NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
APPLIED (CLINICAL) PSYCHOLOGY MASTER PROGRAM

MASTER THESIS

THE EFFECT OF THE GROUP TRAINING WIHT CONCEPTS OF POSITIVE PSYCHOTHERAPY ON DIABETES MELLITUS PATIENTS

SÜREYYA GEYLAN
20033301

SUPERVISOR
ASSOC. PROF. DR. EBRU TANSEL ÇAKICI

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Prepared by : Süreyya Geylan

We certify that the thesis is satisfactory for the award of the Degree of Master of Science in Applied Psychology

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ÖZET

Pozitif Psikoterapi Kavramları İle Yapılan Grup Eğitiminin Diabetes Mellitus Hastaları Üzerindeki Etkisi

Hazırlayan: Süreyya Geylan
Haziran 2010

Diabetes Mellitus (DM) toplumda yaygın görülen bir hastalıktır ve günümüzde bu hastalığın ortaya çıkışı, seyri ve tedavi sürecinde psikolojik faktörlerin önemli yer tuttuğu yaygın olarak kabul görmektedir. Bu çalışmada Pozitif Psikoterapi ilkeleri üzerine oluşturulmuş bir grup eğitim çalışması yapılarak psikolojik faktörler ve tedavi süreçleri arasındaki ilişki konusunda DM'lu hastalara farkındalık kazandırmak hedeflenmiş ve bu eğitim çalışmasının hastalar üzerindeki etkileri araştırılmıştır.

Araştırma grubu DM tanısı almış 9 hastadan oluşmaktadır. 5 hafta boyunca haftada bir kez 2 saat toplanılarak grup eğitim çalışması yapılmıştır. 5 hafta boyunca her hafta farklı bir konu çalışılmıştır. Katılımcıların DM'un yaşamları üzerindeki olumlu ve olumsuz etkilerini farketmeleri, kendi psikolojik durumlarının DM seyri ve tedavisi üzerindeki etkilerini görmeleri sağlanmıştır. Günlük yaşamlarını sağlıklı düzenleme, stresi tanıma ve stresle başetme becerileri kazandırmak bu eğitim gruplarında hedeflenmiştir.

Bu araştırmanın sonucunda DM hastaları grup çalışmasından fayda sağladıklarını belirtmişlerdir. Özellikle 'Denge Modeli' ve stres ve stresle başetme yöntemleri ile ilgili çalışmalardan etkilendiklerini belirtmişlerdir.

DM hastalarının tedavisinde psikolojik faktörlerle ilgili eğitim verilmesi tedavi başarısını arttırabilir ve bu tarz çalışmalarda Pozitif Psikoterapi metotları kullanılabilir.

Anahtar kelimeler: Diabetes Mellitus (DM), Pozitif Psikoterapi

ABSTRACT

The effect of the group training with concepts of positive psychotherapy on Diabetes Mellitus patients

Prepared by Süreyya Geylan
June, 2010

Diabetes Mellitus (DM) is a common chronic disease in community and today it is widely accepted that psychological factors are important at the begining, course and treatment process of this disease. The aim of this study is to have DM patients to acquire awareness about the relation between psychological factors and the treatment process via a group training study based on the concepts of Positive Psychotherapy and to investigate the effects of this training on the patients.

The study group is formed from 9 patients diagnosed as DM. Group training was made once a week for 2 hours during 5 weeks. Every week a different subject was studied. The participants were enabled to realize the positive and negative effects of DM on their lives, and also the effects of their psychological status on the course and treatment of DM. In these training groups it was aimed to have them organize their lives in a healthy way, to recognize stress and to acquire skills to cope up with stress.

At the end of the study, DM patients mentioned that they benefited from the training. Especially they were effected from the studies about the 'Balance Model' and stress and methods for coping up with stress.

Giving training about psychological factors during the treatment of DM patients may improve success of treatment and methods of Positive Psychotherapy can be used in such training programs.

Key Words: Diabetes Mellitus (DM), Positive Psychotherapy

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I would like to thank my supervisor Assoc. Prof. Dr. Ebru T. Çakıcı for all of her support and encouragement. I also would like to thank my family especially my mother, my fiancé and the people who joined my group work. And I would like to thank who helped my group.

CONTENTS

LIST OF SCHEMAS

1. INTRODUCTION

Diabetes Mellitus (DM) is one of the most common chronic disorders. DM is affecting the patient all life. Because of if the person has DM disease, they must be change life. Diabetes is change brings with life style, physical activity level, feeding programs. Diabetes is change human organism and moreover changes psychological situation and according.

DM is physiological disorder. But psychological factor has a role to play in the DM patient lives. For this reason psychological approach or psychological group training is important for DM.

Metabolic control in diabetes is relationship between psychological and behavioral factors and that variety of self- management. Psychological interactions improve both metabolic control and quality of life (Fisher, 2007).

Approximately a quarter of adults with DM- type I do not succeed in achieving satisfactory glycaemic control (Ven, 2005). Psychological factors have negative effect on glycaemic control.

1.1 What is the Diabetes Mellitus?

DM is a serious disease involving the metabolic system. It stems from a failure of the pancreas to produce enough insulin, a substance needed to control the glucose level of the blood. (Taylor, 1986)

DM is a disease that is being diagnosed with increasing frequency. All forms of diabetes involve a hormone from the pancreas called insulin (Guthrie, 1999). Diabetes is a chronic disorder in which the body is not able to manufacture or utilize insulin properly. (Taylor, 1986) The results are that instead of being stored for energy through the action of insulin, the foods you eat raise your blood sugar to higher than normal levels (Guthrie, 1999).

Diabetes is the third most common chronic illness and one of the leading causes of death (Taylor, 1986).

Diabetes is not single disease with a single cause. All forms o diabetes involves a hormone (body regulator) from the pancreas called insulin. (Hillson, 1996) In the United States, another person is diagnosis with diabetes every 60 seconds. (Drum and Zierenberg, 1997) The prevalence is 2 -3 % of the world. (Inceday, 2007)

1.2 The History of DM

Information written on ancient Egyptian papyrus described diabetes as a disease that caused a person to melt into the loins and resulting urine to attract ants. Clinical

features similar to DM were described 3000 years ago by the ancient Egyptians. The term "diabetes" was first coined by Araetus of Cappodocia. The name; Diabetes is from a Greek word, meaning ‘to siphon’. Mellitus, a Latin word, relates to a word meaning ‘honey’ or ‘sweet tasting’. It was only in 1776 that Dobson (Britain) firstly confirmed the presence of excess sugar in urine and blood as a cause of their sweetness. In modern time, the history of diabetes coincided with the emergence of experimental medicine. An important milestone in the history of diabetes is the establishment of the role of the liver in glycogenesis, and the concept that diabetes is due to excess glucose production Claude Bernard (France) in 1857 (Guthrie, 1999).

