



**COPING STRATEGIES IN THE DEVELOPMENT OF
RESILIENCE IN CHILDREN WITH DIABETES MELLITUS**

CORINA CUCUI^a

^a *drd. "Ion Creangă" State Pedagogical University, Chişinău*

Abstract

The reactions of children to stress are influenced by several factors, including parental style, the level of emotional intelligence, but especially by the cognitive, emotional or behavioral strategies they have at their disposal. For children with diabetes, the overlap of medical stress with the normal challenges of development can create additional tensions, such as managing health-related fears, accepting differences from peers, or integrating treatment routines into daily life. This research aimed to identify trends in coping with stress and how diabetes affects the approach to daily and emotional challenges, as well as its impact on self-perception and reactions to perceived threats. The comparative study aimed to observe differences in stress coping between two groups of children: 100 children with diabetes and 100 children without diabetes. Often, children with diabetes have not developed many coping resources, but through dedicated programs, they can learn and develop them. The goal is to implement a multidimensional therapeutic intervention program, helping children not only develop cognitive problem-solving skills, but also cultivate emotional regulation abilities and constructive ways to express emotions and manage behavioral challenges.

Keywords: *children with diabetes, coping, development, resilience, emotional regulation*

1. INTRODUCTION

Negative thoughts in children related to perceived threats, such as physical threats, social threats, personal failure, or hostility, play a crucial role in managing chronic stress and Type 1 Diabetes (T1D). Studies suggest that these thoughts can significantly impact how children develop their coping mechanisms and resilience. Children with Type 1 Diabetes (T1D) are often exposed to negative thoughts related to physical risks, such as hypoglycemia, long-term complications, and the

ongoing stress of managing blood glucose levels correctly. These thoughts can increase anxiety and fear of non-compliance with medical regimens, thereby affecting their quality of life. A study by (Helgeson și colab., 2009) demonstrated that adolescents with diabetes who experience high levels of health-related anxiety are at greater risk for depression and difficulties in disease management. Regarding social threats, differences from peers, stigmatization, and fear of social exclusion can lead to negative thoughts about acceptance in social groups. The study by (Hains și colab., 2006) emphasizes that social anxiety and the fear of not being accepted in communities are common among children with Type 1 Diabetes (T1D), making them more vulnerable to emotional and behavioral issues. The feeling of not managing diabetes well can trigger thoughts of personal failure and self-blame. According to a study by (Whittemore și colab., 2010), the perception of failure in disease management can negatively impact children's self-esteem, reducing their motivation to adhere to treatment plans and exacerbating negative emotional states. Children may experience frustration and anger towards diabetes, viewing the condition as a burden that limits their lives. (Hilliard și colab., 2013) showed that hostility and frustration related to the limitations imposed by diabetes can lead to dysfunctional coping mechanisms, such as avoidance or social isolation.

The impact of coping strategies on negative thoughts

Emotional regulation is essential for managing anxiety related to physical and social threats. According to research by (Skinner & Zimmer-Gembeck, 2007), effective emotional regulation strategies help children reduce anxiety and maintain optimal diabetes control. *Cognitive restructuring* plays a crucial role in modifying negative thoughts related to personal failure and hostility. The study by (Grey și colab., 2009) emphasizes that cognitive-behavioral interventions can enhance children's ability to reinterpret negative thoughts, thereby reducing anxiety and depression. *Social withdrawal* and *wishful thinking* are associated with an increased perception of physical threat and hostility. (Hains și colab., 2006) demonstrated that these maladaptive strategies can exacerbate social isolation and frustration. *Social support* is one of the strongest protective factors. According to (Leonard și colab., 2002), children who receive support from family and peers have lower levels of negative thoughts and are better able to adapt to their condition.

1. OBJECTIVE AND HYPOTHESES

The objective of the research is grounded in the need to identify the coping mechanisms that children with Type 1 Diabetes (T1D) possess and predominantly use, in order to implement a dedicated psychotherapeutic program aimed at helping them develop new adaptive responses to stress. This approach takes into account the chronic nature of the disease, which requires more diverse and effective responses to the lifestyle associated with diabetes. The goal is to support children in strengthening their capacity to respond to daily stressors as well as diabetes-specific stress, promoting flexible and varied strategies that provide a sense of control and autonomy. The research considers the impact of perceived threats, such as negative thoughts related to physical threats (hypoglycemia, complications),

social threats (differences from peers), personal failure (managing diabetes), and hostility (frustration related to the limitations imposed by the disease), and how these threats can be addressed through a psychotherapeutic program tailored to their needs.

