

ON THE **CUTTING EDGE** Diabetes Care and Education

ADDRESSING THE MENTAL HEALTH NEEDS AND PSYCHOSOCIAL BARRIERS TO SELF-CARE FOR PEOPLE WITH DIABETES

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Message from the Theme Editor:

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The time is now that health care providers, including nutrition professionals, educate ourselves about and attend, with greater intentionality, to the emotional wellbeing and mental health needs of people with diabetes and their caregivers. This is a critically important, yet often neglected focus of our work to achieve successful diabetes self-care and management outcomes.

The good news is that we're seeing escalating attention to this topic in recent publications (1), practice papers (2), position statements (3), standards of care (4,5) and consensus reports (6). You'll see these publications noted and detailed in the pages ahead.

Some of the increased attention has been fueled by greater engagement in dialogue, be it via social media/networking or at conferences and other meetings, between people with diabetes, their caregivers and health care providers, diabetes-focused organizations and their leaders and the diabetes industry. Some has been fueled by more mental health providers specializing in diabetes care and more research. Collectively this

is raising awareness about: the unique emotional and mental health needs of people with diabetes, the unique distress that managing this demanding 24/7 disease can cause, the stigma that swirls around diabetes, the language health care providers and society-at-large use to talk about diabetes and to people with diabetes, the need for person-centered holistic care, the value of peer support, and more. Drawing attention to these topics, educating nutrition professionals about their importance and offering a bevy of additional reading and resources are the key objectives of this *OTCE*.

Work on this *OTCE* began nine months ago when Janice MacLeod, MA, RD, LDN, CDE, FAADE, DCE's amazing *OTCE* editor, asked me if I would be the theme editor. It didn't take me long to say yes because this is a topic I've engaged with and been passionate about for years. The next step was to assemble a diverse theme team to map out an *OTCE* on this topic. Goal accomplished! The theme team includes Mark Heyman, PhD, CDE, Monique Richard, MS, RDN, LDN,

NewsFLASH and *On the Cutting Edge* are bi-monthly publications of the Diabetes Care and Education (DCE) Dietetic Practice Group of the Academy of Nutrition and Dietetics (the Academy).

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Library of Congress National Serials Data Program
ISSN #1070-5945, issued 7/93.

Anna Norton, MS, and Toby Smithson, MS, RDN, LD, CDE, and represents a group of individuals with deep clinical diabetes and nutrition management experience as well as, for some, the lived experience of having diabetes for many years. We jointly identified topics to cover and contacted capable authors. Each theme team member became point person for one or more articles and worked with authors and peer reviewers to craft this cadre of excellent articles. I thank each of them for their dedication to this *OTCE*! And a big thanks to Janice MacLeod, RD, CDE, and other contributors listed on page 23.

As you'll see, we've tapped experts who present content on a breadth of topics focused on the mental health and psychosocial barriers to diabetes care. This *OTCE* issue appropriately starts with an "Overview of Common Psychosocial Barriers among People with Diabetes." Mark Heyman, PhD, CDE, psychologist, diabetes educator and person with diabetes, details the most common psychosocial barriers to diabetes care including: emotional barriers, cognitive barriers, social barriers and coping barriers.

Our next article, "The Experience of Diabetes Stigma and the Role Healthcare Providers Play," is authored by Susan Guzman, PhD, a psychologist who specializes in diabetes and is well known for her

leadership in diabetes stigma and the importance of using person-centered language (7). This article is intentionally placed second because we hope *OTCE* readers will explore the part they play in perpetuating diabetes stigma and how to begin to use less stigmatizing language while encouraging others in your practice settings to do so too. And please raise awareness where and when you can!

Without a doubt the relationships a person with diabetes has with family members and others in their daily orbit can have significant impact on their emotional wellbeing and self-care behaviors. Janis Roszler, LMFT, RD, LD/N, CDE, a dietitian and licensed marriage and family therapist, offers readers practical pointers to work effectively with people with diabetes and their loved ones in her article, "Family Relationships and Dynamics as a Psychosocial Barrier in Diabetes Care." She importantly encourages us to be aware of our biases as we counsel.

Being aware and respectful of unique cultural barriers that can play a significant role in successful implementation of diabetes self-care behaviors. In the article, "Cultural Considerations for Counseling Hispanic/Latino-, Black/African- and Rural Americans with Diabetes," we engaged several authors to share their expertise working with people of

STRATEGIC PRIORITY AREAS

GOAL 1: The public trusts and recognizes DCE members as food, nutrition, and diabetes experts

GOAL 2: DCE members optimize the health of individuals and populations impacted by diabetes

GOAL 3: Membership and prospective members view DCE as vital to professional success

MISSION

Empowering DCE members to be leaders in food, nutrition, and diabetes care and prevention.

VISION

Optimizing the health of people impacted by diabetes using food, nutrition, and self-management education.

these cultures, all who experience a higher than average incidence of diabetes. Raquel Franzini Pereira, MS, RDN, CPPM, CSM, shared her expertise on counseling individuals of Hispanic/Latino backgrounds. Robin Nwankwo, MPH, RDN, CDE, shared her expertise on counseling individuals of Black/African background and Karen R. Bailey, MS, RD, LD, CDE, and Elizabeth A. Beverly, PhD, shared their expertise from rural Ohio. Diana M. Naranjo, PhD, a psychologist focused on the psychosocial needs of people and families with diabetes, authored the introduction and conclusion.

As the concluding bookend to his first article, Mark Heyman, PhD, CDE, authored "Practical Techniques to Address Psychosocial Barriers Among People with Diabetes." Recognizing that nutrition professionals are not trained psychologists, Heyman offers us a multitude of easy to implement techniques to integrate into our counseling to address psychosocial barriers to self-care.

The next article, "Applying Minimally Disruptive Medicine in People with Diabetes to Overcome Life and Self-care Challenges," written by Kasey R. Boehmer, PhD, MPH, Jennifer E. N. Fedie, RDN, LD, Susan E. Marschke, RDN, LD and Victor M. Montori, MD, MSc, introduces readers to a relatively new practical counseling approach. Minimally Disruptive Medicine (MDM) has gained attention as an approach that illustrates the difficulties of implementing self-care that emanates from an imbalance of workload and capacity. Using the MDM framework, which is being implemented by RDNs Fedie and Marschke in a research study, can help nutrition professionals reduce treatment burden and increase a person's capacity for self-care.

The role and value of various types of peer support for people with diabetes and their caregivers has been an area of recent research and interest. CEO of DiabetesSisters Anna Norton, MS, and I went directly to people with diabetes and caregivers to bring you their insights and perspectives about why peer support has made a difference in their lives with diabetes. An intent of this article, "The Value of Peer Support for People with Diabetes and How Health Care Providers can Promote in Practice" is to encourage nutrition professionals to refer people you counsel to peer support with references to resources that can help you do this. As you'll read, peer support can be life changing.

Next in our lineup of articles is "Polonsky's Pearls for Practice in Diabetes Care," an interview I conducted with William Polonsky, PhD, CDE. Bill's work spans decades and has been a force behind bringing attention to the mental health needs of people with diabetes. This interview integrates research findings, techniques and a wealth of experiential wisdom.

This *OTCE* issue wraps up with "Diabetes Associations Recognize Importance of Mental Health and Champion Provider Training," a roundup of actions and projects the American Diabetes Association, JDRF and American Association of Diabetes Educators are engaged with to raise the awareness and skill level of health care providers targeting emotional wellbeing and mental health in the outcomes of people with diabetes.

We hope this *OTCE* expands your knowledge, provides references to access further reading and offers resources to improve the care and counsel you offer people with diabetes and their caregivers. Enjoy the read!

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Overview of Common Psychosocial Barriers among People With Diabetes

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Introduction

Although there have been many advancements made in diabetes treatment, many people with diabetes (PWD) still have a difficult time achieving optimal glycemic management (1). Effective treatments only work if people follow their treatment plan and actively engage in diabetes management. The daily tasks involved in managing diabetes can be difficult, and many people have various psychosocial barriers that impact their ability to manage diabetes. Therefore, it is critical for registered dietitian nutritionists (RDNs) who work with PWD to learn about and recognize the common psychosocial barriers to diabetes care so they can help their clients identify, and support them in overcoming, these barriers.

This first article provides an overview of the most common psychosocial barriers to diabetes management. Specifically, it reviews how emotions, thoughts, lack of social support, problem-solving and coping skills can be barriers to diabetes self-care behaviors. This article then presents a framework that RDNs can use to help clients identify their barriers to diabetes care.

Psychosocial barriers are defined “as the psychological and interpersonal factors that impede diabetes management or diabetes-related quality of life” (2). Suboptimal self-

management may be due to inadequate family and/or social support, misinformation or inaccurate beliefs about illness and treatment, emotional distress/depressive symptoms, or deficits in problem-solving or coping skills (3). These psychosocial barriers can be challenging to identify and oftentimes can be difficult for PWD to overcome. This reality makes it all the more important for health care providers (HCPs) to become familiar with these barriers to more effectively work with their clients.

Emotional Barriers

Emotional challenges can be barriers to optimal diabetes management. Emotions can have both a direct and indirect impact on self-care behaviors. For example, if someone is overwhelmed or burned out by the daily tasks of managing diabetes, or if they are experiencing symptoms that impact their motivation, concentration or self-worth, these emotions can have a direct impact on their diabetes care. In addition, people may experience emotions that overwhelm them and distract them from the task at hand, even if that task is diabetes care.

It is common for PWD to experience emotions that potentially impact their self-management behaviors. The experience of living with type 1 (T1D) or type 2 diabetes (T2D) is often described as frustrating and

overwhelming (4) and it can feel like it requires constant attention and vigilance. These ongoing behavioral demands, combined with worry about disease progression and complications often cause people to have significant emotional distress (5). Diabetes can also increase the risk of other psychological conditions, including depression and anxiety (6). Research shows that one in four PWD have depressive symptoms (7) which include depressed mood, lack of energy and motivation, difficulty concentrating and feelings of hopelessness and helplessness. The lifetime prevalence of generalized anxiety disorder (GAD) in people with T1D or T2D has been reported to be 19.5% (8). It should be noted that these statistics do not include the people who experience symptoms of diabetes distress such as anger, frustration and guilt. Review the sidebar “Differentiating between Depression and Diabetes Distress.”

Cognitive Barriers

Thoughts and beliefs about diabetes, commonly known as cognitive distortions, can also be barriers to diabetes management. Cognitive distortions are defined as errors in thinking that negatively skew the way a person sees themselves, other people, and the world (9). Although these patterns of thinking are common in people both with and without diabetes, they are not

accurate and cause negative emotions, making behavior change difficult. Cognitive distortions tend to take on distinct patterns. It is common for people to see things in 'all or nothing' terms, without recognizing that there might be a middle ground. It is also common for people to only focus on negative aspects of a situation and filter out anything positive (10). These are just two examples of cognitive distortions.

