Psychosocial Care for People with Diabetes

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American Diabetes Association®

Disclosures

I have no commercial or financial relationships to disclose.

Learning Objectives

- Describe psychosocial issues associated with diabetes, which range from normative diabetes-related distress to diagnosable mental health disorders.
- Identify paradigms for implementing psychosocial services into team-based care.
- List screening tools for assessing symptoms of psychosocial issues within routine care.
- Indicate appropriate referral and treatment options for people impacted by both sub-clinical and clinical psychological distress.

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association

Diabetes Care 2016 Dec; 39(12): 2126-2140

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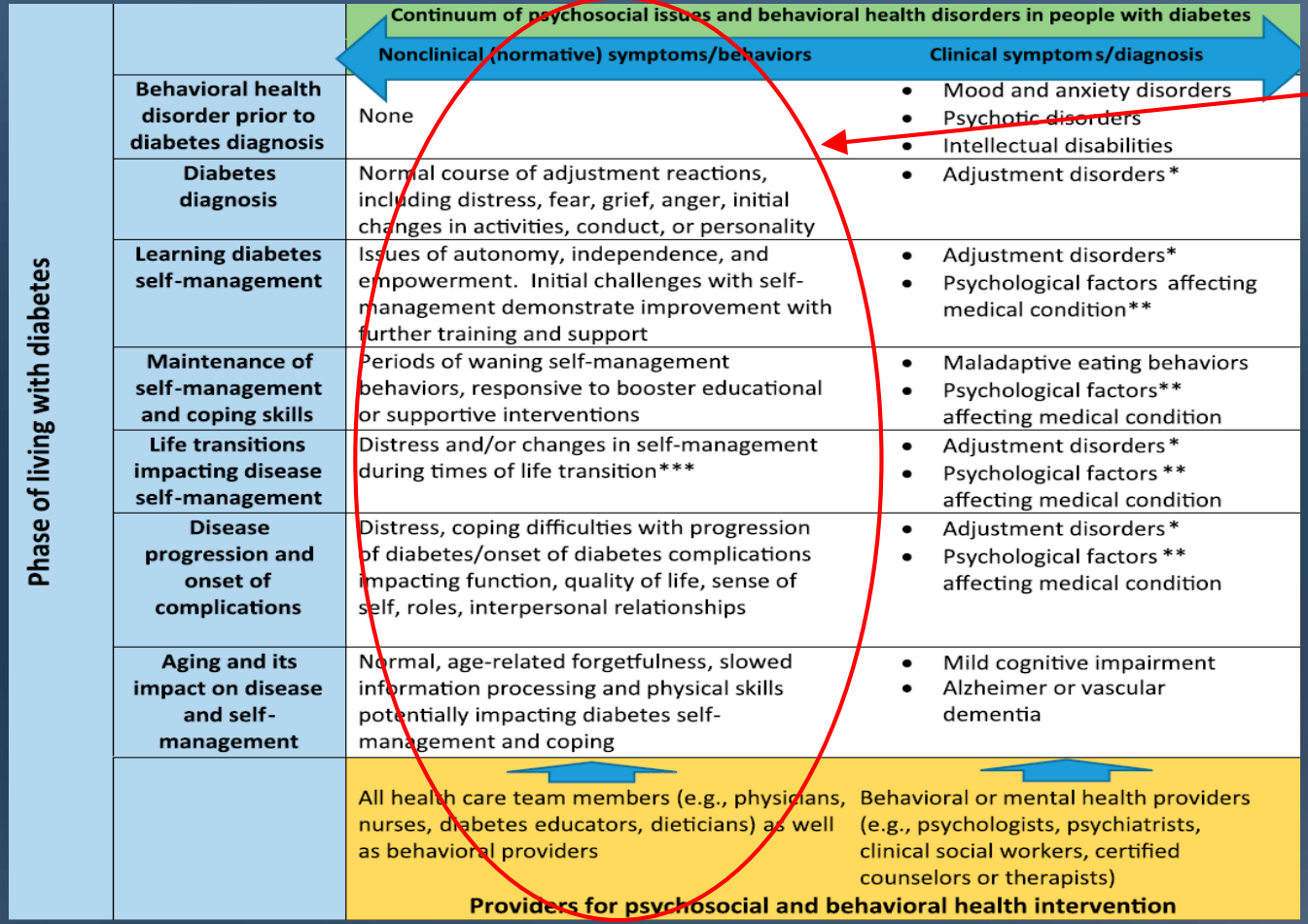
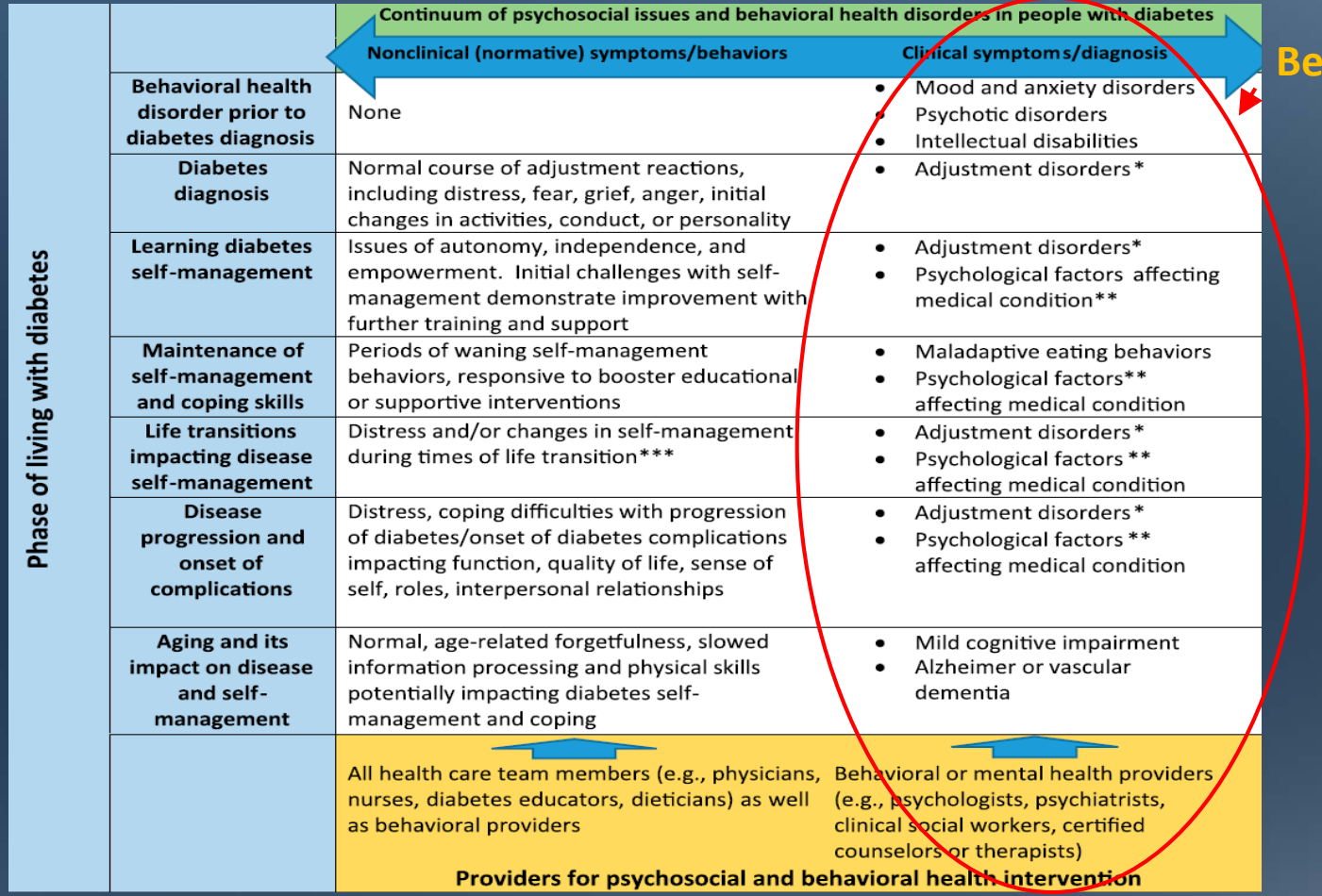
Psychosocial Care: Life Course and Continuum of Care