1.3 Types of DM

Diabetes has been divided into two groups:

a) Type I DM

Type 1 diabetes mellitus is characterized by loss of the insulin-producing beta cells of the islets of Langerhans in the pancreas leading to insulin deficiency. This type of diabetes can be further classified as immune-mediated or idiopathic. Type I DM is believed to be caused by a combination of genetic and environmental stressors. The individual who develops Type I DM has an inability to make insulin. There is a lack of insulin and polyphagia is usually accompanied by weight loss (Guthrie, 1999). Types I DM usually develops relatively early in life and earlier for girls than boys. Type I DM first arises between the age of five and six or later between ten and thirteen. (Taylor, 1986) Type I DM frequency is 10-20% in general diabetes population. (Yuksel, 2007) The only treatment is insulin injection. (Hillson, 1996).

b) Type II DM

Type II diabetes mellitus is characterized by insulin resistance which may be combined with relatively reduced insulin secretion. The defective responsiveness of body tissues to insulin is believed to involve the insulin receptor. People with Type II DM is are usually obese and will have gradually gained weight. There more likely will be weight gain (Guthrie, 1999). In type II DM, insulin is produced by the body, but there is not enough of it. The majority of types DM are obese. Type II DM is the most common type. Type II DM typically occurs after age forty and is milder than type I (Taylor, 1986).Type II DM frequency is 80-90% in general diabetes population. (Yuksel, 2007). Type II DM is the one most common chronic illness. Type II is more common women, whites and individuals of low socioeconomic. (Taylor, 1986). Obesity is risk factor of the Type II DM (Sundaram, 2007).

1.4 Complications of DM

1.4.1 Retinopathy

DM has risk for many complications. One common complication of DM is retinopathy, a disease of the retina, the light-sensing region of the inner eye. Retinopathy is caused by damage to the blood vessels that supply blood to the retina (Cryer and Childs, 1996). In quarter people with Type II DM are diagnosed of early retinopathy. Within 8 years of diabetes diagnosis, half of all people show some retinopathy. After 20 year of diabetic every person shows retinopathy (Smith, 2001).

b)1..2 Nephropathy

These tiny blood vessels, called capillaries, are unable to filter out the impurities in their blood. They become blacked and leaky at the same time. As a result, some of the waste products that should be removed stay in their blood and some of the proteins and nutrients that should remain in your blood are lost in the urine (Cryer and Childs, 1996).

b)1..3 Neuropathy

Neuropathy is loss of the ability to sense pain and temperature in a stocking and glove pattern, starting first in the feet, then spreading to the hands (Smith, 2001). At the half of diabetic people have neuropathy after 25 years of living with diabetes (Cryer and Childs, 1996).

The complication can affect the patient's socioeconomic status, workplace discrimination and other social difficulty (Wasserman and Trifonova, 2006). And many researches show us psychological factor increase risk of the complications.

The poor self- management and complications among those with diabetes and especially, among with negative emotions and diabetes has effectiveness of healthy coping interventions (Fisher, 2007).

b).5 Prevalence of DM

The diabetes mellitus prevalence rate is 2 -3 % of the world. (Incedayı, 2007).

In the United States have more than 18 million type II diabetics. This rate is representing approximately 7 % of population. Black people have an increase rate of diabetes (Lee, 2009).

The prevalence study is the research prevalence rates all ethnic groups for both type I and type II diabetes in England. In 2001 in England there were 2 168 000 people with diabetes. This represents 2 0002 000 with type 2 diabetes mellitus and 166 000 with type I DM. DM prevalence is higher in women than in men of all ages. Age is

potential effect on prevalence with a sharp increase in prevalence with increasing age. People of South Asian and Black African/ Caribbean descent have prevalence that white European and other ethnic groups. The prevalence that 1,3 million women and 0, 86 million men in England have DM. The Total DM is prevalence in England in 4, 41% and prevalence increase with age and higher in South Asian and African (Forouhi et all, 2005).

In a DM prevalence study in Turkey, 1637 diabetic people participated. The sample age range was 20-79 years in Adana. The total diabetes prevalence was 11, 6 %. Prevalence was 12, 9 % for men and 10, 9 % for women. The prevalence of diabetes showed significant increase with age. Prevalence of DM in Adana was 8.8 %. Frequencies of diabetes in urban and rural areas were similar. Prevalence of diabetes was higher in women than men (Göksel, 2003).

These researches show that; psychological disorder and / or symptoms effect of the DM patient. Psychological disorder effect the diabetes mellitus's treatment.

1.5.1 Prevalence of DM in Turkish Republic of North Cyprus

KADEM made prevalence researches of the Turkish Republic of North Cyprus (TRNC). This study sample is 1780. This research sample is 20 -80 age ranges selected to randomly to population. In TRNC diabetes disease rate is % 11.5 and glucose tolerance disorder rate is % 17.9 and general population rate is 70.6. When age is increase, diabetes range is increase both of the male and female. When the increase is the education level, diabetes rate is decrease. DM rate had no deference between male and female. The rate of diabetes patients with diabetes in family of those with diabetes have a family of non diabetes rate is twice (KADEM, 2008).

1.6 Psychology of the Chronic Disease

Many of the chronic medical illness have social, emotional, psychological, economic, impact. And many sciences brief can relate to chronic illness. Quality of life is affected by the chronic disease.

Many studies are suggested the relationship between psychological and social factors interacting with physical diseases. The psychological components interact with pathological physical condition of illness (Priest, 1982).

Chronic medial illness is positively correlated with an increase risk of depression and stress and anxiety. Chronic stress was found to have negative effects of several measures of immune functioning (Greenberg, 2007)
Chronic disorder may require long periods of care and greatly affect the lives of patient and their family (Sheriden and Radmacher, 1992). The diagnosis of diabetes is usually unexpected and significantly make psychological trauma for youths and family members. Diabetes affects patient's social activity, occupation, marital relation, parenting etc. (Wasserman and Trifonova, 2006).

When the person has diagnosis of the diabetes or other chronic disorder, they have live difficulty of their life. The first problem is a coping with a diagnosis. After the diagnosis of chronic disorder: first live shock. Shock, most people go into a state of shock following diagnosis of a serious illness. Being at a shock is characterized by being stunned and bewildered, behaving in an automatic fashion and having feelings of detachment from the situation. Secondly encounter reaction is experienced. This is characterized by disorganized thinking and feeling of loss, grief, helplessness and despair. Thirdly is experienced the process of coping with diagnosis. This is characterized by denial of the problem and its implications and a retreat into the self. (Orgen, 1996)

We know psychological effect of DM for a long time. Chronic disease is diagnosed patient are often in a state of crisis marked by physical, social and psychological disequilibrium. They may in experience intense feeling of disorganization anxiety fear and other emotions. (Taylor, 1986)

The diagnosis of a chronic illness and the life it produces often create psychological problems for patients. We will examine the frequency and function of different emotions reaction to chronic illness (Taylor, 1986).

Some researches show that there are two general areas explain related to each other and interactions between the emotional and physical functioning. The first is emotional states their role the development or exacerbation of certain illnesses. The second area is impact of coping on illness. The discussion on coping will deal with day- to-day responses to stressful events, attitudes, perceptions and the use of religions and social support. There have similarities between emotion state and coping, the coping research tends to focus on responses of the persons assessed to e psychologically (and sometimes physically) healthy (Greenberg, 2007).

