Like all chronic and progressive problems, including normal aging, diabetes has social, psychological, emotional, and spiritual aspects that demand attention. Patients with type 2 diabetes and their health care providers must find their common ground to meet these challenges. Grief and shame at growing older and having medical problems afflict everyone, and denial of these feelings must be recognized and overcome. If not, patients will ignore or resist direction on lifestyle or medications. Psychological resistance to using insulin is a notable example. Providers’ self-awareness and comfort with their similar feelings, empathy with patients’ distress, ability to influence incremental change and place setbacks into perspective, and skill in supporting patients’ positive efforts can strongly influence the process of treatment. Success with modern therapies still depends on individualization of treatment, patient empowerment, and the competency of the professional relationship.

The United Kingdom Prospective Diabetes Study (UKPDS)\(^1\) has shown that the risk of developing diabetes complications grows over time, but with appropriate and progressive treatment this risk can be greatly reduced. Taking control of diabetes can make a difference for type 2 diabetes patients. These findings may help demystify this disorder for patients, help reduce their feelings of anxiety and blame that come from dealing with an unknown and misunderstood entity, and allow them to develop a sense of control.

The question now is how health-care providers can understand and use the study’s results to enhance diabetes management and health status. We believe the UKPDS must be understood from psychological, spiritual, and behavioral (as well as scientific) perspectives by both patients and providers. The goal of this article is to offer a “psychological consultation” that may lead to an updated attitude and improved patient/provider dialogue, resulting in modernized management of type 2 diabetes.

First, we believe that this ground-breaking study will do for type 2 diabetes what the Diabetes Control and Complications Trial (DCCT)\(^2\) has done for type 1 diabetes. That is, it may encourage patients and providers to take type 2 diabetes seriously and actively—not fearfully. This means creating plans for aggressively treating hyperglycemia and other risk factors and recognizing that at any point throughout the life span patients can alter the appearance or progression of diabetes complications. Doing so will require attention to the emotional, social, and behavioral components and interventions, enhancing therapeutic interaction.\(^3\)

Our understanding of the implications of the UKPDS might be summarized in this position statement:

1. We are all fortunate—not burdened—to have learned various ways that patients with diabetes can act to stay healthy. Let us not forget that people with some other illnesses decline and are powerless to contain...
2. Asking a patient to intensify management, taking the personal and social context into account, is taking the patient seriously and is an informed and loving act.

3. We must, from the start and continually, help to improve patients’ lifestyles, including eating habits, weight loss, smoking, exercise, and stress management.

4. We must neither minimize the value of lifestyle changes nor put too much emphasis on their ability to lower blood glucose levels without other methods of treatment.

5. A patient is not getting worse when treatment is intensified, nor does this signify inattention to lifestyle or a character defect. It is merely a predictable need for further and different ways to combat the decline of ß-cell function to achieve the same outcome.

6. We must focus less on what patients should do than on what they can and will do. We must allow medications to share the burden, sometimes compensating for what patients are not yet ready to do. The long-term relationship of patients with their diabetes and with their providers requires patience and compromise through the life span.

7. Because people evolve in various ways and medical treatments evolve as well, patients and professionals can learn to expect change, explore and resolve their resistance to it, and be resilient when anticipated lapses in management occur.

8. Including an individualized spiritual perspective, be it accenting gratitude over loss, working “one day at a time,” or highlighting the pursuit and enjoyment rather than entitlement of good health, may keep patients focused on efforts rather than feared outcomes.

**Personal Meanings for Patients and Providers**

Imagine yourself or someone you love at 45 years of age, sitting in a doctor’s office. The doctor is describing a progressive condition that will change the way you can live. “You can expect diminished eyesight, hearing, energy, memory, libido—even sexual performance. Along with all this, you should expect various aches and pains and a decline of essential internal organs.” You are devastated.

While you are trying to take all this in, the doctor starts telling you how you can challenge and even master this advancing condition. “If you want a good life, you must lose weight, change the way you eat, control your blood pressure, stop smoking, reduce alcohol intake, exercise more, think optimistically, strengthen religious or spiritual connections, optimize relationships with family and friends, and learn to adapt to loss and change with resiliency.”

Needless to say you are shocked to hear this. You are being asked to change every aspect of your life. Hearing all the bad things that can happen to you, your anxiety level is too high to absorb the advice being offered.

When you find the courage to ask the name of this cross you must bear, the doctor says, “It is aging, or, in layman’s terms, getting older.” The prescription for which you were not ready was for successful aging. Such is life.

Although this conversation does not happen on any one medical visit, we are all learning through an ongoing process about aging and what we can do to keep health issues at bay. Even when this information is taken in, people usually do not change lifestyle behaviors quickly or in a neat and linear fashion. What often happens instead is gradual awareness of one’s fragility and mortality and, sometimes, a “mid-life crisis” consisting of sadness, anxiety, denial, escapism, even escalating to acting-out.