2. METHOD

The instruments used in the research to achieve the proposed objectives and goals were as follows: 1. *KIDCOPE* – a brief screening tool designed to assess the use and effectiveness of coping strategies in children and adolescents aged 7 to 18 years (Spirito și colab., 1988). It evaluates 11 coping strategies through self-reporting: distraction, prayer, self-blame, social withdrawal, cognitive restructuring, blaming others, problem-solving, emotional regulation, wishful thinking, social support, and resignation. 2. *Children and Adolescents' Automatic Thoughts Scale (CATS)* – developed by (Schniering & Rapee, 2002), this self-report questionnaire consists of 40 items that measure negative thoughts related to perceived threats, specifically physical threat, social threat, personal failure, and hostility.

Both tests were administered under the same conditions to all children in the research groups, and the obtained results were compared and analyzed. This approach allowed for a detailed understanding of the coping mechanisms utilized by children with Type 1 Diabetes (T1D) and highlighted the differences in perception and management of stress between the two groups. The findings provide a solid foundation for the development of a multidimensional therapeutic program tailored to the specific psychosocial needs of children with diabetes, aiming to enhance their adaptive strategies and improve resilience.

3. RESULTS

The analysis of data and statistical interpretation of research results are essential steps in evaluating the effectiveness of psychotherapeutic interventions, particularly in the context of children with type 1 diabetes (T1D). The purpose of this section is to present the obtained results and interpret their significance within the research framework. The use of appropriate statistical analysis enabled us to identify significant relationships between variables, determine major predictors of coping, and understand the impact of these strategies on their emotional and psychological well-being (Table 1). Additionally, the interpretation of the results was conducted in the context of existing literature, providing an empirical basis for understanding the complexities of coping among children with T1D. These findings also underscore the importance of social support and adaptive strategies in managing the challenges associated with this chronic illness.

Thus, the data analysis and interpretation of results will contribute to formulating recommendations for psychotherapeutic interventions aimed at fostering resilience and effective coping skills among children with diabetes.

Table 1. Descriptive analysis of coping mechanisms

			Level of manifestation	
			Low manifestation	Significant manifestation
V1	Distraction	n	112	88
		%	56.0	44.0
V2	Prayer	n	172	28
		%	86.0	14.0
V3	Self-Blame	n	134	66
		%	67.0	33.0
V4	Social withdrawal	n	126	74
		%	63.0	37.0
V5	Social support	n	125	75
		%	62.5	37.5
V6	Cognitive Restructuring	n	154	46
		%	77.0	23.0
V7	Emotional Regulation	n	183	17
		%	91.5	8.5
V8	Whishful thinking	n	147	53
		%	73.5	26.5
V9	Blaming Others	n	121	79
		%	60.5	39.5
V10	Resignation	n	148	52
		%	74.0	26.0
V11	Problem Solving	N	122	78
		%	61.0	39.0

Low frequencies (<50%) were observed for the manifestation of the 11 coping strategies, with the lowest frequency being noted for *Emotional Regulation* (8.5%). High usage rates were observed for *Distraction* (44%), *Blaming Others* (39.5%), and *Problem-Solving* (39%), followed by *Social Support* (37.5%) and *Social Withdrawal* (37%), *Self-Blame* (33%), and *Resignation* (26%). The analysis of coping methods among children reveals a varied use of stress management and emotional difficulty strategies (Compas și colab., 2001).

The low frequency of *Emotional Regulation* (8.5%) indicates that children face significant challenges in managing and regulating their emotions adaptively. This suggests a critical need for interventions aimed at developing these essential skills for emotional health and stress management.

Distraction (44%) is the most frequently used strategy, involving the diversion of attention from the current problem or stressor to reduce its impact. Distraction may include engaging in enjoyable activities or commitments that shift focus away from the source of stress. *Blaming Others* involves attributing responsibility for encountered problems to others, which can temporarily alleviate feelings of pressure. *Problem-Solving* is the most adaptive and effective strategy for managing stress, based on the search for solutions, and is used by 39% of the children. *Social Support* relies on seeking and utilizing assistance from others to cope with difficulties, including discussions with friends, family, or trusted individuals.