1.7 Psychological Effects of DM

DM is chronic physical disorder but diabetes cause physiological, emotion, social, psychosexual problems. DM is associated with increased risk of psychological disturbance. The DM will effect the way you and your family life. The first step they take will probably involve simple changes in our lifestyle, rather than medical treatment. The second step emotional and social support is important to all people (Drum and Zierenberg, 1996). Psychological factor effect the diabetes treatment and care also effect the onset of the DM. (Robertson).

1.7.1 Depression

A depression is a more extreme condition, experiences little interest, pleasure, motivation, activity, or ability to concentrate (Kalat, 2008). Many researches show that depression is more prevalent in diabetic patient. Depression is common response to chronic illness. The prevalence of depression in the types II DM patients was significantly higher than the normal population. Lifetime prevalence of depression in type II DM was found to be as high as 30 % (Eren and et all, 2008). Depression is increase risk for complications of the metabolic disorder (Anderson and et all, 2001). Depression is uniquely important in diabetes because it's associated with poor glycemic control increase risk for retinopathy and cardiovascular disease (Lustman, 1998)

Some researches have found strong relationship between depressive symptoms and hemoglobin. They found a correlation between symptoms and HbA1c in patients with Type I diabetes but no significant correlation in patients with type II diabetes (Georgiades, 2000).

Lawrence used 2672 youth in 4 American Indian Populations with diabetes. The study is prevalence and correlated of depression among youth with diabetes. The search results is female had a higher depression level than males. After adjusting for demographic factors and duration of diabetes, they found the prevalence of depression mood to be higher among males type II diabetes than those with type I DM (Lawrence and et all, 2006).

If we are comparing with type I and type II depression levels; depression level is lower in type 1 vs. type 2 diabetes. And women had increase prevalence than men (Anderson and et all, 2001). Younger diabetics are more increase incidence than

older diabetics. Both younger diabetics are increase depression rate (Lee and et all, 2009).

Gülseren and colleagues are research to depression and anxiety level of DM patient. Major depressive disorders (DSM_IV) are diagnosed in an average of 15% of DM patient in this research. Age and DM duration predict anxiety level of DM. If the patients have complication, they have high level of depression symptoms (Gülseren 2001).

Depressive symptoms effect of the DM patients hospitalization level. The presence of depression was of the best predictors of hospitalization among adult patient with diabetes. The study is report the relationship between depression and hospitalization among adolescent with diabetes. Depressive episode lasted longer among youths with diabetes than among psychiatric control subjects who were otherwise medically well. Depression does not appear to act entirely through decreased metabolic control. They found relationship between self-report symptoms of depression and hospitalization among adolescence with diabetes. (Stweth et all, 2005).

Higher depression levels of depression are significantly associated with greater diabetes symptom reporting, lower diabetes self- care, and lower physical functioning in type 2 diabetes (Eren and et all, 2008).

Depression and social support has relationship. Social support is beneficial to health Social support buffers against the development of depression as well as against lie stressor. Social support have relationships maintain a positive attitudes and beneficial from their illness tend to have better psychological and physical outcomes. Religion is coping with illness as well as its potential buffering effect against

depression. Religion can be used increase one's social support network (Greenberg, 2007).

Bowser et all research show us length of medical treatment was found to be significantly longer among with depression compared without depression. If the patients have diabetes for a longer time increases the risk of depression (Bowser, 2009).

1.7.2 Decrease of quality of life

The other response is quality of life. DM patient are also at high risk for impairment of quality of life (Sundaram, 2007). Chronic illnesses can affect the patient's quality of life.

Anxiety and depression can negative effect of the DM patient (Gülseren, 2001). Anxiety and depression can affect the quality of life. Some study shows us quality of life and glycemic control has relationship (Sundaram, 2007).
DM has negative effect of the patient. DM can have considerable consequences on the quality of everyday life, with possible limitation in physical activity, social life, family relations and other activity. Eren and colleague's study depression on quality of life. However, major depression is psychiatric disorder that affects the quality of everyday life. Study has 108 samples. 60 patients met the criteria DSM-IV diagnostic criteria for major depressive episode and 48 patients did not have major depressive episode. There were no statistically significant differences between the ages and years of education among depressive and non- depressive groups. These were negative correlations between HbA1c, an indicator of metabolic control, and quality of life. The difference in the duration of diabetes between groups was statistically insignificant. This study shows that the presence depression in DM has a negative effect on the quality of life of the patient, independent of the impact of the physical

illness itself. Treating depression will increase quality of life. Treating of the depression has positive effect on the quality of patients' life (Eren and et all, 2008).

Jacobson and other's research effect of psychological disorder and symptoms quality of life patient with type I and type II DM. Chronic illnesses are decreased quality of life. These were correlations between diabetes mellitus, and psychiatric symptoms and quality of life. (Jacobson and Groat, 1997)

Social support is increase of the quality of life. Social support can be thought of as physical and emotional help that is available to us in our environment (Greenberg, 2007). When the people has a chronic illnesses, they social support need is increase.

1.7.3 Anxiety

A chronic illness, anxiety is also a common response. The Anxiety prevalence rate is 40% for DM patient (Bahar et all, 2006). Anxiety disorders being more commonly diagnosed than in the general population (Tuncay and et all, 2008). Tuncay and other's research relationship between anxiety, coping strategies. They use 161 Turkish adults both types of DM. 79 % of the participant in this study experienced anxiety related to their diabetes. The mean treat anxiety scores were positively correlated with gender, education status and socioeconomic status. Males had higher levels of anxiety than females. Higher decree of education had more anxiety than those with less education. Who have higher socioeconomic status had higher levels of anxiety of than individual less socioeconomic status. Sociodemographic factors account for much of the risk differential among people with diabetes. The problem-focused coping strategies most frequently used (Tuncay and et all, 2008).

Type I DM is increase prevalence of anxiety and depression from childhood into older age. One- third of young adults with type I DM experience considerable psychological distress, including symptoms of depression. Relationship between increased psychological distress and poorer glycemic control is control is preserved in young adults. In this study reported a prevalence of 16% for anxiety and depression 113 young adult with type I DM. They found who reported no severe hypoglycaemic episodes in the past month experience better psychological health. They found relationship between hypoglycaemia and mood / mental health (Hislop and et all, 2008).

Anxiety and stress can affect glycemic control. Sultan and other's study of coping, anxiety and glycemic control. They used 115 patients with types I DM. They found that for people with high trait anxiety, emotion-oriented coping strategies appear beneficial to long-term glycemic control, in a range which is clinically significant when score were low. The relation coping and glycemic control and anxiety are all the more important since several intervention programs have proved to be efficient in modifying coping skills (Sultan and et all, 2008).

Emotional and social support is important. After the diagnosis of diabetes, some new problems in your family and social. You may need psychological treatment or counseling help (Drum and Zierenberg, 1997).

Incedayı's study adolescence problem solving effect on the metabolic control of the DM in Cyprus. Type I DM adolescence has good problem solving. If the adolescence has good problem solving, they have self trust, self control, and little intrapersonal problem, good physical and psychological condition. This research results is metabolic control was effected by a lot factors such as problem solving skill and diabetic responsibility behavior, the effects of problem solving skills to metabolic control is not significantly differences in type I DM (Incedayı, 2007).

