

Il ruolo dello psicologico nella gestione del diabete tipo 1

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La dott.ssa Liliana Indelicato dichiara di aver ricevuto negli ultimi due anni compensi o finanziamenti dalle seguenti Aziende Farmaceutiche e/o Diagnostiche:

- Novo Nordisk

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OBIETTIVI



Problematiche psicologiche in persone con diabete tipo 1



La piramide della salute mentale



STAP Competency Framework



L'intervento psicologico in diabetologia: Verona Diabetes Transition Project



Il Diabete tipo 1 richiede sforzo continuo e ripetuto di adattamento



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

Deborah Young-Hyman,¹ Mary de Groot,²
Felicia Hill-Briggs,³ Jeffrey S. Gonzalez,⁴
Korey Hood,⁵ and Mark Peyrot⁶

Recommendations

- **Psychosocial care** should be integrated with collaborative, patient-centered medical care and provided to all people with diabetes, with the goals of optimizing health outcomes and health-related quality of life. **A**
- Providers should consider an **assessment of symptoms of diabetes distress, depression, anxiety, and disordered eating and of cognitive capacities** using patient-appropriate standardized/validated tools at the initial visit, at periodic intervals, and when there is a change in disease, treatment, or life circumstance. Including caregivers and family members in this assessment is recommended. **B**
- Consider monitoring patient performance of **self-management behaviors** as well as psychosocial factors impacting the person's self-management. **E**
- Consider **assessment of life circumstances** that can affect physical and psychological health outcomes and their incorporation into intervention strategies. **E**
- Addressing psychosocial problems upon identification is recommended. If an intervention cannot be initiated during the visit when the problem is identified, a follow-up visit or referral to a qualified behavioral health care provider may be scheduled during that visit. **E**

Psychosocial Care: Life Course and Continuum of Care

		Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
		Nonclinical (normative) symptoms/behaviors	Clinical symptoms/diagnosis
Phase of living with diabetes	Behavioral health disorder prior to diabetes diagnosis	None	- Mood and anxiety disorders - Psychotic disorders - Intellectual disabilities
	Diabetes diagnosis	Normal course of adjustment reactions, including distress, fear, grief, anger, initial changes in activities, conduct, or personality	Adjustment disorders*
	Learning diabetes self-management	Issues of autonomy, independence, and empowerment. Initial challenges with self-management demonstrate improvement with further training and support	- Adjustment disorders* - Psychological factors affecting medical condition**
	Maintenance of self-management and coping skills	Periods of waning self-management behaviors, responsive to booster educational or supportive interventions	- Maladaptive eating behaviors - Psychological factors** affecting medical condition
	Life transitions impacting disease self-management	Distress and/or changes in self-management during times of life transition***	- Adjustment disorders* - Psychological factors** affecting medical condition
	Disease progression and onset of complications	Distress, coping difficulties with progression of diabetes/onset of diabetes complications impacting function, quality of life, sense of self, roles, interpersonal relationships	- Adjustment disorders* - Psychological factors** affecting medical condition
	Aging and its impact on disease and self-management	Normal, age-related forgetfulness, slowed information processing and physical skills potentially impacting diabetes self-management and coping	- Mild cognitive impairment - Alzheimer or vascular dementia
		All health care team members (e.g., physicians, nurses, diabetes educators, dieticians) as well as behavioral providers	Behavioral or mental health providers (e.g., psychologists, psychiatrists, clinical social workers, certified counselors or therapists)
		Providers for psychosocial and behavioral health intervention	

All providers

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Behavioral providers

Quando inviare per una valutazione psicologica

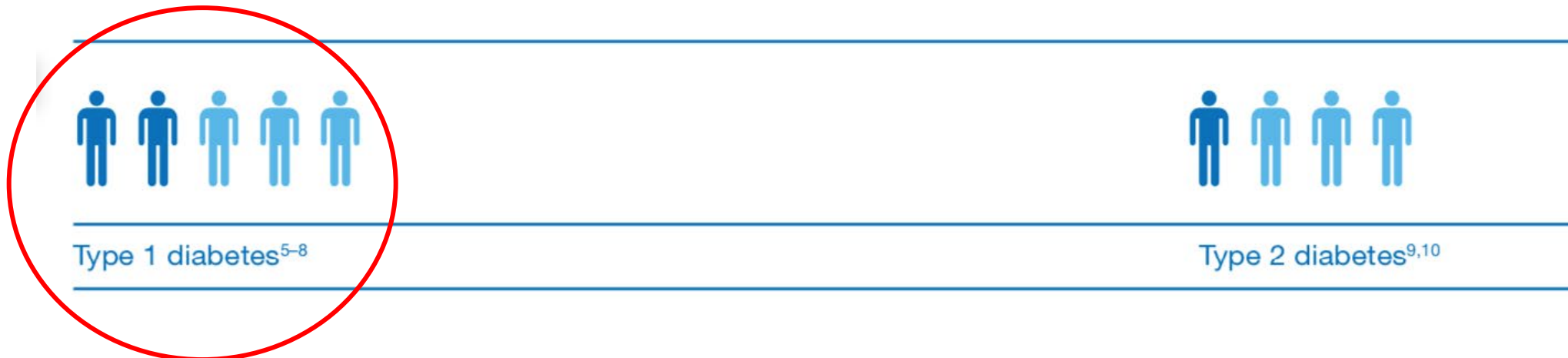
Table 1—Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment

- 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 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

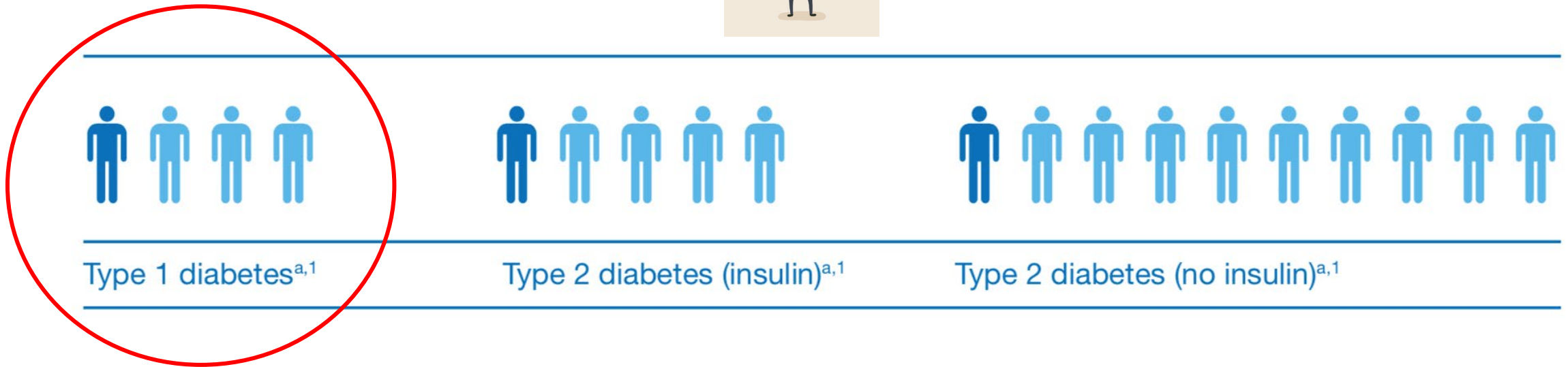
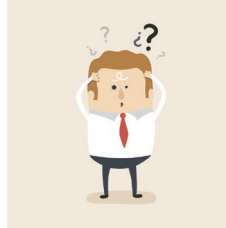
Sintomi depressivi