Social Withdrawal involves retreating from social interactions, which may be used to avoid stressful situations but can lead to isolation and loneliness. *Self-*

Blame entails taking full responsibility for encountered problems, which may result in decreased self-esteem and a sense of helplessness. *Resignation* (26%) involves passive acceptance of the situation and a lack of action to change circumstances, which may indicate a lack of motivation or feelings of frustration. Other mechanisms utilized by children included *Religious Coping* (14%), *Cognitive Restructuring* (23%), and *Wishful Thinking* (26.5%), as illustrated in the following graph (Figure 1).

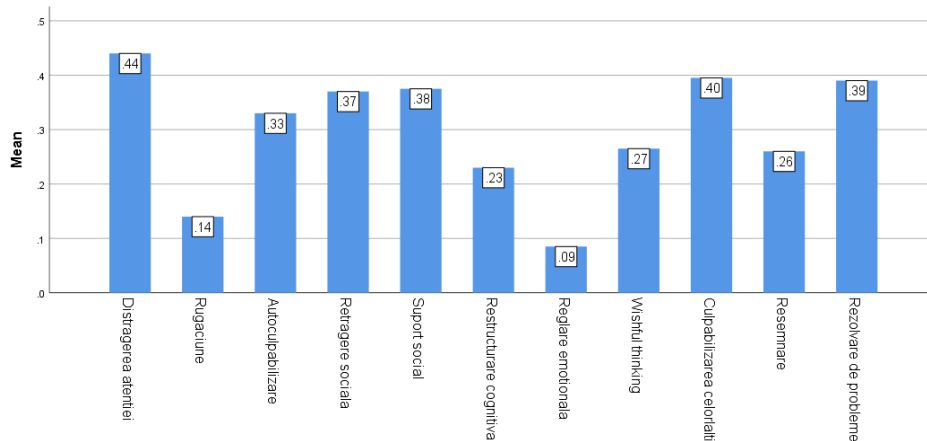


Figure 1. The mean scores for different coping strategies

To test the differences determined by a factor model composed of sex, age, and the presence of Type 1 Diabetes (T1D) in predicting the levels of ordinal variables, binary logistic regression analysis was applied. The results obtained were summarized as follows:

- The statistical significance of the model (Omnibus test) was reported through the Chi-square test value (χ^2) and the statistical significance level (p).
- Predictive capacity (R^2) was assessed using both Cox-Snell and Nagelkerke methods.
- The logistic model coefficients and their significance within the model were reported (B, SE, W, p).
- The odds ratio (OR) was presented through the value of $\exp(B)$.

Distraction

The tested model is statistically significant ($\chi^2=33.12$, $p=0.001$), with a predictive capacity of 20.4% ($R^2=0.204$). The sex difference serves as a negative predictor (B=-1.66, W=27.28, $p=0.001$), indicating a lower level of distraction in girls. In the literature, girls are often described as having greater self-control and better long-term attention maintenance compared to boys (Ruff & Rothbart, 2001).

Prayer (Religious Coping)

The tested model is statistically significant ($\chi^2=11.55$, $p=0.009$), with a predictive capacity of 10.1% ($R^2=0.101$). The presence of the illness serves as a positive predictor ($B=1.02$, $W=5.05$, $p=0.025$), indicating a higher level of prayer among those with Type 1 Diabetes (T1D). The model for religious coping, as measured by prayer, demonstrates that the presence of T1D significantly impacts the use of this coping strategy (Figure 2). This means that individuals with T1D are more likely to resort to prayer as a method of religious coping compared to those without diabetes. This increased use of prayer may reflect a search for spiritual and emotional support in the face of the difficulties and stress associated with diabetes management. In the literature, religious coping, including prayer, is often studied in the context of chronic illnesses. Studies suggest that individuals with chronic conditions, such as diabetes, may utilize prayer and other religious practices as a means of coping with the stress and challenges related to their illness (Koenig, 2012; Pargament și colab., 2004).