Eventually, we adopt our individual approaches to aging, this chronic condition that does not get better and in fact gets worse. We may live our
lives fearing deterioration and death, or we may live well, purposefully, and with maximum quality of life. Improving knowledge does not automatically increase self-care behavior. Who has not been frustrated by repeated attempts—and setbacks—at diets and other changes? Making sense of our personal feelings is often a preliminary step to changing behaviors.

Call this our common ground. With or without diabetes, we all face physical decline and potentially devastating changes. This is the best place to start when we are trying to understand the impact of the UKPDS on people with type 2 diabetes. When we begin with our own vulnerability and insight as human beings, we can better understand and empathize with our patients, remembering that for them there are additional negative possibilities lurking in an unknown future.

As professionals, it is our task to use this understanding and empathy to destigmatize and normalize for our patients their more forbidding struggle and to help them believe that they can adapt and stay well. If they can see their problems as similar to what others without diabetes are facing, their feelings of isolation and resentment may lessen. Nevertheless, we must never deny or trivialize how much energy and tension go into coping with diabetes. Their experience and ours, while qualitatively alike, differ greatly in the tasks required and the long-term consequences.

Examine Grief and Shame
We know that controlling diabetes enhances a person's quality of life. This benefit comes in part from improved physical well-being—through the antidepressant properties of having insulin work in conjunction with food and exercise. In addition, patients get an emotional lift from the sense of efficacy that comes with maintaining a regimen. This feeling includes the relief from fear that comes with knowing that everything possible is being done to avoid complications.

So, why not “just do it?” The chronicity and progression of diabetes implies never-ending tasks and fears to master, a set-up for grieving without closure, and certainly the potential for burnout. With all the losses—social roles, freedom, independence, vitality—patients' work goes beyond managing the biology and includes maintaining morale and hope while living in a world with great demands. For some people, the reaction to a new diagnosis taps hidden resources, resiliency, even a new-found spirituality. For others, the emotional pain is hard to integrate. Until grief for the various losses is confronted, it may be too painful for patients to face the problem of management with full awareness.

Another aspect of the reaction to a new diagnosis of diabetes can be a sense of shame, sometimes intensified by past experiences. Patients may feel responsible for causing diabetes and can be crushed by a belief that their defects and inferiority are now known by others. The best antidote for shame is to identify it with the aim of getting beyond it rather than hiding in a pattern of withdrawal, anger, or perfectionism. When a blood test shows high blood glucose levels, patients can learn to recognize it as a fact to be dealt with and to put aside feelings of shame that lead to withdrawal, doing nothing more (ensuring more shame), or blaming their spouse or doctor for lack of interest. By not telling others about diabetes and avoiding situations where they might receive advice, judgment, and supervision or feel inferior to others, they also limit positive support, connection, protection, appreciation, and warmth. Shame may not be limited to a patient's feeling that “I brought this on myself, and I must deserve it.” It may extend to the professional who feels that “I can't cure this or help my patient control it, so how good am I?”

Denial: Inevitable Stage or Negative Defense Mechanism?
Dealing with the discovery of diabetes and its ongoing requirements implies being bombarded with many difficult feelings. Grief over the loss of wellness and shame and guilt about causing or deserving diabetes are just the start. These feelings may be joined by self-blame for not losing weight to delay diabetes in the first place; anger at medical personnel for not knowing
enough to help them with weight-control; anger at family members for not helping or—worse—sabotaging their exercise and healthy eating efforts; fear of the future—how to maintain independence and deal with setbacks; resentment at dependence on medical assistance and the expense that goes with it; and anger that there is no cure. Would you not want to delay facing those feelings if you thought you could get away with it?

Denial is a defense used to avoid or reduce anxiety and other bad feelings by unconsciously hiding disturbing information from awareness. Lifting denial means facing feelings of grief, shame, anger, and despair. During the grief response—shortly after the diagnosis of diabetes, with introduction of insulin, or when complications set in—a stage of "healthy denial" shields people from dealing with more feelings and more tasks than they can handle at the time.

For this reason, long-term perspectives and plans must be repeatedly revisited. At diagnosis, gradually escalating treatment may be presented as a positive strategy to reduce the sense of helplessness, punishment, or failure. Some patients will feel relieved to hear a long-term plan and find solace in the clarity or the details of manageable short-term goals. Others will find mapping out a future plan too anxiety-provoking and will use denial to limit their discomfort. They will have to hear about long-term plans later. You can determine what people will tolerate by asking what they are thinking and what the information at hand means to them. We have to be responsive to the individuality of each person's ability to take in new ideas and plans. While timing is very important, there is always another opportunity.

