ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 17, Issue, 09, pp.34697-34701, September, 2025
DOI: https://doi.org/10.24941/ijcr.49561.09.2025

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

CAREGIVER-PATIENT RELATIONSHIP, COPING STRATEGIES, ANDTHERAPEUTIC COMPLIANCE IN TYPE II DIABETICS UNDERGOINGFOLLOW-UP CARE AT THE ABIDJAN DIABETES CENTER

MEITE Amadou, DJETE Yaba Christelle Sonia and TOHOURI Arnold Oswald Ephrem Rock

Department of Psychology, Félix Houphouët-Boigny University, Côte d'Ivoire

ARTICLE INFO

Article History:
Received 20th June, 2025
Received in revised form
24st July, 2025
Accepted 29th August, 2025
Published online 30th September, 2025

Keywords:

Caregiver-patient relationship, Communication, Coping strategies, Diabetes, Treatment compliance.

***Corresponding author:**
MEITE Amadou

ABSTRACT

Diabetes is a chronic disease that is often associated with disability and the threat of serious complications. It requires lifelong treatment or treatment over many years. This indefinite duration of treatment could increase the rate of non-adherence to treatment for this disease and lead to difficulties in adaptation among diabetic patients. It is therefore essential to take this adaptive dimension into account and to emphasize holistic care for diabetic patients. This study examines the relationship between coping strategies, the caregiver-patient relationship, and treatment adherence in type 2 diabetic patients in Abidjan. Data were collected using the overall adherence score developed by Duvert and Gonnet (2014), the French adaptation of the W.C.C-R (Ways of Coping Checklist) by Cousson-Gélieand al. (1996) and the experimental Doctor-Patient Communication Scale (CMM-13) by Gibert and Kernou (2014) from 133 participants aged between 24 and 78. The results indicate a relationship between coping strategies and therapeutic compliance on the one hand, and reveal a significant link between coping strategies and therapeutic compliance on the other.

Copyright©2025, MEITE Amadou et al. 2025. *This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.*

Citation: **MEITE Amadou, DJETE Yaba Christelle Sonia and TOHOURI Arnold Oswald Ephrem Rock.** ***2025.*** *"*Caregiver-patient relationship, coping strategies, andtherapeutic compliance in type ii diabetics undergoingfollow-up care at the abidjan diabetes center.". *International Journal of Current Research, 17, (09), 34697-34701.*

INTRODUCTION

Diabetes is the leading chronic, non-communicable disease associated with an increased risk of premature death. According to the World Health Organization [WHO] (2023), 24 million adults currently live with diabetes, and the disease is expected to become one of the leading causes of death in Africa by 2030. In Côte d'Ivoire, according to the National Program for the Control of Metabolic Diseases and Prevention of Noncommunicable Diseases, the prevalence rate of diabetes was 6.2% in 2017 (PNLMM/PMNT, 2017). This clearly demonstrates a real public health problem. The main types of diabetes are type 1 diabetes, type 2 diabetes, and gestational diabetes. Type 2 diabetes is the most common form of diabetes (approximately 90% of cases) worldwide (International Diabetes Federation [IDF], 2019). Its treatment is based mainly on lifestyle and dietary measures, medical monitoring, and medication. Successful treatment requires discipline on the part of the patient (Osterberg & Blaschke, 2005); in other words, strict adherence to the treatment plan. According to Plouin et al. (1979), this adherence to treatment or therapeutic compliance implies a *"degree of concordance between the* doctor's mode of social relations (Fischer, 1999), promotes compliance and is a powerful means of exchange in caregiving (Moro & Kouakou, 2023). The caregiver exchanges information with the person being cared for on an ongoing basis. Their interpersonal skills are crucial and include various elements such as listening, tact, empathy, sensitivity, confidentiality, respect, clarity and sincerity in explanations, as well as informing the patient about their illness (Hurlimann, 2001; Lelorain & al., 2012). Poor communication between the doctor and the patient could therefore lead to poor compliance. In this regard, a study by Fuertes and al. (2007) indicates that, the quality of the therapeutic relationship has a significant impact on the patient's perception of the usefulness of their treatment, their sense of self-efficacy regarding their ability to adhere to their treatment, the rate of therapeutic adherence, and patient satisfaction. It is therefore within the relationship between healthcare professionals and patients that the therapeutic framework is defined, a framework in which therapeutic compliance must be addressed (Grimaldi & Cosserat, 2004; Tarquino & Tarquino, 2007). In other words, adherence begins with the relationship established between the patient and the healthcare professional.