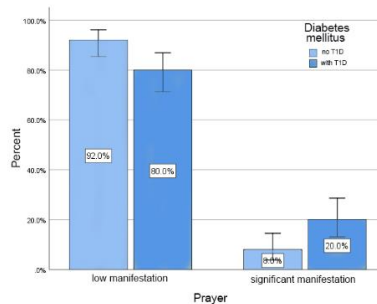


Figure 2. Comparison of Prayer coping strategies between children with and no T1D

Self-Blame

The tested model is statistically significant ($\chi^2=12.64$, $p=0.005$), with a predictive capacity of 8.5% ($R^2=0.085$). Gender differences serve as a positive predictor ($B=1.09$, $W=11.92$, $p=0.001$), indicating a higher level of self-blame among girls. Girls may be more inclined to take personal responsibility for the challenges they face or to excessively blame themselves compared to boys. The literature indicates that gender factors can influence coping styles, and girls may be more susceptible to exhibiting self-blame than boys, due to social norms and various psychological pressures (Nolen-Hoeksema, 2001).

Social Support

The tested model is statistically significant ($\chi^2=9.98$, $p=0.001$), with a predictive capacity of 6.6% ($R^2=0.066$). Age differences serve as a negative predictor ($B=-1.21$, $W=7.99$, $p=0.005$), indicating a decrease in the manifestation of social support as age increases (Figure 3). This result suggests that as children grow and go through different developmental stages, they may experience lower levels of social support. This decline may be linked to changes in social networks, communication technology, increased responsibilities, or different perceptions of social interactions. The reduction of social support with age is a common observation in research on social and psychological development. Studies suggest

that over a lifetime, as individuals age, social support networks may become smaller and relationships more complex (Hughes și colab., 2004).

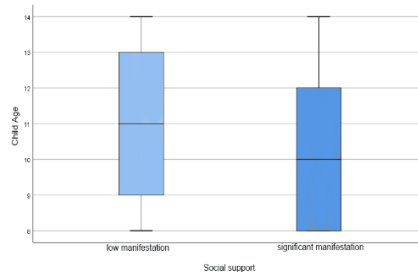


Figure 3. Manifestation of Social support among children by age group

Emotional Regulation

Emotional regulation is poorly manifested among the research subjects, with a clear manifestation rate of only 17%, and all of these subjects belong to the category of children with Type 1 Diabetes (T1D). The low prevalence suggests that children with T1D may face significant challenges in managing their emotions, which can negatively affect their emotional and psychological adaptation (Figure 4). The presence of diabetes can add an additional level of stress and pressure on children, contributing to difficulties in emotional regulation. Generally, children with chronic conditions like T1D may experience greater challenges in emotional regulation due to the additional stress and challenges associated with the disease (Gioia și colab., 2000). Studies have shown that the rigorous management regimen for diabetes and the long-term impact of the illness can affect children's ability to manage their emotions (Lange, K., Aroian, K. J., & Arfken, C. L., 2007).

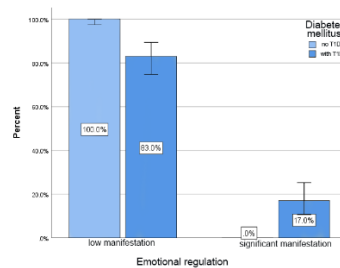


Figure 4. Comparison of Emotional regulation coping strategies between children with and no T1D

Wishful Thinking

The tested model is statistically significant ($\chi^2=13.30$, $p=0.004$) with a predictive capacity of 9.4% ($R^2=0.094$). The presence of Type 1 Diabetes (T1D) serves as a positive predictor ($B=1.07$, $W=9.73$, $p=0.002$), indicating a higher level of manifestation among children with T1D (Figure 5). This result suggests that, among children with T1D, there is a more pronounced expression of the studied effect compared to those without T1D. Wishful thinking refers to the tendency to hope for or dream of favorable situations as a form of coping, rather than addressing problems realistically. This can be a mechanism for adapting to the

ongoing stress and challenges associated with managing a chronic illness. However, excessive reliance on wishful thinking may hinder the development of more practical and realistic coping strategies (Thompson și colab., 2013). Idealistic thinking may be influenced by a lack of adequate information or insufficient emotional support.

