Behavioral Medicine in Diabetes for the Non-Mental Health Care Provider

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AKA: How to be Effective without Working TOO Hard
Presenter Disclosure Information

In compliance with the accrediting board policies, the American Diabetes Association requires the following disclosure to the participants:

Mary de Groot, Ph.D., HSPP
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What’s your biggest challenge in working with your patients with diabetes?

Why don’t my patients just DO what I TELL them to do?!?!
Objectives

• To discuss and practice elements of patient-centered care
• To review the recommendations and rationale for screening and evaluating psychosocial outcomes in clinical practice based on the ADA Position Statement for the Psychosocial Care of People with Diabetes.
• To discuss psychosocial screening and referral processes in clinical practice.

Psychosocial Care for People with Diabetes: A Position Statement

• Published in the Psychosocial Research Special Issue of Diabetes Care, 2016.
General Considerations

- Psychosocial factors exist along a continuum that spans adaptation/health to problematic/diagnosed disorders.
  - Example: Fear of hypoglycemia
- There is a reciprocal relationship between psychosocial factors and diabetes
- There are, by necessity, different roles that members of the diabetes care team can and should play.
- There are different issues that arise across the lifespan.

Stage of Development and Course of Disease

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**Figure 1:** Diagram illustrates the continuum of psychosocial issues and behavioral health disorders in people with diabetes. It categorizes these issues into behavioral health disorder prior to diabetes diagnosis, diabetes diagnosis, learning diabetes self-management, maintenance of self-management and coping skills, life transitions impacting disease self-management, disease progression and onset of complications, and aging and its impact on disease and self-management. The diagram also highlights providers for psychosocial and behavioral health intervention.
General Considerations

- There are as many ways/models that these standards can be incorporated into practice as there are models of practice.
- Integrated psychosocial care within patient-centered care provided to all patients and their families with diabetes.

Psychosocial Guidelines

- Recommendations for All Providers
  - Providing a patient-centered care experience
    - Communication
    - Putting the Patient in the Center of Care
    - Screening for Psychosocial Conditions
    - Referral to Mental/Behavioral Health Providers
Practicing Patient-Centered Care

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Communication

• **Words Matter**
  – What we say and how we say it has a profound impact on our patients, even if it doesn’t feel like it in the moment
  – How we frame our interactions and recommendations to our patients sets the stage for their diabetes experience between visits.

• [#languagematters](https://www.youtube.com/watch?v=Tndg1OmLFkg)  (Greenwood & Mytonomy, 2018)

• https://www.youtube.com/watch?v=Tndg1OmLFkg
Communication

• ADA/AADE Joint Position on the Use of Language in the Care of Diabetes (ADA/AADE, Diabetes Care, 2017)
  – More than “just being PC”
  – Useful guide to assist us from setting inadvertent cognitive traps for our patients that get them stuck.
Communication: Why it Matters

• We make our treatment recommendations on the basis of the Standards of Care for the Medical Treatment of People with Diabetes: The ‘Shoulds’.
  – Based on empirical evidence
  – Designed to maximize health outcomes
  – Suggests to patients that meeting these standards is possible at all times
Diabetes Self-Management

Low

High

6 months

Time

Ideal Point of Diabetes Diagnosis

Diabetes Self-Management

Low

High

6 months

Time
The ‘Shoulds’ of Diabetes

- Assumptions about diabetes and self-care:
  - It should get easier over time
  - It should become so routine that I don’t have to think about it anymore
  - I should be able to prevent extreme low or high BG values.
  - If I work hard at it, diabetes should go away
  - My BG will stay the same in between times I check it.
The Effect of the ‘Shoulds’

• Many patients carry feelings of shame, embarrassment and struggle (Ritholz et al. Chronic Illness, 2014).
  – “My doctor is very important. I don’t want to disappoint him/her or waste their time.”
  – “I don’t want my doctor to know that I’ve failed at my diabetes.”
  – “I’m afraid my doctor will fire me”

The Effect of The ‘Shoulds’

• When patient expectations of their self-care are beyond their actual ability to perform self-care, diabetes-related distress can result.
• Reinforcing the ‘Shoulds’ does not address the gap between expectation and capacity and can deepen diabetes-related distress.
What is Diabetes Distress?

