The Psychology of Diabetes and Diabetes Care

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By attending this lecture, participants will…

• Understand the range of psychological needs experienced by people with diabetes.
• Know how psychological difficulties may present in the podiatry clinic.
• Understand the range of ways that psychologists can support diabetes care.
It could be worse, at least you don’t have diabetes!

- There is no cure for it.
- It is unpredictable – what you need to do to manage it successfully can change from day to day.
- There is no escape from it – the consequences of not managing it are really serious and irreversible.
- It is progressive.
- It can affect your mood – making everything that much harder to do.
- In order to manage it you have to pay attention to several things all at the same time.
- It can have its onset in childhood or adolescence – when you are just trying to figure out who you are.
- It can negatively affect your sex life.
- It is really complicated to manage properly, but this is rarely appreciated by other people.
The problem (as we see it)...

• High levels of non-adherence to medical recommendations which may delay progression to complications;
  – 60% do not follow dietary guidelines
  – 55% do not take any form of exercise
  – 67% monitor blood glucose levels less frequently than desirable
  – 33% do not take oral hypoglycaemics as prescribed
The challenge of Self-Management

The demands of diabetes
- Eating a healthy diet
- Being as physically active as possible
- Taking medication as prescribed
- Monitoring blood sugars
- Having your bloods tests taken
- Checking feet and managing ulcers
- Going to GP and Hospital appointments
- Keeping a positive mindset

The demands of life
- Holding down a job
- Looking after children and grandchildren
- Looking after spouses and parents
- Managing a household
- Living with depression, anxiety or general worries
- Managing financial concerns
- Managing other health problems
Types of Distress…

‘Mental Health Disorders’
• Depression
• Anxiety
• Eating disorders

Diabetes Related Distress
• Aka “Diabetes Burn-Out”
Diabetes Related Distress

General difficulties coping with diagnosis, the day-to-day reality of living with diabetes and its perceived consequences.

• Common concerns amongst adults experiencing diabetes related distress include:
  – Feeling scared and angry about having the condition
  – Worry about the future consequences of the condition
  – Feelings of guilt and anxiety associated with setbacks in self-management
  – Feeling deprived of food and constantly concerned about eating
  – Resentment of the pain and inconvenience associated with self-monitoring blood glucose and injecting
  – Resentment of the impact of diabetes for the rest of one’s life and that it is always there-the
  – ’24-7’ (every hour-every day) phenomenon

(The Emotional and Psychological Working Group of NHS Diabetes and Diabetes UK, 2010)
Impact of Depression in Diabetes

- Depression is more likely, lasts longer, comes back more often and is generally missed in 2/3 cases.
- For both T1 and T2DM, the presence of depression is associated with increased:
  - Mortality
  - Cardiac events
  - Hospitalisation
  - Complications (retinopathy, neuropathy, nephropathy – in fact, all the ophthalmies!)
  - Functional impairment
  - Healthcare costs
  - Medical symptom burden
Depression and foot ulceration

Cohort studies
• Compared with people who are not depressed…
  – People who are depressed present with larger and more severe foot ulcers (Ismail et al., 2007).
  – Have foot ulcers that are slower to heal, and are more likely to reoccur (Monami et al., 2008).

Prospective studies
• Major depression is associated with two-fold increase in development of a first foot ulcer over four years (Williams et al., 2010)
Depression in the foot clinic

Individuals attending outpatient podiatry for treatment of a foot ulcer:
• 23% have mild depression.
• 28% have moderate to severe depression.
• 35% had received a diagnosis of depression.
• 28% of individuals with depression had not been identified as such.

Pearson, Nash and Ireland (2014). Journal of Foot and Ankle Research, (7); 47
Depression or Diabetes Distress?

- Depression – Depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, poor concentration.

- Diabetes Related Distress (DRD) – Symptoms of low mood and anxiety which do not meet diagnostic criteria and are associated with the diabetes and its management.

- DRD may have a greater impact than depression on glycaemic control (Aikens, 2012; Fisher et al. 2010; Zagarins, Allen, Garb and Welch, 2012).

- DRD is possibly more closely associated with disease progression than depression. (Fisher et al. 2007).