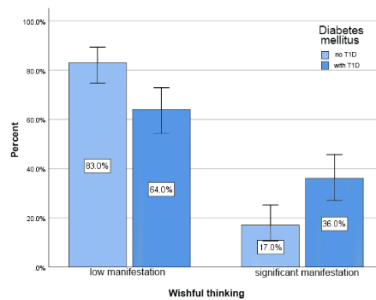


Figure 5. Comparison of Wishful thinking coping strategies between children with and no T1D

Blaming Others

The tested model is statistically significant ($\chi^2=13.17$, $p=0.004$) with a predictive capacity of 8.6% ($R^2=0.086$). The difference in sex serves as a negative predictor ($B=-0.84$, $W=7.61$, $p=0.006$), indicating a lower level of manifestation among girls. Blaming others may be a less constructive coping strategy. Girls tend to exhibit a lower level of blaming others, potentially due to social norms or differences in problem-solving styles. Blaming others refers to the tendency to attribute personal problems or difficulties to external sources (Lazarus & Folkman, 1984).

Resignation

The tested model is statistically significant ($\chi^2=11.89$, $p=0.008$) with a predictive capacity of 8.5% ($R^2=0.085$). Gender difference represents a positive predictor ($B=1.10$, $W=10.41$, $p=0.001$) indicating a higher level of manifestation among girls. Girls tend to exhibit a higher level of resignation. Resignation refers to a passive acceptance of difficult situations, where the individual feels powerless to change the circumstances. This may reflect differences in how girls and boys cope with challenges and stress (Carver, 1997).

Problem Solving

The tested model is statistically significant ($\chi^2=16.71$, $p=0.001$) with a predictive capacity of 10.9% ($R^2=0.109$). The presence of diabetes (DZ) represents a negative predictor ($B=-1.02$, $W=11.12$, $p=0.001$), indicating a higher level of manifestation among children with Type 1 Diabetes (T1D). This result suggests that children with T1D are more likely to employ problem-solving strategies compared to those without diabetes (Figure 6). This may reflect a greater inclination to seek concrete solutions and actively address issues in response to the additional challenges posed by managing a chronic illness (Folkman & Moskowitz, 2004). In the context of psychological and educational interventions, promoting and strengthening problem-solving strategies may be beneficial for children with

T1D. Such strategies can aid in developing the ability to cope with difficult situations and in managing the psychological effects of the disease.

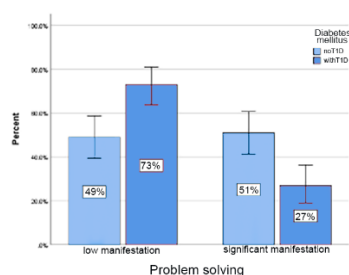


Figure 6. Comparison of Problem solving coping strategies between children with and no T1D

The results of the binary logistic regression analysis do not indicate statistical significance in predicting the use of **Cognitive restructuring** and **Social withdrawal** as coping mechanisms based on demographic variables such as gender, age, and the presence of Type 1 Diabetes (T1D). The model tested for cognitive restructuring (Chi-square = 3.62, $p = 0.306$) and for social withdrawal (Chi-square = 2.83, $p = 0.418$) fails to explain significant variation in the use of these coping strategies. The R^2 values, ranging from 0.014 to 0.019, suggest that the variables included in the models have a limited influence on the outcomes. Other factors, such as family context, social support, or individual psychological traits, may have a greater impact, as suggested by the literature (Compas și colab., 2001; Seiffge-Krenke, 2001).

The research identified significant associations between certain coping strategies and the negative thoughts of children with Type 1 Diabetes (T1D) related to perceived threats (Table 2). Emotional regulation is associated with a normal level of physical threat, suggesting that children who can manage their emotions healthily perceive physical threats (such as hypoglycemia or diabetes complications) at a more manageable level, without exaggerating the perceived danger. Conversely, resignation is linked to an abnormal level of physical threat, indicating that children who resign in the face of difficulties tend to perceive physical threats as greater and more overwhelming, which can amplify stress and anxiety related to the illness.

Social withdrawal and wishful thinking significantly correlate with a normal level of social threat. This suggests that these children are able to minimize the perception of differences from peers or mitigate the social impact of diabetes through temporary withdrawal strategies or fanciful thoughts that help them cope with stressful social situations. In turn, self-blame is associated with a reduced level of personal failure. This indicates that when children take responsibility for their difficulties, it can lessen feelings of failure, as they tend to learn from mistakes and adjust their behavior rather than feel overwhelmed.

