

# Psychosocial Care for People with Diabetes

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## Disclosures

None

# 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

|                               |  | Continuum of psychosocial issues and behavioral health disorders in people with diabetes   |  |
|-------------------------------|--|--|--|
|                               |  | Nonclinical (normative) symptoms/behaviors   | Clinical symptoms/diagnosis  |
| Phase of living with diabetes | Behavioral health disorder prior to diabetes diagnosis | None   | <ul style="list-style-type: none"> <li>Mood and anxiety disorders</li> <li>Psychotic disorders</li> <li>Intellectual disabilities</li> <li>Adjustment disorders *</li> </ul> |
|                               | Diabetes diagnosis                                     | Normal course of adjustment reactions, including distress, fear, grief, anger, initial changes in activities, conduct, or personality  | <ul style="list-style-type: none"> <li>Adjustment disorders*</li> <li>Psychological factors affecting medical condition**</li> </ul>   |
|                               | Learning diabetes self-management                      | Issues of autonomy, independence, and empowerment. Initial challenges with self-management demonstrate improvement with further training and support   | <ul style="list-style-type: none"> <li>Maladaptive eating behaviors</li> <li>Psychological factors** affecting medical condition</li> </ul>                                  |
|                               | Maintenance of self-management and coping skills       | Periods of waning self-management behaviors, responsive to booster educational or supportive interventions   | <ul style="list-style-type: none"> <li>Adjustment disorders *</li> <li>Psychological factors ** affecting medical condition</li> </ul>                                       |
|                               | Life transitions impacting disease self-management     | Distress and/or changes in self-management during times of life transition***  | <ul style="list-style-type: none"> <li>Adjustment disorders *</li> <li>Psychological factors ** affecting medical condition</li> </ul>                                       |
|                               | 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  | <ul style="list-style-type: none"> <li>Adjustment disorders *</li> <li>Psychological factors ** affecting medical condition</li> </ul>                                       |
|                               | 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   | <ul style="list-style-type: none"> <li>Mild cognitive impairment</li> <li>Alzheimer or vascular dementia</li> </ul>  |
|                               |  | All health care team members (e.g., physicians, nurses, diabetes educators, dieticians) as well as behavioral providers<br>Behavioral or mental health providers (e.g., psychologists, psychiatrists, clinical social workers, certified counselors or therapists)<br><b>Providers for psychosocial and behavioral health intervention</b> |  |

All providers

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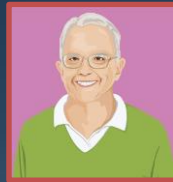
Behavioral providers



23 year old white female  
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BMI 17



52 year old AA female  
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68 year old white male  
Type 2 diabetes X 25 years  
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Death of spouse

## 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 for care, mood, general and diabetes-related quality of life, resources, and psychiatric history

## 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 depression, diabetes-related distress, anxiety, disordered eating behaviors and cognitive impairment
5. Older adults should be considered a high priority population for screening & treatment



## 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



# When to Refer to 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

## Common Psychosocial Issues

- Diabetes distress
- Mental health disorders
  - Depression
  - Anxiety Disorders
  - 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

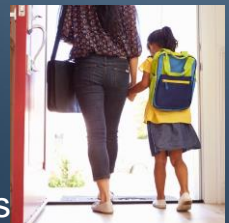


# Recommendation

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

## Diabetes Distress: *Prevalence and Impact*

- 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)





# Diabetes Distress: *Survey Instruments*

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

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 | Severe 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

 American Diabetes Association.

# Diabetes Distress: *Treatment*

- Develop action plan to address key concerns
- Provide emotional support
- Reduce care burden through shared responsibility
- Give feedback about health status and feasible strategies to improve outcomes
- If setting goals, make sure they are "SMART:"
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time-limited in duration
- Don't forget about DSME

 American Diabetes Association.

# Common Psychosocial Issues

- Diabetes distress
- Mental health disorders
  - Depression
  - Anxiety Disorders
  - Disordered eating

## Depression

## Depression: *Impact*

- Affects one in four people with type 1 or type 2 diabetes
- Associated with poorer self-care and medication adherence
- Associated with diabetes complications
- Increases risk for obesity, sedentary lifestyle, smoking
- Increases health care service utilization and costs
- Increases risk for type 2 diabetes

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

 American Diabetes Association.

## Recommendations

- Providers should consider annual screening of all patients with diabetes, especially those with a self-reported history of depression, for depressive symptoms with age-appropriate depression screening measures, recognizing 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 cognitive behavioral therapy, interpersonal therapy, or other evidence-based treatment approaches in conjunction with collaborative care with the patient's diabetes treatment team **A**

American Diabetes Association. 5. Lifestyle management: Standards of Medical Care in Diabetes 2019. *Diabetes Care* 2019;42(Suppl. 1):S46–S60

 American Diabetes Association.

## Association of Depression with Diabetes Self-Care

| Self-Care Activities (Past 7 Days)               | Major Depression (%) | No Major Depression (%) | Odds Ratio | 95% CI    |
|--|----------------------|-------------------------|------------|-----------|
| Healthy eating $\leq$ 1x week                    | 17.2                 | 8.8                     | 2.1        | 1.59-2.72 |
| 5 servings of fruits & vegetables $\leq$ 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) $\leq$ 1x week        | 44.1                 | 27.3                    | 1.9        | 1.53-2.27 |
| Specific exercise session $\leq$ 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

 American Diabetes Association.