In the context of medical care, Phaneuf (2011) argues that the relationship is based on communication, the quality of which

makes it possible to create, with the patient, that meaningful bond known as the caregiver-patient relationship. Relational care, or the caregiver-patient relationship, with which communication is intertwined, is part of a holistic approach to the person receiving care, in that the individual dimension is central to this relationship. The quality of the patient-caregiver relationship is therefore a key factor influencing therapeutic compliance. According to certain studies, notably those by Essoli (2020) and Tlili (2014), the caregiver-patient relationship has an effect on treatment compliance among individuals with chronic diseases, in this case diabetics. Indeed, ongoing support from healthcare professionals and communication could lead patients to take responsibility for their health until therapeutic success is achieved. In addition to support, communication plays a decisive role in the caregiver-patient relationship and is not limited to spoken words, but also takes into account the caregiver's manner, gestures, smile, gaze, posture, facial expression, touch, and tone of voice (Hesbeen, 1994; Tlili, 2014). In short, communication, through its various functions (expressive, emotional, conative, etc.) and components, enables the caregiver to welcome the patient, listen to them, understand them, and show them that they exist (Davis, 1968). A good caregiver-patient relationship is therefore a "mothering" relationship in which the caregiver represents the "good enough mother," according to Winnicott's theory (1956).

A good therapeutic outcome is certainly an indicator of the patient's ability to adapt to their illness and treatment, but it is important to identify the patient's daily difficulties, as well as their resources, in order to provide them with the best possible support during their illness (Benoist, 2004). This means offering them an arrangement that is acceptable to them and compatible with their daily life (Golay & al., 2004). In other words, the patient must take action in response to the medical prescription in order to improve their health and well-being. In many cases, individuals with chronic illnesses find themselves facing a major event that causes them difficulties and leads to a painful experience of being put to the test. However, the individual does not remain passive; they react and try to cope with these difficulties. The set of cognitive and behavioral efforts aimed at reducing and controlling these difficulties is called coping (Lazarus & Folkman, 1984). Coping refers to a set of reactions and strategies used by an individual to deal with stressful situations (Bruchon-Schweitzer, 2001). In fact, it is a multidimensional control strategy aimed at changing either the actual threatening situation or the subject's objective opinion of it. Cousson and al. (1996) identify three types of coping: problem-oriented coping, which corresponds to the patient's cognitive and behavioral efforts; emotion-oriented coping, which aims to manage the emotional responses that the situation may generate; and support seeking coping, which corresponds to the subject's efforts to obtain sympathy or help from others. Other authors, such as Suls and Fletcher (1985), refer to "avoidant coping" or "vigilant coping" as opposed, on the one hand, to "passive" strategies such as avoidance, escape, denial, or stoic acceptance, and, on the other hand, "active" strategies such as seeking information, support, social, and problem-solving plans.

According to Lazarus and Folkman (1984), a coping strategy is good if it allows the subject to control or reduce the impact of the aggression on their physical and psychological well-being. However, it is sometimes difficult to predict which strategy will be most effective in a given situation. In any case, it is clear that it is better to use one of the coping strategies than none at all. Authors have demonstrated that certain strategies are effective because they are appropriate to the situation encountered and that this effectiveness varies according to certain identified characteristics of the situation (Miller & Mangan, 1983). From this point of view, the coping strategy used to deal with the various requirements (constraints related to dosing schedules, the quantity of medication, and sometimes associated dietary restrictions) would vary according to the different meanings that the patient gives to these requirements. For this reason, coping could be considered a central concept in health psychology (Bruchon-Schweitzer & Boujout, 2014).