Disturbi del comportamento alimentare

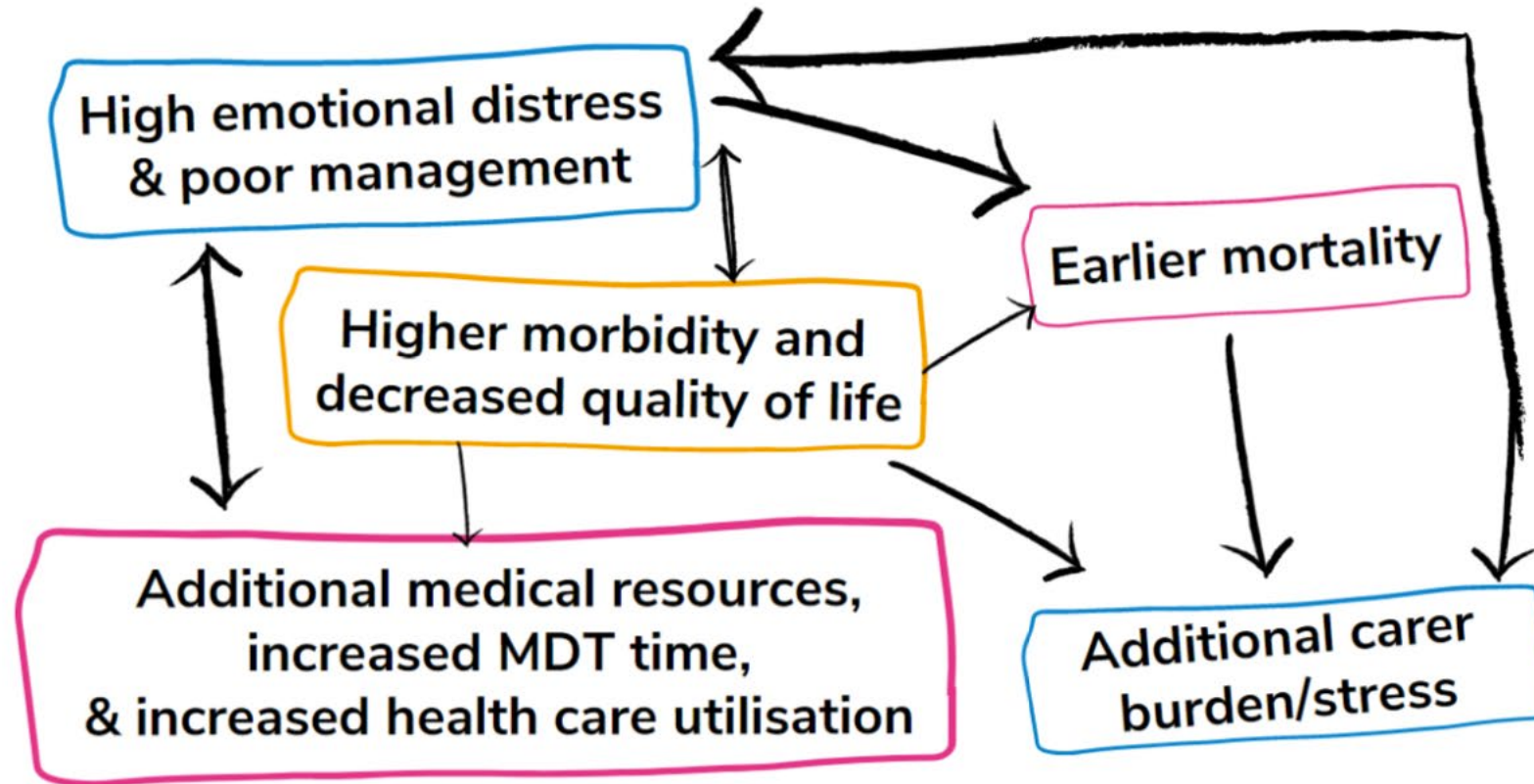


Quanto è frequente il diabetes distress in persone con diabete?

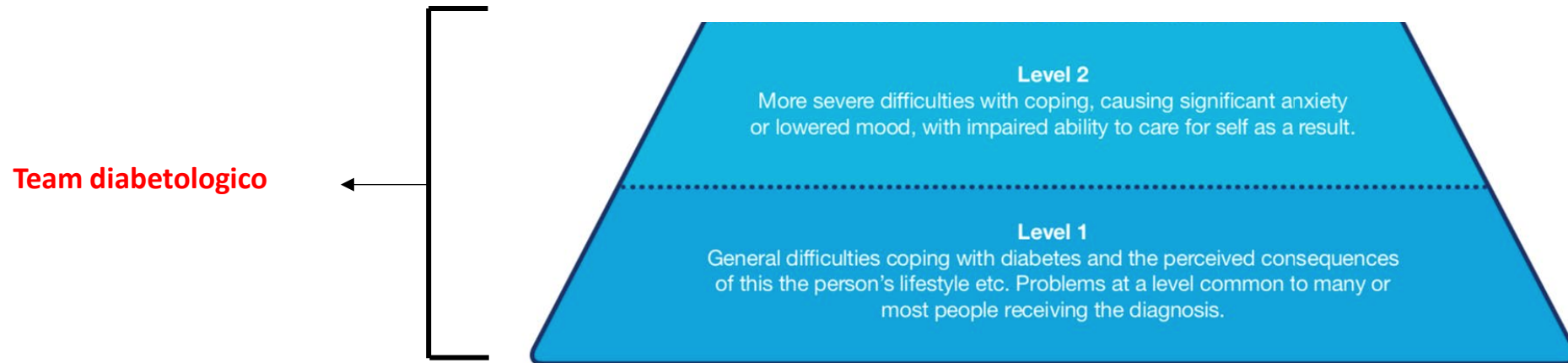


- **Il diabetes distress (DD)** è una forma di **disagio emotivo** causato dal diabete e dalla necessità di dover mettere in atto un complesso regime terapeutico.
- **Il DD** è più comune della **depressione** e in taluni casi le due forme di disagio possono confondersi.

