The Effectiveness of Cognitive-Behavioral Stress Management Training on Glycemic Control, Psychological Distress and Quality of Life in People with Type2 Diabetes

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Objectives: This study was designed to evaluate the effectiveness of cognitive-behavioral stress management training on glycemic control, psychological distress (depression, anxiety and stress) and quality of life in people with type2 diabetes.

Method: 60 type2 diabetic patients (34 females and 26 males; mean age 49.5 ± 5.7 years) were studied. They were randomly divided to two groups. Members of one group attended 10 weekly sessions of cognitive-behavioral stress management training, while other group did not. Test of HbA1c and, DASS and quality of life questionnaires were administered on both groups before and after intervention. This assessment procedure was repeated within 3 months follow up.

Results: After intervention HbA1c, psychological distress and quality of life improved significantly (p<0.01) in trained patients, but there was no significant change in these measures in control group. These results remained constant within 3 months follow up.

Conclusion: Results show that cognitive-behavioral stress management training is an effective intervention to improve glycemic control, psychological well-being and quality of life in people with type2 diabetes.

Key words: Glycemic control, Cognitive-Behavioral Stress Management, Psychological distress, Quality of life

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Introduction

Diabetes mellitus is a major public health problem which affects an increasing number of people around the world. Worldwide rise in number of adults with diabetes has been estimated to be 122%, from 135 million in 1995 to 300 million in 2025 (King, Aubert & Herman, 1998). It seems that 14 to 23% of Iranian people who are more than 30 years old are under the effects of diabetes while the estimates of type2 diabetes reached to 90 - 95% of these cases (Larijani, Zahedi, & Aghakhani, 2003). This is a complex metabolic condition in which the patient has a life-long responsibility for managing their condition. The first aim of diabetes management is the control of blood glucose levels, the so-called glycemic control, which is measured by an HbA1c blood test (Stratton et al., 2000). Just like other chronic diseases, patients suffering type2 diabetes may also experience a variety of stress factors as a result of the illness and its treatment, including pain, disfigurement, impaired physical functioning, life-threat, permanent changes in lifestyle, dependency, self-management tasks, threats to dignity, diminished self-esteem, disruption of normal life transition, decreasing resources, and changes in future perspectives (Bisschop, Kriegsman, Beekman & Deeg, 2004). It has been observed that these disease-related stress factors may play an important role in the development of anxiety and depression among patients with chronic diseases (Zhang, Chen & Chen, 2008). Diabetic patients compared to general population rate higher on depression and anxiety (Peyrot & Rubin, 1997; Anderson, Freedland, Clouse & Lustman, 2001; Huang, Chiu, Lee & Wang, 2011). Such symptoms were associated with poor glycemic control (Lustman et al, 2000), diabetes complications (Groot, Anderson, Freedland, Clouse & Lustman, 2001) and worsened prognosis and quality of life (Tossani, Cassano & Fava, 2005), which in turn may lead to increased activity of sympathetic nervous system and to elevated levels of cortisol and catecholamines, which can elevate the risk of metabolic syndrome (Rosmond, 2005; Lamounier- Zepter, Ehrhart-Bornstein & Bornstein, 2006). Importantly, those patients who experienced significant psychological distress were more likely to have difficulties with diabetes self-care (Das-Munshi, Stewart, Ismail & Bebbington, 2007) leading to worse glycemic control and the development of serious complications (Groot, Anderson, Freedland, Clouse, & Lustman, 2001), which easily turn to a vicious circle (Peyrot et al., 2005). Moreover, the presence of clinical complications of type2 diabetes tends to negatively influence the perception of quality of life (Lloyd, Sawyer, Hpkinson, 2001).

