Management of Psychosocial Issues in the Context of Living with Diabetes

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- April 20, 2022
- Private practice, North Texas

Disclosures to Participants

- **Requirements for Successful Completion:**
- For successful completion, learners must participate in the entire activity and complete and submit a course evaluation at the end of the educational activity.

- **Conflicts of Interest and Financial Relationships Disclosures**
- **Presenters:**
  - Nicole Bereolos, PhD, MPH, MSCP, CDCES, FADCES– No conflicts of interest

- **Disclosure and Mitigation of Relevant Conflicts of Interest:** None – there are no conflicts of interest.

- **Off-label Use**: Learners will be notified of any off-label/investigational discussion.

- Clinical health psychologist
- Certified Diabetes Care & Education Specialist
- PhD – UNT – clinical health psychology/ behavioral medicine
- MPH – UNTHSC – health behavior
- MSCP – master's clinical psychopharmacology
- Has private practice (insurance-based) in North TX
- 2020-23 Editorial Board for *Diabetes Spectrum*
- 2019-20 Advisor for *Diabetic Living*
- 2018-2021 ADCES Board of Directors
- living with T1D since 1992

Learning Objectives

At the end of this presentation, participants will be able to:

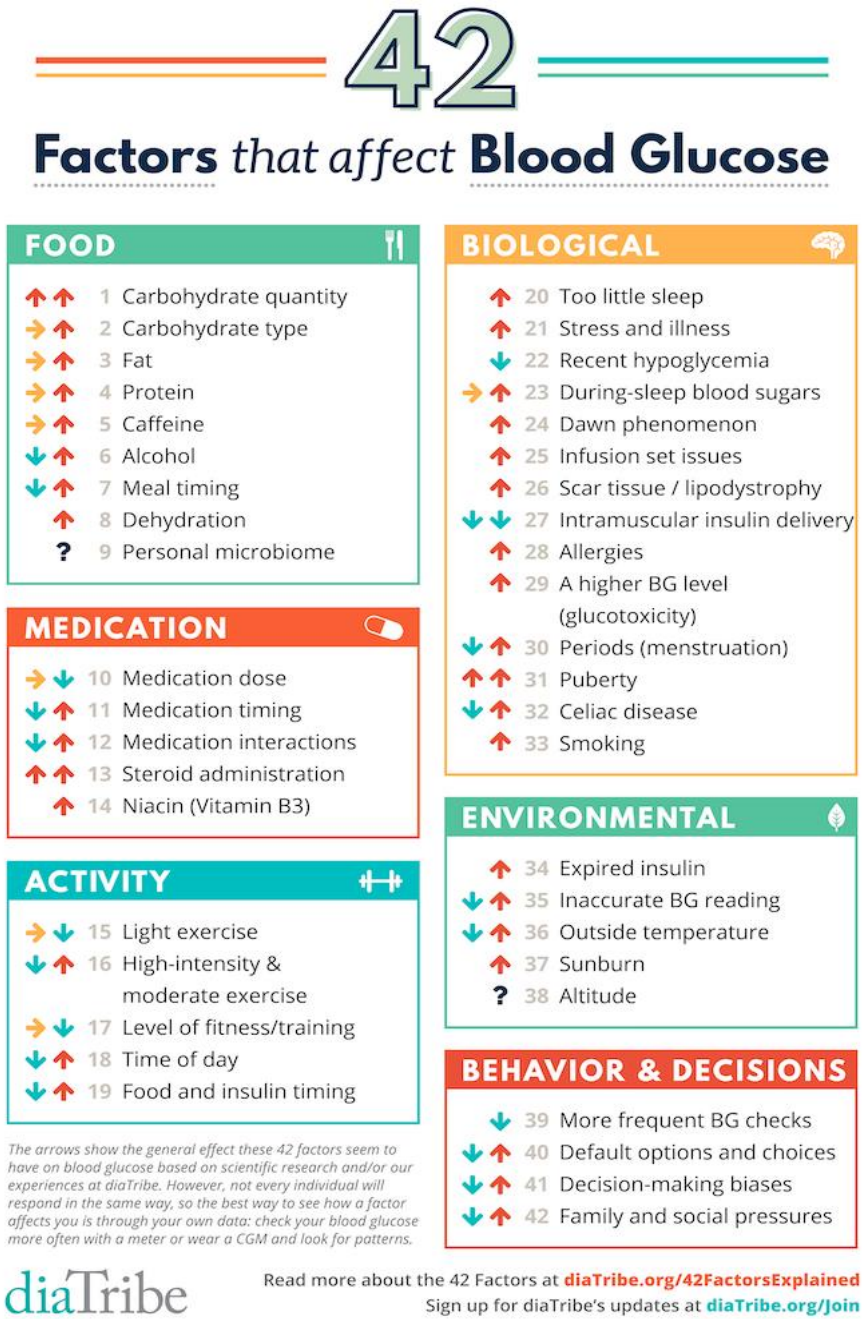
- Describe the signs and symptoms of depression, diabetes burnout/distress, disordered eating in the person with diabetes
- Identify evidence-based assessment tools that can be utilized by the DCES in the evaluation of depression, diabetes distress, anxiety, and disordered eating in the person with diabetes
- Examine current treatments for the psychosocial factors of living with diabetes
- Identify 3 best practice tips for assisting the person with diabetes to manage psychological distress and behavior change