The age is increase while depression and anxiety is level increase. Single patient anxiety and depression point is high than married patient. But they have not significant correlation (Yuksel, 2007).

Bahar and others is research level of anxiety and depression of DM patient. They used hospital anxiety and depression scale. They found significant relationship between hospital anxiety and depression scale and age, gender, education, profession, economic status, staying at hospital due to DM and knowledge about illness was determined. The age and education level are increase while the depression level is increase. Depression treatment is important. Because of depression can affect glycemic control (Bahar et all, 2006).

1.7.4 Stress

Stress is a person's response to events that are threatening or challenging. (Feldman, 2005). Stress is most prevalent in general population and diabetic population (Cryer, 1996). Stress effects control of the hormones and self-management activities. Many researches shows us stress can affect glycaemic control. Stress and DM has relationship and stress is increase the diagnosed (Soo and Lam, 2009). Stress increases risk for DM. (Salleh, 2008)

Stress is effected blood glucose control. Stress is effected the patient take care yourself. On the other hand, stress is effected patient's hormone balance. These hormones get their body ready quick action by breaking down stores forms glucose into the blood glucose. This sends their blood glucose levels up (Cryer and Childs, 1996).

Stress is impaired the blood glucose control. If the person has stress, they do not feel hungry but they want to eat. For this reason is increased the cortisone and adrenaline hormones. Cortisone send message to brain and increase the appetite. And increase the blood glucose and blood pressure. Stress effect of the onset of the DM (Kumcağız, 2007).

Stress is part of the life. Stress is necessary to our life. But when the stress level is increase, these made negative effective the person. For example; some person may become a very stressed when trying to complete a difficult math problem; other person may find the activity fun and challenging (Greenberg, 2007).

Stress can negative effect the diabetes and severity to diabetes. Stress can affect way of the autonomy nervous system to diabetic control and can decrease of diabetic control. (Robertson).

In people with diabetes, stress can alter blood glucose levels. People under stress may not take good care of themselves. They may drink more alcohol or exercise less. They may forget, or not have time, to check their glucose levels or plan good meals. Stress may also alter blood glucose levels directly (Soo and Lam, 2009).
Chronic psychological stress has been associated with higher levels of HbA1c (which means poor blood glucose level control). And Stress can affect the onset of the DM; both type I and type II (Lloyd, 2005).

Stress management programs have been used effectively DM, medical conditions cardiovascular and cancer in group interventions. Stress management should be beneficial in diabetes management. Relaxation training and biofeedback are beneficial the psychological arousal and subsequent influence on metabolic control (Soo and Lam, 2009).

1.8 DM and Psychosocial Factors

DM disease causes the many difficulties the diabetic patient. These difficulties make negative effect the psychological factor to diabetics.

When the education levels is increase, the diabetes and rate of the glucose tolerance disease is decrease. The economic status is increase while DM rate is decrease. When the women have 4 and more child, the diabetes and rate of the glucose tolerance levels is increases. When the weight is increase, the DM and hypertension risk is increase (Kadem, 2008)

2. PSYCHOLOGICAL HELP FOR DM PATIENT

Psychological help for the DM patient made different approach. May be individuals help the diabetes mellitus patients or may be help for group training.

Group intervention is part of the DM treatment. Psychological group intervention is effectiveness. In patients with chronic illness, group intervention has become popular. Group intervention has requirements to chronic illness. Group intervention is superior to individual education. Group interventions advantages are obtaining emotional support from other people similar experiences and use experiences of others as a model. For the diabetics educations probability used group intervention or individual education. Education is most important to DM care and DM treatment (Ven, 2005).

Group intervention can be delivered by professionals with psychologists, diabetes educator/nurse specialists, doctors and social workers. The goals of the cognitive behavioral group training (GBGT) is to help to cope more effectively with their

diabetes regimen, in order to improve glycaemic control, without compromising, and possibly enhancing, psychological well-being. Cognitive and behavioral techniques are used to help patient to diminish diabetes-related distress, to reduce perceived barriers to various aspect of self-management and to enhance coping skills. This should result in improved self-care behaviour and consequently in improved glycaemic control. The effect of CBGT will be described in terms of changes in diabetes-related psychological functioning (emotional distress, coping behaviour), perceived barriers, self-care, glycaemic control and emotional well-being. CBCT appears to be successful in improving HbA1c while reducing diabetes-related distress and preserving well-being (Scoek and Skinner, 2000).

Lustman and others are researches cognitive behavior for depression in type II DM patients. This research shows us cognitive behavioral therapy (CBT) is effect non-drug treatment for major depression. Depression level is decreasing %70, 8. The difference in efficacy in the CBT and control group was clinically significant. CBT-treated patient showed lower HbA1c than control group (Lustman, 1998).

Cook and colleagues research are diabetes education program effecting to adolescence problem-solving and A1C levels. There was significantly differences experimental group blood glucose level compared with the control group. There was significantly increase in their problem-solving scores and significantly decrease blood glucose (Cook and et all, 2002).

Cognitive behavioral methods make changes negative attitudes towards diabetes a modified self-management behaviors and metabolic control (Soo and Lam, 2009).

Self-management, psychological factors, coping, quality of life and metabolic control has relationship.

3. POSITIVE PSYCHOTHERAPY

Positive psychotherapy is a short-term psychotherapeutic method, with a psychodynamic model, a humanistic world-view, and a transcultural approach. It has been developed since 1968 by Dr. Nossrat Peseschkian.

3.1 How Did Positive Psychotherapy Arise?

Since 1968 he has been working on a new concept of psychohygiene and psychotherapy, differentiation analysis. He may have been motivated in part by the fact that to a certain degree he lives in transcultural situation. As a Persian (Iranian) he has lived Europe since 1954. This perspective made his aware of the importance of psychosocial norms in socialization and the development of spiritual and interpersonal conflicts.

3.2 The Balance Model in Positive Psychotherapy

Human life is conceptualized in terms of four dimensions of human existence: Body/senses, Work/achievement, Contact/relationship, Future/ spirituality. When conflicts arise people tend to favor a particular dimension to deal with the problem. Some individuals react by developing physical symptoms, others escape into fantasy. Life-Balance means to gain self-esteem from all these four qualities of life.

Shame 1. Schematic Overview of Escaping Reactions into Four Dimensions

Body/sense

Future/spirituality Work/achievement

Contact/relationship

These forms for processing our conflicts are relatively broad categories that each person establishes with his own ideas, wishes, and conflicts. Each person develops his own preferences for dealing with problems that arise. Through hypertrophy of one way of dealing with conflict, the other forms fade into the background. The choice of one particular form depends to a extent on the individual's learning experiences, especially ones stemming from childhood. The four forms of reaction are modeled in the concrete life situation as typical concepts (Peseschkian, 1996).

Body/ senses:

This part is important of the body. How does one perceive his body? Physical reactions to conflict are: physical activity, eating, sex, disorders of bodily functions and psychosomatic reactions.