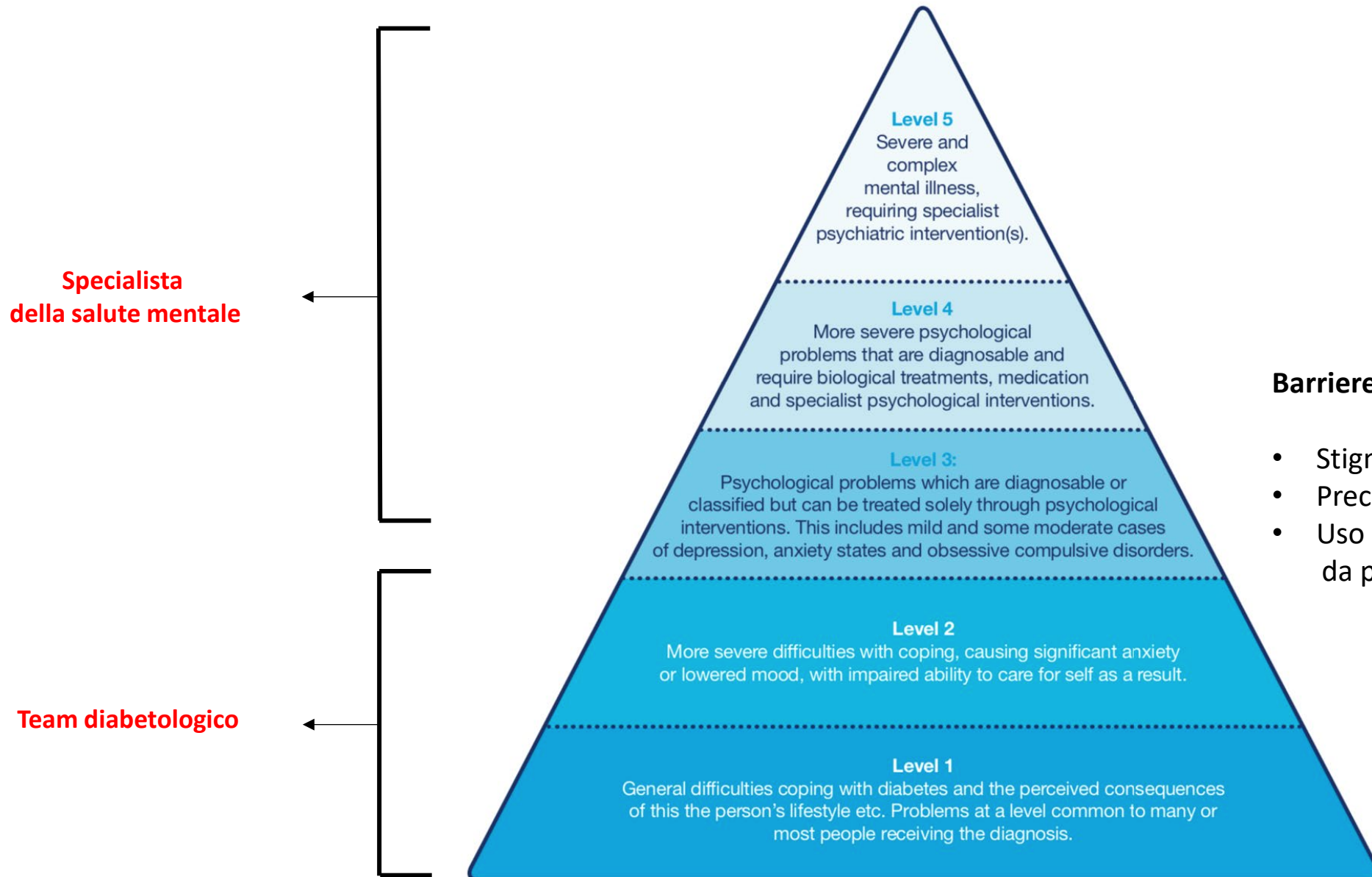
Impact of unmet psychological need in people with long-term physical health condition