Unresolved grief and persisting, unhealthy denial gets in the way of daily living in many ways. Among these may be inability to reach out for medical help or follow-through with treatments. In response to denial, providers and family members often resort to nagging, criticizing, avoiding, or being angry with people with diabetes. Health professionals need to learn to identify denial and to use counseling techniques to intervene.

For example, from a male perspective, there is often a need to block out vulnerability and loss of control, leading to heightened denial. Beginning with "unconditional positive regard," a professional sets a tone that conveys sincere acceptance in spite of shortcomings of effort or outcome. This is a model for patients who must learn to accept their own diabetes. Through an empathic connection with a provider, patients can express fears and anxieties that block success.

Families, too, have to be included in conversations that stimulate constructive interest in patients and new thinking about diabetes. When health professionals and family members experience denial, too, we know that they are enabling patients to remain in a state of denial. All must be prepared to feel some anxiety to get past the denial and move on to active management.

### Placing Diabetes Within the Context of Normal Aging and Hope

There is a model for helping individuals come to terms with advancing medical difficulties over the entire life span. It is emerging in the literature on healthy aging. Gerontologists have moved from focusing on seniors’ frailty, filled with ageist stereotypes, to a more positive approach that emphasizes what older people can do to continue living vigorous lives. This positive view declares: "We no longer see disability as the inevitable correlate of aging." People can and do change over their lifetimes and find ways to cope with adversities.

Considering diabetes as just one of the challenges of aging, we can apply this positive view to our medical efforts. Each response to change or loss related to diabetes must fight to minimize denial and feelings of powerlessness and pessimism through relationships that combine empathy, clear expectations, and the belief that people can evolve.

In this context, the findings of the UKPDS contain both good news and bad. Patients can participate in therapies that will improve their outcomes, which is good, but they must implement most of the difficult tasks involved themselves, and every day, which is powerful bad news for some. Over time
they must take on more complex therapeutic tasks, which might be negative for some, but with the positive expectation that these treatments will indeed work.

Our task is to help patients see this process of management in the most positive light and realize the evolutionary capacity of patients, which is possible at any age or stage.\textsuperscript{14} Patients must be empowered to set achievable goals, appreciate their successes, then move on optimistically to the next challenge within a framework of hope.\textsuperscript{15} This stance is in contrast to denial (a rejection of reality), false hope (self-deception that leads to passivity or ineffectiveness), or hopelessness (negative expectations that lead to poor motivation and inability to act). Hope supports both biological functioning (immune system) and the ability to change behavior and develop greater resiliency. It also allows families and friends to be better support systems.\textsuperscript{16} This positive mindset is expressed in the "three Cs" of healthy aging: commitment (involvement and interest in one's life), control (feeling that you can influence your life's course), and challenge (seeing new events as opportunities rather than as cause for fear).\textsuperscript{17}

**Challenging the Problematic Responses**

An individual's adaptation to diabetes requires emotional awareness and skills to meet daily challenges from existing complications, stress, dietary choices, exercising, blood testing, taking medications, and making decisions. How effectively these challenges are met will be influenced by the individual's personality dynamics, unfinished business in dealing with past losses, level of family function, family life cycle stage, gender, and cultural perspective.

Many patients "underachieve" in this arena. That is, there is a discrepancy between their ability to make changes and their actual performance.\textsuperscript{18} This apparent lack of motivation may have various roots: patients may give up too easily; think it is too late for help; expect failure from past experiences (negative conditioning); think that if they are not perfect they are not okay (and diabetes is never perfect); feel they have no control over what happens; or say they do not care (translation: "I feel so bad about myself and diabetes that it is safer not to care or to try").

Providers can help patients who appear unmotivated by using an empowerment model. This means questioning in a wondering rather than interrogating way, promoting problem-solving rather than giving advice, focusing on efforts rather than outcomes, concentrating on understanding emotions rather than reacting to situations. It also means accepting the concept of lapse, relapse, and collapse—knowing that individuals can and will deviate but also can and will, with help, return to a healthy path.\textsuperscript{19} Introducing psychotherapy as a way for people to leave behind their destructive patterns of underachievement and achieve their health potential avoids the stigma of labeling them "bad" or "crazy."

Rates of depression and other psychological difficulties are higher among people with diabetes and among obese people seeking treatment compared to those without diabetes. Addressing psychological issues is a key to alleviating the effect of mood or anxiety disorders on performance of health-maintenance routines, a common cause of poor or "brittle" diabetic control,\textsuperscript{20,21} and to improving quality of life.

