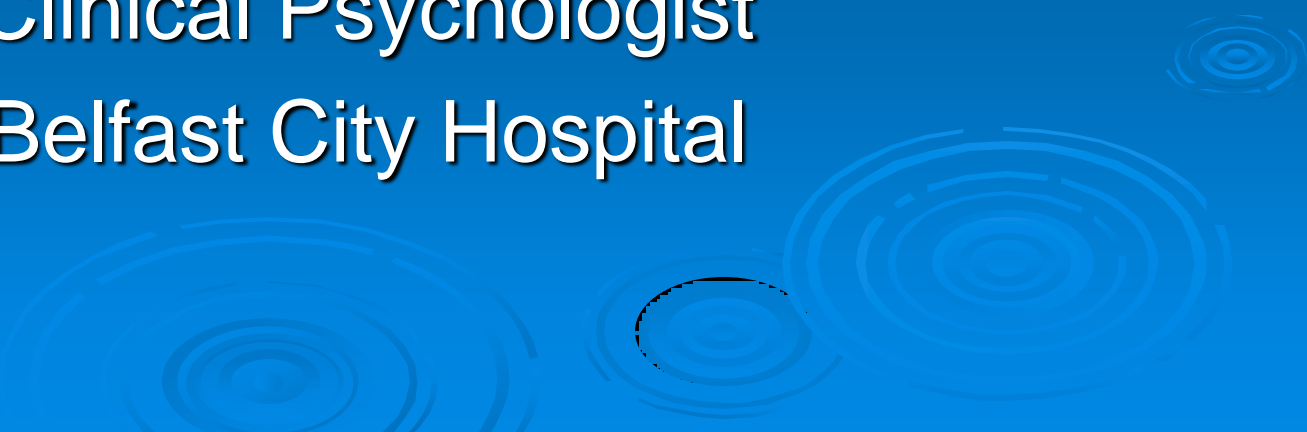# Should we routinely screen for psychological distress in the diabetes clinic?

Dr Mark Davies

Clinical Psychologist

Belfast City Hospital

Quotes……..

➤ Initial thoughts are yes - there is inherent stress with any illness especially one in which the patient has to be so proactive in contributing to the treatment and I think a lot of patients simply cannot handle that level of stress

Consultant Diabetologist

Quotes……

➢ I think screening for distress is an excellent idea but how would you propose that it is done and how long would it take and who would do it ?

Consultant Diabetologist

Quotes…..

➤ How would we screen? Who would do it? Would it be new patients or a yearly test? If we uncovered a lot of 'psychological distress' have we the resources to do any thing about it? My experience is that a number of patients do not admit to not coping with diabetes and suffer in various ways as a result. So in an ideal world yes patients should be screened

DSN

Quotes……

I think that when working with patients in the clinic that we should have sufficient awareness that patients may be distressed, that we are sensitive to the concept of such distress, receptive to the idea and if so that it should not be ignored. To assess for distress would require an instrument for screening, folk who are able to use it & then a clinical pathway to send patients along if they were found to be distressed - are these available?

DSN

Psychological Distress

- Anxiety e.g. general, needles, hypos
- Diabetes specific 'stress'
- Obsessional-compulsive disorder
- Trauma responses
- Personality disorder
- Alcohol misuse
- Drug misuse

Depression

- **Prevalence**
  - Type 1
    - Bernard et al (2006) prevalence 12% (3.2%)

  - Type 2
    - Ali et al (2006) 1.77 increase in rate
    - Anderson et al (2001) depression x 2 risk
    - Peyrot & Rubin (1997) prevalence 41.3%

How to Screen for Depression

➢ Ask the patient!
- Reliable but time consuming

- "...*a process that often takes more than one consultation and evolves in a context of trust*"   *Kessler et al, BJGP, 2005*

➢ Use a standardised assessment
- e.g. PHQ-9, BDI-II, HADS, CESD, GHQ
  - Quick but unreliable

➢ Look for signs
- Quick but unreliable

Signs of Depression

- sleep disturbance
- poor appetite
- early morning wakening
- anhedonia
- diurnal variation
- weight loss
- loss of libido

- poor concentration
- social withdrawal
- triad of negative cognitions
- irritability
- tearfulness
- suicidal ideation

Depression & Complications

➢ Polonsky (1997) Longitudinal study T2, n= 400+

➢ Over a 3 year period depression was the strongest predictor of hospitalisation

➢ Over a 10 year period x 3 incidence of cardiovascular disease

➢ Over a 10 year period x 3 incidence of retinopathy

What do we do?

➢ Talk: psychotherapy, Cognitive Behavioural Therapy, counselling, peer support

➢ Tablets: Prozac, Lustral, Zispin, Cipramil, Prothiaden, Seroxat, Efexor etc.

➢ How do we decide?