Work/Achievement:

It includes the way the norms of achievement are defined and incorporated into one's self-concept. Though and reason make it possible to solve problems in a systematic, conscious way and to optimized achievement.

Contact/tradition:

This area comprises the ability to develop and maintain relationships: with oneself, one's mate, family, other people, groups, social classes, and foreign cultural circles and animals, plants and things. Patterns of social behavior are characterized by individual experiences and by tradition. Our possibilities for forming contacts and the socially acquired criteria that govern them are regulated: one expects his partner to show, e.g., politeness, honesty, order; activity in certain areas of interest, et cetera and one seeks partners who match these criteria in some way.

Fantasy / contact / relationship:

Intuition seems related to the psychic process of the dream or fantasy- processes that can also represent a way of dealing with problems and conflicts. One can also represent to conflicts by activating one's fantasy-by fantasizing about the antagonist solution, by imagining the desired results, by picturing that the antagonist is published or even killed.

They can follow this phase of treatment plan: first phase is Observation and Description. An account is given, preferably in writing, as to the reason for being upset, who caused it, and when. Second phase is Inventory. By using the differentiation analysis, they determine the areas of conduct where the patient himself and partner have positive qualities as well as the ones under criticism. In this way, we

can counter the tendency toward generalizations. Third phase is Situational Encouragement. To build up a trusting relationships strengthen individual traits that we find acceptable and that correspond to the negatively labeled traits. The forth phase is Verbalization. To overcome speechlessness or the distortion of speech the conflict, communication with the partner is developed step by stem. There are discussions about positive as well as negative traits and experiences. The last phase is Broadening of the Goal. The neurotic narrowness of perspective consciously broken down. One learns not to carry the conflict over other areas. At same time, one learns to open up new goals that perhaps never been experiences before. The treatment is thus based two procedures that run parallel and are intertwined: psychotherapy ground; self-help, whereby the patient takes over therapeutic within the circle of people he is closely involved with (Peseschkian, 1996).

3.3 The Positive Starting Point

The term 'positive psychotherapy' should point toward transcultural thinking. In accordance with its original meaning (Latin positum), 'positive' means 'factual', 'given'. Illnesses, disorders, and unsuccessful attempts to solve problems are not the only things that are factual and given, included among the givens are the capabilities and potentials that each person has, potentials that enable him to find new, different, and perhaps even better solutions. It seems especially important to remember that the patient does not just bring his illnesses with him; he also brings the ability to overcome it. It is the therapist's task to help him with this. In the positive starting point, there is an attempt to work with the patient to transmit alternative possibilities and solutions, which, till the time, lay beyond the horizon of consciousness. They enable us to change our perspective and draw on the other models of thought than which had kept us more trapped in our old conflicts in the first place (Peseschkian, 2006).

3.3 The Four Model Dimensions

The four model dimension deals with the concepts that were valid in the original family group. In developing this model, we hold to two conditions: first, the concepts must have meaning for socialization; second they must describe relationships to the environment. These concepts are transmitted by relatives such as parents, siblings, and grandparents or by people who have taken over these relatives' functions. The four model dimensions describe the pattern of family concepts in which the individual grows up in a way that reflects the individual's experience of them.

To understand the conflict, it is necessary to understand its background and the concepts involved. The development of the personality is stamped to a great degree by the person's primary social ties. We have found that it is worthwhile to use model dimension to determine why a person prefers some relationships and rejects others. The relevant information deal with the following:

- Ties that the relational person (parents) and siblings (or other playmates) have with the child ("I");
- The relationship between the parents themselves ("you");
- The parents' relationship to their environment ("we");
- The parents' relationship to religion and their philosophy of life (Primal "We").

This model is also valid if the child grows up in an incomplete family. In such a case, other people (grandparents, foster parents, or even teachers) represent the parents whose role they have more or less adopted. The stability that these relationships can develop is also included in the model.

The extent to which any of these four model dimensions is emphasized can vary with the individual. They are touched upon during the initial interview, but the problems they bring to light must be treated more extensively if and when therapy takes place later on.

Schema 2. Model Functions in the Development of the Four Models

Parents/Sibling

I

Parent/ parent
religion between original-we you
themselves

Parents/Environment We

Relationship to I (parents/sibling –child):
The model dimension for the relationship to the I is the relationships to parents and siblings. The relationship of a person to himself depends particularly on how his desires and needs are satisfied. For example, for the self-image, the self-evaluation, and self trust.

Relationship to You (parents between them):

The relationship to you is already preformed through the experiences of the symbiotic mother-child relationship. The close emotional relationship between parents and child is especially favorable to imitation of this model. The relationship to “I” that forms here is the initial stage of a differentiated relationship to one’s partner. An emotional relationship like this, which can be describe with terms like affection, love and community, marks the relationship to you.

Relationship to We (parents –environment):

The parents are a model for outside contacts. But the parental model is not only determinant for the relationship to the societal environment. They invite their friends or they are invited, take part social events, meet old friends, have discussion in or out family members. Other people that a child has contact in the course of his development influence his understanding of interpersonal relationship. The role, which is given to a person by family, has influence in the work place in the social dynamics.

Relationship to the Origin-We (parent-religion/ philosophy of life):

This dimension of human development is the relationship to the ideological construct that is termed the “Primal We”. This concept refers to the fact that our perception and actions all take place within a system that is culturally transmitted. The person’s relationship to the “primal we” depends first of all on the parents attitudes religion and philosophy.

Although the uniqueness of the family, the family does not create its own laws. The family is connected to the rules, orders, and laws set by social, religious, and political groups and institutions. The existing order determines the relationship to parents,

sibling, contact outside the family, opportunities for selecting a partner, and the definition a friend (Peseschkian, 1996).

3.4 Use of Stories

Stories offer give us process of thinking in new ways. The linearity of logical thought does not lead us out of our problems often enough. In fact, as paradoxical as it may seem, such thought often intensifies the problem. Stories, on the other hand, present solutions that are unexpected and baffling but nonetheless "real" and "positive". Although they seem to contradict logic and custom, they can enable us to take a giant leap out of the cage of out conflicts.

Stories can work in many ways. We were interested mainly in those functions that dealt with the origin and evolution of concepts and their educational or therapeutic meaning. In this respect, we stayed with four areas that represented the main centers of conflict: the relationship to one's body; the relationship to achievement / career; the relationship to other people and groups (contact/ tradition); and the relationship to intuition, fantasy, and the future.

Stories seem to belong to two different groups:

a. Stories that stabilize the existing norms;
b. Stories that relativize existing norms.

Despite all their contradictions, these two goals are not mutually exclusive. For one thing, the "lessons" of the story depend to a great extent on how the reader reflects on them. And second, the relavitization of individual norms, the "change in perspective," does not take place free of values, but in view of other values which the person holds. The reverse is also true. Emphasis on prevailing norms means that other views are called into question or are repudiated. In human interactions as well

as in experience and its mental processing, there are certain processes linked to the confrontation with stories. We describe these processes as the “functions” of stories.