• Diabetes distress is the emotional stress of caring for diabetes related to:
  – Struggles with self-care routines
  – Health care team
  – Limited sources of social support
  – Feelings of failure or disappointment
  – Depressed mood or anxiety
  – Powerlessness

(Polonsky, et al., 1995)

Diabetes Distress

• 38-45% of adults with type 1 or type 2 diabetes report moderate to high levels of distress. (Fisher et al., Diab. Med. 2008; Karlsen 2011; Snoek et al., 2011; 2012)
• Diabetes distress is more closely associated with higher A1c than depressed mood (Zoffman et al., 2014)
• Diabetes distress can be alleviated with diabetes education (Welch et al., 2010).
**Cycle of Distress**

- “My BG is ~250 mg/dl”
- “My BG is always the same (or never the same), no matter what I do.”
- “That number is ‘Bad’”
- BG values categorized as ‘good’ or ‘bad’
- “I’m bad at diabetes”
- Self-blame, guilt, helplessness
- Stop checking

**Breaking the Cycle**

- Every criticism feels like a ‘paper cut to the soul’ – Visits to health care providers can feel like the lemon juice.
- Focus on the behaviors; less on the numbers.
- Is the routine getting boring? How can you mix it up safely?
- Get specific with changes to self-care *micro-behaviors* and the thoughts that accompany them.
Breaking the Cycle of Distress

“My BG is ~250 mg/dl”

“It’s just a number, not a judgment”

“What can I do about it?”

Concrete steps that will affect change in BG

Problem solving

Increased confidence; decreased anxiety

Keep checking

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Patient Centered Care

All health care providers are in a position to effectively address the psychosocial needs of people with diabetes and their families.

- **Asking the patient**: What do *you* want from your appointment today?
- Problem solve *with* the patient rather than ‘fix’ the patient when they struggle with self-care.
- Say ‘no’ to serving as the ‘Diabetes Police’
- Work with multidisciplinary teams – virtually or co-located

Communication Strategies

- Simplify message: focus on 1 recommendation at a time
- Try multiple communication formats/styles to match PWD’s literacy and learning style
- Use “teach me back” method to ensure comprehension
- Ask open-ended questions to learn about PWD and tailor information to their context
Goal-Setting

• Identify **personal motivation** for behavior change

• Major changes can be daunting: break large behavior change aims into **incremental, stepwise goals**
  – Start with small, achievable goal likely to result in success

• Focus on **behavior** goals
  – Not biomarkers/numbers – these are influenced by many factors out of personal control

• Each step achieved will reinforce management behaviors

Problem-Solving

1. **Specify Problem**
   - Be as precise as possible
   - Focus on 1 aspect of problem at a time

2. **Brainstorm**
   - Generate many ideas
   - Think outside box, don't evaluate

3. **Pick a Solution**
   - Evaluate pros & cons of each idea
   - Select 1 to try first

4. **Implement**
   - Create a specific plan to implement solution
   - Details, next slide

5. **How did it go?**
   - Well! Great, reinforce & carry on!
   - Not well - go back to solution list and try again
Behavioral Planning Strategies

Plan to implement recommended health behavior changes ASAP after recommendation is given

Link new behavior with existing routine

Establish system to provide prompt, motivating feedback to reinforce success with behavior
Celebrate every success!

Integrate social supports and sources of accountability for behavior

Praise Behavior, Not Numbers

- So many influences on BG & other diabetes outcomes
  - Punishing numbers → “Blame and shame”
    - Not effective to change behavior or improve mood!
- Teach PWD to catch & reward themselves for doing well with diabetes management:
  - More likely to happen again
  - Create positive atmosphere
  - Develop confidence & ownership
Treatment & Culture

Psychosocial treatments have cultural assumptions

Congruence with cultural & social norms and values is critical

Less congruence = decreased effectiveness and benefit

Goal is to increase congruence and capitalize on strengths

Patient Empowerment

PWD is Central

PWD does majority of diabetes care and therefore must guide decision-making about daily self-management

Healthcare team helps PWD

Team’s primary mission is to provide ongoing diabetes expertise, education & psychosocial support to support PWD in making informed decisions about daily diabetes care.

Personal meaning matters

People are much more likely to make and maintain behavior changes if those changes are personally meaningful and freely chosen

People can make changes

All people, regardless of their situation, have the capacity to make choices that can make a difference in the quality of their lives.
Therapy Strategies Toward Empowerment

- **Ask questions** to help PWD identify and commit to behavior change plan to improve their ability to live with and care for their diabetes.