- DRD may mediate the relationship between depression and glycaemic outcomes in treatment trials. (Fisher et al., 2007/2008; van Bastalaar et al., 2010; Levya et al., 2011).
Anxiety in the Context of Diabetes

- High prevalence levels, similar to depression.
- Proportionally less attention paid to anxiety, although can be equally as devastating for disease progression.
- Disease-specific forms of anxiety exist:
  - Fear of hypoglycaemia
  - Psychological insulin resistance
Psychological Insulin Resistance

- Fear of starting to take insulin.
- 17 – 40% of individuals with T2DM may try to avoid taking insulin.
- Consequence is persistent hyperglycaemia, increased risk of progression to complications, and higher levels of diabetes-related distress.
- PIR is associated with:
  - Depression
  - Negative beliefs about insulin
  - Injection anxiety
  - Beliefs about disease progression and personal failure.
Fear of Hypoglycaemia

- Hypoglycaemia is due to excess insulin levels in relation to circulating glucose.
- If untreated, hypoglycaemia may affect brain function, both cognitive and motor.
  - **Severe hypoglycaemia:** Convulsions, coma or death may occur.
  - **Recurrent severe episodes of hypoglycaemia:** Behavioural changes, cognitive impairment, and unawareness of hypoglycaemia.
- Because of these negative consequences, patients may develop psychological fear of hypoglycaemia. This fear can become phobic, reduce quality of life, and impact adherence with diabetes management.
- May start to: Run blood glucose high to avoid hypo, eat more than needed, restrict activities where hypo episode would be more challenging, e.g. driving, travelling or public transport.
How well are we supporting people with Diabetes?

??% health professionals report that they regularly ask about how diabetes affects peoples lives.

??% patients report being asked about their well-being in the last year.

Holt et al., (2013), Kovacs et al., (2013)
How well are we supporting people with Diabetes?

52% health professionals report that they regularly ask about how diabetes affects peoples lives.

??% patients report being asked about their well-being in the last year.

Holt et al., (2013), Kovacs et al., (2013)
How well are we supporting people with Diabetes?

52% health professionals report that they regularly ask about how diabetes affects peoples lives.

24% patients report being asked about their well-being in the last year.

Holt et al., (2013), Kovacs et al., (2013)
Barriers to Talking About Well-Being

- Opening “Pandoras box”
- Don’t feel quipped to handle the question
- Dislike of mechanistic processes
- Well being at the end of the checklist
- Tools feel to blunt
- Fear of stigmatising and or/alienating patients

Maxwell et al., 2013; Coventry et al., (2011)
It’s not just about distress…
Case Study

- Fiona, 66 years old, 20 years with T2D, glycaemic control fine.
- Referred from Podiatry due to several year history of picking at feet resulting in infection and ulceration which has been resistant to change.
- Repeatedly presents in crisis.
- Insistence on ‘beautiful shoes’ that are completely inappropriate for the diabetic foot!
Psychological Assessment

- Unhelpful behavioural cycles (1):

  - Sensation of picking
  - Negative reinforcement of behaviour
  - Reduced awareness of other difficulties
  - Narrow Attentional Focus
Psychological Assessment

- Unhelpful behavioural cycles (2):
  - Shame associated with diabetes
  - Avoids hospital until unavoidable
  - Presents in crisis to podiatry team
  - Feels ‘told off’ by podiatry team
Joint psychology-podiatry case management

- 2 foci of management:

(a) Increased attendance and reduce delay to presenting to podiatry services – secondary prevention of further harm.

(b) Increased awareness of the psychological function of picking behaviour and training in cognitive and behavioural strategies to reduce this.
What does the service offer?

- **Strategic input to the IPU**
  - PROMS
  - Models of care
  - Evaluation and audit
  - Pathway development (e.g. Serious Mental Illness)

- **Direct client work**
  - Assessment and triage service
  - Time-limited therapy (8-12 sessions) on issues directly affecting individual ability to self-manage, or distress caused by diabetes.
  - Group delivery (e.g. Bengali Group)
  - Joint psychology/DSN/Dietetic/Podiatry working

- **Indirect work**
  - Consultation to staff on psychological aspects of their work with clients
  - MDT discussions
  - Training in behaviour change or needs assessment
Summary

• Psychosocial issues are one of the main preventable causes of distress and early progression to complications in Diabetes.

• Support for psychological wellbeing are a need to have and not an optional extra for ‘lucky’ services.

• Nevertheless, there are a number of barriers to proactive management of this important source of distress and disability:
  – **Capability**; having practical screening tools that can easily integrated into existing practice, and the skills to manage resulting conversations.
  – **Opportunity**; access to services that can support, and strong culture of asking about distress.
  – **Motivation**; a belief that enquiring about wellbeing is a core part of professional identity, and an acknowledgement that whilst it is not always easy to do, it is in the patients best interests.