**Addis Ababa University**

**College of Education and Behavioral Studies**

**School of Psychology**

# Psychosocial Problems and Coping Mechanisms of People with Diabetes: A Case of Armed Forces Comprehensive Specialized Hospital Addis Ababa

**By: Berknesh Mico**

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**A Thesis Submitted to the School of Psychology, Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts Degree in Counseling Psychology**

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**Approval of the Board of Examiners:**

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## Abstract

*The main objective of the study was to explore the psychosocial problems and coping mechanisms of people with diabetes. Psychosocial problems are common in patients with diabetes. However, data on psychosocial issues affecting patients with diabetes in Ethiopia are scarce. The study employed a qualitative research approach to answer the questions and achieve the research objectives. Data were collected from 10 people with diabetes and 2 healthcare providers through in-depth interviews and from 8 care givers through focus group discussion. As to the sampling technique, the study used purposive sampling for all. Data were analyzed following thematic content analysis approach. Based on the data analysis, the following findings were obtained. During the first phase of living with diabetes, patients experienced diabetes diagnosis distress, fear, grief, anger and initial changes in activities, and conduct and personality changes. These problems continued during all phases of living with diabetes too. And even though the patients are getting free medical service in Armed Forces Comprehensive Specialized Hospital, there were occasions medications are unavailable in times of disease progression and on set of complications. Moreover, the hospital has no a trend of supporting patients in association with psychosocial problems. Diabetes patients try to cope up their problems by using their own way. But there is common coping mechanism that most of the respondents' use were seek spiritual help, doing exercise, accepting the illness and family support are important coping mechanisms. Based on the findings above, this study concluded that people with diabetes in Armed Forces Comprehensive Hospital have several psycho-social problems. The patients have not received services beyond clinical intervention. There is no as such significant communication between patients and health providers including care givers to the extent it can serve as instrument in alleviating psycho-social problems. So, there should be patient education. In addition, care providers should implement intervention to address the day today problems of living with diabetes-related to self-management behaviors, as well as diabetes-related family conflict.*



*Key words: People with diabetes, psycho social problems, coping mechanisms*

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# Acronyms

| | |
|---|---|
| ADA | American Diabetic Association |
| CDA | Canadian Diabetics Association |
| DM | Diabetes Mellitus |
| FBS | Fasting Blood Sugar |
| FGD | Focus Group Discussion |
| GWAS | Genome Wide Association Studies |
| HgbA1C | Hemoglobin AIC |
| IDF | International Diabetic Federation |
| MODY | Maturity Onset Type Diabetes of the Young ages |
| IDDM | Insulin Dependent Diabetes Mellitus |
| NDDM | Non Insulin Dependent Diabetes Mellitus |
| NCD | Non-Communicable disease |
| WHO | World Health Organization |

# Chapter One: Introduction

## 1.1 Back ground of the study

Type 1 diabetes usually strikes children and young adults, although its onset can occur at any age and the cause is idiopathic. However, type 2 diabetes is the most common form of diabetes and is characterized by insulin action and insulin secretion, ranges from predominant insulin resistance with relative insulin deficiency to a predominant secretor defect with insulin resistance. However, these type of diabetes occurs most often in middle aged and older people (Amed and Oram, 2016). Type 2 diabetes is primarily due to life style factors and genetics. A number of life style factors are known to be important to the development of type two diabetes, including obesity, lack of physical activity, poor diet, stress, and urbanization (Riserus et al,2009).

Diabetes is a major life threatening condition to global public health and rapid getting worse, biggest impact on adults of working age group and worldwide 3.2 million deaths every year. And it also high risk for receiving a non-traumatic lower-extremity amputation and mental health disorder (Berbrayer,2015). Although new and more efficacious diabetes medication and improved medication delivery systems have been developed, the majority of diabetic patients do not achieve optimal blood glucose control (Peyrot et al, 2004). Therefore, unmet blood glucose targets are still a major concern to the patients.

A study by Holt and Kalra (2013) confirmed that multiple psychosocial problems are common in association diabetes. This is particularly true for conditions such as injecting insulin, checking the blood glucose, counting carbohydrates, eating healthy, balancing carbohydrates with exercise and visits the health care providers; and each of these may impact a patient's emotional wellbeing and social life. One of the biggest problems among patients with diabetes is suboptimal diabetes self-care (Kumar, Nagpal and Bahartia, 2008).

According to Peyrot et al (2004) negative attitudes, coping difficulties and psychological problems such as depression, anxiety and eating disorders are common in diabetes and can contribute to poor outcomes. Several studies have also confidently estimated that there are increased chances of emergent adults with type 1 diabetes developing distress, or low life satisfaction over time (Jewell and Gorey, 2019).

In addition, according to Northam, Anderson & Adler (1996) children and other family members of people with diabetes live with a significant amount of extra stress (Howard, 2017). Diabetes distress refers to the emotional distress related to living with and managing diabetes, not attributable to other causes of overall emotional distress or mental health problems (Hapunda, Ali et al, 2015).

According to Huffman et.al, (2015) many adults with diabetes experience high levels of emotional distress stemming from their concerns and worries about diabetes. It has been realized that psychological disorders negatively impact on patients' quality of life and ability to handle aspects of their management. Lastly this leads to poor glycemic control and further worsening in quality of life. According to Mezuk et al (2008), diabetes and depression appear to have a consistent bidirectional relationship, with depression often preceding the development of Type2 diabetes. Inadult's psychological syndromes such as depression and anxiety have been consistently associated with poor outcomes in patients with Type 2 diabetes. For example, depression is associated with impaired glucose control, functional disability, end-organ complications, and mortality (Huffman et.al, 2015). It is hoped that proper management of psychosocial problems will lead to better outcome in patients (Jennifer and Rita, 2008). Meanwhile, patient and provider reported psychosocial problems and barriers are not in the right way for effective self-care and resources for dealing with those barriers.

The need to behaviorally regulate metabolic process that are normally controlled by autonomic physiologic functioning makes coping with diabetes different from other chronic illness (Kalsen & Bru,2002). People living with diabetes must control the timing, quality and quantity of their nutritional intake and optimize their activity and exercise levels to achieve the targets set for optimal metabolic control. Coping with diabetes is a lifelong necessity and impacts on the health outcomes achieved by self-management (Gafvels &Wandell,2006). For health care providers caring for patients with diabetes it is essential to have understanding of the patient's perception of their stress and their ways of coping with it (Bandura, 2010).

Research has indicated that patients and providers differ substantially in their perceptions and attitudes, which may lead to confusion and conflict and in turn to poor outcomes (Peyrot et al, 2004). So, this study was designed to have complete opinion about psychosocial problems and coping mechanisms from the perspective of people with diabetes, care givers/family members and healthcare providers in Armed Forces Comprehensive Specialized Hospital. Though many

researchers studied about diabetes all over the world, there are few researches that studied about psychosocial problems and coping mechanisms of people with diabetes to mention some of them, psychosocial functioning in individuals living with diabetes in Zambia (Hapunda, 2015). But as the best knowledge of the researcher there is no research that is conducted specifically on Armed Forces Comprehensive Specialized Hospital. So, the investigator wishes to study the psychosocial problems and coping mechanisms of people with diabetes at Armed Forces Comprehensive Specialized Hospital.

## 1.2. Statement of the problem

According to Peyrot et al (2004) new and more efficacious diabetes medication and improved medication delivery systems have been developed; however, the majority of diabetic patients do not achieve optimal blood glucose control, leading to poor health outcomes. Negative attitudes, coping difficulties and psychological problems such as depression, anxiety and eating disorders are common in diabetes and can contribute to poor outcome.(Peyrot et al,2004) The psychosocial problems can eventually develop into depressive or other psychological disorders that are associated with poor self-care behavior, poor metabolic outcomes, increased mortality, functional limitations, increased health care cost, loss of productivity and reduce quality of life (Kumar et al, 2008).

Evidence indicates that diabetes and its complications are strongly associated with psychological and psychiatric problems (Cieechanowski, Katon & Russo, 2001). These include depression, poor eating habit and fear of hypoglycemia, In addition, patients with type-2 diabetes mellitus also have a twofold greater risk for co morbid depression compared to healthy controls, hampering the quality of life of patients (Bajwa, Saroha, &Bajwa, 2015). Moreover, empirical studies also indicate that patients with diabetes suffer from high level of diabetes – specific emotional stress; this is associated with functional impairment, poor adherence to exercise, diet and medication, and inadequate glycemic control (Bhuanti, Karla and Verma, 2014).

Coping is a psychological process developed at conscious level used when one tries to manage difficult and stressful situations in life and coping has been demonstrated to be able to influence the individual's response at a biological level leading to a normal or pathological reaction in humans, a mechanism that depends on its efficiency in reducing the psychological distress (Habra et al, 2016).

In the context of Ethiopia data on psychosocial problems and coping mechanisms associated with diabetes are inadequate particularly in the study area. So; the researcher gets this as a gap.

Therefore, by taking these problems in to consideration, the researcher has an interest in studying the psychosocial problems and coping mechanisms of people with diabetes at Armed Forces Comprehensive Specialized Hospital.

## 1.3. Research questions

- What are the psychosocial problems of people with diabetes are facing as they live with diabetes?
- How do people with diabetes cope up the psychosocial problems they encounter in their daily life?

## 1.4. Objective of the study

### 1.4.1. General objective

This study was designed to explore the psychosocial problems and coping mechanisms of people with diabetes.

### 1.4.2. Specific objectives

- To explore psycho-social problems people with diabetes are facing as they live with the illness
- To investigate the coping mechanisms of people with diabetes to deal with the problems they encounter in their daily life in Armed Forces Comprehensive Hospital

## 1.5. Significance of study

The study would helpful to provide basic information for diabetes patients, health practitioners those who might be inquiring the relationship between psychosocial problems and diabetes mellitus. It might be also helped health professional to initiate early screening, diagnosing and management of psychosocial problems in diabetic patient based on the finding. Additionally, it could be contributed a body of knowledge to further study and other researchers who might be conduct a study on related topic and also organizations working with diabetes patients. Finally, it could be aided support to make policy program, healthcare providers, patients and their families in the encouraging early recognizing, screening and managing the psychosocial problems of people living with diabetes.

