Semana de Congresos y Jornadas Nacionales 2017
"Por un niño sano en un mundo mejor"
24, 25, 26, 27 y 28 de abril de 2017
Panamericano Buenos Aires Hotel & Resort – Carlos Pellegrini 551 – Ciudad de Buenos Aires
EXE Hotel Colón – Carlos Pellegrini 507 - Ciudad de Buenos Aires

Estrés y Agotamiento de los cuidadores

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Estrés y Agotamiento de los cuidadores

¿Quienes son los cuidadores?


26
MODERN
FAMILY


26
MODERN
FAMILY


26
MODERN
FAMILY


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MODERN
FAMILY


26
MODERN
FAMILY

Estrés y Agotamiento de los cuidadores

¿Qué es estrés y agotamiento?

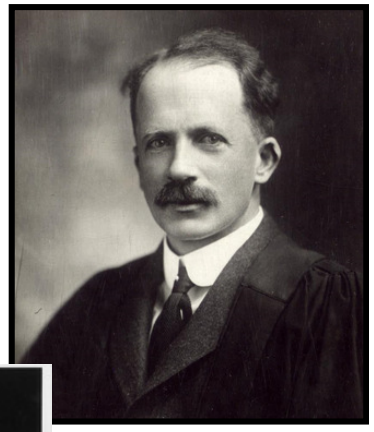
Burn Out

Estrés- Agotamiento

- El **Estrés** es la respuesta que da nuestro cuerpo ante diversas situaciones que provocan tensión suficiente como para considerarlas una amenaza.

- **Agotamiento** es el acto y la consecuencia de **agotar**: consumir, gastar o vaciar la totalidad de algo, provocar un cansancio extremo.

Verano de 1921…



Estrés- Agotamiento- Burnout.

- Con el descubrimiento de la insulina la diabetes tipo 1 paso de ser una enfermedad aguda y mortal a una enfermedad crónica con posibles episodios de descompensación aguda.

El estrés y el agotamiento se superponen.

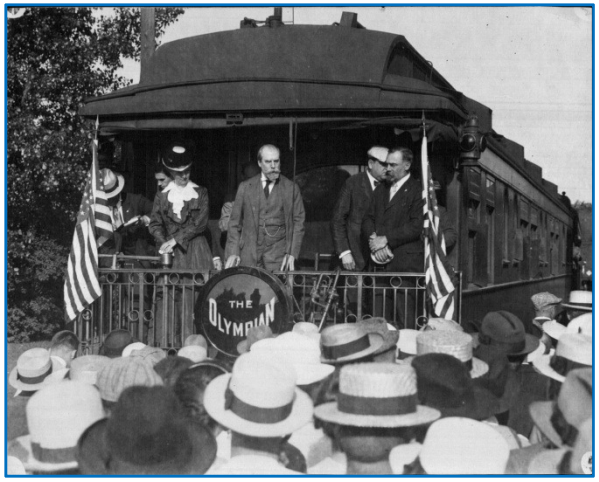
Objetivos a trabajar

- Como atemperar el estrés inicial.
- Como prevenir el agotamiento.
- Como favorecer la separacion y la autonomia.

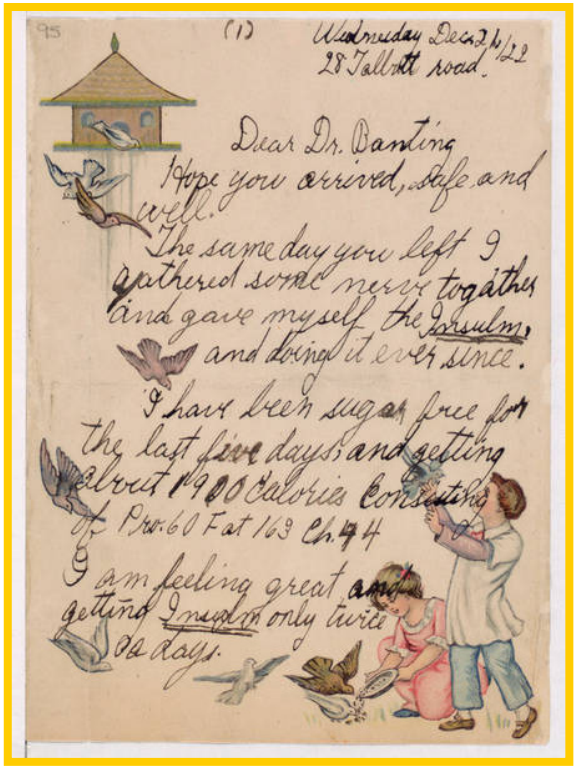
Debut-Onset

- Primera actuación en público de una compañía teatral o de un artista.
- La primera vez en una actividad .

La aparicion de la diabetes es brusca y definitiva.

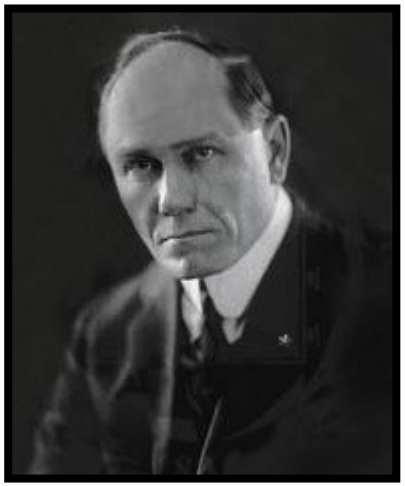


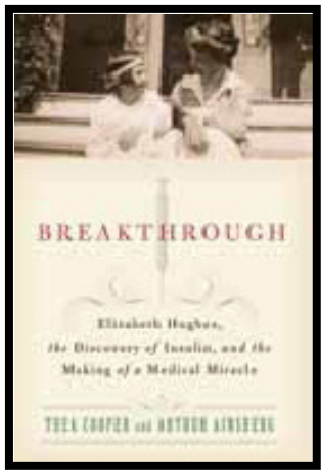
Despite coming close to winning the presidency in 1916 Hughes did not seek the Republican nomination again in 1920.



Wednesday Dec 24/22
28 Talbott road.

Dear Dr. Banting
Hope you arrived, safe and well.
The same day you left I gathered some nerve together and gave myself the Jerusalem, and doing it ever since.
I have been sugar free for the last five days and getting about 1900 Calories Consisting of Pro. 60 Fat 163 Ch. 44
I am feeling great and getting I need in only twice 24 days.





Dificultades al debut

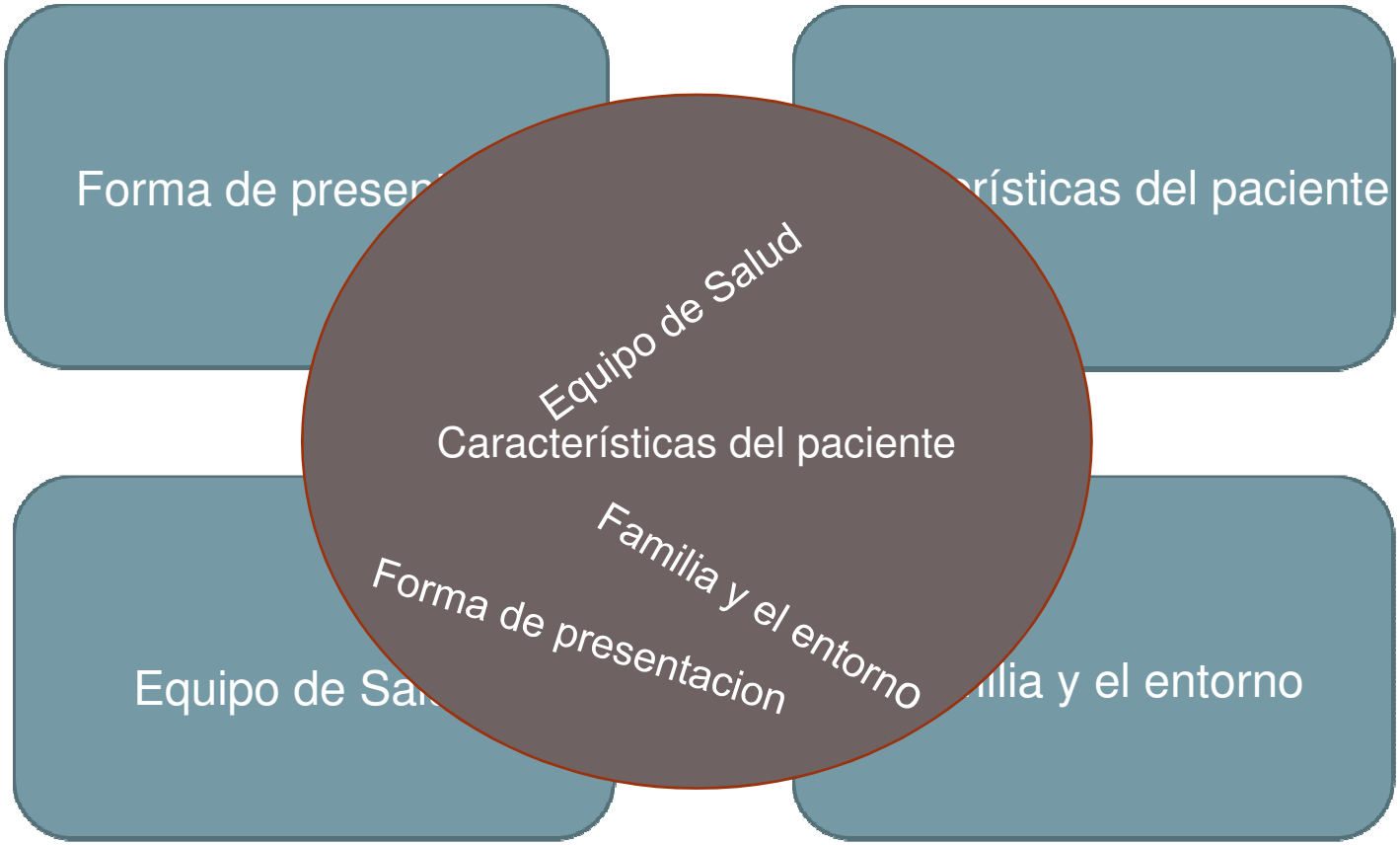
Forma de presentacion

Características del paciente

Equipo de Salud

Familia y el entorno

Dificultades al debut



Al debut

- Tener en cuenta los sentimientos iniciales
- Si bien se necesita cierto grado de alerta para aprender, la información nueva es múltiple y compleja.

Los sentimientos iniciales se reiteran en cada momento de cambio durante la evolución.

Estres al diagnostico

Los sentimientos de los padres/del cuidador sobre y/o las respuestas al diagnóstico de diabetes tipo 1 en un niño pueden incluir:

- Shock[1]
- Tristeza[2]
- Pena[2]
- Temor[3]
- Culpa[3]
- Ansiedad[3]
- Distrés emocional[3]
- Agobio[4]
- Frustración[3,5]
- Preparación para la enfermedad[3]
- Sentido de pérdida[1]
- Desconfianza[5]

Debido a la severidad de la enfermedad y a un mayor riesgo de morbilidad y mortalidad cuando un niño presenta cetoacidosis diabética (CAD) en el momento del diagnóstico,[6,7] puede resultar más estresante para los cuidadores.

1. Lowes L, et al. *Diabet Med.* 2004;21(6):531-538. 2. Wennick A, Hallström I. *J Fam Nurs*. 2006;12(4):368-389.
3. Whittemore R, et al. *Diabetes Educ*. 2012;38(4):562-579. 4. Beck J, et al. *Diabetes Educ*. 2012;38(2):280-288.
5. Smaldone A, Ritholz MD. *J Pediatr Health Care.* 2011;25(2):87-95. 6. Rodacki M, et al. *Diabetes Res Clin Pract*. 2007;78:259-262. 7. Daneman D, et al. *Ped Child Health*.1999;4(1)57-63.