The Mirror Function: The abundance of images in stories makes their contents seem closer to the ego and thus helps the reader identify with them more easily. He can Project his needs onto the story and can shape its meanings in a way that matches his own psychic structures at that time. These reactions, for their part, can become objects of the therapeutic work. By associating with a story, the patient talks about himself, his conflict, his wishes. Comprehension and receptivity to the stories are made easier by drawing on the patient’s fantasies and memories. Separated from the direct world of experience, stories, if used intentionally, can help lead the patient to a distanced relationship to his conflicts. In this way, he is no longer victim of his illness; he can take a position with regard to his conflicts and to the customary solutions, which are themselves full of conflict. The story becomes a mirror that reflects and can be reflected.

The Model Function*:* Stories are model. They reproduce conflict situations and reveal possible solutions, *i.e.,* they point to the results of individual attempts to resolve the conflicts. They promote learning by working with the model. But this model is not rigid. It contains a number of possible interpretations and connections to the situation at hand. Stories provide a test situation, where we can try out unusual answers in out thoughts and feelings and then apply them to our conflicts it an experimental way.

The Mediator Function: Patients demand a high price for their basic ideas and personal mythologies. Rightly or wrongly, these ideas eventually help them come to terms with existing conflicts. This is especially true if a patient is not really sure that the therapist can offer him something of equal or greater value. The patient develops opposition and defense mechanisms that can hinder the therapeutic process on the

one hand, but can also provide an entry into the conflict, provided they can be recognized clearly enough.

In the therapy situation, the confrontation between therapist and patient is broken down by the presence of stories as an intermediary between these two fronts. It is a sign of respect for the patient and speaks to his narcissistic wishes. The subject of conversation is not the patient, who would have to produce symptomatic behavior, bu the hero of the story. In this way, a three-sided process begins: *patient-story-therapist.* The story takes on the functional role of a filter.

The Repository Effect*:* Because of their imagery, stories can be easily retained and put into operation in other situations. They are present in the patient's daily life as well as in his treatment, regardless of whether a similar situation calls them to mind or whether there is a need to work through questions that the story has evoked. Under different circumstances the patient can interpret the story differently. He enlarges the story's original meaning and actualizes new concepts that help to differentiate his own mythology. In this sense, the story Works as a storehouse. It affects the patient over a long period of time and makes him independent of the therapist.

Stories as Transmitters of Tradition.: Stories transmit tradition, regardless of what the tradition is: culture, family, society, or individual tradition as the results of one's own experience. A story thus goes beyond a momentary individual life and transmits thoughts, reflection and associations. Passed from generations to generations, stories always seem to be the same. But, depending on the person who hears them, they take on a new, perhaps unknown, meaning. If we turn our attention to the content of stories and the concepts they contain, we can finds attitudes and patterns of behavior that from the basis for a unique tradition of neurotic behavior and susceptibility to conflict.

Stories of as an Aid to Regression: The atmosphere in which stories are told is not dry, abstract, or marked by wide chasms between therapist and patient. On the contrary, the atmosphere is generally open, friendly, and cooperative. The medium that is addressed by them is intuition and fantasy takes on the meaning regression, backslide into an early phase of development.

Stories as counter- concepts: Stories are therefore can thus intervene one- sidedly into a conflict.

Change of Perspective: Most of our stories go beyond pure description and certain a reverse experience such as we know from optical illusions. Without expending a lot of effort, the hearer or listener gains a change of perspective, which comes as a surprise to him and elicits a reaction of ‘Aha!’(Peseschkian, 2006).

4. METHOD OF THE STUDY

4.1 The Importance of the Study

DM is one of the most common chronic illnesses. DM can affect the diabetic patient's life at many dimensions. And also the life style of the patient and the psychological factors in his life can effect the course of DM and the success of its treatment. Being aware of these psychological factors and taking preventive measures can affect diabetic care in a positive way.

4.2 Aim of the Study

The aim of this study is to apply group training to DM patients with concept of Positive Psychotherapy and to investigate its perceived effects in their lives. Especially the 'Balance Model' is expected to be a helpful device for DM patients to organize their lives and to have better adaptation to treatment.

4.3 Study Group

The sample of this study was formed from 10 participants. The study was announced to the members of the Cyprus Turkish Diabetes Association. We took the associate's member list of DM patients in Cengiz Topel Hospital in Lefke in TRNC. We telephoned to all 32 people from this list. And we gave information about this study.

10 people agreed to participate the group study. One of the participants came to only one group and then he left the study without mentioning any reason. Then this group continued with 9 participants. There were 2 male and 7 female participants. The mean of their age was 49.50±. The age range was between 29-70.

4.4 Application

After the beginning of the study informed consent was taken from the participants. Participants were informed about the study. This group training consisted 2 hours sessions delivered every week for 5 times. Every Thursday the group met between 17.00-19.00 in Güzeyurt Hotel which is a supporter of activities of Cyprus Turkish Diabetes Association.

THE FIRST GROUP TRAINING WORK

At the first session, participants had been given detailed information about the group training work. They listened the purpose of the practice, rules and advantages they can obtain from the group.

After group members met with each other, psychological factors which affect DM have been explained to them. It has been emphasized that DM is an illness that affects patients' whole life and besides it is a physical illness it also forms changes of patients' psychological states. It has been explained that psychological factors affect blood glucose control and they discussed this in the group. DM is a new life experience for the patients and it requires adaptation effort, along with these it can cause problems and conflicts. They discussed that those issues can affect blood glucose control psychologically.

It has been explained that stress is one of the most common psychological factors which affects DM. It has been explained that the stress affects DM and they

discussed this in group. It has been emphasized that stress is an important factor that disrupts the blood glucose control and also it has been indicated that the stress issue will be discussed elaborately at the second group work.
After that, they discussed the depression issue which is one of the most common psychological problems that is seen along with DM. It has been explained that depression affects DM patients. It has been emphasized that depression affects patients' adaptation of the illness, quality of life, treatment adaptation, respond to the treatment and the course of the disease negatively. The target is to inform the patients and create awareness about this matter.

The matter of who's ill and who's healthy has been discussed with the participants by positive psychotherapy approach. It has been emphasized that a healthy person is not an unproblematic person; a healthy person is a person who can deal with problems. The aim is, to change the DM patients' perception of considering themself as ill and make them notice that if they get through DM well, they will be healthy.

'Balance Model', which is one of the fundamental conceptions of positive psychotherapy, has been explained to the participants. It has been explained to the participants that practice and Balance Model consists of the fields of body, achievement, contact and future (imagination, instinct). Participants were asked for drawing their own Balance Models and they discussed this in group. The aim is to see how the participants perceive both themselves and their environment at this four fields by the Balance Model.

SECOND GROUP TRAINING WORK

This session has started with a reading called 'About the Courage to risk a test' (pp. 52). The participants were asked what they felt about the story, the aim is to make them discuss this in group. In positive psychotherapy, stories are very important. The

aim is to benefit from stories' specialties of providing a solution which is unexpected and amazing but at the same time 'real and positive'. The target is to benefit from stories' model quality and their quality of bringing up the conflict situation again and introducing possible solutions. The expectation from the story is to help the participants gain a different point of view so that they can find new solutions.

