DOCUMENT RESUME

ED 391 998 CG 026 829

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TITLE The Difference in Self-Esteem between Type I Diabetics and Type II Diabetics.
PUB DATE [95]
NOTE 14p.
PUB TYPE Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Diabetes; Diseases; Personality Traits; Physical Health; Physiology; *Self Esteem; Special Health Problems

ABSTRACT

Diabetes Mellitus is a disease which can affect an individual both physically and emotionally. Type I diabetics, representing about 10% of the diabetic population, can be characterized as having little or no insulin supply in their pancreas. Usually under the age of 30, they are required to take one or more insulin injections daily and must follow a strict exercise and diet regime. Type II diabetics, representing 90% of the diabetic population, can be characterized as having some insulin in their pancreas and may be able to survive on oral insulin medication, diet or exercise. Diabetes affects an individual emotionally in different ways and at different times in an individual's life. The more diabetics come to terms with their illness the better they fell about themselves. This paper discusses the emotional differences between Type I and Type II diabetics. It was hypothesized that Type I diabetics would have a lower self-esteem than the Type II diabetics. The participants, 12 Type I and 45 Type II diabetics, were surveyed using a self-esteem questionnaire. The hypothesis was not supported by the results of the survey. Contains 17 references and a copy of the survey. (JBJ)

Running Head: SELF-ESTEEM IN TYPE I AND TYPE II DIABETICS

The Difference in Self-esteem Between Type I Diabetics and Type II Diabetics

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Abstract

This article discusses the emotional differences between Type I and Type II diabetics. It was hypothesized that Type I diabetics would have a lower self-esteem than the Type II diabetics. The participants very surveyed using a self-esteem questionnaire developed by the writer. The hypothesis was not supported by the results of the survey.

The Difference in Self-esteem Between Type I Diabetics and Type II Diabetics

Diabetes Mellitus is a disease which can affect an individual both physically and emotionally. Diabetics can be divided into two groups; Type I diabetics and Type II diabetics. Type I diabetics can be characterized as having little or no insulin supply in their pancreas. These individuals represent 10% of the diabetic population. They are usually under the age of thirty and are required to take one or more insulin injections daily as well as follow a strict diet and exercise regime. Onset of Type I is usually during the developmental years, especially adolescence. Other names also give to Type I diabetes are Juvenile Diabetes; because of the age of onset, and Insulin Dependent Diabetes Mellitus. Type II diabetics can be characterized as having some insulin in their pancreas and may be able to survive on oral insulin medication, diet or exercise. Type II diabetics represent 90% of the diabetic population. Onset for these individual is usually after the age of thirty. These individual are usually overweight and have a family history of diabetes. Type II diabetes is also know as Insulin Independent Diabetes Mellitus. (American Diabetes Association 1994, National Diabetes Data Group 1994, National Institute of Diabetes and Digestive & Kidney Disease 1994, National Institute of Health, 1994, Lifescan, 1989)

There has been very little research done comparing Type I and Type II diabetics. Also, the physical effects of diabetes has been researched at great length, while the emotional effects have not had as much research. Of the research on emotional effects of diabetes, the majority of them focus on the effects as they apply to Type I diabetics and adolescents. The research on Type II diabetes and its emotional effects is very little.

The adolescent is often characterized as having low self-esteem, and a poor sense of self. Since onset of Type I diabetes is usually at this age, research was done to see if there was a

significant difference in self-esteem compared to the self-esteem of Type II diabetics. This researcher has predicted that there is a significant difference in the self-esteem of Type I diabetics compared to the self-esteem of Type II diabetics.

Background

Diabetes affects an individual emotionally in different ways and at different times in an individuals life. Depending upon the age, other people; such as family members, parents, baby-sitters, teachers and even doctors, may be hesitant about caring for the needs of a diabetic. Friendships are often discouraged by parents of other children. An individual may have problems obtaining a driver's license and may be discriminated against by perspective employers. The individual may be seen as a less desirable marriage partner and the female diabetic may be viewed as an unhealthy or have problems conceiving and delivering a healthy child. Onset of complications is associated with interruption of employment, major medical expenses, and an increase in reliance on others. (Brodoff & Blecher 1982)

Brodoff and Blecher (1982) state that the earlier in development that diabetes expresses itself, the greater is the vulnerability to adaptive impairment through the disruption of the fundamental psychological process. The young child may not show overt distress following diagnosis, whereas the teenager may be thrown into a turmoil of self doubt, shame, anger and rebellion. They go on further to say that the developmental impact of diabetes in infants and very young children is primarily mediated by the responses of their parents, for the diagnosis is always stressful and sometimes devastating. As the child enters the ages of four to six, the individual may feel they are being punished for some real or imagined wrong doings. Diabetic children of elementary school age, may have an increase of absence in school due to complications. When this

occurs, a sense of shame and inferiority may accompany the awareness of being different from other children because of their illness. Other children of this age may do well negotiating this period but have trouble as they enter puberty.