Eating Disorder

➢ **Prevalence**

- Females with type 1 are twice as likely to develop eating difficulties (Nash & Skinner, 2005)

- Kenardy et al (1994) 14% NIDDM (4% controls) reported binge eating

- Herpertz & Nielsen (2003) 20% NIDDM reported binge eating

- Von Mensenkampff & Davies (unpublished) 18% of newly diagnosed NIDDM females reported moderate to severe binge eating behaviour

Anorexia Nervosa - Diagnostic Criteria

➢ Refusal to maintain bodyweight that is normal for age and height (<15%)

➢ Intense fear of becoming fat

➢ Disturbance in the way body / shape/ weight is experienced

➢ Absence of at least 3 consecutive menstrual cycles

Bulimia Nervosa- Diagnostic Criteria

- Recurrent episodes of bingeing
- Feelings of lack of control over eating behaviour during binges
- Self induced vomiting and/or laxative use and/or strict dieting and fasting in between episodes of bingeing to prevent weight gain (also vigorous activity).
- Minimum of averages 2 binges per week for 3+ months
- Persistent over-concern with body shape and weight

Binge Eating Disorder Diagnostic Criteria

A. Recurrent binge eating

B. Associated with $\geq$ 3 of the following: rapid eating, eating till too full, eating large amounts when not hungry, eating alone because of feeling low, embarrassed or disgusted

C. Marked distress during binge eating

D. Binge eating occurs at least 2/7 a week for 6/12

E. No regular use of compensatory behaviours

NB - obesity not part of the definition

How to identify eating disorder

➢ Ask the patient

➢ Use a standardised assessment
  ● e.g. Eating Attitudes Test, Eating Disorder Inventory, Binge Eating Scale

➢ Look for signs

Patient characteristics

➤ Low BMI Eating Disorder
  - Female
  - IDDM
  - Low BMI
  - Poorly controlled HbA1C
  - DNAs
  - Early onset complications esp. retinopathy
  - Hypoglycaemia or DKA
  - 90% cases AN/BN follows DM

Patient Characteristics

- High BMI Eating Disorder
  - Female
  - NIDDM diagnosed pre-50
  - High BMI
  - Weight fluctuations
  - Emotional
  - History of contact with MH services
 - Majority of cases DM follows BED

Eating Disorders & Complications

➢ Colas (1991) three times higher rate of retinopathy

➢ Rydall et al (1997) twice the rate microalbuminuria

➢ Steel at al (1987) increase in the rate of painful neuropathy

Treatment Options

- Good evidence for CBT & IPT and BN/BED (but high drop out rate is typical)
- Little evidence for CBT as a single treatment for AN
- If aetiology is multifactorial then so should treatment
- Severe AN should be referred to specialist ED service

Who should do it?

- General Practitioner
- Consultant Physician
- Diabetes Nurse Specialist
- Practise Nurse
- Podiatrist
- Dietitian
- Renal team
- Vascular team

Winner of the "Not My Job" Award - ADOT Litchfield Park, AZ 85
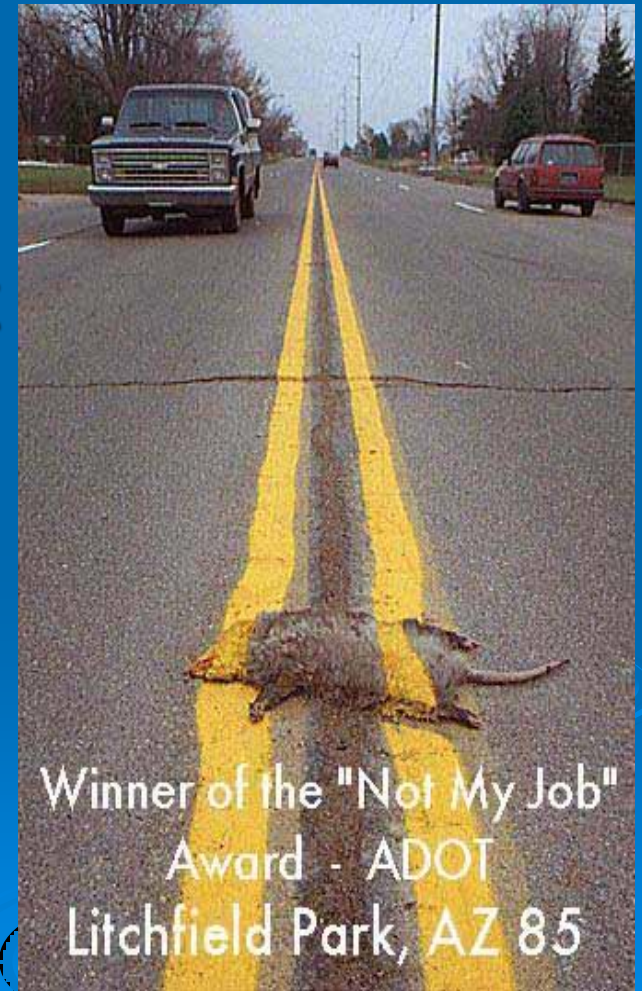
Perceived Competence

➢ Motivation

- How *important* is it that we screen for psychological distress and respond appropriately?

- How *confident* are you that you can do so?

What would have to change to make us more confident?

➢ Depression
- 15 - 20% will opt for anti-depressants
- Not everyone needs 'therapy'
- For diabetes related depression consider peer support or support of diabetes professional

➢ Eating Disorder
- Severe AN, BN and BED refer to ED service
- BN and BED train dietitians in CBT

Yes because……

➢ there is a high rate of psychological distress in the population of PWD

➢ Psychological distress predicts non-adherence and poorer biomedical outcomes

➢ PWD see psychological and emotional support as a priority area for service development

No because…

➢ Many HCPs do not not feel confident about identifying psychological distress

➢ Perception of having no time to screen for psychological distress

➢ Reality of too few services to refer people to once the difficulties are identified

Slides available from:

mark.davies@belfasttrust.hscni.net