Policy makers, health sector, nongovernmental organizations and other stake holders would be helped to identify the existing gap and then make their implementation program using this as

evidence based practice. Finally, this enables then to compare their final achievements. On the other hand, researchers would use this finding for review of literature in the future research and make the finding more up-to-date.

## 1.6. Scope of the study

Psychosocial problems and coping mechanisms of people with diabetes are broad issues, which consist of numerous interactions but the scope of this study is restricted to uncover psycho-social problems and coping mechanisms of people with diabetes in a view to deal with the problems they encounter in their daily life. And it is limited to Armed Forces Comprehensive Specialized Hospital.

## 1.7. Definition of Important terms

- Caregiver: For this study a person who gives supports for a diabetes patient and live with him/her.
- Psychosocial problem: Is the maladaptive, negative or unhealthy interpersonal, behavioral and emotional status which leads an individual to develop unhealthy relationship building, and malfunctioning.
- Health worker: For this study, a health worker is a professional who treats diabetes patients at the out -patient department of Armed Forces Comprehensive Specialized Hospital.
- Coping mechanisms; are ways to which external or internal stress is managed, adapted to or acted upon.

## 1.8. Limitations of the study

The limitation of the study was unable to generalize the finding of the study to the general population because of few numbers of samples taken for the study. Also the participants struggled psychosocial problems with diabetes; they may felt the need to provide desirable survey responses.

# Chapter Two: Review of Related Literature

## 2.1. Introduction

This chapter presents theoretical and empirical review of the literature on such topics as definition, classification, symptom and diagnostic criteria, prevalence, risk and protective factors of diabetes; impact of diabetes on patients and caregivers; psychosocial problems and coping mechanisms of people with diabetes.

## 2.2. Definition of Diabetes Mellitus

Diabetes mellitus is recognized as being a syndrome, a collection of disorders that have hyperglycemia and glucose intolerance as their hallmark due to either to insulin deficiency or impaired effectiveness of insulin's action or to a combination of these (American Diabetes Association, 2012). There are two types of diabetes, type 1 and type 2. Type 1 diabetes. Type 1diabetes strikes children and young adult, it is account s for 5% while Type 2 accounts for about 90%to 95%of all diagnosed cases which associated with older age, obesity, family history, history of gestational diabetes physical inactivity, and race and ethnicity (American Diabetes Association,2013).

Diabetes mellitus is becoming a pandemic worldwide (Engström, Leksell, Johansson, 2016). In terms of numbers diabetes mellitus is estimated to affect as many as 408 million people worldwide in 2013, and it is a disease that acquires epidemic form and constitutes one of the major threats to human health in the 21$^{st}$ century (1). The World Health Organization 300 million people will suffer from the diabetes by 2025 (Raval et al,2010) Diabetes the fourth leading cause of death (Borgers et al,2014) has affected. Based on type, Type 2 diabetes share will be significantly higher than other types. This prediction is mostly due to obesity and lack of exercise that are thought to arise from rapid economic development, improved living standard and an aging population (Gold, Deary&Frier, 2010). Unfortunately, there is no cure for diabetes but by controlling blood sugar levels through a healthy diet, exercise and medication the risk of long term diabetes complications can be decreased. Long-term complications that can be experienced include Eyes- cataracts and retinopathy (gradual damaging of the eyes) that may lead to blindness, Kidney- disease and kidney failure Nerves- neuropathy (gradual damaging of nerves), Feet- ulcers, infections, gangrene, etc. (American Diabetes Association, 2012).

## 2.3 Classification of Diabetes Mellitus

A major requirement for orderly epidemiologic and clinical research on and for the management of diabetes mellitus is an appropriate classification. Furthermore, the process of understanding the etiology of a disease and studying its natural history involves the ability and differentiate between its various forms and place them into a rational Etiopathologic framework (American Diabetes Association, 2012). Two major forms of diabetes are recognized: insulin dependent diabetes mellitus (NIDDM, type I diabetes) and non-insulin dependent diabetes (NIDDM, TYPE II DIABETES). The evidence of this heterogeneity is overwhelming and include the following. There are many distinct disorders, most of which are individually rare, in which glucose intolerance is a feature. There are large differences in the prevalence of the major forms of diabetes among various racial or ethics groups worldwide. (American Diabetes Association,2012).

Collective evidence has been used to divide diabetes mellitus into four distinct types namely: insulin dependent diabetes, non-insulin dependent diabetes, malnutrition related diabetes and other types of diabetes (American Diabetes Association, 2012). The classification highlights the marked heterogeneity of the diabetic syndrome. Such heterogeneity has important implications not for clinical management of diabetes but also for biomedical research (Expert Committee on the Diagnosis and Classification of Diabetes Mellitus, 2003). In this study the focus was mainly on type I diabetes.

### 2.3.1 Insulin dependent diabetes mellitus (IDDM)

Type I diabetes is thought to result from an infectious or toxic environmental contingency in people whose immune systems are genetically predisposed to develop a vigorous autoimmune response pancreatic B cell antigens. Extrinsic factors that might affect B cell functioning include damage caused by viruses such as the mumps virus and coxsackie virus B4, by chemical agents, or by disruptive cytotoxins and antibodies released from sensitized immunocyts. (Gregg and Benjamin, 2003).

An underlying genetic defect relating to pancreatic B cell replication or function may predispose a person to the development of B cell failure after viral infections. Observation that pancreatic B cell damage appears to be lessened when immunosuppressive drugs such as cyclosporine or azathioprine are given at the initial manifestation of type I diabetes support the importance if auto aggression by the immune system as a major in the pathogenesis of this type of diabetes (Kosaka et al 2002).

### 2.3.2 Non-insulin dependent diabetes mellitus (NIDDM)

The pathogenesis in type II diabetes is that the pancreas produces insulin but the body does not utilize the insulin correctly. This is primarily due to peripheral tissue insulin resistance where insulin receptors or the other intermediates in the insulin signaling pathways within body cells are insensitive to insulin and consequently glucose does not readily enter the tissue leading to hyperglycemia or elevated blood glucose concentrations. Obesity, which generally results in impaired insulin action, is a common risk factor for this type of diabetes and will ultimately require multiple anti-diabetic agents to maintain adequate glycemic control (Gregg and Benjamin, 2003).

## 2.4 Symptom and diagnostic criteria

A diagnosis of diabetes mellitus is achieved by proving the chronic continuation of a hyperglycemic state. A diagnosis of diabetes is made if the results of a second test performed on another day confirm a judgment of diabetic type. However, in at least one of the two tests either the initial or the repeated test it is essential that the plasma glucose level must be reached to the diabetic type, and a diagnosis based on repeated HbA1c tests alone is not acceptable (Bhuanti, Karla &Verma, 2014). If plasma glucose and HbAlc are measured at the same time and both confirm a diabetic state, it is possible to diagnose diabetes at the initial examination. The plasma glucose level indicates and in one of the subsequent items is recognized, a diagnosis of diabetic can be made (Gregg EW, Benjamin SM, 2003).

When there are typical of diabetes, such as thirst, polyuria and weight loss and when there is a definite evidence of diabetic retinopathy. Even if the plasma glucose and HbAlc levels obtained do not exceed the reference values for diabetes, the existence of a past record (in the test data) of the diabetic type, or of any record of the above conditions raises suspicious of diabetes. Therefore, the care should be taken as such for diagnosis during pregnancy including gestational diabetes (Engström et al, 2016).

## 2.5 Treatment for diabetes

The goal of diabetes management is to keep blood glucose levels as close to normal as safely possible. Since diabetes may greatly increase risk for heart disease and peripheral artery disease, measures to control blood pressure and cholesterol levels are essential part of diabetes treatment as well. People with diabetes must take responsibility for their day to-day care. this includes monitoring blood glucose levels, dietary management, maintain physical activity, keeping weight and stress under control, monitoring oral medications and, if required, insulin use via injection or pump. (Bhuanti, Karla and Verma, 2014).

### 2.5.1 Diet therapy and exercise therapy

Educate patients about how diabetes develops and progress and how they can carry out diet and exercise, exercise can reduce the glucose in the blood, and exercise can also help people with type2 diabetes avoid long-term complication, especially heart attack, diet and exercise alone will control diabetes for some people, for others, a combination of medications and healthy habits will keep them at best. (Gregg and Benjamin, 2003)

### 2.5.2 Pharmacotherapy

Early initiation of pharmacologic therapy is associated with improved glycemic control and reduced long term complications in type2 diabetes. Oral hypoglycemic agents (given by mouth) and insulin (give in injection form) are initially administered in small doses, but these doses are gradually increased with an attentively on the blood glucose level, the target for glycemic control is established for each patient by the physician in charge taking into account the patient's age and the condition (Engström, Leksell, &Johansson, 2016).

### 2.5.3 Diabetes education

According to Gregg and Benjamin (2003). Diabetes education is to be implemented on a routine daily basis with the target audience being patients with diabetes themselves. The goals of diabetes education are to promote an understanding of diabetes among patients with diabetes; to help patients with diabetes cultivate a willingness to achieve their ability to continue diabetes care .Thus, education is not merely provision of knowledge but provision of relevant knowledge or information on procedure required to achieve the above treatment goals, according to his/her motivation toward diabetes treatment and readiness for behavioral change through continued dialogues with each patient (Gregg and Benjamin, 2003).

## 2.6 Prevalence of Diabetes Mellitus

Today diabetes mellitus (especially type 2 diabetes mellitus) affected the world population in epidemic forms. This epidemic has been triggered by social and economic development as well as urbanization, which is linked with general improvements in nutrition and increasing life expectancy. They are aggravated by some risk factors such as unhealthy dietary habit, smoking, excessive alcohol consumption, hypertension, obesity, overweight, increased body mass index and sedentary life style (Kosaka, kanuma, &Goto, 2002).

For instance, in 2014 as reported by International Diabetes Federation, there were 387 million people living with diabetes worldwide. The majority of them are aged 40-59 years, and 80% of them live in low-and middle income countries. If the trend continues, by 2035, some 592 million people, or one adult in 10, will have diabetes (Manjunath et al, 2011). The International Diabetes Federation, states that currently the top 5 countries with the highest amount of diabetes patients are China, India, USA, Russia and Brazil; however, the countries with the highest prevalence are nations such as Saudi Arabia, (NauruM, Gregg & Benjamin, 2003)

According Hill-Briggs (2001) this is still higher in people who have moved away from the traditional way of life, either to live in towns and cities or through migration to another country. But, the prevalence of type 2 diabetes is lowest among people who still have a conventional or primitive lifestyle as either hunter-gathers or subsistence farmers. Mabuchi Indians in Chile, rural Bantu in Tanzania and rural communities in the pacific Islands and South Asia are the pertinent example (Hill-Briggs, 2001).

