

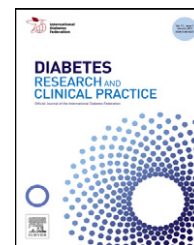


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Psychosocial problems in patients with newly diagnosed diabetes: Number and characteristics

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ABSTRACT

Early in the course of diabetes, it is important to identify and support patients whose psychosocial situations and reactions to the diagnosis may affect their ability to adjust or take adequate responsibility for self-care. We aimed to identify (a) the number and characteristics of patients, 18–65 years, newly diagnosed with diabetes, who needed psychosocial interventions and (b) the type of psychosocial problems they had. A total of 106 patients (72 men) were included in the study. Interviews showed that 41.5% had psychosocial problems. Fifteen dropped out early in the study; 38% of those remaining had psychosocial problems (PSP). More than half had problems with their life situation; most commonly in relationships. About a third had problems related to diabetes, most commonly, work-related. Compared to other participants, PSP patients lived in more strained social situations, especially regarding personal finances and social support. More of the PSP patients were anxious and depressed. They used negative coping strategies more often and more frequently expected that diabetes would negatively affect their future. In conclusion, early in the course of diabetes, screening instruments should be used to identify PSP patients. Treatment by medical social workers skilled in diabetes care should be offered.

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1. Introduction

Diabetes is a disease that affects life in many ways. Findings from several studies over the years show that the disease has a negative impact on both well-being and quality of life [1–3].

An important part of treatment is self-care, which is the patient's own responsibility. The management of diabetes self-care is regarded as highly affected by a person's psychological and social situation. Psychosocial stress, anxiety, and depression have a negative impact on the disease itself [4–6], its outcome [7,8], and its management [9]. Coping is a behaviour often discussed in connection with the management of diabetes self-care. There are several different coping strategies, all with the purpose of managing a stressful

situation and avoiding the anxiety it causes [10]. Problem-oriented coping strategies are found to be positively related to successful management of diabetes self-care [11]. Coping is also regarded as associated with metabolic control. Researchers have found a connection between negative coping strategies such as resignation, protest, and intrusion (of the disease into life) and higher HbA1c-values [12]. Studies show that psychological and psychosocial interventions and enhanced support have positive effects on diabetes self-management and psychological well-being in patients with type 1 and 2 diabetes [13–15]. Findings regarding psychosocial problems in diabetes often are derived from studies on patients with a long disease duration. Patients with a disease duration of ≥ 15 years seemed to be more anxious about

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developing diabetes complications than they were about diabetes self-care [16]. However, it may be even more important to identify patients with psychosocial problems that may affect their management of self-care early in the course of the disease. This early identification would enable the provision of psychosocial interventions and support that could help prevent unnecessary negative physical and social consequences of the disease. Psychosocial work in health care in Sweden is conducted by specialized social workers and includes both social/psychosocial diagnostics and interventions such as crises treatment, emotional adaptation support, and social advice and assistance. Many medical social workers are also educated in psychotherapy.

The aims of the study were to identify (a) the number and the characteristics of patients between the ages of 18 and 65, newly diagnosed with diabetes, who needed psychosocial interventions at the time of diagnosis and (b) what type of psychosocial problems they had.

2. Patients and methods

2.1. Sample

All patients with a diagnosis of any type of diabetes, no later than 3 months before they were included, were invited to participate in the study by a nurse at the adult day care ward or the inpatient ward of the Department of Diabetes and Endocrinology, Karolinska University Hospital, Stockholm. The patients were informed verbally by a nurse, and they also received written information. They were informed that the aim of the study was to gain knowledge about how newly diagnosed patients experience the significance of their diabetes diagnosis, and about what type of support they need to be able to manage life with diabetes. Recruitment took place between January 2001 and December 2004. Only patients between 18 and 66 years of age who were Swedish-speaking were included. One hundred and six patients agreed to participate and provided their informed consent.

2.2. Measurements

An extensive questionnaire (Form A) including 84 questions was used to measure the social situation regarding family, education, employment, housing, certain life events, social network and support. The form also contained questions regarding attitudes and knowledge about diabetes and reactions to the diagnosis. Most of the questions about social situation were used earlier in a study of patients with another chronic disease (early rheumatoid arthritis) [17]. Because of the relatively small sample, some of the variables in Form A were grouped into fewer response alternatives than in the original version of the questionnaire. Educational level was defined as highest completed level; i.e., compulsory school, high school, and university. The original questions regarding reaction to the diagnosis included the following response alternatives: (1) I was shocked, (2) I was sad, (3) I was worried, (4) I was angry, (5) I did not believe it was true, (6) I felt nothing special, (7) other reactions. These were collapsed into three composite response alternatives: (1) little or no reaction, (2)

was shocked or did not believe that it was true, and (3) various emotional reactions such as sadness, anxiety, and anger. The original question regarding if and how the patients believed the disease would affect their future included the following response alternatives: (1) not at all, (2) somewhat, (3) moderately, (4) a lot, (5) much, and (6) very much. These were also collapsed into three composite alternatives: (1) little or no, (2) moderate, and (3) great or very great.

The Hospital Anxiety and Depression Scale (HADS) was used to measure anxiety and depression. The scale was developed by Zigmond and Snaith to detect anxiety and depression in patients with somatic conditions [18] and was evaluated in a Swedish population by Lisspers et al. [19]. The instrument is self-administrated and consists of two subscales (anxiety and depression) with 7 items, each rated on a 4-point Likert scale from “no” to “maximum”. The items are summed up into a dimensional score for each state with ≤ 7 indicating “no case”, 8–10 “possible case”, ≥ 11 “probable case”. They are also summed up into a summary score.

The 13-item Sense of Coherence (SOC) scale was used to measure attitudes and resources for handling psychosocial stress. The scale was developed and later modified by Antonovsky [20]. Important components measured by the scale include comprehensiveness, meaningfulness, manageability, and resistance resources. The scale should be treated as a single entity with no subscales, and the values may vary between 13 and 91. The higher the SOC scores, the better the ability to cope with stress.

Coping strategies were measured with the General Coping Questionnaire (GCQ), which was developed and evaluated by Persson and co-workers [21]. The scale has previously been used in studies of patients with type 2 diabetes in Swedish primary health care [12,22]. The instrument is divided into five coping orientations dichotomised into positive and negative opposites; i.e., self-trust/fatalism, problem-focusing/resignation, cognitive reevaluation/protest, social trust/isolation, and minimization/intrusion. These 10 scales are scored between 0 and 100. The orientations are also summarized into a total positive and a negative summary score.

All of the patients were also interviewed using a structured interview form (Form B) that included 27 questions developed especially for the study. This form was based on an anamnesis model often used in medical social work. Form B is a structured interview guide for assessing patients' social and psychosocial history and was used by the medical social worker to diagnose whether the patients were in need of psychosocial treatment or not.

2.3. Collection of psychosocial data

The participating patients were asked to fill in the four different questionnaires regarding their social situation (Form A), depression and anxiety (HADS), and coping attitude and strategies (SOC and GCQ) within 3 months after they were diagnosed. Later, they were interviewed by a medical social worker using a structured interview form (Form B). The interviewing social worker was not involved in the study and had long-standing clinical experience with the identification of psychosocial problems. The aim of the interview was, together with the patient, to assess whether he or she had

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