What We Already Know!!!

- Diabetes is really challenging!!
- PWD are 2x more likely to experience depression (CDC, 2021)
- PWD are 20% more likely to experience anxiety (CDC, 2021)
- Those with type 1 DM are 2x more likely to have disordered eating (ADA)
- Majority of PWD have diabetes distress at some point (Fisher et al, 2015)
- Behavioral health treatment is still stigmatized (Vidourek & Burbage, 2019)

A Great Handout

- DiaTribe, Feb 2018
- Adam Brown




lost
no
never
certainly
I'm stuck

Why Some PWD Go “off-track”?

- LACK OF EDUCATION
- FEAR
- GUILT
- COST
- STAGES OF CHANGE
- LITERACY LEVELS
- PROVIDER ATTITUDE

- PERCEIVED BURDEN
- LOW SELF-EFFICACY
- SELF-CARE NOT PRIORITIZED
- ILLNESS IDENTITY (ESP TEENS)

Diabetes Distress (DD)

- refers to the worries, concerns and fears among individuals with diabetes over time as they struggle with managing a chronic, progressive condition like diabetes.
- is of significant clinical concern due its high prevalence and its clinically significant relationship with disease management, medication adherence, glycemic control, and quality of life.
- part of living with and managing diabetes over time
- is distinct from clinical depression
- Can be episodic or continuous
- is highly responsive to clinical attention

www.diabetesdistress.org

Diabetes Distress

- Feeling overwhelmed with the burden of managing a chronic condition
- Afraid & anxious about the unknown and potential onset of co-occurring/related conditions
- Feeling discouraged/defeated when best efforts do not yield desired results

DD vs MDD

Factors	DD	**MDD**
Etiology	Diabetes behaviors	None
Duration	Episodic	Episodic
Treatment provider	Diabetes-specialist	Behavioral Health Specialist
Type of treatment	Motivational interviewing/solution-focused	Medication/counseling/TMS

Assessing Diabetes Distress

- Type 1-diabetes distress Scale (T1-DDS) – for those 19y/o+ with t1D
- Addresses:
  - Powerlessness – feeling discouraged
  - Management distress – disappointment with self-care efforts
  - Hypoglycemia distress – concerns about hypoglycemic events
  - Negative social perception distress – concerns about negative judgment
  - Eating distress – concerns eating is out of control
  - Physician distress – disappointment with current HCP's
  - Friend/family distress – perception that too much focus on diabetes amongst by loved ones
- Diabetes distress scale (dds) - for those 19 y/o+ with T2D
- Addresses:
  - emotional burden – feeling overwhelmed about managing demands of diabetes
  - regimen distress – feeling they are failing by not managing diabetes well
  - interpersonal distress – feeling they are not receiving sufficient support
  - physician distress – worries about healthcare & obtaining sufficient support from HCP's

Screening Tools

- PHQ-9 (PHQ-2)
- CES-D
- GAD-7
- HADS
- GDS (Geriatric Depression Scale)
- *BDI-ii
- *BAI
- Diabetes Distress Scale - https://diabetesdistress.org/access-dds
- PAID – Problem Areas in Diabetes
- CAGE/AUDIT-C

Unhealthy Eating Patterns

- Omitting insulin to lose weight (diabulimia)
- Binge eating – focus is lack of control
- “Fear” of carbohydrates
- “fear” of dining out, trying new foods
- Treatment goals=focus on small change, success, stress management, reframe negative statements (progress can be very slow)

Diabulimia

eating disorder characterized by intentionally withholding insulin to result in weight loss

insulin restriction results in high levels of glucose in the blood that spill over into the urine, leading to the excretion of the calories from glucose

as many as a third of women with type 1 diabetes report insulin restriction, with higher levels among those between the ages of 15 and 30

Nationwide inpatient programs focused on Diabulimia

www.diabulimiahelpline.org - 425-985-3635

Recovery toolkit – We are Diabetes

WE ARE DIABETES

DIABULIMIA HELPLINE
Dream. Believe. Hope.