Afterwards they moved on to another subject which was: stress and how to deal with it, as was mentioned last week. Stress was explained to the participants. In group, they discussed what sort of changes occur in case of stress, especially causes of stress and if positive situations cause stress or not. It has been pointed out that, individual differences are important when stress appears.

They discussed the affect of stress on blood glucose control. It has been emphasized that, stress is an important factor which disrupts blood glucose control, when someone is stressful it can rise of his blood glucose level. In a stressful situation, hormones of cortisol and adrenaline rise up. Cortisol hormone sends signal to the brain and increases appetite and rises up the blood glucose and tension.

It has been emphasized that stress is a natural part of life; it is not possible to purify life out of stress but that the important thing is to learn how to interpret and respond to the stress. The target is to make the DM patients notice a stressful situation and deal with it effectively. In order to help the participants to cope up with stress effectively, they were taught breathing exercises and muscle relaxation exercises.

THE THIRD GROUP TRAINING WORK

After sharing impressions about the previous session, they read the story of 'The Crow and the Parrot' (pp. 53). The purpose of reading this story is to make DM patients notice the characteristics that they ignore, just like the crow which ignores

the peacock's positive characteristics'. They mentioned sharing's about DM patients' feelings and thoughts when they first found about the diabetes diagnosis. The aim was to help them notice how they feel about the DM and the feelings that this illness can affect their life.

The aim is to make them understand if there is any change with their feelings and thoughts about the diabetes between the feelings they felt when they first found out that they had diabetes and the feelings they feel now after that they shared their feelings.

After that, they discussed how the diabetes affected their life in the last five years by using the Balance Model. According to the Balance Model, every participant exposed how the DM affected the fields of body, achievement, contact (relationships) and the future in last five years and they discussed this in group.

THE FOURTH GROUP TRAINING WORK

The Fourth session has started with sharing impressions about the previous session. Participants discussed how the DM affected their life and how this illness added positive things to their lives. They discussed that every illness gives a message to individuals and also they discussed what the illness expressed. It has been emphasized that the interpretation of the illness by the patient and the approach of the family to the illness is important. For example, they discussed about a person who starves during the day and has a malnutrition and if those issues mean anything or not when this person becomes a diabetic. In group, they indicated that this is a message for gaining a balanced diet habit. The target here is, to help patients improve alternative behaviors against their illnesses and adjust easier to the treatment.

‘Model Dimensions’ has been discussed for the rest of the session. Participants have determined their own Model Dimensions and they discussed these models in group. The aim was reflecting the participants’ family concept which they were brought up and their experiences belonging these concepts by using the Model Dimensions.

THE FIFTH GROUP TRAINING WORK

They started the last session with a summary of all the groups. The participants told their feelings and thoughts about these meetings. They were asked to evaluate their experiences, the information they learned and the contribution they got from the group. Here, the aim was to make the participants notice each others feelings and thoughts.

After sharing the participants’ feelings and thoughts, the group work was finished with the muscle relaxation exercise. The aim was to make the participants leave the group with relieved and positive feelings.

4.5 Material/ instrument

To evaluate the effects of this study, an evaluation form was used. This form investigated the changes that people realize after group training, and what caused these changes and what the group found to be useful and useless. The aim of the evaluation form is to enable the participants to express their opinions about this study in their own words.

5. RESULTS

The research group consists of 2 male and 7 female patients. Total is 9 participants. All the participants had type II DM.

Table 1. Education level frequency

	Female		Male	
	n	(%)	n	(%)
Primary School	4	(50)	1	(50)
Secondary School	2	(33.3)	0	(0)
High school	1	(16.7)	1	(50)
Total	7	(100)	2	(100)

(P=0.513)

When compare the education level of diabetic patient's according to gender by chi-square analysis, we find no statistically differences between the male and female participants (p=0.513).

Question 1. Can you express your feelings about joining this study?

Participants were asked to evaluate the group study. Some participant think about this study is useful. Some participants think this study gives different information about DM. A participant mentioned he felt something but he couldn't explain it. Some participants realized that they felt relaxed in this group. Most of the participant thought that the group was useful

Question 2. What kind of changes did you realize since you have started this group? (If there are any)

Participants evaluated the differences. Some participants learned different information about DM. Some participants thought that there weren't any differences. They emphasized this group changed their ideas for DM diseases.

Question 3. Were these changes important and meaningful?

Most of the participants said that changes were important and meaningful but some participants said that the changes were not important and meaningless. 70 % of the participants experienced differences and these differences were very important.

Question 3a. Did you expect these changes?

All participants expected these changes.

Question 3b. If there wasn't this group, would these changes happen?

The participants told that the group caused 60 % the changes. But some participants told that if this group didn't exist, these changes would happen.

Question 4. Was this group beneficial?

This group was found very beneficial by 70 % of the participants. And some participants thought that this group was little useful. But none of the participants evaluated this group as useless.

Question 5. Did the group give benefit for your DM treatment?

The sessions didn't change their blood glucose level. And they did not distinguish changes. Some participants evaluated that the group was beneficial for their diabetes. Because they learned to behave more carefully. Some participants' evaluated diabetes was a very different disease. Because DM is never cured. DM lives with you all of your life. For this reason, the person is very irritable. But after this group she felt some relaxation.

Question 6. Can you sum up the benefits of this group?

This group study gave awareness about why their diabetes started. Participants said that balance model was important. They learned sport, family and carrier must be balanced. Some participants thought that this session wasn't useful for him but it was useful for other participants. Some participants evaluated that the stress session was very effective. The session changed their thoughts. They learned to behave relaxed.

Question 7. After the group, did your thoughts change about the DM?

Participant evaluated DM related thought; this group gave more different information. This group was beneficial. Other participants said that this group was beneficial. If DM was considered as a disease, this disease wasn't a very big disease.

Question 8.Did any negative change happen since you have started the group?

All of the participants said after this group there wasn't any negative change.

Question 9. Was there anything incomplete for you in the group?

The participants evaluated this group didn't have anything missing.

Question 10. Did you have any suggestions about the group?

The participants made some suggestions. Such this group should be made occasionally.

6. DISCUSSION

Our study shows that group training affect the diabetics' lives. The participants have awareness of the psychological factors on diabetes in these group training. We apply group training to DM patients with concepts of Positive Psychotherapy. Participants evaluated this group training gave benefit to their lives.

Our study shows that the group training combined with diabetes group training is effective on the DM patients lives. The finding DM patients gave benefit to group training of their lives.

Participants would like to use the balance model. Balance model has a very important role in positive psychotherapy. Balance model is important for all people and especially for DM patients as DM affects patients' body, social life, achievement and future. When patients learn about this model, they gain some different perspective for

their lives. The balance model despite all culture and social differences and the uniqueness of each individual, we can observe that all people rely on four methods for dealing with the conflict (Peseschkian, 1996).

Participants liked the stress training; breathing exercises and relaxation exercises for cope up with to stress. Stress may have more prevalence in DM patients that in general population Stress is the most important problem in modern population. Stress affects the blood glucose control in diabetes mellitus patients. And stress training gives benefit to DM patients lives. When they learn how to cope up with stress, this results with better glucose control. For this reason, they may like this stress session (Cryer and Childs, 1996).