The WHO STEP wise approach for chronic non communicable disease survey which was undertaken in a few African countries reported that the prevalence of diabetes varies widely from one country to another, ranging from 3-11%. The island of Seychelles and Democratic Republic of Congo have some of the highest rates of diabetes in the region. The absolute and relative mortality rates from diabetes are highest in the 20-39 years of age group that are most economical and productive population in Africa. Over the past few decades, diabetes mellitus has emerged as an important non communicable disease in sub-Saharan Africa (Within 20 years, unless something is done to curb the rising prevalence of risk factors for diabetes, the number of cases will be expected to increase by 98% (Hapunda, Ali et al,2015). An increment in the magnitude of diabetes over time and to younger population is documented; indeed, as age increase odds of having DM increases in

about 6-fold. Urban dwellers, centrally obese, overweight, and hypertensive individuals have higher odds of getting diabetes mellitus (Hill-Briggs, 2001).

Another study conducted in the Democratic Republic of Congo, revealed e highest prevalence of diabetes when it was compared with studies conducted in other Sub Saharan African countries. The degree of urbanization (westernization) and life style changes were thought to be a clear determinants factor for the increased in the number of diabetes in this study (Kosaka, kanuma, and Goto, 2002).

Studies undertaken on the epidemiology of diabetes demonstrated an increasing prevalence of diabetes that previously thought as a rare medical case in Ethiopia. In addition, IDF reported Ethiopia to be ranked 3$^{rd}$ among ten top countries in Africa with 2.9 million cases and estimated prevalence of 4.85. The number of people with impaired glucose tolerance also estimated 6.9%. Among these more than 1.4 million people were undiagnosed for diabetes mellitus and its prevalence is higher in urban than rural population (Greg and Benjamin, 2003).

## 2.7 Etiology of diabetes

Type 1 diabetes occurs by deficiency of insulin due to the destructive lesions of pancreatic beta cells, which usually leads to absolute insulin deficiency. Auto-immune process is thought to be the main mechanism to destroy beta cells, but in a few cases the evidence for autoimmune mechanism cannot be obtained. Such cases are classified as a group of idiopathic etiology. Type 2 diabetes comprises the majority of diabetic patients and is a progressive disease encompassing defects in both insulin secretion and use (Vallitutto, 2008). This type of diabetes develops by a decrease in insulin secretion and/or a decrease in insulin sensitivity or insulin resistance.

The relative contribution of these two factors varies among patients. Obesity is common, and even if the patients are not obese at present, many of them have been obese before the onset of diabetes (American Diabetes Association, 2012). Probably, the genetic and precipitating environmental factors of type 2 diabetes are quite heterogeneous. Other types of diabetes and glucose intolerance due to specific causes are divided into two groups. Group A includes diabetes in which specific DNA abnormalities have been identified as a cause of diabetes, and Group B includes diabetes associated with other pathologic conditions or diseases. Group A is further divided into genetic abnormalities of beta cell function, and genetic abnormalities of insulin action mechanisms (American Diabetes Association, 2012).

Group A (1) includes so-called MODYs (maturity-onset type diabetes of the young), non-insulin-dependent diabetes of autosomal dominant inheritance with onset at young ages. Several different DNA abnormalities have been recently discovered in MODY families. Group A (1) also includes abnormalities of insulin gene and mitochondrial DNA. Group A (2) includes various abnormalities of insulin receptor gene. Diabetes and glucose intolerance associated with other diseases or conditions (Group B) are similar to the previous classification, this group includes so-called 'secondary diabetes' such as pancreatic diseases, endocrine diseases and so on (Gregg and Benjamin, 2003).

## 2.8 Risk and protective factors

According to Kornellis(2012) diabetes has become a major public health concern globally. Diabetes is a heterogeneous disease involving complex genetic, behavioral and metabolic factors. The protective factors are eating healthy foods, get more physical activity, loss excess pounds and to keep your weight in a healthy range. Prospective studies have improved the understanding of modifiable risk factors for type 2 diabetes. Individual responses to behavioral lifestyle risk factors vary, likely due to many factors including differences among individual's psychology, intervention adherence and the possibility of complex gene-environment interactions that are not clearly understood (Kornellis ,2012).

### 2.8.1. Demographic risk factors

One of the demographic characteristics of individuals as a risk factor for developing diabetes could be age**.** The prevalence of diabetes increases with age in most populations. The incidence of diabetes is low before age 30years but increases rapidly and continuously with older age. Perspective observational studies have generally reported age to be a strong risk factor, independent of major correlated lifestyle risk factors, including obesity (Hill-Briggs, 2001).

In the European prospective investigation into cancer and nutrition (EPIC), higher risk of diabetes in men compared with women was observed consistently across different European countries. However, this consistency was not as clearly evident in the United States population because the incidence of diabetes among men compared to women was higher in2010 but lower in 2013, based on NHIS data (Lin, Katon and Von Korff, 2004).

### 2.8.2. Genetic Risk Factors

A family history of diabetes has been linked with increased risk for diabetes. Early efforts to identify genetic variants for diabetes heritability in epidemiologic studies involved genome wide linkage and candidate gene approaches. With the introduction of studies incorporating high through put, parallel genotyping technologies, including genome wide association studies (GWAS), thefield has rapidly advanced, identifying and replicating multiple novel loci associated with diabetes (Mezuk, Eaton, Albrecht and Golden, 2008).

There are indications that genetic factors do have relevant influence on diabetic risk. For one thing, twin and family studies show that type 2 diabetes has a strong inherited component (estimated at >50%). (Nolan et al,2011). Foranother, recent studies suggest the existence of genetic predisposition to develop diabetes in the presence of "diabetogenic"environmental factors such as high calorie nutrition and lack of exercise. (Erdman, Linsel &Schunkert ,2010)

### 2.8.3. Behavioral and Lifestyle Risk Factors

Behavioral and life style factors have been attributed to urbanization and environmental transition leading to sedentary behavior and over nutrition. The major lifestyle risk factor for diabetes is dietary intake. The roles of nutrients, foods and dietary patterns on diabetes progression are a mandatory (Zimmet& Albert, 2008). History of depression, current depression, and antidepressant medications use are risk factors for the development of type two diabetes, especially if the individual has other risk factors such as obesity and family history of type 2 diabetes (Lutsman, Griffith, &Clouse,1988). Evidence show that life style changes namely, improvements in physical activity and diet, leading to weight loss reduces diabetes risk significantly. (Schenberg ,& Dryden ,et al,2013).Similarly, a study among Swedish adults showed that the genetic predisposition to diabetes may be offset by physically active life style and weight loss is the strongest predictor of reduced diabetes incidence.( Brito , Lysenko ,Renstrom et al,2009).

## 2.9. Psychosocial problems of people with diabetes

According Hill-Briggs (2003). Psychological issues, such as depression, anxiety and stress, are linked with an increased risk for the onset of diabetes. In addition, diabetes increases the risk of depression, stress, diabetes specific emotions such as fear of hypoglycemia and worrying about future complications. These psychological factors in turn, negatively influence people with diabetes. The importance of addressing psychosocial issues has long been recognized in care

behavior which in turn can hamper glycemic control. Therefore, psychosocial factors are relevant to nearly all aspects of diabetes care (Hill-Briggs, 2003). One of the biggest problems among patients with diabetes is suboptimal diabetes self-care, this is particularly true for conditions such as injecting insulin, checking the blood glucose, eating healthy, balancing carbohydrates, exercise and visit the health care providers each of this impact a patient`s emotional wellbeing and social life. (Kumar, Nagpal & Bahartia, 2008).

There are evidences that suggest the bidirectional relationship between depression and diabetes (Mezuk , Eaton, &Albrecht ,2008).With depression developing earlier in life leading to an increased risk of diabetes (Young and Unachukwu, 2012) and diabetes increasing the subsequent risk of depression (Mezuk ,Eaton,& Golden, 2008 ). In addition to being a risk factor of diabetes, depression with diabetes increases the risk of developing diabetes related complications (diabetic retinopathy, nephropathy, neuropathy, macro vascular complications, and sexual dysfunction (Groot, Anderson , and Freedland,2001) .In addition, it is evidenced in many studies co morbid depression is associated with poor adherence to self-care regimens (adherence to diet, exercise, disease control medications, and cessation of smoking recommendations (Young- Hyman et al, 2016).

Depression remains undiagnosed in 50% -75% of disease cases (Bajwa, Saroha & Bajwa, 2015). It may be untreated or undertreated in individuals with type-2 diabetes and untreated depression may further exacerbate the progression of diabetes (Reyrot et al, 2004). The prevalence of depression varies from 9% to16% among hospitalized diabetes patients. The finding in one US study indicated that nearly 18% of diabetes patients have major depression, (Waitzfelder, Gerzoff&Karter,2010), while another study among US Hispanics showed that 30.2% of patients met criteria for major depressive disorder (Reyrot et al, 2004). Another study revealed that 11% - 31% of patients with diabetes have depression or clinically significant symptoms of depression (Rosland, Pietti and Lyles, 2014).

Emergent adults contend with a variety of challenges and transitions, such as to independent living, post-secondary education, full-time employment, and increasingly intimate relationships, perhaps including marriage and parenthood (Jewell and Gorey, 2019). Therefore, it seems reasonable to assume that the addition of a chronic illness such as type 1 diabetes to this transitional stage greatly increases the chances of burden.

In addition, diabetes increases the risk of depression (Mommersteeg et al,2010), stress (Luthra .2010), diabetes-specific emotions such as fear of hypoglycemia and worrying about future complications. These psychological factors, in turn, negatively influence diabetes self -care behavior which in turn can hamper glycemic control. Therefore, psychological wellbeing is an important goal of medical care and psychosocial factors are relevant to nearly all aspects of diabetes care. Fear of complications is a major component of diabetes distress, and depression associated with complications increases mortality (Winkley, Sallis, et al., 2012).

