Psychological Aspects of Diabetes

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Inter-relationship of diabetes and its psychological impact is to be recognised at different stages of disease.

Initial response at diagnosis.
Restriction of daily life pattern.
Burden of chronic disease.
Apprehension of complications and likely disability.

At diagnosis, there is initial shock, denial and anger and queries as 'why me' are met with.

This can bring in feeling of being different in one's life from the peers, loss of spontaneity and family concern in each and every activity of the person.

Such reactions can be resolved after full explanation of nature of onset of the metabolic disturbance and successful management of blood glucose. It may take upto one year for psychological equilibrium to be re-established.

Regimentation of life style, fear of hypoglycaemia and certain amount of dependency introduces anxiety. Close follow-up by the diabetes care team, education and reinforcement assist in normalizing one's attitude towards daily care. Understanding reasons for fluctuating blood glucose and need for appropriate insulin adjustment, meal pattern and physical activity and behavioural modifications greatly help to salvage the psychological effects.

With long term nature of diabetics and frequent periods of fluctuations in blood glucose diabetics are at increased risk for affective and anxiety disorders. In many studies it has been shown that about 30% of such patients suffer from depression. The other psychological symptoms observed refer to phobic anxiety or cognitive functioning.

Onset of complications in a diabetes brings in additions to be management regimen and extra psychosocial problems.

The main issue is degree of handicap affecting the individual in daily life due to ensuing complications and how well the diabetic can cope with the resulting limitation. Any opportunities available for rehabilitation will ameliorate the setback due to such complications.

Such patients are more vulnerable to unstable daily routine and added worrying problems.

In such circumstances, the health care team becomes the major source of consolation for the patient and the family.

Thus relevance of understanding emotional component of diabetes care is very important for the health worker.

Group meetings and events, participation in local patient association activities or even patient association mailing can help to reduce feelings of isolation and enhance self-evaluation and self-care as well as increasing confidence, and self assurance. Camp and group holidays are chosen for their ability to recognise the needs of he people with diabetes themselves and can provide valuable counseling, particularly at times of unexpected events.

EMOTIONAL NEEDS

At diagnosis and sometimes for the rest of their lives, people with diabetes can feel isolated and perplexed. This often means that comprehensive diabetes education must be delayed while counseling needs are being met. Provision of contact with other people with diabetes may be helpful.

Children with diabetes have their own specific needs, including the need for psychological guidance.

EMOTIONAL BARRIERS

Particularly at the time of diagnosis, the person with diabetes may be discouraged from acquiring appropriate self-care strategies by two internal factors:

Perception of health care in terms of the classical model, in which a doctor provides the treatment. Self-care is severely undermined by the view that others are responsible for one's health.

Misconceptions, or lack of perception, about vulnerability to future health problems. The person's perception of his/her vulnerability is an important part of motivation for optimal self-care.

* *From WHO, New Delhi.*

The classical health belief model (as above) and unfamiliarly and insecurity in dealing with the health care system can mean that people with diabetes fail to gain as much as they could from their contacts with the health care team. Lack of contact with other people with diabetes can make the person feel isolated with his/her problems. Frequently insufficient psychological support is provided, especially in the case of children with diabetes. The problem can be sustained or exacerbated by the inappropriate views of "significant others" whether relatives or friends.

OVERCOMING EMOTIONAL BARRIERS

Effective diabetes education programmes based on appropriate theory should act as a means of empowerment, helping people to overcome barriers and obtain the maximum reasonable benefit from the health care system. They should be aimed at careers and "significant other" as well as people with diabetes themselves. Other simple strategies, such as encouraging people with diabetes or their carriers to write down questions before meetings with physicians or other members of the health care team can help to ensure that the best possible use is made of contact time with providers.

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Therefore there is a need for inclusion of behavioural management in the educational programme. Such inputs also enhance the self-management abilities to cope with demands of the diabetes treatment (eating behaviour, physical activity, monitoring blood glucose, foot care).