REPORT TO THE EDITOR

A Conference on Adjustment Problems in Juvenile Diabetes

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On April 22 and 23, 1963, the United States Public Health Service, Diabetes and Arthritis Program; the National Institute of Arthritis and Metabolic Diseases; the Child Guidance Center of Mercer County; and the New Jersey State Department of Health sponsored in Princeton, New Jersey, a conference on the psychosomatic aspects of juvenile diabetes. Approximately fifty persons attended, coming from the fields of medicine, pediatrics, psychiatry, nursing, dietetics, social service, psychology, and sociology. There was representation from medical schools, the PHS, state health departments, and private practice.

The conference began with five formal presentations:

1. *T. S. Danowski, M.D.* Dr. Danowski opened the seminar with a description of the development and course of juvenile diabetes. He elaborated on the abruptness of symptoms at onset, the difficulties in achieving chemical control, the emotional swings encountered, and the eventual development of vascular disease.

2. *L. E. Hinkle, M.D.* Dr. Hinkle described the metabolic response to stress. There may be lowering of the blood sugar, elevation of the blood ketones and free fatty acids, nitrogen loss, increased oxygen utilization, and free water diuresis. He emphasized that this disruption of homeostasis may be especially marked in the diabetic patient.

3. *C. R. Swift, M.D.* Dr. Swift reported on forty juvenile diabetics observed by himself, a psychologist, and a psychiatric social worker. Psychologic tests, home evaluations, and examinations of patient adjustment to the disorder were made. In comparison to controls he found high intelligence, increased prevalence of anxiety, dependence, damaged or inadequate perception of body image, hostility, oral pre-occupation, and denial of disorder. About one third of the patients were believed to be psychoneurotic, and half had over-protective parents. More satisfactory chemical control was related to a good adjustment to the disorder, short duration of diabetes, better general health, absence of psychoneurosis, less anxiety, better emotional tone of the home, and more secure body image.

4. *M. K. Opler, Ph.D.* Dr. Opler opened his remarks with a description of the Midtown Manhattan study, wherein relations between chronic illness and environmental factors are being investigated. Diabetes was low in prevalence in contrast to arthritis, hypertension, asthma, and other disorders. He reviewed evidence for the development of diabetes as a response to stress and suggested that in the future as more illiterate people are swept into colonial and urban family conditions, psychosomatic conditions will become more prevalent.

5. *A. Montagu, Ph.D.* Dr. Montagu reviewed the problems of embryologic development in the offspring of diabetic and prediabetic mothers and emphasized the influence of prenatal factors on the eventual life course.

The remainder of the conference was devoted to eight discussion groups from which the subject matter and tentative conclusions were presented to the general assembly for further deliberation. The conference and the workshops considered the following:

1. *The Emotional Status of the Juvenile Diabetic.* There was discussion of the emotional behavior and adjustment of the teen-age diabetic. Many of the clinicians felt that the most difficult problems are encountered when diabetes is diagnosed during the growth-spurt years. There was agreement that the patient often expresses hostility because of the need for self-assertion. Elements of anxiety are present, and there may be denial or unwillingness to admit the presence of diabetes. It was proposed that the behavior patterns observed are not qualitatively different from those of the nondiabetic subject, but represent exaggeration of traits occurring normally in adolescence. Some participants believed that the concept of a "diabetic personality" should not be discarded, and that such a state might be present even before the appearance of diabetes.

2. *The Development of Emotional Disturbance.* There was no general agreement concerning factors predisposing to the behavior patterns of the juvenile diabetic patient. The view was expressed that the emotional patterns of the prediabetic are already abnormal. It was

The address of Dr. Arthur Krosnick, who was Moderator of the Conference, is 383 West State Street, Trenton, New Jersey.

also suggested that a genetic factor might cause a personality disturbance. Some of the participants felt that there were early disturbances in sexual identification and body image. Another view was that there is a delay in gratification of oral needs. Parental attitudes were believed to be of great significance. The presence of the over-protective mother, the fears of the parents concerning diabetes, and the guilt felt by parents when apprised of the disease all lead to difficulties in the adjustment of the patient to the disorder.

There was discussion of a need for studies to identify variables and influences present at the time of diagnosis and those most likely to determine the eventual behavior patterns of the juvenile diabetic patient. Such studies would of necessity be long term. Little enthusiasm was voiced for these studies because of lack of knowledge of the proper factors to look for.

3. *The Management of the Juvenile Diabetic.* There was general agreement that the most satisfactory management of juvenile diabetes entails keeping a balance between the needs of the disease and the needs of the patient. Too often the individual is forgotten. For example, he or she is called a "juvenile diabetic." This connotes a disease with a patient attached, whereas in reality there is an individual with a disease attached. The benefits of care from a single physician with a good doctor-patient relationship were compared to those obtainable via a group approach. It was realized that a busy practitioner may not have adequate time to manage all the needs of the patient. On the other hand, in a large group organization, the doctor-patient relationship may lose significance. The participants tentatively concluded that optimal therapy includes a firm doctor-patient relationship with adequate nursing and social worker assistance in controlling environmental influences. It is believed that, though juvenile diabetes is rare in occurrence, the disorder requires so much emotional guidance that teachers, school nurses, social workers, and other paramedical personnel must have knowledge of its vicissitudes.

Specific points dealing with treatment included the following:

1. *The Treating Physician.* He must be the guide for the patient no matter how taxing the role may be. He cannot be either too dogmatic or permissive because of subsequent rejection by the patients. Care must be taken to prevent transfer to the patient of any anxiety problems of the physician.

2. *The Parents.* The family must be educated and counseled as soon as possible following diagnosis. In the first few days after diagnosis the shock of the situation may prohibit education. At this time the physician can only allay fears. Later he must bring to light any family anxieties, guilt, or hidden grief. It was suggested that in juvenile diabetic clinics group therapy for parents might be helpful.

3. *The Patient.* It was generally held that, until more knowledge is at hand, every effort should be made to return the child promptly to the usual environment. The diabetic child is not to be thought of as different, and should not be punished but rather allowed to develop his own motivation for good treatment. The disorder is to be looked upon as a nuisance, not a handicap.

4. *Camps.* Camps for diabetic children are believed very helpful. Here the patient learns an orderly way of life, and sees himself and others accomplishing feats that he formerly may have thought impossible. Those present who had worked in camps did not believe that hypoglycemic episodes were disturbing to the general camp group.

The entire proceedings will be available through a private printing and may be requested through Dr. Krosnick.