These patterns of thinking are common in PWD and have been shown to be a significant barrier to diabetes management (11). If a person has an out of range blood glucose and they have the thought, "There's nothing I can do to get my blood glucose in range and it's always going to be high," they will likely be less motivated to continue working to manage their diabetes. People often also have thoughts about what having diabetes means about them as a person. For example, a person may think, "It's my fault I have diabetes. I did this to myself because I don't have any self-control." This thought can be a barrier because they may believe that by trying to manage diabetes, they are setting themselves up for failure.

Social Barriers

PWD need social support to help manage diabetes. Defined as support that people receive from others, social support can take several forms, including emotional and instrumental support (12). Emotional support occurs when others do things to make us feel cared for such as providing a listening ear or helping with chores. For PWD, this can mean providing empathy and encouragement or a willingness to engage in healthy activities with the person so they do not feel alone. Instrumental support is when

someone provides something tangible, like a ride to the pharmacy or babysitting while their friend or family member goes to an HCP appointment.

Research has shown that there is a positive relationship between supportive relationships and diabetes self-management behaviors (12). Conversely, when PWD feel that they lack support from others in their lives, it can be a significant barrier to self-care. People who lack support often feel isolated, like they are alone in dealing with diabetes. They may also think that diabetes makes them different when they just want to fit in and not be noticed. Others may find that the people in their lives from whom they most need support sabotage their efforts. These types of unsupportive relationships around diabetes can create an environment that make the sustained behavior change required to manage diabetes very difficult. HCPs who work with PWD can provide emotional support and teach them skills to get the support they need from others.

Coping Barriers

Coping skills are behaviors that help protect people from being overwhelmed by difficult experiences. Effective coping skills help people manage the difficulties that they face in life. There are two primary types of coping: emotional coping and problem-focused coping. Emotional coping skills are strategies that people use to deal with ongoing stressors that are difficult to change. Problem-focused coping, also known as problem solving skills, are used when a person encounters a situation that they can change (13).

Diabetes is a condition that requires both problem-focused and emotional coping skills, and people

who lack these coping skills often find that this is a barrier to diabetes care (14). Managing diabetes can require people to make complex decisions that impact their health, such as what and how much to eat, how much insulin to take and how to prevent and treat hypo- and hyperglycemia. These decisions involve critical thinking and the ability to solve problems that may not always have a clear-cut answer. People who lack problem-solving skills or who are not confident in their problem-solving ability may experience challenges in making important decisions.

It is critical for PWD to find strategies to deal with the stresses of living with diabetes. People who do not have effective strategies to do so tend to avoid thinking about, and actively managing, their diabetes in an attempt to reduce this stress. Lack of emotional coping skills makes diabetes management a lot more difficult and therefore becomes a barrier to diabetes management.

Other Barriers

PWD encounter other types of barriers that impact their ability to take care of themselves. These include difficulty with accessing healthcare services, paying for diabetes-related healthcare costs and navigating insurance coverage (15). While these types of barriers are distinctly different from psychosocial barriers, it is helpful to note that people who experience psychosocial barriers may also have a harder time dealing with these other barriers. For example, people with limited social support may find it more difficult to deal with some of the logistical challenges of diabetes care, including transportation and meal planning. Also, people who feel overwhelmed, or experience other negative

Differentiating between Depression and Diabetes Distress

The American Diabetes Association Standards of Care details the importance of screening, diagnosis, and management of both major depressive disorder (MDD) and diabetes distress (DD) (16). Both conditions are common in people with diabetes, have been linked to poor health outcomes (5,17) and need to be differentiated to treat properly. MDD is a serious mood disorder that impacts activities of daily living. Symptoms of depression include depressed mood, irritability and feelings of hopelessness and helplessness. Research suggests that a combination of genetic, biological, environmental, and psychological factors can lead to MDD (18). DDs has been defined as “the unique, often hidden emotional burdens and worries that are part of the spectrum of patient experience when managing a severe, demanding chronic disease like diabetes” (5). Current thinking suggests that although MDD and DD often look similar, DD is emotional distress that is directly related to diabetes, as opposed to MDD which is more general and is a result of multiple factors (19). To differentiate between MDD and DD it can help to administer a measure of diabetes distress, such as the Diabetes Distress Scale (DDS17) (20), and a measure of depression, such as the Patient Health Questionnaire-9 (PHQ-9) (21).

diabetes-related emotions, may lack the motivation needed to find lower-cost options for their diabetes care.

Summary

HCPs, including RDNs, who work with PWD play many important roles in diabetes management. In addition to providing people medical care and education, they also support people in identifying and overcoming psychosocial barriers. Learning to recognize psychosocial barriers is crucial and a task that is critical to improving diabetes self-care behaviors.

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The Experience of Diabetes Stigma and the Role Health Care Providers Play

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Introduction

Stigmatization occurs when some socially identifiable characteristic is perceived by others as “different” in some negative or undesirable way. As a result, people are treated differently because of that characteristic (1). Some stigmatizing social cues for People with Diabetes (PWD) are observable diabetes technology/ devices, blood glucose monitoring, taking insulin and medications, excess weight, food choices (seen as either healthy or unhealthy), attendance at diabetes treatment/ education and events, self-disclosure of diabetes, and even medical lab results (2,3).

The stigma of diabetes reflects the idea that PWD have done something bad or wrong and now they are being punished. Studies have shown that stigma comes from diabetes being seen as a self-inflicted disease resulting from a character flaw, such as being weak, fat, lazy, gluttonous, or of low socio-economic status, as well as lacking intelligence or burdensome to the health care system (2–5).

Feeling stigmatized by others is associated with feelings of shame, embarrassment, fear, guilt and depression, and can lead to hiding behaviors and isolation. For example, those who feel stigmatized may not

tell others that they have diabetes, and as such, they may avoid important self-care behaviors in front of others, such as blood glucose monitoring, taking oral medications or injecting insulin. There may even be a reluctance to seek diabetes education or treatment for fear of experiencing further shame and judgment about having diabetes or how they are managing it (3). In fact, those who report higher rates of diabetes stigma are the highest risk PWD and have a significantly elevated A1C and/or BMI (5). PWD who could most use the help, support and compassion of health care professionals (HCPs) are most likely to report feeling judgement and blame (5).

HCPs May Contribute to Diabetes Stigma

The complexity of diabetes and the current standards of care require an individualized-treatment approach that respects the person’s choices, life circumstances, needs and values (6). The way we talk to PWD about diabetes doesn’t always reflect this approach, and instead can add to the stigma of having diabetes. For example, describing PWD as being “diabetic” does not put the person first; it describes the person by their disease. The use of “uncontrolled” or “noncompliant” is a judgment about the person and not an objective

assessment. PWD report that these labels make them feel judged, not understood, and that their efforts go unnoticed (7,8). When providing Diabetes Self-Management Education and Support (DSMES) and Medical Nutrition Therapy (MNT), the HCP providing these services might say that the PWD “should,” “has to” or “needs to” do something to manage their diabetes. This language does not consider the person’s choices, needs or barriers, and implies failure if the person does not reach their metabolic goals or does not follow the HCP’s directives (8–10).

The public hears that type 2 diabetes (T2D) is a “preventable disease.” So what does that say about those who go on to develop it? It is understandable how many, from the onset of diagnosis, feel self-stigmatization that they are to blame for developing prediabetes or diabetes, especially if they have long struggled with their weight. The connection between T2D and excess weight presents a particularly challenging conversation for many HCPs. HCPs may have difficulty discussing the role of weight loss in diabetes management without blaming the person for weight challenges, oversimplifying weight loss, or giving the impression that developing diabetes was a choice resulting from overeating and “laziness.”

HCPs and PWD are often at odds when it comes to treatment intensification (11). The continued loss of functioning pancreatic beta cells over time is the natural course of T2D, therefore treatment intensification over time is nearly always necessary. Many PWD have the desired goal of either never starting to take or getting off of their glucose-lowering and other diabetes-related medication; an understandable wish as nobody wants to be on any or additional medication. HCPs may offer the incentive of possible medication reduction or elimination in an effort to motivate people for behavior change. However, this incentive is neither realistic nor safe for most PWD and sends the message to PWD that the goal in diabetes management is to be on less medication and needing to take medication means that they were unsuccessful in making changes (11). This is a stigmatizing message in that “needing medication means you have failed and are to be punished.”

Suggestions to HCPs for Combatting Diabetes Stigma

Be mindful of the messages you send, both directly and indirectly. To combat stigma, create an environment and clinical experience that says, “Welcome in. Diabetes is not your fault and now that you have it, there is a lot you can do to manage it to live a long and healthy life. Let’s work together to make a plan that works for you.” A non-stigmatizing environment is welcoming, supportive, respectful and emotionally safe.

Consider the physical space of your office. Is it welcoming? Lists of symptoms of diabetes, posters of

the statistics of negative outcomes or photos of complications can be stigmatizing and experienced as shaming and blaming. Many people with diabetes find these messages and images unhelpful and discouraging (9). Instead, consider images and messages that promote the hopeful concept that PWD can live a healthy life with diabetes.

Be aware that language is powerful. What you say and how you say it can define the experience of diabetes (10,12). The AADE/ADA guidance on the use of language in diabetes care provides four guiding principles: fact-based and neutral; free from stigma; strengths-based and empowering; and collaborative. Examples for suggested language that is non-stigmatizing includes replacing “bad/good” with “safe/unsafe,” referring to “people with diabetes” instead of “diabetics,” and describing the objective behaviors such as “takes medication half of time” instead of “noncompliant” or “nonadherent” (10).

The ongoing challenges PWD face in making changes in eating behavior and physical activity lead many to feel like they are failing at diabetes management and they experience high levels of distress about it (13). HCPs can help PWD learn how to face daily challenges with self-compassion, realistic expectations and achievable goals.

Summary

HCPs have the unique opportunity to challenge and dispel myths and stereotypes that contribute to the stigma of diabetes in the general public and in PWD. Many people will start their life with diabetes with many misbeliefs and outdated concepts about diabetes and how it

is managed, and furthermore, may even have internalized the stigma of diabetes well before diagnosis. At diagnosis they may self-stigmatize blame for developing diabetes and believe that they are now being punished for their flaws. Right from the beginning, this may be a significant obstacle for the person’s engagement with diabetes management and with DSMES and MNT. HCPs can use each interaction as an educational opportunity to combat these misconceptions and help create an experience of diabetes that is inclusive, fact-based and non-judgmental.

Diabetes is not a choice; how a person manages it is.

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Family Relationships and Dynamics as a Psychosocial Barrier in Diabetes

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Introduction

The relationships people with diabetes (PWD) have with their family members can affect their ability to manage diabetes-related tasks and self-care behaviors. Supportive relatives can help loved ones achieve improved glucose results, make healthier lifestyle decisions, and feel more confident about their ability to live with diabetes.

A lack of support can make it more challenging to achieve diabetes goals. This article presents the role and impact family relationships and dynamics can have, either positive or negative, on PWD and their ability to manage self-care tasks. The article also offers Registered Dietitians Nutritionists (RDNs) steps to more effectively deal with family relationships and dynamics as they relate to diabetes self-care and education.

