

# Type 2 Diabetes Mellitus from an Individual Psychological Perspective: An Adlerian Interpretation of a Clinical Case Vignette

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**ABSTRACT** – This paper presents a theoretical analysis of type 2 diabetes mellitus management from an Individual Psychological perspective, illustrated by a clinical case vignette. Utilizing Adlerian concepts — specifically lifestyle, private logic, safeguarding mechanisms, and iatrogenic discouragement — the author examines how a patient's subjective perception of medical authority shapes treatment adherence and autonomy. The case vignette details a patient presenting with an illness history of approximately 32 years and an severe hyperglycemic phase. This analysis explores the patient's retrospective perceptions of medical encounters. The discussion highlights how a collaborative therapeutic alliance can address perceived authoritarian discouragement. Ultimately, this Adlerian interpretation suggests that integrating a patient's private logic into diabetes care plans may offer a valuable conceptual framework for understanding individual differences in chronic illness management while respecting patient autonomy.

## Keywords:

Type 2 diabetes mellitus; Individual Psychology; Lifestyle; Heteronomous discouragement; Externalization vs. Internalization; psychosomatics

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## Introduction

In modern diabetology, type 2 diabetes mellitus is considered a complex, chronic illness whose successful management is inextricably linked to a profound behavioral adaptation on the part of the patient. Those affected often face the lifelong task of fundamentally restructuring their diet, permanently increasing physical activity, and precisely coordinating what is usually a complex medication regimen. In clinical practice, however, repeated failure to achieve therapeutic target values (particularly the HbA1c level) frequently leads to frustration on the part of practitioners. This not uncommonly culminates in a subtle devaluation of the patient, who is quickly labeled as "resistant to advice" or "non-compliant". This perspective overlooks the fact that human behavior is always embedded within the overall psychosocial personality and invariably follows the underlying unconscious goals of the individual (Caballero et al., 2024).

The relevance of these psychosocial factors is supported by current epidemiological and socio-clinical data. For instance, in a large-scale quantitative analysis, Hu et al. (2025) empirically demonstrated that a pronounced imbalance between a high subjective threat perception of the disease

and simultaneously blocked self-efficacy correlates statistically significantly with poor medication adherence and inferior metabolic control.

While such quantitative cross-sectional studies can render the statistical correlations of threat and adherence visible at the population level, the question of unconscious biographical causes and the individual dynamics of these phenomena in daily clinical routine often remains unanswered. Here, Alfred Adler's (1927, 1933) *Individual Psychology* provides a valuable, complementary explanatory model for psychosomatic diabetology. Adler's teleological approach views the individual as a goal-oriented, active subject whose dynamics are driven by an unconscious "private logic" as well as the elemental urge to overcome feelings of powerlessness and inferiority. In the modern, expanded interpretation by Rieken et al. (2011), the phenomena of power and powerlessness increasingly shift into focus within the context of somatic illnesses.

## Case Material and Conceptual Framework

Instead of an empirical qualitative investigation, this paper adopts a theoretical approach illustrated by a clinical case vignette. The narrative material is based on a retrospective clinical history of a patient managing type 2 diabetes mellitus. Informed consent was obtained from the participant, and all identifying details have been carefully anonymized to ensure ethical standards and confidentiality. The purpose of this case vignette is not to establish empirical generalizations or document verified objective interactions, but rather to serve as a concrete clinical illustration of Adlerian concepts—such as private logic and safeguarding behaviors—in the context of chronic illness management.

### Case Study: The Case of Peter H. (73 y.o.)

#### Anamnesis and 32-Year Course of Disease

The illness biography of Peter H. (73 years old, slim appearance, physically and mentally fully functional, and despite having reached retirement age, still highly motivated and working part-time as a lecturer) sheds light on an individual's permanent, unconscious defensive struggle to maintain psychological sovereignty against directive, guideline-driven medicine. The anamnesis reveals a highly autonomy-oriented person whose self-esteem is primarily defined through intellectual control and independence.

When interpreting the subsequent biographical data, a strict methodological distinction must be maintained between objective clinical indications and the patient's retrospective, subjective conceptualization. The descriptions of medical encounters explicitly reflect the phenomenological perspective of the individual experiencing the illness. Consequently, patient recollections of highly urgent biomedical interventions required to prevent acute metabolic crises must not per se be misinterpreted as inherently indicative of an authoritarian treatment style.