Diabetes distress is very common and is distinct from a psychological disorder (Nicolucci, Burns, Holt et al, 2013). The constant behavioral demands (medication dosing, frequency, titration; monitoring blood glucose, food intake and eating patterns, and physical activity) of diabetes self-management and the potential or actuality of disease progression are directly associated with reports of diabetes distress (Fisher, Hessler, Polonsky, 2012). Its prevalence is reported to be 18–45% with an incidence of 38–48% over 18 months (Aikens,2012).

High levels of diabetes distress significantly impact medication-taking behaviors and are linked to higher hgbA1C (is a blood test to determine a blood sugar level over a period of three months) lower self-efficacy, and poorer dietary and exercise behaviors (Fisher, Hessler, Glasgow et al,2013). It may be helpful to provide counseling regarding expected diabetes-related versus generalized psychological distress at diagnosis and when disease state or treatment changes (Fisher, Skaff, Mullan et al, 2007).About one-third of adolescents with diabetes develop diabetes distress, which may be associated with declines in self-management behaviors and sub optimal blood glucose levels (Hagger et al 2016).

Both type 1 and 2 diabetes have been associated with deteriorating cognitive functioning (Brismar, Maurex, Cooray,2007). A study in Sweden revealed that children who developed type 1 diabetes during 1977-2000 had poorer school performance compared to non-diabetes peers (Dahlquist, Kallen 2007). Common cognitive problems in people with type 1 and 2 diabetes include attention, processing speed and concentration problem (Umegaki, 2014). Hypoglycemia seems to be associated with impaired intellectual abilities, memory, attention, perceptual and motor skill problems in people with type 1 and type 2 diabetes (Umegaki, 2014).

It is therefore not surprising that people with chronic illness such as diabetes may potentially find it difficult to have romantic relationships. There are several factors other than diabetes that are implicated to include medical costs, psychological pressure, discrimination and traditional beliefs. (Amenia,2000).

### 2.9.1 Impact of diabetes on patients and caregivers

Diabetes gradually deteriorate the body over the period of years as the glucose clogs and damages the small capillaries that feed the kidneys, eyes, feet and heart. As a result, at least 9 out of every day 10 diabetes develop one or more of the following long term disease complications: Kidney disease, eye disease, nerve damage, cardiovascular disease (Hapunda, Ali, et al, 2015). The economic burdens are related to health care costs especially if they don't have good health care coverage, the financial impact will still be significant because the medical costs will increase as the diabetes gets worse (Gonzalez et al, 2011).

According to Macully, 2018 psychologically (emotionally) being diabetic not only changes someone, it also brings about a myriad of feeling and dark emotions that can be difficult to express or deal with Many of these emotions affect the patent on a subconscious level, and he/she may not be aware of how they are being affected. Some dark emotions include denial, fear, depression, anger, apathy, ignorance, blind trust, lack of hope and shame (Macully, 2018). Diabetes certainly has a pronounced emotional impact upon families and particularly on those with a close relationship with those who have the disease. A number of different factors related to diabetes can contribute to anxiety. Living in a high stressful environment makes it difficult to control blood sugar as well as make good decision about eating the right food (Brunkodo, 2016).

According Holt and Kalra(2013) a diagnosis of diabetes can be stressful event for families as a whole. People who have been diagnosed with diabetes may sometimes go through stages of grief and some of the stages may be shared by the family. Anxiety about the long term health of a partner or family members is relatively common. While diabetes is certainly a serious condition that carries a number of potential health complications (Holt and Kalra, 2013).

When diabetic complication set in, caregivers experience a reduction in social activities, increased family tensions and lost time from work, all of which have a negative impact on quality of life. A particular problem for family caregivers is the financial cost of diabetes, where a British

study found that caregivers who lost earnings reported higher level of strain, and only one third of the caregivers received state benefits (Jewell and Gorey, 2019). The problems are worse in developing countries.

## 2.10 Coping mechanisms of people with diabetes

Coping mechanisms represent a crucial component of our capacity to maintain emotional homeostasis. Without them the conscious mind would be much more vulnerable to negatively charged emotional input, such as that pertaining anxiety and sadness (Young- Hyman et al, 2016). Coping strategies refer to the process by which a person attempts to manage stressful demands. Two general types of coping strategies can be distinguished: Problem-solving efforts and emotion focused coping(Young and Unachukwu, 2012).

There are many definitions of coping (almost as many as there are studies),but probably the most commonly used is that of pearlin and schooler, who define coping as behavior that protects people from being psychologically harmed by problematic social experiences .coming serves a protective function that can be exercised in three ways:1)by eliminating or modifying stressful condtions;2)by perception controlling the meaning of the stressor; or 3)by keeping emotional consequences in bounds.(Perlin &schooler,2000)

Several studies have suggested that patients with diabetes, both adults and youths, by learning strategies that they can apply to dealing with diabetes, (Rubin ,et al, 2000) .This approach is often called ‘coping skill training” or “problem solving skill training” Coping skill training builds on traditional diabetes education by providing tools that help clients apply what they have learned on a day today basis. Generally, four coping skills are taught and reinforced; these skills include social problem solving, communication skills training; cognitive behavior modification, and conflict resolution.

Social problem solving is designed to help clients when faced with peer pressure or any decision a dilemma. For patients with diabetes, teaching problem solving techniques can be helpful in managing complex situations such as pressure to over eat. Such techniques can be used to identify what situation creates difficulty for those struggling to control their weight and to generate approach to solve the problem in a way that is helpful to that person. (Greg,et al 1997). Communication skill training aims to help clients express themselves in ways that are clear,

appropriate, and constructive and social skill training models strive to teach clients how to work with others in a way that will result in positive outcomes for all. Assertiveness training enables one to communicate in ways that are direct, honest and appropriate. Working in a group setting allows members to observe the behavior of others as well as practice and obtain feedback on how effectively they communicate with the other member of the group. These models can also be used to help clients with eating situations, such as ordering food prepared in a healthy manner in a restaurant and assuring that one's needs are met (Rubin, et al,2000).

Healthy coping, defined as responding to a psychological and physical challenge by recruiting available resources to increase the probability of favorable outcomes in the future, is essential to effective self-management by people with diabetes (Young &Unachukwa,2012). Coping is a psychological process developed at a conscious level and used when one tries to manage difficult and stressful situations in life. Coping styles may be adaptive (meaning that the individual tries to reduce the stress) or maladaptive (described by a situation in which the individual keeps or even amplifies the current symptomatology). Coping has been demonstrated to be able to influence the individual's response at a biological level, leading to a normal or pathological reaction in humans, a mechanism that depends on its efficiency in reducing the psychological distress.(Habra et al 2003). Different coping mechanisms have already been demonstrated to be associated with improved or worse prognosis in other chronic diseases, such as chronic obstructive pulmonary disease (Papaya, &Enatescu,2016). Coping is a psychological process developed at a conscious level and used when one tries to manage difficult and stressful situations in life. Coping styles may be adaptive (meaning that the individual tries to reduce the stress) or maladaptive (described by a situation in which the individual keeps or even amplifies the current symptomatology (Hennessey& peters,2019).

Coping is described as a dynamic system which is highly interactive (Folkman,2010). Coping refers to the thought and behaviors used by individuals and is subdivided in to three types (a) emotion focused coping centered on regulating distress,(b) problem based coping centered on managing the problem causing distress and (c) meaning based coping centered on the ability to maintain positive wellbeing (Folkman ,2010).

# Chapter Three: Research Methods

## 3.1 Study area

This study was conducted among diabetic patients in the Out-patient department of Armed Forces Comprehensive Specialized Hospital which is found in Woreda 2, Lideta sub city, Addis Ababa. The hospital was founded in 1948 by Emperor Haile Selassie in the memorial of his daughter (Princess Tsehay). The Armed Forces Comprehensive Specialized Hospital was renamed after the 1974 revolution which was previously called Princess Tsehay Memorial Hospital.

In Armed Forces Comprehensive Hospital, there are different Departments, Units and Clinics that provide specialized services for clients and patients. The hospital has 600 beds and well organized human resources, instruments and infrastructure. This hospital gives services for military people and their family members, civilians who are working in the Ministry of Defense and also gives services to the community with payment. This information gets from Administrative office of Armed Forces Comprehensive Specialized Hospital. The reason to select this hospital to conduct the study is because diabetic patient flow is high and when I observed diabetic patients during supervision in this hospital the patients worried about their condition.

## 3.2. Study design

This study used a qualitative descriptive research design. Qualitative design would help to investigate the problem in a better way; it also gives freedom to the researcher so that the researcher would stretch and see different aspects of the issue as per the need and widens of the research. The qualitative method relied on descriptive approach with ethnographic exploration; both in-depth interview and Focus group discussion were employed. The reason for using a qualitative descriptive research design for this study was to enable the researcher to have complete opinion about psychosocial problems and coping mechanisms of people with diabetes from the perspective of people with diabetes, caregiver's members and health providers in Armed Forces Comprehensive Specialized Hospital.

## 3.3 Sample

The sample of this study was diabetic patients in outpatient department of Armed Forces Comprehensive Specialized Hospital. Who are getting treatment and aged (30-59) years. A total

of 10 patients with diabetes, 5 males and 5 females, and 8 care givers were selected and participated in the study. In addition, 2 key health workers (one Internist and one General Practitioner) participated.

### 3.3.1 Sample Size

Based on the information available at the Out-patient Department of Armed Forces Comprehensive Specialized Hospital, the researcher purposely selected 10 people with diabetes who fulfilled the criteria (5 Male and 5 Female aged 30 -59 years who are getting treatment and 8 caregivers. Additionally, the researcher purposely selected 2 health workers (one internist and one general practitioner). The reason behind choosing diabetic patients, care givers and health workers is in order to get deep information about the study area from different perspectives and sources. Generally, sample size used in qualitative research is not justified, even though researchers are concerned about using the right sample size (Dworkin, 2012). Need to ensure there is enough, but not too much, data (>30 too large; (Boddy, 2016). And the reason behind selecting 10 diabetic patients, 8 care givers and 2 health workers is as we know qualitative study requires a minimum of but not too much samples so the researcher used the sample size of this study was 20

### 3.3.2 Sampling technique

The researcher obtained formal written permission to carry out this research from the principals of the sampled Hospital. Then preliminary visits were made to the Hospital through these visits, Informed consent was also obtained Then, 10 diabetic patients, 8 care givers and 2 health workers were selected using the widely used sampling technique in qualitative research which is purposive sampling in order to identification and selection of information–rich cases for the most effective use of limited resources. And to collect data from these samples focus group discussion and in-depth semi-structured interview was conducted.