Strategies for Behavior Change

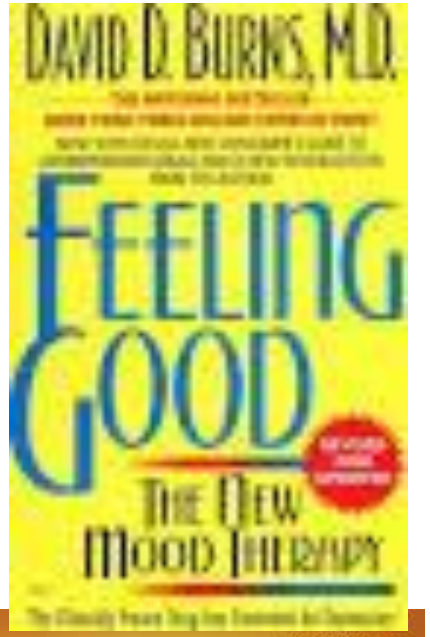
- Normalize feelings/behaviors
- Be supportive
- Be aware of your own language
- Talk about what they ARE doing not what they are not
- Be the cheerleader
- Work within THEIR framework
- Help them to recognize the many factors they can control
- Normalize the utility of Behavioral Health Providers early
- What is your body language saying?
- Being aware of HCP privilege
- Be mindful of provider burnout

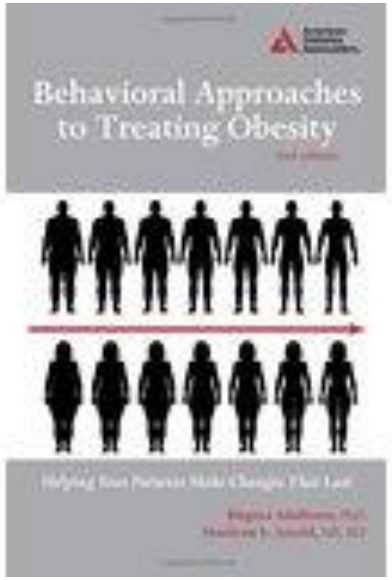
Strategies for Behavior Change

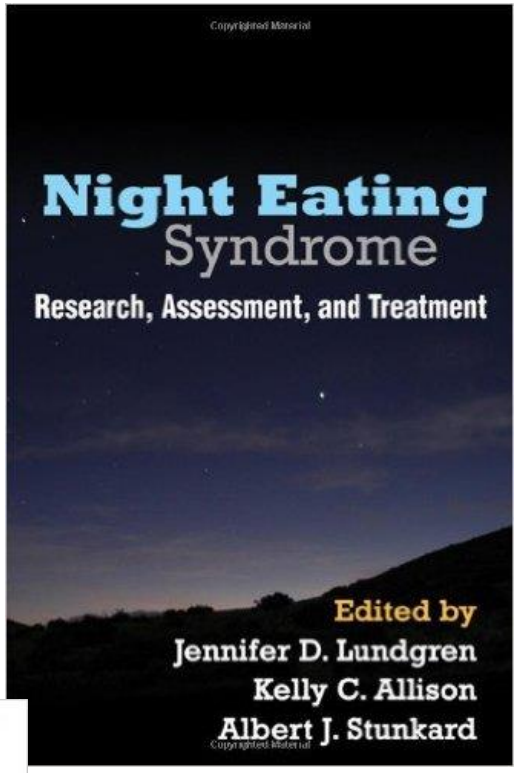
- Allow the PWD set the agenda even if different than your own
- Set them up for SUCCESS – doable goals
- Use examples in practice that are relatable to the PWD
- Don’t be afraid to ask
- Discuss change that is realistic and feasible given the SDH factors
- Build self-efficacy, be their rockstar/champion