## Major Depressive Disorder (MDD)

- Either depressed mood or loss of interest/pleasure for 2 week period, AND at least five additional symptoms:
  - Depressed mood                      --Insomnia or hypersomnia
  - Diminished interest/pleasure      --Feelings of worthlessness/excessive guilt
  - Lack of energy                         --Thoughts of death/suicide
  - Concentration difficulties          --Significant weight loss/gain, appetite change
  - Psychomotor retardation/agitation
- 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

 American Diabetes Association.

# 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

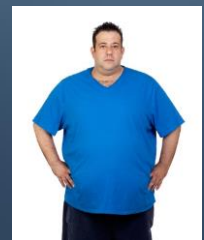
Gonzales et al. *Diabetes Care* 2011; 34: 236-239

 American Diabetes Association.

## Depression: *Who to Screen*

Routine screening recommended for persons with:

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



 American Diabetes Association.



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## 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 fidgety 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                |

PHQ-9 SCORE:  
 0 + 1 + 2 + 3  
 \*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       | Vary difficult           | Extremely difficult      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

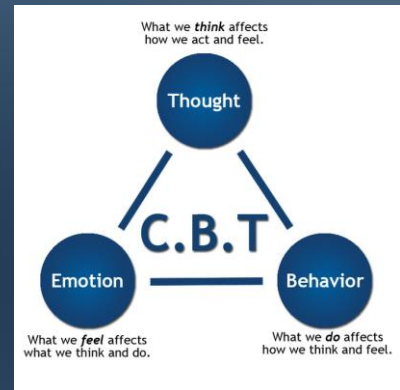
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# Depression: *Referral*

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

- Cognitive behavioral therapy (CBT)
- Problem-solving therapy

Pharmacotherapy should also be considered if symptoms interfere with effective self-care behaviors. Referral to a psychiatrist familiar with diabetes is preferred



# Anxiety Disorders

## Anxiety: *Common Disorders*

- Generalized anxiety disorder (GAD)
- Body dysmorphic disorder
- Obsessive compulsive disorder (OCD)
- Specific phobias, particularly needle phobia and fear of hypoglycemia (FoH)
- Post-traumatic stress disorder (PTSD)



## Anxiety: *Prevalence and Impact*

- Lifetime prevalence of GAD is 19.5% in those with either type 1 or type 2 diabetes
- Common diabetes-specific anxiety:
  - Fears related to hypoglycemia
  - Not meeting blood glucose targets
  - Insulin injections
  - FoH
- 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: *Who to Screen (Cont'd)*

- Preoccupation with an imagined defect in appearance that interferes with social, occupational, or other areas of function - body dysmorphic disorder
- Exhibits excessive diabetes self-management behaviors to achieve glycemic targets
- Reports repetitive negative thoughts about inability:
  - to prevent poor health outcomes
  - that interfere with daily living – OCD
- Severe hypoglycemia - PTSD and PTSD-like and panic disorder symptoms



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## Anxiety: *Survey Instruments*

- State-Trait Anxiety Inventory (STAI) and for Children (STAIC)
- Beck Anxiety Inventory (BAI)
- Hypoglycemia Fear Survey – II (HFS-II)
- Children’s Hypoglycemia Index (CHI)



## Anxiety: *Referral and Treatment*

- In hypoglycemia unawareness (can co-occur with fear of hypoglycemia)
  - Treat using Blood Glucose Awareness Training (BGAT) to help re-establish awareness and reduce fear
- In OCD
  - Referral to a mental health professional familiar with OCD treatment should be considered if diabetes re-education is not effective in reducing obsessive thoughts, behaviors, or feelings of general anxiety

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
- Binging (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



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## 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

## 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 to identify potential treatment-related effects on hunger/caloric intake
- If night eating syndrome (recurrent eating at night) is diagnosed, change medication regimen until maladaptive eating patterns are modified
- Adjunctive medication such as GLP1-RA may help
  - Meet glycemic targets
  - Regulate hunger and food intake
  - Potential to reduce uncontrollable hunger



## Disordered Eating: *Referral and Treatment*

- Evaluate bulimia, the most commonly reported symptom in persons with diabetes, in the context of treatment, especially insulin dose
  - If a diagnosis of Bulimia Nervosa is established via clinical interview by a qualified professional, use of anti-depressant and anti-anxiety medications is often effective when accompanied by psychotherapy
  - In severe cases of Bulimia or Anorexia, hospitalization may be necessary to stabilize diabetes and mental health

## Other Considerations



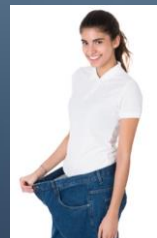
## Older Adults

- 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



## 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)

 American Diabetes Association.

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.

 American Diabetes Association.

# Helpful Resources

## 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](https://www.professionaldiabetes.org/ERP)**

# Diabetes Mental Health Provider 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



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](https://professional.diabetes.org/ada-mental-health-provider-directory)

Thank You!