Literature Review

Individuals who feel supported by their families are three times more likely to follow medical recommendations than those who lack family support (1,2). A 2017 review of 23 studies of educational programs that included a teaching component for families of people with poorly managed type 2 diabetes (T2D) was conducted in Western countries and in one Asian country (3). Approximately 40% of the studies implemented individual counseling as the educational method, and approximately 60% used both individual and group sessions. All

programs taught goal-setting and problem solving and helped relatives play supportive roles in their relative’s self-management efforts. The reviewers concluded that family involvement had a “...positive impact on healthy diet, increased perceived support, higher self-efficacy, improved psychological well-being and better glycemic control” (3).

A 2017 paper reviewed five studies that examined the effects family support had on individuals with T2D (4). Many family members demonstrated non-supportive behaviors, such as preparing foods their loved one with diabetes couldn’t eat, ignoring his or her meal timing wishes, acting annoyed, and/or refusing to help their relative deal with diabetes challenges (4). Some also questioned “the need for prescribed medications” to which PWD responded by feeling “annoyed, aggravated or angry” (4).

A 2012 study of 106 adults with T2D showed that PWD who were unsupported by family members were less likely to take their medication as directed (5). In another study, individuals struggled with self-care tasks when relatives prepared food they preferred not to eat (6).

One other research study demonstrated that the attitude diabetes educators have toward working with families also impacts

how involved and supportive family members may become. A survey of 225 Certified Diabetes Educators throughout the 50 U.S. states revealed a positive association between the educator's "personal values of family support" and the frequency in which family members were invited to educational sessions (7).

Steps to Effectively Deal with Family Relationships and Dynamics

RDNs can take the following steps to help manage issues that arise between PWD and their loved ones:

Before You Meet with Family Members

Many PWD bring family members to their counseling sessions. Prepare yourself for possible negative comments by using the STOP, DROP and ROLL technique (8) to help you feel more relaxed before you enter the room:

STOP – Stop what you are doing and breathe.

DROP – Drop any negative thoughts and adopt a more compassionate perspective. For example, Uncle Jerry may seem difficult, but he still came. He must care about his loved one.

ROLL – Roll forward with your new attitude.

In the room, use the LEAP approach (8) to give everyone an opportunity to be heard. Let them know that you appreciate how challenging diabetes is and give them a chance to share their thoughts and feelings.

- LISTEN to comments family members make.
- EMPATHIZE with them; it's very difficult to watch a loved one struggle with medical issues.
- AFFIRM that many families feel the same way.

- POSITIVELY REFRAME critical comments as signs that they really care.

If family members criticize you, don't take it personally. Family members may be struggling with medical and administrative issues that they choose to take out on you. Also, remember that not all families function as your family does. The behavior you see as domineering and intrusive may be viewed by the PWD as loving and caring.

Encourage PWD to tell their loved ones what they need. Remind them to be specific so everyone understands what is expected. For example, they may ask a sister to drive them to the grocery store or want their spouse to inspect their feet.

Should We Work Differently with Men and Women?

According to Lise Eliot, researcher at the Department of Neuroscience, Chicago Medical School, there are differences between male and female brains but such effects on learning and behavior are minimal and have been distorted by the media (9). Structurally, male brains are about 11% larger than female brains and have a "slightly higher proportion of white matter," while "...female brains have a larger proportion of gray matter in most cortical areas," but in actuality, that means very little (9). So, treat everyone you see as having unique wants and needs.

Adolescents and Parents

Adolescents are usually encouraged to assume a significant role in their diabetes care. The Family Approach to Diabetes Management (FADM) (10) is a tool that helps achieve this goal. FADM was developed with the understanding that even the most

informed adolescent may not follow through with important diabetes self-care behaviors (10). To keep maturing children safe, the model focuses on behavior change *before* attitude change, which differs from motivational interviewing, which encourages attitude change as a precursor to new behaviors (11). This is done because, "...no one has the luxury of being able to wait years for children and parents affected by [diabetes] to have an 'A-ha!' experience about the importance of maintaining optimal metabolic control" (10).

Try the following with families and their adolescents with diabetes (10):

- Identify the role each family member has in their loved one's diabetes care.
- Invite parents and children to list diabetes-related tasks the child can do to assume an increased level of responsibility.
- Help them set consequences for tasks that are not completed.
- Help the family create a communication plan that eliminates excessive monitoring. For example, have the child mark completed diabetes self-care tasks in a journal that is accessible to their parents.
- Encourage parents to hold a 5-10-minute weekly family meeting to review the progress of the diabetes management plan. If the week was successful, everyone can offer congratulations. If a task wasn't completed, they should discuss ways to manage it better. Parents should implement the consequence for not doing the task.
- If possible, schedule follow-up appointments and phone calls to monitor how well the family manages the new plan.

Managing Your Personal Bias

As mentioned earlier, RDNs who enjoy a positive relationship with their own families are more likely to invite families of PWD to educational sessions (7). If you don't have a positive family history, try to manage your own negative feelings about family involvement. Recognize the value of family support as a tool in your educational toolbox. Don't insert your personal feelings into counseling sessions by using negative body language. For example, if a family member makes a negative comment, don't roll your eyes. If you don't understand a certain behavior, ask for clarification. This can be helpful if you are working with individuals from a different religious, cultural or social background.

If you struggle with a family's behavior, ask other health care providers you work with to share how they manage these situations. You can also reach out to a therapist to help you understand their family dynamics better. The DCE electronic mailing list and other forms of colleague support can be helpful.

Summary

Working with PWD and their families can be very challenging, but is critically important as most individuals thrive when loved ones support their diabetes self-care efforts. RDNs can manage their own feelings prior to meeting with challenging families with the STOP, DROP and ROLL technique. They can also employ the LEAP approach during family sessions to help all attendees feel respected and heard. As young PWD enter adolescence, RDNs can help guide their families with FADM.

Practical Pointers

Steps RDN can implement with families:

- Encourage the family member with diabetes to be specific when asking for help. Encourage them not to assume their loved ones know their needs.
- Tell loved ones not to take it personally if their relatives with diabetes decline their offer of assistance. Some prefer to be independent.
- Recommend reliable articles, websites and books to help family members learn about diabetes.
- During a session, if a question requires additional time, suggest family members join their loved one at an additional appointment to discuss the issue in greater detail. They can also attend a diabetes class, read a book or view appropriate videos.
- Recommend a family therapist to relatives who don't emotionally support their loved one with diabetes. The therapist may be able to help them better manage their feelings.
- Encourage individuals who lack family support to share their frustrations with a trained mental health provider.

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Cultural Considerations for Counseling Hispanic/Latino-, Black/African- and Rural Americans with Diabetes

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Introduction

It is important for health care providers (HCPs) to understand cultural barriers that can make diabetes self-management challenging. This article focuses on how registered dietitian nutritionists (RDNs) can incorporate knowledge about cultural barriers in three at-risk populations: Hispanic/Latino Americans (Latino), non-Hispanic black Americans (African Americans), and rural Americans.

Latinos are the largest ethnic minority in the United States. People of Hispanic origin make up 17.8% of the U.S. population (1) and have a 16.4% age-adjusted prevalence of diagnosed and undiagnosed diabetes among adults (2). African Americans make up 13% of the U.S. population (1) and have a 17.7% age-adjusted prevalence of diagnosed and undiagnosed diabetes among adults (2). Americans living in rural areas make up an estimated 19.3% of the nation's population (3) and have a 12-15% rate of diabetes (4). All three of these groups are disparately affected by diabetes (5-7) and their cultural barriers and access to care contribute to worse health outcomes and poorer self-management than non-Hispanic urban whites (6,8,9).

Understanding cultural and geographical barriers can help RDNs support people in these cultural groups to develop successful, diabetes-focused self-management

skills, such as understanding carbohydrate counting and generating healthful eating plans that are acceptable and concordant with cultural norms.

Hispanic/Latino Americans

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Common cultural barriers

Latinos vary not only genetically and racially (10), but also culturally. This variation includes whether a person's origins are Latin or European, their level of education, social economic status and acculturation in the U.S. Therefore, cultural barriers to diabetes can vary. Common barriers include (5,11-15):

- Cultural stigma to diabetes
- Negative interactions with HCPs
- Stress around immigration and economic status
- Language barrier regardless of level of English fluency
- Lack of exposure to healthy lifestyle habits
- Lack of social support, proper resources, health and numeracy skills
- Belief that traditional foods can't be incorporated into healthy menus
- Incorporation of traditional and alternative medicine

- Fear and anger regarding diabetes
- Belief that diabetes management is complex, difficult and out of one's control
- Trust in relatives and friends as it relates to diabetes management

Common beliefs about life, health and diabetes

Latinos traditionally value family over individual or community needs (14), therefore families play an essential role in diabetes management (16). Family structure and beliefs can influence the self-management of the person with diabetes (PWD) both positively and negatively depending on the family's resources and level of diabetes knowledge (17). Faith can also play a central role in coping and self-management. This can take the form of resilient coping by providing strength, comfort, and a rubric to make sense of negative afflictions, which is linked to positive health outcomes and decreased incidence of metabolic syndrome (18). However, faith can also take the form of passive coping leading to fatalism, resulting in inaction or a resigned acceptance of diabetes (19). This coupled with exposure to generations of family members experiencing poor diabetes health outcomes can equate the diagnosis of diabetes to a "death sentence" (15).

Due to their social connectedness and values, Latinos may benefit from using shared medical appointments

(SMAs). These group visits can increase understanding and community via social support and be a feasible means to improve care and outcomes (20). However, HCPs must be mindful of the potential for the dissemination and exchange of misconceptions by participants.

Black/African Americans

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Common cultural barriers

Black/African Americans are diverse in regards to geography, levels of education, social economic status and ancestral country of origin (forcible immigration through slavery or more recent immigration through choice). Therefore, cultural barriers vary, but common barriers include (21–32):

- Experience with individual and systemic-level racism leading to distrust of and negative interactions with health care staff
- Differing cultural priorities from HCPs
- Poverty and all comorbid associations, such as: lacking access to health care, prohibitive cost of prescribed medications, and food and housing insecurity
- Traditionally unhealthy family habits
- Lack of social support
- Fear and anger regarding diabetes
- Spirituality, religion, fatalism and traditional beliefs dating back to slavery
- Food preferences and body norms such as heavier body weights accepted as common
- Low health literacy and numeracy

Common beliefs about life, health and diabetes

Black/African Americans often have large extended families with

caregivers of intergenerational family members. Food-focused family gatherings and putting other family member's needs before their own can pose challenges to managing diabetes (27). Taking insulin is a disruptive change of identity and when key figures in the family develop diabetes, it can lead to a perceived loss of the caregiver who now needs care (25). Diabetes can pose a threat to both emotional and physical well-being, indicating a loss of control with fatalistic expressions such as "It must be my time..." becoming an acceptable path to coping amidst the challenges of poor health (24,25).