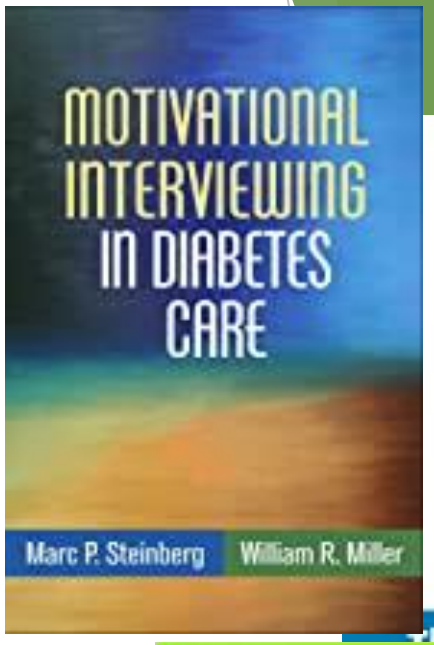
Examples of Healthy Coping

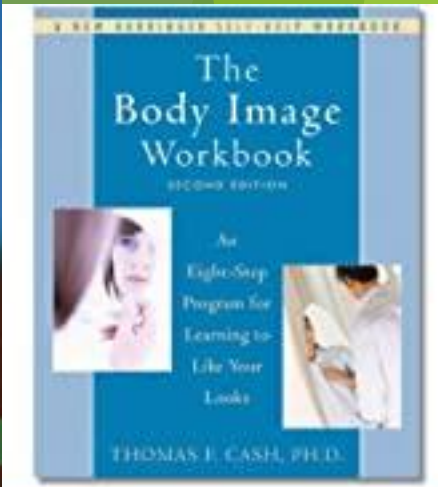
- Fulfilling health care obligations (keeps appointments, takes medication)
- Expressing emotions
- Seeking help; looking for answers
- Demonstrating basic problem-solving skills
- Incorporating physical activity into one's life
- Being proactive
- Demonstrating self-efficacy
- Overcoming barriers
- Having an adaptive coping style
- Being motivated
- Being optimistic

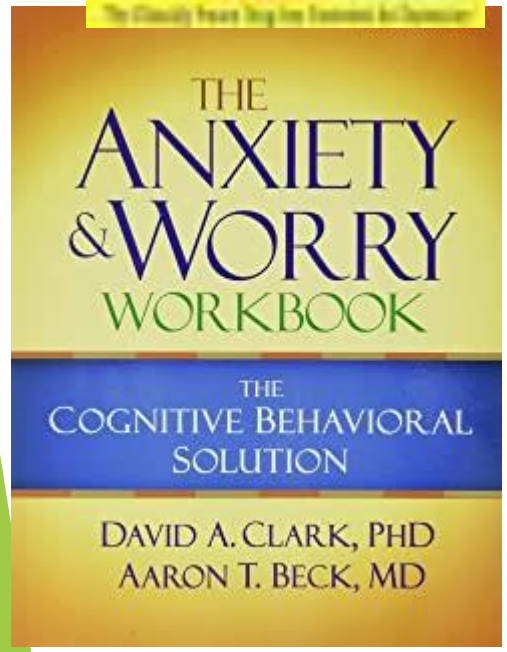

DAVID D. BURNS, M.D.
FEELING GOOD
THE NEW MOOD THERAPY

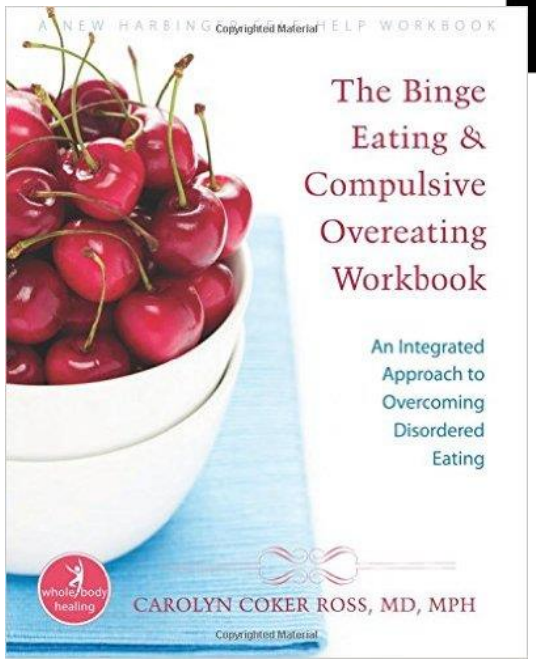

Behavioral Approaches to Treating Obesity

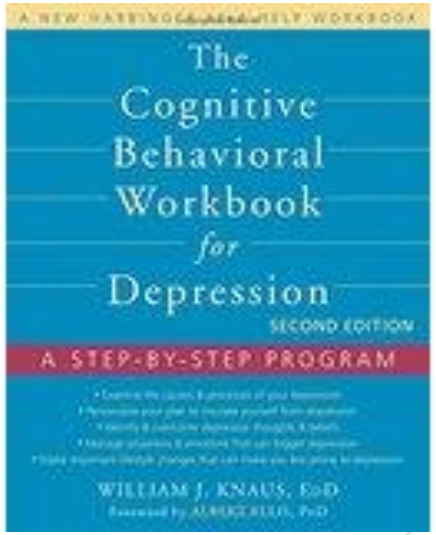

Night Eating Syndrome
Research, Assessment, and Treatment
Edited by
Jennifer D. Lundgren
Kelly C. Allison
Albert J. Stunkard