The United Kingdom Prospective Diabetes Study (UKPDS, 1998) has demonstrated that intensive blood glucose control is essential for reducing the risk of diabetic complications in type2 diabetic patients. Essentially, no glycaemia thresholds have been observed for any type of diabetes complication: the lower the glycaemia, the lower the risk of complications (Stratton et al., 2000). Alam, Sturt, Lall and Winkly (2009) suggest that patients with long-standing sub-optimal glycemic control may benefit from psychological interventions. Also many people with diabetes perceive that they need additional help and support with the psychosocial issues associated with
diabetes (Davies, Dempster, & Malone, 2006). Psychological interventions appear to be effective in improving psychological distress and glycemic control, however there is a shortage of psychological specialists in diabetes care systems and psychological treatments are difficult to access for most patients living with diabetes (Alam, Sturt, Lall, & Winkley, 2009). Peyrot and Rubin (2007) in their report suggest that, rather than waiting for a specific problem or deterioration of psychological status to be identified, psychological screening, assessment and treatment should be routinely incorporated into patients’ care. Among different psychological interventions, cognitive-behavioral interventions have been used for improving psychological distress in type1 (Snoek, Nicols, Ven, & Lubach, 1999; Amsberg et al., 2009) and type2 (Welschen, Oppen, Dekker, Bouter, Stalman, & Nijpels, 2007; Pourisharifi et al., 2010) diabetes.

Considering shortage of psychological specialists and psychological treatments in diabetes care systems, group interventions based on approved approaches like cognitive-behavioral therapy can be helpful. This study is aimed to assess the effectiveness of cognitive-behavioral stress management on glycaemic control, psychological distress and quality of life in type2 diabetic patients.

Methods

This study was conducted on 60 type2 diabetic patients (34 females and 26 males; mean age 49.5 ± 5.7 years) referred to Isfahan charity diabetes center. The subjects were able to read and write and at least 6 months had passed after diagnosis of diabetes. Those subjects who abused drugs, needed hospitalization, insulin therapy or psychiatric medication because of diabetes complications, were excluded from the study. The results of 53 patients were analyzed, the rest dropped out due to different problems including diabetes complications or not attending therapy or follow up sessions.

Measures

- Glycosylated Hemoglobin (HbA1c): Patients’ physiologic glycemic control was measured using the glycosylated hemoglobin (HbA1c) blood test, which reflects glycemic control over the previous 2 to 3 months (American Diabetes Association, 1999).
- Depression, Anxiety and Stress Scale (DASS-42): Patients psychological distress was measured using the Depression, anxiety and stress scale. This scale includes 42 items and 3 subscales (i.e. Depression, anxiety and stress). In Afzali, Delavar, Borjali and Mirzamani’s study (2007), the depression subscale showed a high correlation (0.849) with the BDI in a 0.01 level of statistical significance. The stress subscale also found to have a 0.757 correlation co-efficient with SSS, again statistically significant at a 0.01 level. The rates of Chronbach alpha for the depression, anxiety and Stress subscales were found to be 0.94, 0.85 and 0.87 respectively. The KMO rate for the present study was 0.88 which indicates a large-enough sample size for factor
analysis. The Cruet-Bartlett’s test also showed a chi-square rate of 0.794 with a degree of freedom equal to 861, which was again significant at a 0.01 alpha level.

- Iranian brief form of WHO Quality of Life Questioner (IRQOL): IRQOL comprises 26 items and includes 4 domains of quality of life (physical health, psychological health, environment and relationships). This questionnaire was translated by Nasiri (2006) to Persian language. He reported 87% split-half reliability coefficient and reasonable concurrent validity with GHQ. Also this is a sensitive instrument to change in clinical settings.

The design of our research was randomized clinical trial applied through pre-test/post-test with control group. Our intervention was 10 weekly 2-hours sessions of cognitive-behavioral stress management training, including the following topics: what is stress?, relation between stress and diabetes, coping styles, progressive relaxation, problem solving, time management, anger management, cognitive restructuring (2 sessions) and healthy life style (Fata, Bolhari & kazemzade atufi, 2006). The pretest administered before the start of intervention and the post test administered immediately 10 weeks after the last session of intervention. The follow up assessment administered 3 months after the post test.

**Statistical Analysis**

Statistical analyses were performed using the SPSS 15.0. Results were analyzed through repeated measures ANCOVA.