Food is central to identity and is a unifying force in the family. Food preparation and seasoning expresses love; whereas, dieting or restricting intake is a rejection of love. In a focus group (28), African American participants complained that nutrition recommendations from their medical providers were unclear and lacked context (33). In addition, heavier weights are accepted as common and normative, especially among women. In one study, women equated losing weight with a loss of identity (26).

Health beliefs can also make managing diabetes challenging. For example, many Black/African Americans believe diabetes is only present when blood glucose levels are high, and therefore medications are only needed episodically. In addition, some believe that diabetes is not controllable (29) and that insulin is optional and can be omitted without harm, while others believe the need for insulin confirms a diabetes diagnosis (25).

Spirituality provides strength, stress release, reminds one to stay grounded in their belief of self while

giving hope and counsel against worry. However, in addition to faith being a source of support, it may also mask awareness that diabetes is a threat (24). Harnessing the power of faith alongside the message that God is ultimately responsible for health and will never leave the believer can sway choices to improve their quality of life (30).

Rural Americans

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Barriers to Accessing Health Care in Rural Areas

Rural Americans are culturally diverse and spread broadly across the country. Twenty percent of America's population live in rural areas yet only 10% of physicians practice in rural areas. Rural Americans are less likely to have timely access to emergency medical services, hospitals and clinics. The most common barriers impacting diabetes management are listed below (34):

- Lack of public transportation, unpaved roads, and extreme weather conditions
- Lack of quality health care
- Lack of diabetes specialists in the region
- Financial constraints
- Lack of comprehensive insurance coverage
- Lack of access to fresh food
- Lack of adequate housing
- Social isolation

Population Specific Interventions

Travel to medical visits can be difficult. HCPs need to be aware of available resources so they can help

coordinate transportation. For example, Medicaid will cover the cost of transportation for eligible individuals to and from a physician's office, hospital, or another medical office for Medicaid-approved care (35). However, states have different rules about when transportation is necessary.

Successful rural Diabetes Self-Management Education and Support (DSMES) interventions have incorporated social support (36). Use of virtual delivery of care is a promising model for delivering DSMES. Interventions have observed improvements in glycemic control compared to usual care (37). However, HCPs need to consider the potential for limited or complete lack of internet access.

Social support positively influences the performance of diabetes self-care and glycemic control (38). Involving family members, especially spouses and partners, in self-care is important. These tips can help the person who does not have family nearby build a social support network:

- Offer group DSMES
- Offer in-person diabetes support groups
- Recommend an online peer support group
- Encourage outreach to friends when they need extra support or advice; schedule regular get-togethers, video or phone calls, and texts
- Encourage joining a local club, activity, religious or spiritual group, and/or volunteer organization

Tips and Strategies for Counseling all People with Diabetes

Diana M. Naranjo, PhD

Motivational Interviewing (MI) lends itself well to working with people of varied cultural backgrounds because it applies person-focused strategies and active listening. In addition, the strategies listed below can be useful when considering cultural values and norms (6,11–14,39,40):

Useful strategies when considering cultural values and norms:

- Gauge health literacy, numeracy and English fluency
- Use verbal and nonverbal communication
- When appropriate have bicultural providers, skilled community health workers, or those fluent in the PWD's language deliver education
- Explore subtle cultural differences among different groups to adjust counseling approach
- Involve supportive family members upon treatment initiation
- Use strategies that increase the PWD's sense of empowerment and self-efficacy
- Focus on decreasing depressive/distress symptoms in the PWD, if present
- Ask about the use of alternative medicine and respect its role as long as it does not conflict with traditional medical care
- Address diabetes as a manageable disease common among a variety of populations
- Adapt educational sessions and materials to avoid literal translation of content and saliency in different cultures
- Create disease management and behavioral intervention sessions for delivery in social environments such as cooking demonstrations/ classes, school/community events and/or at work settings instead of in traditional health care settings
- Assess the role of faith/spirituality in understanding disease identity, fatalism and coping

Summary

Hispanic/Latino-, Black/African- and rural Americans are all disproportionately burdened with diabetes and negative health outcomes associated with the disease for a variety of reasons including cultural barriers (6–8). The RDN's understanding of these cultural barriers can enhance communication, person-centered approaches, and improve the quality of care these groups receive. All of these groups of Americans would benefit from expanded access to health care, more culturally sensitive HCPs and additional research studies targeting how to overcome cultural barriers (32).

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Practical Techniques to Address Psychosocial Barriers among People with Diabetes

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Introduction

This article provides Registered Dietitian Nutritionists (RDNs) with simple techniques to address psychosocial barriers among people with diabetes. It also provides ways to use aspects of Diabetes Self-Management Education and Support (DSMES), with a focus on problem solving and healthy coping, cognitive behavioral strategies and acceptance, with PWD who are experiencing psychosocial barriers to managing their diabetes.

Research shows that positive emotional health not only improves PWD's quality of life, but it can also help them increase self-care behavior and improve health outcomes (2). RDNs have a unique opportunity to help PWD address psychosocial barriers to diabetes care to have a direct impact on PWD's emotional and physical health. Implementing techniques presented here can serve as a guide to their use.

Diabetes Self-Management Education and Support

DSMES is a critical element of care for all PWD (3). DSMES should be comprehensive and personalized, providing information about diabetes and how it is managed while addressing the challenges that make it difficult for the individual to engage in diabetes self-care behaviors. The National Standards for Diabetes

Self-Management Education and Support encourages clinicians to use a personalized, person-centered approach in their work, which includes identifying and addressing psychosocial barriers to diabetes care (3).

Use of the AADE7 Self-Care Behaviors in problem solving and healthy coping within counseling are particularly helpful with PWD experiencing psychosocial barriers.

Problem Solving: Diabetes is a self-managed condition that requires PWD to make decisions about their health constantly. PWD have to cope with the unexpected and ever-changing requirements of the condition and often need to make adjustments in their management via rapid decision making. Proficiency with problem solving skills is a critical aspect of DSMES (4).

RDNs can support PWD in developing problem solving skills in the following ways:

- **Use past experiences:** Talk about a challenge that the PWD has experienced in the past that they do not think they handled well. Ask questions to help them understand what got in their way, and what they would have done differently if given the opportunity.
- **Plan for the future:** Identify a challenge that the PWD may experience in the future with their

diabetes management and help them develop a plan to overcome this challenge. This will equip the PWD to anticipate the challenge, think through their response, and get feedback in a safe, non-threatening environment.

Healthy Coping: Living with diabetes can feel overwhelming. Therefore it is important for PWD to develop ways to cope with stress that support their diabetes management (5).

RDNs can work with PWD to help them find healthy coping strategies in the following ways:

- **Deep breathing:** Breathing can help reduce stress, relieve tension and can have a calming effect when a person is feeling overwhelmed. Taking long, slow deep breaths can slow the heart rate, relax the muscles and slow thoughts (6). RDNs can use the following instructions to teach deep breathing as a healthy coping strategy:
 - o *Sit down in a comfortable, quiet place*
 - o *Take a deep breath in through your nose*
 - o *Hold the breath for about 4 seconds*
 - o *Exhale slowly through your mouth*
 - o *Repeat 5-6 times*
- **Get active:** Another healthy coping strategy RDNs can suggest is physical activity, like taking a

walk. Physical activity can give PWD the chance to clear their head, and allows for the release of chemicals that can reduce stress. Being active can also make it easier for PWD to keep their blood glucose levels in their target range (5) as well as achieving a host of other benefits.

- **Find support:** It is helpful to have people who can support you when you are upset or experiencing stress. RDNs can help PWD identify people in their life who can support them and teach them how to ask these people for the support that they need (5).

- **Other healthy coping skills:** There are many other strategies that PWD can use to manage stress. RDNs can make suggestions and help PWD find strategies that will work for them. Anything that helps a PWD improve their mental and emotional well-being is a healthy coping behavior (7). Examples of healthy coping behaviors include reading, writing, watching television, taking a relaxing bath or shower, playing with children or pets and practicing yoga. Consider spending a few minutes with a PWD asking them to tell you what might be several healthy coping behaviors for them.

Cognitive Behavioral Techniques

Cognitive Behavior Therapy (CBT) is a therapeutic approach that focuses on the relationship between thoughts, emotions and behaviors. CBT helps people become aware of how inaccurate or negative thinking can lead to negative emotions and unhealthy behaviors. It then teaches people how to evaluate their thoughts in an objective manner, and if appropriate, reframe their thoughts to be more realistic, allowing them to

respond in a more effective manner (8). CBT has been shown to be effective in helping PWD who are experiencing difficult emotions related to diabetes (9). Although RDNs are not trained in conducting psychotherapy, there are several effective cognitive behavioral techniques they can use to help PWD deal with the psychosocial barriers of managing diabetes, such as:

- **Education:** RDNs can explain the relationship between thoughts, emotions and behaviors in the context of diabetes management. For example, if a PWD says something like, "My diabetes is impossible to manage," RDNs can ask the person how this makes them feel. The person may respond that they feel like a failure, or that they feel hopeless. RDNs can point out that feeling this way probably has a negative impact on their diabetes self-management behaviors. For many people, just becoming aware of the connection between thoughts, emotions and behaviors can be helpful.

- **Challenge:** If a person with diabetes says something that does not seem accurate, or is extreme (e.g., uses words like always, never or impossible), it might be helpful to push back and challenge what they are saying. For example, if someone says, "I'm never going to be able to get motivated to manage my diabetes," RDNs might say, "Never is a pretty extreme word. Has there ever been a time when you've had even just a small bit of motivation?" If RDNs can help the person find an exception to their extreme thoughts, RDNs can help them see that their thoughts may not be completely accurate.

- **Reframe:** Once the RDN helps a person identify a thought that is

not completely realistic, they can work with them to come up with a more realistic thought. For example, if a person says, "I am completely alone in my diabetes," RDNs can help them reframe this thought to, "I have some people, including my dietitian, who help me with my diabetes, but I wish I had more people to support me."

Acceptance

Living with diabetes is challenging and there may be certain aspects of diabetes, including difficult thoughts and emotions, that PWD may not be able to control or change. In fact, trying to control these experiences often makes them more intense and can also take a significant amount of time and energy with little chance of success. Although on the surface it may seem counterintuitive, working with PWD to accept uncomfortable thoughts and emotions can help them be more flexible in how they respond to diabetes-related stressors. Acceptance is the ability to experience an emotion without trying to change it or to observe a thought or behavior without trying to control it (10).

RDNs can work with PWD to help them accept, as opposed to control or avoid, uncomfortable thoughts and emotions in the following ways:

- **Educate:** Teach PWD that it is not always possible to control negative thoughts and emotions related to diabetes. Help them see that the strategies that they use in an attempt to control these things may work in the short-term but often make things worse in the long-term. This can help PWD to change the way they think about their desire to control their experience.