### 3.3.3 Inclusion Criteria

The study sample was selected using the following inclusion criteria.

- People with diabetes in Armed Force Comprehensive Specialized Hospital.
- Military patients whose age ranges from 30 to 59 years old.
- Patients who are getting treatment.

## 3.4 Methods of data collection

To achieve its objectives, this study used the following information gathering methods (i.e. individual in-depth interview and Focus Group Discussion).

### 3.4.1 In-depth interview

In-depth interview seeks to make the respondent to freely tell feelings and beliefs about the subject of interest and provide a more detailed response (Davis, 2000). For the consumption of qualitative content analysis this study carried out in depth interview people with diabetes and health professionals. An in-depth interview was conducted by using semi structured interview. As Seidman (2002) noted, through semi structured interviews that guide the conversation, but allow for participants to provide information that is important to them but not necessarily reflected in the interview questions, we can come to understand the details of people's experience from their point of view.

A focus group discussion was held by using guiding questions or topic guides with the intention of gaining rich data to answer the research questions. Furthermore, the in-depth interview and focus group discussion were designed in a flexible manner in order to make the participants interactive. Participants were involved only after they sign the informed consent. Regarding focus group discussion and interview. In-depth Interviews took place at the hospital in a comfortable quiet room for 30 minutes.

### 3.4.2 Focus Group Discussion

Zikmund (2003) defines focus group discussion as 'an unstructured, free-flowing interview with a small group of people'. A focus group allows the researcher to collect information from a small group, while observing nonverbal behavior, and guiding and probing the participants so that all the information required can be uncovered (Cavana et al. 2001).

Focus group discussion is among the most often used techniques in social science research. Focus groups are a very effective way of gaining insight and exploring the issue to be addressed especially if there is limited information available (Cavana et al 2006). In this study, one focus group discussion was conducted with caregivers. In the focus group discussion 8 participants 5 female and 3 males were involved. Participants were asked questions related to psychosocial problems and coping mechanisms of people with diabetes. The focus group discussion session was conducted by a moderator and a note taker and it lasted for about one hour. The focus group

discussion took place in a conducive and quiet room maintaining confidentiality with a circular sitting arrangement.

## 3.5. Methods of Data Analysis

The data were narrated and thematically analyzed. The data analysis process passed through recording of data, transcription, translation, coding, evaluation of relevance, and list of categories, and identification of thematic patterns. Audio taped in-depth interviews and focus group discussions were transcribed in Amharic then, translated in to English language, coded and categorized based on the themes. The coded and categorized data were interpreted and analyzed by relating the data within and across the categories, in a way that gives meaning and answers to the research questions.

## 3.6. Ethical Considerations

To collect data, official support letter was taken from Addis Ababa University, School of Psychology. Permission was also requested from Armed Forces Comprehensive Hospital to conduct the study. The respondents were asked respectfully to receive the required information based on their willingness. Responses of respondents were unnamed. The researcher disclosed the privacy of respondents and kept secretly the information collected from respondents. Confidentiality was considered in all levels of the study during information gathering.

# Chapter Four: Results

In this chapter, the findings of the study are presented in statement form with the objectives of the study. The section includes demographic characteristics of participants and qualitative findings related to the psychosocial problems and coping mechanisms of people with diabetes

## 4.1 Socio- Demographic Characteristics of in-depth interview participants

A total of 12 participants were involved in the in-depth interview of the study (10 diabetic patients and 2 health workers). Among 10diabetes participants 5 of them were males. In terms of age group, 7 of the participants were age 30-50 years and 3 of them were 51-59 years, in terms of their Religion, 7 of them were Orthodox Christian followers whereas 2 of the participants were Protestant and the rest participants were Muslims. And 6 of them who were interviewed were bachelor degree holders and 2 participants were diploma holders and 2 of them were completed high school, from these 10 diabetic patients, 7 of them were married and 2 of them were divorce, and the rest was widow. And in terms of their occupation, all of the participants were Military. According to diabetes type, all of the participants were Type-2 diabetes. And when we come to the period of illness patients had, 6 of the participants were ill for about 6 to 8 years and 2 of them were 9 to 11 years and 2 participants were ill for 6 months to 2 years. In terms of History of diabetes in their family, 4 of them have history of diabetes and 6 of them do not. Finally, when we see the relationship of the 2 of them live with their daughters and sons and the rest 8 participants live with their wives and husbands.

Among to 2 key health workers (one internist and one general practitioner), 2 of them were male, in terms of age group were between 35-50, in terms of religion 2 of them were orthodox Christian, and 1 of them is specialized in internal medicine, and the rest has degree in medicine, and in terms of their occupation 2 of them are military, 2 of them are married.

### 4.1.1 Demographic Characteristics of Focus Group Participants

A total of 8 participants were involved in the study. From these participants most of them were females. In terms of age group, 6 of the participants were age between 30-50 years and 4participants were 51-59 years. In terms of their Religion,8 of them were Orthodox Christian followers whereas 1 of the participant was Protestant and the rest participants were Muslims.

And 5 of them who were interviewed were bachelor degree holders and 2 participants were diploma holders, and the rest high school completed. From these participants 5 of them were married and 2 of them were divorce, and the rest were single.

## 4.2. Psychosocial problem

Five themes emerged from the data: *psychosocial problems and coping mechanisms of people with diabetes experience i) distress, fear, anger, anxiety and denial ii) Financial problems faced upon shortage of medicine iii) Relationship problems with family members, friends and the community; No psychosocial support from the hospital (no non- clinical health services); and* coping mechanisms, including going to spiritual places, family support, and physical exercise.

### 4.2.1 Distress, fear, anger, anxiety and denial

After the diagnosis of diabetes most participants felt distress, fear, anger and denial. There were some initial changes in activities, conduct and personality and some of these feelings are still with the clients. Most clients at first time knowing about their disease put themselves in a harsh situation not accepting about the illness. There was distress and/ or changes in self-management during times of life transition. In the transition which mainly includes life style modification and medication treatment specially in type- 2 diabetes the injection had many side effects and it affected many of them psychologically, and some couldn't resist the load and stress their disease requires and were struggling in every aspect of life. In this regard, one of the participants said the following:

*When I first heard that I was diabetic, I felt shock, fear, and sadness. There was initial change in activities, conduct and personality and I did not accept my result at all. These feelings are still with me. But progressively I tried to accept and move on with my life through the Doctors advice and life style modification. Because as we know diabetes is a lifelong disease you have to take medicine daily for survival. (Person with diabetes, female, age 40).*

Most of the participants at first put themselves in a stress in which they fear or having tension that they cannot cope with both the physical and mental stress led them to depression and other mental issues as they are living in a very stressful society which is constantly putting them under pressure. This pressure is too much too handle for them. Some of them worry too much and develop anxiety, but most of them after the diagnosis are anxious about their condition.

*I felt sorrow and anxious and did not know what to do when I find out that I am diabetic. I directly thought of the complication and its effect in life because I had known the experience but I have seen one of my family struggling with it. But after long time I accept it and try to live with the disease that am dealing with by exercising, proper diet and medication. (Person with diabetes, female, age, 40)*

*A doctor stated the impact of diabetic as follows Sometimes associated with burden of diabetes and its treatment; worries about adverse consequences and lack of social and economic resources; diabetic distress happens on some patient's poor psychological states e.g. depression, anxiety, eating disorder, cognitive impairment happens (Medical Doctor, in Armed Force Comprehensive Specialized Hospital).*

**4.2.2 Shortage of medicine**

Actually military staffs in the defense sector have a privilege to get the medication and the service for free in Armed Forces Comprehensive Specialized Hospital. Meanwhile, there are occasions medicines are unavailable in times of disease progression and on set of complication. Financial problems cannot be seen as a separate entity. The economic crisis that the family goes through after the patient's illness was very challenging. It is not usual to clients/patients to earn a living after they retire from the army and have own family.

*In most cases I got free medication from the hospital, but sometimes in times of shortage we have forced to buy by ourselves and as I am on retirement and it is very difficult because of inflation, and even sometimes it became really expensive and it will be very difficult for me to buy and use it.( Person with diabetes, male, age 59)*

*As I am diabetic for the last 9 years I get a free medication. When there is shortage of medication, we have to buy from outside in which way that will affect my economy because of this cannot afford buying and I ask for help from my family and they help me in such conditions (person with diabetes, male ,48)*

*For the military staff member's medication is given for free, and even after they retire from the Army, but occasionally if there are no medicines on stock, there will be shortage so that they have to buy from outside and due to this they face economic problems. (Internist and Medical doctor in Armed Force Comprehensive Specialized Hospital).*

### 4.2.3 Relationship problem with family members, friends and the community

Most diabetic patients get irritated easily due to this they argue with family members and friends. As the respondents said most clients show the above behaviors. Due to this many of the clients are facing these problems because they get angry and easily irritable and lead disagreement. .

*Sometimes I have no a good relationship and communication with my family and friends as well, I easily got annoyed and angry and easily irritable even I could not be able to express my ideas but at last they understand me and they will treat me patiently. (Person with diabetes, female, 51)*

*At first when I know that I am ill, I was really aggressive and emotional. I couldn't control my anger and I found myself in unconditional ways but my family was always there for me, in good or bad situations. As the doctors advise on this conditions mostly happened because of my high glucose level and I was told to control it as well. (Person with diabetes, female, 49).*

Regarding to relationship from the community, most of the time diabetes patients are not stigmatized by their community. But sometimes there is discrimination by their surroundings due to some cases in which way the disease gets complicated it leads to serious disabilities (blindness, kidney failure, incontinency, etc.) and puts the client in hard situation that will isolate them from the environment. It also can cause undesirable consequences in all parts of human body, therefore devastating complication of the disease are strong evidence that should be considered.