- **Key components:**
  - Discover the issue of importance to them re: diabetes
  - Explore with them their feelings about diabetes
  - Solicit possible alternatives from them
  - Explore their commitment to changing their situation and perception of self-efficacy in self-management tasks
  - Consider possible action steps toward improving self-management
  - Initiate their action plan

Time for Self-Reflection…
Time for Self-Reflection…

Interview Your Neighbor:

• What are some of the elements of patient-centered care that exist in your practice?
• If you could change one thing about your current practice setting, what would it be?
• What change(s) would improve your quality of life as a provider?
• What change(s) would improve the quality of life of your staff?

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Recommendations for Screening and Evaluation

- Psychosocial factors impacting self-care (e.g. diabetes distress) and psychological states (e.g. depression, anxiety) should be **routinely monitored**.
- For all patients, monitoring should occur at the **first visit and on a periodic basis**.
- Screening and evaluation should also take place during disease (e.g. onset or significant exacerbation of complication), treatment (e.g. initiation of new devices) and life **transitions** (e.g. changes in work or social roles).
- Prospectively **every 6 months** through these transitions (Young-Hyman et al., *Diabetes Care*, 2016)

Screening by All Providers

- Diabetes-related Distress
- Depression
- Anxiety
- Disordered Eating Behavior/Eating Disorders
- Serious Mental Illness
- Onset or exacerbation of medical complications
Diabetes Distress

- Diabetes-related distress should be routinely monitored (B).
- Distress should be monitored when treatment targets are not met.
- Distress should be monitored with the onset or exacerbation of diabetes complications.

Assessment:
- Problem Areas in Diabetes (PAID; Polonsky, et al. 1995)
- Diabetes Distress Scale (Polonsky et al., 2005)

Depression

- Consider annual screening for depression with all patients and routine screening for those with a history of depression.
- Screen for depression at the onset of complications or changes in medical status

Assessment
- PHQ-9 (Spitzer et al., JAMA, 1994)
- Beck Depression Inventory (Beck et. al, 1996)
Anxiety Disorders

- Consider screening for anxiety in those exhibiting anxiety symptoms, excessive worry about complications, insulin administration and/or hypoglycemia that interferes with self-care.
- Look for fear, dread, irrational thoughts, avoidance behaviors, excessive repetitive behaviors and/or social withdrawal.

Assessment
- Generalized Anxiety Disorder (GAD)-7 (Spitzer et al., Archives of Intern Med, 2006)
- Beck Anxiety Inventory (Beck et al., 1993)
- Hypoglycemia Fear Survey-II (Cox et al., 1987)

Disordered Eating Behavior

- Providers should consider re-evaluating the treatment regimen of patients who present with disordered eating behaviors, eating disorders (e.g. anorexia, bulimia) or disrupted patterns of eating.
- Screen for disordered or disrupted eating using validated measures when hyperglycemia and weight loss are unexplained by self-reported self-management. A review of the medical regimen is recommended to identify potential treatment-related effects on hunger/caloric intake.

Assessment
- Diabetes Eating Problems Survey (Markowitz et al., Diabetes Care, 2010)
- Diabetes Treatment and Satiety Scale (Young-Hyman et al., Diabetes, 2011)
Serious Mental Illness

- Annually screen individuals for pre-diabetes/diabetes who are prescribed atypical antipsychotic medications.
- Incorporate monitoring of diabetes self-care activities into treatment goals for people with diabetes and SMI.

Youth and Emerging Adults

- At diagnosis and during routine care, assess psychosocial issues and family stresses that could impact disease management. Provide referrals to mental health professionals with experience in childhood diabetes (preferred).
- Monitor youth and their parents about social adjustment (peer relationships) and school performance to determine whether further evaluation is needed.
- Assess for diabetes-related distress by ages 7-8 years.

Assessment:
- Problem Areas in Diabetes – Pediatric Version (Markowitz et al., *Diabetes Care*, 2012).
Diabetes Complications and Functional Limitations

• Consider routine monitoring for chronic pain associated with diabetes complications and impact on quality of life.

Adults

• Providers should assess social support (e.g. family, peers) that may facilitate self-management behaviors, reduce burden of illness and improve diabetes and general quality of life.
Older Adults

- Annual screening for early detection of mild cognitive impairment and/or dementia is indicated for adults age 65 and older.
- Assessment of neuropsychological function and dementia should use standardized evaluation approaches.

