Positive experiences of type 2 diabetes in Japanese patients: An exploratory qualitative study

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Abstract

Background: Previous research on self-management in people with diabetes mellitus mostly focused on the negative aspects of the disease, such as depression, lack of support, and psychological stress.

Objectives: The purpose of this study was to explore the existence of positive experiences in people with type 2 diabetes. ‘Positive experience’ is operationally defined as positive thoughts or good feelings in coping with diabetes expressed by the participants.

Design: An exploratory qualitative design using constant comparative method.

Method: Convenience sampling was used to recruit participants receiving care in two hospitals in Kansai area, Japan. The following eligibility criteria were used: (1) individuals diagnosed with type 2 diabetes; (2) individuals capable of conversing in Japanese; and (3) individuals receiving care at either setting. Data collection and data analysis were conducted concurrently. Each verbatim transcript was read several times, and the data were coded line by line. Codes were constantly compared with each other for similarity and dissimilarity and were grouped to form categories.

Results: Ten patients from the outpatient department and seven patients from the inpatient education program were interviewed between June and December in 2002. All the participants expressed positive experience in coping with diabetes. Three categories emerged from repeated coding: (1) positive appraisal; (2) diversion; and (3) bonding.

Conclusion: A tentative model of coping from the patient’s perspective was proposed for a future research. Asking the patient about positive experience with their illness is important to elicit positive thoughts and experience.

Keywords: Coping; Face-to-face interview; Positive experience; Type 2 diabetes; Qualitative study

What is already known about the topic?

- The majority of qualitative studies on people with type 2 diabetes mostly reported the management of the disease.
- Positive aspects were reported in patients who experienced life-threatening conditions such as myocardial infarction or cancer, but such aspects have drawn little attention in diabetes research.

What this paper adds

- Face-to-face interviews revealed specific positive experiences after they were diagnosed with diabetes.
mellitus, regardless of the duration of illness, age, and the existence of complications.
- Asking the patient about positive illness experience is important to elicit positive thoughts and experience.

1. Introduction

Quality of life research has become a major research area in the social and medical fields. Various diabetes-related quality of life scales have been developed to evaluate the effectiveness of interventions. According to Polonsky (2000), disease-specific health-related quality of life refers solely to the patient’s sense of how the disease in question is compromising their well-being across three broad areas of physical, psychological, and social functioning. These scales largely represent negative perspectives of the disease experience.

In contrast to the quantitative quality of life research, qualitative studies on people with diabetes have mainly examined the patients’ coping mechanism. In a meta-synthesis of seven qualitative studies published in the past 20 years of people with type 2 diabetes, patterns of responses to diabetes were synthesised (Campbell et al., 2003). These responses to diabetes were summarized from a health-care provider’s perspective, such as adherence and positive responses to treatment. Of the six concepts pertaining to coping, three were related to treatment, i.e., a less subservient approach to health-care providers, strategic non-compliance to medication, and effective support from health-care providers (Campbell et al., 2003).

Although a review on coping is beyond the scope of this paper, the health care provider’s perspective on the patient’s coping and its outcomes are summarized in Fig. 1. Illness experience is generally considered negative, and health care professionals work to increase the patient’s competency in self-management. Empowerment is also a construct by which health care providers assess the patient’s powerless state. Success of the intervention is generally measured in terms of treatment outcomes and patient’s satisfaction.

Coping from the patient’s perspective has been examined in recent qualitative studies, which have focused on health beliefs, the patient’s understanding of diabetes (Coronado et al., 2004; Gillibrand and Flynn, 2001; Gregory et al., 1999), or problems related to self-management (Wenzel et al., 2005; Samuel-Hodge et al., 2000; Gregory et al., 1999). The study populations mostly comprised ethnic minorities in North America, e.g., native Canadians (Gregory et al., 1999; Hernandez et al., 1999), Mexican Americans (Coronado et al., 2004; Hunt et al., 1998), African Americans (Wenzel et al., 2005; Samuel-Hodge et al., 2000), and Chinese immigrants in the United States (Jayne and Rankin, 2001). Furthermore, the researchers tended to focus on problems associated with care or self-management.

