

Summary Prepared by Rob Lindsay, MD

## PARDON MY PLANET

by Vic Lee



### Psychosocial Issues

It really could not be a proper diabetes meeting if we didn't have a long session on psychosocial problems with diabetes. It just wouldn't be right. On Monday we had a major session on Diabetes In Youth-Psychosocial Challenges. Dr. Kory Hood first talked about depression. He pointed out that depression is common in Type I diabetes and it is estimated that 15 to 25% of adolescents with diabetes have depressive symptoms. Another 23% have sub-clinical depression. These rates are similar to the rates found in adults. Depression can be significantly disruptive and often leads to sub-optimal control because of poor adherence. He felt that sub-clinical depression was just as disruptive as clinical depression. In one study, patients with no depression had a Hgb A1c of 8.3% while patients found to have sub-clinical depression had an average Hgb A1c of 9.0% versus the patients with clinical depression who had a Hgb A1c average of 9.5%. He pointed out that depression creates a fertile ground for family conflict. He said that the first step must be that we suspect depression. We must be mindful of symptoms, ask probing questions and then assess. The problem is there is no good systematic screening device. Most of them are too time consuming or costly. He felt that the CES-D and the CDI take about five to ten minutes and have an appropriate clinical cutoff. It was suggested that we use these as screens to assess our patients that we are concerned about. As far as treatment is concerned, he pointed out that there are too few professionals in the community to really help all of the patients that we have. Plus there is no empiric evidence of major impact with treatment. He felt that the most important aspects to teach are coping skills and problem solving. Even then, the studies have shown small effect on Hgb A1c levels. Psychotherapy apparently is effective but again it is time consuming, expensive and there are simply not enough professionals to go around. He felt that the combination of cognitive behavioral therapy plus the use of Prozac is perhaps the most effective approach he has found. To evaluate the patients we need to watch for changes in adherence (such as self-blood glucose monitoring and eating) and the patient must have more frequent visits. *Dr. Hood presented many of the problems that we encounter with depression in diabetes. Many of these are very difficult to overcome. Perhaps the most difficult is for the professionals and the parents to recognize that there is a problem in the first place. We have had many instances where we wanted to get psychological help for patients but the parents really did not feel it was necessary. We need to recognize that this is a very common problem and that we will not have much chance at success in diabetes management until we deal with it. In many cases, we must rely on the parents to voice their concerns in order for us to set the process moving.* Dr. Anne

once again we have little evidence base and more research is absolutely necessary. She stated that if we look at eating disorders in general, five million Americans suffer from them and 1,000 die annually from anorexia. It is the third most common cause of death among adolescent girls, causing approximately 4% of all deaths. She felt that females with diabetes have about a 2.4 times greater chance of having eating disorders. Bulimia occurs in about 1 to 2% of all late adolescent girls. It is defined as having recurrent binge eating with recurrent purging and it has to occur twice weekly for three months to fit the diagnosis code. Diabulimia is the most common eating disorder amongst teenage girls with diabetes. In this instance, they intentionally omit insulin so that they can lose weight. The Joslin Clinic has evaluated their patients and they found 31% of women between the ages of 13 and 31 years of age intentionally omitted insulin for weight loss at one time or another. These women have a threefold increase chance of mortality within the next eleven years. She said that recognizing the problem obviously is the first step. We shouldn't be afraid to ask if this is a problem and parents should specifically ask. She stated that we should use non-leading questions so that the adolescents can respond appropriately. We should all be looking for significant changes in weight and significant changes in Hgb A1c. Another sign is repeated, unexplained diabetic ketoacidosis. *All of the care providers are very much aware of these potential symptoms. It is extremely difficult, however, to convince parents that an eating disorder is really the cause for all the changes. We very much need our parents to be more tuned in to this possibility.* She pointed out that early detection is critical and that the best prognosis is in patients who have had the shortest duration of symptoms. Again she felt cognitive behavioral therapy was the best approach. The patient and family have to take active roles in the treatment and it will require a multi-disciplinary team. First we must focus on safety and teach the seriousness and signs of DKA. Then the therapist and family can work on the basic causes of the disorder. During the discussion period, one physician pointed out that new frequent hypoglycemia may be a clue because it is secondary to vomiting. *I had not really thought of hypoglycemia as a potential sign of eating disorders. It just goes to show we learn something new each time. Eating disorders have been a serious concern for us. We have had patients who have died of anorexia and we have had many others that have had long time poor control with Hgb A1c levels in the teens strictly due to intentionally omitted insulin. Again it is sometimes very difficult to convince children and parents of the seriousness of this problem. The statistic that she gave of a threefold increase in mortality is very sobering.* Finally Dr. Barbara Anderson from Houston discussed transitioning from pediatric to adult medical care. The power went out during her talk due to a severe thunderstorm so she did an admirable job of winging it with no slides. She went through quite a bit of the psychology literature on transitioning. She pointed out that the high school period is emerging adulthood but it does not mean that they have achieved adulthood by the time of graduation. The 21 to 23 year olds are a unique group in that most are not married, most have no children, the education is ongoing and there are job and living changes. She felt that the criteria for adulthood should include 1) accepting responsibility for one's actions, 2) making independent decisions and 3) being financially independent. She felt if we used this diagnosis then we are talking about patients in their late 20s. The post-high school period presents unique barriers. There are usually decreased medical visits after transfer to adult care, and there are very few published studies to show how effective this transition can be. The

challenges include depression and burnout, eating disorders (as mentioned above), changes in diabetes management support (families, peers, medical providers), and inaccessibility of health insurance. She stated that the ADA defines youth as up to 30 and felt that many of the needs of the 18 to 30 year old age group are not being met by the adult task group. *This is an ongoing issue at our clinic. Because of logistic issues, many of us have to give up our patients after high school graduation. The studies indicate that this is probably not the best time to shift patients over. Some patients are mature and able to take on the adult responsibilities but many are not. Parents need to understand that just because an adolescent has finished high school, he or she is very likely not a true adult. We must continue to provide adequate support for these individuals as we are trying to help them gain the independence that they need.*

There were a few abstracts that I thought were important in this category. The ADAPT study group from our clinic reported on shared decision making between adolescents with Type I diabetes and physicians. They examined if team reports of shared decision making were associated with perceptions of confidence, affect and treatment problems and whether shared decision making moderated teen responses to physician recommendations to increase parental involvement. They found that perceived shared decision making was associated with teen reports of more positive affect, higher diabetes competence and fewer problems with diabetes treatment. However, when physicians made recommendations to increase parental involvement, shared decision-making was associated with decreased competence six months later. They felt that the findings suggest that shared decision making between physicians and adolescents is associated with adolescents feeling better able to handle their diabetes. *We learn from our psychology colleagues each year. The ADAPT study has been fascinating for all of us.* A group from Yale looked at the quality of life on metabolic control in school-aged children with Type I diabetes. They found that child quality of life was associated with better child coping (the diabetes is less hard and upsetting and more warm and caring diabetes support) and greater child responsibility/higher self-efficacy. They concluded that “management of Type I diabetes in school-aged children ideally considers strategies to increase child responsibility and self-efficacy and strategies to enhance warm and caring diabetes support to improve coping and quality of life. For children with a more negative family environment with elevated parent depressive symptoms and conflict, initiating pump therapy may lower child quality of life compared with multiple daily injection therapy.” Finally there were several reports on various screening tools to look for depression amongst our adolescents. These screening devices were mentioned in the discussion above but I wanted to include that they were being studied to show how important this aspect of diabetes management has become.