- **Practice mindfulness:** Mindfulness means paying

attention to one's experiences in the present moment without judging them. Being mindful helps give PWD space to notice what is happening without reacting. This can allow space to accept uncomfortable thoughts and feelings.

RDNs can encourage PWD to be mindful and notice what is going on around them, as if the person is an outside observer of themselves using the following simple steps:

- o *Have the person to take a deep breath*
- o *Ask them to do a quick scan of their body and notice any physical sensations. Do they have any pain? Do they feel any tension in their muscles? Does any part of their body feel calm or relaxed?*
- o *Ask them to take a minute to observe any thoughts that they are having. Remind them to notice their thoughts without judgement, as opposed to getting wrapped up in their thoughts.*
- o *Ask them to pay attention to their emotions. What emotions do they have? What do these emotions feel like? Do they feel them in certain parts of their body?*

• **Set goals:** Identifying and working towards a goal that is important to a person can make it easier for them to tolerate and accept uncomfortable experiences. This allows them to see that any discomfort they have is in service of something that they want to accomplish (10). RDNs can work with PWD to help

them set goals, and also focus on the reasons why the goal is important to the person. They can talk about the challenges the person might have in the process of achieving this goal and identify the reasons why they are willing to endure these challenges to get there.

Summary

It is important for RDNs to address the psychosocial barriers that impact a person's ability to perform diabetes self-care behaviors. If addressing these barriers is a regular part of the RDN's counseling, PWD are more likely to feel that their provider is working with them collaboratively. It also offers RDNs the opportunity to understand the challenges PWD may encounter. This article sought to provide RDNs with practical techniques they can use to support PWD who encounter psychosocial barriers. By introducing strategies such as problem solving, healthy coping, cognitive behavioral techniques and acceptance, RDNs can increase their comfort level in talking to PWD about common psychosocial barriers and actively work with PWD to address them.

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Applying Minimally Disruptive Medicine in People with Diabetes to Overcome Life and Self-care Challenges

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Introduction

Current treatment guidelines for persons with type 2 diabetes (PWT2D) include daily self-management tasks such as glucose self-monitoring, exercise, healthy eating, stress management, and taking medications (1,2). Furthermore, PWT2D are recommended to see their physician at least two times a year in addition to attending appointments with other health care providers (HCPs), such as Care Coordinators, Diabetes Educators, Registered Dietitian Nutritionists (RDNs), and Health and Wellness Coaches (1,3).

Research has focused on interventions intended to improve medication taking and engagement in prescribed health behaviors, and subsequently, measures of diabetes management. These interventions often focus on self-management education and support (4,5), computer or mobile device applications for self-monitoring (6,7), nutrition programs (8,9), and exercise regimens (10,11). Yet, self-management remains challenging, and many PWT2D have measures of hemoglobin A1c (A1c) greater than recommended levels (12). Not taking medication as recommended or limited engagement in health behaviors has downstream clinical and economic consequences such as diabetes-related complications (13).

Minimally Disruptive Medicine (MDM)

Minimally Disruptive Medicine (MDM) is a model that offers a new frame to care for PWT2D. It is defined as “pursuing patient goals with the least possible healthcare footprint on their lives” (14). First proposed in 2009, it has been noted as one of the most important innovations in medicine in the past two decades (15). The concepts of MDM that drive care are described in the Cumulative Complexity Model (CuCoM) (Figure 1) (16). MDM defines complexity, including challenges to self-management, as arising from the balance of **workload** and **capacity** in patients’ lives. This balance affects

PWT2D’s ability to access and use health care and enact self-care, which in turn can affect outcomes. When HCPs respond to worsening outcomes (e.g. A1C) with treatment intensification, which increases treatment burden while illness burden also increases (16). This continues as a vicious cycle unless the problem of imbalance of workload to capacity is addressed in care.

MDM divides the person’s workload of managing chronic illness into four distinct types: sense-making; planning and enrolling others; enacting; and appraising (Table 1) (17,18). Best estimates suggest that caring for a single condition requires 2.5 hours each day (19), and given

Figure 1. The Cumulative Complexity Model (CuCoM) ²⁵

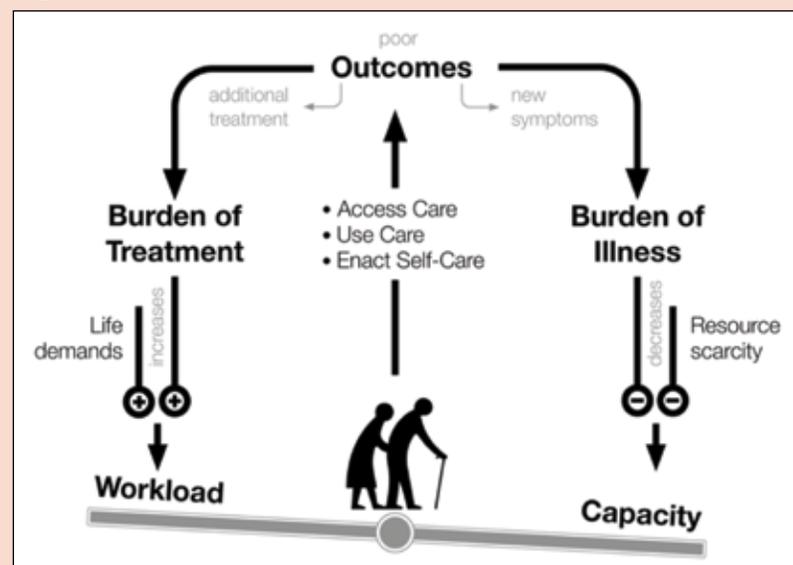


Table 1. Types of Work Done by PWT2D

Patient Work Type Examples	
Sense-making	Reading patient education materials, understanding diagnosis and treatment options, making sense of treatment instructions.
Planning and enrolling others	Organizing pills into a pill box, planning balanced meals and deciding who will prepare the meals.
Enacting	Going to the pharmacy, taking the pills, eating the prepared meal instead of stopping for takeout.
Appraising	Taking stock of whether they feel better or if the potential benefit of improved future health outcomes is worth the day-to-day work (particularly difficult when patients are asymptomatic).

Table 2. Domains of Capacity for PWT2D

Capacity Domain	Definition & impact on capacity
Biography	Life story, roles, meaning making. Chronic illness, T2D included, interrupts this biography. Successful renegotiation of biography to include illness improves patient capacity for self-care.
Resources	Finances, transportation, literacy, etc. Availability of and knowledge of how to access these resources and others improves capacity.
Environment	The health care environments where patients receive care. Health care environments where patients find understanding of their unique life stories, symptoms, and needs improves capacity.
Work	Experiential accomplishment of completing the tasks associated with types of patient work. When patients are supported in starting small to gain a sense of accomplishment, capacity grows.
Social	The social network of the patient. Social networks that are supportive, accommodating, and understanding of illness and patient work, improve capacity.

that the majority of PWT2D have at least one additional condition (20), it may feel like a part-time job managing their own health. Treatment burden is the *subjective impact* of these types of work on well-being and quality of life (21).

Taking on self-management work requires capacity, a multifaceted concept described by the Theory of Patient Capacity (22). Capacity has these five domains: Biography, Resources, Environment, Work, and Social (BREWS), as delineated in Table 2.

Tools and Strategies to Support MDM in Practice

The ICAN Discussion Aid

The ICAN Discussion Aid is the first tool developed to support MDM in practice (Figures 2 and 3) (23). It is designed to uncover **workload** and **capacity** through conversation. The HCP asks the PWT2D to complete the ICAN Discussion Aid at the beginning of their visit. To begin the visit, the HCP reviews the back of the form (Figure 2). They then initiate conversation with a question about the person’s response to one or more of the questions they have answered (e.g. “You say spending time with

your grandchildren brings you joy. Can you tell me more about that?”). After a brief discussion, the HCP turns to the inside of ICAN Discussion Aid (Figure 3) and asks, “What stands out to you from what you filled in here?” This question is useful in helping the PWT2D prioritize issues that matter most to them in the context of their HCP visit.

ICAN Discussion Aid research is still ongoing in its continued attempt to identify how it can be best implemented across multidisciplinary teams, in addition to determining its efficacy in improving communication. It is being tested in a cluster-randomized trial nationally in diverse settings across Kentucky, North Carolina, Minnesota and Wisconsin. The Agency for Healthcare Quality and Research has also funded research, which will conclude at the end of 2019, to create an implementation toolkit for a variety of HCP to use ICAN to create person-centered care plans. The RDN co-authors on this article have participated in this implementation research. Our recent pilot study of ICAN in primary care encounters showed persons living with chronic illness were more likely to bring up issues of medication taking, eating habits and food choices, and exercise when using the aid. It was furthermore demonstrated that use of the aid did not add time to visits (24).

Capacity Coaching

The ICAN Discussion Aid can also be used to practice Capacity Coaching (25). This coaching approach draws on many of the ideas and practices of traditional HWC, but is distinct in its focus on helping persons live well with chronic illnesses using the MDM frameworks (25). In practice, once a person is referred for Capacity Coaching, they and their coach meet

together at a convenient time and location to begin their conversation with ICAN. The coach then uses an appreciative inquiry approach (26) to work together to understand the person's life context, create a vision, small action steps towards that vision, and ultimately perform progress appraisal. A coaching approach enhances this work because coaching works to find solutions within the person's knowledge. Before offering any advice, a coach works through what a person knows and asks permission to share potential solutions, if absolutely necessary. The coaching approach is an ongoing process and future visits or asynchronous communication are arranged as needed. Capacity Coaching does not currently require certification, as does traditional HWC, but training in coaching techniques is helpful. However, Appreciative Inquiry steps and coaching actions outlined in Table 3 can be adopted by RDNs.

Practical Pointers for RDN to Use MDM in Practice

While there is no manual or algorithm for practicing MDM, these are a few ways to adopt it in practice:

- 1) Begin the visit conversationally with ICAN.
- 2) Pose the question, "What are you doing when you are not sitting here with me?" early in the visit. Our research shows that when RDNs use this question they gain valuable insight into PWT2D's daily lives which helps customize the consultation.
- 3) When taking the PWT2D's food intake history, using the list of activities that the person shares in steps 1 and 2 helps orient the RDN questions. For example, rather than, "Do you eat lunch? If so, what do you usually have?"

tailor the questions specifically to the person; for example, "So you talked about having two jobs. Does your eating during the day differ depending on which job you are working? When is the first time you eat on your shift?" Every question should be placed within the person's context.

- 4) Consider what you know about what the PWT2D is being asked to do to manage their health conditions: sense-making, planning and enrolling, enacting and appraising. Consider how each type of work applies to the self-management tasks you are helping the person implement.