The theme of wellness was explored in an action research study carried out on six women in Australia (Koch et al., 1999). However, the participants expressed various difficulties in coping with diabetes, and a positive theme was limited to ‘taking time out’ (Koch et al., 1999). Koch and associates then pursued the theme in five male participants with diabetes (Koch et al., 2000) and found that the participants presented a view that diabetes had a positive impact on their lifestyle (Koch et al., 2000). Six themes, including ‘feeling good’ and ‘partnership’, were viewed in a positive light (Koch et al., 2000).

In a Korean qualitative study, the positive impact of diabetes was reported alongside the negative impact (Choe et al., 2001a). The positive impact was represented by overall well-being, harmonious relationships, a rewarding life, and spiritual satisfaction, while the negative impact was represented by depression, fear, lack of support, and psychological stress (Choe et al., 2001a). Descriptions of both the positive and negative impacts were limited. These two studies indicated the existence of positive impacts of chronic illnesses among people with diabetes.

Several studies have examined the positive aspects of the illness experience among people who have experienced life-threatening conditions, such as myocardial
infarction or cancer (Petrie et al., 1999; Fromm et al., 1996; Taylor, 1983). A review article also shows that positive affects were found alongside negative affects in people who were under severe and persistent stress (Folkman and Moskowitz, 2000). Study populations included hospitalized patients with severe illness, patients with spinal cord injuries and bereaved parents, and caregivers of people with AIDS. It can be concluded that positive experience in patients with type 2 diabetes mellitus has not been a major focus in qualitative or quantitative studies.

The purpose of this study was to explore the positive experience among people with type 2 diabetes by describing what the participants considered as positive while coping with diabetes after being diagnosed with the diabetes.

2. Methods

This exploratory qualitative study used the constant comparative method (Strauss and Corbin, 1990) to describe the positive experience in dealing with diabetes mellitus. The operational definition of the positive experience was the reporting by the participant of any positive thoughts or good feelings in coping with type 2 diabetes mellitus.

2.1. Data collection and analysis

Using convenient sampling, participants were recruited from two hospitals in Osaka Japan: an outpatient department in O hospital and a 10-day inpatient diabetes education program in S hospital. The eligibility criteria for the study were as follows: (1) individuals diagnosed with type 2 diabetes; and (2) individuals capable of conversing in Japanese.

The interview questions were based on some major themes in relation to the participant’s experience with diabetes, and the following questions were asked: (1) describe their life after they were diagnosed with diabetes mellitus; (2) report their feelings regarding diabetes; (3) list any barriers or obstacles they faced in relation to coping with diabetes; and (4) describe any helpful adaptation or positive experiences in coping with diabetes. After explaining the purpose of the study, the questions were asked in the order listed. The authors deemed it necessary to first ask the participant to describe their illness experience because this was the first time the interviewer had met the participants.

All the questions included under the above mentioned themes were reviewed by the co-investigator with regard to their clarity and ease of acquiring answers from them. After each interview, the content of the interview was reviewed.

The following information was extracted from the participants’ charts: demographic characteristics, medical information (type of treatment, duration of diabetes, diabetic complications, and HbA1c), and family history of diabetes.

The recorded data were transcribed verbatim within 24 h after the interview by the first author. The verbatim data were read through in order to get an overall sense of the interview. Next, the data were read line-by-line in order to identify statements related to positive experience of the impact of diabetes on the participants, and the participants’ thoughts after the diagnosis. These statements were marked, and tentative codes were written in the margin for the detection of emerging patterns. Differences and similarities between codes were compared, and codes that were similar in content were subsequently grouped and classified into various categories based on commonly shared participants’ perspectives. The codes were repeatedly reviewed to ensure consistency of the coding across all the participants. Memos were taken to document the analytic ideas and insights in the themes throughout the analysis process. To increase the validity of coding, all the transcripts and coding scheme were reviewed by the co-author and diabetes educator.

Two weeks after the interview, a mail survey containing six closed questions and one open-ended question was conducted to inquire about the interview. The content of the questions were: (1) clarity of the questions and attitude of the interviewer; (2) any changes in time spent on self-management; (3) any conversation with the family or friend about the interview; (4) any changes in thoughts or behavior regarding diabetes after the interview, and (5) current thoughts about living with diabetes.

2.2. Ethical considerations

At the time of the study, the researchers conducting qualitative studies were not required to submit proposals to the human subjects committee. The following items were explained to each eligible patient: (1) purpose of the interview; (2) its content; (3) confidentiality of the recorded information; and (4) destruction of all recorded data upon completion of the study. In addition, the participants were informed that they could quit the interview at any stage. The participants were also informed about the mail survey which they were not obligated to return. The written informed consent was obtained from all the participants, and all the interviews were recorded after obtaining the written consent.