Ketoacidosis at Diabetes Onset Is Still Frequent in Children and Adolescents

A multicenter analysis of 14,664 patients from 106 institutions

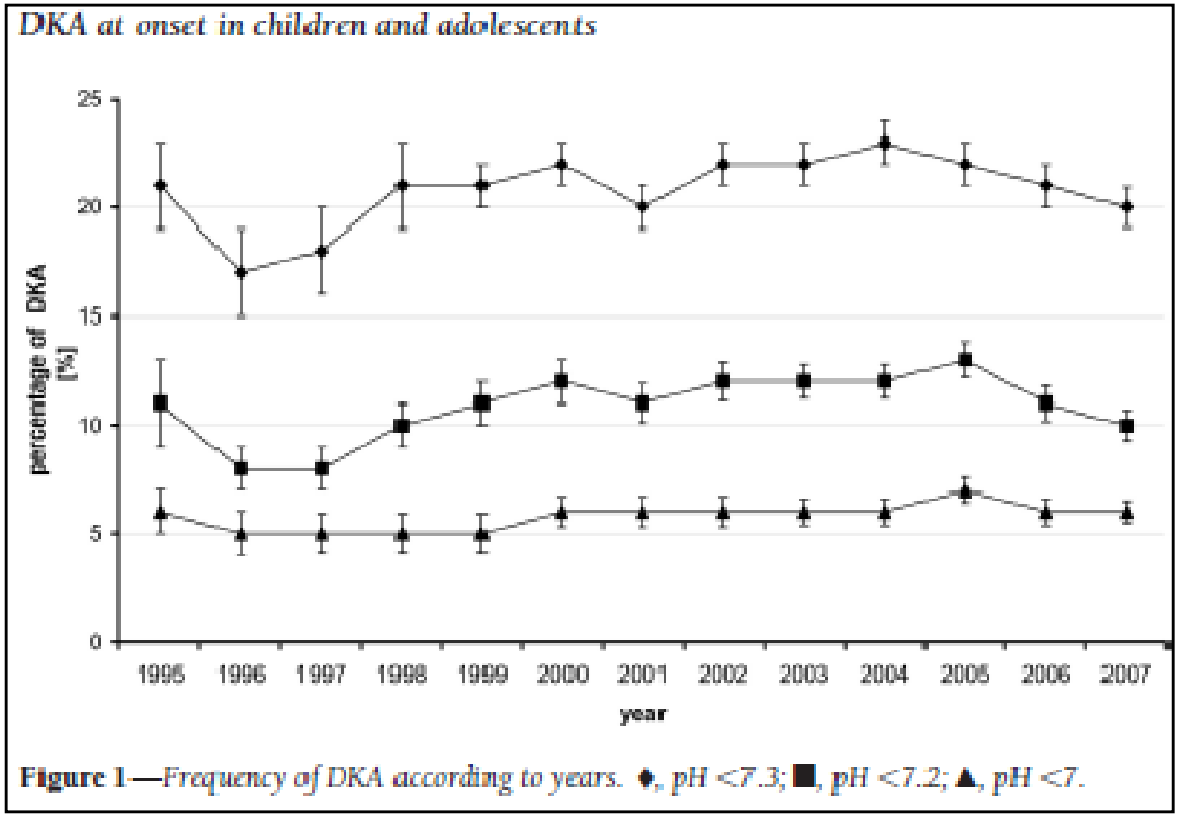


Figure 1—*Frequency of DKA according to years.* ♦, *pH <7.3;* ■, *pH <7.2;* ▲, *pH <7.*

Neu A.Diabetes Care 2009:32(9) 1647-48.

Pediatr Clin N Am ■ (2015) ■–■
http://dx.doi.org/10.1016/j.pcl.2015.04.002

Table 1
Frequency of diabetic ketoacidosis at disease onset of type 1 diabetes mellitus

Country	Diabetic Ketoacidosis (%)
United Arab Emirates	80
Romania	67
Saudi Arabia	40–77
France	54
Kuwait	38–49
Poland	33–54
China	42
Oman	42
Lithuania	35
Austria	37
Italy	32–41
Bulgaria	35
Germany	26–53
United States	27–44
Turkey	29
United Kingdom	25–38
Ireland	25
Finland	19–22
Canada	18.6
Sweden	13–14

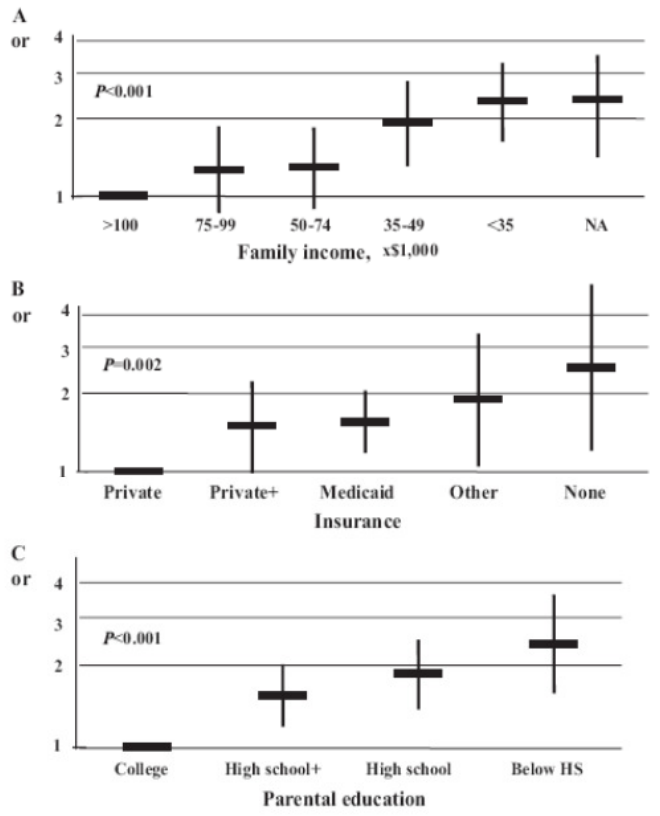


FIGURE 2
Relationship between annual family income (A), insurance type (B), or parental education (C) and the presence of DKA at diagnosis of diabetes in youth. ORs and the 95% CIs were adjusted for center, age, gender, race or ethnicity, type of diabetes, and family history of diabetes.

Internacion al debut o manejo ambulatorio

Al inicio de su enfermedad el paciente debe tener un período de contacto estrecho con el equipo tratante, que será con internación o ambulatorio según la situación particular de la institución y la familia del paciente.

- Siempre serán hospitalizados los niños:
- menores de 2 años de edad.
- Los que vivan lejos del Centro de Referencia
- Familias de riesgo (dificultades socioeconómicas importantes o trastornos emocionales severos)
- Los que presenten otras patologías agregadas (infecciones, desnutrición grave, etc.)
- Los que no tengan tolerancia gástrica
- Cetosis aunque sea leve

El período de internación es variable, estimándose un término medio de 7 a 15 días, con el objeto de ajustar la dosis de insulina a los requerimientos del paciente y realizar educación diabetológica y contención psico-social que permita a la familia continuar el tratamiento domiciliario.

www.hospitalelizalde.org/area_medica/Normas/**diabetes**.doc

La comunicacion del diagnostico: Nunca hay una segunda posibilidad para una primera impresión

- Una vez que el médico diagnostica una enfermedad crónica en un niño, sus padres tienden a recordar más tarde:
  - El evento[1]
  - Cómo se sintieron[2]
- Es importante asegurar la comprensión de la situacion:
  - en forma precisa[3]
  - en forma efectiva[1]
  - mostrando empatía[1]

1. Levetown M. *Pediatrics.* 2008;121(5):e1441-1460. 2. Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2006;31(1): 24-31.
3. Thomas M. *AAP News*. 2002;21:178-180.

Cómo dar las malas noticias:

Posibles consideraciones:

- ❑ Decidir quién debería estar presente.[1]
- ❑ Elegir un entorno adecuado.[1-3]
- ❑ Comunicar la información con claridad.[1,3]
- ❑ Demostrar empatía, preocupación y compasión.[1]
- ❑ Individualizar su abordaje.[1,3]
- ❑ Otorgarle a los papas tiempo para que en soledad puedan absorber la información, reaccionar y formular preguntas.[1,3]

- No dar mas informacion que la necesaria o solicitada.
- No calmar nuestra propia ansiedad.
- Hacer sentir a la familia que estamos disponibles.

1. Boyd JR. *J Neurosci Nurs*. 2001;33(1):14-20. 2. Thomas M. *AAP News.* 2002;21:178-180. 3. Levetown M. *Pediatrics.* 2008;121(5):e1441-1460.

American Diabetes Association

The crisis of diagnosis

The diagnosis of diabetes is a time of crisis for the child and the family. The diagnosis has an initial psychological impact on the individual, their siblings and parents. Indeed, the diagnosis may exacerbate preexisting problems. Poor initial adaptation, with depression, anxiety and low self-esteem, predicts later psychological difficulties (8). The ability of the family to provide support for the child varies depending on the educational, economic and emotional resources of the family. Although some families may take the diagnosis in their stride and manage the new responsibility well, other families at diagnosis have known risk factors for poor diabetes control, including single-parent families, families living in poverty and parents coping with other major stressful life events. These families may require extra time, education, attention and financial assistance at diagnosis. Some parents may require help to address faulty ideas such as personal shame or guilt over having a child with diabetes (Table 1).

- Crisis familiar.
- Ansiedad, depresión disminución de la autoestima.
- Profundiza conflictos previos.
- Factores de riesgo pobreza, perdidas anteriores, soledad.

Diabetes Care.2005:28:186-212

Consideraciones al debut

- Aceptar lo inevitable

Enfrentar el diagnostico

- Aceptar la tristeza

« Mi hija dice que lo mas dificil de la diabetes es ver a la mama llorar por los rincones»

- Prepararse para volver a casa.

No decir la vida sigue igual.

- Reconstruir la vida con nuevas rutinas

«Vivir con el reloj»

El diagnóstico de diabetes tipo 1 cambia la vida

En el momento del diagnóstico, los niños y sus padres rápidamente deberian:

- Comprender información compleja[1,3]
- Repensar el estilo de vida de su familia[2]
- Aprender capacidades específicas de supervivencia, esto incluye ser capaz de[3]:
  - Administrar insulina.
  - Identificar y manejar episodios de hipoglucemia e hiperglucemia que posiblemente pongan en riesgo la vida.
  - Calcular el contenido de carbohidratos de los alimentos y planificar horarios para actividades y comidas.

1. Swift PGF. *Pediatr Diabetes*. 2007;8(2):103-109. 2. Malerbi FE, et al. *Diabetol Metab Syndr*. 2012;4(1):48. 3. Schmidt CA, et al. *MCN Am J Matern Child Nurs*. 2012;37(2):88-94.

Lista de responsabilidades de manejo diarias de los padres/cuidadores

Las habilidades que deben tener los cuidadores de un niño con diagnóstico reciente de diabetes tipo 1 se dividen en 4 categorías principales[1,2]:

Manejo de la condición

- Cuidado práctico
- Monitoreo e interpretación de signos y síntomas
- Resolución de problemas
- Toma de decisiones

Cómo mantener la unidad familiar

- Equilibrar la diabetes tipo 1 y las demandas familiares.
- Intentar satisfacer las necesidades de salud y el desarrollo de cada miembro de la familia.

Identificar, acceder a y coordinar recursos

- Evaluar y negociar recursos de la comunidad, eso incluye a los profesionales de la salud.

Mantener el Yo

- Salud mental
- Bienestar emocional
- Salud espiritual

1. Sullivan-Bolyai S, et al. *Pediatr Nurs.* 2003;29(6):457-461. 2. Sullivan-Bolyai S, et al. *Pediatr Nurs.* 2004;30(1):52-56.