Psychosocial Care: Life Course and Continuum of Care



Psychosocial Care: Life Course and Continuum of Care

Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	Clinical symptoms/diagnosis
Behavioral health disorder prior to diabetes diagnosis	None	• Mood and anxiety disorders • Psychotic disorders • Intellectual disabilities
Diabetes diagnosis	Normal course of adjustment reactions, including distress, fear, grief, anger, initial changes in activities, conduct or personality	• Adjustment disorders*
Learning diabetes self-management	Issues of autonomy, independence, and empowerment. Initial challenges with self-management demonstrate improvement with further training and support	• Adjustment disorders* • Psychological factors** affecting medical condition
Maintenance of self-management and coping skills	Periods of waning self-management behaviors, responsive to booster educational or supportive interventions	• Maladaptive eating behaviors • Psychological factors** affecting medical condition
Life transitions impacting disease self-management	Distress and/or changes in self-management during times of life transition***	• Adjustment disorders* • Psychological factors** affecting medical condition

*With depressed mood, anxiety, or emotion and conduct disturbance. **Personality traits, coping style, maladaptive health behaviors, or stress-related physiological response. ***Examples include changing schools, moving, job/occupational changes, marriage or divorce, or experiencing loss.

(continued)

Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	**Clinical symptoms/diagnosis**
Disease Progression and onset of complications	Distress, coping difficulties with progression of diabetes/onset of diabetes complications impacting function, quality of life, sense of self, roles, interpersonal relationships	• Adjustment disorders* • Psychological factors** affecting medical condition
Aging and its impact on disease and self-management	Normal age-related forgetfulness, slowed information processing and physical skills potentially impacting diabetes self-management and coping	• Mild cognitive impairment • Alzheimer's or vascular dementia
	All healthcare team members (e.g., physicians, nurses, diabetes educators, dieticians) as well as behavioral providers	Behavioral or mental health providers (e.g., psychologists, psychiatrists, clinical social workers, certified counselors or therapists)
	Providers for psychosocial and behavioral health intervention	

Screening Recommendations

Remember: These issues should be understood through a life-course lens. Life circumstances and needs will change over time.

1. Include routine psychosocial assessment using a collaborative, person-centered approach.

2. Screening and follow-up should include attitudes, expectations, mood, general and diabetes-related quality of life, resources, and psychiatric history.

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

Continued...

Screening Recommendations (Cont'd)

3. Upon screening, symptoms that reach the level of clinical significance require referral to appropriate care providers.

4. Routinely screen for diabetes-related distress, depression, anxiety, and disordered eating behaviors.

5. Older adults should be considered a high priority population for screening & treatment.

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

When to Screen

- At diagnosis
- Regularly scheduled visits
- Changes in medical status
- During hospitalization(s)
- When new-onset complications occur
- Whenever problems are identified with:
  - Glucose control
  - Self-management
  - Quality of life

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

When to Refer to a Mental Health Provider

Table 5.2—Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment

- If self-care remains impaired in a person with diabetes distress after tailored diabetes education
- If a person has a positive screen on a validated screening tool for depressive symptoms
- In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- If intentional omission of insulin or oral medication to cause weight loss is identified
- If a person has a positive screen for anxiety or fear of hypoglycemia
- If a serious mental illness is suspected
- In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- If a person screens positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery if assessment reveals an ongoing need for adjustment support

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

Common Psychosocial Issues

- Diabetes distress

- Mental health disorders
  - Depression
  - Anxiety Disorders
  - Disordered eating (vs. eating disorders)

Polling Question #1

- Select all that apply: Which of the following behavioral health issues do you currently screen in your practice?