Adolescence is a time of change for and individual both physically and emotionally. An individual who has diabetes must learn to deal with these change as well as handle the daily care of their diabetes. The diabetic adolescent wants to gain some control of their diabetes and may struggle for independence and cause rebellion against the restrictions of their illness (Brodoff & Blecher 1982, Colwell 1978). Denial and acceptance may also be prominent due to the constant reminder of their illness through injections and blood testing. Taking insulin and having the responsibility of making decisions that will affect their life can become highly conflicted, resulting in anxiety, guilt, anger, depression and serious family discord (Brodoff & Blecher 1982, Meldman 1987, Pesman 1989). Self acceptance is highly predicted on acceptance by others (Brodoff & Blecher 1982, Meldman 1987), the adolescent who feels different suffers great torment and is vulnerable to self rejection and identity diffusion. The adolescent also has some fears and ambivalence about telling others of their illness. They fear how others will treat them because of their diabetes. They fear that they will be treated like a child, or feel insulted by the treatment they receive by others when they experience insulin reactions. They fear they may be labeled as being different, a freak or weird. Others fear they will lose friends and significant others. Some may feel that they are unable to make long-term plans because of their uncertain future and fear of complications (Betschart & Thom 1995, Meldman 1987). Denial is also seen in many diabetic adolescents. They become quite independent and may refuse to diet or follow instructions (Colwell 1978). Along with denial is non-compliance. Researchers have found that some

adolescents will deliberately sabotage their treatment plans by recording false blood glucose results, dieting, skipping meals, skipping insulin injections, or eating high sugar foods in attempts to receive attention, manipulate caregivers, overcome feelings of guilt, gaining independence, or losing weight (Betschart & Thom 1995, Colwell 1978, Lancet 1994, Wessberg-Benchel, Glasgow & Tynan, et al 1995). Self-esteem also plays a factor in the development of the diabetic adolescent. When diabetes is out of control, it is hard for the adolescent to keep their self-esteem high. They may feel embarrassed or worry that the doctor will think they are not following their regime. They may get tired of telling others about their personal problems and may be afraid that their questions are stupid (Just For Teens, 1994). Ryan & Morrow (1986) found that females who developed diabetes before the age of five had poorer self-concept scores than males in this age group based on the Piers-Harris Self-concept Scale to examine self-esteem. Whereas, males and females in the later onset group had equivalent scores. They found that this interaction was restricted to physical appearance and anxiety. Their data suggests that diabetic females and males developed very different strategies for coping with their physical and psychosocial problems associated with their disease. They also state in their research that adolescent females are more affected by changes in physical appearance than males, perhaps because they feel that their popularity will be determined by how they look, whereas males are more likely to believe that it will be determined by what they do.

Brodoff and Blecher (1982) state that in later adolescence and young adulthood, concerns of sexual attractiveness come to include anxieties around sexual adequacy and reproductive capacity. The diabetic in young and middle adulthood with Type I diabetes often come to reasonable terms with their diabetes and a relatively latent period may follow. Onset of diabetes in

later life or the appearance of complications is associated again with many adaptive challenges, heightening the sense of vulnerability and mortality.

In comparing Type I and Type II diabetics, Schwartz (1994) states that the more diabetics come to terms with their illness, the better they feel about themselves. She goes further to state that diabetes can be a lonely and isolating disease, which allows it to make the diabetic submissive and often pushes them further away from friends and family. She also states that resentment, denial, guilt and fear can be present in both types of diabetes.

Smith, Mauseth, Palmer, Pecora & Wenet (1991) state that diabetic adolescents who were in better metabolic control reported more conflict on the Sullivan Diabetic Adjustment Scale regarding issues of independence and family relationships than those in lesser degrees of diabetic control.

