

Podcast 22 - Understanding Diabetes Distress: Implications for Primary Care

Transcript

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular and Diabetes Health Collaborative, also known as Cardi-OH. This is Dr. Michael Conston from the Case Western Reserve University School of Medicine, and I serve as the principal investigator for Cardi-OH, a statewide network of Ohio's seven medical schools. Cardi-OH is funded by the Ohio Department of Medicaid and shares best practices to improve cardiovascular health, diabetes outcomes, and to eliminate health disparities in Ohio's Medicaid population. The opinions and recommendations in this podcast are those of the presenters and not those of Cardi-OH and its sponsors and are not intended to be a substitute for medical advice. I hope you enjoy today's podcast.

Randy Wexler: Hi, I'm Randy Wexler. I'm a professor of family medicine at the Ohio State University, a primary care physician, and a site principal investigator for Cardi-OH. Today I'm here with my colleague Dr. Liz Beverly, and we appreciate her being here. I'd like to ask Liz to go ahead and introduce herself.

Liz Beverly: Thank you so much, Randy. I'm happy to be here. Hi, I'm Liz Beverly. I'm an associate professor and co-director of the Diabetes Institute at Ohio University and a site principal investigator for Cardi-OH. My research in behavioral diabetes focuses on the linkages between psychosocial issues, self-care, and health outcomes.

Wexler: Thank you, Liz. Today, we're going to go ahead and discuss diabetes distress and its significance to clinical outcomes and patient self-care. The purpose of this podcast is to provide you with information on differentiating diabetes distress from other psychosocial issues, the use of screening tools, and evidence-based strategies to help patients better manage this condition at home. We're starting to hear a lot more about diabetes distress in research and clinical practice. Liz, can you go ahead and tell the audience what this is?

Beverly: Sure, I'd be happy to. Diabetes distress is not a new phenomenon and has been discussed for more than three decades. In basic terms, it refers to the fears, concerns, and worries that people with diabetes experience on a day-to-day basis. For example, someone might have fears about developing complications, worry about the cost of insulin, or have concerns about their family not supporting them. It is the most common psychosocial issue in diabetes and occurs in both type 1 and type 2 diabetes.

Wexler: So, when talking to patients or other providers, does that mean we should think of this as a mental illness?

Beverly: That's an excellent question, but no, diabetes distress is not a mental illness. It is a construct used to describe the emotional experience of living with a chronic, progressive condition. Randy, I have a question for you: How often are you seeing this in practice?

Wexler: I would say almost all of my patients diagnosed with diabetes have apprehension of some type at the time of their diagnosis. Though this uneasiness is not synonymous with diabetes distress right away, these are related concerns. It is important to understand the patient's perception because you can help to allay a patient's fears, especially when the diagnosis is new. For example, many patients presume they will immediately need insulin or eventually an amputation due to past experiences with family or what they see on TV. It is helpful to note that those with type 2 diabetes can often reverse or remit what's going on physiologically with medication and weight loss. Liz, I'd like to know more about what you're seeing in the academic research.

Beverly: All people with diabetes experience some degree of diabetes distress, which can range from very mild to severe at any time throughout their illness. For some, low levels won't interfere with their management or quality of life. On the other hand, severe or high levels of distress negatively impact diabetes self-care behaviors and quality of life. Recent meta-analyses show that approximately 22% to 36% of people with diabetes report high levels of diabetes distress. Individuals who identify as women and those who are younger tend to report higher levels. We need to care about this because high distress is associated with fewer self-care behaviors, higher hemoglobin A1C levels, increased complications, and lower quality of life. Furthermore, high levels of distress can rise to the level of generalized anxiety disorder (GAD). Adults with diabetes have a 20% increased prevalence of anxiety disorders compared to the general public.

It is important to screen because symptoms of anxiety and diabetes distress can overlap. The major difference is the source of the symptoms. Diabetes distress is focused solely on the symptoms of living with and coping with diabetes. GAD extends beyond diabetes to include excessive worries about things like work, finances, and safety. If the anxiety comes from diabetes, the treatment is focused on the diagnosis. If it is GAD, treatment focuses on behavioral health and medication. Randy, do many of your patients have both, and how do you change your approach?