Figure 2. ICAN Discussion Aid (Front Cover and Back Cover)



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Figure 3. ICAN Discussion Aid (Inner Pages)

Are these areas of your life a source of satisfaction, burden, or both?			What are the things that your doctors or clinic have asked you to do to care for your health? Do you feel that they are a help, a burden, or both?		
Leave blank if not part of your life	Satisfaction	Burden	Leave blank if not part of your life	Help	Burden
My family and friends	<input type="checkbox"/>	<input type="checkbox"/>	Take medications	<input type="checkbox"/>	<input type="checkbox"/>
My work or finances	<input type="checkbox"/>	<input type="checkbox"/>	Monitor symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Free time, relaxation, fun	<input type="checkbox"/>	<input type="checkbox"/>	Manage my diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality or life purpose	<input type="checkbox"/>	<input type="checkbox"/>	Get enough sleep	<input type="checkbox"/>	<input type="checkbox"/>
Where I live	<input type="checkbox"/>	<input type="checkbox"/>	Come in for appointments or labs	<input type="checkbox"/>	<input type="checkbox"/>
Getting out and transportation	<input type="checkbox"/>	<input type="checkbox"/>	Reduce alcohol use, smoking, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Being active	<input type="checkbox"/>	<input type="checkbox"/>	Insurance or support services	<input type="checkbox"/>	<input type="checkbox"/>
Social media, TV or screen watching	<input type="checkbox"/>	<input type="checkbox"/>	Manage stress	<input type="checkbox"/>	<input type="checkbox"/>
My emotional life	<input type="checkbox"/>	<input type="checkbox"/>	Write in any others	<input type="checkbox"/>	<input type="checkbox"/>
My memory or attention	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
The food I eat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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Table 3. Appreciative Inquiry and MDM-oriented coaching actions

Appreciative Inquiry Step	MDM-Oriented Coaching Actions
Discover	Use the ICAN Discussion Aid; understand patient's life context (what brings them joy, what they do day-to-day) and the work they have been asked to do to care for their health (usually we see the enacting medication taking or the recommended healthy eating as the work and forget the sense-making, planning and enrolling, and appraising work).
Dream	Understand what adapting and thriving with T2D and other comorbidities looks like to this patient.
Design	Help the patient create small experiments that are steps towards their idea of adapting and thriving. Sometimes this means ignoring what guidelines say.
Deliver	Offer to follow-up with the patient in-person or asynchronously by phone or email regarding how their experiments went. Ideally, follow-up occurs within 1-2 weeks but timing and modality should be dictated by the patient.

- 5) Consider what you know about the PWT2D's capacity. Remember that capacity is not just about resources. Think about whether you need more information about their Biography, Resources, Environment, Work or Social network, to truly customize their self-management plan and, subsequently, grow their capacity.
- 6) Consider implementing an appreciative inquiry approach as detailed in Table 3.
- 7) Close visits with a summary of what you have talked about, experiments to try this week (or other designated time period), and ask when and how the PWT2D would like to follow-up. Ask if there are other ways in which you can be supportive.

Summary

In summary, MDM prompts practitioners to consider the **workload** and **capacity** of each person they see. Undiagnosed workload-capacity imbalance can lead to problems accessing and using health care and enacting self-care.

RDNs can apply practical pointers here to use MDM in their practice. RDNs who want to learn more may contact the authors of this article, visit minimallydisruptivemedicine.org, and/or attend the annual Minimally Disruptive Medicine Workshop (27).

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OTCE Acknowledgments

THANK YOU!

Many thanks to the following people for assisting with the development of this issue of *On the Cutting Edge*:

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The Value of Peer Support for People with Diabetes and How Health Care Providers Can Promote in Practice

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Introduction

The burdens of diabetes care, regardless of type, rests mainly on people with diabetes (PWD) and/or their caregivers (if available and involved) (1). Successful management requires the understanding and application of numerous concepts and technologies as well as the wherewithal to make hundreds of daily self-care decisions. Though some PWD obtain sufficient care, self-management education and support from their health care providers (HCPs), most do not (1). Even for those who receive optimal interactions with HCPs, it's relatively minimal (2).

Minimal attention has been paid by HCPs to the role of one's mental health in managing diabetes. Through the leadership of some HCPs and PWD, attention to mental health and the importance of addressing psychosocial barriers to achieve positive outcomes is rising as evidenced by this issue of *On the Cutting Edge* and other publications (3).

A small but growing body of research demonstrates the value of peer support in the mental health and emotional wellbeing of PWD (4–8). The global reach of the internet and the growth of social media and social networking have facilitated the availability and use of peer support among PWD and has led to an evolving array of Peer Support

Communities (PSC), personal blogs, Twitter chats, discussion boards and more (9–11). Some peer support takes place within and outside of the PSC as well as online and in-person. While the amount of peer support has increased significantly, a relatively scant number of PWD and caregivers access it most likely due to lack of awareness. HCPs can increase this by exposing PWD to peer support (11).

To provide insights about the value of peer support, the authors sought input from PWD active in diabetes peer support. These insights will provide the registered dietitian nutritionist (RDN) with the importance of and need for referral to peer support and encourage RDNs to include the critical role of peer support in counseling and refer PWD and caregivers to reliable resources (12,13).

Literature Review

A small but growing body of research demonstrates the value of various types of peer support in the mental and emotional well-being of PWD (4–8,11). The global work of Peers for Progress, much of which has focused on diabetes, reports an average absolute 0.76% A1C improvement (5). Cherrington et al has shown that the addition of a peer advisor to Diabetes Self-Management Education and Support (DSMES) over the course of one year in a rural living, low income, majority African American population of mildly or moderately depressed people with type 2 diabetes (T2D) improved some clinical outcomes and reduced acute care visits and hospitalizations (8). Several studies have additionally demonstrated positive findings, such as greater engagement in self-care with online

Definition of Peer Support

Peers for Progress, an international network of peer support researchers, experts, and advocates, defines peer support as linking people with a chronic condition, such as diabetes, to share knowledge and experiences (4). It further defines peer support as being frequent, ongoing, accessible and flexible and can take many forms, from phone calls to group meetings, home visits and text messaging. Peer support augments and enhances other, more formal health care services and has four core functions: 1) assistance in daily management; 2) social and emotional support; 3) linkages to clinical care and community resources; and 4) ongoing support delivered over time. Other terms, such as "peer health" (7), peer health advice and peer to peer health care, are also used (11). This article uses the term peer support.

peer-driven peer support (6,7). A concern raised by these publications is that the lack of acknowledgement of or an unsupportive attitude of online peer support causes PWD to either not use these resources or not share the use of them with their HCP.

Insights from People with Diabetes

Overwhelmed

Most people with diabetes use the word overwhelmed to describe their initial feelings upon diagnosis. They're overwhelmed with the diagnosis itself, the medication and treatment routine, the changes and recommendations in eating habits, food choices and physical activity. Added to this list are the financial stresses of managing a chronic illness, the possibility of complications, and more importantly, the feeling that HCPs focus significantly more time on treatment rather than mental health and wellbeing.

Renza Scibilia with T1D diagnosed in 1998 shares:

"Diabetes can be overwhelming, tedious and terrifying. There are things I hide away and don't even want to think about, much less talk about. However, there have been times when I have been able to speak of them with peers and I always walk away feeling lighter and reassured."

Importance of Engagement

Since the mid- 2000s (9,15), peer support and virtual PSC, referred to by some as the Diabetes Online Community (DOC), has existed as a place for PWD and caregivers to feel less isolated and offers a channel by which to reach out for practical guidance 24/7, share victories, move through life's challenges as well as stages and ages while giving and receiving emotional support more

readily and regularly. Early on it was a place for people to ask questions, share concerns, and discuss complications, treatments and technologies. It has since become a haven, home to friendships, validation, and for some, improved diabetes care and outcomes. In-person, grassroots organizations have contributed to the rise of PSC realizing the need for discussions outside medical offices to achieve better health outcomes.

Mike Barry with T1D diagnosed in 1984 shares:

"Peer support from the DOC has been very important to my physical and mental health since I discovered it in 2008. I enjoyed learning I was not 'alone' but part of a big crowd of great people working together. Starting pump therapy served as a catalyst to find the DOC; the solid peer support provided there helped me attain better management of my diabetes and swapping diabetes stories with others immediately helped my confidence. This has been the greatest mental health benefit for me."

Engagement in PSC stretches across generations and continents, with the ease of technology and social media bridging what was previously a gap in learning about disease management from others. It also provides a 24/7 forum for people seeking support.

Richard Vaughn with T1D diagnosed in 1945 shares:

"I did not know another person with diabetes. I knew very little about complications. Diabetes seemed very simple and I was not scared because of my ignorance. I joined an online support group, and after 61 years living with diabetes, learned what proper diabetes management should be. I began insulin pump

therapy. My roller coaster blood glucose control was greatly improved."

PSC provide support between medical visits, at times when it may not be possible to reach a HCP. PSC also provide opportunities for PWD to give and receive support.

Shelby Kinnaird with T2D diagnosed in 1999 shares:

"Having diabetes is a series of ups and downs. When you're up, you are eating in a way that works for you, your blood sugars are in range, you are sleeping soundly and exercising regularly, and you are managing stress well. Other times, when you are 'down,' you may feel like no matter what you do, you can't get your diabetes under control. These are times you need help from others. Your peer support community is there for both your 'ups' and 'downs'. Sometimes you can give, sometimes you need to take."

For caregivers, PSC have also provided safe refuge to discuss their loved ones' illness, with conversations ranging from disease education to their own fears about complications, and ways to offer support during emergencies.

Debbie Antoniadis, the parent/caregiver of person with T1D since 2004. Her elderly father was diagnosed with T2D in 2011.

"My daughter invited me to a conference for PWD and their loved ones, and in order to spend time with her, I agreed. Little did I know how life altering and lifesaving the conference would turn out to be for both of us. The most emotional moment came when my beautiful daughter admitted that she had been dealing with some serious life

threatening, diabetes-related personal issues for many years... struggles she had been keeping completely to herself. She was met with unconditional acceptance, understanding and peer support. She was provided with an invaluable network of resources she utilized immediately on her road to recovery. For me, I was in a complete emotional display, finally able to share with others (and my daughter) my fears and concerns. We both left that weekend feeling strong, courageous, empowered and confident about the future in our own way. Our communication with each other has deepened and we've each found a network of supporters and new friends."

Giving Back to Others

The positive effect of PSC, both online and in-person, has cultivated PWD-advocates and organizations that organize and lead movements to improve the lives of their peers and caregivers.

Richard Vaughn with T1D diagnosed in 1945 shares:

"I wanted to give support to others. I had received so much help online, I wanted to return the favor by offering encouragement, inspiration and hope. I do this on my Facebook timeline, some of the type 1 diabetes groups (also on Facebook). I join parent groups, where they seem to be encouraged to know a 72-year old with type 1 diabetes who does not have any serious complications. I've even met some of these people at in-person diabetes conferences."

PSC have at times received scrutiny from HCPs who question their validity

in the medical space. Several diabetes educators and professional organizations, including the American Association of Diabetes Educators (AADE) (11) have been instrumental in reversing these myths and misconceptions. They've begun partnering with PWD-led organizations to support outreach to more HCPs, PWD and caregivers, highlighting positive effects of peer support in enhancing life with diabetes (16).