    - Diabetes Distress
    - Depression
    - Anxiety
    - Disordered Eating

Diabetes Distress

Diabetes Distress

- Significant negative emotional reaction
  - Diagnosis of diabetes
  - Worry and fear regarding health, longevity, complications
  - Financial and behavioral burden of living with diabetes
  - Onset of complications
  - Impact on lifestyle of self-management demands
  - Lack of social support or resources for managing diabetes

Gonzales et al. *Diabetes Care* 2011; 34:2222–2227

Diabetes Distress: Prevalence and Impact

- 18-45% with an incidence of 38-48% over 18 months
- High levels significantly impact medication-taking behaviors
- Linked to higher A1C, lower self-efficacy, poorer dietary and exercise behaviors
- 1/3 of adolescents with diabetes develop diabetes distress (associated with declines in self-management behaviors and suboptimal blood glucose levels)

- **ADA Recommendation:** Routinely monitor (e.g., treatment targets are not met and/or at onset of complications)

Recommendation

- Routinely monitor people with diabetes for diabetes distress, particularly when treatment targets are not met and/or at the onset of diabetes complications. B

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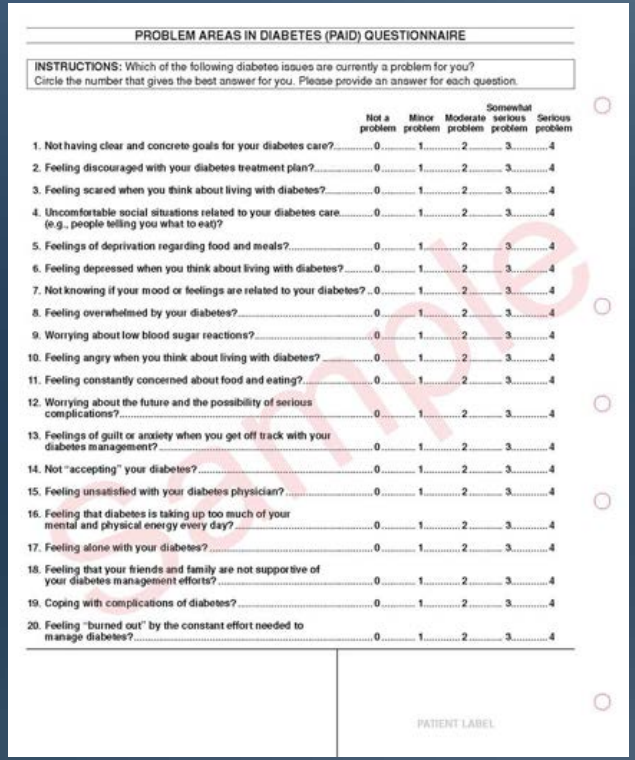
Diabetes Distress: Survey Instruments

- Problem Areas In Diabetes (PAID)
  - PAID-Peds
  - PAID-Teen Version
  - PAID-Parent Revised Version
- Diabetes Distress Scale (DDS)



PROBLEM AREAS IN DIABETES (PAID) QUESTIONNAIRE

INSTRUCTIONS: Which of the following diabetes issues are currently a problem for you? Circle the number that gives the best answer for you. Please provide an answer for each question.

	Not a problem	Minor problem	Moderate problem	Somewhat serious problem	Serious problem
1. Not having clear and concrete goals for your diabetes care?	0	1	2	3	4
2. Feeling discouraged with your diabetes treatment plan?	0	1	2	3	4
3. Feeling scared when you think about living with diabetes?	0	1	2	3	4
4. Uncomfortable social situations related to your diabetes care (e.g., people telling you what to eat)?	0	1	2	3	4
5. Feelings of deprivation regarding food and meals?	0	1	2	3	4
6. Feeling depressed when you think about living with diabetes?	0	1	2	3	4
7. Not knowing if your mood or feelings are related to your diabetes?	0	1	2	3	4
8. Feeling overwhelmed by your diabetes?	0	1	2	3	4
9. Worrying about low blood sugar reactions?	0	1	2	3	4
10. Feeling angry when you think about living with diabetes?	0	1	2	3	4
11. Feeling constantly concerned about food and eating?	0	1	2	3	4
12. Worrying about the future and the possibility of serious complications?	0	1	2	3	4
13. Feelings of guilt or anxiety when you get off track with your diabetes management?	0	1	2	3	4
14. Not "accepting" your diabetes?	0	1	2	3	4
15. Feeling unsatisfied with your diabetes physician?	0	1	2	3	4
16. Feeling that diabetes is taking up too much of your mental and physical energy every day?	0	1	2	3	4
17. Feeling alone with your diabetes?	0	1	2	3	4
18. Feeling that your friends and family are not supportive of your diabetes management efforts?	0	1	2	3	4
19. Coping with complications of diabetes?	0	1	2	3	4
20. Feeling "burned out" by the constant effort needed to manage diabetes?	0	1	2	3	4

