Psychological aspects of diabetes management

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Abstract

Optimal management of diabetes mellitus is a significant challenge for patients; understanding how best to help is a similarly complex task for healthcare professionals. Achieving optimal plasma glucose is difficult, and many issues affect adjustment and self-management. Understanding how diabetes weaves into the complexity of an individual's personality and their life is crucial. As well as coping with the lifestyle and intellectual challenges demanded by their diagnosis, patients are also required to process the emotional consequences of having to live with a demanding, progressive condition for the rest of their lives. Psychological ill-health is more common in people with diabetes than in the general population, and is associated with poorer biomedical outcomes; a psychological element to care is therefore important, and evidence exists to support the effectiveness of a range of psychological interventions. Ultimately, people with diabetes themselves make the final decisions about how they manage their condition, and healthcare professionals can find their consequent sense of disempowerment unfamiliar and frustrating. Building mutually respectful collaborative relationships, which encompass an emotional dimension, should be a central goal of all those involved in diabetes care.

Keywords Adjustment; depression; diabetes distress; mental ill-health; MRCP; patient empowerment; psychological intervention; self-management

Introduction

People diagnosed with diabetes mellitus are required to take on the challenge of understanding the nature and course of the condition and how best to manage it; this invariably involves them making unwanted changes to their lifestyle. Moreover, to a greater or lesser degree, everybody who lives with diabetes experiences understandable emotional distress when faced with the almost constant demands of a progressive, life-long condition.

Adjusting to the behavioural, intellectual and emotional demands of diabetes places a significant burden on patients and those who care for them. Many struggle with loss of freedom, relentless decision-making and a perceived reduction in quality of life, particularly in type 1 diabetes. The benefit of good control often seems uncertain and, for many, elusive. For those who have to inject insulin, tighter control often leads to an increase in episodes of hypoglycaemia, which many patients are anxious to avoid. As testimony to the scale of the challenge, most individuals, even in highly supervised, controlled studies, which tend to select highly motivated patients, are not able to optimize plasma glucose.

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Key points

- Build mutually respectful, collaborative relationships with your patients. Patients do not learn anything from doctors they do not like. Resist the temptation to 'wag the finger' at patients with suboptimal metabolic results
- Strive to understand diabetes mellitus management within the context of patients' lives and personalities
- Do not pathologize understandable emotional distress, but refer those with identifiable mental ill-health for psychological or psychiatric intervention
- Embrace the philosophies and practices of patient empowerment and patient-centredness
- Psychological distress predicts poorer biomedical outcomes. Doing nothing, as an individual or a service, is not a good option

The complications of diabetes are insidious and anxiety-provoking, and newly diagnosed individuals are required to balance the risk of complications with more immediate demands and stresses in their lives. Healthcare professionals are acutely aware of the danger of patients developing microvascular and macrovascular complications, and ultimately of risk of death, which remain the dominant outcome measures of modern-day diabetes medicine. Patients, on the other hand, tend to be more mindful of their immediate quality of life and often prioritize accordingly. Conveying the message that diabetes requires the patient to balance quantity of life with quality of life is delicate and difficult. The idea that we find it hard to take action now that will benefit us in the future is not a novel one.

Psychological adjustment

Many factors associated with poor adjustment are beyond the control of the average healthcare professional. For example, poor literacy skills, health illiteracy and poverty increase the risk of both developing diabetes and poorer clinical outcomes (see Further reading). Disadvantaged groups, such as people with learning disabilities or severe and enduring mental health problems, require additional support. Specific cultural issues can make living with diabetes more difficult. For example, people from South Asia, who are at higher risk of developing type 2 diabetes, frequently follow traditional diets that tend to be high in fat, and many culturally important religious festivals involve feasting or abstaining from food altogether. Different languages and culturally mediated health beliefs can also present challenges to our Westernized, scientific healthcare system.

Life stage

The psychological impact of diabetes varies across the life stages. The needs of young children are invariably mediated by parents and families, and are very different from those of patients who develop diabetes later in life. The appearance of childhood diabetes can be an overwhelming shock for parents and families, who commonly experience significant grief and trauma when the diagnosis is made. The parent or parents often require as much support as the child at this time. The continuing stress of caring for a child with diabetes also places a great deal of stress on individuals and on relationships.

Adolescence is a life stage during which education, independence, freedom and experimentation are important. Developing identity, sexuality and body image are sensitive issues, and the influence of peers is paramount. Diabetes makes all these issues more complicated and, perhaps unsurprisingly, diabetes control worsens for many during this stage of life. In a minority of cases, the approach to diabetes control can be reckless and life-threatening. Diabetic ketoacidosis, insulin omission, eating disorders and diabulimia often coexist, and such situations can be extremely difficult to manage.