As we can see, the chronic nature of diabetes-related stress requires learning different strategies that promote treatment adherence and establishing a quality relationship between the caregiver and the patient. In Côte d'Ivoire, the problem of diabetes management is acute despite the actions taken to prevent this disease. Despite the oftenfatal outcome and significant psychological suffering caused by these chronic diseases, nearly one in two patients does not follow medical prescriptions correctly (Abodo & Lokrou, 1995; Oga & al., 2006).

In addition, numerous studies highlight the main problems in the quality of care, namely underuse, errors leading to complications ("misures"), and lack of communication in the caregiver-patient relationship (Lokrou & Gnangbomon-Boye, 1991; Schen & Giet, 2010). The proposed study is therefore part of this systematic research aimed at understanding this pathology in a holistic approach in this country. Its objective is to study the relationship between coping strategies, the caregiver-patient relationship, and therapeutic compliance using a holistic approach.

METHODS

Participants: The survey covers 133 type 2 diabetic patients monitored at the Abidjan Anti-Diabetes Center (CADA). Specifically, it covers 42 men (average age = 56.90) and 91 women (average age = 56.90).

Materials

For the purposes of this study, questionnaires were developed to gather information on the relationship between patients and healthcare staff, the coping strategies developed by patients, and the quality of their therapeutic compliance. These included: a personal information form, the Duvert and Gonnet (2014) therapeutic compliance questionnaire, the Ways of Coping Checklist, and the Physician-Patient Communication Questionnaire (CMM13).

Information sheet: The information sheet was designed to collect sociodemographic data from study participants. This data provided information on age, gender, level of education, marital status, place of residence, occupation, duration of illness, length of follow-up at the CADA, health insurance coverage, and the presence of comorbidity.

Duvert & Gonnet (2014) treatment adherence questionnaire: The overall compliance score (OG) questionnaire developed by Duvert and Gonnet (2014) is unique in that it takes two dimensions into account: "medication compliance" and "non-medication compliance." The "medication adherence" dimension comprises three questions (rated from 1 to 4 on a

Likert scale: 1 = no, 2 = somewhat no, 3 = somewhat yes, 4 = yes, definitely), one binary question (yes/no), and one supplementary question. The average score for this sub-section ranges from 3 to 12. When the participant's average score is close to 12, they are considered to be adhering to their medication prescriptions. The Cronbach's coefficient obtained for this sub-section is 0.78. The "non-medication compliance" dimension comprises four sub-dimensions÷ "adherence to additional tests," "adherence to health and dietary guidelines," and "follow-up consultations." Each sub-dimension is rated from 1 to 4 on a Likert scale (1 = no, 2 = somewhat no, 3 = somewhat yes, 4 = yes, absolutely) and includes a supplementary question and a binary question. Questionnaire on coping stratégies: Way of Coping Checklist (WCC-R).

The Way of Coping Checklist (WCC-R) questionnaire is a general scale adapted to the assessment of various coping and adaptation strategies used in response to a threatening situation (Folkman & Lazarus, 1980). The French version validated by Cousson-Gélieand al. (1996) measures the types of adaptation strategies used in response to stress. It comprises twenty-seven (27) questions, including ten (10) problem-focused questions (items 1, 4, 7, 10, 13, 16, 19, 22, 25, and 27), nine (9) emotion-focused questions (items 2, 5, 8, 11, 14, 17, 20, 23, 26) and eight (08) questions focused on social support (items 3, 6, 9, 12, 15, 18, 21, 24). Each item is rated on a Likert scale ranging from 1 to 4 points (No: 1, Somewhat No: 2, Somewhat Yes: 3, Yes: 4), except for item 15, which is rated in reverse (No: 4, Somewhat No: 3, Somewhat Yes: 2, Yes: 1). The results of the questionnaire are obtained by adding up the item scores corresponding to each dimension. In terms of psychometric properties, Cronbach's alpha coefficients are moderate for emotion-focused coping strategies (0.72) and social support-focused coping strategies (0.73), while slightly higher for problem-focused coping strategies (0.79). Communication questionnaire: Physician-Patient Communication CMM-13 The Physician-Patient Communication Questionnaire (PPC-13) is used to assess the impact of interventions during a consultation and provides information on the quality of care. It is short, easy to use, and measures doctor-patient communication independently of the pathological context. This tool comprises 13 items rated on a Likert scale from 1 to 4 points (No: 1, Rather No: 2, Rather Yes: 3, Yes: 4). Patients are asked to answer questions such as: "*Did the doctor listen to you carefully during the consultation?* (Item 1)" and "*Did the doctor involve you in the decision-making process*? (Item 11)." The total score is the sum of the 13 items. The average score ranges from 13 to 52. Patients with a CMM score < 42 were considered to have "poor" communication, while patients with a score ≥ 52 were considered to have "good" communication. The CMM-13 has good internal consistency with a high Cronbach's alpha coefficient of 0.89 (Gibert & Kernou, 2014).