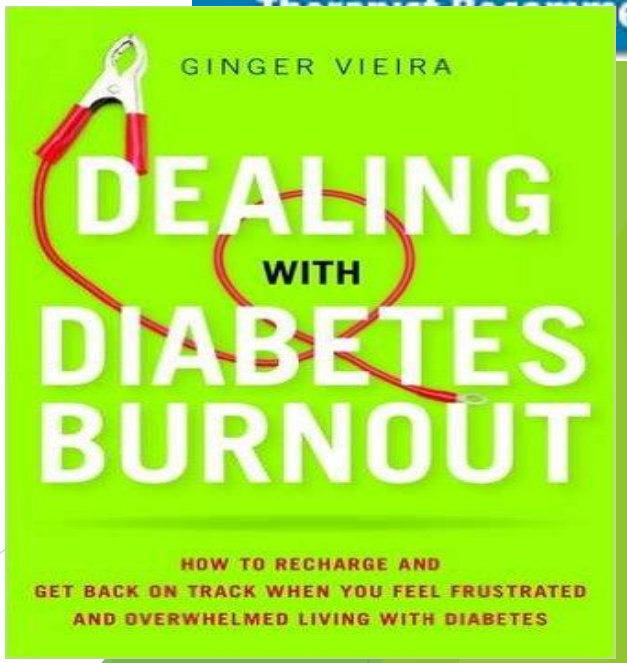

MOTIVATIONAL INTERVIEWING IN DIABETES CARE
Marc P. Steinberg
William R. Miller

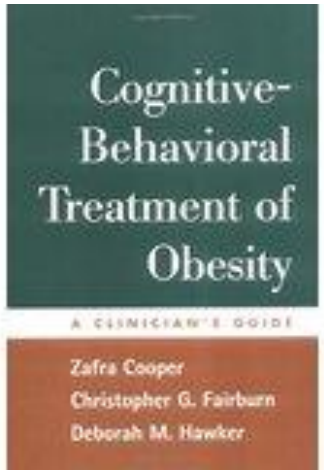

The Body Image Workbook
THOMAS F. CASH, PH.D.

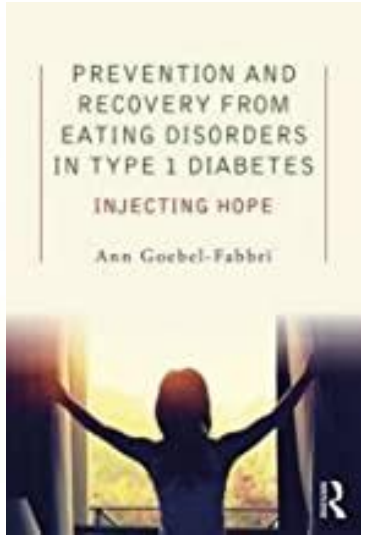

THE ANXIETY & WORRY WORKBOOK
THE COGNITIVE BEHAVIORAL SOLUTION
DAVID A. CLARK, PHD
AARON T. BECK, MD

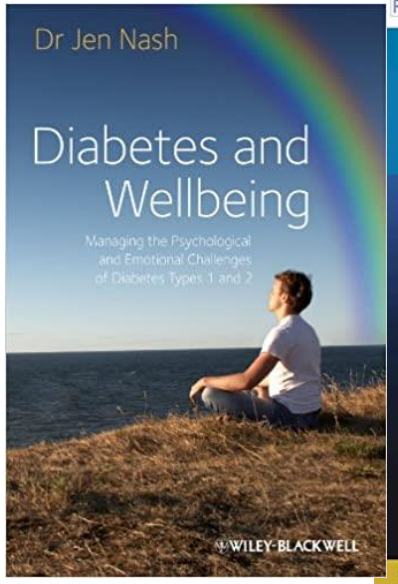

The Binge Eating & Compulsive Overeating Workbook
An Integrated Approach to Overcoming Disordered Eating
CAROLYN COKER ROSS, MD, MPH