Psychological group training is important role in the DM patients' treatment. Because psychological factors affect patients' lives and orientation to treatment. Kumcağız investigated the effects of psychological group counseling on hopelessness level of DM. Psychological group counseling has significant effect of the hopelessness level of the DM. They compared the experimental and control group motivation levels. It has been concluded that group counseling has lowered the level of hopelessness in diabetics (Kumcağız, 2007).

Psychological support is important for the DM control and increase the quality of life. This research result shows us this. Because of the group training made social and psychological support. Social and psychological support is potential buffer effect of the DM patients' life. (Greenberg, 2007)

DM disease affects and restricts the patient's lives. Psychological support is important for DM patients. And DM patient has education and psychological training. The aim of our study was to give psychological training to DM patients.

Because psychological factor was most affect the DM patient's lives and psychological factor increased complication risks (Sundaram, 2007).

Cook and colleagues research support this study. Cook and colleagues made 6 week problem solving diabetes education. They had two groups. Experimental group and control group. They compared the experimental and control group. The experimental group participant showed significantly improves problem solving test score.

Snock and Skinner emphasized the DM relation to psychological functioning. The cognitive behavioral group training is a very effective on the control of blood glucose, depression, coping up with stress, well- being. And patient has benefit to cognitive behavioral group training. For this reason, emphasized the importance of the individual or group psychological help to diabetics' lives (Snock and Skinner, 2000).

Lustman and colleagues investigated the effects of Cognitive Behavioral Therapy for depression in diabetes mellitus patients. Their study shows that CBT with combined diabetes education is an effective the nonpharmacologic treatment for major depression in the patients with diabetes. Their finding of depression level is decrease in 70.8 %. The difference in efficacy in the CBT and control groups was also clinically significant (Lustman, 1998).

7. Conclusion

This study investigates the effects of the group training with concepts positive psychotherapy on DM Patients. Especially 'Balance Model' and Stress Training were applied. This study investigates if Positive Psychotherapy is a helpful device for DM patients to organize their lives and to have better adaptation to treatment. Group training gave awareness of the patient negative feelings and thoughts, cope up with this, control to disease's and increase of quality of lives.

Our study shows that the group training is effective on the DM patients lives. DM patients found group training effective on their lives. This study once again emphasize psychological factors is important and effective to diabetes mellitus patients.

Giving training about psychological factors during the treatment of DM patients may improve success of treatment and methods of Positive Psychotherapy can be used in such training programs.

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Appendixes 1

Değerlendirme Formu

Bu değerlendirme formunun ana konuları gruba başladığınızdan beri farkettiğiniz değişiklikler, bu değişiklikleri neyin ortaya çıkardığına ilişkin inançlarınız ve grubun yararlı ve yararlı olmayan yanlarıdır. Lütfen bize olabildiğince çok ayrıntı anlatınız.

Sorular:

1. Böyle bir araştırma grubuna katılmak size ne hissettirdi?

2. Eğer varsa gruba başladığınızdan beri sizde ne <u>değişiklikler</u> oldu?

3. Kişisel olarak, bu değişikliğin sizin için ne kadar <u>önemli</u> veya <u>anlamlı</u> olduğunu düşünüyorsunuz? (Bu ölçüm ölçeğiniz kullanınız:)

a. Hiç önemli değil
b. Biraz önemli
c. Orta derecede önemli
d. Çok önemli
e. Aşırı derecede önemli

3a. Her bir değişiklik için bunu ne kadar beklediğiniz, ne kadar şaşırtıcı olduğunu belirtiniz. (Aşağıdaki ölçüm ölçeğini kullanınız:)

(1) Bunu çok bekliyordum
(2) Bir şekilde bekliyordum.
(3) Ne bekliyordum ne de sürpriz oldu

(4) Bir şekilde şaşırdım.
(5) Buna çok şaşırdım.

3b. Her bir değişiklik için lütfen bunun grupta olmasaydınız ne kadar olabileceğini düşündüğünüzü ölçünüz. (Bu ölçüm ölçeğini kullanınız:)
(1) Grupta çalışılmasaydı olması olmaz gibi (açıkça olmazdı)
(2) Grupta çalışılmasaydı biraz olmaz gibi (olasılıkla olmayacaktı)
(3) Ne olur gibi ne olmaz gibi (söylenmesi zor)
(4) Grupta çalışılmasaydı da olur gibiydi (olasılıkla olacaktı)
(5) Grupta çalışılmasaydı da çok mümkündü (her şekilde olacaktı)

4. Sizce bu eğitimler ne kadar faydalı oldu?

a. Çok faydalı oldu
b. Biraz faydalı oldu
c. Orta derede faydalı oldu
d. Ne faydalı ne faydasız
e. Hiç faydalı olmadı

5. Bu grup çalışması sizce Diyabet hastalığınıza yarar sağladı mı?

6.Buraya kadar grup ile ilgili nelerin yararlı olduğunu özetleyebilir misiniz? Lütfen örnekler veriniz. (Örneğin genel özellikler, özgül olaylar.)

7. Diyabet hastalığı hakkında düşüncelerinizde grup sonrasında bir değişme oldu mu? Lütfen açıklayınız.

8. Gruba başladığınızdan beri kötüye doğru bir değişiklik oldu mu?

9. Grupta sizin için eksik olan bir şey var mıydı? (Grubu sizce daha etkin ya da yararlı yapacak şeyler neydi?)

10.Grupla ilgili olarak bize herhangi bir öneriniz var mı? Bize söylemek istediğiniz başka bir şey var mı?

Appendix 2

About the Courage to Risk a Test

A king put his court to a test for an important post. Powerful and wise men stood around him in great numbers. “You wises men,” said the king, “I have a problem, and I want to see who of you is in a position to solve it.” He led the men to a huge door, bigger than anyone had ever seen. The king explained, “Here you see the biggest and heaviest door in my kingdom. Who among you can open it?” Some of the courtiers just shook their heads. Others, who work counted among the wise men, looked at the door more closely, but admitted they couldn’t do it. When the wise men had said this, the rest of the court agreed that this problem was too hard to solve. Only one vizier went up to the door. He checked it with his eyes and fingers, tried many ways to move it, and finally pulled on it with a hefty tug. And the door opened. It at just been left ajar, not completely shut, and nothing more had been needed but the willingness to realize it and the courage to act boldly. The king spoke, “You will get the position at the court, for you don’t rely just on what you see or here; you put your own powers in to action and risk a test.”

The Crow and the Parrot

A parrot was sitting with a crow in a cage. Ah, how the poor parrot suffered from the presence of the black-feathered monster! ‘What an ugly black, what a terrible figure, what an ordinary facial expression. If a person had to look at something like that at sunrise, his whole day would be ruined. There isn’t a more disgusting companion than you anywhere.’

As strange as it may seem, the crow also suffered from the presence of the parrot. Sad and depressed, the quarreled with the stroke of fate that had brought it together with that unpleasant multi- colored comrade. ‘Why does this bad luck have to strike me? Why did my lucky star forsake me? Why did my happy days end up in such days of darkness? It would have been much more pleasant to sit on a garden wall with another crow, enjoy the things we have in common, and to be happy.’