Procedure

To collect information, each participant completed questionnaires on treatment adherence (OG), coping strategies (WCC-R), and communication (CMM-13). The administration of the instruments took 30 to 40 minutes per participant. Each questionnaire was completed while patients were waiting for their consultation at the CADA. Furthermore, it should be noted that, in order to control for any order effects, the study participants were randomly divided into three groups. The first group first completed the questionnaire on overall adherence, followed by the WCC-R and the CMM-13. The second group first answered the WCC-R, then the CMM-13, and finally the OG. Finally, the third group was asked to start with the CMM-13, followed by the OG, and finish with the WCC-R. All three groups completed the information sheet before filling out the various questionnaires. Statistical analyses using the chi-square test, performed using SPSS 2021 software, revealed the link between the different variables studied, in particular the caregiver-patient relationship, coping strategies, and therapeutic compliance (good compliance, poor compliance). As recommended by Tabachnick and Fidell (2007), extreme values in the data series were identified in order to check for distribution bias.

RESULTS

The results presented in Tables 1 to 4 concern the link between the caregiver-patient relationship (good communication, poor communication), coping strategies (problem-focused coping, emotion-focused coping, social support-focused coping), and therapeutic compliance (good compliance, poor compliance). In Table 1, statistical analysis indicates that there is a relationship between the caregiver-patient relationship and therapeutic compliance [$\chi^2(1) = 8.72$, $p \leq .05$].

Table 1. Caregiver-patient relationship and therapeutic compliance among type 2 diabetics at the Abidjan Diabetes Center

		Therapeutic compliance		TOTAL
		Good	Poor	
Caregiver patient relationship	Good communication	59 (44,36%)	28 (21,05 %)	87 (65,41%)
	Poor communication	19 (14,29 %)	27 (20,30 %)	46 (34,59%)
TOTAL		78 (58,65 %)	55 (41,35 %)	133

In other words, good communication between the caregiver and the patient promotes good compliance with additional tests and health and dietary advice, adherence to medication schedules and prescribed doses, and attendance at follow-up appointments. With regard to the relationship between coping strategy and treatment adherence, statistical analysis reveals the existence of a significant relationship [$\chi^2(2) = 11.35$, $p \leq .05$]; suggesting that coping strategies focused on emotions, problems, and social support are linked to adherence to medication prescriptions and the application of health and dietary advice in diabetic patients (Table 2). On the one hand, when considering the relationship between the different variables under study (Table 3), i.e., the caregiver-patient relationship, coping strategies, and therapeutic compliance, we observe that when there is good communication in the caregiver-patient relationship, therapeutic compliance differs according to the coping strategies used by patients [$\chi^2(2) = 6.21$, $p \leq .05$]. On the other hand, when there is insufficient or no communication in the caregiver-patient relationship, statistical analysis of the chi-square shows that diabetic patients manage their strategies differently with regard to therapeutic compliance [$\chi^2(2) = 2.32$, $p \leq .05$] (Table 4).