The responsibilities of adulthood (family, work, mortgage, etc.) can be burdensome, and for many, particularly those who lack support, diabetes is one responsibility too many. Diabetes can represent a threat to independence (e.g. driving), sexual satisfaction and personal autonomy. Time pressures, working environment and willingness to engage with health services are frequent issues for patients of working age. Gestational diabetes complicates pregnancy and often heightens anxiety and concern.

For older people, quality of life is particularly important, and the fear of approaching death and the challenge of coping with multiple health problems, accompanied by loss of role and status, often lead to unhappiness.

Emotional distress

Over 40% of people with diabetes experience measurable psychological distress that is both a risk factor for, and a consequence of, diagnosis.[1] Significant psychological ill-health is more likely among people with diabetes, and psychological distress has a negative impact on diabetes self-care, leading to poorer biomedical outcomes, increased complications and healthcare costs, lost productivity and increased mortality.[2]

It is important to recognize that most people's distress is not pathological, but simply represents the unique, often hidden emotional burdens that are part of the range of patient experience when managing a severe and demanding chronic illness (see Further reading). Acknowledging and helping people to understand and manage emotional upset, interpersonal tension and the stress of coping with the burden of their diabetes regimen should be the responsibility of everyone who cares for and about people with diabetes. It is also important to recognize that a great deal of distress results from patients' experience of the healthcare professionals and healthcare systems upon which they depend.

Mental ill-health

Although over-pathologizing the emotional distress of people with diabetes is not to be encouraged, it should nevertheless be acknowledged that formal mental health disorders are more common in this population. Published prevalence rates vary, but it is generally recognized that diabetes healthcare professionals frequently encounter patients with depressive symptoms, anxiety and eating difficulties, and that these co-existing issues have a significant impact on the well-being of the patient and on clinical outcomes (see Further reading). Severe difficulties coping with diabetes frequently reflect complexities of personality.

It would thus seem reasonable to suggest that intervening to improve psychological functioning should have a consequent benefit in terms of diabetes control, and research exists to support this hypothesis. Meta-analyses support the notion that psychological treatments can improve glycaemic control in children and adolescents with type 1 diabetes.[3] In addition, in those with type 2 diabetes, psychological interventions, such as counselling, cognitive behavioural therapy, family therapy and psychodynamic therapy, lead to improvements in long-term glycaemic control in addition to reduced psychological distress.[4]

Emotional and psychological support

Despite numerous guidelines and reports (see Further reading) highlighting the importance of increasing access to psychological support for people with diabetes, service improvements have been limited. It has been suggested that diabetes care requires more specialist psychological practitioners, while others have proposed that changing the philosophy and organization of current services might be a more profitable approach — perhaps a little of each is required.

Undoubtedly, the starting point is to engage with patients about their emotional lives and psychological needs. There remains something of a 'Pandora's box' attitude to such enquiries, although whether this reflects lack of time, absence of referral pathways or a lack of confidence among healthcare professionals remains unanswered. Solutions are not always easy to identify, but assessing the problem from the point of view of the patient is seldom unhelpful (Table 1).

As the patient is the final arbiter of decisions regarding diabetes control, healthcare professionals find themselves in an unfamiliar, somewhat responsive role. Unlike acute or emergency medicine, where health professionals are empowered to take decisions and have the final say, with the patient being a passive recipient of care, diabetes care involves the patient being in control while healthcare professionals find themselves in a comparatively disempowered role. Many find this adjustment difficult, and consequently relationships sometimes can be strained.

Patient satisfaction with treatment often focuses on themes such as mutual goal-setting, maintaining a sense of control in dealings with healthcare professionals, being treated as an equal, being treated with attentiveness and courtesy, and being treated in a way that increases, rather than decreases, confidence. Healthcare professionals are often asked to reflect on their practice and how their service is delivered. It would seem that, too often, how people are treated depends on their most recent glycated haemoglobin result, with a low figure conferring the status of 'good patient' and a high figure leading to a tendency to 'wag the finger', which is seldom welcome or helpful.

Diabetes control invariably has to compete for attention with a host of other issues in people's lives, and finding out more

What is helpful to know?

- *Personal history* — birth family, childhood, education, career, relationships, interests
- *Current circumstances* — family, work, housing, including life stresses
- *Health history* — previous and concomitant ill-health
- *Details of how diabetes was diagnosed* — including finding out whether the patient has been referred for structured diabetes education
- *Initial adjustment* — including an understanding of diabetes and self-efficacy in relation to management
- *Mental health history* — including history of previous trauma, depression or eating disorder
- *Current psychological functioning* — may include psychometric assessment
- Patient's perception ('*What's the problem?*') and experience ('*How does that feel?*') of being diagnosed with or living with diabetes
- Patient's goal ('*What do you want?*'), strategies ('*What did you do?*', '*How did it work?*') and needs ('*Is there anything I can do to help?*')

Source: Anderson B, Funnell M. The art of empowerment: stories and strategies for diabetes educators, 2nd edn. American Diabetes Association, 2005.