Table 1. Parent/Caregiver Responsibilities and Activities Associated with the Day-to-Day Management of Raising a Child who has a Chronic Condition

Learning about the condition and care
1. Develops working knowledge of disease process
2. Develops working knowledge of treatment plan

A. Monitoring condition & behavior
   1. Identifies subtle changes in condition and behavior
   2. Observes verbal and nonverbal indicators
   3. Uses instruments to monitor condition when appropriate
   4. Uses appropriate level of vigilance
   5. Makes accurate observations
   6. Keeps written record when appropriate
   7. Notices patterns of responses

B. Interpreting
   1. Recognizes deviations from normal
   2. Recognizes something is "different" or wrong
   3. Recognizes seriousness of a problem
   4. Seeks explanation for unexplained signs & symptoms
   5. Asks questions to assist in developing explanation
   6. Makes correct attributions
   7. Uses a reference point in making sense of observations
   8. Considers multiple explanations for an observation

C. Providing hands-on care
   1. Maintains adherence to treatment plan
   2. Performs personal care safely
      a. bathing
      b. feeding
      c. dressing
      d. ADLs
   3. Performs condition-related treatments safely
      a. administers medications
      b. administers treatments
      c. tube care/management
      d. stoma care/management
      e. dressings
      f. equipment care/management
   4. Provides emotional/developmental support
      a. spends time with child
      b. plays with child
      c. provides developmentally appropriate activities
      d. offers developmentally appropriate guidance, including "coaching"
      e. anticipates needs of child within a developmental context
      f. supports spiritual development

D. Making decisions
   1. Takes into account multiple care demands
   2. Weighs competing demands
   3. Weighs the importance of conflicting priorities
   4. Attends to multiple care issues at once
   5. Thinks ahead about possible consequences of a given action

E. Developing care routines
   1. Uses effective reminders to time actions
   2. Uses timing to coordinate care needed
   3. Develops routines to manage complex tasks
   4. Takes child's characteristics into consideration when developing routine
   5. Involves child in care as developmentally appropriate
   6. Uses a system for remembering when actions are due
   7. Has ability to take action on multiple issues at once

F. Making treatment adjustments/problem-solving
   1. Identifies and defines problem(s) that need alternative solution(s)
   2. Decides what part of care or task needs to be altered/changed
   3. Considers possible solutions
   4. Tries multiple strategies until a solution to problem found
   5. Reacts appropriately to symptom changes
   6. Modifies routines to accommodate illness situation
   7. Modifies environment to accommodate illness situation
   8. Adjusts care to optimize comfort and symptom management, including
      a. amount of food
      b. PRN medications
      c. rest
      d. exercise
   9. Calls for expert information when appropriate
   10. Knows which health care team member to call when necessary
   11. Uses mistakes as an opportunity for learning
   12. Considers what led to mistakes, and alters what appears to be source of problem
   13. Searches for an alternative when one illness care strategy no longer works
   14. Uses creativity in problem-solving
   15. Deals with emergency situations appropriately
   16. Evaluates outcomes

G. Guiding or coaching child in self-care: striving for interdependence versus control

H. Teaching others how to care for child (e.g. teachers, sitters, family members)

II. Identifying, accessing, and coordinating resources

A. Assessing needs and strengths
   1. Takes initiative in seeking resources
   2. Seeks resources wisely: casts a wide net
   3. Seeks authoritative advice when appropriate
   4. Uses advice judiciously
   5. Weeds out erroneous, inaccurate, or inadequate advice (including internet)
   6. Persists in obtaining resources until finding what is really needed
   7. Determines which providers are most accessible, helpful, and knowledgeable
   8. Makes own needs known
   9. Considers the following resources in quest to meet child's and family units needs
      a. primary care
      b. specialized care
      c. home care services
      d. babysitting
      e. respite
      f. daycare
      g. school services
      h. social opportunities
      i. sports
      j. special camp experiences

Table 1. Parent/Caregiver Responsibilities and Activities Associated with the Day-to-Day Management of Raising a Child who has a Chronic Condition (continued)

B. Negotiating health-related issues (ability to advocate for child & family)
   1. Expresses opinions with health care and school professionals
   2. Evaluates care received in the health care system
   3. Seeks assistance from health care team in a timely manner
   4. Works in partnership with the health care team
   5. Works in partnership with home care services
   6. Works in partnership with the school system
   7. Advocates for child and self when necessary

C. Negotiating emergency plan
   1. Develops an emergency plan in partnership with the health care team to address:
      a. medical emergencies and complications
      b. malfunctioning of medical equipment
      c. power & electricity outages
      d. support person(s) illnesses
      e. schools/daycare closures

D. Providing coordination of care
   1. "Concierge" or monitor for individual and family unit's physical, developmental, emotional, social, and spiritual needs
   2. Works in partnership with the health care team to develop a plan of home care
   3. Works in partnership with insurance plan on case management if appropriate
   4. Identifies family, friends, and neighbors who can offer assistance
   5. Accesses community-based resources
      a. equipment company
      b. home health agency
      c. pharmacy
      d. therapies
   6. Maintains flexibility built into coordination plan
   7. Develops back-up plans
   8. Develops re-hospitalization plan as needed
   9. Integrates primary care into care plan
   10. Identifies support groups
   11. Develops respite care plan
   12. Explores alternative-care options as appropriate

III. Maintaining family unit

A. Balances illness and family demands

B. Continues to participate in family traditions, rituals, and routines

C. Monitors family member health status

D. Identifies family strengths

E. Addresses individual family member & family unit developmental needs (such as child and sibling "chauffeur," helping with homework, or in some cases coordination and provision of home schooling, coordination of social and recreational sports and activities, planning family activities and vacations)

F. Defines, and redefines, meaning of illness related to developmental milestones for the child, other family members, self, and the family unit

G. Organizes family activities to include the child with a chronic condition

H. Integrates "couple" time into schedule (if 2 parent family)

I. Maintains the household (or coordinates efforts if performed by others)
   1. Household maintenance and repair
   2. Meal preparation
   3. Cleaning
   4. Laundry
   5. Errands
   6. Grocery shopping
   7. Bill paying
   8. Gardening

J. Manages economic issues
   1. Insurance companies
   2. Equipment & medication costs
   3. Special programs such as private tutoring, pt, ot, speech programs

IV. Maintaining self

A. Meets personal physical and mental health care needs
   1. Regular check-ups
   2. Sleep
   3. Exercise
   4. Balanced diet
   5. Weekly time out
   6. Recognition and expression of grief, other emotions
   7. Spiritual needs

B. Expresses sense of capability in caregiving role

C. Identifies ways of relieving day-to-day stress

D. Addresses personal and career goals

E. Nurtures significant-other relationship & other close friendships

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      b. malfunctioning of medical equipment
      c. power & electricity outages
      d. support person(s) illnesses
      e. schools/daycare closures

D. Providing coordination of care
   1. "Concierge" or monitor for individual and family [illegible] and spiritual needs
   2. Works in partnership with the health care team to develop a plan of home care
   3. Works in partnership with insurance plan on case management if appropriate
   4. Identifies family, friends, and neighbors who can offer assistance
   5. Accesses community-based resources
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   7. Develops back-up plans
   8. Develops re-hospitalization plan as needed
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D. Identifies family strengths

E. Addresses individual family member & family unit developmental needs (such as child and sibling "chauffeur," helping with homework, or in some cases coordination and provision of home schooling, coordination of social and recreational sports and activities, planning family activities and vacations)

F. Defines, and redefines, meaning of illness related to developmental milestones for the child, other family members, self, and the family unit

G. Organizes family activities to include the child with a chronic condition

H. Integrates "couple" time into schedule (if 2 parent family)

I. Maintains the household (or coordinates efforts if performed by others)
   1. Household maintenance and repair
   2. Meal preparation
   3. Cleaning
   4. Laundry
   5. Errands
   6. Grocery shopping
   7. [illegible]
   8. Gardening
   9. Manages economic issues
      1. Insurance companies
      2. Equipment & medication costs
      3. Special programs such as private tutoring, pt, ot, speech programs

IV. Maintaining self

A. Meets personal physical and mental health care needs
   1. Regular check-ups
   2. Sleep
   3. Exercise
   4. Balanced diet
   5. Weekly time out
   6. Recognition and expression of grief, other emotions
   7. Spiritual needs

B. Expresses sense of capability in caregiving role

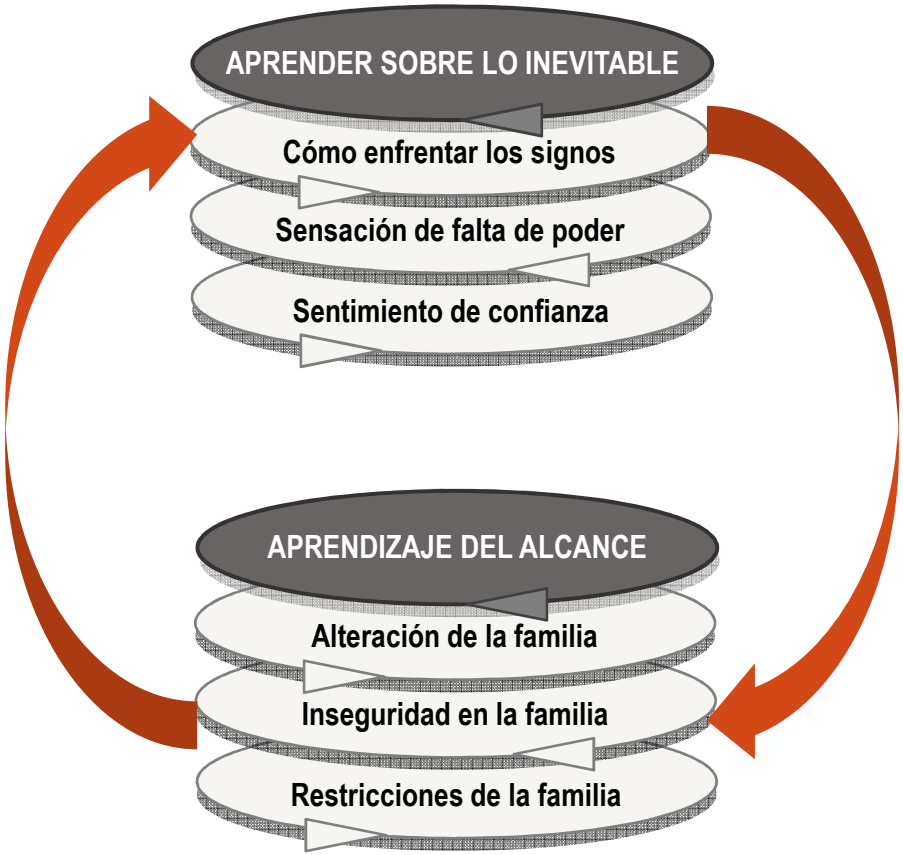
C. Identifies ways of relieving day-to-day stress

D. Addresses personal and career goals

E. Nurtures significant-other relationship & other close friendships

El diagnóstico de diabetes infantil tipo 1 es el comienzo de un proceso de aprendizaje

- La diabetes no es una enfermedad estática[1]
  - El impacto psicológico cambia con el tiempo
  - Las situaciones que se manejan en un principio pueden convertirse en problemáticas meses más tarde.
- El conocimiento adquirido en el hospital puede tornarse limitado en términos de su posibilidad de uso[2]
  - Los miembros de la familia experimentan nuevas dimensiones de la enfermedad.
  - Surgen nuevas situaciones y contextos, que aumentan el alcance de lo que se ha aprendido.



1. Wennick A, Hallström I. *J Adv Nurs.* 2007;60(3):299-307. 2. Wennick A, Hallström I. *J Fam Nurs.* 2006;12(4):368-389.