DISCUSSION

The main objective of our study was to examine the relationship between coping strategies, the caregiver-patient relationship, and treatment adherence. Data concerning the link

Table 2. Relationship between coping strategies and therapeutic compliance in type 2 diabetics at the Abidjan Anti-Diabetes Center

		Therapeutic compliance		
		Good	Poor	TOTAL
Coping strategy	**Problem-focused** coping	35 (57,38%)	26 (42,62%)	61 **(45,87%)**
	Emotion-focused coping	11 (36,67%)	19 (63,33%)	30 **(22,56%)**
	Coping focused on **social support**	32 (76,20%)	10 (23,80%)	42 **(31,57%)**
TOTAL		**78 (58,65%)**	**55 (41,35%)**	**133**

Table 3. Good communication in the caregiver-patient relationship, coping strategies, and therapeutic compliance in type 2 diabetics at the Abidjan Anti-Diabetes Center

	Coping strategy	Therapeutic compliance		
		Good	Poor	TOTAL
Good communication	**Problem-focused** coping	24	10	34**(51,52%)**
	Emotion-focused coping	5	10	15**(22,73%)**
	Coping focused on **social support**	11	6	17**(25,76%)**
TOTAL		**40(66,61%)**	**26(39,39%)**	**66**

Table 4. Poor communication in the caregiver-patient relationship, coping strategies, and therapeutic compliance among type 2 diabetics at the Abidjan Anti-Diabetes Center

	Coping strategy	Therapeutic compliance		TOTAL
		Good	Poor	
Poor communication	**Problem-focused** coping	16	11	27**(40,30%)**
	Emotion-focused coping	6	9	15**(22,39%)**
	Coping focused on **social support**	16	9	25**(37,31%)**
TOTAL		**30 (44,78%)**	**29 (43,28%)**	**67**

between the caregiver-patient relationship and treatment adherence confirm that diabetic patients who have a good relationship with healthcare staff adhere well to additional tests, lifestyle and dietary advice, medication, and medical appointments. These results are consistent with the work of Lelorain and Fontesse (2021), who showed that the quality of the relationship promotes therapeutic treatment, reduces patient distress, and improves their well-being. The results are also consistent with those of Hojatand al. (2011) and Hulimann (2001), who, in a conceptual approach to quality of care, suggest taking into account patients, their experience of care, communication, and the relationship with caregivers. This is because caregiving is not limited to performing a technical act. It also involves presence, support, and accompaniment (Benoist, 2004). This holistic approach to care involves both the caregiver and the patient in their individual, subjective, and emotional dimensions and is similar to a "mothering relationship" in which the caregiver represents the "good enough mother," in reference to Winnicott's theory of maternal preoccupation (1956). The present study also showed that satisfactory communication is necessary for this comprehensive approach to diabetic patients, in line with the study by Davis and al. (1968), who found that caregivers who inform patients clearly, warmly, and honestly about the main treatment options, side effects, risks, and benefits of treatments, as well as the prognosis and progression of the disease, enables the patient to take ownership of and make sense of their illness, learn to live with it, and remain in control of their life. Communication in caregiving is therefore synonymous with the caregiver's special attention (Hesbeen, 1994) and, according to humanistic psychology, with the "helping relationship" based on *"the development of a relationship of trust between the caregiver and the patient. (*Manoukian & Masseboeuf, 2011, p. 48)". With regard to the relationship between coping strategies and treatment adherence, the data show that diabetics who use strategies focused on emotion, social support, and the problem itself have good treatment adherence. In other words, the patient's cognitive and behavioral efforts and ability to manage the emotional responses that the disease can generate are undeniably important in the care of diabetic patients. The individual dimension, more specifically the sense of self-efficacy, is therefore central to this care. We might therefore think that patients with adaptive and emotional regulation skills are those who are able to follow medication and non-medication prescriptions. If we refer to Bandura's (1977) theory of self-efficacy, according to which self-efficacy refers to "*an individual's belief in their ability to influence their psychosocial functioning and the events that affect their life* (Bandura, 1977)." Indeed, beliefs in one's own efficacy, whether derived from one's own perception, emotional experiences, or the support of loved ones, enable patients to regulate and control the intensity and expression of these emotions and to adhere more rigorously to their treatment in the long term. Therefore, the way in which patients perceive their own abilities to cope with and control events influences how they react to illness. This concept of self-efficacy is part of an interactionist perspective according to which individuals react in different and contrasting ways to the various situations in their lives (Miller & Mangan 1983). However, the statistical technique used did not allow this intra-individual variability to be highlighted.