DIVERSI LIVELLI DI INTERVENTO PSICOLOGICO



DIVERSI LIVELLI DI INTERVENTO PSICOLOGICO



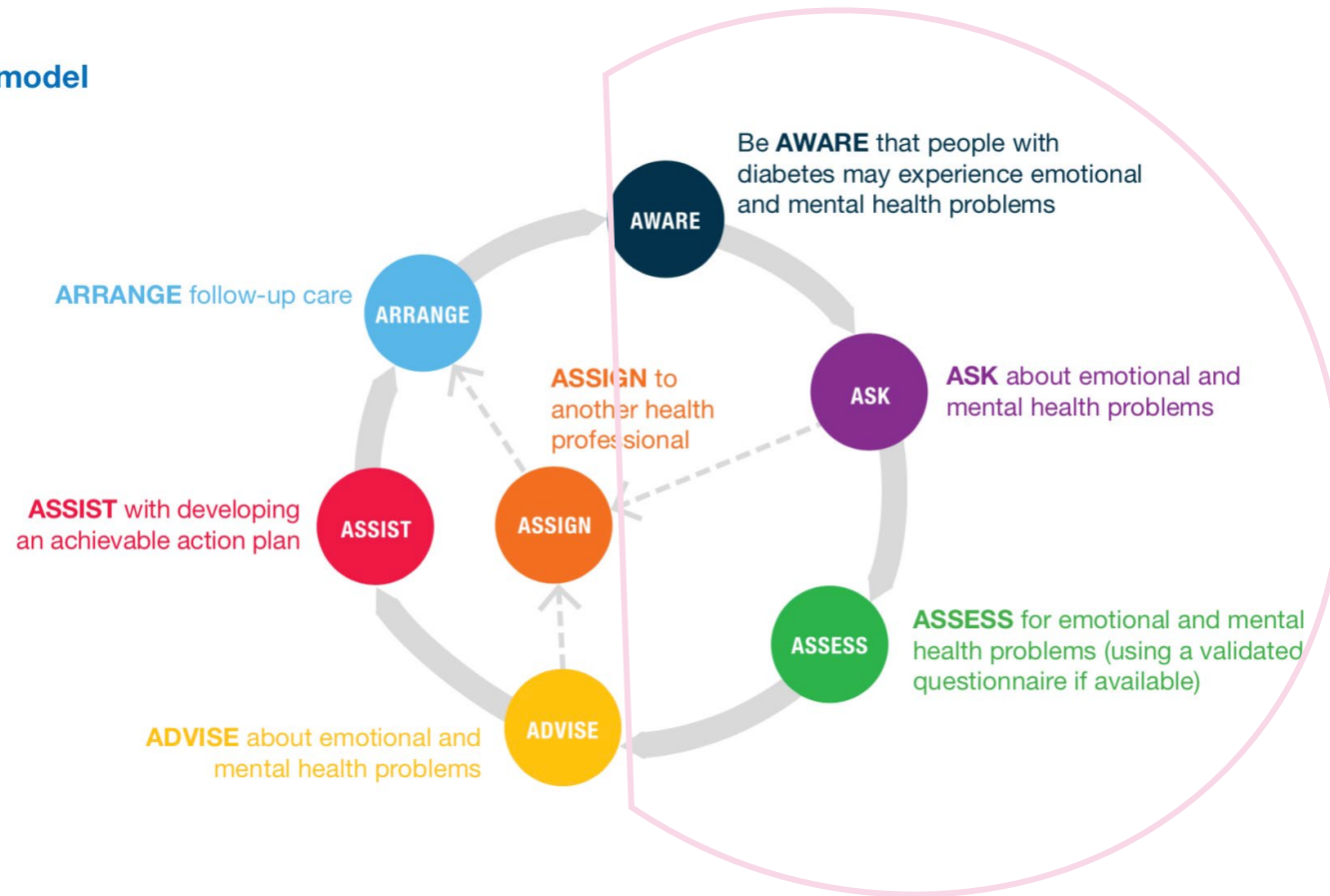
Barriere all'intervento psicologico

- Stigma interiorizzato
- Precedenti esperienze negative
- Uso di un linguaggio inappropriato da parte del medico

7A's model

Come posso intervenire?

ADVICE
ASSIST
ASSIGN
ARRANGE



Come posso riconoscere il disagio psicologico?

Be AWARE
ASK
ASSESS

Roles and competencies of the clinical psychologist in adult diabetes care—A consensus report

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Katarzyna Cyranka^{6,7} | Christel Hendrieckx^{8,9} | Norbert Hermanns^{10,11} |
Liliana Indelicato¹² | Brian E. McGuire¹³ | Andreia Mocan¹⁴ | Giesje Nefs^{15,16,17} |
William H. Polonsky^{18,19} | Rose Stewart²⁰ | Michael Vallis²¹

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Abstract

Aims: Psychological care is recognised as an integral part of quality diabetes care. We set out to describe the roles and competencies of the clinical psychologist as a member of the multidisciplinary adult diabetes care team, focused on secondary care.
Methods: The authors are clinically experienced psychologists involved in adult diabetes care, from Australia, Europe and North America, and active members of the international psychosocial aspects of diabetes study group. Consensus was reached as a group on the roles and competencies of the clinical psychologist working in adult diabetes secondary care, building both on expert opinion and a selective review and discussion of the literature on psychological care in diabetes, clinical guidelines and competency frameworks.

Results: The clinical psychologist fulfils multiple roles: (1) as a clinician (psychological assessment and therapy), (2) as advisor to the healthcare team (training, consulting), (3) as a communicator and promotor of person-centred care initiatives and (4) as a researcher. Four competencies that are key to successfully fulfilling the above-mentioned roles in a diabetes setting are as follows: (a) specialised knowledge, (b) teamwork and advice, (c) assessment, (d) psychotherapy (referred to as STAP framework).

Conclusions: The roles and competencies of clinical psychologists working in diabetes extend beyond the requirements of most university and post-graduate curricula. There is a need for a comprehensive, accredited specialist post-graduate training for clinical psychologists working in diabetes care, building on the proposed STAP framework. This calls for a collaborative effort involving diabetes organisations, clinical psychology societies and diabetes psychology interest groups.

KEY WORDS

clinical psychologist, competencies, diabetes care, roles, training



STAP

Acronimo proposto recentemente da un panel di esperti per definire le principali competenze dello psicologo in diabetologia

Specialised Knowledge
Teamwork
Assessment
Psychotherapy

Roles and competencies of the clinical psychologist: STAP Framework

Roles

1. **As a clinician** psychological assessment and therapy
2. **As a advisor** to the healthcare team (training, consulting)
3. **As a communicator and promoter** of person-centred care initiatives
4. **As a researcher**

General psychological support and disease-specific therapies

- Focused on diabetes distress
- Fear of hypoglycaemia
- Type 1 disordered eating
- Technologies

Competencies (STAP framework)

1. Specialised knowledge
2. Teamwork and advice
3. Assessment
4. Psychotherapy

Summary of key competencies for clinical psychologists in diabetes care (STAP framework)

Specialised (diabetes) knowledge

- Ezologia e epidemiologia del diabete
- Sintomi, segni e rischi
- Ipoglicemia/iperglicemia
- Complicanze diabete correlate
- Trattamenti
- Metriche: HbA1c, Time in Range, Time Above Range, Time Below Range, variabilità
- Impatto del diabete sulle capacità cognitive
-

Assessment

- Modello Bio-psico-sociale
- Conoscere e usare strumenti specifici per il diabete (Es. PAID, HFS)
- Esordio, credenze, vissuti correlati al diabete
- Auto-regolazione
- Supporto sociale/familiare
- Salute sessuale
- Principali problematiche psicologiche correlate al diabete
- Comportamento alimentare, disturbi alimentari con caratteristiche specifiche associate al diabete