PATIENT LABEL

Diabetes Distress: Treatment

- Develop a *customized* action plan to address key concerns
  - Provide emotional and instrumental support
  - Reduce care burden through shared responsibility
  - Give feedback and elicit feasible strategies to improve outcomes

- Incorporate diabetes self-management education (DSME)
  - Healthy eating, glucose monitoring, improving physical activity, reducing risks

- Engage PWD in setting SMART goals
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time-limited in duration

Common Psychosocial Issues

- Diabetes distress

- Mental health disorders
  - Depression
  - Anxiety Disorders
  - Disordered eating (vs. eating disorders)

Depression

Depression Impact

- Affects one in four people with type 1 or type 2 diabetes
- Associated with
  - Poorer self-care and medication adherence
  - Diabetes complications
- Depression increases
  - Risk for obesity, sedentary lifestyle, smoking
  - Risk for developing type 2 diabetes
  - Health care service utilization and costs

Ciechanowski PS, et al. *Arch Intern Med* 2000; 160:3278–3285
Lin EHB, et al. *Diabetes Care* 2004; 27:2154–2160

Association of Depression with Diabetes Self-Care

Self-Care Activities (Past 7 Days)	Major Depression (%)	No Major Depression (%)	Odds Ratio	95% CI
Healthy eating ≤ 1x week	17.2	8.8	2.1	1.59-2.72
5 servings of fruits & vegetables ≤ 1x week	32.4	21.1	1.8	1.43-2.17
High-fat foods 6x week	15.5	11.9	1.3	1.01-1.73
Physical activity (30 min) ≤ 1x week	44.1	27.3	1.9	1.53-2.27
Specific exercise session ≤ 1x week	62.1	45.8	1.7	1.43-2.12
Smoking: yes	16.1	7.7	1.9	1.42-2.51

Egede LE, Ellis C. *Diabetes Res Clin Pract* 2010;87:302-12

Recommendations

- Consider annual screening of all patients with diabetes, especially those with a self-reported history of depression and recognize that further evaluation will be necessary for individuals who have a positive screen. B

- Beginning at diagnosis of complications or when there are significant changes in medical status, consider assessment for depression. B

- Referrals for treatment of depression should be made to mental health providers with experience using evidence-based treatment approaches. A

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

Major Depressive Disorder (MDD)

- Either depressed mood or loss of interest/pleasure for 2 week period, AND at least five additional symptoms:
  - Depressed mood
  - Diminished interest/pleasure
  - Lack of energy
  - Concentration difficulties
  - Psychomotor retardation/agitation
  - --Insomnia or hypersomnia
  - --Feelings of worthlessness/excessive guilt
  - --Thoughts of death/suicide
  - --Significant weight loss/gain, appetite change
- Clinically significant impairment in social, occupational, or other important areas of functioning; Represents a marked change in functioning
- Not attributable to the physiological effects of a substance or to another medical condition

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5

Depressive Symptomatology

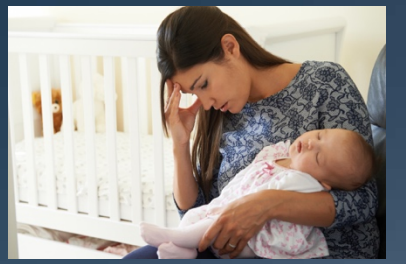
- Symptoms, but not meeting criteria for Major Depressive Disorder (MDD)
  - Depressed mood
  - Diminished interest
  - Lack of energy
  - Concentration difficulties
  - Psychomotor retardation/agitation
  - --Changes in sleep
  - --Feelings of worthlessness/excessive guilt
  - --Thoughts of death
  - --Changes in appetite/weight
- Common among people with diabetes
- Associated with poor self-care, complications, and mortality

