetes becomes insignificant and unimportant in the close environment at the care home, where everyone has it, it becomes very significant and almost the sole identifier for the young people when they attend school or are in any other relational context outside the care home. This sharply defined contextual difference seems to amplify the feeling that diabetes is a lonely disease that makes mutual identification difficult in contexts outside the care home.

“Everybody is just so prejudiced about people living in care homes. They think it’s only people wearing bad clothes, who don’t have parents, who smoke weed and do drugs . . . Sometimes when I do tell people that I live in a home, they look at me and see that I wear Adidas and have an iPhone and stuff . . . And they’ll ask ‘are you sure you live in a home.’ They don’t think that we can look just like regular people” (current resident #5, female).

All of the interviewees reported experiencing these external categorizations, and although they dealt with them in different ways, they were all affected by them in terms of their own self-understanding and their general social imaginaries. This significantly affected their expectations of their future diabetes trajectories and their hopes and dreams connected to their construction and understanding of their own narratives.

Most of the ex-residents explained how the transition when moving away from the care home was difficult, primarily in terms of being more alone again. Many of them mentioned that being in the care home had meant that the relations were automatically there and that you did not have to work on them all the time. Being in the outside world, in life after living at the residential home, often entailed a return to being misunderstood and externally categorized as different.

“There was just someone to be with all the time. There was someone to talk to if you were happy or mad about something or if you were sad . . . It was basically just great to be with other people all the time. Especially because it was someone with the same disease as you. Because if you talk about it with someone who hasn’t got diabetes, then they just don’t understand it the same way” (ex-resident #5, female).

4. Discussion

Considering our three main thematic findings as a whole—(1) the young people report a high level of personal growth and maturity after moving to the care home; (2) the importance of identifying with others and how forming relations plays a significant role in the young people’s personal development; and (3) the young people have a constant fear of being different—it is clear that identity formation and identity repair are of significant importance to the young people living at the residential home.

In line with Hartog et al.’s [2] findings on how people create illness narratives in order to construct a sense of meaning and coherence that ultimately leads to improved quality of life, our results show that this is exactly what happens with these young people when they experience the drastic change in their relational environment upon moving into the residential care home. In this environment they can mirror themselves in the other residents’ narrative understanding of themselves and gradually start to construct meaningful narratives, now based on a much more positive view of diabetes than they had before moving.

This heightened sense of meaning seems to be closely tied to the experience of personal growth and becoming a more mature and autonomous person. The young people observe

themselves as less vulnerable and as someone very dissimilar from the person they were before. This is somewhat in line with Noble-Carr and Woodman's [1] findings on how young people who have experienced multiple adverse life events construct identities based on their longing to be someone else and their expectations of living up to constructions of an ideal self. The realization that it is actually possible to be a changed and "normal" person in spite of the diabetes seems to speed up this process and affirm them in their construction of a more ideal self. This is also in line with Taylor's theories on how social imaginaries shape the way people imagine their overall social existence and how they fit together [26].

This aspect of fitting together with others is probably the most striking everyday change that the young people experience upon moving into the residential home. From one moment to the next, they go from an extreme feeling of not fitting in at all to the opposite extreme of now fitting in with everyone. While this is of course a simplification of what actually happens, it is more or less the feeling the young people have because the difference is so significant. Sapiro and Ward [18] explored facilitators of and barriers to forming connections with others for marginalized young people, and they found that establishing positive relationships was extremely difficult for these young people and that this signified a critical component of their transition to adulthood. Our findings add new dimensions to an explanation of these difficulties, as the peer-to-peer effect of having diabetes as the common denominator seemingly makes it easier and more natural to form positive relationships with fellow residents as well as with social care workers at the residential home. However, significant difficulties in forming solid relationships outside the care home still remain.

The very specific setting of the residential care home has been a highly suitable context in which to study identities, enabling us to illuminate and discuss rather specific aspects of identity theory. Jenkins' theories on social identities [21] are very well suited to this research setting. The social identification at the care home clearly shows us how everyone in the relatively small group there is entangled in a constant process of identifying themselves and identifying others, while these others are simultaneously identifying themselves. An overall result of the analysis was that the mutual interaction with other residents very quickly and to a very significant extent became part of each of the residents' own identification.

Waterman's [23] focus on the need for meaningful goals and values in building a positive and constructive identity and Marcia's [24] description of constructing a coherent and meaningful sense of oneself as having continuity with the past, active direction in the present, and a future trajectory are important theoretical elements which can help us pinpoint the potential that staying at the care home has to create lasting effects, such as an improved sense of self and the feeling of having a more coherent sense of positive identity. This aspect, however, is in many cases challenged by the fact that it is still difficult for the young people to relate to and identify with new people outside the diabetes context after moving away from the care facility. Nonetheless, it also seems that even though identifying with others is still hard, it has a less negative effect on the young people owing to their now increased sense of narrative identity and more well-established set of meaningful goals and values.

Being able to define and shape one's identity against a background that includes a meaningful perception of diabetes is key to understanding why life at the care home is so identity-changing for the young residents. The daily routines and the way in which diabetes is normalized through dialogue and practices seem to make diabetes something the young people can and want to relate to. Where they once used to spend a great deal of energy on distancing themselves from diabetes, because they could not at all relate to the disease or anything associated with it, it is now a normal and accepted part of themselves. This does not mean diabetes is a part of themselves they promote themselves with, but rather that when it is no longer a negative identifier it takes on a less significant role in their self-definition and thus becomes an authentic part of who they are. It is still used to some degree to distinguish themselves from other people, but in a less self-

excluding way. In Taylor's theoretical terms [25], the domains of recognizable and therefore possible self-definitions have changed, and therefore the scope of issues important enough to be different from others has also changed. As these horizons of significance are also directly connected to individual choice, the scope of choices to act positively on the basis of diabetes knowledge has increased—thereby making positive choices regarding diabetes self-management more acceptable and more in line with perceptions of identity.

The residential care home under study constitutes a very small setting, with only 11 enrolled young people at the time of interviewing. This limited the number of potential interviews, as we wanted to conduct approximately the same number of interviews with ex-residents. We do believe, however, that the collected data were strong enough to allow us to carry out the thorough, theory-informed analysis we were aiming for. The small setting, however, is also a strength, as it gave us an opportunity to study a sharply defined closed setting, which limited the contextual complexities and thereby made it easier to analytically focus on elements related to identities.

The external validity or transferability of the study at hand is somewhat difficult to assess given the novelty of the setting. The challenges regarding identity issues among young people with diabetes are, however, not limited to people living in care facilities, and the present results are therefore applicable to both researchers and practitioners working with young people with diabetes or indeed with other chronic diseases. An important next step would be to incorporate our findings into existing guidelines on how to provide psychosocial support for young people who, for various reasons, find daily life with chronic illness difficult.

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Institutional Review Board Statement: The study was approved by the Danish Data Protection Agency (P-2019-199) and carried out in accordance with the Declaration of Helsinki. According to Danish legislation, interview studies require no approval from an ethics committee.

Informed Consent Statement: All participants gave their informed consent based on a thorough explanation of the purpose of the study. All participants were told that they had the right to abstain from answering any question and that they could stop the interview at any time if they were uncomfortable with the situation. Furthermore, they were given details concerning whom to contact for answers to questions about the research and the rights of research subjects.

Data Availability Statement: The data presented in this study are available on request from the corresponding author.

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