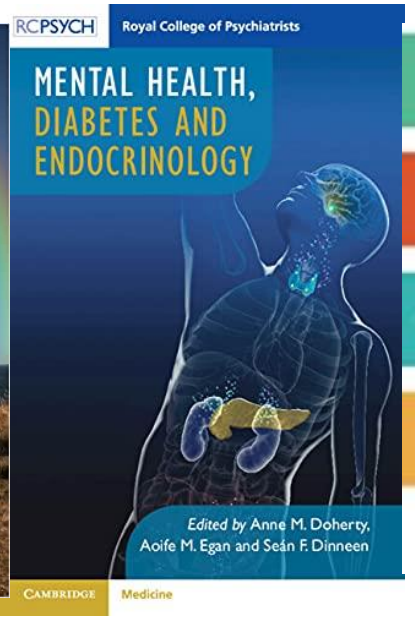

The Cognitive Behavioral Workbook for Depression
SECOND EDITION
A STEP-BY-STEP PROGRAM
WILLIAM J. KNAUS, EdD

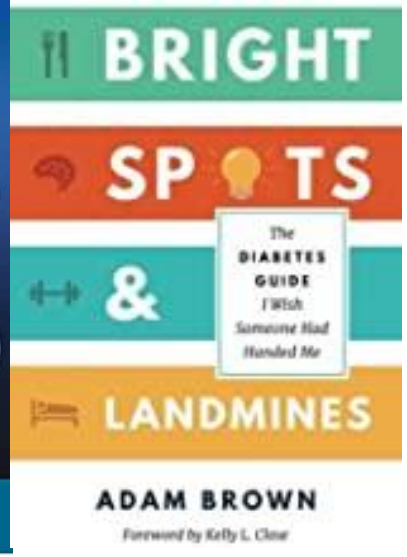

GINGER VIEIRA
DEALING WITH DIABETES BURNOUT
HOW TO RECHARGE AND GET BACK ON TRACK WHEN YOU FEEL FRUSTRATED AND OVERWHELMED LIVING WITH DIABETES