Psychological Experience of Parents of Children With Type 1 Diabetes:

A Systematic Mixed-Studies Review

Robin Whittemore, PhD, APRN, FAAN, Sarah Jaser, PhD, Ariana Chao, MSN, Myoungock Jang, MSN, and **Margaret Grey, DrPH, RN, FAAN**
Yale School of Nursing, New Haven, Connecticut

Results—The prevalence of parental psychological distress across all studies ranged from 10% to 74%, with an average of 33.5% of parents reporting distress at diagnosis and 19% of parents reporting distress 1 to 4 years after diagnosis. Parental psychological distress in parents of children with T1DM, regardless of how it was defined, was associated with higher child self-report of stress and depressive symptoms, more problematic child behavior, and lower child self-report of quality of life. Parental psychological distress also had negative effects on diabetes management. Themes of the qualitative synthesis indicated that parents perceived T1DM as a difficult diagnosis that contributed to significant family disruption. Adjustment occurred over time; however, ongoing stress was experienced.

Conclusions—Screening for psychological distress in parents of children with T1DM is indicated, and preventive interventions are needed.

El 33,5 % de los padres reportaron estres al diagnostico y el 19 % a lo largo de la evolucion.

Diabetes Educ. 2012 July ; 38(4): 562–579.

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- **El estres en los padres se asocio a:**

- Mayor alteración en la comunicación familiar
- Incremento de los conflictos
- Disminución de la efectividad de los padres como cuidadores
- Peor salud tanto emocional como fisica.

Diabetes Educ. 2012 July ; 38(4): 562–579.

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- **El estres en los padres se asocio en los hijos a:**

- Mayor numero de síntomas depresivos
- Trastornos de conducta
- Menor calidad de vida
- Peor control metabólico.

Diabetes Educ. 2012 July ; 38(4): 562–579.

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- **Los sintomas depresivos se asociaron a**:

- Menor disciplina, menor presencia paterna y acompañamiento, menor adaptación y cohesión familiar y mayor numero de conflictos.

- **La ansiedad parental :**

- Mayor control materno, sobreproteccion y dificultad en la autonomia.

Diabetes Educ. 2012 July ; 38(4): 562–579.

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Clinical Recommendations for Parents of Children With Type 1 Diabetes Mellitus

Assess parental stress, anxiety, and depression with a brief assessment form or in private consultation.
Stress—Pediatric Inventory for Parents[61]
Anxiety—State–Trait Anxiety Inventory (STAI)[45]
Depression
Center for Epidemiologic Studies–Depression (CES-D)[62]
Beck Depression Inventory (BDI)[63]
Brief Depression Screening Tool[42]
Anxiety and Depression
General Health Questionnaire (GHQ)[64]
Psychosocial Adjustment
Psychosocial Assessment Tool (PAT2)[65]
Identify high-risk parents such as single parents, those from minority groups, or those without social support.
Inform parents that stress and distress are common in parents of children with T1DM.
Encourage parents to actively seek support from family, friends, peers, and professionals.
Provide parents with Internet sources of peer support.
Refer parents with elevated symptoms of stress, anxiety, or depression to their primary care provider or a mental health professional.
Educate parents with elevated symptoms of stress, anxiety, or depression that their emotional status not only affects them negatively but also affects their child and family, thus reinforcing the importance of effective management.

Diabetes Educ. 2012 July ; 38(4): 562–579.

Malerbi *et al. Diabetology & Metabolic Syndrome* 2012, **4**:48
http://www.dmsjournal.com/content/4/1/48

DIABETOLOGY & METABOLIC SYNDROME

RESEARCH Open Access

Assessment of psychosocial variables by parents of youth with type 1 diabetes mellitus

Fani Eta Korn Malerbi[1*], Carlos Antonio Negrato[2], Marilia B Gomes[3] on behalf of the Brazilian Type 1 Diabetes Study Group (BrazDiab1SG)

Abstract

Purpose: To evaluate the impact of type 1 diabetes (T1D) on family functioning and child-rearing practices from parents' point of view, to assess parents' health-related quality of life and to explore the relations between psychosocial variables and diabetes care outcomes in youth with diabetes.

Methods: This research was part of the cross-sectional multicenter Brazilian Type 1 Diabetes Study, conducted between December 2008 and December 2010 in 28 public clinics of 20 cities across four Brazilian geographical regions. Psychosocial questions 1,079 parents of patients with T1D low socioeconomic levels. Parents were also submitted to health-related quality of life instruments (EQ-5D+EQ-VAS). Clinical data from the last medical appointment were collected by a physician using standardized chart review forms. The demographic, educational and socioeconomic profiles were also obtained and HbA1c levels registered.

(89.3% mothers, 52.5% Caucasians, 38.6 ± 7.6 years old). Overall, 72.5% of the families were from low or very low socioeconomic levels. Parents were also submitted to health-related quality of life instruments (EQ-5D+EQ-VAS).

in family functioning after the diagnosis, although they neither treated their diabetic children differently from the others (76.3%), nor set prohibitions (69.1%) due to diabetes. The majority was worried about diabetes complications (96.4%) and felt overwhelmed by diabetes care (62.8%). Parents report of overwhelming was significantly associated with anxiety/depression, as measured by the EQ-5D questionnaire. Less than half of the patients had already slept over, and the permission to do it increased as a function of children's age. Nearly half of the parents (52%) admitted to experiencing difficulties in setting limits for their children/adolescents. HbA1c levels in patients from this group (9.7 ± 2.5%) were significantly higher than those of children/adolescents whose parents reported no difficulties towards limit-setting (8.8 ± 2.1%). Parents whose children/adolescents reported the occurrence of hypoglycemic episodes in the last month complained significantly more about anxiety/depression (55.1%) than parents from patients who did not report it (45.7%). Also a significantly greater proportion of parents whose children/adolescents had been hospitalized due to hyperglycemia reported anxiety /depression (58.7%) than those whose children/adolescents had not been hospitalized (49.8%).

Conclusions: After the diagnosis of T1D, the lifestyle of all family members changes, what interferes with their quality of life. Mothers are still the primary caregivers for children/adolescents with diabetes. Difficulty to set limits for children/adolescents may be a risk for poor metabolic control. The study demonstrates the importance of family context in the adjustment of young patients to T1D. The specific needs of T1D patients and their impact on a family routine must be considered for future improvement on therapy elements and strategies.

Keywords: Type 1 diabetes, Family functioning, Psychosocial variables, Diabetes in youth, Glycemic control

Malerbi et al. Diabetology & Metabolic Syndrome 2012, 4:48
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Table 3 Number and percentage of parents' answers to questions focusing psychosocial aspects related to their children's diabetes

Parents assertions	n (%)
Family functioning was modified by my child with diabetes	842 (78.5%)
After the diagnosis the relationship with my spouse changed	324 (31.6%)
There is always an adult (mother/father/grandparent/etc.) involved in diabetes care	1,041 (96.8%)
I do not treat my child with diabetes differently from my other children	781 (76.3%)
I do not set prohibitions to my child because he/she has diabetes	741 (69.1%)
The patient is encouraged to perform diabetes management tasks	978 (91.7%)
I am worried about diabetes complications	1,032 (96.4%)
I am worried about hypoglycemic episodes	1,005 (93.9%)
I'm afraid that diabetes develops in another sibling	706 (69.1%)
I have already checked my non-diabetic children's blood glucose	654 (64.2%)
I feel overwhelmed with caring for my child's diabetes	672 (62.8%)
My child has already slept over	440 (41.0%)
I have had difficulties in setting limits for my child with diabetes	555 (52.0%)

Malerbi *et al. Diabetology & Metabolic Syndrome* 2012, **4**:48
http://www.dmsjournal.com/content/4/1/48

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Table 4 Number and percentage of parental answers reporting problems in the five health aspects of the EQ-5D questionnaire

I do have problems with	Fathers+Mothers n (%)	Fathers n (%)	Mothers n (%)	P-Value
Mobility	77 (7.2%)	10 (8.8%)	67 (7.0%)	0.47
Self-care	19 (1.8%)	2 (1.8%)	17 (1.8%)	0.99
Usual activities	73 (6.8%)	7 (6.2%)	66 (6.9%)	0.78
Discomfort	385 (36.0%)	29 (25.7%)	356 (37.3%)	0.05
Anxiety/depression	547 (51.2%)	37 (32.7%)	510 (53.4%)	<0.001

Casi la mitad de las madres tenian ansiedad o depresion

Malerbi et al. Diabetology & Metabolic Syndrome 2012, 4:48

Factores puede contribuir al desarrollo del agotamiento

Algunas factores internos/rasgos de personalidad:

- Expectativas idealistas del yo.
- Acción y compromiso con el punto de sobreestimación del yo y de sentir una sobrecarga.
- Supresión de las necesidades propias.
- Sentimiento de ser irreemplazable y de no querer delegar.

Algunos factores externos:

- Grandes demandas de tareas a realizar.
- Falta de libertad para la toma de decisiones
- Mayores responsabilidades
- Ausencia de apoyo social
- Instrucciones contradictorias
- Falta de un comentario positivo
- Falta de recursos

Kaschka WP, et al. *Dtsch Arztebl Int.* 2011;108(46):781-787.

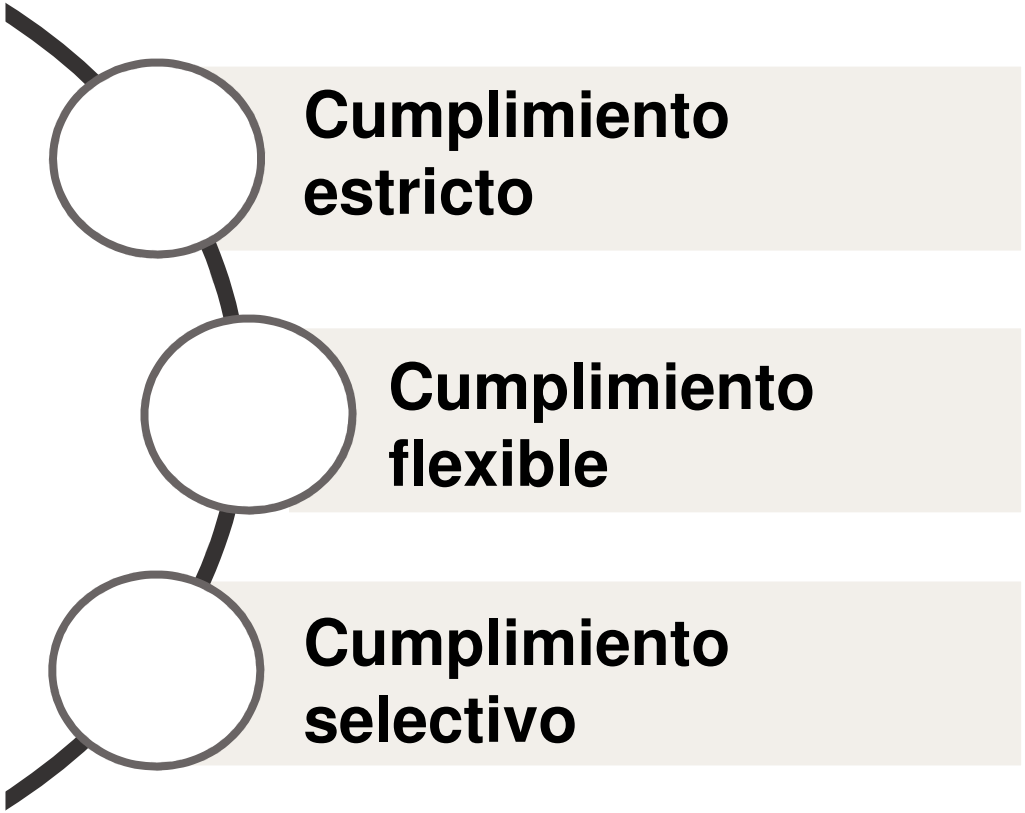
Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

- Los padres necesitan conocimientos, acompañamiento y contacto con otras familias en situación similar.
- Son parte esencial del proceso terapéutico y es importante que sus consideraciones y puntos de visita sean tenidos en cuenta.
- Hacerlos sentir expertos y los profesionales sus asesores.
- El medico será empático, honesto y bien informado fuente de fortaleza para los cuidadores.