CONCLUSION

This study has helped to understand the link between the caregiver-patient relationship, coping strategies, and therapeutic compliance in type 2 diabetics monitored at the Centre Antidiabétiqued'Abidjan (CADA). The results indicate that diabetics who have a good relationship with their healthcare provider and who adopt appropriate behaviors using coping strategies are more likely to follow medical recommendations. These data could be of considerable importance in that they contribute to making therapeutic education more efficient and to addressing the medical and

psychological care of diabetic patients in a holistic approach. Improving the quality of professional practice and communication in a healthcare context is therefore necessary. Furthermore, the results reveal that when there is good communication in the caregiverpatient relationship, therapeutic compliance differs according to the coping strategies used by patients. It is therefore essential to understand the healthcare system as an ecosystem with patients, healthcare professionals, and payers as key players, connected by a strong and inseparable relationship.

REFERENCES

Abodo, R. J. & Lokrou, A. (1999). Aspects du diabète sucré chez le noir africain à l'hôpital militaire d'Abidjan. A propos de 423 cas colligés du 1er janvier 1995 au 31 décembre 1999*, Med Afr Noire*, *42* (7), 372-382.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215.

Benoist, L. (2004). Prendresoin. *Gestalt*, *26*(1), 23-25.

Bruchon-Schweitzer, M. (2001). Concepts, Stress, Coping : le coping et les stratégiesd'ajustement face au stress. *Rechercheensoinsinfirmiers*, *4*(67), 68-83.

Bruchon-Schweitzer, M. & Boujout, E. (2014). *Psychologie de la santé: modèles, concepts et méthodes*. Dunod.

Cousson-Gélie, F., Bruchon-Schweitzer, M., Quintard, B., Nuissier, J. & Rasclen, N. (1996). *Analyse multidimensionnelle d'une échelle de coping : validation française de la WCC (Ways of Coping Checklist)*. Psychologie Française.

Davis, M. S. (1968). Variations in patient's compliance with doctors' advice: an empirical analysis of patterns of communication. *American Journal of Public Health*, 58(2), 274-288.

Fédération Internationale du Diabète [FID]. (2019). *Atlas du diabète de la FID,* 9ème Edition.

Fisher, G. N. (1999). Le concept de relation enpsychologiesociale. *Rechercheensoinsinfirmiers,* 56, 4-11.

Folkman, S. & Lazarus, R. S. (1980). An analysis of coping in middle-aged community sample. *Journal of health and social behavior, 21*(9), 219-239.

Fuertes, J. N., Mislowack, A., Bennett, J., Paul, L., Gilbert, T. C., Fontan, G. & Boylan, L. S. (2007). The physician–patient working alliance. *Patient education and counseling*, *66*(1), 29-36.

Gibert, C. & Kernou, A. (2014). *Élaboration d'une échelle mesurant la communication médecin-malade : validation et description de ses déterminants à partir d'une étude réalisée aux urgences.* Médecine humaine et pathologie.

Golay, A., Howles, M. N., Mateiciuc, S., Bufacchi, T. & Amati, F. (2004). Améliorerl' observance médicamenteuse. *Médecine et hygiène*, 909-912.

Grimaldi, A., &Cosserat, J. (2004). *La relation médecin-malade*. Elsevier.

Haynes, R. B., Taylor, D. W. & Sackett, D. L. (1979). *Compliance in health care*. Johns Hopkins University Press.

Hesbeen W. (1994). Pour uneréorientation du soininfirmier, *ObjectifSoins*, 28, 1-8.