#### Initial Diagnosis at Age 40

Based on the fasting blood glucose reference values applicable at the time, a routine preventive check-up yielded a laboratory value of 6.1 mmol/l for the patient. The treating physician immediately established a definitive diagnosis of type 2 diabetes. According to the diagnostic thresholds established at that time (cf. Deutsche Diabetes Gesellschaft [DDG], 2000; World Health Organization [WHO], 1999), a confirmed fasting plasma glucose  $\geq 6.1$  mmol/l (or  $\geq 110$  mg/dl) in whole blood was classified as impaired fasting glucose or diagnostic of diabetes depending on the specific clinical setting.

To the patient's objection that this was merely a minimal deviation of 0.1 mmol/l from the reference norm (6.0 mmol/l), the physician reacted mockingly: "Being a little bit pregnant is still being pregnant!", enjoying the applause of the present nursing staff.

The patient experienced this incident as a deep insult and an act of massive disrespect, as it completely negated the gradual nature of a metabolic disorder. Triggered by this early iatrogenic

discouragement (Titze, 1984), the patient denied the physician both technical and human competence, refused the initiated oral medication, and withdrew from any further examination or follow-up regarding the diabetes for the following 15 years.

### **The Crisis-Like Escalation at Age 55**

At the age of 55, the patient suffered a life-threatening pulmonary embolism. In this context, his primary care physician also measured his blood sugar levels. Laboratory diagnostics revealed a massive metabolic derangement: the HbA1c stood at 12.0%, and the fasting blood glucose the following day was 15.0 mmol/l, representing a state of severe hyperglycemia and a highly critical clinical situation. Faced with these findings, the primary care physician prepared to initiate immediate insulin therapy by retrieving insulin syringes from the practice refrigerator. Because the patient subjectively felt completely disenfranchised and treated as a mere object of medical intervention in this situation, he strictly rejected this treatment. As a compromise, he requested oral therapy with metformin.

Specifically regarding the initial presentation, an acute metabolic decompensation with an HbA1c level of 12.0% may constitute a potentially life-threatening hyperglycemic crisis from a biomedical standpoint. The physician's immediate preparation for insulin therapy represented standard, essential, and guideline-driven medical care aimed at preventing acute metabolic collapse. In line with the previously mentioned methodological distinction, this urgent intervention must not per se be misinterpreted as indicative of an authoritarian treatment style, despite the patient's subjective perception.

### **Pharmaceutical Polypragmasy**

Over the subsequent 18 years, changing practitioners attempted to lower his values using oral antidiabetics and, later, a GLP-1 receptor agonist. Despite these ongoing medical interventions, the HbA1c level remained at an unsatisfactory 8.8%, which was attributable to the patient's pronounced, unconsciously driven selective non-adherence. When the diabetologist treating him at the time also pushed heavily for insulin therapy, the patient aborted this treatment as well. Relying on his own literature research—which indicates that an HbA1c value of approximately 8.0% is entirely sufficient in a geriatric context (DDG & DGG, 2024)—he targeted practitioners who would accept his objective. As the reason for his strict refusal of insulin, he cited a traumatic event involving his mother: His overweight mother, who also suffered from diabetes, experienced severe hypoglycemia under insulin therapy, fell, and broke both arms. This transgenerational trauma subsequently shaped his private logic. In parallel, the patient largely switched his diet to whole grains and vegetables but maintained his “islands of indulgence” (cake, chocolate).

### **Current Status at Age 73**

Currently, the patient is seeing a new diabetologist who shows understanding for his stance and acknowledges him as a partner in the treatment process. The doctor biochemically diagnosed a sufficient endogenous residual insulin production (preserved C-peptide status), which is why exogenous insulin therapy can be avoided for the time being. With the administration of further oral antidiabetics, they succeeded in stably reducing the current HbA1c level to 8.0%—exactly the target value the patient had previously autonomously defined for himself. The patient feels entirely validated in his persistence and self-determination by this outcome.

