



RESPONSE TO COMMENT ON YOUNG-HYMAN ET AL.

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association. *Diabetes Care* 2016;39:2126–2140

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

The first issue raised is based on the view that ADA recommendations focused on mental illness rather than well-being or improvement of quality of life. We agree that psychosocially informed diabetes care involves more than attention to psychiatric comorbidity. We point the authors to the first set of general recommendations that cites the goal of care as “optimizing health outcomes and health-related quality of life,” which includes “addressing psychosocial problems upon identification” (2). Figure 1 (2) is structured to indicate that there are psychological adjustment issues, which are common, involving distress and diminished well-being but are not psychopathological, occurring on a continuum with more severe

psychopathologic conditions. Following this framework, the article articulates that poor quality of life and well-being may be illness related, life-stage specific, and/or exacerbated in vulnerable individuals. We also emphasize the importance of attending to nonpsychopathological emotional distress and improving emotional well-being by leading the position statement with recommendations for psychosocial issues impacting self-management and diabetes-related distress. As Snoek et al. state, there is need to include information on approaches practitioners can implement to promote positive well-being. However, attention devoted in our article to psychological distress reaching the level of diagnosis reflects the frequency with which providers can expect to encounter these problems, the likelihood that self-management will be adversely affected, and the strength of the evidence base to the support recommendations.

Starting the exploration of the issues outlined in the position statement with a general question such as “How well are you doing?” as suggested by Snoek et al. (1) appears quite reasonable and is consistent with our recommendation that “all care providers should include queries about well-being in routine care” (2). The

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

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

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