



COMMENT ON YOUNG-HYMAN ET AL.

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association.

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Articles in the December 2016 issue of *Diabetes Care* addressing psychosocial issues are important for diabetes care (1). Our recent comment in *The Lancet* also addresses the “forgotten burden” of mental illness in diabetes (2). We highlight our concerns below.

Although the recommendations of the American Diabetes Association (ADA) (3) are based on “patient-centered care” (now becoming cliché), we have yet to see this model in action, despite extensive publication about it over past decades. Many well-intentioned care providers, believing they already practice “patient-centered care,” continue to increase the patient’s anxiety and guilt by implying blame for above-target glycemic control and emphasizing the patient’s risk of complications because of “noncompliance.” We are concerned that these traditional attitudes, ingrained in clinical diabetes management and publications and focusing mainly on patient behavior, will not empower less judgmental care provider attitudes. Care providers’ behavior and attitudes are addressed (3) predominantly in the context of the patient’s behavior. Weinger et al. (1) reinforce the focus on patient behavior by quoting William James: “human beings can alter their lives by altering their attitudes of mind.”

Current diabetes care is often fragmented and episodic, despite recommendations for long-term care. Care models involving “patient-centered care” require long-term care (3), but how this is achieved in current medical systems is not addressed. An extensive review of diabetes distress treatments reported that general care providers were associated with reduced diabetes distress, perhaps owing to this long-term relationship (4). Long-term relationships require trust between care providers and patients, allowing patients to express lifestyle choices and feelings in a nonjudgmental environment where care providers grant patients responsibility for their actions and diabetes outcomes.

Unsurprisingly, “diabetes education” was recommended for treating diabetes distress (3), as repeatedly endorsed in the literature. However, this implies a lack of patient knowledge that has not been scientifically validated. Importantly, the study by Greenfield et al. (5) reported patients’ attitudes about their diabetes management. Instead of a lack of knowledge or the popular concept that patients “do not care” about their diabetes, they found patients actually “understood only too well their disease and their responsibilities” and frequently struggled “to accommodate diabetes” into their life (5). Their article highlights the enormity of living with

diabetes and the often unattainable expectations of care providers. In an extensive review of treatment options, diabetes education alone did not significantly alleviate diabetes distress (4). We believe the specific content and manner of diabetes education necessary to alleviate diabetes distress is unknown. Furthermore, when diabetes education “fails,” referral to a mental health provider is decided by the care provider (3), whose own attitudes are not scrutinized. Psychological interventions alone also did not significantly alleviate diabetes distress (4), which may not surprise as these options often do not address the context of the mental health problem.

Our concerns are that most behavioral and attitudinal change requirements center only on the patient and none center on the care providers. Long-term care is essential, but practical ways to achieve it are not sufficiently addressed, and most treatment options have not yet been validated in large randomized controlled trials.

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