## **Individual Psychological Phenomenon Analysis**

### **The Struggle for Autonomy Against Iatrogenic Discouragement**

From an Adlerian perspective, the patient encounters the medical system with an emancipated role-understanding and decisively rejects authority-based, asymmetrical doctor-patient relationships. His psychological stability and self-esteem are closely tied to his ability to preserve autonomy, self-

determination, and intellectual control. When he questions directives in a therapeutic context, this can be interpreted as a legitimate need to be accepted as an equal partner. He does not blindly comply with directive medical orders; instead, he demands to actively participate in medical decisions. Successful treatment therefore benefit from a consistently participatory approach via shared decision-making.

The iatrogenic discouragement (Titze, 1984) caused by the verbal boundary violation of the initial diagnostician (“Being a little bit pregnant is still being pregnant!”) struck exactly this vulnerable core of the patient. The doctor permanently violated the patient’s psychological integrity by exposing him in front of the nursing staff, relegating him to a position of subordination.

According to Rieken et al. (2011), the patient’s subsequent 15-year refusal behavior reflects an acute, unconscious conflict over psychosomatic equality: The patient resists the purely somatic reduction of his person by the treating physicians and instead demands recognition of his position as the individual experiencing the illness. The dynamic described by Adler (1927) becomes apparent here in its classic form: Because the patient experiences a massive social devaluation, he compensates for this induced feeling of inferiority by devaluing the medical profession as a whole, denying their competence, and thus unconsciously attempting to establish equality or even superiority. Non-adherence is therefore viewed here not as a mere behavioral deficit, but as a plausible theoretical interpretation of an unconscious, teleological act to salvage psychological sovereignty.

### **Insulin Refusal as a Transgenerational Safeguarding System**

The mother’s fall resulting from hypoglycemia inextricably linked the medication insulin with loss of control, helplessness, and severe physical injury within the patient’s private logic. Refusing the insulin syringe therefore appears to have functioned as an individual psychological safeguarding system (Ansbacher & Ansbacher, 1982), protecting him from the panic-inducing fear of repeating his mother’s fate.

An interesting aspect here is the physical and psychological boundary the patient drew between himself and his mother: While the mother passively suffered her diabetes and obesity and consistently externalized it through phrases like “This stupid diabetes, if I didn’t have it...”, viewing the illness as a hostile, external object, the patient pointed out to her even back then that it was her diabetes. For himself, the patient chose the biographical countermodel: He is slim, keeps himself physically fully functional, and internalizes the illness.

Psychosomatically, the behavior of Peter H. can be understood as an attempt to realize “life integration through self-responsibility” (Oberegelsbacher et al., 2017). For him, diabetes is not an administrative case for doctors, but his highly personal one. From this perspective, the refusal of insulin also becomes comprehensible as an active, autonomous self-protection of a human being who refuses to cede sovereignty over his own body to a therapeutic system he subjectively classifies as threatening. Within his inner private logic, insulin occupies the role of a heteronomous agent. However, it is vital to contextualize the clinical reality: with an HbA1c of 12.0%, the physician’s strong recommendation to initiate immediate insulin therapy likely represents standard, life-saving medical care for severe hyperglycemia, rather than inherent evidence of an authoritarian approach. Because this analysis relies on a retrospective report, these dynamics primarily reflect the patient’s subjective perceptions of the encounter. What the patient experienced as “iatrogenic discouragement” may have been driven by legitimate medical concerns and urgent safety protocols on the part of the healthcare provider. Furthermore, the patient’s treatment preferences and resistance may also have been shaped by alternative factors, including personal lifestyle choices, unexpressed fears, or past family experiences with chronic illness.

### **Lifestyle Arrangement: Islands of Indulgence as Symbols of Freedom**

The patient’s selective adherence—the consistent restructuring of main meals alongside a steadfast adherence to cake and chocolate—is a classic Adlerian arrangement (Adler, 1933). The patient

contributes significantly to mastering the life task of health yet sets conscious boundaries of obedience. He cooperates only on his own terms.

In line with the function of "creative fictions" in lifestyle described by Rieken (1996), the patient constructs a subjective sense of security here: The conscious consumption of delicacies proves to him daily that he remains the directing subject of his life and does not submit entirely to medical dictation. Chocolate thus functions, in a sense, as a tangible symbol of his psychological freedom.