*I did not cooperate with my community members as before, the disease has fatigue and because of that I did not participate in societal activities. I have a fear that I might cut my hands while I am working, and I get picky while choosing food in ceremonies or other programs and I thought I might annoy other people who are watching me. (person with diabetes, female, 37).*

A medical doctor shared his observation as follows

*Most of the time there is no stigmatization from other people in their community. In some cases, after the diseases gets worsen and puts in hard situations like getting isolated from the environment (Medical Doctor, in Armed Force Comprehensive Specialized Hospital)*

In some get together and reunions, many can be affected in such kinds of conditions because some people are pushing them to eat food that were not supposed to eat, and it really made them uncomfortable. One respondent stated his concern as follows

*Sometimes in my community whenever there are celebrations most of the time they pushed me to eat which should not be eaten for diabetic people so that thing mostly affects my social relationship (Person with diabetes, male,50)*

Also sometimes being diabetic can also reduce sexual feeling. Some of the respondents are facing these problems. A woman respondent mentioned her challenge as follows.

*My sexual desire decreases due to the illness and it puts me in to an argument with my husband and brings disagreement towards the marriage and gets less support from my family (Person with diabetes, female, 48).*

Another respondent experienced the same problem. He stated his challenge as follows.

*I used to be active in sex. After I get diabetes, I have lost interest in sex. My wife is angry at times. I have tried all my best to motivate myself. Unfortunately, I could not. I am not sure what will happen to my marriage in the future. (Person with diabetes, male, 50).*

### 4.2.4 Psychosocial support from the Hospital (absence of non-clinical health services)

Most of the respondents indicated that the hospital has no trend of supporting patients in association with psychosocial problems. The Hospital has not been involved in identifying the patient's psychosocial problems and providing treatment. Almost all the services from the hospital are clinical services. In this connection a patient said:

*The doctor helped me in most of the cases about my illness and gives me good care and close follow-up and tell me what to eat and what not to eat, and most basically to eat healthy food and do exercise. I also get a free medical service from the hospital because I am a military, but we don't have education on diabetes because of that we do not have enough knowledge about the illness. (Person with diabetes, male, 52).*

A medical doctor also agrees with the above respondents:

*The hospital has no trend of enlisting members of the patient's social support network to aid in the identification, prevention, and resolution of psychosocial problems. So far the Hospital has no a trend to detect psychosocial problem early. (Internist and Medical Doctor in Armed Force Comprehensive Specialized Hospital)*

**4.2.5 Coping mechanisms**

This theme refers to the experiences of people with diabetes endured as they have no choice but to undertake living with the illness. People with Diabetes try to survive and cope up with their own way they prefer. There are common coping mechanisms that the respondents use and all have their own way of coping mechanism. But for most of the respondents, go to spiritual places, accepting the illness and physical exercise, family support are the common coping mechanisms. Coping mechanism have their own role in patients' lives. They helped patients feel protected on their system.

*In spite of the pain, I am accepting the challenges of the disease and learning to live with it. So, I get proper medication; and follow the doctor's advice. Reading books and discuss about the disease with other diabetic patients who are living around helped me deal with the illness. Additionally, as I am Orthodox Christian, my spiritual life is strong and that is really helpful (Person with diabetes, female, age 37)*

Another respondent shared his coping mechanism as follows.

*The main thing, I got free medical services from the Hospital and took my medication properly, I do physical exercise and adjust my eating habit. I never took sweat and fatty food; and I hope that my health will be improved. Also after diabetes I am anxious and sad to relief from this I go to church and pray. (Person with diabetes, age50)*

A woman respondent stated her strategy to overcome the adverse impacts of being a diabetic patient as follows.

*I tried to get relief from the symptoms of the disease by telling myself and believing that I should be strong, so I follow the doctors advise in which way that I think I can get a cure, exercise regularly and go to holy places and drink holy water. Group discussion should be*

*considered because they are really helpful in such situations like sharing each other stories, knowing each other thoughts and coming up with new ideas on prevention ideas, educating other peoples. (Person with diabetes, female, age 40)*

Some participants mentioned the role of socializing in dealing with the pain. A woman respondent said:

*Regarding to coping mechanism I adhere to proper medication, eating healthy, doing exercise and hope that my health condition will be improved. Additionally, discuss about the illness with people in my neighborhood and friends who are with the illness and visit holy places. (Person with diabetes, female, age 51)*

An intern noticed patient's coping mechanism and commented on it as follows:

*Some patients have anxiety symptoms such as avoidance behaviors which means avoid their treatments and went to traditional healers or holy water as negative coping mechanism skill. Sometimes associated with poor psychological condition patient lack of improvement in health (Internist in Armed Force Comprehensive Specialized Hospital)*

Some respondents use spiritual life as a coping mechanism. One respondent shared his experience as follows.

*It is not easy to deal with such kinds of illness. It has affected me physically and psychologically. I have been depressed for a long time. What has helped me is going to a church. I realized that God is good despite my challenges. I am able to comfort by the living word of God. (Person with diabetes, male, 52)*

For some respondent's social life is a good coping mechanisms. One respondent describes its as:

*I visit my family when I feel depressed. I forget everything when I have fun and talk with them. They support and advise me to be strong, healthy and happy. I wish I could live with them forever to forget my pain (Person with diabetes, female, 49)*

The other important coping mechanism was doing exercise. One participant said:

*I wake up early in the morning and run. It helps me feel good. If I don't do that, I am more likely to be depressed. I am glad that I found something to enjoy. (Person with diabetes, male,50)*

### 4.2.6 Analysis of Focus group discussion.

### 1. Psychosocial problem

Four themes emerged from the data: *psychosocial problems of people with diabetes, care givers observed, 1) fear, anger, anxiety and denial 2) Shortage of medicine 3) Relationship problems with family members, friends and the community; 4) No psychosocial support from the hospital.*

Below are some observations that get from the care givers participated in the focus group discussion. Were easily irritable and anxious for further complications.

Most care givers mentioned

*During the phase of diabetes diagnosis, the patient felt anxiety, fear and anger, there was change of behavior and activities. Also diabetes patient in a family are emotional, irritable and lack in their communication. (Care giver, age 45).*

Shortage of medicine

There are occasions medicines are unavailable in times of disease progression and on set of complication. The economic crisis that the family goes through after the patient's illness was very challenging.

Most of care givers explained

*In most cases get free medication from the hospital, but sometimes in times of shortage must buy the medication outside, in which way that will affect the economy because of this cannot afford buying and he ask help from family, (Caregiver,35)*

One respondent mentioned that

*My husband is retired from the Army, occasionally there were shortage of medicine in the hospital so that he had to buy from outside and due to this face economic problems. (Care giver,49).*

**Relationship problem with family members, friends and the community**

Most diabetic patients get irritated easily due to this they argue with family members and friends.

Most care givers mentioned as

*Sometimes he had no a good relationship and communication with family and friends as well, he easily got annoyed and angry and easily irritable and leads to disagreement mostly we treat him patiently." (Care giver, female, 50)*

Regarding to relationship from the community, most of the time diabetes patients are not discriminated by their community. But sometimes there is discrimination by their surroundings. One respondent states his concern.

*Most of the time there is no stigmatization from other people in their community. In some cases, after the diseases gets worsen, and the patient keep herself in the house or distant, they don't mostly participate in social gathering (Care givers, male,52).*

**Psychosocial support from the Hospital**

Most of the care givers mentioned that the Hospital has not been involved in identifying the patient's psychosocial problems. Almost all the services from the hospital are clinical services. In this connection. Care givers also unaware of psychosocial problems related to diabetes.

*All the care givers and patients explained that they have health progress checkups and follow ups but didn't mention that psychosocial services provided to them on their stay other than checkups and follow ups.*

The respondent raised the same point:

*The hospital does not provide diabetes education by health workers regarding to social and psychological problems and there is no discussion between diabetic patients and care givers because of this I have no idea about the service. (Caregiver, female, 52).*

# Chapter Five: Discussion

## 5.1 Psychosocial problems of people with diabetes

This study indicated that people with diabetes in Armed Forces Comprehensive Specialized Hospital have several psycho-social problems. Most of the participants (diabetic patients) manifest distress, fear, grief, anger and initial change in activities during the first phase of diabetes (i.e. diabetes diagnosis). Conduct and personality changes happen during all phases of living with diabetes, as psychosocial problems.

Beeney et al. (1996) found that patients were distressed at the time of diagnosis with emotions ranging from anxiety, shock, anger, or denial. Similar results were observed in other studies as well. Studies indicate that diabetes and its complications are strongly associated with depression, anxiety, reduced autonomy, role impairment, and reduced overall physical function and quality of life (Vileikyteet al., 2009). Fear of complications is a major component of diabetes distress, and depression associated with complications increases mortality (Palmer et al., 2013).
Even though the patients are getting free medical services in Armed Forces Comprehensive Hospital; meanwhile, there are occasions medicines are unavailable in times of disease progression and on set of complication. At the same time the household may have no financial freedom to finance household consumption.

Health workers in Armed Force Hospital strengthened this information. For instance, they have said that financial constraints are associated with burdens of diabetes and its treatment, patients' worries about adverse consequences and lack of social and economic resources. At the result diabetes distress happens.

Since the hospital is not attending the patients in respect of psycho social issues it could not design alternation to treatment plan. Actually health providers also echoed this issues by saying that the hospital has no health provider - patient's/ families communication. In addition, the hospital so far has no a trend to identify and remediate psychosocial issues that impede regimen. Moreover, it has no a trend of enlisting members of the patient's social support network to aid in the identification, prevention, and resolution of psychosocial problems. It means the hospital has no a trend to detect psychosocial problems early. At the result Most of the participants (diabetic patients)and care givers do not have knowledge of psychosocial problems related to diabetes so the patients would not be able to treat themselves properly and could not give the required

attention to the disease. The care givers also would not be able to give the appropriate care and understand the patients' problems.

Meanwhile, Young- Hyman et al (2016) emphasized going beyond. It is necessary to detect psychosocial problems early and prevent health deterioration. All people with diabetes should be evaluated at the initial visit and on a periodic basis going forward even if there is no patient specific indication. In addition, evaluation is indicated during major disease and life transitions, including the onset of complications and significant changes in treatment, or life circumstances (i.e., living arrangements, job, and significant social relationships), with prospective monitoring for 6 months (a period of increased risk).