Psychological evaluation at diagnosis would be most effective, but it is most urgent when self-care is disrupted, as evidenced by high glycosylated hemoglobin (HbA\textsubscript{1c}) values despite medical follow-up, when complications appear, or with progressive obesity or substance-abuse disorders.\textsuperscript{22} Our obligation includes working with patients to eliminate additional risk factors, such as smoking, high lipid levels, or high blood pressure.\textsuperscript{23}

Psychological distress from living with diabetes or from complications may be inevitable, but it is certainly treatable when identified. In fact, diabetes is sometimes discovered when a person seeks help for depression. Poor metabolic control may in itself contribute to fluctuating or poor mood states. Depression increases medical vulnerability in general and is associated with
poor glycemic control leading to diabetic complications. Treatment of depression in people with diabetes has been successful, particularly with cognitive and/or pharmacological therapy.

Differentiating persistent from transitional depression by repeated evaluations reminds us that we are treating people over their evolving life cycle. We must be sensitive to the fact that men are less likely than women to seek or accept help for depression. While the physical symptoms of depression are universally recognizable, we should be attentive to other signs, such as irritability or use of alcohol, when asking about mood in our male patients so as not to miss something so treatable.

Obesity is a chronic metabolic disorder that may or may not overlap with a psychiatric or eating disorder. Unfortunately, it has been difficult to treat because we do not know enough about its pathogenesis. We do know that dietary issues are the most resistant to change and that obesity sometimes begins with restraints and dieting.

The National Institutes of Health guidelines for obesity assess past history of adherence, present factors such as readiness to change (precontemplation, contemplation, preparation, action, and maintenance), current resources such as social support, and cultural or environmental stressors. Research shows that tangible weight loss is achieved and maintained only with regular, long-term professional support.

We also want to fight "weightism," the bias against self-worth and individuality of obese patients. One way to help initiate success without focusing on weight is with computer-assisted learning programs that help patients make healthy lifestyle changes, such as reducing fat intake and thus lipid levels, in some cases more quickly than with weight loss.

Documentation of the array of psychologically oriented screening tools available will soon be provided by a task force of the National Diabetes Education Program. We hope these instruments can be used in much the same way as HbA$_1c$, foot exams, blood pressure measurements, and other medical outcomes. We should be able to identify and, in some cases, intervene with various disorders using short, standardized pencil-and-paper methods.

**Medication Resistance**

Individualize, individualize, individualize—this is the key concept in understanding medication resistance. People may intentionally or unintentionally misuse or reject part or all of their medications for a myriad of reasons. Medication-taking patterns include infrequently missed medication, self-reduction of dosage, or even complete discontinuation of prescribed medication. Our goal should be to view this as "intelligent noncompliance" and take time to identify the person's underlying personal motivation, always reminding patients that the ultimate goal is lowering blood glucose levels by whatever means necessary. We can ask nonjudgmental questions, such as: "People often change their medications for one reason or another. What about you?"

**Scenario**

Henry is an intelligent, 70-year-old man who retired after 30 years as a successful dentist. Surprisingly, given his professional accomplishments and self-reported compulsive nature, he still knew little about diabetes 5 years after his diagnosis. When asked about this incongruity, he remembered that his doctor, perhaps to help him cope with this diagnosis, told him that because onset of the illness was late in life he "probably die from something else." His reaction was to be relieved and to infer that diabetes was not such a serious disorder. With this operating belief, he put diabetes out of his mind and actions.

Henry's wife felt a different sense of urgency about diabetes based on experience with her parents' health. She urged him to seek further advice from the diabetes team at their local hospital. When Henry finally did so, it was some time into his appointment before he mentioned symptoms of
extreme fatigue, mild depression, and reduced libido, thinking these were all a normal part of aging. His weight had increased by 10 lb, his HbA1c had jumped to 10.2%, and his blood pressure was high.

The information he received at this appointment allowed him to make a connection between his poorly controlled diabetes and what he now understood as his compromised physical and mental health. He left the office with a resolve to cut back on food and increase exercise.

Henry was unable to make these lifestyle changes. Consequently he kept postponing medical appointments, being unable to show progress. Now feeling diabetes was a more serious threat, he felt depressed and fearful about his future and ruminated over needing medication.

When he finally did return for a visit, his doctor began by reflecting on the pattern of his behavior—specifically his appointment avoidance and difficulties making behavioral changes. In an empathic manner, the doctor said he had seen the same depression and anxiety in many of his patients when they confronted the reality of diabetes. He asked Henry if this description seem to fit for him, too. He went on to say that he was impressed that despite these obvious difficulties, Henry made himself return for a visit. The physician clarified that appointments were about remotivation or discussing fears, not just about reporting success. He then asked Henry to talk about his thoughts and feelings about having to take medication.