3. Results

The first author conducted all the face-to-face interviews from 17 patients between June and December 2002, and each eligible patient participated in one interview. The researchers were not involved in the care
of the interviewees, and all the patients interviewed met
the first author for the first time at the interview.

At O hospital, patients were selected from a sequential
list of patients of the diabetes specialist. The nurse in
charge of the outpatient department invited the patients,
who had an appointment in the early afternoon when
the diabetes specialist consulted the patients, to partici-
pate in the study. One interview was conducted each
week so that recorded data could be transcribed and
reviewed. After interviewing 10 patients at O hospital,
interviews at S hospital were started. At S hospital,
patients receiving diabetes education program were
invited to participate in the study by the nurse who
was in charge of education program.

Of 17 patients interviewed, two were excluded from
the analysis because the spouse was present during the
interview, and the spouse answered part of the
questions. The characteristics of the participants are
listed in Table 1. The average interview duration was
59 min; the longest interview lasted for 89 min and the
shortest, 33 min.

We extracted words that were considered to indicate
‘positive experience’ based on the operational definition;
a total of 62 codes indicating positive experiences were
extracted. Although the participants expressed various
problems in coping with diabetes, only the positive
experiences were included in the analysis. These codes
were then grouped to obtain seven subcategories that
were further grouped into categories based on the
similarity in implication (Table 2). Although particip-
ants were prompted to talk about positive experience,
the interviewer did not provide any examples of positive
experiences during the interviews.

The positive experiences resulting from the develop-
ment of diabetes mellitus were classified into the
following three categories: (1) positive appraisal; (2)
devision; and (3) bonding.

Table 2 shows the categories and their respective
subcategories.

3.1. Positive appraisal

This category comprises three subcategories, which
reflect the positive appraisal of the stressor, i.e., type 2
diabetes, by the participant.

<table>
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<tr>
<th>Table 1</th>
<th>Characteristics of the participants</th>
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<td>Sex</td>
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3.1.1. Opportunity for lifestyle change

This subcategory presents statements of participants that the diagnosis of diabetes gave them an opportunity to stop their immoderate eating and/or drinking habit, which they perceived as ruining their health but did not previously have enough courage or incentive to stop it. This subcategory was extracted from more than half of the participants’ interviews.

Participant no. 7 talked about irregular meal hours due to his demanding job and felt unable to improve the lifestyle even though he was chronically fatigued prior to the diagnosis of diabetes. After talking about these problems for 30 min, he stated the following:

Since I am not very young anymore, I think that I need to keep regular habits. (In response to our question, ‘Have you started thinking that way after you were diagnosed with diabetes?’) ‘Yes. This is a good opportunity for me to improve my lifestyle...’ (No. 7)

Participant no. 3 talked for 5 min about her negative experience when she was diagnosed with diabetes. At that time she faced various family problems that prevented her from modifying her lifestyle. Then, she started talking about her hospitalization.

...Well, I gave priority to solving these problems over my health. When I was diagnosed with diabetes, I realized the importance of managing my health. Despite severe family problems, I decided to be admitted to a hospital for health management. The diagnosis of diabetes has provided me with a good opportunity to regularize my lifestyle and diet... (No. 3).

3.1.2. Feeling secure

This subcategory represents the awareness of participants with regard to the fact that undergoing treatment for diabetes mellitus and exercising self-management would improve their health or could help prevent other diseases. This subcategory was extracted from almost all the participants’ interviews.

Some of the participants expressed the feeling that the development of any severe diseases other than diabetes mellitus could be prevented thanks to the regular medical checks that are performed to examine their blood sugar levels as well as their improved lifestyle due to self-management. The following example is of participant no. 8 who had rarely visited medical institutions for check-ups despite poor health before he was diagnosed with diabetes mellitus. Initially, he described the difficulty in managing his blood glucose level and he felt resigned to diabetes. When he started talking about diabetic complications, he seemed to realize the positive aspect of diabetes as undergoing regular medical checks for controlling his blood sugar level was akin to health management. His feeling of security is reflected in the following statement:

I feel the regular medical checks ensure the prevention of other diseases. (No. 8).