Dasbach, Klein, Klein, & Moss (1994) found that younger onset diabetics who rated their health in comparison to their peers as "worse" or "don't know" were no more likely to die than those who rated their health as "the same" or "better" when physical status was controlled. The Older onset diabetics, on the other hand, who rated their health as "worse" or "don't know" were almost twice as likely to die as those rating their health as "the same" or "better" when physical status was controlled. If the physical status was not controlled, the results were found to be much different. They stated that self-rated health in people with diabetes is a predictor of mortality when the data are not adjusted for physical health status.

Method

57 diabetics, 12 Type I and 45 Type II, were chosen randomly as they came to a diabetic clinic to see a diabetes specialist. The self-esteem questionnaire was developed by the researcher

based on a five point Likert scale. It was administered by clinic staff and returned the same day as the visit. The questionnaire asked such questions as age of onset, gender, insulin therapy, and complications.

Results

The 57 questionnaires were then compared and evaluated to see if there was any differences among the groups. Of particular interest was the difference in the Type I and Type II diabetics. The results showed that there was no difference on any questions of combination of questions at the .05 level of significance via a 2-tailed *t* test. Reliability was found to be .90 based on the Cronbach Alpha internal consistency.

Discussion

The hypothesis stated in the introduction was inconsistent with the results, although the research backs it up. There could be a couple of reasons for this inconsistency such as the questionnaire was not completely reliable and did not test for self-esteem. Also there could have been some problem in sampling error. These diabetics were chosen randomly from a diabetic clinic in which they were receiving treatment and education. If the sample had been chosen randomly from some other source, perhaps the results would be much different. Since the research shows that adolescents do have some problems in dealing with self-esteem and in dealing with their illness, perhaps further research should be done and effective treatments could be put into place to help them deal with their illness.

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June 10, 1995

Dear Fellow Diabetic,

I am a graduate student at Bowling Green State University. I am working on a research project dealing with the self-esteem of diabetic patients. I am trying to see if there if a difference in self-esteem between Type I and Type II diabetics. I have asked the permission of Mary Ellen Good and Dr. Rhodes to distribute these surveys to you so that I can conduct my research and hopefully answer some of the questions I have.

Please take some time and answer the questions honestly and to the best of your ability. Please turn finished surveys into Mary Ellen, Dr. Rhodes or the receptionist. All surveys will remain confidential. When my research is finished, I will relay any new information I have received to Mary Ellen and Dr. Rhodes.

Thank you for your cooperation and time, it is greatly appreciated.

Linda Kay Ellerbrock

Self-Esteem Survey of Diabetic Patients

Age ___ Male ___ Female ___

Age at onset ___

Type I Diabetes ___

Type II Diabetes ___

Insulin Therapy
1-2 daily injections ___
Intensive Therapy (3 or more injections daily) ___
Insulin Pump __
Oral Medication ___

Complications
Retinopathy (eye disease) ___
Neuropathy (nerve disease) ___
Nephropathy (kidney disease) ___
Cardiovascular Disease ___
Infections ____

Please circle the number that best describes how you are feeling at this time.
For example:
I have trouble managing my diabetes according to my doctor's order.
Strongly Agree if I do all of the time.
Agree if I do more than half of the time.
Disagree if I do less than half of the time.
Strongly Disagree if I do none of the time.

1. I have not accepted my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

2. I have trouble managing my diabetes according to my doctor's order.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

3. I have trouble testing my blood sugar levels daily or as directed by my doctor.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

4. I have faked, falsified or manipulated my blood sugar readings.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

5. I feel bad about my self when I go off my diet.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

6. I feel bad abut myself when I do not exercise.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

7. My friends are not very supportive of my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

Self -Esteem Survey of Diabetic Patients

8. My family is not very supportive of my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

9. I do not openly share or tell others about my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

10. I feel bad about myself when by blood sugar readings are high or low.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

11. I feel bad about myself when I miss an injection or oral medication.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

12. I have been embarrassed or ashamed to tell others about my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

13. I have felt suicidal at times about my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

14. I have used my diabetes to get my way.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

15. I do not have a supportive friend or family member to talk to about my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

16. I have often gone off my treatment (diet, exercise, medication) to fit in with peers or co-workers.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

17. I am self-conscious about testing my blood sugar or taking medication in public places.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

18. I am afraid people will not accept me if they know about my diabetes.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

19. I often dread going to the doctor for diabetic care.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree

20. When I have an insulin reaction, I feel embarrassed to ask for help.
   1. Strongly Agree, 2. Agree, 3. Disagree, 4 Strongly Disagree