Henry was startled and relieved to have the doctor ask him something so honest and personal. When his physician approached the subject in a nonjudgmental manner, he let down his defenses. He answered that if he did not see the team he could "get away with it," taking his chances that nothing would happen. He surprised himself with all the negativity that then poured out. Diabetes and medication made him feel sickly, old, and dependent. It seemed to him that if he needed medication his body had failed and his strength of character seemed diminished, too. He felt emasculated having to depend on something external to heal him rather than being able to do it himself. He also felt that medications would be a crutch and that he, an "all or nothing guy," would use medications instead of watching his food, perhaps even letting go and increasing his intake out of anger and the thought that the medications would give him "license to cheat."

This communication brought up information that was very helpful to both of them. The doctor had been careful to remind him that medication was not punishment or failure but part of nearly every patient's course of treatment, along with efforts to improve lifestyle. Henry had seen medication as an escape from the rigors of self-care rather than part of a progressive and predictable regimen. He needed to see medication as his outside tool for empowering his control of diabetes. Altering this attitude was just as important as correcting his faulty knowledge of what to expect in the course of treatment.

We are reminded to look at the individual nature of our patients' interpretations of information and get feedback from them on the impact of our communication. The interpersonal skills of the health professional are especially crucial when dealing with chronic problems of basically well and sometimes very independent people, as in Henry's case, as opposed to acute management of specific disorders.

Looking at the process of Henry's experience that allowed him to change for the better, we can begin with his social support—his wife's encouragement. Next we see the doctor labeling and legitimizing healthy denial—time-limited—that when continued kept Henry from returning for follow-up or acting on his intellectual understanding of the behaviors needed to manage diabetes. Using empathy and exploring his individual personality, the physician prodded Henry to identify thoughts that might keep him from making changes. He accentuated the positive, noting that Henry had forced himself to return for the visit in spite of skepticism and depression. At the end of the encounter, the doctor asked him to turn to his past successful professional life and his meticulous and compulsive nature for guidance
—accenting past competence and the ability to make a choice to apply it to his diabetes.

We know from the literature that Henry's resistance to medication was both stereotypical and individual to him. We can keep in mind other typical reasons for resistance to help patients identify their personal barriers. In addition to denial, shame, and dependency are such possibilities as economic burdens; confusion or forgetfulness stemming from the complexity and inconvenience of the regimen; stubbornness and rebellion; attempts to individualize and maintain self-control rather than rely on outside experts; influence from friends, family, or the media; disruptions in one's daily routine; and fear (justified or not) of the side effects of drugs.  

**Step Therapy: Sometimes More Is Better**

Over time with diabetes we have to ask more of ourselves to stay healthy. We know that in time β-cell function declines and cannot keep pace with the body's need for insulin. To balance this need, we have step therapy, in which medications are used sequentially and in combinations. Combinations of oral agents can delay the need for injected insulin. When insulin becomes necessary, it can be added to oral treatments gradually, allowing a transition that is easier for both patients and providers.  

The progression of diabetes, matched by a progression of efforts and medications, can be compared to what happens in the developmental cycle of school, work, and family life.

In kindergarten you need only play and learn the beginning of socialization to take home messages that say: "Lovely, wonderful child." To maintain the same success next year in first grade and take home an A, the child has to do more work, including learning how to read. The next year, homework begins, gradually increasing the time it takes to get the desired reward. More work for the same feedback? That does not seem fair. And it does not stop there. At your workplace or in family life, more continues to be required. Adjusting to everyday, progressively increasing demands requires recognizing and accommodating tensions that may arise.

While we may be annoyed by rising expectations, most of us accept the principle. Although quality of life may be impaired by these increased efforts, there can be trade-offs. As for the 5-year-old who has to give up freedom to gain what school offers, feeling the power to change and maintain our lives well is part of life's quality.

**Psychological Insulin Resistance**

Psychological insulin resistance (PIR), a term coined to identify the avoidance of insulin by providers and patients, is an often-missed diagnosis. Providers and patients may mutually collude in their denial of the need for insulin. After many failed attempts to lose weight before trying insulin, we may find patients in a compromised metabolic state with complications advancing and both parties in a defeated emotional state. The often inevitable need for insulin demands that we understand the reasons—specific to each individual—for avoiding insulin and become skilled at coaching our patients past these barriers.

Letting this resistance remain in place weighs heavily on both parties. Patients with uncontrolled diabetes are at greater risk for physical symptoms and for moodiness and depression and may suffer from guilt, anger, and feelings of failure. The cycle of bad feelings, denial, and avoidance of medical care tends to continue. Providers, too, can suffer from feelings of inadequacy, guilt, and anger at themselves or at patients. Mutual resistance to using insulin may come from various sources, including denial of the seriousness of diabetes; the symbolic meaning of starting what seems a last-ditch treatment; procrastination as a personality feature; fear of confrontation (the provider's insistence on insulin versus the patient's resistance); the time, cost, and energy required; and fear of insulin itself, weight gain, and hypoglycemia.