Gonzales et al. *Diabetes Care* 2011; 34: 236-239

Depression: Who to Screen

Routine screening recommended for persons with:

- Pre-diabetes (particularly overweight patients)
- Type 1 and type 2 diabetes
- Gestational diabetes
- Postpartum diabetes



Depression: Survey Instruments

- Patient Health Questionnaire (PHQ-2, PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Child Depression Inventory (CDI-2) in ages 7-17 years
- Geriatric Depression Scale (GDS) ages 55-85 years

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so figgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

0 + _____ + _____ + _____

*Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

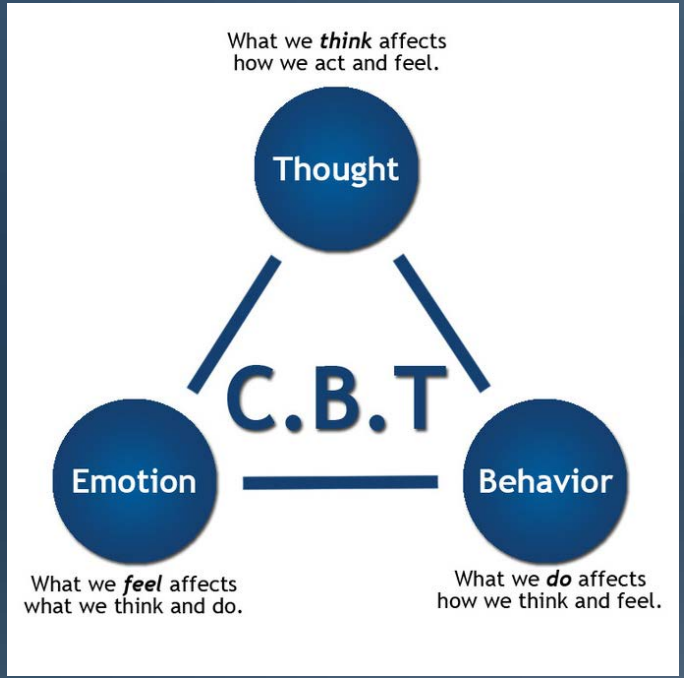
Depression: Referral

Referrals for treatment of depression should be made to mental health providers with experience in:

- Cognitive Behavioral Therapy (CBT)
- Acceptance & Commitment Therapy (ACT)
- Problem-solving Therapy

Pharmacotherapy should also be considered if symptoms interfere with effective self-care behaviors.

Referral to mental health providers familiar with diabetes is preferred.



Polling Question #2

- Which one best describes your situation:
- Within in my current practice setting,
  - I have access to a behavioral health consultant on site that can provide assessment and/or intervention.
  - I have access to a behavioral health consultant outside of my practice to which I can refer.
  - I do not have access to any behavioral health consultants to support my patients.

Anxiety Disorders

Anxiety: Common Disorders

- Generalized anxiety disorder (GAD)
- Specific phobias, particularly needle phobia and fear of hypoglycemia (FoH)

Anxiety: Prevalence and Impact

- Lifetime prevalence of GAD to be 19.5% in people with either type 1 or type 2 diabetes
- Common diabetes-specific anxiety:
  - Fears related to hypoglycemia
  - Not meeting blood glucose targets
  - Insulin injections
- General anxiety is a predictor of injection-related anxiety and fear of hypoglycemia

Anxiety: Who to Screen

- Exhibiting anxiety or worries that interferes with self-management behaviors regarding:
  - Diabetes complications
  - Insulin injections or infusion
  - Taking medications
  - Hypoglycemia
- Express fear, dread, or irrational thoughts and/or show anxiety symptoms:
  - Avoidance behaviors (including medical care)
  - Excessive repetitive behaviors
  - Social withdrawal

Continued...