### **The Teleological Triumph and the Therapeutic Alliance**

By reaching his current status, Peter H. achieved his individual target corridor, illustrating from an Adlerian view how his private logic interacted with guideline-driven medicine. Analyzing the case on the basis of the findings by Hu et al. (2025), the inner psychodynamic transformation of the patient becomes clearly visible: while the model of Hu et al. assumes a high conscious perception of threat when adherence is poor, the case of Peter H. shows an individual psychological modification of this mechanism. Based on this retrospective account, the patient himself never subjectively felt somatic threat; rather, his private logic and safeguarding system allowed him to focus defense mechanisms on the preservation of autonomy.

The primary threat against which he unconsciously defended himself was the imminent loss of his autonomy due to perceived iatrogenic discouragement by his practitioners. His apparent "non-compliance" was therefore not a state of experienced helplessness, but an active defensive struggle to salvage his psychological sovereignty. This pathogenic cycle was broken only by changing practitioners.

Only the current diabetologist succeeded in severing the vicious circle of perceived discouragement by meeting the patient's attitude with genuine appreciation. Through this empathy and subsequent medical validation—the biochemical proof of preserved endogenous insulin production—the physician established a genuine therapeutic alliance on eye level. The doctor relieved the patient of the pressure of inferiority, whereby the clinical self-efficacy called for by Hu et al. (2025) was reactivated psychodynamically via a relational realignment. By mirroring the patient's psychosomatic unity and need for autonomy, the practitioner transformed destructive resistance into a constructive, self-responsible integration of the illness (Rieken et al., 2011).

## **Practical Implications for Diabetology**

From the depth-psychological analysis of Peter H.'s case, substantial recommendations can be derived for modern, psychosomatically oriented diabetological practice that extend beyond the single case.

### **Shifting from an Authority-Based Compliance Model to a Therapeutic Relationship**

Blind obedience and purely directive orders often generate psychodynamic resistance in autonomy-oriented patients. Practitioners must decipher therapeutic non-adherence or treatment dropouts as an unconscious psychosomatic attempt at protection (safeguarding system) to rescue a jeopardized self-esteem. The goal should be a participatory model in the spirit of shared decision-making which validates the patient as an expert on their own lifestyle and establishes a cooperative alliance on equal footing (Rieken et al., 2011).

### **Biographical and Transgenerational Anamnesis Before Therapeutic Escalation**

Prior to a far-reaching therapy escalation, particularly before switching to exogenous insulin, subjective theories of illness, transgenerational experiences, and fears must be systematically explored. Standardized inquiries such as "What experiences does your family have with insulin?" or "What do you personally fear when thinking about injections?" should be an integral component of every diabetological anamnesis. Only in this way can deep-seated defense structures be identified in time and iatrogenic discouragements avoided.

### **Acceptance of Subjective Target Corridors in Old Age (Individualized Therapy)**

The patient eventually achieved a stabilized HbA1c level of 8.0%. Within an Individual Psychological framework, this outcome can be viewed as a plausible illustration of how aligning treatment with a patient's private logic through a collaborative therapeutic alliance might foster cooperation. However, this clinical observation must be interpreted with caution and should not be seen as a definitive validation of the patient's resistance to insulin, nor as empirical proof of clinical effectiveness. Diabetes management is highly individualized, and an HbA1c of 8.0%, while improved from 12.0%, still carries long-term microvascular and macrovascular risks. Therefore, this case is presented strictly to demonstrate a conceptual framework for individual psychological differences, rather than to draw definitive conclusions regarding medical efficacy or to challenge standard metabolic treatment protocols (DDG & DGG, 2024).

The future challenge of modern diabetology lies in navigating the narrow corridor between objective vascular risk minimization and the preservation of patient autonomy without dismissing biomedical evidence. Clinicians should adopt a collaborative coaching approach to integrate this intrinsic motivation dynamically, rather than jeopardizing the fragile therapeutic alliance through renewed, purely directive pressure.

### **Limitations of the Investigation**

The present work provides interesting insights into the psychodynamics of coping with illness but exhibits methodological limitations that must be taken into account when interpreting the results.