The UKPDS and other studies have mitigated the bad name of insulin therapy in at least four ways: 1) Fear of cardiovascular and microvascular
side effects from insulin is not warranted. 2) When used in conjunction with metformin, insulin causes only minimal weight gain, which is important for both health and vanity. 3) There is less risk of hypoglycemia with insulin treatment of type 2 diabetes than has been seen with type 1. 4) The step-therapy approach, with gradual addition of insulin while continuing oral therapies, allows patients to learn to use and to accept insulin more gradually. Also, the idea that sometimes insulin may be needed only temporarily is very encouraging to patients, even if it promises only a short-term respite.

Scenario
Peter, a psychologist in his 50s, was somewhat intimidating to the nurse educator assigned to work with him. She, a young woman in her 30s, was aware of and inhibited by his age and credentials as she tried to help implement the doctor's instructions to start insulin.

He was angry with her from the previous year when she had told him many type 2 diabetes patients eventually need to use insulin. He did not appreciate being like everyone else, and he did not like her dampening his future. Peter likes to feel special and unique and gets angry or depressed when that view is challenged. To him, as with many patients with a similar narcissistic personality style, it is demeaning to be the same as others. It was perfectly natural and accurate for the nurse to have said what she did, because many patients are relieved to learn they are like others.

In this case, Peter's "difficult nature" was the cause for his referral to the team psychologist. He found it difficult to be told what to do by someone younger who did not have his background. The nurse, feeling anxious in the presence of someone of his age and professional status, had immediately gone into a long-winded lecture. At a deeper level, what seemed like Peter's arrogance was, in part, an effort to get control back in his life by firing the educator. More than likely, considering his defenses, he was guarding against feeling dependent and "less than.”

With this in mind, the consulting psychologist did not confront him on his feelings of being special or try to prove the medical team's point. Instead, she began the relationship by validating Peter's expertise as a psychologist and asked him to give an opinion of the difficulty of patients facing the choice of insulin, allowing him to approach his own feelings at a safe distance.

After a few sessions, a joint meeting with the nurse was introduced. The mutual respect between the psychologist and nurse transferred to an alliance with Peter as the empowered head of his team. With her new appreciation for his personality style and what would be most effective for his learning, the nurse—sensing Peter's anxiety and shame about being a grown man who was afraid of a shot—did not tell him that many of her patients were apprehensive. Instead she suggested that he experience a shot before more discussion.

In the end, Peter was annoyed over the fuss. Why hadn't we told him that insulin was in fact easy to use, didn't hurt at all, and would give him flexibility with his eating that he wouldn't otherwise have? Team members saw their mission accomplished. They stopped taking his anger and criticism personally. Removing their own egos from the interaction and taking the time to understand his personality dynamics allowed them to meet their mutual goal of helping him feel in control and able to accept the medical regimen as an enhancement.

Sometimes we must learn by trial and error what helps or does not help an individual patient, avoiding seeing ourselves as correct or incorrect in the process. This can be done by listening to the patient's responses, sharing frustrations with team members, and consulting with mental health specialists. In cases like this, we may hope to positively reframe the situation by welcoming the patient's open—albeit negative—feedback as important to the process of his care.

People without personality disorders but with distinct personality styles—
narcissistic, dependent, passive-aggressive, or paranoid—are able to problem-solve their health situations in their own way, especially with helpful interactions with others. Patients with diagnosable personality disorders are often unhelpfully labeled as difficult patients rather than recognized as psychologically dysfunctional with their offending behavior as a defense. They can be identified by pervasive and persistent negative behaviors, such as anger, blame, or excessive dependence, that distract them from solving problems while arousing anxiety and anger in those around them.31,32 Such people have even greater need of expert psychological assessment.

Empowering Ourselves and Our Patients

We have asked you, as you read this article, to focus on your own feelings and needs as professionals in tandem with understanding those of your patients. We each begin with our own story, something we do automatically. Based on our life's experiences as well as our gender and cultural backgrounds, we develop expectations and transfer them to others. Are our patients motivated by underlying ideas of self-reliance, stoicism, or rejection of support or by food as love; or family over individual needs; or valuing the young over the old? Which are our own ideas and which are those of our patients?