**Results**

Participants’ baseline scores are shown in Table 1, which demonstrates no significant differences between the two groups in HbA1c, depression, anxiety, stress and quality of life.

<table>
<thead>
<tr>
<th>variables</th>
<th>intervention</th>
<th>Control</th>
<th>differences</th>
<th>t</th>
<th>P. value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>7.60 (0.88)</td>
<td>7.92 (1.05)</td>
<td>0.32</td>
<td>-1.17</td>
<td>0.320</td>
</tr>
<tr>
<td>Depression</td>
<td>20.34 (5.82)</td>
<td>21.55 (6.06)</td>
<td>1.19</td>
<td>-0.740</td>
<td>0.943</td>
</tr>
<tr>
<td>Anxiety</td>
<td>18.19 (5.85)</td>
<td>19.18 (5.39)</td>
<td>0.99</td>
<td>-0.642</td>
<td>0.807</td>
</tr>
<tr>
<td>Stress</td>
<td>18.80 (6.84)</td>
<td>20.29 (7.57)</td>
<td>2.11</td>
<td>-0.749</td>
<td>0.729</td>
</tr>
<tr>
<td>Quality Of Life</td>
<td>75.34 (6.65)</td>
<td>73.25 (8.41)</td>
<td>2.07</td>
<td>0.998</td>
<td>0.521</td>
</tr>
</tbody>
</table>

The results of repeated measures ANCOVA indicate that our intervention effectively decreased HbA1c (P=0.007), depression (P<0.001), anxiety (P=0.001) and stress (P<0.001) scores and increased quality of life (P=0.011) score in post-test and follow up compare to pre-test. Observed powers for all variables are reasonable (Table 2).
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Table 2. Tests of within-subject Effects

<table>
<thead>
<tr>
<th>Variables</th>
<th>Type III sum of square</th>
<th>df</th>
<th>F</th>
<th>P. value</th>
<th>Partial eta square</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>2.217</td>
<td>2</td>
<td>5.14</td>
<td>0.007</td>
<td>0.09</td>
<td>0.815</td>
</tr>
<tr>
<td>Depression</td>
<td>132.982</td>
<td>2</td>
<td>10.213</td>
<td>&lt;0.001</td>
<td>0.16</td>
<td>0.984</td>
</tr>
<tr>
<td>Anxiety</td>
<td>168.418</td>
<td>2</td>
<td>7.10</td>
<td>0.001</td>
<td>0.122</td>
<td>0.924</td>
</tr>
<tr>
<td>Stress</td>
<td>304.756</td>
<td>2</td>
<td>17.742</td>
<td>&lt;0.001</td>
<td>0.258</td>
<td>1.00</td>
</tr>
<tr>
<td>Quality Of Life</td>
<td>170.161</td>
<td>2</td>
<td>4.735</td>
<td>0.011</td>
<td>0.085</td>
<td>0.780</td>
</tr>
</tbody>
</table>

Results of tests between subject effects (Table 3) show that differences between two groups are significant for HbA1c (P = 0.005), depression (P = 0.012), anxiety (P = 0.009), stress (P = 0.001) and quality of life (P = 0.006). Here also observed power for all variables are reasonable specially for stress (∆ = 1.00), depression(∆ = 0.984) and anxiety(∆ = 0.924).

Table 3. Tests of between-subject Effects

<table>
<thead>
<tr>
<th>Variables</th>
<th>Type III sum of square</th>
<th>df</th>
<th>F</th>
<th>P. value</th>
<th>Partial eta square</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>16.314</td>
<td>1</td>
<td>8.510</td>
<td>0.005</td>
<td>0.143</td>
<td>0.816</td>
</tr>
<tr>
<td>Depression</td>
<td>572.238</td>
<td>1</td>
<td>6.87</td>
<td>0.012</td>
<td>0.119</td>
<td>0.730</td>
</tr>
<tr>
<td>Anxiety</td>
<td>563.678</td>
<td>1</td>
<td>7.34</td>
<td>0.009</td>
<td>0.126</td>
<td>0.758</td>
</tr>
<tr>
<td>Stress</td>
<td>1159.227</td>
<td>1</td>
<td>11.404</td>
<td>0.001</td>
<td>0.18</td>
<td>0.912</td>
</tr>
<tr>
<td>Quality Of Life</td>
<td>949.736</td>
<td>1</td>
<td>8.804</td>
<td>0.006</td>
<td>0.137</td>
<td>0.797</td>
</tr>
</tbody>
</table>

Finally results show that our intervention effectively improved glycemic control, psychological well-being and quality of life in patients with type2 diabetes.