AAP Technical Report. Pediatrics Vol 121, Nº5, May 2008.

Tres abordajes que los padres pueden utilizar para manejar el cuidado de la diabetes tipo 1 de su hijo



Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2003;28(3):160-166.

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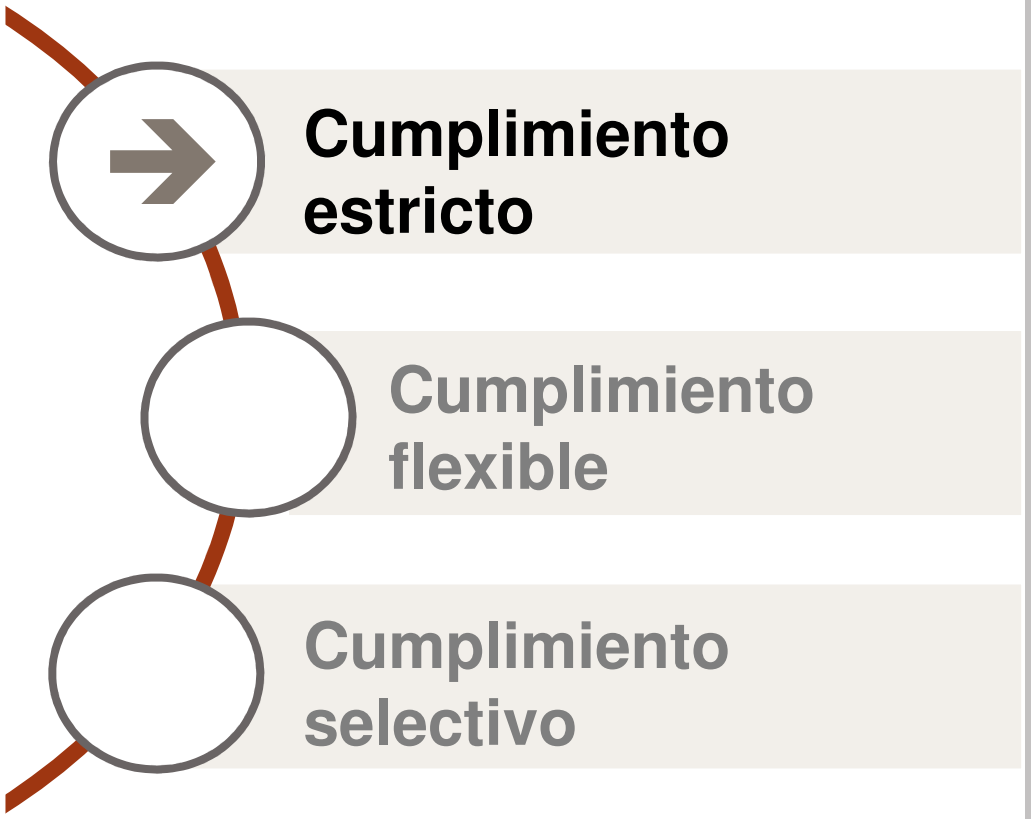

- Un estilo de manejo estricto es el que generalmente se adopta después del diagnóstico de diabetes tipo 1.
- Los padres cuidan a sus hijos como vigilantes, en gran medida por los temores (p. ej., hipoglucemia, complicaciones a largo plazo).
- Los padres se colocan a sí mismos bajo la gran presión de hacer un buen trabajo.
- Las madres pueden hacer una pausa en sus carreras para concentrarse en el cuidado.
- Los padres tienden a mantenerse dentro del ambiente del hogar: buscan la familiaridad

Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2003;28(3):160-166.

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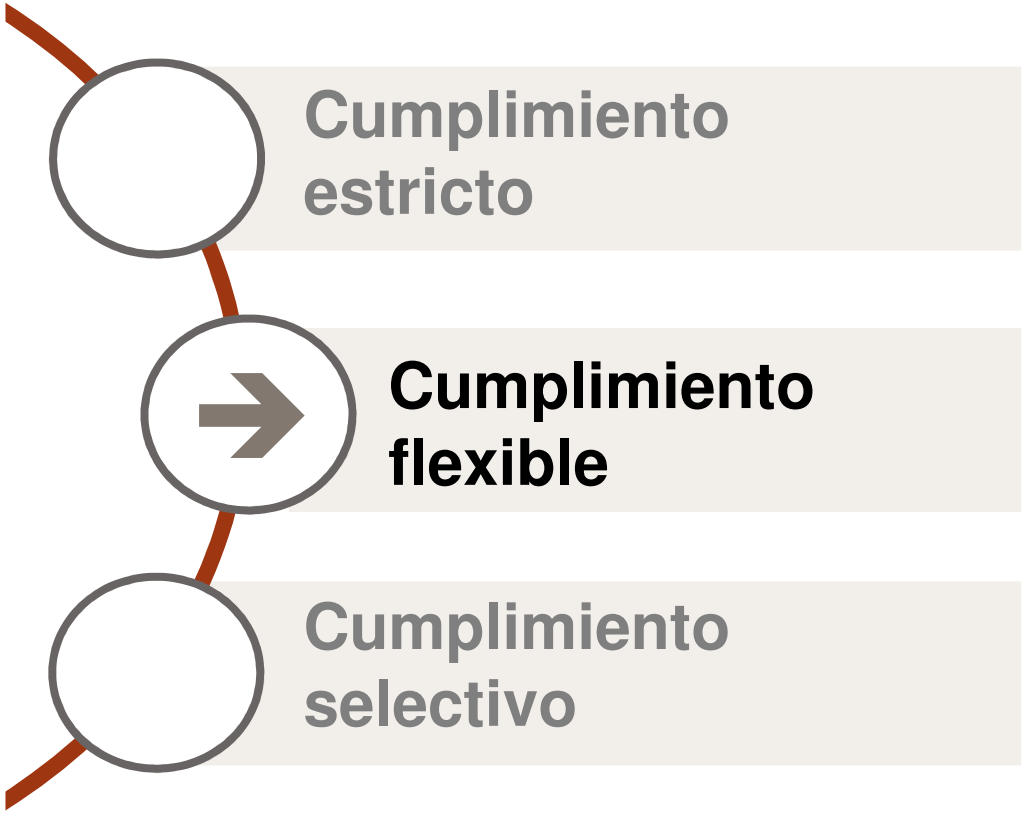
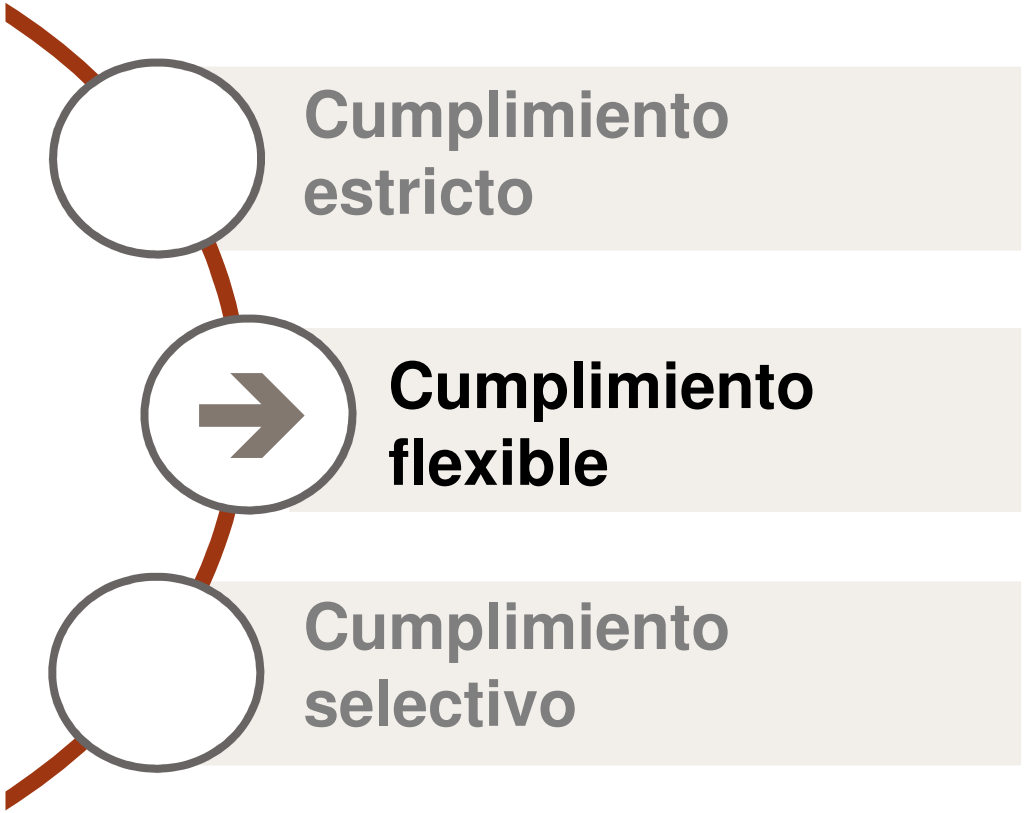


- Los padres generalmente avanzan hacia este estilo de manejo 6-12 meses después del diagnóstico de diabetes tipo 1.
- El cambio indica un avance en la confianza.
- Los padres se muestran proclives a modificar el regimen de tratamiento para:
  - Hacer que la vida sea más vivible.
  - Manejar mejor los desafíos normales
- Este abordaje implica el uso de ensayo y error para aprender cómo manejarse.

Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2003;28(3):160-166.

Momento de reforzar la educacion
Puede aparecer tristeza o depresion

Tres abordajes que los padres pueden utilizar para manejar el cuidado de la diabetes tipo 1 de su hijo



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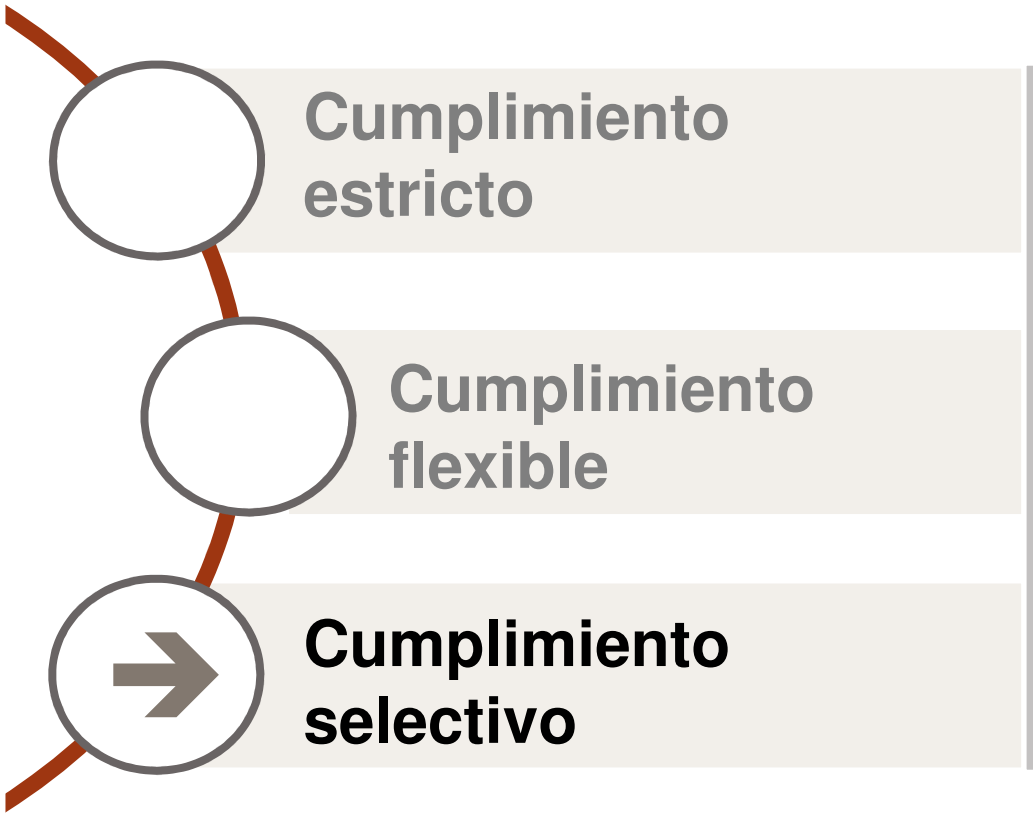


- Los padres pueden ser selectivos con respecto a su foco de concentración.
  - Ocasionalmente pueden utilizar una conducta de manejo extremo para intentar y manejar mejor la diabetes tipo 1 de su hijo.
  - Pueden esconder al profesional de la salud cómo se sienten o manejan la enfermedad en el hogar.

Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2003;28(3):160-166.

Cumplimiento estricto

Cumplimiento flexible

Cumplimiento selectivo

Recomendaciones

- Brindar:
  - Información.
  - Apoyo con afirmaciones positivas
  - Apoyo emocional
  - Atmósfera de no juicio
  - Elogiar el trabajo realizado
- Escapar de las categorías de familias “que cumplen” vs. familias “que no cumplen”.
- Crear asociaciones con familias que desarrollan objetivos colaborativos y realistas.
- Ayudar a los cuidadores a identificar estrategias alternativas para lidiar con sus temores y construir confianza.

Sullivan-Bolyai S, et al. *MCN Am J Matern Child Nurs*. 2003;28(3):160-166.

Fathers' Reflections on Parenting Young Children With Type 1 Diabetes

- Las sensaciones iniciales fueron similares a las de las madres
- La preocupación de los padres tendían a tener que ver con el futuro y las de las madres con lo inmediato.

Susan Sullivan-Bolyai, DNSc, CNS, RN,
Rachel Rosenberg, and Micaela Bayard.MCN.VOLUME 31 | NUMBER 1
January/February 2006

Los hermanos

- La evidencia muestra que los ajustes de los hermanos y de los padres están interrelacionados.[1]
- Se ha demostrado que los hermanos de niños con condiciones crónicas se encuentran en mayor riesgo de problemas emocionales y de comportamiento.[2]

Los factores asociados con un peor ajuste de los hermanos incluyen[2]:

- ❑ Mayor edad del hermano en el momento del diagnóstico.
- ❑ Mayores niveles de estrés de los padres.
- ❑ Temperamento más difícil del hermano.
- ❑ Peor ajuste del niño con diabetes tipo 1.
- ❑ Percepciones más negativas del hermano respecto de la diabetes y su impacto en la familia.

Simplemente preguntar a los padres por el hermano sano puede iniciar una conversación necesaria.[1]

1. Newton K, Lamarche K. *Home Healthc Nurse.* 2012;30(5):E1-E8. 2. Jackson C, et al. *Pediatr Diabetes.* 2008;9(1):308-311.

Algunos sentimientos que pueden favorecer el Agotamiento

- Amenaza continua de castigo
- Temor al error terapéutico
- Perdida de la espontaneidad
- Vigilancia continua (el control es el centro)
- Restricción de la actividad social
- Sensacion de caminar entre precipicios.

La linea del tiempo

Los niños pequeños

- La carga y el estrés de los cuidadores pueden ser más pronunciados cuanto menor es el niño con diabetes tipo 1.[1]
  - Los niños en la primera infancia tienen capacidad limitada de reconocer los síntomas, comunicar, razonar[2] y de automanejo.[3]
  - La mayor parte de la responsabilidad de las tareas relacionadas con la diabetes deben ser asumidas por el cuidador.[4]
  - Los niños en la primera infancia se encuentran en mayor riesgo de presentar hipoglucemia nocturna.[4]
  - La presentación de CAD puede ser de hasta el 37% en los niños en la primera infancia con diabetes tipo 1.[2]

1. Stallwood L. *J Pediatr Health Care.* 2005;19(5):293-300. 2. Smaldone A, Ritholz MD. *J Pediatr Health Care.* 2011;25(2):87-95.
3. Mitchell SJ, et al. *Fam Syst Health.* 2009;27(4):314-324. 4. Monaghan MC, et al. *Fam Syst Health.* 2009;27(1):28-38.

Los niños pequeños

-La Diabetes en un niño pequeño genera una marcada ansiedad familiar.

Situaciones que generan ansiedad:

- Sociedad poco familiarizada con la diabetes en niños tan pequeños.
- Rutina de vida erráticas y dificultad para generar hábitos.
- Compromiso extremo de las madres en el cuidado:

- Lange y Danne evaluaron el impacto económico y social de la diabetes en 580 familias con niños menores de 14 años.
- Concluyeron que existía impacto económico y menor desarrollo laboral particularmente en las madres y en especial de niños con diagnóstico antes de los 6 años de edad.[1]

1. Dtsch.Med.Wochenschr.129(20);1180-4.2004.

Los niños pequeños

Estrategias prácticas que pueden ayudarle a asistir a los cuidadores.

- Asegurar que la educación sobre la diabetes incluya evaluaciones periódicas del estrés de las familias[1]
- Reconocer el estrés percibido, incluso en los padres de niños en la primera infancia con niveles de HbA_{1c} dentro del rango objetivo.

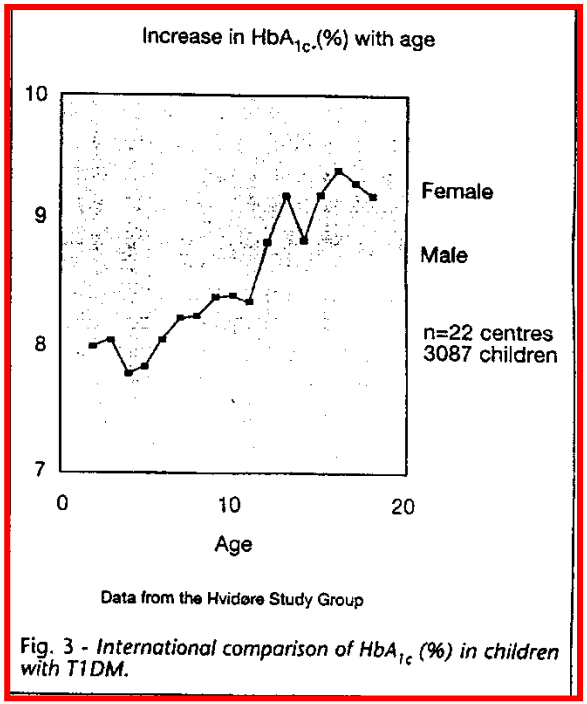


Fig. 3 - *International comparison of HbA_{1c} (%) in children with T1DM.*

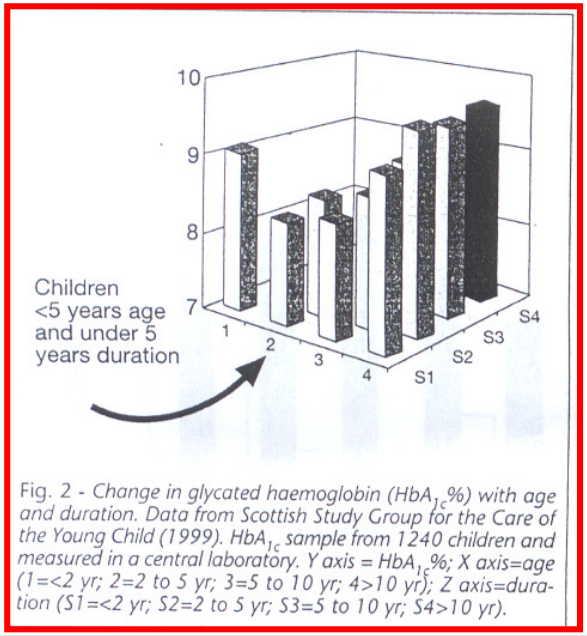


Fig. 2 - Change in glycated haemoglobin (HbA_{1c}%) with age and duration. Data from Scottish Study Group for the Care of the Young Child (1999). HbA_{1c} sample from 1240 children and measured in a central laboratory. Y axis = HbA_{1c}%; X axis=age (1=<2 yr; 2=2 to 5 yr; 3=5 to 10 yr; 4>10 yr); Z axis=duration (S1=<2 yr; S2=2 to 5 yr; S3=5 to 10 yr; S4>10 yr).

International Society for Pediatric and Adolescent Diabetes + Australasian Paediatric Endocrine Group

ISPAD + APEG 2015

October 7 – 10, 2015

Brisbane, Australia

Recomendaciones para ayudar a reducir el estrés nocturno

- Ayudar a los padres a comprender mejor cómo reconocer los patrones de la glucemia nocturna.
- Evaluar periódicamente la frecuencia de los monitoreos nocturnos.
- Preguntar si el niño duerme solo.
- Informar a los padres sobre la disminución del riesgo de hipoglucemias utilizando adecuadamente basal bolo o infusión continua de insulina.

INV16 - Parenting a toddler with diabetes

J. Ivancsik[1]

[1] *The Children's Hospital at Westmead, Institute of Endocrinology and Diabetes, Westmead, Australia*

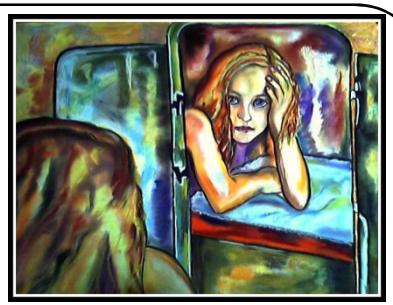
Healthcare professionals play an important role in shaping the way parents think about their child with diabetes. This presentation will integrate current literature, clinical practice wisdom and caregivers' experiences to explore the impact of parenting on health outcomes and psychological adjustment to diabetes.

Research suggests that the diagnosis of diabetes is a crucial variable that influences parent's psychological wellbeing and their ability to parent. Due to the pace of growth in infancy and toddlerhood (0-3 year olds), children have more rapid changes in development and behaviour than at any other stage of childhood. Therefore the treatment and management of diabetes in infants and toddlers pose unique challenges for their caregivers and healthcare professionals alike.

Post the diagnosis of diabetes parents are faced with the complex task of balancing competing needs and demands to achieve optimal glycaemic control and quality of life for their child. Carers of toddlers often struggle to adjust their parenting approach to keep normality in their child's life in a way that promotes positive physical, cognitive and emotional development, while integrating the day-to-day management of diabetes. Parents of toddlers with diabetes report higher parenting stress as well as higher levels of anxiety and fear associated with managing the condition, in particular fear of hypoglycaemia. These diabetes-specific worries and anxieties often lead to maladaptive coping strategies, such as over-protective parenting, which is shown to increase child-perceived vulnerability. This sense of vulnerability has been linked with an increased risk of depression and anxiety later in life.

Social Work can provide early intervention and support for parents with a toddler with diabetes which may be the key to establishing a solid parental framework; this is created through parent education, counselling and a multidisciplinary approach.

Crisis adolescente en el contexto de la Diabetes.



- Egocentrismo.
- Importancia del aquí y ahora.
- Falta de conflicto en relación a la brecha generacional.
- Las consignas no son claras.
- La autoridad de los padres como modelo está cuestionada.
- El futuro es incierto.

Factores que influyen en el deterioro del control glucémico y aumentan el riesgo de complicaciones

- Deseo de no ser diferente a sus pares.
- Adicciones “recreativas”.
- Baja autoestima.
- Depresión.
- El abandono de la consulta.
- Trastornos de la conducta alimentaria.

Lee P Diabet Med. 2009 26(4):328-333.

Dunger D. Diabetes Care. 2003:26:1052-1057.

Peveler R. Diabetes Care. 2005 28(1):84-88.

Bryden K. Diabetes Care.2001:24:1540-1536.

Pediatric Diabetes 2014: 15(Suppl. 20): 245–256.

El agotamiento de los padres.