Teamwork and advice

- Lavorare in team
- Consultazione
- Formazione, supervisione
- **Agire come ponte tra la diabetologia e i servizi territoriali**
- Condurre ricerche e divulgazione scientifica
-

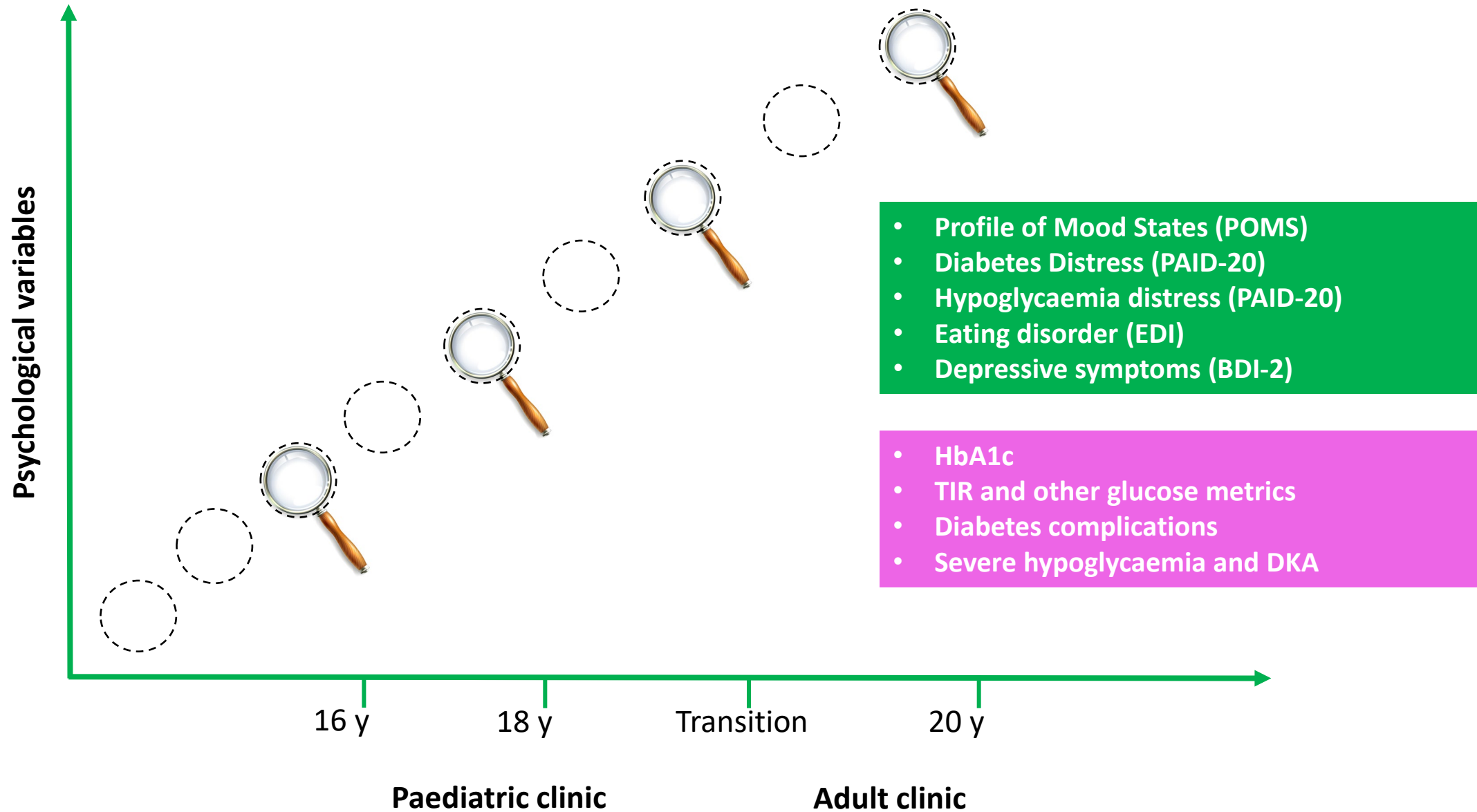
Psychotherapy

- Psicoterapie evidence-based
- Setting diversificati (face-to-face e/o online, gruppo/individuale, coppia/familiare)
- Promuovere engagement nella cura del diabete
- Promuovere la salute mentale
- Adattare l'intervento psicologico agli obiettivi terapeutici
-

Verona Diabetes Transition Project:

Liliana Indelicato

on behalf of S. Zaffani, S. Fasoli A. Csermely L. Santi, V. Mancioffi, R. Bonadonna, C. Maffei, M. Trombetta



Clinical features of Boys and Girls with T1D enrolled in the “Verona Diabetes Transition Project” before Transition (at age 16)