Table 1

about the lives and personalities of individuals who have diabetes is often a better starting point for understanding the challenges it presents. Moreover, all diabetes professionals would benefit from reflecting on questions such as 'How would I feel if I discovered I had diabetes?' and 'What can I do to make it easier for people to manage and live with this condition?' ◆

KEY REFERENCES

1 Nicolucci A, Kovacs Burns K, Holt RIG, et al. Diabetes attitudes, wishes and needs second study (DAWN2): cross-national benchmarking of diabetes-related psychosocial outcomes for people with diabetes. *Diabet Med* 2013; **30:** 667–77.

2 Pouwer F, Nefs G, Nouwen A. Adverse effects of depression on glycemic control and health outcomes in people with diabetes: a review. *Endocrinol Metab Clin North Am* 2013; **42:** 529–44.

3 Winkley K, Landau S, Eisler I, Ismail K. Psychological interventions to improve glycaemic control in patients with type 1 diabetes: systematic review and meta-analysis of randomised controlled trials. *Br Med J* 2006; **333:** 65.

4 Ismail K, Winkley K, Rabe-Hesketh S. Systematic review and meta-analysis of randomised controlled trials of psychological interventions to improve glycaemic control in patients with type 2 diabetes. *Lancet* 2004; **363:** 1589–97.

FURTHER READING

Anderson B, Funnell M. The art of empowerment: stories and strategies for diabetes educators. 2nd edn. American Diabetes Association, 2005.

Diabetes UK and National Health Service Diabetes. Emotional and psychological support and care in diabetes. 2010. Diabetes UK , https://www.diabetes.org.uk/professionals/resources/shared-practice/psychological-care (accessed 8 October 2018).

Fisher L, Gonzalez JS, Polonsky WH. The confusing tale of depression and distress in patients with diabetes: a call for greater clarity and precision. *Diabet Med* 2014; **30:** 764–72.

Houle J, Lauzier-Jobin F, Beaulieu MD, et al. Socioeconomic status and glycemic control in adult patients with type 2 diabetes: a mediation analysis. *BMJ Open Diabetes Res Care* 2016; **4:** e000184.

Young-Hyman D, de Groot M, Hill-Briggs F, et al. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association 2016. *Diabetes Care* 2016; **39:** 2126–40.

TEST YOURSELF

To test your knowledge based on the article you have just read, please complete the questions below. The answers can be found at the end of the issue or online here.

Question 1

A 17-year-old woman was admitted to hospital with diabetic ketoacidosis for the third time in 9 months. She had had type 1 diabetes for 4 years. She had been brought up in care, and both her parents were dead. Her baby daughter had recently been taken into care by social services. Her boyfriend had recently ended their abusive relationship and thrown her out of their flat, and she had no support and nowhere to live. She appeared to be of limited intellectual ability. Her most recent HbA_{1c} had been 109 mmol/ml (12.1%) but it had been lower in the past. She reported that her biggest problem was 'nowhere to live', and diabetes self-management was not an issue for her by comparison.

What is the next best action while she is an inpatient?

A Refer her to social services to address the housing issues
B Stress that poor diabetes control is probably a bigger threat to her than being homeless
C Empathize with the problem of homelessness but try to increase her appreciation of the importance of diabetes control
D Refer her to mental health services for depression
E Sort out the immediate medical problems and discharge her

Question 2

A 36-year-old man presented for review. He had recently been found to have type 1 diabetes and was emotionally distressed by his diagnosis. He has been taking insulin as prescribed and his current HbA_{1c} is 56 mmol/ml (7.3%). On clinical examination, his body mass index was 29 kg/m^2, and blood pressure 142/90 mmHg.

What is the priority for this consultation?

A Take a full medical history
B Check his eyes and kidney function
C Refer him for structured diabetes education
D Listen to how he feels about being diagnosed
E Refer him to mental health services for depression.

Question 3

A 58-year-old woman presented for review. She had type 2 diabetes that was not satisfactorily controlled and had been advised to initiate insulin therapy, but she had refused to do this. She had a long history of suicidal ideation, depression and eating difficulties, and her GP described her as being ‘a difficult patient to help’. During the assessment, she was emotionally distressed and accused her GP of neglecting her.

What should be the goal of the doctor in this consultation?

A To convince her that her GP is doing everything she can to help
B To refer her for diabetes education
C To discuss the possibility of a referral to a mental health service
D To convince her to start insulin
E To assess whether or not she is suicidal