Participant no. 10 also expressed his bitter feeling about self-management in the beginning of the interview. When he was young, he thought he could eat to his heart–content. While growing old, his peers started to develop various chronic illnesses. He began focusing on his improved lifestyle, which helped him to avoid other lifestyle-related diseases.

...However, I would rather consider diabetes in a favourable light. After the diagnosis, I started focusing on my health. Now, I think I have lived to this old age because I developed diabetes. (No. 10).

3.1.3. Pleasant surprise

This subcategory is assigned to the statements indicating that the diagnosis of diabetes and the methods for managing it have been easier than anticipated. The participants’ understanding of the disease and the required self-management improved after being actually diagnosed with diabetes compared with their original understanding, which was based on information obtained through the media. The participants had negative ideas with regard to the quality and quantity of food intake. These images as well as those related to the manner of exercising and the relationships with friends were extracted.

Participant no. 5 told the interviewer that diabetes was a disease which she wished to have avoided at all

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### Table 2

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<th>Categories</th>
<th>Positive appraisal</th>
<th>Diversion</th>
<th>Bonding</th>
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<td>Subcategory</td>
<td>Opportunity for lifestyle change</td>
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<td>Enjoying a new social network</td>
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<td>Feeling secure</td>
<td>Enjoying a healthy life</td>
<td>Improving family relationships</td>
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<td>Pleasant surprise</td>
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cost and thought she could not eat any delicious food any longer. Her physician told her that obesity caused her diabetes. She described the difficulty in dieting in her own way and lost 8 kg in the first month. Then, she admitted herself for diabetes education.

I did my best to understand what kind of food would be appropriate, and I was aware of how much food I should consume. Moreover, I have started enjoying my meals. (No. 5).

3.2. Diversion

This category comprises two subcategories representing the notion that participants divert their attention from diabetes to cope. These subcategories include statements indicating that the participant indulged oneself to combat the stress of managing diabetes or the participant viewed oneself healthy and enjoyed activities pleasing him/her.

3.2.1. Pursuing an individual way of life

This subcategory presents statements that reflect the change in a participant’s attitude toward life or a change in participants’ behavior, such as trying out various activities. A typical statement indicated, 'doing what I am interested in'.

Participant no. 4 had a long history of diabetes and suffered cerebro-vascular ischemic attack. After she described her struggles with diet and exercise, she started to talk about her decision that she had to change her way of living in order to avoid building up stress.

I have joined a drawing class to combat stress. I have always wanted to do so. (No. 4).

3.2.2. Enjoying a healthy life

This subcategory represents statements indicating that participants perceived themselves healthy and enjoyed various recreational activities.

Participant no. 10 admitted that self-management was not easy. However, he talked positively about his life with diabetes throughout the interview.

(Although the participant was diagnosed with diabetes mellitus) ‘I enjoy a healthy life. I can attend a concert or go to the theatre whenever I desire’. (No. 15)

3.3. Bonding

This category comprises two subcategories including statements indicating the participants’ sense of well-being due to a new social network or their improved relationships with their family after the diagnosis of diabetes.

3.3.1. Enjoying a new social network

This subcategory represents a satisfying feeling resulting from an increased social network resulting from joining a club or activities for lifestyle change. A following vignette illustrates a new social network enjoyed by participant no. 3. She described her trial and error approach about self-management for 10 min. Then, she started to talk about a walking group, which she joined to do exercise as a part of her health management. The participant enjoyed the company of the members living in the same condominium.

I have lost 8 kg with encouragement from the members of the walking group. I have not suffered any severe disease since I took up walking as an exercise… (Speaking with a smile) After an enjoyable round of walking exercise, we take breakfast. All these experiences are new to me. All the members of the group are kind people… (No. 3).

3.3.2. Improving family relationships

This subcategory represents statements indicating that the participants took advantage of the opportunity to improve their relationship with family and friends and, thereby, felt satisfied or experienced a sense of fulfillment. This subcategory includes statements indicating that the participants perceive that their family has been paying attention to their health condition and has been cooperating in self-management, or that the participants have restored family relationships.

Participant no. 12 spent most of the interview describing how hard it was for a busy business man like him to do self-management. Then, he started to talk about his family. After his wife learned about his diabetes, she studied the disease and expressed great concern over his health. His talk about his wife made him realize the existence of positive experience.