- Los padres de adolescentes pueden comenzar a descomprometerse prematuramente, generando:

  – Relaciones familiares tensas
    - Falta de supervisión de los padres en el manejo de la diabetes .

  – La transferencia de las tareas de cuidado relacionadas con la diabetes a los adolescentes antes de que estén completamente listos y sean capaces de aceptar la responsabilidad.[1]

1. Carcone AI, et al. *J Dev Behav Pediatr.* 2012;33(4):343-351.

El conflicto padre-adolescente puede surgir a medida que los adolescentes avanzan hacia una mayor autonomía

- Los padres deben enfrentar:
  - Un cambio en el papel que juegan en la vida de su hijo
  - Los hijos pueden considerarlos ‘‘molestos’’ y ‘‘fastidiosos’’.

Los métodos de los padres pueden exacerbar el conflicto con el niño adolescente mediante:

- La vigilancia[1]
- El control psicológico[2,3]
- El control inadecuado de la conducta[3]

1. Malerbi FE, et al. *Diabetol Metabol Syndrome.* 2012;4(1):48. 2. Weissberg-Benchell J, et al. *J Pediatr Psychol*. 2009;34(9):977-988. 3. Smetana JG, Daddis C. *Child Dev*. 2002;73(2):563-580

La familia puede tener dos tipos extremos de adaptacion

- Compromiso excesivo:

Solo se habla y vive para la enfermedad

- Desapego general:

Solo una persona se hace cargo creandose una dependencia masiva; cuando el joven se independiza el cuidador queda sin rol.

El estrés, el agotamiento y la reacción de huida.

- Abandono
- Muerte

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CLUSTERING OF PREMATURE MORTALITY IN 1,761 INSULIN-DEPENDENT DIABETICS AND THEIR FAMILY MEMBERS

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Cohorte de 1781 pacientes el 5 % de las madres y el 13 % de los padres habian fallecido.

Las causas mas frecuentes fueron enfermedad cardiovascular y cancer.

Comparando padres de hijos fallecidos /padres de hijos vivos la mortalidad era de 18 vs 8% a la edad de 55 años.

POBLACION SEGÚN SEXO Y GRUPOS QUINQUENALES DE EDAD ESTIMADA AL 30 DE JUNIO DE 2010 POR JURISDICCIONES.

AMBOS SEXOS

JURISDICCION	TOTAL	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80 y más
Total del país	**40.518.951**	**3.419.673**	**3.321.992**	**3.414.646**	**3.449.559**	**3.349.723**	**3.209.903**	**3.248.807**	**2.712.018**	**2.373.257**	**2.225.891**	**2.068.656**	**1.903.397**	**1.627.136**	**1.329.074**	**1.071.331**	**845.028**	**948.860**
Ciud. Aut. Bs. As.	3.058.309	199.698	204.093	176.958	180.279	200.745	231.834	256.213	228.288	196.981	182.357	174.466	166.814	154.849	138.913	118.120	100.829	146.872
Buenos Aires	15.315.842	1.219.317	1.211.695	1.225.146	1.224.306	1.225.284	1.195.742	1.265.715	1.076.176	934.369	856.384	804.247	744.661	650.870	532.795	424.586	342.836	381.713
Catamarca	404.240	43.281	40.298	39.773	38.967	34.497	31.280	30.862	26.078	22.119	19.931	18.383	16.338	12.967	9.842	7.714	5.985	5.925
Córdoba	3.396.685	249.448	249.656	277.733	278.037	278.325	282.529	288.496	221.981	195.023	189.428	176.582	166.352	148.190	123.871	101.446	80.047	89.541
Corrientes	1.035.712	103.075	96.267	102.612	103.161	96.506	83.970	75.895	59.602	55.021	54.483	48.870	43.362	34.242	26.548	21.165	15.201	15.732
Chaco	1.071.141	106.698	98.492	113.301	114.207	101.930	87.682	77.149	61.652	56.318	55.722	50.703	43.286	32.487	25.039	20.359	14.524	11.592
Chubut	470.733	41.664	40.171	41.477	43.105	41.114	37.391	36.844	32.818	29.191	27.790	24.646	21.480	16.785	12.990	10.072	6.891	6.304
Entre Ríos	1.282.014	114.179	108.834	111.205	110.758	107.161	97.876	93.551	81.524	74.072	71.849	65.562	60.731	51.654	42.639	34.679	26.224	29.516
Formosa	555.694	60.088	53.494	59.450	63.116	53.812	42.466	36.631	31.265	29.521	28.693	25.110	21.397	16.231	12.379	9.856	6.645	5.540
Jujuy	698.474	72.149	66.712	69.115	71.427	62.202	57.234	53.726	45.004	37.959	34.270	30.307	27.264	21.801	17.211	13.530	9.698	8.865
La Pampa	341.456	27.304	26.285	27.571	29.562	28.925	25.604	24.666	22.884	20.776	20.370	18.221	17.021	14.495	12.502	9.863	7.467	7.940
La Rioja	355.350	32.830	31.273	34.134	36.496	31.608	29.484	30.606	23.971	20.463	18.828	16.397	14.299	11.161	8.388	6.459	4.629	4.324
Mendoza	1.765.685	156.619	148.109	147.100	153.731	150.661	140.138	137.779	113.874	97.676	91.257	88.097	84.730	73.068	59.010	46.204	36.596	41.036
Misiones	1.111.443	127.485	116.687	117.470	117.150	103.354	85.660	73.989	63.956	58.652	56.718	49.812	40.807	30.479	23.820	19.396	13.841	12.167
Neuquén	565.242	50.848	48.746	50.486	52.592	51.726	45.301	44.754	40.959	36.313	33.190	28.825	24.586	18.824	13.727	10.057	7.151	7.157
Río Negro	603.761	52.728	50.187	52.212	55.711	53.695	46.352	42.893	40.036	36.578	35.358	31.939	28.499	23.706	18.875	14.512	10.403	10.077
Salta	1.267.311	139.552	129.181	130.643	131.226	113.942	102.134	92.740	78.362	67.887	61.284	53.201	47.541	37.411	28.538	22.391	16.252	15.026
San Juan	715.052	69.733	66.450	65.205	64.638	59.187	55.320	54.808	47.617	39.813	36.326	34.098	32.042	27.568	21.460	16.080	12.044	12.663
San Luis	456.767	45.373	43.088	42.228	41.194	37.534	34.460	35.710	29.652	26.598	24.619	21.969	19.864	16.581	13.354	10.070	7.313	7.160
Santa Cruz	234.087	22.305	21.724	21.776	21.671	19.876	17.248	18.128	17.937	15.637	14.265	12.113	9.837	7.116	5.350	4.136	2.726	2.242
Santa Fe	3.285.170	252.750	246.890	255.293	267.931	273.806	271.532	268.577	210.060	186.736	184.519	173.673	162.402	140.705	118.786	100.030	79.902	91.578
Sgo. del Estero	883.573	79.952	76.413	96.404	95.601	82.023	72.460	68.488	55.500	46.962	42.659	39.545	35.279	28.450	21.982	17.926	12.468	11.461
Tucumán	1.511.516	139.746	134.793	144.824	141.935	129.888	126.632	130.409	92.616	79.166	75.836	74.028	69.495	54.003	38.852	31.197	24.416	23.680
Tierra del Fuego	133.694	12.851	12.454	12.530	12.758	11.922	9.574	10.178	10.206	9.426	9.755	7.862	5.310	3.493	2.203	1.483	940	749

TABLA 22: DEFUNCIONES SEGUN EDAD, POR JURISDICCION DE RESIDENCIA Y SEXO. - REPUBLICA ARGENTINA - AÑO 2010

AMBOS SEXOS

JURISDICCION DE RESIDENCIA	25 a 29	30 a 34	35 a 39	40 a 44	45 a 49	50 a 54	55 a 59	60 a 64	65 a 69	70 a 74	75 a 79	80 a 84	85 y más	Sin especif.
REPUBLICA ARGENTINA	**3.267**	**3.721**	**4.136**	**5.226**	**7.621**	**11.456**	**16.800**	**22.250**	**27.048**	**32.660**	**40.364**	**46.974**	**78.085**	**901**
Ciud. Aut. de Buenos Aires	179	228	256	353	536	805	1.256	1.804	2.191	2.918	4.131	5.581	12.153	21
Buenos Aires	1.269	1.470	1.752	2.180	2.922	4.557	6.578	8.880	11.109	13.193	16.325	19.496	32.370	584
Partidos del Aglom. GBA	856	1.019	1.239	1.564	2.023	3.073	4.441	5.945	7.297	8.589	10.229	12.121	18.883	362
Catamarca	26	23	26	45	56	75	139	146	251	224	283	309	520	3
Córdoba	199	243	299	370	570	859	1.363	2.014	2.430	2.942	3.656	4.416	7.262	9
Corrientes	68	102	102	141	217	279	427	499	574	690	763	817	1.176	49
Chaco	117	97	134	152	267	389	506	682	784	886	949	1.047	1.467	4
Chubut	57	62	46	71	106	142	199	253	261	301	342	354	592	7
Entre Ríos	104	110	116	152	253	370	596	751	893	1.099	1.259	1.394	2.286	16
Formosa	52	64	56	84	111	177	197	254	303	357	348	366	495	3
Jujuy	82	73	94	92	128	186	268	321	393	442	501	496	655	3
La Pampa	22	19	31	45	52	86	126	178	185	299	312	374	616	1
La Rioja	29	22	26	52	69	74	130	158	180	205	208	253	390	3
Mendoza	139	142	162	155	240	429	665	878	1.068	1.347	1.718	1.964	2.856	5
Misiones	119	125	115	166	235	328	441	465	698	714	755	746	913	36
Neuquén	47	56	65	71	93	129	162	211	253	274	308	340	489	8
Río Negro	45	49	61	65	109	161	225	288	349	427	443	526	799	11
Salta	123	137	145	160	214	289	404	549	656	721	891	845	1.177	0
San Juan	49	68	69	76	101	170	275	396	488	531	626	623	926	0
San Luis	32	35	24	39	89	104	153	216	265	299	387	365	533	0
Santa Cruz	20	26	33	40	62	81	88	123	113	143	162	117	177	1
Santa Fe	269	287	297	413	723	999	1.431	1.950	2.468	3.124	4.013	4.825	7.631	3
Santiago del Estero	76	67	77	109	157	229	330	425	494	515	611	638	957	34
Tucumán	190	156	116	146	226	346	588	745	895	988	1.300	1.356	1.987	25
Tierra del Fuego	13	8	10	9	21	31	42	43	39	54	45	34	41	0
Otros países	28	26	29	31	36	50	46	60	55	43	54	55	51	4
Lugar no especificado	24	23	23	33	36	34	43	34	53	54	37	43	61	34

SECRETARIA DE POLITICAS, REGULACION E INSTITUTOS
DIRECCION DE ESTADISTICAS E INFORMACION DE SALUD

Poblacion general CABA Buenos Aires

25-45 a	Total	Varones	Mujeres
Poblacion	5.385.318	2.685.418	2.699.900
Mortalidad	7.671	4.979	2.680
% Mortalidad	0,14	0,18	0,099

Padres HGNPE. N:600

25-45 a	Total	Varones	Mujeres
	1200	600	600
Mortalidad	13	5	8
% Mortalidad	1,08	0,8	1,3

POBLACION SEGÚN SEXO Y GRUPOS QUINQUENALES DE EDAD ESTIMADA AL 30 DE JUNIO DE 2010 POR JURISDICCIONES.