In-person gatherings hosted by PWD-led organizations bring together PWD and their caregivers to discuss the successes and challenges of managing diabetes, as well as invite HCPs to discuss distress and anxiety and find avenues for continued care if needed (15).

Nicole Bereolos, PhD, MPH, CDE with T1D diagnosed in 1992 shares:

"I discovered the DOC four years ago and was immediately amazed at the practical and matter-of-fact topics: treating adhesive rashes, off-label medication uses, and the pros and cons of pumps on the market that I had never heard of, even as a CDE. During times when I was frustrated with my own health, individuals from the diabetes community responded supportively. I have been fortunate to meet many in-person and the unspoken mutual understanding is very powerful. I hope that others, regardless of diabetes type or treatment regime, have the opportunity to be touched as much as I have. It is exciting to see the strength of this community and that it works to make the health of people living with diabetes better."

Phyllisa Deroze with T2D diagnosed in 2011 shares:

"Peer support has been invaluable to me for a few reasons. First, by establishing a connection with other people living with diabetes, they offer me emotional support and practical guidance for managing diabetes daily. Secondly, I never feel rushed when I share my conversations with other people living with diabetes. I'm more than my A1c with them and that's vital to my mental health."

Summary:

Peer support, in all of its forms, is increasingly being recognized as a potentially critical component in achieving quality diabetes outcomes. HCPs should become more aware of the importance of mental health and well-being in the lives of PWD and their caregivers. HCPs should recognize the value of peer support in the holistic care of PWD and become knowledgeable about the expanding research on peer support. RDN should be aware of PSC and other avenues for peer support in their communities and refer PWD open to or in need of these resources to them.

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CPE CREDIT ANSWER KEY

See the CPE credit self-assessment questionnaire on page 34.

1. B
2. C
3. C
4. A
5. B
6. C
7. D
8. C
9. D
10. C

Polonsky's Pearls for Practice in Diabetes Care

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Introduction

William H. Polonsky, PhD, CDE is president and founder of the Behavioral Diabetes Institute (BDI) (<https://behavioraldiabetes.org/>) and an associate clinical professor in psychiatry at the University of California, San Diego. Bill has been involved in diabetes care for more than 30 years during which he has been an active and prolific researcher, speaker and leading advocate for considering the psychosocial needs of people with diabetes. In this interview Bill shared pearls for practice and thoughts about how Registered Dietitian Nutritionists (RDNs) counseling people with diabetes (PWD) and their care givers can engage more collaboratively and successfully.

Q1: *As we counsel PWD, what should be core premises to keep in mind?*

A1: We're asking all health care providers (HCPs) to think about PWD differently. Don't shame and blame PWD and stop stigmatizing them (refer to article by Guzman in this *OTCE*).

Consider these core premises (1):

- *Living with diabetes is tough*, it's a time-consuming job that is not easy. It's a balancing act that requires vigilance and dealing with frustration. You have it for the rest of your life and you don't get paid to manage it.

- *No one is unmotivated to live a long and healthy life*, yet diabetes is mostly an invisible and seemingly non-urgent disease that carries with it tons of obstacles to successful implementation of self-care. To be successful with PWD, give them personalized feedback on metabolic goals and their numbers. Congratulate them on ANY achievement. The value of positive reinforcement for actions increases with ongoing contact.



- *Well-managed diabetes is the leading cause of NOTHING!* (see image). Stop trying to scare PWD about diabetes complications. Do address the doom and gloom that they may already feel by using the principles of "evidence-based hope." Let PWD know that with good care and efforts, odds are good that they can live a long and healthy life with diabetes.
- *Address discouragement.* We need to help PWD see that their self-care actions can make a positive, tangible difference. Use discovery learning, life-applicable experiments.
- *Reframe the need for/use of glucose-lowering medications.* PWD may fear the potential negative effects of medication

but may have never had a conversation about how to weigh the pros vs. the cons. Taking medication doesn't equal failure. Reinforce that it's not the number or amount of medication one takes that indicates how well they're managing diabetes, rather it's the results and management of metabolic control.

Things that get in the way of managing diabetes can be emotional, attitudinal, behavioral, interpersonal and environmental. Given the range of obstacles, diabetes management would be tough for *anyone*. Thinking this way should mean you and your clients are on the same side. You don't have to use insulting terms like being in denial or non-compliant. We need to understand, recognize and remove critical obstacles. When we think about PWDs differently and consider their realities, HCPs can work more successfully and collaboratively.

Q2: *How do we keep these core premises in mind and pick up on clients' words and body language?*

A2: Ask very precise, open-ended questions. Start with the most important question. I ask: "Can you tell me a couple of the ways that diabetes is driving you crazy?" Another one: "What about managing your diabetes do you

find most challenging?" Then listen well. Getting answers to these questions offers the best way to understand the individual. From answers received, provide a summary statement: "Let me see if I understand what you're telling me..." Then ask follow up questions and listen closely. By asking "What's driving you crazy?" or, "What gets in your way of managing diabetes?" you're much more likely to have a successful encounter.

Q3: *Does asking these types of questions have the potential to confuse people or, worse, put them off? They're thinking, "I came in to talk about food," or, "I came in to get a 'diet.'"*

A3: RDNs can lay out a few premises to begin the dialogue. For example: "We're here to talk about eating well with diabetes." Then follow up with one of these questions: "What does that mean to you? What have you been told? What's keeping you from managing your diabetes as well as you might want to?" Then use "normalizing language" to help the person feel that they are not "bad" or abnormal at all. For example: "Just like you, many people have shared with me how overwhelmed they feel by all of the dos and don'ts about foods and food choices they need to manage diabetes." Questions like these allow the RDN to follow up and get to the nugget of content that will be most important and relevant to this person today.

Q4: *Tell me more about the concept and value of using normalizing language?*

A4: Using this language allows clinicians to state what they think

is happening with the person, but in a way that makes the person feel comfortable and doesn't make them feel judged or accused. It lets them know you've seen the same with other people and that it's normal. For example, the RDN may say: "Many of the things that you're telling me are the kinds of things I often hear from someone who's having significant problems with [fill in]." Then stop and ask: "Is that true for you?" Using this kind of approach and language doesn't put a person in a box in which they feel a need to get defensive. Rather, it lets them speak to the topic. Helping people feel that their thoughts and feelings are normal and that they are not "bad" has the biggest effect in every population we've ever worked with. Having PWD feel that their clinician "gets it" is an enormous relief. It can put the RDN on the same side of the table with clients.

Q5: *How can RDNs address potential obstacles to clients' success?*

A5: Consider that obstacles to making changes might be lurking. The client could be depressed. They could be unconvinced that they have diabetes or that they can do anything about it. They may think diabetes is a death sentence or is in God's hand. Getting potential obstacles on the table at the beginning is a good idea. Using language such as: "Before we get into specifics about making changes in your eating habits, let's talk about what might make making changes difficult for you?" Some of these obstacles may come out in the Diabetes Distress Scale (DDS) (see Q/A7). RDNs can review DDS results and integrate observations into their assessment questions.

Q6: *What are some of the psychosocial assessment tools you suggest RDNs use?*

A6: There are many (2,3). Limit yourself to one or two (so as not to overwhelm your client). Use at least one diabetes-specific measure. I recommend the DDS (2). It's an excellent conversation starter, especially as you review their responses together and then allow this process to further direct your assessment questions. For measures that are not diabetes-specific, it can be valuable to ask the PHQ-2 questions (first 2 items of the PHQ-9 depression scale) though be forewarned that this is just a screener for depression (3). (Note: see Table 2 in reference 3 (open access article): Selected measures for the evaluation of psychosocial constructs in the clinical setting.) Another simple tool for understanding the individual and starting a useful conversation is the WHO-5, the World Health Organization five-item well-being scale (4).

Q7: *How can RDNs determine if/when a client needs a referral to a mental health provider/eating disorder specialist?*

A7: Using the normalizing language detailed above, state: "Many of the things that you're telling me are the kinds of things I often hear from someone who's having significant problems with depression or feeling out of control about eating." Then ask: "Does this fit your experience?" It says to the PWD, I'm alerted and I'm concerned that something serious is going on. If the client then confirms that this is true, the RDN can feel more confident that a referral is warranted.

Furthermore, using an approach like this makes it more likely that the client will accept such a referral. (Note: **See Table 1**—*Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment in the final article in this issue, Diabetes Associations Recognize Importance of Mental Health and Champion Provider Training.*)

Note: Polonsky and colleagues have developed a no-cost web-based program with nine video modules titled *Critical Psychosocial Issues in Diabetes*. CE credit is offered for CDE, PA, NP, RN and MDs. Access these (as well as the mugs) on the Behavioral Diabetes Institute website: <https://behavioraldiabetes.org>.

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Diabetes Associations Recognize Importance of Mental Health and Champion Provider Training

Introduction:

With increased recognition of the role of mental health (1) and peer support (2) in the short- and long-term health of people with diabetes (PWD), several diabetes associations have developed programs, publications and trainings. While these efforts take different approaches, they all focus on two key goals: 1) raising awareness among health care providers (HCPs) about the mental health of PWD; and 2) improving the skills of HCPs to attend to and treat the mental health of PWD. Registered Dietitian Nutritionists (RDNs) should be aware of and track these initiatives in order to engage in learning opportunities appropriate for skill building and continuing professional education.

American Diabetes Association: Mental Health Diabetes Education Program

The Mental Health Provider Diabetes Education Program Steering Committee, Alisa Barksdale, MPH, Associate Director of Professional Services & Collaborations, and Ryan Woolley, MSPH, RD, Associate Director of Evaluation and Outcomes Research

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In 2017 the American Diabetes Association (ADA) partnered with the American Psychological Association (APA) and mental health

experts to develop the Mental Health Provider Diabetes Education Program (MHDEP). This program was initiated to fill the growing need for mental health providers trained in the complexities of diabetes management and effective treatment strategies specific to PWD (1). The program is designed to teach mental health providers: 1) the demands of diabetes therapy on PWD and their mental health status and how to integrate this knowledge into mental health therapy; and 2) issues specific to adults or pediatric populations that enable mental health providers to better understand how diabetes uniquely impacts youth, young adults and adults across the lifespan.

For MHDEP training inclusion, participants must identify as a mental health provider. It's up to the participant to determine if the APA continuing education credits would apply to their specific credentials. To be listed in the directory, participants must show proof of state licensure as a mental health provider. Participants have primarily been PhD psychologists, social workers, and other licensed mental health professionals.

The program consists of a one-day, in-person workshop, followed by an online 5-hour course. Participants who meet all requirements are added to the ADA Mental Health Provider Referral Directory (<https://>

professional.diabetes.org/mhp_listing) as a resource to HCPs, PWD and their caregivers.