Anxiety: Survey Instruments

- Generalized Anxiety Scale (GAD-7)
- State-Trait Anxiety Inventory (STAI) and for Children (STAIC)
- Beck Anxiety Inventory (BAI)
- Hypoglycemia Fear Survey – II (HFS-II)
- Children's Hypoglycemia Index (CHI)

Disorders with Overlapping “Anxiety” Symptoms

- OCD
  - Exhibits excessive diabetes self-management behaviors to achieve glycemic targets
  - Reports repetitive negative thoughts about inability to prevent poor health outcomes that also interferes with daily living
- Body Dysmorphic Disorder
  - Preoccupation with an imagined defect in appearance that interferes with social, occupational, or other areas of function
- PTSD
  - Severe hypoglycemia could result in a trauma response (PTSD, PTSD-like, and panic disorder symptoms)

Anxiety: Referral and Treatment

- Referral to mental health providers with training in:
  - Cognitive Behavioral Therapy (CBT)
  - Exposure with Response Prevention (OCD-related disorders)
  - Cognitive Processing Therapy or Prolonged Exposure (PTSD)
- Interventions for fear of hypoglycemia (without symptoms of hypoglycemia) or for hypoglycemia unawareness
  - Blood Glucose Awareness Training (BGAT)

Continued...

Anxiety: Referral and Treatment (cont'd)

- FoH without symptoms of hypoglycemia
  - A structured program (BGAT) should be delivered in routine clinical practice to improve A1C, reduce the rate of severe hypoglycemia and restore hypoglycemia awareness

Disordered Eating Behavior

Disordered Eating: Behaviors and Impact

Persons with disordered eating, disrupted eating patterns, and eating disorders have higher rates of diabetes distress and FoH than those without these symptoms

Type 1 diabetes:

- Insulin omission causing glycosuria in order to lose weight is the most commonly reported disordered eating behavior.

Type 2 diabetes:

- Patients treated with insulin, also frequently report intentional omission.
- Bingeing (excessive food intake with an accompanying sense of loss of control) is most commonly reported.

Disordered Eating: Who to Screen

- Unexplained hyperglycemia and weight loss, despite self-report of adherence to medical regimen including medication dosing and meal plan.
- Self-report of excessive caloric restriction and/or excessive physical activity.
- Expression of significant dissatisfaction with body size, shape or weight.
- Report of loss of control over eating.
- Repeated unsuccessful dieting attempts.

Disordered Eating: Survey Instruments

- Eating Disorders Inventory-3 (EDI-3)
- Diabetes Eating Problems Survey (DEPS-R)
- Diabetes Treatment and Satiety Scale (DTSS-20)

Disordered Eating: Screening Considerations

- Potential confounders to the identification of symptoms are:
  - Behaviors prescribed as part of treatment (carb counting, calorie restriction)
  - Behaviors or effects e.g., loss of control over satiety regulation
  - Adverse effects of treatment, such as excessive hunger secondary to hypoglycemia

Continued...

Disordered Eating: Screening Considerations (Cont'd)

- Consider etiology and motivation for the behavior
  - Missed insulin injections due to suboptimal self-management differ significantly from intentional medication omission to produce weight loss
- Assessment and screening requires methods that account for:
  - Treatment prescription, regimen behaviors and diabetes-specific eating problems

Disordered Eating: Referral and Treatment

- Review medical regimen
  - Consider treatment-related effects on hunger/caloric intake
  - Consider timing of medications (alter dosing to address maladaptive eating patterns, i.e., night eating syndrome)
  - Consider adjunctive medications, such as GLP-1 RA
    - Meet glycemic targets
    - Regulate hunger and food intake
    - Potential to reduce uncontrollable hunger
- Include behavioral health providers
  - Assessment and treatment of bulimia nervosa, binge-eating disorder or other eating disorders

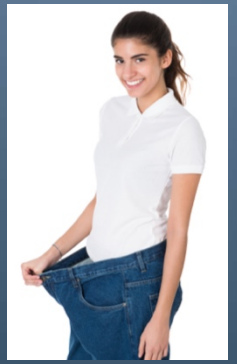
Other Considerations

Older Adults

- Older adults with diabetes:
  - 73% increased risk of all types of dementia
  - 56% increased risk of Alzheimer's dementia
  - 127% increased risk of vascular dementia
- Screening for early detection of mild cognitive impairment or dementia and depression is indicated for adults 65 years of age or older at the initial visit and annually as appropriate. B

American Diabetes Association. 5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: Standards of Medical Care in Diabetes 2020. Diabetes Care 2020;43(Suppl. 1):S48-S65.