Regarding hostility, it is influenced by both maladaptive coping mechanisms, such as resignation and social withdrawal, and adaptive mechanisms, such as cognitive restructuring and social support. Thus, children who engage in cognitive restructuring and receive support from those around them are better able to manage

hostility, whereas those who resign or socially withdraw tend to exhibit higher levels of hostility.

These findings highlight the importance of developing adaptive coping mechanisms and promoting social support, cognitive restructuring, and emotional regulation within a dedicated psychotherapeutic program. Such a program could reduce the perception of threats and enhance children’s ability to manage diabetes-related stress while cultivating resilience.

Table 2. Descriptive analysis of Threats

Threats		Omnibus Test		R ²		Model coefficients				
No.	Factor	$\chi^2(3)$	<i>p</i>	C-S	N	<i>B</i>	<i>S</i> <i>E</i>	<i>Wal</i> <i>d</i> (<i>df</i> =1)	<i>p</i>	<i>Exp</i> (<i>B</i>)
Physical threat	Resignation					1.2	0.	5.3	0.0	3.6
	Emotional regulation	49.	0.0	0.2	0.3	9	56	9	20	2
Social threat	Social withdrawal					-	0.	4.9	0.0	0.1
	Wishful thinking	30.	0.0	0.1	0.1	2.1	95	8	26	2
Personal failure	Self-blame					1				
		30.	0.0	0.1	0.1	1.4	50	3	04	4
Hostility	Resignation					5				
	Social support	26	0.1	0.40	0.83	-	0.	5.8	0.0	0.3
Hostility	Cognitive restructuring					1.1	48	2	16	2
	Whishful thinking					6				
Hostility	Social withdrawal					-	0.	9.9	0.0	0.2
		41	0.1	0.41	0.89	1.3	43	8	02	6
Hostility	Resignation					3.2	0.	24.	0.0	25.
	Social support					3	65	47	01	34
Hostility	Cognitive restructuring					1.9	0.	12.	0.0	7.1
	Whishful thinking	56.	0.0	0.2	0.3	7	54	90	01	8
Hostility	Social withdrawal					1.7	0.	8.8	0.0	5.9
		75	0.1	0.47	0.33	8	60	1	03	0
Hostility	Resignation					1.4	0.	7.2	0.0	4.1
	Social support					3	53	0	07	7
Hostility	Cognitive restructuring					1.3	0.	6.2	0.0	4.0
	Whishful thinking					9	56	4	12	1

4. CONCLUSIONS

The research guides the development of a psychotherapeutic intervention aimed at supporting resilience in children by strengthening and developing new coping strategies, thereby reducing negative thoughts associated with perceived threats. Through such interventions, we aim to promote a sense of competence and self-efficacy, helping children take control of challenging situations through effective emotional regulation and problem-solving strategies. We specifically

recommend addressing ways to manage hostility through cognitive restructuring and social support, fostering an atmosphere of encouragement and acceptance. The ultimate goal is to equip children with the necessary tools to manage both daily challenges and those specific to diabetes, thereby reducing the negative impact of dysfunctional thoughts and strengthening the internal resources needed for optimal adaptation to life with a chronic illness.