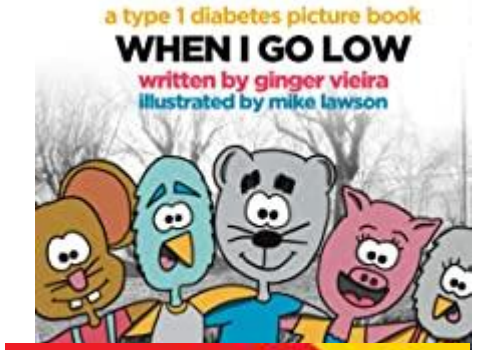


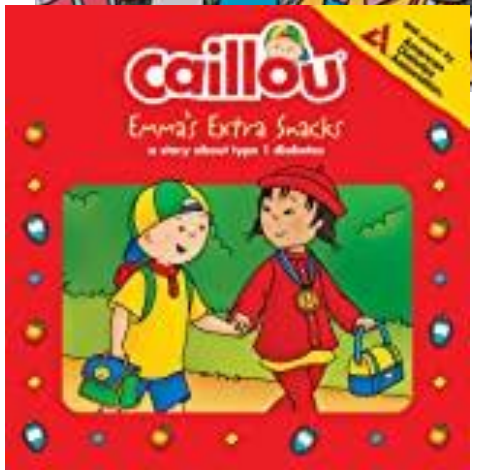


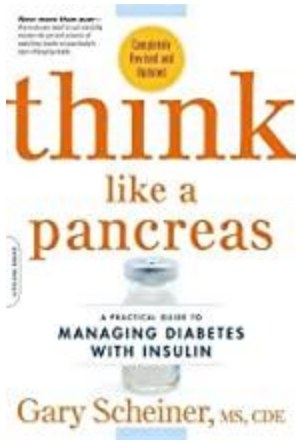


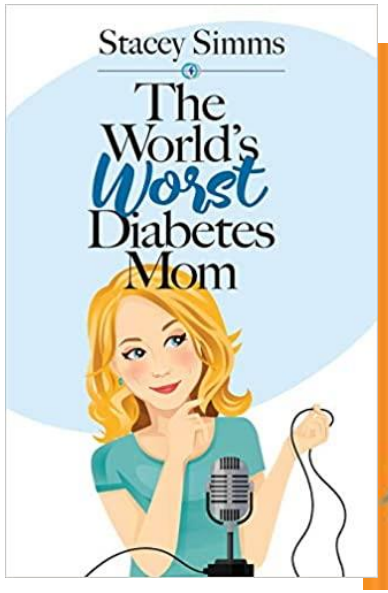


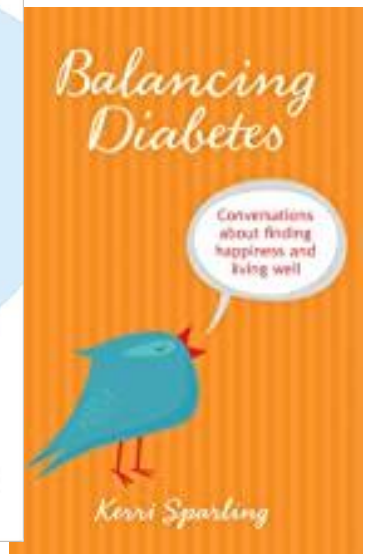


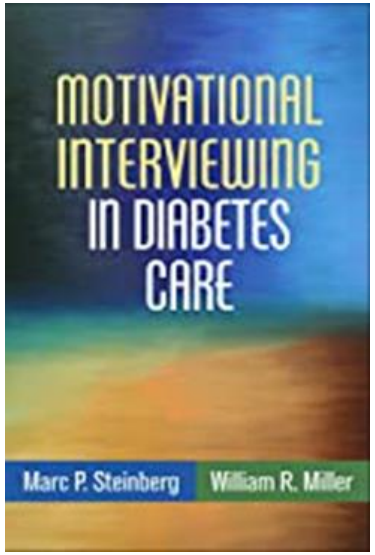


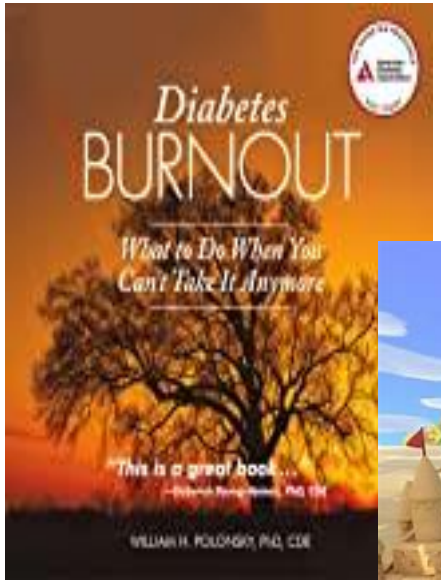












M. Heyman, PhD, CDCES (in press) Diabetes Sucks and How You Can Handle It: Guide to Managing Emotional Challenges of T1D

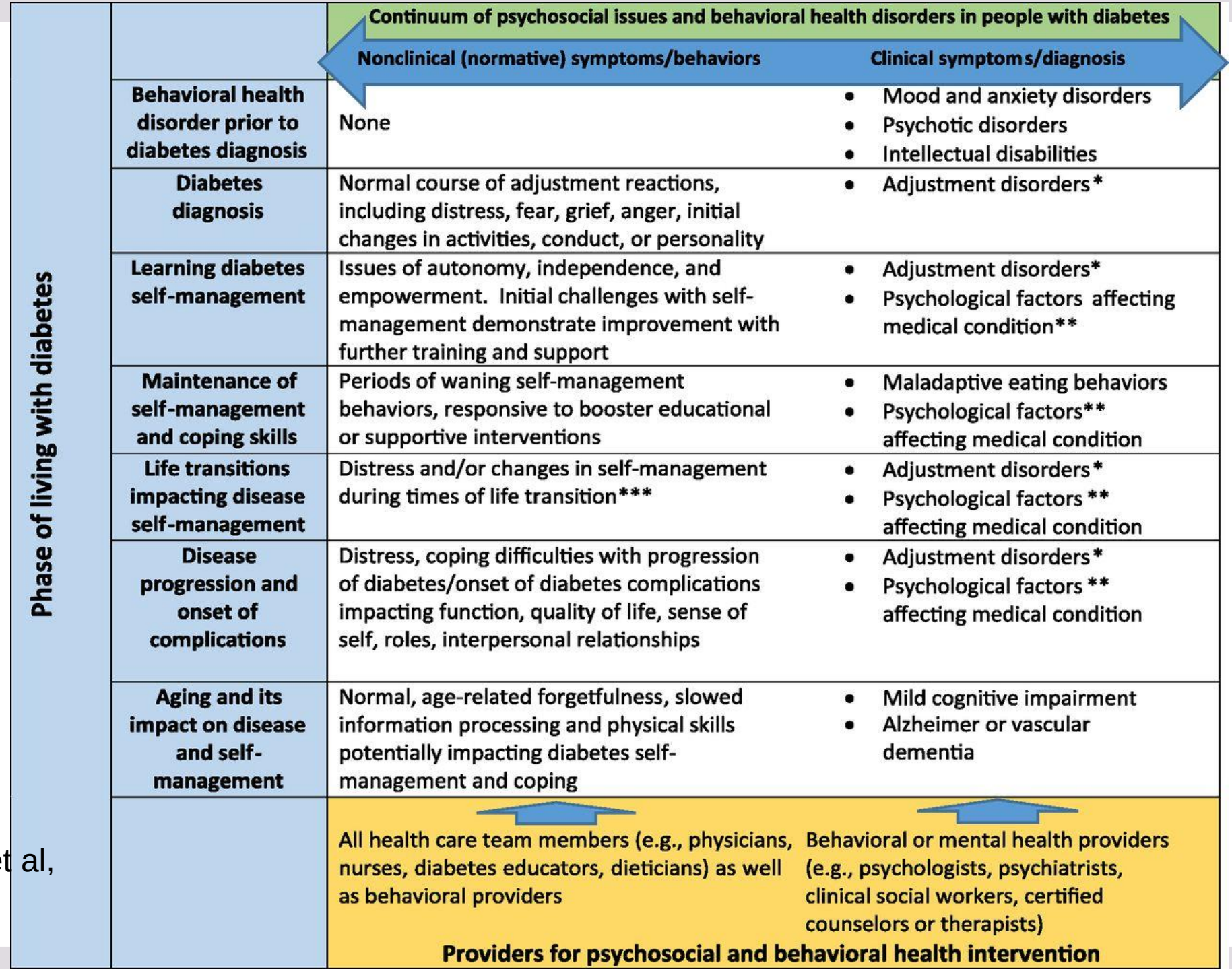
When to Refer to Behavioral Health Specialist