ADA’s Standards of Medical Care (2) recommends that HCPs routinely screen PWD for psychosocial challenges, including mental health concerns, and, if or when an issue is identified, refer individuals to a mental health provider with knowledge and experience in diabetes (1). Table 1 provides a list of situations that warrant referral of a PWD to a mental health provider (1). However, as this screening becomes part of routine diabetes care, there are a limited number of mental health providers with the knowledge and experience necessary to provide high quality mental health care for PWD.

Since the launch of this program in June 2017, 261 mental health providers have participated in the 7-hour in-person workshop. To gain insight into the motivations of participants and determine the impact of the program, the ADA conducted pre- and post-program evaluations. Among the 2018 program participants, 82% currently treat PWD. Most participants were primarily motivated to attend the training to gain knowledge to better treat their current patients. Our preliminary analysis using paired sample tests showed significant improvement in all areas of diabetes-related knowledge assessed ($p < 0.05$), most notably in psychological treatment approaches for PWD. In addition, self-efficacy to treat people with type 1 (T1D), type 2 (T2D), and prediabetes and populations of children/adolescents, adults, and parents significantly

improved ($p < 0.05$). Most program attendees currently treat adults with T2D, and in turn attendees reported the greatest perceived increase in confidence was in the treatment of these individuals. ADA will conduct follow-up evaluation of participants to assess the longer-term impact of the program.

With MHDEP well into its second year of implementation, focus is renewed on awareness campaigns to increase utilization of the Mental Health Referral Directory, as well as on-going education and resource support for participants who have completed the program. At least three in-person programs will be offered in 2019 at both ADA and APA professional education meetings, with additional opportunities pending. To address this significant need ADA continues to ensure support for the psychosocial challenges faced by PWD and their families.

For questions visit <https://professional.diabetes.org/mentalhealth> or email mentalhealthprogram@diabetes.org.

JDRF

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Anyone with type 1 diabetes (T1D), or who has a loved one with T1D, knows managing diabetes is an around-the-clock job of checking glucose levels, counting grams of carbohydrate, and dosing insulin (by pump or injection) to give just the right amount of insulin at just the right time. The physical elements of the job are then compounded by the emotional burden of life with a chronic disease. There are often overwhelming moments of fear, frustration and exasperation. The emotional burden and associated distress of managing diabetes have been observed to have a measurable

Table 1. Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment (1)

• If self-care remains impaired in a person with diabetes distress after tailored diabetes education
• If a person has a positive screen on a validated screening tool for depressive symptoms
• In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
• If intentional omission of insulin or oral medication to cause weight loss is identified
• If a person has a positive screen for anxiety or Fear of Hypoglycemia (FoH)
• If a serious mental illness is suspected
• In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
• If a person screens positive for cognitive impairment
• Declining or impaired ability to perform diabetes self-care behaviors
• Before undergoing bariatric surgery and after if assessment reveals an ongoing need for adjustment support

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impact on the clinical outcomes and overall health of people with T1D. In medical literature, distress is a better predictor of glycemic control than depression, especially amongst children and teenagers with T1D; and the burden and distress affect not just the overall health of the person with T1D, but also his or her family.

JDRF is committed to helping people with T1D manage the burden of diabetes to live their best lives possible. We are investing in psychosocial work as a part of the mission at JDRF. This means we are committed to helping people with T1D at all points along the life course and are creating programming for all ages and stages of people with T1D.

During 2018 we created several opportunities for young adults, including the JDRF College Internship Program, which places young adults with T1D with companies and diabetes organizations nationally, and the annual JDRF Young Adult Conference program (March 2019 in Dallas). We're collaborating on projects for women with T1D related to body image and expect to release a video series on life with T1D targeted to adults.

To train HCPs, JDRF is funding a program that improves capacity in psychological services for people with T1D. We are funding up to five specific diabetes psychology fellowships each year and orchestrating a T1D training program for those fellows. To date JDRF has trained seven fellows and all seven are now clinically licensed and working with individuals and families with diabetes.

JDRF is also integrating psychology into each of our 50+ Type One Nation

Summits. The diabetes community has shared their struggles with us and we have designed curriculum for the local summit events to meet those needs. Topics covered include family conflict, diabetes distress, diabetes transitions and more. We have amassed a team of approximately 35 psychologists nationwide who are participating in our summit programs and advising JDRF on our other psychology-related initiatives.

In November 2018, JDRF convened a meeting of national diabetes associations, clinicians, clinical psychologists, and research psychologists to identify opportunities to address the psychosocial needs of PWD. We identified the need for more evidence of cost saving of behavioral medicine to be able to integrate behavioral medicine services as a standard of diabetes care. A need to gather more evidence for group education/therapy and the use of digital resources to deliver care was also identified. Meeting attendees noted the need to make behavioral health services available and easy to access.

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The American Association of Diabetes Educators (AADE) and diabetes educators have, for many years, been engaged with and promoted the ongoing support of PWD as part of Diabetes Self-Management Education and Support (DSMES). The most recent 2017 National Standards for DSMES more strongly emphasizes the critical nature of support as an important aspect of successful diabetes care (3). The 2015 Joint Position Statement from ADA, AADE and the Academy of Nutrition and Dietetics developed an algorithm for the four critical junctures when DSMES should occur: at diagnosis, annually, when complicating factors arise, and during transitions in life and care (4). This joint statement is being revised for publication in 2019.

Regarding peer support and peer support communities (PSC), from 2010 to 2015, AADE began to collaborate with several PSC. Efforts during this timeframe centered on active participation at AADE's annual conferences (5). AADE has become increasingly committed to raising awareness of and referral to peer support and PSC to improve diabetes self-care, outcomes and positive mental health. In 2017, AADE formalized this collaboration and held two in-person meetings (5).

As part of this effort AADE has developed website content focused on peer support (<http://www.DiabetesEducator.org/peersupport>) that presently contains a video, a non-copyrighted resource list of reliable peer support resources (6) and more. A practice paper on mental health is now available (7). A publication on the value of online

and in-person peer support in diabetes care and the role of diabetes educators in recommending peer support to PWD is currently in development.

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CPE Credit Self-Assessment Questionnaire

After reading this issue of *On The Cutting Edge*, Overview of Common Psychosocial Barriers among People with Diabetes, current DCE members can earn 4.0 hours of free continuing professional education units (CPEUs level 2) approved by the Commission on Dietetic Registration (CDR). CPE eligibility is based on active DCE membership status from June 1, 2018 to May 31, 2019.

DCE members must complete the post-test of the CPEs page on the DCE website: <http://www.dce.org/resources/cpeus/> by 4/30/2021. For each question, select the one best response. After passing the quiz, to view/print your certificate, access your CPEU credit history or view the learning objectives, go to: <http://www.dce.org/account/history>.

Please record 4.0 hours on your Learning Activities log and retain the certificate of completion in the event you are audited by CDR. The certificate of completion is valid when the CPE self-assessment questionnaire is successfully completed, submitted, and recorded by DCE/Academy of Nutrition and Dietetics. *OTCE* is considered Pre-Approved Self-Study.

4 CPEUs are awarded for reading this issue and successfully completing the quiz. Access quiz and certificate by going on to www.dce.org professional resources. The website automatically logs your CPEU history.

1. "All or Nothing Thinking" is an example of which type of self-management barrier for persons with diabetes ?
 - a) Emotional
 - b) Cognitive
 - c) Social
 - d) Coping
2. Which of the following approaches used by health care providers inadvertently contribute to diabetes stigma?
 - a) Describing diabetes and available treatment options using highly-complex or technical language.
 - b) Avoiding discussions regarding the role of contributing factors such as weight and dietary intake.
 - c) Using language that infers failure when a person with diabetes does not reach suggested goals.
 - d) Discussing nutrition goals and food choices while avoiding terms such as "good" or "bad."
3. The Family Approach to Diabetes Management (FADM) includes which of the following recommendations for helping adolescents with diabetes and their parents with diabetes management tasks?
 - a) Having the diabetes educator assign roles or tasks to each family member to ensure that important tasks are being done regularly.
 - b) Help the family create a communication plan that uses frequent and thorough monitoring and questioning multiple times per day to assure that tasks are being performed.
 - c) Invite parents and children to list diabetes-related tasks the child can do themselves to allow them to assume more responsibility.
 - d) Assume that a very informed adolescent will nearly always follow through with important diabetes self-care behaviors on their own so reduced parental monitoring is appropriate.
4. Why might Latinos benefit from using Share Medical Appointments (SMAs) to deliver diabetes care?
 - a) Group visits can enhance social connectedness and community support valued in many Latino cultures.
 - b) Information shared between participants in a group can be more correct and appropriate because of shared beliefs.
 - c) Group participants are more likely to share faith-based beliefs which will always have a positive impact on how diabetes care approached.
 - d) Taking advantage of the family structures and beliefs always result in positive outcomes in spite of family backgrounds and beliefs
5. Which of the following statements are true regarding the role and importance of food in the black/African-American culture?
 - a) Dieting or restricting food is often seen as a strength that promotes positive change within the family.
 - b) Food preparation and seasoning are often seen as expressions of love.

- c) Food recommendations that focus on weight change are often more acceptable.
 - d) Discussions involving foods are equally important when blood sugar levels are well controlled or not.
6. Which of the following is a core premise for RDNs to keep in mind when counseling PWD?
- a. Managing diabetes has become easier over the years and it is not that difficult to manage on a day-to-day basis.
 - b. Well-controlled diabetes is the leading cause of blindness and kidney failure.
 - c. No one is unmotivated to live a long and healthy life.
 - d. The number of medications a PWD is taking reflect how well they manage their diabetes.
7. The technique of using normalizing language tends to make the client feel:
- a. Uncomfortable and judged.
 - b. It is best if the clinician decides what is best for the client to do.
 - c. They are in "a box" and often become defensive.
 - d. They can speak to the topic and that they are not "bad".
8. Minimally Disruptive Medicine is a model that defines treatment burden as:
- a. An objective measure of a person's workload in managing chronic illness
 - b. Pursuance of the patient's goals that have the least impact on their daily life
 - c. A subjective assessment of the impact of a person's workload on their well-being and quality of life
 - d. Being decreased when there is an intensification of treatment
9. Cognitive behavior therapy is a therapeutic approach that focuses on:
- a. Avoiding having the person attempt to reframe unrealistic thoughts.
 - b. Descriptors that use extreme words such as "never" or "impossible".
 - c. Problem-solving to enable the PWD to make rapid decisions necessary to manage their diabetes.
 - d. The relationship between thoughts, emotions, and behaviors.
10. A key function of peer support is to:
- a. Provide access to a network of support during acute crisis periods only.
 - b. Replace more formal health care services.
 - c. Provide linkages to clinical care and community resources.
 - d. Allow the PWD to remain isolated since all communication is done electronically.

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LETTERS TO The Editor

Have you ever wanted to ask an *OTCE* author a question after reading an article? Did you ever disagree with an author? Or maybe you just wanted to comment on something you read. The Letters to the Editor column is a forum to ask questions or comment about any of the *OTCE* articles that interest you. Please send your questions or comments to the *OTCE* editor at the following address:

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Let us hear from you!

