

How important are the psychosocial aspects of diabetes?

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ARTICLE POINTS

- 1 The biomedical model of diabetes fails to meet patients' psychosocial needs.
- 2 Diabetes places a constant strain on patients to maintain the required change in lifestyle.
- 3 Living with diabetes can mean loss of health, independence and freedom.
- 4 The emphasis on glycaemic control means that patients often feel 'victims' by health professionals when they fail to achieve it.
- 5 Professionals need to cease their fixation on glycaemic control, and concentrate more on the wider aspects of diabetic instability.

KEY WORDS

- Biomedical model
- Psychosocial aspects
- Victim blaming
- Empowerment

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Introduction

Most healthcare professionals would argue that improving the quality of life for their patients is one of their ultimate goals. But is this what we really do for people with diabetes? Or do we send them further down the road of psychological distress? Metabolic control may be important, but is it the most important factor of diabetes care? This article briefly describes some of the research exploring psychosocial issues in diabetes and discusses ways of integrating these perspectives into care.

The Diabetes Control and Complications Trial (DCCT) provides impressive evidence that the intensive management of diabetes delays the onset and progression of the long-term complications of insulin-dependent diabetes (DCCT Research Group, 1996). But at what cost to the patient?

Adjusting to chronic illness is a personal, lived experience, requiring frequent adjustments to treatment regimens and carrying many uncertainties (Jessup and Stein, 1985). Landis (1996) found that uncertainty was strongly related to psychosocial adjustment and had a negative effect on the ability to adjust to daily living with diabetes: the greater the uncertainty, the poorer the adjustment.

The threat of diabetes has also been shown to be associated with lower self-esteem, decreased happiness and reduced life satisfaction (Connell et al, 1991).

Polonsky et al (1995) investigated the effect of diabetes on quality of life, and found that emotional distress was common among their subjects. Worries and the possible development of long-term complications of diabetes, together with feelings of guilt and anxiety regarding poor adherence to their diabetic regimens, were the most prominent concerns.

Sturrock and Moriarty (1995) found that the perceived wellbeing of patients with diabetes was not as good as that of an equivalent age-matched control population, and Gallichan (1995) argues that poor

glycaemic control is associated with anxiety, depression and problems with daily living.

Living with diabetes

Living with diabetes is by no means easy. Wikblad et al (1996) point out that a treatment regimen that diminishes the possibilities of acting spontaneously is liable to affect quality of life. Indeed, Nichols (1996) suggests that many patients find the experience of diabetes to be associated with insecurities and constant strain with regard to maintaining the required change in lifestyle. Nichols emphasises that the volume of demand made upon the person is one of the most significant issues with regard to compliance.

Coles (1996) suggests that living with diabetes can mean the loss of health, independence and freedom to do as one pleases. It may also lead to loss of prestige and confidence. McFarland et al (1989) believes that the patient's desire to avoid complications has a 'tremendous emotional impact'. In addition, in striving to achieve good diabetic control, patients may suffer many hypoglycaemic attacks. On the other hand, fear of hypoglycaemia may induce the individual to purposely run higher than ideal blood glucose levels (Richmond, 1993), causing a see-saw effect on their control.

Victim blaming

Poor diabetic control is often attributed by health professionals to poor compliance with treatment regimens. Inlander

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Figure 1. Patients require advice and education regarding their disease but do not want to be directed, ordered, controlled or blamed*.

PAGE POINTS

1 Blaming or labelling people can further damage self-esteem and create a barrier to improving diabetic management.

2 Guilt induced by blame is an added burden for diabetic patients.

3 Patients require advice and education about their disease — they do not want to be controlled or blamed for the conduct of their daily lives.

4 It has been claimed that nurses use language that exerts power over patients.

(1992) believes that individuals must take responsibility for their own health care. However, patients are often 'victimised' by the very people who should be helping them.

Blaming or labelling people can further damage self-esteem and create a barrier to improving diabetic management (Bradley and Gamson, 1994). Perkins (1992) argues that guilt induced by blame is an added burden which diabetic patients should not be made to carry.

It has been claimed that nurses use language that exerts power over patients (Hewison, 1995). For example, stating that a patient is 'non-compliant', or 'cheats' with his/her diet, or has 'poor diabetic control' does little to improve that nurse/patient relationship. Hewison argues that, unfortunately, in many cases, this situation is accepted as the 'norm' and is a major factor in 'the professional is powerful, the patient is powerless' scenario. Indeed, Anderson (1995) argues that the physician is viewed as active, powerful, knowledgeable and in control of the care process, suggesting to patients that the individual has no say in his/her health care. This results in a significant amount of frustration for patients.

Patients require advice and education

regarding their disease but, according to Anderson (1995), they do not want to be 'directed, ordered, controlled or blamed for the conduct of their daily lives.'

The way forward

Diabetes cannot be treated in isolation from the social, emotional, cultural and psychological aspects of a person's life. The biomedical model is disease specific and therefore fails to meet the needs of someone with diabetes (Brennan, 1996). What, then, can be done to improve the lot of the person with diabetes?

Open and collaborative consultations with patients are constrained by pre-existing power relationships (Hewison, 1995). However, Anderson et al (1988) suggest that treatment regimens might be enhanced if healthcare professionals were more fully conversant with patients' experiences, beliefs and attitudes regarding their disease. Professionals need to adopt more supportive attitudes, thus empowering patients to actively participate in their own health care (McCord and Brandenburg, 1995).

Most chronically ill people work hard at trying to achieve good metabolic control and it is difficult to estimate the psychological damage incurred by blaming people for their diabetic instability. It is time that healthcare professionals ceased their fixation with blood glucose control, and concentrated on the wider psychological aspects associated with instability. The process may be helped by the use of neutral terminology (McFarland et al, 1989) thus avoiding feelings of guilt and failure.

The need for psychological support cannot be emphasised too strongly. In point of fact, Bradley and Gamson (1994) believe that psychological well-being should be monitored in parallel with metabolic control to highlight specific problems with coping. Allowing patients to voice their fears and anxieties in a comfortable, non-threatening environment and encouraging them to take an active role in the decision-making process with regard to their own care may also help to reduce the depression and frustration experienced by many chronically ill patients. Only when these issues have been addressed will our patients begin to feel better. ■

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