RESPONSE TO COMMENTS ON YOUNG-HYMAN ET AL.

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association. Diabetes Care 2016;39:2126–2140

Deborah Young-Hyman,[1] Mary de Groot,[2] Felicia Hill-Briggs,[3] Jeffrey Gonzalez,[4,5] Korey Hood,[6] and Mark Peyrot[7]

Diabetes Care 2017;40:e131–e132 | https://doi.org/10.2337/dci16-0051

Thanks to Drs. Kalra, Balhara, Mezuk, Pouwer, and Campbell and Ms. Macdonald for their careful consideration (1–3) of the first American Diabetes Association (ADA) psychosocial guidelines Position Statement (4). Kalra and Balhara (1) note the overlaps and differences in the content of the ADA and Indian position statements, with particular emphasis on the cultural appropriateness and specificity of recommendations. Mezuk and Pouwer (2) question the need for routine screening for depression in persons with impaired glucose metabolism and undiagnosed diabetes based on meta-analytic results (5) and note the need to address disparities in diabetes burden and quality of care. They further suggest the need for action steps for practitioners once psychosocial issues are identified that impact health outcomes. These concerns are echoed by Macdonald and Campbell (3) when identifying that emphasis on compliance can cause blame to be placed on patients through misguided interpretation of the patient-centered paradigm. They suggest that this might be avoided through "long-term" care, by which they appear to mean the relationship formed through long-term follow-through by a consistent care provider.

These authors identify social issues that are not explicitly addressed in the ADA Position Statement: barriers to getting married, gender-based issues, geographically based management challenges, culturally specific intervention strategies for increasing well-being, disparities in burden and quality of care for racial/ethnic minorities, and the need for relationship-based care, i.e., provider understanding of personal needs rather than only reliance on treatment algorithms. The importance of individual needs and cultural context is thereby emphasized. Whether with regard to phase of life, availability of medical resources, and/or broader cultural issues that are endemic and therefore interact with care, no one set of guidelines or recommendations will be applicable to all people affected by this global epidemic. Thus, person-based and contextual factors must always be considered in order to optimize treatment and outcomes (4).

As noted, some content areas such as compassion fatigue of caregivers, provider assumptions regarding burden of care and burnout, and drug addiction were not included in the ADA Position Statement. This first Position Statement was limited to topics regarding psychosocial issues with evidence-based literature that included problem prevalence and effective treatment approaches and that provided support for recommendations. It is our expectation that additional evidence-based reviews and future position statements will address special topics and populations not covered in this first statement. The need for tested interventions to remediate disparities in burden of care, delivery, and quality of care is particularly critical given exponential increases in global diabetes prevalence (6).

Also highlighted were issues addressed in the ADA guidelines but not recommended in European and Indian guidelines: preconception counseling, diabetes distress, fear of hypoglycemia, depression screening for those individuals with prediabetes, etc. The Australian authors (3) also suggest that patient-centered care as actually implemented may increase diabetes distress and that diabetes self-management education and support or psychological treatment may be unable to alleviate diabetes distress (although

[1]*Office of Behavioral and Social Sciences Research, Office of the Director, National Institutes of Health, Bethesda, MD*
[2]*Department of Medicine, Indiana University School of Medicine, Indianapolis, IN*
[3]*Department of Medicine, Johns Hopkins University School of Medicine, and Welch Center for Prevention, Epidemiology and Clinical Research, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD*
[4]*Ferkauf Graduate School of Psychology, Yeshiva University, New York, NY*
[5]*Department of Medicine and New York Regional Center for Diabetes Translation Research, Albert Einstein College of Medicine, Bronx, NY*
[6]*Stanford University, Stanford, CA*
[7]*Department of Sociology, Loyola University Maryland, Baltimore, MD*

Corresponding author: Deborah Young-Hyman, deborah.young-hyman@nih.gov.

The content and views expressed represent those of the authors and do not represent the position of the Office of Behavioral and Social Sciences Research, National Institutes of Health.

the review they cited identifies these interventions as effective strategies). The ADA Position Statement emphasis on patient-centered care may reflect the Western view of health care and individual agency in determining health outcomes, with emphasis on self-management behavior (7) and decision-making (8), but it needs to be implemented within a context that does not engage in patient blaming. Another important point made by Macdonald and Campbell (3) is the differences between approaches to psychological intervention: screening, coping paradigms, and therapies to facilitate well-being and adaption to burden of illness. Although they may be called different things—risk assessment in the case of depression (9), interpersonal or cognitive behavioral therapy—simultaneous medical and psychological treatment has been shown to potentiate well-being and health for people with diabetes (10,11). Given that depression and other psychiatric disorders are known risk factors for development of diabetes and a significant percentage of those affected by diabetes remain undiagnosed (9), preclinical screening in vulnerable individuals is justified. Effective care paradigms that include routine screening and improve well-being and health outcomes need to be more broadly adapted and offered. As Mezuk and Pouwer (2) and Macdonald and Campbell (3) note, capacity building of providers and health care systems, as well as actionable provider treatment algorithms, are key to achieving this goal. Provider behavior must also be altered to facilitate shared treatment goals and decision-making. How this is best accomplished has not been systematically studied. Development of effective collaborative care systems and delineation of provider roles in team care is in its infancy (12). In considering implementation of the ADA psychosocial guidelines, it has been suggested that a systematic review of existing care systems and provider attitudes and roles could be informative.

