

DC2.1 Why Do We Need Diabetes Team Care?

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DC2.2 Psychological Challenges in Diabetes

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Kierkegaard (1959) noted rightly that "If you really want to help somebody, first of all you must find him where he is and start there. This is the secret of caring....Helping somebody implies your understanding more than he does, but first of all you must understand what he understands....All true caring starts with humiliation". Experienced clinicians have long realized that management of chronic illnesses like diabetes cannot rely on a one sided, authoritative or paternalistic approach from the doctor or specialist nurse dictating what patients should or should not do. To effectively manage the challenges imposed by diabetes, the prerequisite task is to establish a safe and trusting therapeutic rapport with the patient before moving on to strive to contain the harm of diabetes with collaborative and synergistic efforts between the clinician and the patient. "Compliance" or adherence to medical advice, whether it be the medication regimen, habit and lifestyle changes, blood glucose monitoring or behavioural preventive measures, is not automatic. There is a danger that metabolic goals are vigorously pursued at the psychological expense of miserable patients so much so that they eventually choose to abandon the agreed quest for metabolic perfection when face with unacceptable psychological costs. Compliance is not automatic. A patient's motivation is complex and frequently goes beyond simple health concerns. Important patient related variables had been highlighted in the literature on health belief. Patients' perceptions of their vulnerability, the severity of the illness, sense of control, effectiveness of the treatment, related costs and barriers to treatment are potent variables affecting adherence. On the other hand, Ley (1997) reminded us that the consultation related variable which is consistently associated with compliance is "the patient's satisfaction with the consultation". The psychological challenges of diabetes extend beyond blood glucose control and prevention of long-term complications. In particular, the clinician has to manage the high prevalence of dysphoric emotions (with an estimated ten percent of the diabetic population suffering from a major depressive disorder and thirty percent having depressive symptomatology), help patients maintain an optimal and satisfying quality of life despite the illness, promote effective stress management, satisfactory weight control, and deal with idiosyncratic concerns like sexual dysfunctions. In managing diabetes, the clinician also has to work against the adverse influence of the life long nature of the illness. A life-long affliction creates almost certain periodic fatigue, demoralization, and resentment in patients, particularly during periods of high stresses. The clinicians' effectiveness in managing diabetes rests largely in their success in empowering patients to do what is best for themselves, in the most willing and informed manner. The skills required are multifaceted. Good management starts with effective psychoeducation, clear communication, successful formation of trusting rapport and a long lasting therapeutic relationship. The challenge in managing diabetes is to be able to cut through ignorance to knowledge, from knowledge to realistic attitudes and beliefs, and finally from attitudes/beliefs to effective actions. The effective clinician is one who can balance and deliver informational as well as emotional care. A good clinician strives to be one whom patients can trust and work with; one who understands, respects and is respected in return, one who listens and is willing to answer questions; and one who is comfortable to be with.