Metabolic Surgery



- Increased risk of:
  - Depression and other major psychiatric disorders
  - Body image disorders, sexual dysfunction and suicidal behavior
- Patients considering metabolic surgery should be assessed by professional familiar with weight-loss interventions and post-bariatric surgery behavioral requirements
- If psychopathology is evident (particularly suicidal ideation and/or significant depression), consider postponement of surgery until psychosocial issues are resolved or stabilized
- Consider ongoing mental health services to help patients adjust post-surgery

Implementing Team-Based Psychosocial Care

Collaborative Care Model (CCM)

- In primary care
- Integrated behavioral care carried out by behavioral health Care Manager, with Psychiatrist consultant
- Weekly team meetings include PCP, CM, psychiatrist consultant
- Use of a dashboard and metrics for individual patient progress monitoring

**Billing codes available under CMS as of 2017*

Embedded Behavioral Specialist

- In primary care and diabetes specialty clinics
- Behavioral care carried out by a psychologist or clinical social worker embedded within the clinical practice site
- Behavioral specialist participates as consultant and/or engages with practice as member of interdisciplinary team

Referral to Behavioral Provider

- Referral outside of the medical practice
- Concurrent, non-integrated behavioral care provided by behavioral specialist or mental health practice
- Arrangement of formal methods of communication (e.g. medical records sharing, formal methods for behavioral provider ongoing progress feedback to referring physician)

2016-11-02

Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention

CMS.gov
Centers for Medicare & Medicaid Services

Mental and Behavioral Health: CMS is finalizing payments for codes that describe specific behavioral health services furnished using the psychiatric **Collaborative Care Model**, which has demonstrated benefits in a variety of settings. In this model, patients are cared for through a team approach, involving a **primary care practitioner, behavioral health care manager, and psychiatric consultant**. CMS is also finalizing payment for a new code that broadly describes behavioral health integration services, including payments for other approaches and for practices that are not yet prepared to implement the Collaborative Care Model.

Cognitive Impairment Care Assessment and Planning: CMS finalizes payment to physicians to perform cognitive and functional assessment and care planning for patients with cognitive impairment (e.g., for patients with Alzheimer's). This is a major step forward for care planning for these populations.

Helpful Resources

Diabetes Mental Health Provider Education Program

American Diabetes Association. | American Psychological Association

Mental Health Provider Diabetes Education Program

ADA and American Psychological Association (APA) partnered to create the first ever, diabetes-focused, continuing education (CE) program for licensed mental health providers.

Upon successful completion of the Continuing Education program, the provider can:

- Become an ADA member at the Associate level
- Receive 12 CE credits from the APA
- Become eligible for inclusion on the Mental Health Provider Referral Directory
- Access the ADA's new listserv for behavioral health and psychosocial topics
- Access monthly "mentoring" calls with experts in the field

ADA's Online Mental Health Provider Referral Directory

American Diabetes Association. | American Psychological Association

Mental Health Provider Diabetes Education Program

Living with diabetes is exhausting. People need support and empowerment to live their best life.

ADA is pleased to announce the launch of the new Mental Health Provider Referral Directory, which can help you locate mental health professionals in your area with demonstrated expertise in diabetes care.

professional.diabetes.org/ada-mental-health-provider-directory

Diabetes Self-Management Education

- Find a recognized Diabetes Self-Management and Support program
- Become a recognized provider of DSME/S
- Tools and resources for DSME/S
- Online education documentation tools

Professional.Diabetes.org/ERP

Thank You!