Hojat, M., Louis, D. Z., Markham, F. W., Wender, R., Rabinowitz, C. & Gonnella, J. S. (2011). Physicians' empathy and clinical outcomes for diabetic patients. *Academic medicine*, *86*(3), 359-364.

Hurlimann, C. (2001). Approcheconceptuelle de la qualité des soins. *Actualité et dossier en santé publique*, 35, 23-28.

Lazarus, R. S. (1984). Puzzles in the study of daily hassles. *Journal of Behavioral Medicine.* 7(4), 375-389.

Lelorain, S. & Fontesse (2021). *Empathie et déshumanisation en milieu médical*. De Boeck Supérieur.

Lokrou, A. & Gnangbomon-Boye, J. (1991). Le diabète non insulino-dépendanten Côte d'Ivoire. Etude de 3950 cas. *Revue françaised'endocrinologieclinique, nutrition et métabolisme*, *32*(6), 581-588.

Manoukian, A. & Masseboeuf, A. (2011). *La relation soignant-soigné*. Editions Lamarre.

Ménard, J. (1979). Le bilan de l'hypertension artérielle. *Annales de Cardiologie et d'Angéiologie*, *28*(1), 5-8.

Miller, S.M. & Mangan, C.E. (1983). Interacting effects of information and coping style in adapting to gynecologic stress: should the doctor tell all? *J Pers Soc Psychol*. 45(1), 223-236.

Moro, M. D. & Kouakou, M. (2023). Gestion de la prise en charge des diabétiques de l'hôpital militaire d'Abidjan (HMA), *Revue Internationale du chercheur,4*(2), 534- 552.

Oga, A. S. S., Tebi, A., Aka, J., Adouéni, K. V., Malan, K. A., Kouadio, L. P. & Lokrou, A. (2006). Le diabètesucrédiagnostiqueen Côte d'Ivoire: des particularitésépidémiologiques. *Médecinetropicale*, *66*(3), 241-246.

Organisation Mondiale de la la Santé [OMS]. (2023). *Rapport sur les Résultats 2023 de l'OrganisationMondiale de la Santé* [OMS] *2023.*

Osterberg, L. & Blaschke, T. (2005). Adherence to medication. *New England journal of medicine*, *353*(5), 487-497.

Phaneuf, M. (2011). *La relation soignant-soigné : l'accompagnement thérapeutique.* Chenelière Éducation

Plouin, P. F., Degoulet, P., Bautier, P. & Menard, J. (1979). Le traitement de l'hypertension: stratégie à long terme. *Rev Prat*, *29*(57), 4409-4416.

Programme National de Lutte contre les Maladies Métaboliques et de Prévention des Maladies Non Transmissibles [PNLMM / PMNT] . (2017). *Prévalence et caractéristiques du diabète en Côte d'Ivoire* – PREVADIA-CI 2017. 55p.

Schen, A. J. & Giet, D. (2010). Non-observance thérapeutique: causes, conséquences, solutions. *Revue Médicale Liège, 65* (5-6), 239-245.

Spire, B., Carrieri, P., Raffi, F., Salmon, D., Chêne, G., de Jaureguiberry, J. P., ... & Leport, C. (2004). La non-observance et l'observancemodérée aux antirétrovirauxsont-ellesexpliquées par les mêmes facteurs? Analyse de 4 années de suivi de la cohorteaproco de patients ayantinitieunemultithérapie avec inhibiteur de protéase. *Médecine et Maladies Infectieuses*, *34*, S75- S75.

Tabachnick, B.G. & Fidell, L.S. (2007). *Using multivariate statistics*. Pearson, Allys, & Bacon.

Tarquino, C. & Tarquino, M. P. (2007). L'observance thérapeutique : déterminants et modèles théoriques. *Pratiques Psychologiques*, 13, 1-19.

Tlili, F. (2014). Relation soignant-soigné dans le cadre des maladies chroniques. *Revue internationale de santé publique*, 117-121.

Winnicott, D. W. W. (1956)**.** La préoccupation primaire. In : *De la pédiatrie à la psychanalyse (*pp. 168-174). Payot.

****