#### **Limited Generalizability (N=1)**

As a qualitative single-case analysis, this study naturally has an idiographic orientation. The reconstructed dynamics—such as the specific transgenerational safeguarding system and the resulting teleological triumph—are deeply rooted in the patient's individual biography. They do not permit statistical generalizations to the entirety of all patients with type 2 diabetes mellitus. However, the case functions as a theoretical prototype model illustrating structural psychosomatic mechanisms.

#### **Retrospective Nature and Recall Bias**

The reconstruction of the 32-year medical history relies to a significant extent on the subjective accounts of the patient in depth interviews. Emotional key experiences in particular—such as the iatrogenic discouragement during the initial diagnosis more than three decades ago—carry the risk of retrospective distortions, secondary rationalizations, or unconscious affective reappraisals. Although medical progression data were used for triangulation, the narrative data primarily reflect the patient's subjective reality and not necessarily the objective historical sequence of events.

#### **Selection Bias**

Peter H. represents an individual with an above-average level of education and autonomy (employment as a lecturer). His pronounced ability to drive targeted literature research and confront practitioners on eye level distinguishes him substantially from more vulnerable patient groups with lower health literacy. The coping strategies observed here and the specific neurotic safeguarding system are therefore closely tied to these socio-cultural resources.

#### **Researcher Subjectivity in Hermeneutics**

The individual psychological and phenomenological interpretation of textual material is a deeply hermeneutic process. Despite conducting communicative validation and interdisciplinary supervision, an influence of the evaluator's theoretical preconceptions on the accentuation of the results cannot be completely ruled out.

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## References

- Adler, A. (1927). *Menschenkenntnis*. Hirzel.
- Adler, A. (1933). *Der Sinn des Lebens*. Passer.
- Ansbacher, H. L., & Ansbacher, R. R. (1982). *Alfred Adlers Individualpsychologie: Eine systematische Darstellung*. Reinhardt.
- Caballero, A. E., ElSayed, N. A., Golden, S. H., Bannuru, R. R., & Gregg, B. (2024). Implicit or unconscious bias in diabetes care. *Clinical Diabetes*, 42(2), 308–315. <https://doi.org/10.2337/cd23-0048>
- Deutsche Diabetes Gesellschaft (DDG). (2000). Diagnostik, therapie und verlaufskontrolle des diabetes mellitus Typ 2. *Diabetes und Stoffwechsel*, 9(Suppl. 2), 1–24.
- Deutsche Diabetes Gesellschaft, & Deutsche Gesellschaft für Geriatrie. (2024). S2k-Leitlinie: Diabetes mellitus im Alter. *Diabetologie und Stoffwechsel*, 19(S 02), S226–S235. <https://doi.org/10.1055/a-2312-1137>
- Hu, J., Bass, S. B., Swavely, D., Zisman-Ilani, Y., Chen, S. K., Kim, S., Kelly, P. J. A., Hoadley, A., & Rubin, D. J. (2025). Socio-clinical correlations with threat perception and self-efficacy in people with Type 2 diabetes. *Diabetes Spectrum*, 38(4), 529–536. <https://doi.org/10.2337/ds24-0044>
- Oberegelsbacher, D., Rieken, B., Sindelar, B., & Stephenson, T. (2017). Individualpsychologie. Lebensintegration durch Selbstverantwortung. In D. Berthold et al. (Eds.), *Psychotherapeutische Perspektiven am Lebensende* (pp. 175-190). Vandenhoeck & Ruprecht.
- Rieken, B. (1996). »Fiktion« bei Vaihinger und Adler. Plädoyer für ein wenig beachtetes Konzept. *Zeitschrift für Individualpsychologie*, 21(4), 280–291.
- Rieken, B., Sindelar, B., & Stephenson, T. (2011). *Psychoanalytische Individualpsychologie in Theorie und Praxis: Psychotherapie – Pädagogik – Gesellschaft*. Springer.
- Titze, M. (1984). *Die heilende Kraft des Doktors: Die individualpsychologische Arzt-Patient-Beziehung*. Fischer.
- World Health Organization (WHO). (1999). *Definition, diagnosis and classification of diabetes mellitus and its complications: Report of a WHO consultation. Part 1: Diagnosis and classification of diabetes mellitus*. World Health Organization.