Only with introspection can we determine where we fit in the continuum ranging from expecting too much from to asking too little of our patients—being too critical or harsh versus being undemanding and nonchallenging. Do we fear imposing demands for too rigorous a regimen on patients, thinking this will burden them, when in fact the literature suggests that intensified control relieves anxiety and depression?33 What are our thoughts about the elderly, minority groups, obesity, gender differences, the ways people handle pain? Our views of human nature, our spiritual or religious connection or disregard, and our optimism or pessimism will influence our patients' behavior and how we understand or judge them. What are our own feelings of self-efficacy, our skill in finishing what we set out to do, and our attitudes toward our patients' abilities to do so? We know that our expectations as teachers markedly affect our patients' efforts and performance.

Please do not forget to take the time to understand and empathize with yourself. Health care providers face great challenges, work hard, and carry heavy responsibilities. We have stress coming from many directions—the health system, our personal and family lives, and frustration, fear, and anger in relation to our patients. Yet we have a remarkable opportunity to create lifelong relationships with patients and their families and sometimes to change the course of their lives. Most of us want to lighten our patients' burdens, and to do so requires effective management of our own. Good health care begins with a well and self-aware health care provider.

We can best manage stresses through self-awareness, learning new ways to think, react, and plan ahead. These are in fact the same skills we want our patients to have. We begin by understanding the concept of an "internal dialogue," the thoughts and feelings that flow through our heads, sometimes without awareness, with the power to lead us to either helpful or destructive behaviors and interactions.34 We can become aware of how we are thinking—our self-talk—and then use cognitive techniques to challenge and change unhelpful patterns of thought. Moving on from knowing how we think, we can use the following skills to improve our interactions with people: empathy, normalization, questioning, and positive reframing.

- **Empathy and reflection:** Truly learning to appreciate the intimate feelings of another with kindness and without judgment.

- **Validation and normalizing:** Legitimizing a person's feelings or experience as important and logical.

- **Questioning, exploring, confronting:** Facing issues and seeking feedback on an individual's experience, thoughts, and feelings without judgment for growth and improvement.

- **Cognitive reframing with accent on competence:** Challenging
potentially negative ways of thinking and viewing a situation in a positive and realistic light.

**Situation**

A patient tells you: "I did exactly what you said, and it didn't work."

Internal dialogue: "She irritates and frustrates me. On the other hand, it sounds like Mrs. S. is frustrated; can't blame her, diabetes is difficult. Anyway, she's often too critical of herself, not to mention me." Now that you have gone from honest feelings of irritation to a nondefensive and constructive posture, you realize the problem is about her, not you. At this point, you are ready for effective communication.

Interaction: "You sound frustrated [empathic reflection]. It's hard trying new things and having them not work right away [normalization]. Tell me what you did well [positive reframing] and where you went off track."

All lifestyle and medication issues and psychological insulin themes are certainly initially understandable. When identified, they must not be minimized or bypassed but empathically and skillfully confronted.

**Situation**

Your patient persists in avoiding insulin despite your best efforts to convince him that it is needed. Reviewing your self-talk, you work through your anger and frustration and are ready to continue without impatience.

Patient: "I feel like taking insulin makes me a slave to my diabetes."

Provider: "There certainly are lots of demands on you by your diabetes, all the time [empathy]. I'm sure I would feel the same way at times. Many people feel like you do in the beginning [normalization and positive reframing]. What bothers you the most about it [questioning]?"

Other PIR themes that may consciously or unconsciously prompt our patients to postpone necessary use of insulin include: This means I'm getting worse. I'll be addicted to it; I'll never get off it. What's the big deal? I feel perfectly fine now. I hate shots. Taking insulin shots inconveniences my family and friends. Insulin causes complications. I've seen people go blind when they take it. If I have to take insulin it means I have the bad kind of diabetes with complications and hypoglycemia.

**Situation**

Your patient has just started on insulin and is anxious and frustrated after an episode of hypoglycemia.

Internal dialogue: "I see how hard I work at being there for my patients and how easy it is to be negative when problems arise despite my effort [empathy]. I need to remind myself that I can't control everything that happens. I can look clearly at what happened and still know we are on the best course [positive reframing]. What am I so worried about? How can I comfort both of us and reassure him so he doesn't stay anxious or let his blood glucose run too high [questioning]?" Aware of your anxieties and fears your are now in a better position to help your patient.

Interaction: "Hypoglycemia happens to good people who have good health care providers [normalization]. I'm impressed, and you should be too, that you and your wife knew exactly what to do; you caught and treated the hypoglycemia right away [positive reframing]. Tell me what you concerns are . . . why you think it happened and how you think it will affect how you feel and what you do in the future [questioning]."