Bariatric Surgery

- Comprehensive mental health assessment by a professional familiar with weight loss interventions is recommended for patients presenting for bariatric surgery.
- Consider assessment of ongoing mental health services to assist patients with medical and psychosocial adjustment post-surgery.
The ‘How To’s’ of Screening and Evaluation for Psychosocial Conditions

Barriers to Psychosocial Screening and Evaluation

Common Concerns

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Barriers to Psychosocial Screening and Evaluation

**Common Concerns**
- It takes time
- It’s complicated
- It’s “too academic”
- I might learn something I don’t want to know
- I might create a problem just by asking
- This is somebody else’s idea, not mine.

**Counterpoints**
- Can be done with patient flow
- Can take many simple forms
- Good evaluation is clinically useful.
- Response relies on established clinical procedures
- Asking may reveal a problem, but not create it.
- Externally imposed standards create opportunities to enhance clinical care
Rationale for Screening and Evaluation

- Psychosocial considerations affect every aspect of a patient’s life and can impact diabetes management and outcomes directly or indirectly (e.g. Hood et al. Pediatrics, 2009).
- Screening and evaluation allows clinicians to identify psychosocial barriers and resources to overcome these barriers.
- Not knowing an important barrier to self-care results in missed targets for intervention and improvement in patient health and well-being.

Rationale for Screening and Evaluation

Evaluation facilitates:
- Learning about barriers that would be otherwise unknown and unaddressed
- Confirming clinical observations with objective data.
- Inform treatment recommendations or changes in treatment.
- Accountability
  - For health care providers
  - For patients
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Clinical Decision Making

For Provider and Patient Teams:
• Consider the patient’s priorities and what resources are needed to address this problem
  – Referral sources are available within and beyond my practice
• Consider steps needed to facilitate the referral
• Referral Follow-Up: Checking back with the patient to identify gaps in care. Did the referral make a difference? If not, why not?
Now What Do I Do?

Issues Requiring Referral to Behavioral Health

• Depression
• Anxiety
• Eating Disorders
• Serious Mental Illness
• Life changes
• Impairment in social or role functioning
When a Referral is Needed

• Keep a list of providers/do outreach to have a source of referrals that you can trust and have confidence in their expertise.
  – ADA/APA Directory of Mental Health Providers: www.professional.diabetes.org/mhp_listing

• Provide a rationale to the patient why a behavioral health referral may improve diabetes outcomes.
• Whenever and wherever possible, integrate and coordinate care
• Conduct follow-up screening with patients at subsequent visits

Depression

• Refer to a mental health provider for follow-up assessment and, if needed, treatment.
• Collaborative care for depression using evidence-based treatments is recommended (e.g. cognitive behavioral therapy).
Anxiety Disorders

• Blood Glucose Awareness Training is recommended for treatment of those with hypoglycemic unawareness and fear of hypoglycemia.

Youth and Emerging Adults

• Encourage developmentally appropriate family involved in diabetes self-care, recognizing that premature transfer of care can result in poor self-management and decreased glycemic control.
• Consider inclusion of children in the consent process as early as developmental level indicates understanding of health consequences.
• Adolescents may have time by themselves with care providers starting at age 12 years.
Youth and Emerging Adults

- Initiate discussions of care transition to adolescent medicine/transition clinic/adult medicine 1 year prior to transfer, starting preferably in early adolescence (~ age 14 years).
- Monitor support from parents/caretakers of emerging adults and encourage instrumental support (e.g., ordering supplies) and collaborative decision making among caregivers.
- Preconception counseling should be incorporated into routine care for all females starting at puberty.
- Consider counseling males for adoption of healthy lifestyles to reduce the risks of sexual dysfunction starting at puberty.

Adults

- In adults with childbearing potential, discuss life choices that could be impacted by diabetes self-management such as pregnancy and sexual functioning.
Older Adults

- Within primary care settings, the collaborative care model that incorporates a nurse case management system, is recommended to treat depression in older adults with diabetes.

Diabetes Complications and Functional Limitations

- Appropriate pain management interventions including referral to behavioral health providers for pain management strategies should be provided.
Bariatric Surgery

• If psychopathology is evident (e.g. suicidal ideation, depression), postponement of surgery should be considered so that patient suffering can be addressed before adding the burden of recovery and lifestyle adjustment.

Time for Self-Reflection…

• What forms of screening already exist in your practice?

• To whom do you make referrals for behavioral health issues?

• Is there any part of this process you would like to ‘tune up’?
Summary

- Psychosocial concerns have the capacity to affect every aspect of diabetes self-care and medical outcomes.
- Use of patient-centered care and screening tools can be successfully incorporated into clinical practice and decision making.
- Empowering patients through dialogue and evaluation represents an important opportunity to identify barriers and use joint decision-making to support to people with diabetes and their families.