REFERENCES

- Carver, C. S. (1997). You want to measure coping but your protocol' too long: Consider the brief cope. *International Journal of Behavioral Medicine*, 4(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6
- Compas, B. E., Connor-Smith, J. K., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Psychological Bulletin*, 127(1), 87–127. <https://doi.org/10.1037/0033-2909.127.1.87>
- Folkman, S., & Moskowitz, J. T. (2004). Coping with Stress: A Review of Theory, Research, and Applications. *Annual Review of Psychology*, 55(1), 745–774. <https://doi.org/10.1146/annurev.psych.55.090902.141456>
- Gioia, G. A., Isquith, P. K., Guy, S. C., & Kenworthy, L. (2000). TEST REVIEW Behavior Rating Inventory of Executive Function. *Child Neuropsychology*, 6(3), 235–238. <https://doi.org/10.1076/chin.6.3.235.3152>
- Grey, M., Whitemore, R., & McDonnell, M. (2009). The impact of cognitive-behavioral interventions on anxiety and depression in children with diabetes. *Journal of Pediatric Psychology*, 34(7), 781–790.
- Hains, A. A., Berlin, K. S., Hobart Davies, W., Smothers, M. K., Sato, A. F., & Alemzadeh, R. (2006). Attributions of Adolescents with Type 1 Diabetes Related to Performing Diabetes Care around Friends and Peers: The Moderating Role of Friend Support. *Journal of Pediatric Psychology*, 32(5), 561–570. <https://doi.org/10.1093/jpepsy/jsl040>
- Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2009). Health-related quality of life in adolescents with diabetes: The role of social support. *Journal of Pediatric Psychology*, 34(6), 607–617.
- Hilliard, M. E., Wu, Y. P., Rausch, J., Dolan, L. M., & Hood, K. K. (2013). Predictors of Deteriorations in Diabetes Management and Control in Adolescents With Type 1 Diabetes. *Journal of Adolescent Health*, 52(1), 28–34. <https://doi.org/10.1016/j.jadohealth.2012.05.009>
- Hughes, M. E., Waite, L. J., Hawkey, L. C., & Cacioppo, J. T. (2004). A Short Scale for Measuring Loneliness in Large Surveys: Results From Two Population-Based Studies. *Research on Aging*, 26(6), 655–672. <https://doi.org/10.1177/0164027504268574>
- Koenig, H. G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *ISRN Psychiatry*, 2012, 1–33. <https://doi.org/10.5402/2012/278730>
- Lange, K., Aroian, K. J., & Arfken, C. L. (2007). Diabetes management in children and adolescents: A review of the psychosocial aspects. *Diabetes Care*, 30(3), 582–589.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping* (11. [print.]). Springer.
- Leonard, B. J., Wysocki, T., & Harris, M. A. (2002). Family and peer support and adaptation to diabetes in children and adolescents. *Diabetes Care*, 25(9), 1748–1753.
- Nolen-Hoeksema, S. (2001). Gender Differences in Depression. *Current Directions in Psychological Science*, 10(5), 173–176. <https://doi.org/10.1111/1467-8721.00142>

Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious Coping Methods as Predictors of Psychological, Physical and Spiritual Outcomes among Medically Ill Elderly Patients: A Two-year Longitudinal Study. *Journal of Health Psychology, 9*(6), 713–730. <https://doi.org/10.1177/1359105304045366>

Ruff, H. A., & Rothbart, M. K. (2001). *Attention in Early Development: Themes and Variations*. Oxford University Press. <https://books.google.ro/books?id=8tj2NV3WqE0C>

Schniering, C. A., & Rapee, R. M. (2002). Development and validation of a measure of children's automatic thoughts: The children's automatic thoughts scale. *Behaviour Research and Therapy, 40*(9), 1091–1109. [https://doi.org/10.1016/S0005-7967\(02\)00022-0](https://doi.org/10.1016/S0005-7967(02)00022-0)

Seiffge-Krenke, I. (Ed.). (2001). Coping with Diabetes: A Longitudinal Study. In *Diabetic Adolescents and their Families: Stress, Coping, and Adaptation* (pp. 25–41). Cambridge University Press; Cambridge Core. <https://doi.org/10.1017/CBO9780511500022.005>

Skinner, E. A., & Zimmer-Gembeck, M. J. (2007). *The development of coping and self-regulation: Vol. Handbook of socialization: Theory and research* (In J. E. Grusec & P. D. Hastings (Eds.)). Guilford Press.

Spirito, A., Stark, L. J., & Williams, C. (1988). KIDCOPE: A coping measure for children and adolescents. *Journal of Consulting and Clinical Psychology, 56*(6), 900–907.

Thompson, R. A., Virmani, E. A., Waters, S. F., Raikes, H. A., & Meyer, S. (2013). The Development of Emotion Self-Regulation. In *Handbook of Self-Regulatory Processes in Development*. Routledge. <https://doi.org/10.4324/9780203080719.ch2>

Whittemore, R., Melkus, G. D., & Grey, M. (2010). The impact of diabetes management on the psychosocial functioning of children and adolescents with diabetes. *Diabetes Educator, 36*(5), 754–766.

Copyright: Submission of a manuscript implies that the work described has not except in the form of an abstract or as part of a published lecture, been published before (or thesis) and it is not under consideration for publication elsewhere; that when the manuscript is accepted for publication, the authors agree to automatic transfer of the copyright to the publisher.