**Considering the Risks: Hypoglycemia and Weight Gain**

The UKPDS showed that using metformin limited weight gain and that insulin treatment causes much less hypoglycemia in type 2 diabetes than many people had expected. These findings offer reassurance on two issues that had cast doubt on applying tighter standards of blood glucose control. This does not mean that we cannot improve the way we attend to those who are at risk for these problems. We know that some people particularly fear low
blood glucose in the middle of the night, perhaps because of a bad experience or because they live alone. They increase bedtime snacks to feel safer, but then gain weight. And of course achieving a desired improvement of glucose control can be associated with weight gain despite good efforts with lifestyle. The disappointment that may follow, if not anticipated and confronted, can lead to unpleasant feelings that subvert further lifestyle efforts.

Like most issues, hypoglycemia is best addressed with an individualized perspective. It is helpful to define what we think of as elderly when are concerned about tight control and its risks of hypoglycemia. People are living longer than before, and a 65-year-old woman can expect about 19 more years of life, hopefully life of high quality and good health.\textsuperscript{35} We must be aware of any ageist assumptions, adjusting upward the actual age of what we formerly considered elderly, so we do not mistakenly consider a vigorous person too vulnerable for aggressive treatment. Good glucose control using insulin is possible for many such people.

On the other side of the problem, among the issues that may increase risk of hypoglycemia at any age are anxiety over hyperglycemia that leads to overuse of insulin; hypoglycemia unawareness or inattentiveness; excessive use of alcohol; inadequate testing due to the high cost of strips (patients may be ashamed to mention this problem); cognitive or emotional difficulty with the regimen and process of decision-making; interfering mood states, such as depression or anxiety; unreported weight-loss that may require adjustment of insulin dosage; and family or social concerns competing for attention or financial or emotional resources. Solutions to these problems are just as individual and can be approached in the same way as other problems related to starting and adjusting treatments.

**Finding Support From Other People and From Institutions**

Providers and patients both need to feel that they can talk openly about fears and inadequacies and be understood and respected. Professional team or patient groups can provide this kind of support and a chance for role-modeling and improving problem-solving skills. Providers can make themselves knowledgeable about outside resources for patients. Many self-help books, media presentations, online activities, organized community activities, and support groups are available. Support from family and friends can be mobilized, and psychotherapy is better thought of as an adjunct to medical treatment than as a last resort. The format for successful support will differ widely among individuals as well as by gender, with women seeking affiliation and men more often looking to take action.

Beyond these traditional resources, a wider appreciation of the implications of the UKPDS in the entire community would be helpful. After all, type 2 diabetes is a public health threat of major and growing proportions, and controlling it is central to preventing a cascade of other medical problems in the present and even the next generation.\textsuperscript{21} Public health resources might be redirected toward prevention of diabetic complications, in the form of support for widespread continuing education for providers on both the biology and psychology of diabetes, similar to efforts being undertaken for AIDS and drug abuse.

We know that people do not change behaviors with information alone,\textsuperscript{36} nor do providers help them change without the skills to do it.\textsuperscript{37} The messages of the UKPDS—the seriousness of type 2 diabetes, its chronicity, its progressive nature, and the benefits of effective intervention—should be heard, and professionals with skills to use this information should be trained and supported in the effort. To do so will require awareness and action by the infrastructure of our society—employers, the government, insurance companies, the media, community and religious organizations—all groups with a stake in the well-being of people.\textsuperscript{38}

Success in this will be signaled by a transition from overemphasis on acute treatment of complications of diabetes to appropriate attention to the opportunity to prevent them. It will require a chronic-disease model based on ongoing reassessment of the problem at hand, support of people's ability to
change and cope over time, recognition of all aspects of human experience (medical-social-emotional-behavioral), and outcomes measured in terms of the years of life well lived and enjoyed.  

### A Personal Note

As one of the authors of this paper who has worked more than 20 years in diabetes, I have reached older-person status (cringe), am susceptible to developing diabetes, and am now married to a might-have-previous-considered-elderly person with type 2 diabetes. This is not exactly the way I like to picture myself and my spouse, but it is certainly the way I might be viewed on entering a doctor’s office. From this viewpoint (Hey, it's still me inside this aging body), I make a particularly strong case to treat our type 2 patients aggressively and supportively, making sure we do not minimize their value as they grow older.

Looking back to when I was a young woman on an equally youthful team of professionals, I wonder whether we dismissed our older patients in any way. Did we give them enough respect, believe they could actually change, see their individuality behind the gray hair and wrinkled faces, think them as deserving of our hard work as our younger type 1 patients? At times we were intimidated by their age and accomplishments and (speaking for many female professionals) afraid of the power of those who were both older and men, accommodating to what we thought they wanted rather than asserting our expertise to their benefit? Oh, if only we knew then what we know now . . . How annoying it was to hear our parents say that!

After all this time—all the wonderful changes and research—helping patients still is about our relationships with them, which allow us to use our medical and psychological skills to empower them to make healthy choices in self-managing diabetes amid the pressures of their busy lives.—W.S.R

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