Psychosocial Care for People with Diabetes

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Presenter Disclosure Information

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

Elaine Parton, APNP

Disclosed no conflict of interest
Learning Objectives

• Describe psychosocial issues associated with diabetes.
• List screening tools for assessing symptoms of psychosocial issues within routine care.
• Identify ways to implement psychosocial services into team-based care.
• Indicate appropriate referral and treatment options for people impacted by psychological distress.

Common Psychosocial Issues

• Diabetes distress
• Mental health disorders
  – Depression
  – Anxiety
  – Disordered eating
• Life Course Considerations
Diabetes Distress

18 year old Teenager with T1D

- Diagnosed in May 2016 and attends a private prep school
- Experienced an extended honeymoon (over 12 months) He is an athlete.
- He is on the Omnipod insulin pump and Dexcom glucose sensor – frustrated with the technology as will come off prematurely
- Increasing insulin needs having Hgb A1C increase from 6.7% up to 8.5%
- Recently was out of school for 1 week for influenza A and continuing to recover.
- Became very tearful and showing signs of Diabetes Distress.
- His parents fearful of an event happening at school if he doesn’t use his Dexcom.
Diabetes Distress

- Significant negative psychological reactions related to emotional burdens and worries specific to an individual’s experience in having to manage a severe, complicated, and demanding chronic disease such as diabetes
- Very common
- Distinct from other psychological disorders

American Diabetes Association. 4. Lifestyle management: Standards of Medical Care in Diabetes. Diabetes Care 2018; 41 (Suppl. 1): S38-S50

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

American Diabetes Association. 4. Lifestyle management: Standards of Medical Care in Diabetes. Diabetes Care 2018; 41 (Suppl. 1): S38-S50
Diabetes Distress: Prevalence and Impact

- 18-45% with an incidence of 38-48% over 18 months
- High levels of diabetes distress 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)
- Parents of children with type 1 diabetes prone to diabetes distress, which impacts their ability to provide support for their child

Diabetes Distress: Survey Instruments

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

11 year old Male with T1D

- PHQ-9 Score was 7 (positive score = >11) but positive answer to feelings that he would be better off dead several days in last 2 weeks. He also had serious thoughts in the last 2 weeks of ending his life. This was the 1st time he completed the screen.
- Hgb A1C – 9.5%, recent ED visit for hyperglycemia – no DKA
- Started having issues with bullying at school
- Family had a previous therapist but was not in active counseling
- No suicidal plan
Depression Impact

• Affects 1 in 4 people with type 1 or type 2 diabetes
• Associated with poorer self-care and med adherence
• Associated with diabetes complications (micro- and macro-vascular, sexual dysfunction)
• Increases risk for obesity, sedentary lifestyle, smoking
• Increases health care service utilization and costs
• Increases risk for type 2 diabetes


Major Depressive Disorder (MDD)

Either depressed mood or loss of interest/pleasure for 2 week period, AND at least five (5) additional symptoms:

<table>
<thead>
<tr>
<th>Depressed mood</th>
<th>Thoughts of death/suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia or hypersomnia</td>
<td>Concentration difficulties</td>
</tr>
<tr>
<td>Diminished interest/pleasure</td>
<td>Lack of energy</td>
</tr>
<tr>
<td>Feelings of worthlessness/guilt</td>
<td>Psychomotor retardation/agitation</td>
</tr>
<tr>
<td>Significant weight loss/gain, appetite change</td>
<td></td>
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</tbody>
</table>

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5
Major Depressive Disorder (MDD)

- 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
- Can have symptomatology without meeting diagnostic criteria

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

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
Anxiety

18 year old Trans Male, Natal Female with T1D

• Has had diabetes since he was 14 years old
• Younger sister treated for Leukemia – now in remission
• Repeated episodes of DKA, ED visits, poor control – Hgb A1C levels over 14 %
• Inpatient and day treatment Psych admissions
• Poor functioning at school – unable to sustain regular attendance with significant accommodations
• This last year revealed gender identity issues – identified now as “Aidan” – will be seen in CHW Gender Health clinic
Anxiety: Common Disorders

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

Anxiety: Prevalence and Impact

- Lifetime prevalence of GAD to be 19.5% in T1D or T2D
- Common diabetes-specific anxiety:
  - Fears related to hyperglycemia
  - Not meeting blood glucose targets
  - Insulin injections
  - Fear of hypoglycemia (FoH)
- General anxiety predicts injection-related anxiety and FoH

Young Hyman D, et al. Diabetes Care 2016, 39 (12) 2126-2140
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