AMBOS SEXOS

JURISDICCION	TOTAL	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80 y más
Total del país	**40.518.951**	**3.419.673**	**3.321.992**	**3.414.646**	**3.449.559**	**3.349.723**	**3.209.903**	**3.248.807**	**2.712.018**	**2.373.257**	**2.225.891**	**2.068.656**	**1.903.397**	**1.627.136**	**1.329.074**	**1.071.331**	**845.028**	**948.860**
Ciud. Aut. Bs. As.	3.058.309	199.698	204.093	176.958	180.279	200.745	231.834	256.213	228.288	196.981	182.357	174.466	166.814	154.849	138.913	118.120	100.829	146.872
Buenos Aires	15.315.842	1.219.317	1.211.695	1.225.146	1.224.306	1.225.284	1.195.742	1.265.715	1.076.176	934.369	856.384	804.247	744.661	650.870	532.795	424.586	342.836	381.713
Catamarca	404.240	43.281	40.298	39.773	38.967	34.497	31.280	30.862	26.078	22.119	19.931	18.383	16.338	12.967	9.842	7.714	5.985	5.925
Córdoba	3.396.685	249.448	249.656	277.733	278.037	278.325	282.529	288.496	221.981	195.023	189.428	176.582	166.352	148.190	123.871	101.446	80.047	89.541
Corrientes	1.035.712	103.075	96.267	102.612	103.161	96.506	83.970	75.895	59.602	55.021	54.483	48.870	43.362	34.242	26.548	21.165	15.201	15.732
Chaco	1.071.141	106.698	98.492	113.301	114.207	101.930	87.682	77.149	61.652	56.318	55.722	50.703	43.286	32.487	25.039	20.359	14.524	11.592
Chubut	470.733	41.664	40.171	41.477	43.105	41.114	37.391	36.844	32.818	29.191	27.790	24.646	21.480	16.785	12.990	10.072	6.891	6.304
Entre Ríos	1.282.014	114.179	108.834	111.205	110.758	107.161	97.876	93.551	81.524	74.072	71.849	65.562	60.731	51.654	42.639	34.679	26.224	29.516
Formosa	555.694	60.088	53.494	59.450	63.116	53.812	42.466	36.631	31.265	29.521	28.693	25.110	21.397	16.231	12.379	9.856	6.645	5.540
Jujuy	698.474	72.149	66.712	69.115	71.427	62.202	57.234	53.726	45.004	37.959	34.270	30.307	27.264	21.801	17.211	13.530	9.698	8.865
La Pampa	341.456	27.304	26.285	27.571	29.562	28.925	25.604	24.666	22.884	20.776	20.370	18.221	17.021	14.495	12.502	9.863	7.467	7.940
La Rioja	355.350	32.830	31.273	34.134	36.496	31.608	29.484	30.606	23.971	20.463	18.828	16.397	14.299	11.161	8.388	6.459	4.629	4.324
Mendoza	1.765.685	156.619	148.109	147.100	153.731	150.661	140.138	137.779	113.874	97.676	91.257	88.097	84.730	73.068	59.010	46.204	36.596	41.036
Misiones	1.111.443	127.485	116.687	117.470	117.150	103.354	85.660	73.989	63.956	58.652	56.718	49.812	40.807	30.479	23.820	19.396	13.841	12.167
Neuquén	565.242	50.848	48.746	50.486	52.592	51.726	45.301	44.754	40.959	36.313	33.190	28.825	24.586	18.824	13.727	10.057	7.151	7.157
Río Negro	603.761	52.728	50.187	52.212	55.711	53.695	46.352	42.893	40.036	36.578	35.358	31.939	28.499	23.706	18.875	14.512	10.403	10.077
Salta	1.267.311	139.552	129.181	130.643	131.226	113.942	102.134	92.740	78.362	67.887	61.284	53.201	47.541	37.411	28.538	22.391	16.252	15.026
San Juan	715.052	69.733	66.450	65.205	64.638	59.187	55.320	54.808	47.617	39.813	36.326	34.098	32.042	27.568	21.460	16.080	12.044	12.663
San Luis	456.767	45.373	43.088	42.228	41.194	37.534	34.460	35.710	29.652	26.598	24.619	21.969	19.864	16.581	13.354	10.070	7.313	7.160
Santa Cruz	234.087	22.305	21.724	21.776	21.671	19.876	17.248	18.128	17.937	15.637	14.265	12.113	9.837	7.116	5.350	4.136	2.726	2.242
Santa Fe	3.285.170	252.750	246.890	255.293	267.931	273.806	271.532	268.577	210.060	186.736	184.519	173.673	162.402	140.705	118.786	100.030	79.902	91.578
Sgo. del Estero	883.573	79.952	76.413	96.404	95.601	82.023	72.460	68.488	55.500	46.962	42.659	39.545	35.279	28.450	21.982	17.926	12.468	11.461
Tucumán	1.511.516	139.746	134.793	144.824	141.935	129.888	126.632	130.409	92.616	79.166	75.836	74.028	69.495	54.003	38.852	31.197	24.416	23.680
Tierra del Fuego	133.694	12.851	12.454	12.530	12.758	11.922	9.574	10.178	10.206	9.426	9.755	7.862	5.310	3.493	2.203	1.483	940	749

TABLA 22: DEFUNCIONES SEGUN EDAD, POR JURISDICCION DE RESIDENCIA Y SEXO. - REPUBLICA ARGENTINA - AÑO 2010

AMBOS SEXOS

JURISDICCION DE RESIDENCIA	25 a 29	30 a 34	35 a 39	40 a 44	45 a 49	50 a 54	55 a 59	60 a 64	65 a 69	70 a 74	75 a 79	80 a 84	85 y más	Sin especif.
REPUBLICA ARGENTINA	**3.267**	**3.721**	**4.136**	**5.226**	**7.621**	**11.466**	**16.800**	**22.250**	**27.048**	**32.660**	**40.364**	**46.974**	**78.085**	**901**
Ciud. Aut. de Buenos Aires	179	229	256	353	536	805	1.256	1.804	2.191	2.918	4.131	5.581	12.153	21
Buenos Aires	1.268	1.470	1.752	2.180	2.922	4.557	6.578	8.880	11.109	13.193	16.325	19.496	32.370	584
Partidos del Aglom. GBA	856	1.014	1.234	1.564	2.023	3.073	4.441	5.945	7.297	8.589	10.229	12.121	18.883	362
Catamarca	26	23	26	45	56	75	139	146	251	224	283	309	520	3
Córdoba	199	243	288	370	576	856	1.363	2.014	2.430	2.942	3.656	4.416	7.262	9
Corrientes	68	102	102	141	217	279	427	499	574	690	763	817	1.176	49
Chaco	117	97	134	152	267	389	506	682	784	886	949	1.047	1.447	4
Chubut	57	62	46	71	106	142	199	253	261	301	342	354	592	7
Entre Ríos	104	110	116	152	253	370	596	751	893	1.099	1.259	1.384	2.286	16
Formosa	52	64	56	84	111	177	197	254	303	357	348	369	495	3
Jujuy	82	73	94	92	128	186	268	321	393	442	501	496	655	3
La Pampa	22	19	31	45	52	86	126	178	185	299	312	374	616	1
La Rioja	29	22	26	32	66	74	130	158	180	205	256	253	390	3
Mendoza	139	142	162	155	240	429	605	878	1.068	1.347	1.718	1.964	2.936	5
Misiones	110	125	115	166	235	328	441	465	698	714	755	746	913	36
Neuquén	47	56	65	71	93	129	162	211	253	274	308	340	489	8
Río Negro	45	48	61	66	109	161	225	288	349	427	443	526	799	11
Salta	123	137	145	160	214	289	456	549	656	721	891	845	1.177	0
San Juan	49	68	66	76	101	170	275	396	486	531	626	623	926	0
San Luis	32	35	24	39	89	104	153	216	265	299	387	365	533	0
Santa Cruz	20	26	33	40	62	81	88	123	113	143	162	117	177	1
Santa Fe	269	287	297	411	723	999	1.431	1.950	2.468	3.124	4.013	4.825	7.631	5
Santiago del Estero	76	67	77	109	157	229	330	425	494	515	611	638	957	34
Tucumán	190	156	116	146	226	346	588	745	895	988	1.300	1.356	1.987	25
Tierra del Fuego	13	8	10	9	21	31	42	43	39	54	45	34	41	0
Otros países	28	26	29	31	36	50	46	60	55	43	54	55	51	4
Lugar no especificado	24	23	23	33	36	34	43	34	53	54	37	43	61	34

SECRETARIA DE POLITICAS, REGULACION E INSTITUTOS
DIRECCION DE ESTADISTICAS E INFORMACION DE SALUD

La mortalidad es 9 veces mayor a predominio materno.

Poblacion general CABA Buenos Aires

25-45 a	Total	Varones	Mujeres
Poblacion	5.385.318	2.685.418	2.699.900
Mortalidad	7.671	4.979	2.680
% Mortalidad	0,14	0,18	0,099

Padres HGNPE. N:600

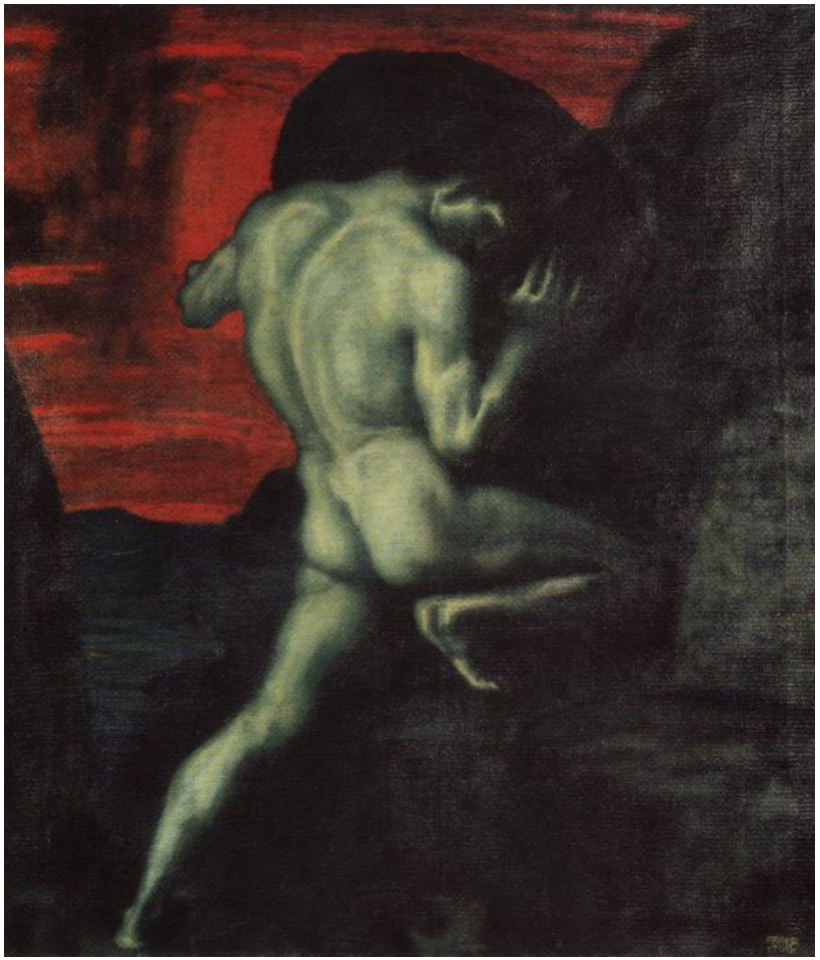
25-45 a	Total	Varones	Mujeres
	1200	600	600
Mortalidad	13	5	8
% Mortalidad	1,08	0,8	1,3

Padres: 3 Infartos 2 Accidentes
Madres :7 Tumores 1 Desconocida.

- *Cuando el paciente y la diabetes se convierten en el epicentro familiar aparecen sentimientos de compasión, lastima, desamparo, sobreproteccion, impotencia y sus contracaras.*

Los sentimientos circulan entre el niño, padres , hermanos.

La capacidad de adaptacion y afrontamiento de la familia depende de sus propios recursos



No eludir el conflicto.
Acompañar el proceso que es diferente para cada persona, familia y cultura.
Mantener la individualidad y favorecer la autonomia.