There are now a number of position statements regarding psychosocial care that represent foundational steps to address these important issues (13). There are varying paradigms for provision of care, with some medical milieus more or less amenable to shared decision-making, collaborative care, and long-term care provision. More effort needs to be made to synthesize and learn from implementation of recommendations among diverse populations to help establish best practices that may have greater universality and/or applicability to a variety of cultural milieus.

Acknowledgments. The content of this response reflects the views of the ADA psychosocial guidelines Position Statement authors. The National Institutes of Health supports the science that informs clinical guidelines.

Funding. Funding for the participation of M.d.G. in the preparation of this article came in part from the National Institute of Diabetes and Digestive and Kidney Diseases (R18-DK-092765). J.G. is supported by grants from the National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (R01-DK-104845, R18-DK-098742, and P30-DK-111022).

Duality of Interest. F.H.-B. is a member of the ADA Board of Directors. K.H. has served as a consultant to Bigfoot Biomedical and Johnson & Johnson Diabetes Institute and received research support from Dexcom. M.P. has received research grants from Bristol-Myers Squibb, Genentech, and Novo Nordisk; has received consulting fees from AstraZeneca, Calibra, Genentech, Eli Lilly, and Novo Nordisk; has received speaking honoraria from Novo Nordisk; and has participated in advisory panels for GlaxoSmithKline, Eli Lilly, and Novo Nordisk. No other potential conflicts of interest relevant to this article were reported.

References

1. Kalra S, Balhara YPS. Comment on Young-Hyman et al. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association. Diabetes Care 2016:39:2126–2140 (Letter). Diabetes Care 2017;40:e126. https://doi.org/10.2337/dc16-2599

2. Mezuk B, Pouwer F. Comment on Young-Hyman et al. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association. Diabetes Care 2016:39:2126–2140 (Letter). Diabetes Care 2017;40:e127–e128. https://doi.org/10.2337/dc16-2694

3. Macdonald GC, Campbell LV. Comment on Young-Hyman et al. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association. Diabetes Care 2016:39:2126–2140 (Letter). Diabetes Care 2017;40:e129–e130. https://doi.org/10.2337/dc16-2718

4. Young-Hyman D, de Groot M, Hill-Briggs F, Gonzalez JS, Hood K, Peyrot M. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association [published corrections appear in Diabetes Care 2017;40:287 and Diabetes Care 2017;40:726]. Diabetes Care 2016;39:2126–2140

5. Nouwen A, Nefs G, Caramlau I, et al.; European Depression in Diabetes Research Consortium. Prevalence of depression in individuals with impaired glucose metabolism or undiagnosed diabetes: a systematic review and meta-analysis of the European Depression in Diabetes (EDID) Research Consortium. Diabetes Care 2011;34:752–762

6. World Health Organization. Global report on diabetes [Internet], 2016. Geneva, World Health Organization. Available from http://apps.who.int/iris/bitstream/10665/204871/1/9789241565257_eng.pdf. Accessed 3 May 2017

7. Funnell MM, Brown TL, Childs BP, et al. National standards for diabetes self-management education. Diabetes Care 2010;33(Suppl. 1):S89–S96

8. Fitzpatrick SL, Schumann KP, Hill-Briggs F. Problem solving interventions for diabetes self-management and control: a systematic review of the literature. Diabetes Res Clin Pract 2013;100:145–161

9. Ward M, Druss B. The epidemiology of diabetes in psychotic disorders. Lancet Psychiatry 2015;5:431–451

10. Gois C, Dias VV, Carmo I, et al. Treatment response in type 2 diabetes patients with major depression. Clin Psychol Psychother 2014;21:39–48

11. Safren SA, Gonzalez JS, Wexler DJ, et al. A randomized controlled trial of cognitive behavioral therapy for adherence and depression (CBT-AD) in patients with uncontrolled type 2 diabetes. Diabetes Care 2014;37:625–633

12. Huang Y, Wei X, Wu T, Chen R, Guo A. Collaborative care for patients with depression and diabetes mellitus: a systematic review and meta-analysis. BMC Psychiatry 2013;13:260

13. Psychosocial Aspects of Diabetes (PSAD) Study Group. Psychosocial guidelines [Internet]. Available from https://uvtapp.uvt.nl/tsb11/ws.ws.frmShowpage?v_page_id=3742924699326460. Accessed 3 May 2017