Regarding to relationship from the community, most of the time diabetes patients are not stigmatized by their community. But sometimes there is stigmatization by their surroundings due to some cases in which way the disease gets complicated which leads to serious disabilities (blindness, kidney failure, incontinency, etc,) and sometimes puts the client in hard situation that will isolate them from the environment.

There is a limited understanding of the prevalence of diabetes stigma in the general population, and few studies have examined stigma in both type 1 and type 2 diabetes. Few studies found that Majority of people with type 1 or type 2 diabetes reported stigma associated with their disease (Browne et al, 2013). This perception was significantly higher in individuals with type 1 diabetes compared to people with type 2 diabetes. Diabetes stigma appeared to be associated with uncontrolled diabetes and higher visibility of the disease.
(Tak-Ying et al, 2005).

From the finding of this study, some patients with diabetes have decrease sexual feelings and this leads to marriage problems. Diabetes has been associated with sexual dysfunction in men (Feldman et al, 2009). Diabetes is an established risk factor of sexual dysfunction in men; a threefold increased risk of erectile dysfunction was documented in diabetic compared with non-diabetic men (Giugliano et al., (2010), it is still not clear whether hyperglycemia, which is a determinant of vascular diabetic complications, may participate in the pathogenic mechanisms of sexual dysfunction in diabetes. Otherwise, diabetic people may present with several clinical conditions, including hypertension, cigarette smoking, obesity, metabolic syndrome or dyslipidemia, which are themselves risk factors for sexual dysfunction in both sexes (Esposito et al, 2005).

## 5.2 Coping mechanisms of people with diabetes

This study showed that diabetes patients try to survive and cope up using their own way they prefer. But there are common coping mechanisms that most of the respondents use. Most of the respondents usually seek spiritual help through prayers, doing exercise, accepting the illness and normalizing the situation so that they did not feel they were alone with their condition were other coping strategies. Patients also reported that following the doctor's order and family support are important coping mechanisms.

The health providers in Armed Forces Comprehensive hospital explained that there are deficits in problem-solving or coping skills among some patients, even they said that some patients have irrational thoughts and/or show anxiety symptoms such as avoidance behaviors as negative coping mechanism skills. Moreover, health providers said that on some patients associated with pessimistic outlook negative coping mechanism developed and reflected by unchanged baseline health behavior.

Review suggests that the onset of illness may render the individual, being a believer or non-believer to realize the lack of control over his / her life. However, the use of spiritual coping may enhance self-empowerment, leading to finding meaning and purpose in illness. This implies that holistic care incorporates facilitation of various spiritual coping strategies to safeguard the wholeness and integrity of the patients (Christie ,2007).

Clarke and Forde (2017) argued that diabetes is a progressive condition which requires alterations to treatment plans to achieve optimal control despite the best efforts of the person with diabetes in dietary and exercise adherence. For most of them the aforementioned psycho social problems are costing them in life with poor communication skill. It is inevitable that solid communication skills are essential (Hennessey and Peters, 2019).

# Chapter Six: Summary, Conclusions and Recommendations

## 6.1 Summary

This study explored the psychosocial problems and coping mechanisms of people with diabetes and discussed implications for possible psychosocial interventions. To this end, the study tried to answer the following research questions 1) what are the psychosocial problems people with diabetes are facing as they live with the illness? 2) How do people with diabetes cope up the psychosocial problems they encounter in their daily life? In Armed Forces Comprehensive Hospital.

The study employed a qualitative descriptive research design to answer the questions and achieve the research objectives. the researcher purposely selected 10 people with diabetes who fulfilled the criteria (5 Male and 5Female aged 18 -59 years who are getting treatment for the last more than six and 8 caregivers. Additionally, the researcher purposely selected 2 health workers using the widely used sampling technique in qualitative research which is purposive sampling in order to identification and selection of information–rich cases for the most effective use of limited resources. And to collect data from these samples focus group discussion and in-depth semi-structured interview was conducted then the data were narrated and thematically analyzed and Based on the analysis of the data collected, the following major findings were obtained that most of the participants (diabetes patients) in Armed Forces Comprehensive Specialized Hospital have psycho social problems such as diabetes distress, fear, grief, anger and initial change in activities, conduct and personality change during all phases of living with diabetes. All patients have not received services beyond clinical intervention.

People with Diabetes try to survive and cope up with their own way they prefer. There are common coping mechanisms that most of the respondents use, including going to spiritual places, accepting the illness and follow the doctor's order and family support.

## 6.2 Conclusion

Based on the findings of the study the following conclusions are made. This study concludes that diabetes patients in Armed Force Comprehensive & Specialized Hospital have psycho social problems such as diabetes distress, fear, grief, anger and initial change in activities, conduct and personality during all phases of living with diabetes. The patients have not received services beyond clinical intervention. There is no as such significant communication between patients and

health providers including care givers to the extent it can serve as instrument in alleviating psycho social problems. Actually military staffs in the defense sector have a privilege to get the medication and the service for free. Meanwhile, there are occasions medicines are unavailable in times of disease progression and on set of complication. The economic crisis that the family goes through after the patient's illness was very challenging.

This study showed that diabetes patients try to cope up with their problems through different coping mechanisms. But there are common coping mechanisms that most of the respondents use. Most of the respondents usually seek spiritual help through prayers, doing exercise, accepting the illness and normalizing the situation so that they did not feel they were alone with their condition were other coping strategies. Patients also reported that following the doctors order and family support are important coping mechanisms.

## 6.3. Recommendations

Based on the findings and discussion the following are recommendations

- Diabetes is associated with psychosocial problems. The hospital need to consider providing patient education. Clients and families should aware of the possible psychosocial services that they can get from the hospital. In addition, suitable counseling room and places are essential to conduct group and individual counseling session.
- The health professional should receive training in the recognition, identification and provision of information and counseling on psychosocial problems related to diabetes.
- All people with diabetes should be evaluated at the initial visit and on a periodic basis going forward even if there is no patient specific indication. Support from a behavioral health provider may be effective when difficulties are persistent. However, as soon as there is indication of a diagnosable psychological condition, consultation and/or referral should be sought with a provider having the appropriate mental health expertise.
- The hospital should widely work on providing the basic supplement to fulfill patients need, because the shortage of medicine has made the patients face economic problem.
- Policy maker's legal institutes, educational institutes, community workers, medias, both governmental and non-governmental health related institutes have to work in harmony to raise awareness among the community

- Awareness and raising projects have to be well developed so that the care givers and also the people with diabetes have improved knowledge about the psychosocial problems with diabetes and managing way.
- Professional psychologists have given emphasis while counseling on coping up with the new life style that people with diabetes are going to have and in helping diabetic patients and the care givers to understand.
- Finally, further studies should have to be done on psychosocial problems and coping mechanisms of people with diabetes.

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# Appendices

## Appendix I: Informed consent form (English Version)

**Introduction**

This study was anticipated to assess psychosocial problems and coping mechanisms of people with diabetes. You are invited to participate in this study. If you are willing to participate, you need to understand and sign the agreement form. Subsequently to, you are interviewed by the data collector. You do not need to write your name or to tell your name to the data collector and all your response and the results obtained are kept confidential by using coding system.

**Risk/Discomfort**

You may feel discomfort while you sit for interview. I hope you will participate in the study for the sake of the benefit of the research result. There is no risk in your participation.

**Benefits:**

If you participate in this research, there may not be direct benefit to you but your participation will likely help us to meet the research objective. Ultimately, this will help us to improve services for the community.

**Incentives**

You will not be provided any incentives or payment to take part in this study.

**Confidentiality**

The information collected from this research will be kept confidential. Information will be filed, without your name, only code number is used. All the information you provide is confidential and is used only for the purpose of this study.

**Right to refuse or withdraw**

You have full right to refuse from participating in the research. You can choose not to respond to some or all question if you do not want to give your response. You have also full right to withdraw from this study at any time you wish without losing any of your right.

**Person to contact**

If you have any question you can contact the researcher and you may ask any time you want.

**1. Contact address of investigator: -**

Tel;

Email:

If you agree to participate in this study, please sign below

Signature_____

Date_____

Code of respondent: -_____

**Thank you in advance for your cooperation.**

## Appendix II: Topic guide or Interview guide for diabetic patients.

**Socio-Demographic characteristics**

1. Name----------
2. Gender----------
3. Age ----------
4. Diabetes type----------
5. Educational level----------
6. Marital status ----------
7. Occupation ----------
8. Period of illness…….
9. History of diabetes in the family……

**Guiding questions**

1. What kinds of problems are you facing after you become ill? (Are you facing problems related to economic, social, and family, health, social support, stigma,
   - How did your family and friends react and treat you?
   - Is there anyone who supports you financially?
2. How do you comment your communication with the community you are living with?
   - Do you go to different community gatherings? Do the people in the community isolate and stigmatize you?
3. What kind of support did you get at the hospital? How much did it help you?
   - Psychosocial; individual counseling, group counseling, linking with support group,
4. How do you manage the economic, social, familial, and health, problems you are facing?
   - What kind of activities or methods do you use to cope-up?

## Appendix III: Topic guide or FGD guide (English version)

**Socio-demographic characteristics**

1. Name----------
2. Gender----------
3. Age ----------
4. Relationship with the patient ----------

**Guiding questions**

1. What kind of problems does the patient is facing after he\she becomes ill?
    - Is he\she facing problems related to economic, social, health,
2. How is the family's treatment and reaction towards the patient?
    - Did they treat and accept him/her as before?
    - Is there anyone who supports him/her financially?
3. How do you comment his/her communication with the community he/she is living in?
    - Does he/she go to different community gatherings?
    - Do the people in the community isolate and stigmatize him/her?
4. What kind of support did he/she get at the hospital? How much did it help him/her?

    Psychosocial; individual counseling, group counseling, linking with support group,

## Appendix IV: Topic guide or Interview guide for health professionals

**Socio-demographic characteristics**

1. Name----------
2. Gender ----------
3. Position ----------

**Guiding questions**

1. From your experience, what major problems do people living with diabetes face?
    - Is he/she facing problems related to economic, social, and family, health, social support,?
2. How is the family's treatment and reaction towards the patient?
    - Is there anyone who supports him/her financially?
    - Do the people in the community isolate and stigmatize him/her?
3. What kind of support does the hospital provide? How much does it help him/her?
    - Psychosocial; individual counseling, group counseling, linking with support group,
4. How patients cope up and their problems by their own?
    - What should be done to improve the life of people with diabetes?