• 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, and/or has related thoughts and behaviors that interfere with daily living – OCD

• Severe hypoglycemia - PTSD and PTSD-like and panic disorder symptoms
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)

Disordered Eating Behavior
14 year old Female with T1D

- Has had diabetes since was 5 years old, Managed on Omnipod & Dexcom
- Never experienced honeymoon and always higher than average insulin needs. Long time Fear of Hypoglycemia by parent
- Family history of depression/anxiety in mother and older brother.
- Always very active but early teen – obsessed with own body image and daily intense activities.
- Poor diabetes control Hgb A1C of 9.0%
- Older brother had unsuccessful suicide attempt in January 2017
- Diagnosed with eating disorder in the Fall 2017
- Referred to a day treatment program followed by outpatient therapy.
- Parents very involved and disclosed abnormal eating habits and bingeing episodes, vomiting, and excessive exercise – No weight changes

Disordered Eating: Behaviors and Impact

- In T1D, insulin omission causing glycosuria to lose weight is most commonly reported disordered eating behavior
- People with T2D treated with insulin also report intentional omission
- In T2D, bingeing is most commonly reported
- Persons with disordered eating, disrupted eating patterns, and eating disorders have higher rates of diabetes distress and FoH than those without these symptoms

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

Life Course 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
• People ≥65 years of age should receive screening annually for mild cognitive impairment or dementia


Metabolic Surgery

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

American Diabetes Association.
POP QUIZ

1) When a patient has problems with glucose control, self-management, or quality of life, what treatment option should be considered?

A. Provide patient with a strict meal plan
B. Screen patient for psychosocial issues
C. Lecture patient about increasing physical activity
D. Increase dosage of medications
Screening Recommendations

- Psychosocial assessment part of ongoing diabetes care
- Psychosocial issues will change over time
- Screening and follow-up should be all inclusive
- Referrals should be provided for clinically significant symptoms
- Routinely screen for diabetes-related distress, depression, anxiety, and disordered eating behaviors
- High priority to older adults 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
Referral and Treatment Options

Psychosocial Care:
Life and Disease Course Perspectives

<table>
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<tr>
<th>Phase of living with diabetes</th>
<th>Continuum of psychosocial issues and behavioral health disorders in people with diabetes</th>
<th>Nonclinical (normative) symptoms/behaviors</th>
<th>Clinical symptoms/diagnosis</th>
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</table>
| 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.
Psychosocial Care: Life and Disease Course Perspectives

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<td>Disease Progression and onset of complications</td>
<td>Nonclinical (normative) symptoms/behaviors • Distress, coping difficulties with progression of diabetes/onset of diabetes complications impacting function, quality of life, sense of self, roles, interpersonal relationships</td>
</tr>
<tr>
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<td>Clinical symptoms/diagnosis • Adjustment disorders' • Psychological factors* affecting medical condition</td>
</tr>
<tr>
<td>Aging and its impact on disease and self-management</td>
<td>Nonclinical (normative) symptoms/behaviors Normal age-related forgetfulness, slowed information processing and physical skills potentially impacting diabetes self-management and coping</td>
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<td>Clinical symptoms/diagnosis • Mild cognitive impairment • Alzheimer's or vascular dementia</td>
</tr>
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Providers for psychosocial and behavioral health intervention

- 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)

*D 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.

Implementing Team-Based Psychosocial Care

1. Collaborative Care Model
2. Embedded Behavioral Specialist
3. Referral to Behavioral Provider
When to Refer to a Mental Health Provider

- Self-care impaired
- Evidence of persistent diabetes distress
- Positive screen
- Symptoms or suspicions disordered eating
- Intentional omission of insulin or oral medication

When to Refer (cont’d)

- Serious mental illness
- Behavioral self-care difficulties
- Screen positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Metabolic surgery
Helpful Resources

Position Statement

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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Mental Health Directory

The American Diabetes Association Mental Health Provider Directory lists individuals who meet the psychosocial mental health needs of people with diabetes. Listing in the Directory is available to providers that certify that they meet the following criteria:

1. Active ADA membership;
2. Hold a current license as a mental health provider; and
3. Demonstrate either (a) successful completion of the American Diabetes Association - American Psychological Association continuing education program or (b) at least two years of practical experience treating the mental health needs of people with diabetes.

Disclaimer: The Association does not render medical advice nor recommend specific providers or treatments.

Professional.Diabetes.org/MHDirectory

Professional Education

- Other webcasts and information on psychosocial care and behavioral health

Professional.Diabetes.org/CE
Thank You!