Wexler: Patients can indeed have both GAD and diabetes distress. While treatment for GAD helps moderate distress, it doesn't necessarily address the driving force behind the diabetes distress. The best approach employs a multidisciplinary team, including social workers, clinical pharmacists, and registered dietitians, to help patients manage their condition. Distress can be caused by the fear of self-management, complication fears, or the high cost of medications. Discussing generic options or pharmaceutical assistance programs can help. Another big stressor is the reaction of family and friends. Lack of support or unintentional sabotage, like pressuring a patient to eat birthday cake, can be overwhelming. We work with patients to establish small, achievable goals, like walking three times a week, to build confidence. Liz, are there validated screening tools to determine the degree of distress?

Beverly: Yes, there are several great measures. The first, written 30 years ago, is the Problem Areas in Diabetes (PAID), a 20-item measure. We have validated a five-item version which has a 95% sensitivity and 89% specificity, making it excellent for office screening. There is also a one-item PAID questionnaire. For type 2 diabetes specifically, there is the Diabetes Distress Scale (DDS), which is 17 items and looks at four domains: emotional burden, physician-related distress, regimen-related distress, and interpersonal distress. There is also a short version of the DDS that is 95% sensitive. For those with type 1, there is the Type 1 Diabetes Distress Scale (T1-DDS), which has 28 items and unique domains like powerlessness and hypoglycemia distress.

Wexler: How should a provider initiate a discussion, so the patient doesn't feel accused?

Beverly: Patients just want providers to ask how they are doing and about their emotional well-being. Using open-ended questions like "What areas of your diabetes are causing stress for you?" is effective. Providers should normalize the idea that diabetes distress is common and can occur at any time, especially during major life events or the onset of complications.

Wexler: What are some evidence-based interventions for these patients?

Beverly: The first-line therapy for high distress is Diabetes Self-Management Education and Support (DSME/S), with an emphasis on coping and social support. Research shows this addresses sources of frustration and self-care. Lay-led education from peers or community health workers has also shown to lower distress. If there is no improvement after three months, the next step is a referral to behavioral health. Specific successful techniques include problem-solving therapy, cognitive behavioral therapy (CBT), motivational interviewing (MI), and emotional regulation.

Wexler: How do social determinants of health (SDOH) play a role?

Beverly: SDOH, such as discrimination, education level, unemployment, and neighborhood deprivation, have a real impact on mental and emotional well-being. The more social determinants of health an individual experiences, the higher the rates of diabetes distress. Randy, how can you continue to support these patients, so they thrive?

Wexler: Frequent follow-up is vital, so patients know you are there to help. It's also important to celebrate small victories, like an A1C dropping from 8.1 to 7.9. This is a journey, and an improving trajectory matters. I often use anecdotes to motivate patients, such as a friend who successfully managed her diabetes by packing her lunch and taking five-minute walks during the day. Activity is cumulative, and a little bit throughout the day adds up.

Beverly: I agree that anecdotes and SMART goals are powerful. I want to reiterate the need for routine screening to identify moderate and high distress. Behavioral interventions like mindfulness-based CBT can reduce distress levels and improve A1C.

Wexler: Are there billable codes for this?

Beverly: Because diabetes distress is not in the DSM-5, there is no specific ICD-10 code. The best fit is adjustment disorder, which is well-accepted and conveys the same meaning to both mental health and diabetes professionals.

Wexler: It's vital for primary care providers, who manage 90% of this care, to understand the seriousness of diabetes distress. Our takeaways are that we have effective screening tools, and patients with high distress should be referred to team-based DSME/S. If no improvement is seen after three months, consider a behavioral healthcare referral. Liz, thank you for participating today.

Beverly: Thank you so much for having me.

Wexler: Thank you to our listeners for tuning in to Cardi-OH Radio.

[Jazzy instrumental outro music]

[Voiceover] Konstan: Be sure to visit Cardi-OH.org to learn more. This concludes today's podcast.

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