- Possibility of self-harm or harm to others (SI/HI)
- Disregard to diabetes self-management
- Stress affecting work-life-health balance
- Severe mental illness
- Signs of unhealthy eating habits/insulin omission
- Better to refer early than wait for a problem
- Behavioral specialists are a complement to what you are already doing!!

- Make sure the referral is not perceived as a punishment
- Encourage the use of a behavioral health provider at diagnosis. Normalize It!!!

Common Referral Questions

PWD won't wear diabetes-related tech	Fear of hypoglycemic events	Fear of trying new foods	Fear of going "high" so limit CHO intake
Weight management	Insulin omission	Not taking medications consistently	Communication problems with partners



(Young-Hyman et al, 2016)

Peer Support Communities

- Beyond Type 1/Beyond Type 2 – multiple languages
- DiabetesSisters
- College Diabetes Network
- #DSMA
- #DOC
- diatribe
- Children with Diabetes (Friends for Life)

Community Based Resources

- Crisis Centers/Mobile Units
- Case Management Services
- Faith Based
- Local substance abuse treatment programs
- Outpatient mental health professionals – ideally who are knowledgeable about DM
  - State association for psychologists or licensed professional counselors
  - Consult hospital based social worker
  - Certified eating disorders specialist (www.iaedp.org)
  - ADA/APA - https://professional.diabetes.org/mhp_listing

National Mental Health Resources

- SAMHSA's National Helpline, 1-800-662-HELP (4357) (24/7)
- NAMI helpline, 1-800-950-NAMI (6264) (M-F 10a-10p ET)
- Mentalhealth.gov
- Depression and Bipolar Support Alliance
- Suicide Prevention Line – 800-273-8255
- Trevor Lifeline – LGBTQ+ youth – 866-488-7386
- Veteran Crisis Line – 800-273-8255
- Anxiety Disorders Association of America
- 1-800-SUICIDE
- Celebrate Recovery
- Catholic Charities
- Salvation Army

Case Study

- 55 year-old Hispanic (Mexican) American female living with T2DM
- Hypertension, hypothyroid, fibromyalgia, history of ovarian cancer
- Caring for aging parent with Vascular Dementia and has young adult son who is in and out of jail since being a teen; work full-time as a store manager
- insomnia, generalized joint pain, lethargy, no longer going to church, loss hope
- .7% increase in A1C that she attributes to forgetting her weekly diabetes-related injectable

- What are some questions you'd ask to help you assess?

Case Study #2 -

- 22 y/o, college senior, plan to graduate 12/21, parents divorced, no siblings
- T1D on CGM and MDI
- Recently lost 60 pounds going from 210-150 lb (intentional)
- Living in apt alone in college, closest family 2 hours away
- Refers to over 140 mg/dl as “high” (a1c=high 5, low 6%)
- High anxiety over many things
- Not want to be a burden & people pleaser

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Questions?

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