I could realize my wife’s affection because she expressed great concern about my health. In that sense, diabetes might have its good points’. (No. 12).

3.4. Mail survey after the interview

All 15 participants returned the questionnaire. Even though it was anonymous survey, they all identified their name and address on the returned envelope. All of the participants reported to understand the questions asked. Furthermore, most of the participants had discussed the interview with their family. Three participants commented the following in the margin: (1) surprised at being interviewed on positive experience (No. 6); (2) delighted that someone listened to my story (No. 3); (3) felt good about the interview (No. 10).
In response to the question ‘spending more time to think about living with diabetes’, five participants marked ‘yes’. Eleven participants reported positive experiences at the time of filling out the questionnaire, although only two specified the type of positive experience. Participant no. 14 wrote that he was delighted to have established a good lifestyle, and participant no. 5 reported that it (diabetic diet) was good for the family as well. All the participants requested a copy of the research report, which was mailed to them.

Although we did not particularly solicit comments on the report, participant no. 5 called the first author and told the author that it is good for people with diabetes to know that living with diabetes is not a problem if we are ingenious. Furthermore, she commented that health care professionals should support the patients to think positively.

4. Discussion

This exploratory qualitative study attempted to elicit the positive experiences of type 2 diabetes amongst Japanese patients. Personal interviews identified specific positive experiences of patients after they were diagnosed with diabetes mellitus, regardless of the duration of illness, age, and presence of other complications. The three categories that emerged from the study were ‘positive appraisal’, ‘diversion’, and ‘bonding’.

The subconstruct similar to ‘positive appraisal’ was reported by Folkman and Moskowitz (2000) in a meaning-based coping, which involve creating, reinstating, or reinforcing meaning in the midst of stress. It is defined as coping processes that induce positive emotion, which in turn sustains the coping process by allowing re-enactment of problem- or emotion-focused coping. Meaning-based subconstructs identified are: positive reappraisal, revised goals, spiritual beliefs, and positive events (Wenzel et al., 2002).

Meaning-based coping was also found in our study as ‘positive appraisal’, which includes ‘opportunity for lifestyle change’ and ‘feeling secure’ subconstructs. These are affected by how patients view the disease and its cause. In other words, the patients’ belief system plays a major role in positive appraisal of the stressor. Japanese health-care providers usually advise patients by quoting an old saying, ‘having a disease makes one pay attention to his/her own health, which would result in a healthy lifestyle’. Since almost all the participants were advised similarly, the health belief model in Japan appears to have an impact on the positive appraisal of the stressor. Research has shown that health beliefs of health-care professionals contribute to self-management, although the measurement of health beliefs has not been established (Whittemore, 2000).

‘Bonding’ can be considered as meaning-based coping, which differs from problem-focused coping. The themes similar to ‘bonding’ reported in previous studies were ‘harmonious relationships’ in the Korean study (Choe et al., 2001b), ‘relationship’ in the Australian study, and ‘improved close relationship’ in the Petrie’s study (Petrie et al., 1999). ‘Bonding’ represented by ‘improving family relationships’ or ‘expanding social network’ would impact the psychosocial well-being of those affected by the illness.

‘Diversion’ appears to be a theme unique to our study. Although “diversion” is associated with a positive affect, which the participants expressed, it may not belong to meaning-based coping because no interpretation of the meaning is associated with illness experience. This category comprises two different types of coping, which seem to share the feature of diverting focus from diabetes. ‘Pursuing an individual way of life’ represented the view that having diabetes is very stressful, and participants felt the need to be involved in activities that they had always wanted to undertake. In a sense, the diagnosis of diabetes had cathartic effects on some participants. In contrast, some participants considered themselves to be healthy and undertook any activity that they considered enjoyable.

To summarize our finding in the framework of existing literature on coping, a patient-centered model of coping was proposed (Fig. 2). The primary appraisal of the stressor is influenced by the patient’s health belief and personality characteristics. Health belief reflects the patient’s view of the cause of the disease and perceived severity of the disease. Social and material resources are important for secondary appraisal of the stressor and would affect the type of coping employed. Cognitive resources represented by self-esteem and self-efficacy play similar role to social and material resources. In this model, the coping process consists of three subconstructs, and the outcome of the patient’s centre’s coping model is quality of life.