	All (n=91)	Boys (=43)	Girls (n=48)	P value
CGM/SMBG (%)	86.7/13.3	90.7/9.3	83/17	.36
CSII/MDI (%)	51.1/48.9	42.9/57.1	58.3/41.7	.20
% sensor active time	80.9±21.5	83.0±15.9	79.0±24.7	.69
BMI (kg/m ²)	23.5±4.1	22.6±3.8	24.3±4.2	.05
TIR (%)	60.2±14.6	62.0±16.1	59.0±13.5	.57
HbA1c (%)	7.4±0.8	7.4±0.8	7.5±0.8	.66
Profile of Mood States -POMS-T (Score)	46 [41-54]	43 [38-51]	52 [43-62]	<.001
Profile of Mood States-POMS-D (Score)	46.5 [42-54]	44 [41-47]	51 [44-58]	<.001
Profile of Mood States-POMS-A (Score)	49 [44-59]	48 [43-55]	52 [45-63]	.01
Profile of Mood States-POMS-V (Score)	56 [48-63]	59 [51-64]	51 [44-61]	.02
Profile of Mood States-POMS-S (Score)	54 [46-63]	48 [46-57]	59 [50-68]	<.001
Profile of Mood States-POMS-C (Score)	50 [43-59]	45 [41-52]	54 [45-63]	<.001
Diabetes Distress –PAID (Score)	11 [6-22]	8 [4-16]	17.5 [9-26]	<.001
Beck Depression Inventory BDI – II (Score)	7 [4-13]	6 [2-11]	10 [5-17]	.00
Eating Disorder Inventory - EDI DT (Score)	5 [1-14]	3 [0-6]	12 [2-17]	< .001
Eating Disorder Inventory - EDI B (Score)	2 [0-5]	1 [0-3]	3 [1-6]	.00
Eating Disorder Inventory - EDI BD (Score)	7.5 [1-20]	4 [0-8]	17 [4-24]	<.001

Data are presented as mean ± DS, median [interquartile range] or percentages



Glucose control, psychosocial factors and distress in all subjects with T1D enrolled in the “Verona Diabetes Transition Project” before Transition and at first adult clinic attendance

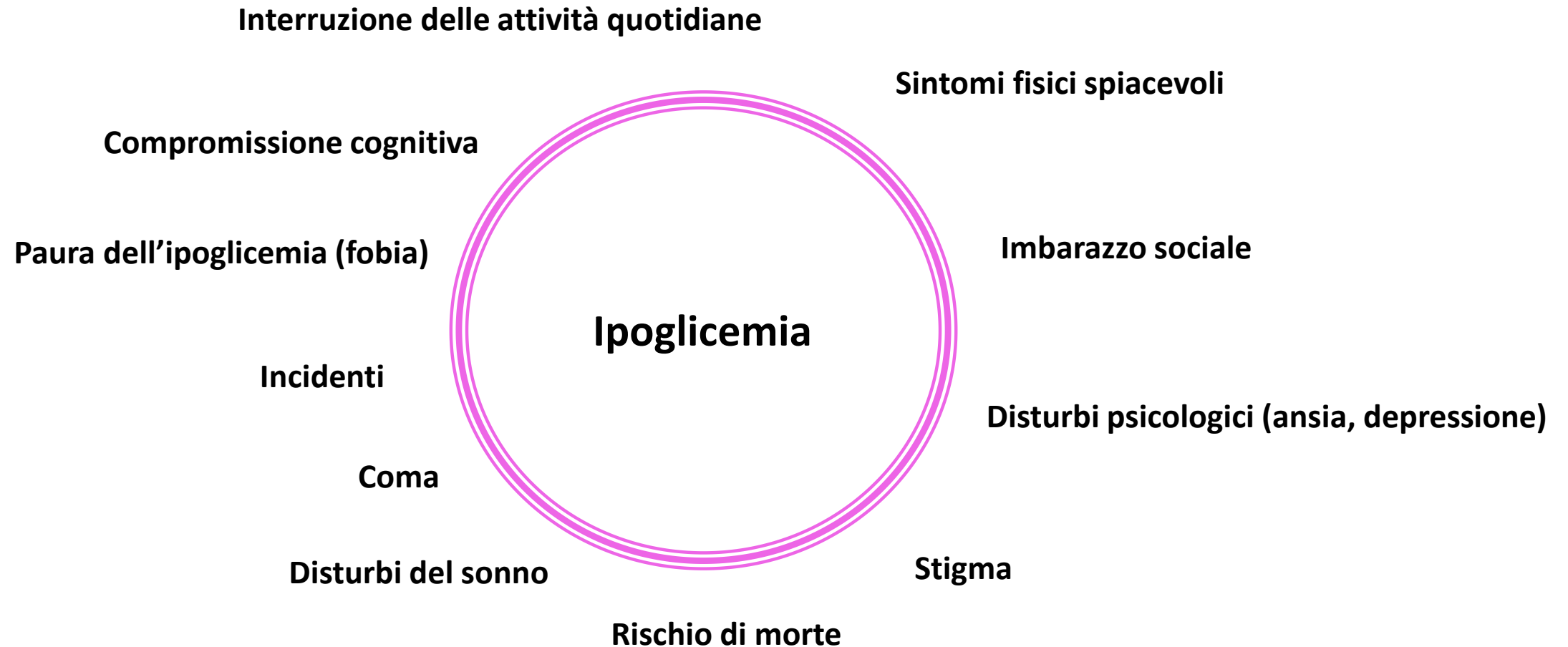
Variables	Baseline 16y (n=41)	Follow-up 18y (n=41)	P-value
HbA1c (%)	7.4 ± 0.8	7.6 ± 1.0	.33
POMS – T	46 [41-55]	49 [43-54]	.09
POMS – D	46 [42-54]	49 [43-51]	.05
POMS - A	49 [44-59]	47 [44-56]	.14
POMS – V	56 [48-63]	54 [41-63]	.03
POMS – S	54 [46-63]	54 [48-61]	.16
POMS - C	50 [43-60]	52 [47-56]	.16

