Coping Strategies In Diabetes

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Abstract

Coping strategies are an important, yet neglected, aspect of diabetes care, especially in the elderly. This article reviews various negative and positive coping strategies, giving simple examples, and suggests a practical method of coping skills training for people with diabetes.

INTRODUCTION

Diabetes is a chronic disorder, the diagnosis of which is accompanied by considerable physical and mental stress. This is especially true of geriatric patients, who resent the intrusion of doctors and drugs into their life.

While physical stress, such as loss of weight, weakness and frequent infections can be taken care of by insulin and oral hypoglycemics, it is the mental or psychological stress which is difficult to handle. This mental stress often causes poor glycemic control and suboptimal quality of life. Patients diagnosed to have diabetes react to the news in a variety of methods. Denial, anger, sadness, resignation and fear are some of the commonly seen reactions after a patient receives a diagnosis of diabetes.

The way in which a person handles stress is called coping. Coping is defined as an individual's efforts to master demands (conditions of harm, threat or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources.

Coping mechanisms can also be classified as unconscious cognitive processes, e.g., projection, denial, and conscious cognitive processes, e.g., self blame, other blame, rumination and catastrophizing. The conscious coping strategies are self regulating methods of emotion regulation and stress management.

Coping can be classified as problem – focused or emotion –focused. The problem –focused coping strategies comprise all coping mechanisms which directly address the stressor, while emotion –focused coping strategies regulate the emotions associated with the stressor. Problem –focused strategies are thought to be more functional, but this classification is not adequate.

Problem oriented coping can further be classified as cognitive (thought patterns related to coping) and behavioral (action related to coping).

Cognitive coping skills are usually stable for any individual, as she or he tends to behave in a similar manner when faced with various stresses. However, they can be changed, learned, unlearned and influenced by oneself, or through influence of others.

Clinical psychological literature mentions various cognitive coping strategies. These include negative mechanisms such as self blame, i.e., blaming oneself for what one has experienced; catastrophizing, i.e., emphasizing the terror of the experience; and other –blame, i.e., blaming others for one's own experiences and rumination, i.e., thinking all the time about the negative event.

Positive mechanisms of coping include acceptance, i.e., resigning oneself to what has happened; positive refocusing, i.e., thinking of other, pleasant matters instead of the negative event; refocus on planning, i.e., planning steps to deal with the event; positive reappraisal, i.e., attaching a positive meaning to the negative event; and putting into perspective, i.e., playing down the seriousness of a stressor event.

Functional or positive coping mechanisms are essential to ensure health of any individual, but are even more important for those with a chronic disease such as diabetes mellitus.

DIABETES COUNSELLING

While diabetes education programmes try to cover the basics

of diabetes self –management, such as self- monitoring, nutrition, physical activity, insulin administration, self –management, they are silent on the issue of how to cope with the stress of having diabetes.

Healthy coping with diabetes involves assessing the individual's personal coping style, relearning negative coping mechanisms, and learning positive coping strategies. This can be accomplished by cognitive behavior therapy or coping skills training, administered by a clinical psychologist or a trained diabetes care professionals.

DIAGNOSIS OF COPING

Diagnosis of coping styles can be done using various questionnaires, one of which is the Cognitive Emotion Regulation Questionnaire (CERQ), written by Garnefski and Kraaij (1). This questionnaire assesses the extent to which one uses nine different coping strategies, both positive and negative.

The questionnaire scores these strategies relative to norms for similar gender and age groups. It gives the therapist or diabetes counselor a starting point to begin therapy or training.

DELEARNING NEGATIVE SKILLS

Once an inventory of coping skills is made, the next step is to relearn negative or dysfunctional skills. Rumination, catastrophizing and self blame are strategies which are counterproductive, and are related to psychopathology, as well as poor quality of life and clinical outcomes.

The patient should be encouraged to identify negative cognitions and exercise self- will to stop them. Examples of rumination will include thinking about diabetes the whole day, worrying about an insulin injection four hours before it is due, and having day dream about an insulin injection four hours before it is due, and having day dream about developing kidney failure "because I saw it on T.V".

Catastrophizing manifests as 'I am going to die today because of diabetes'. 'The world will come to an end because of diabetes' or 'No one will ever love because I have an incurable disease'.

Self –blame is a common self- defeating coping mechanisms, in which the patient feels 'I ate too many chocolates –it's my fault I got diabetes' or I must have committed sins in my previous life – now I must suffer from diabetes in this life.'

LEARNING POSITIVE SKILLS

Once, the patient has learnt how to identify negative coping skills, or he can be trained to use positive skills.

The easiest protective coping strategies to learn are positive refocusing and positive reappraisal, and are good starting points for people with diabetes.

Positive refocusing means changing thought patterns and focusing on pleasant, happy and unrelated matters, instead of original stressor, such as diabetes. The patient can learn how to replace negative diabetes –related cognition with thoughts about things such as picnics, vacations, family or friends. An example of positive refocusing would be thinking about an upcoming marriage or social function or day –dreaming about a close friend or spouse. This is a method of overcoming rumination.

Positive reappraisal is the opposite of catastrophizing and involves a reassessment of one's condition, with focus on its positive aspects. 'Diabetes has helped me improve my self – confidence', 'Diabetes management has made me more balanced', or 'Diabetes teaches us self – control' are ways of finding a positive aspect of the disease.

'Having diabetes gives me the motivation to work harder and be successful' is another example of positive reappraisal, which should be encouraged. This overlaps with 'focus on planning' which means thinking about future activities and action, e.g., 'I will go for a diabetes camp this weekend', or 'I will join healthy cooking classes'.

Other blame is a coping mechanism which is used by some to explain diabetes. Witchcraft, voodoo, tantricism and envious relatives or spouses are blamed for diabetes, and become a target for hatred and dislike.

Putting into perspective is a positive or protective mechanism whereby one analyzes her or his life, and realizes that diabetes and other illness are just one aspect of existence. 'Diabetes will not prevent me from living life' is a way of putting the disease into perspective, as is 'I can continue to play cricket, watch movies and attend dance classes, so why bother about diabetes?'

REINFORCEMENT

Once negative mechanisms have been controlled, and positive or protective mechanisms learnt, it is a matter of practice.

Support from friends, family and the diabetes care team help

the patient strengthen her or his positive mechanisms, until they become not only a part of coping with diabetes, but with life in general.

Sessions with the clinical psychologist at regular (3 to 6 monthly) intervals should be arranged to ensure continued motivation, and to sort out any problems that he individual patient might face.

GROUP THERAPY /PEER COUNSELLING

Coping skills can also be taught in groups, and by peers. These approaches are cost- and time –efficient, and may be more effective in improving patient motivation as well.

CONCLUSION

An exhaustive knowledge of coping strategies will help the physician mange patients of diabetes better. This applies especially to geriatric patients.

References

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