The current study only included positive aspects of illness in people with diabetes to explore the existence of positive experience. The paucity of literature on the positive experiences of type 2 diabetes research may reflect the lack of questions that elicit positive experiences or thoughts that are related to the illness. We identified two previous studies that have reported positive findings included questions on positive experiences. In the Korean study, questions related to the positive experiences of diabetes were based on the patients’ satisfaction with life and ‘(what does) well-being mean to you (Choe et al., 2001a)’. In the Australian study, the following questions were included. First, what factors (people or services) have helped you to manage diabetes? Second, can you identify some activities or experiences that make you feel good? (Koch et al., 2000).
Specific questions on positive experiences related to the illness were also included in a study on positive experiences in patients who had suffered a heart attack or had cancer. "What positive effects/changes do you feel may have occurred in your life due to the heart attack/cancer? (Petrie et al., 1999) It may be that study participants are unlikely to describe positive experiences or thoughts related to illness unless questions on positive experiences are asked.

Positive experience is attracting increasing attention in cognitive behavioral therapy research (Wenzel et al., 2002) although terminology to express it varies among studies. Type 2 diabetes is not a life-threatening disease for most of the disease trajectory. Nonetheless, coping strategies found in our studies share similarities in the study population with life-threatening disease or severe chronic stress. Our research highlights the need to examine positive appraisal and positive experience in people with diabetes.

4.1. Methodological considerations

To increase credibility, we have discussed the process of analysis and the findings in seminars, and with two faculty members with type 2 diabetes. Although the interview was conducted once for each participant, the following mail survey supports the credibility of our study. A good rapport seems to have been established between the interviewer and the participants because all the participants identified themselves in the anonymous mail survey, and all requested a copy of the preliminary study report.

Reliability of the study was also confirmed by the mail survey, in which the participants’ responses were consistent with the interview content. With regard to transferability, the sampling procedures and participants’ characteristics were fully described. Because the participants were either receiving regular medical checkups or were motivated enough to participate in an inpatient diabetes education program, our findings may not be applicable for those who were less motivated to do self-management. Even though this is a convenience sample, our study findings share common themes with the Korean and Australian study. However, our study finding may not be applicable in a society where access to health care is limited. In addition, cultural values shared by Japanese health care professionals may not be found in the other cultures.

With regard to confirmation, all the verbatim transcripts with extracted codes were independently reviewed by the second author and the volunteer diabetes educator. Then, the entire transcripts were reviewed again in the process of revising the manuscript after receiving comments from the reviewers. Although the codes were renamed using more abstract terms, the coding scheme itself remains the same.

The major limitation of the research is that only positive experiences were extracted. In order to describe both positive and negative experiences, a series of interviews will be necessary. A prospective qualitative study is ideal to describe changes in the patient’s perspectives.
4.2. Implications for practice and future research

Although the difficulty associated with self-management tends to be the central focus in clinical settings, inquiring about the existence of positive experiences of diabetes may prompt the patient to reflect on the positive experiences. The act of interviewing patients can itself function as a type of intervention (Wright and Leahey, 1994).

Inquiring once about the positive experiences of a disease may not be sufficient. A small study reported the changes in patients’ perceptions during the 2 week diabetes educational sessions (Akimoto et al., 2001). In the first session, mostly negative emotions or attitudes, such as anxiety or remorse were noted, while in the third session, more positive emotions and attitudes toward self-care and satisfaction were frequently expressed (Akimoto et al., 2001).

The health-care providers’ perspective on their patients tends to focus on compliance or adherence. It is important for health-care providers to understand their own perspectives as well as those of the patients. Illness experience tends to be viewed as a negative experience by health-care professionals as well as health-care researchers, and it appears that the positive aspect of illness experience, represented by meaning-based coping, has been investigated in the domain of psychology (Folkman and Moskowitz, 2000). Folkman and Moskowitz (2000) stressed the importance of the positive aspect of coping and suggested qualitative studies to include narrative accounts of the positive experience in people under chronic stress.

5. Conclusion

This exploratory qualitative study was conducted to investigate the positive experiences of diabetes on Japanese patients receiving regular care. The three major categories identified were ‘positive appraisal’, ‘diversion’, and ‘bonding’. Positive experiences were identified regardless of background factors such as duration of illness and the resulting complications. Further research is essential to examine the positive experience in people with diabetes in a variety of settings and populations and to identify factors associated with the positive experiences, in addition to the negative experience reported in previous studies.

Acknowledgments

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