Conclusion

Significant differences in HbA1c between the two groups were observed 10 weeks after intervention and were maintained in 3 months follow up. Also significant differences were observed in depression, anxiety, stress and quality of life between two groups 10 week after intervention and 3 month follow up. Questions concerning the underlying mechanism(s) of improving glycemic control through this intervention and – the routs in which glycemic control is linked with psychological distress were considered closely. Psychological interventions may affect diabetes controllers in three ways. The first step is to help the patients to accept their disease. Second is to make them improve their self-care and self-efficacy behaviors, and third is to eliminate psychological distress which makes it much harder to control the disease (Poursharifi, 2010). It is assumed that psychological distress may lead to increased sympathetic
nervous system activity and to elevated levels of cortisol and catecholamines, which can elevate the risk of metabolic syndrome (Rosmond, 2005; Lamounier-Zepter, Ehrhart-Bornstein & Bornstein, 2006). In other words, the link between symptoms of depression and anxiety and later onset of diabetes may be an over-activity of the HPA axis resulting in elevated cortisol level that inhibits insulin function in a variety of ways (Ehlert, Gaab & Heinrichs, 2001). It is controversial that which one of anxiety or depression is more related to glycemic control and diabetes. Shaban, Fosbury, Cavan, Kerr and Skinner (2009) after controlling for demographic and medical characteristics suggested that anxiety is predictive of HbA1c not depression. Furthermore the association between anxiety and HbA1c is mediated by diabetes specific psychological distress. Thus the emotions and cognitions associated with diabetes may lead to maladaptive behaviors that result in sub-optimal control. On the other hand depression is an important factor in metabolic control and diabetes. For example, Leonard, Egede, Anouk, Grubaugh & Ellis, (2010) suggest that individuals with diabetes and depression are less likely to engage in a wide range of preventive health practices that are not specific to diabetes disease management. Another study suggested that possible mechanisms include the influence of depressive symptoms on behavioral factors, such as sedentary lifestyles, smoking, and overeating, resulting in metabolic disturbances, which may explain the onset of diabetes (Engum, 2007). Also altered activities in the hypothalamic–pituitary–adrenal (HPA) axis with cortisol elevations during depressive episodes, which affect approximately half of all patients, may increase the risk of type2 diabetes. However, Anxiety and depression as possible risk factors for diabetes could not be investigated separately, because of common co morbidity of these two (Brown, Campbell, Lehmann, Grisham & Mancell, 2001).

Our findings show that in addition to improving glycemic control and psychological well-being, Cognitive Behavioral Stress Management improves quality of life in diabetic patients. Quality of life is a subjective concept encompassing a wide range of inter-related factors, such as physical, functional, psychological and well-being, as well as religious and spiritual factors (cerrer et al., 2008) and patients with diabetes have a poorer quality of life than do subjects of the same age and gender without the disease (Estebany Pena et al., 2010). It is suggested that perception of quality of life is positively correlated to the severity of general psychopathology, but not with metabolic control, evaluated by HbA1c levels (Papelbaum, Lemos, Duchesne, Kupfer, Moreira, Coutinho, 2010). So the improvement in quality of life in our study may be the result of improvement in psychological distress (i.e. decrease in depression, anxiety and stress).

In conclusion Cognitive-Behavioral Stress Management training as a simple and relatively short intervention is effective for diabetic patients. This is not an expensive intervention where as having good effects on glycemic control, psychological well-being and quality of life. So, we propose this intervention to be incorporated to usual treatment programs of diabetes.
Acknowledgements

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References


