RESPONSE TO 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

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

Diabetes Care 2018;41:e33–e34 | https://doi.org/10.2337/dci17-0037

We thank Snoek et al. (1), writing on behalf of the Psychosocial Aspects of Diabetes Study Group of the European Association for the Study of Diabetes (EASD), for support of the importance of the first American Diabetes Association (ADA) psychosocial position statement (2). These authors, who have been involved in the development of EASD and ADA collaborative guidelines (3–5), raise important considerations for both the focus of psychosocial recommendations and their implementation.

The first issue raised is based on the view that ADA recommendations focused on mental illness rather than well-being or improvement of quality of life. We agree that psychosocially informed diabetes care involves more than attention to psychiatric comorbidity. We point the authors to the first set of general recommendations that cites the goal of care as "optimizing health outcomes and health-related quality of life," which includes "addressing psychosocial problems upon identification" (2). Figure 1 (2) is structured to indicate that there are psychological adjustment issues, which are common, involving distress and diminished well-being but are not psychopathological, occurring on a continuum with more severe psychopathologic conditions. Following this framework, the article articulates that poor quality of life and well-being may be illness related, life-stage specific, and/or exacerbated in vulnerable individuals. We also emphasize the importance of attending to nonpsychopathological emotional distress and improving emotional well-being by leading the position statement with recommendations for psychosocial issues impacting self-management and diabetes-related distress. As Snoek et al. state, there is need to include information on approaches practitioners can implement to promote positive well-being. However, attention devoted in our article to psychological distress reaching the level of diagnosis reflects the frequency with which providers can expect to encounter these problems, the likelihood that self-management will be adversely affected, and the strength of the evidence base to the support recommendations.

Starting the exploration of the issues outlined in the position statement with a general question such as "How well are you doing?" as suggested by Snoek et al. (1) appears quite reasonable and is consistent with our recommendation that "all care providers should include queries about well-being in routine care" (2). The addition of routine screening measures helps to better understand what the person is reporting and the potential need for follow-up assessment. As Snoek et al. indicate, screening alone would not be sufficient for identifying people with diabetes in need of treatment or for selecting the appropriate treatment. Caution to providers is also suggested regarding unintended consequences of routine screening. Specifically, Snoek et al. focus on potential stigmatization of people with diabetes who are asked about their mental health. However, the scenario they correctly fear—labeling people with diabetes with disorders based on nothing more than a numerical result from a screening test—would represent not only an incorrect implementation of the recommendations in the ADA position statement but also incompetent care. We explicitly recommend a stepped sequence of assessment, with positive findings leading to further evaluation. We also recommend "starting with informal verbal inquiries for monitoring followed by questionnaires for assessment (e.g., PHQ-9) and finally by structured interviews for diagnosis" (2) and emphasize the importance of the values and preferences of the person living with diabetes when selecting and recommending treatments.

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

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

Snoek et al. further highlight this important point: psychosocial care for people with diabetes must go beyond a "ticking the box" approach. Successful implementation of psychosocial guidelines will be specific to individuals, practice setting, and available resources. Implementation of a stepped approach is designed to optimize use of resources for evaluation and treatment. Practitioners knowledgeable about psychosocial issues inherent in living with and managing the disease will facilitate effective collaboration.

Funding. M.d.G. was funded partially by the National Institute of Diabetes and Digestive and Kidney Diseases (R18 DK092765). J.S.G. is supported by grants from the National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (R01 DK104845, R18 DK098742, and P30 DK111022).

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 has received research support from Dexcom. M.P. has received research grants from Bristol-Meyers Squibb, Genentech, and Novo Nordisk; consulting fees from AstraZeneca, Calibra, Genentech, Lilly, and Novo Nordisk; and speaking honoraria from Novo Nordisk. He has participated in advisory panels for GlaxoSmithKline, Lilly, and Novo Nordisk. No other potential conflicts of interest relevant to this article were reported.

References

1. Snoek FJ, Hermanns N, de Wit M, et al.; Psychosocial Aspects of Diabetes Study Group of the European Association for the Study of Diabetes. 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 2018; 41:e31–e32. https://doi.org/10.2337/dc17-1102

2. 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. Diabetes Care 2016;39:2126–2140

3. Delamater AM, de Wit M, McDarby V, Malik J, Acerini CL; International Society for Pediatric and Adolescent Diabetes. ISPAD clinical practice consensus guidelines 2014. Psychological care of children and adolescents with type 1 diabetes. Pediatr Diabetes 2014;15(Suppl. 20):232–244

4. IDF Clinical Guidelines Task Force. Global guideline for type 2 diabetes: recommendations for standard, comprehensive, and minimal care. Diabet Med 2006;23:579–593

5. Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycaemia in type 2 diabetes, 2015: a patient-centered approach. Update to a position statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetologia 2015;58:429–442