**Appendix V: Consent form (Amharic version)**

**አዲስ አበባ ዩኒቨርሲቲ**

**የትምህርት እና ስነ-ባህሪ ኮሌጅ**

**የስነ-ልቦና የትምህርት ክፍል**

**የመረጃና የስምምነት ውል ቅጽ**

**መግቢያ**

ይህ ጥናት የተዘጋጀው የስኳር ህመምተኞ የሚያጋጥማቸውን ችግር እንዲሁም በምን መልኩ ሊቋቋሙ እንደሚችሉ ከሳይኮ ሶሻል ድጋፍ አንፃር በማየት ለማጥናት ሲሆን ጥናቱም በጦር ሀይሎች ኮምፕርሄንሲቭ ስፔሻላይዝድ ሆስፒታል ነው::

በዚሁ ጥናት ላይ እርስዎ ተሳታፊ እንዲሆኑ ተጋብዘዋል፡፡በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ከሆኑ በደንብ ሊረዱት እና

የመረጃና የስምምነት ውል ቅጽ ሊፈረም ይገባል፡፡በመቀጠልም መረጃውን የሚሰበስበው ሰው ቃለ መጠይቅ ያከናውናል፡፡

ስም መጻፍ ወይንም መረጃውን የሚሰበስበውሰው ስም መንገር አያስፈልግም፡፡

**አተገባበር**

በዚህ ጥናት ለመሳተፍ ፈቃደኛ የሚሆኑ ከሆነ ተሳታፊ በመሆንዎ በጣም ደስተኞች ስንሆን የጥናቱን ዓላማ በግልጽ እንድረዱና የስምምነት ውሉን እንዲፈርሙልን እንፈልጋለን፡፡በዚህ መሰረትም መረጃውን የሚሰበስበው ሰው መጠይቅ ሲሆን መረጃውም ለሌላ ጉዳይ የማይውል መሆኑን አሳውቃለሁ፡፡

**ሊደርስ የሚችል ጉዳት**

በዚህ ጥናት ተሳታፊ በመሆንዎ ምክንያት የሚደርስብዎ ምንም ዓይነት ጉዳት የለም ምናልባት መጠይቁን ለመሙላት በዚህ ጥናት ተሳታፊ በመሆንዎ ምንም ዓይነት ማበረታቻ ወይም ክፍያ አይሰጥዎትም፡፡

**ሚስጥራዊነት**

በዚህ ጥናት ፕሮጀክት የሚሰበሰበው መረጃ ሚስጢር እንዲሆን ጥንቃቄ ተደርጎበታል፡፡ የሚሰበሰበውም መረጃ የተሳታፊው ስም የማያካትት፤ሚስጥራዊ ቁጥር ብቻ ይሆናል፡፡

**በጥናቱ ያለመሳተፍ ወይም የማቋረጥ መብት**

በዚህ ጥናት ያለመሳተፍ መብትዎ ሙሉ ሙሉ የተጠበቀ ነው።ለጥያቄዎቹ በሙሉ ወይም በከፊል መልስ አለመስጠት ይችላሉ። እንዲሁም በፈለጉት በማናቸውም ሰዓት ማንኛውን መብትዎን ሳያጡ የማቋረጥ ሙሉ መብት አለዎት።

**ማግኘት የሚችሉአቸው ሰዎች**

መረጃ ለማግኘት ከፈለጉ በሚከተሉት አድራሻች ማግኘት ይችላሉ።

ስልክ

ኢሜል፡-

በጥናት ለመሳተፍ ፈቃደኛ ከሆኑ እባክዎን ከዚህ በታች ይፈርሙ።

ፊርማ----------

ቀን----------

የመላሽ መለያ ቁጥር----------

ስለምታደርገው/ጊው ትብብር በቅድሚያ አመሰግናለሁ።

**አዲስ አበባ ዩኒቨርሲቲ**

**የትምህርት እና ባህሪ ጥናት ኮሌጅ**

**የስነ-ልቦና ትምህርት ቤት**

**የጥናታዊ ጽሁፉ መምሪያ ጥያቄ**

**ሀ. ከህመሙ ጋር ላሉ ሰዎች**

**የግለ ድህር**

1. ስም----------
2. ዕታ----------
3. እድሜ----------
4. የስኳር ህመሙ መደብ----------
5. የትምህርት ደረጃ----------
6. የጋብቻ ሁናቴ----------
7. የስራ ሁኔታ----------

**የጤና ሁኔታ**

1. በቤተሰብ የስኳር ህመም ያለበት አለ?----------

• በበሽታው ከተያዙ ስንት ጊዜ ሆነሽ//ህ

መጠይቅ

1.ከታመም ክ/ሽ ወዲህ ምን አይነት ችግሮችን እየተጋፈጥ ህ/ሽነው?

- እያጋጠመህ/ሽ ያለው ችግር ከኢኮኖሚ፣ማህበረሰብአዊ፣ ከቤተሰብ፣ የጤና፣የወዳጆች ድጋፍ፣እየወሰድከው /ሽው
- ከጓደኞችህ/ሽ ጋር እና ከቤተሰብ ጋር ያለህ ተግባቦ ምን መልኩ ታየዋለህ/ሽ?
- ከቤተሰቡ አባላት ጋር ጥሩ አይነት ግኑኝነት አለ?
- ጓደኞችህ እና ቤተሰብህ ያበረታቱሃል፤ ይታገሱሃል፤ እንዲሁም በምትፈልጋቸው ግዜ

ካጠገብህ ይሆናሉ? \ ጓደኞችሽ እና ቤተሰብሽ ያበረታቱሻል፤ ይታገሱሻል?

2 ከአካባቢህ/ሽ ሰዎችጋር ያለህ/ሽ ተግባቦ ምን መልኩ ታየዋለህ/ሽ?

- በአካባቢህ/ሽ ያሉ ሰዎች ይነጥሉሃል/ሻል፤ያገሉሃል/ሻል?

3. ከሆስፒታሉ ምን አይነት ድጋፍ እያገኘህ/ሽ ነው? ምን ያህል ስረድቶህል/ሻል?

- ሳይኮሶሻል፡ - የግል እና የቡድን ምክክር፣ ከደጋፊ ቡድኖች ጋር መገናኘት፣

4. እየተጋፈጥካቸው/ሻቸው ያሉትን የኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣የጤና ችግርህን/ሽን እንዴት ትቆጣጠራቸዋለህ/ሪያቸዋለሽ?

- ችግሩን ለመቋቋም ምን አይነት እንቅስቃሴ ወይም ዘዴዎች እየተጠቀምክ/ሽ ነው

**አዲስ አበባ ዩኒቨርሲቲ**

**የትምህርት እና ባህሪ ጥናት ኮሌጅ**

**የስነ-ልቦና ትምህርት ቤት**

**የጥናታዊ ጽሁፉ መምሪያ**

**መጠይቅ**

**ለ. ከህመሙ ጋር ያሉ ሰዎች ቤተሰቦች**

1. ስም----------

2. ዕድሜ----------

3. እድሜ----------

4. ከታማሚው ጋር ያለ ዝምድና----------

**መጠይቅ**

1. ህመምተኛው ከታመመ ወዲህ ምን አይነት ችግሮች እየገጠመው/ማት ነው?
   - እያጋጠመ ያለው ችግር ከኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣ የጤና፣ የወዳጆች ድጋፍ፣ መድሎ፣እየወሰደው/ችው ያለው መድሀኒነት የጎንዮሽ ጉዳት ጋር ተያያዥነት አለው?
2. በተሰብለ ህመምተኛው ምን ዓይነት ድጋፍ እየሰጠ/ችነው?
   - ቤተሰብህ መምተኛውን ታበረታቱታላችሁ፤ ትታገሳላችሁ፤ እንዲሁም በሚፈልጋቸው ግዜ ካጠገቡ ትሆናላችሁ?
   - በገንዘብ የሚያግዘው/ዛት ሰው አለ ?
3. ህመምተኛው ከአካባቢው/ዋ ሰዎች ጋር ያለው/ላት ተግባቦ በምን መልኩ ታየዋለህ/ሽ?
   - በአካባቢው/ዋ ያሉ ሰዎች ይነጥሉታል/ላታል፤ያገሉታል/ላታል ?

4.እንደቤተሰብ ከሆስፒታሉ ምን አይነት ድጋፍ እያገኘህ/ሽነው? ምን ያህልስ ረድቶታል/ታል?

- ሳይኮሶሻል፡ - የግል እና የቡድን ምክክር፣ ከደጋፊ ቡድኖች ጋር መገናኘት፣ የስራ ተሃድሶ

**ሐ. ለባለሞያዎች**

1. ስም----------
2. ዖታ----------
3. የስራድርሻ----------

***መምርያ መጠይቅ***

1. ከልምድህ/ሽ የስኳርህ መምተኛ በዋነኝነት የሚያጋጥሙት/ማት ችግር ምንድን ነው?
   - ኢኮኖሚያዊ፣ ማህበረሰባዊ፣ የሚወሰዱ መድሀኒቶች ጋር፣ ስነ ልቦና?
2. ከጓደኞቹ/ች ጋር እና ከቤተሰብ ጋር ያለህ ተግባቦበም መልኩ ታየዋለህ/ሽ?
   - ጓደኞችህ እና ቤተሰብህ ህመምተኛውን ያበረታቱል?
   - በህምሙ ውስጥ ያሉ ሰዎች ከአካባቢህ/ሽ ሰዎች ጋር ያለው/ላት ተግባቦት በምን መልኩ ታየዋለህ/ሽ?
3. ከሆስፒታሉ ምን አይነት ድጋፍ እያገኘ/ች ነው? ምን ያህልስ ረድቶታል/ታታል? ሳይኮሶሻል የግል እና የቡድን ምክክር፣ከደጋፊ ቡድኖች ጋር መገናኘት፣
4. እየተጋፈጣቸው/ጠቸው ያሉትን የኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣የጤና ችግርህን/ሽን እንዴት ትቆጣጠራቸ ዋለ?
   - ችግሩን ለመቋቋም እንዲችሉ ምን አይነት እንቅስቃሴ ወይም ዘዴዎች ትጠቀማላችሁ?