Data are presented as mean ± DS, median [interquartile range]

I dati preliminari del **Verona Diabetes Transition Project** confermano la necessità di interventi psicologici strutturati in **giovani con diabete tipo 1** al fine di ridurre l’impatto negativo del distress correlato alla malattia

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**Making emotional and psychological
support routine in diabetes care.**

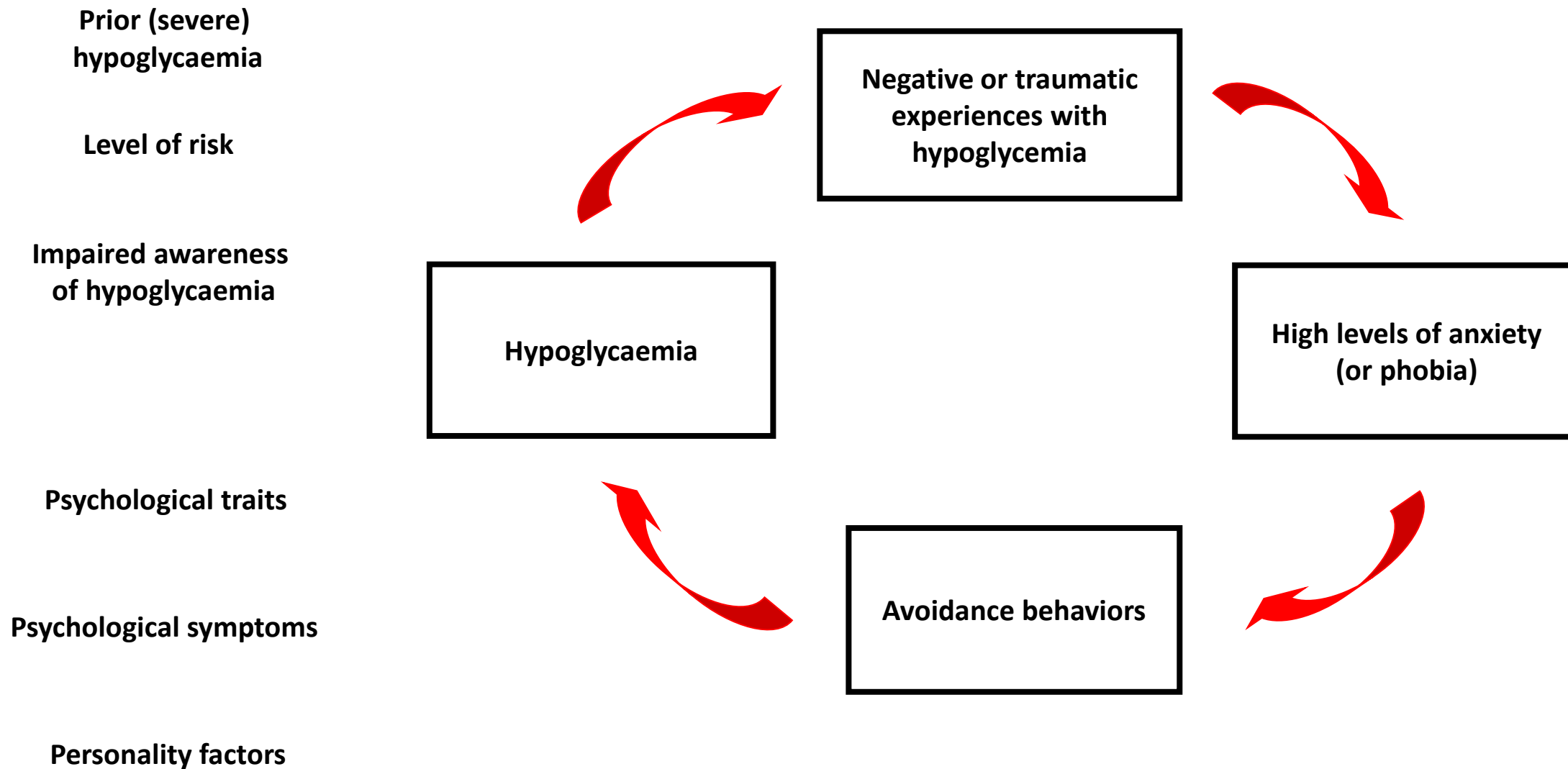


Paura dell'ipoglicemia (FOH): Paura associata a un episodio di ipoglicemia e alle sue possibili conseguenze (Gonder-Frederick et al., 2011).

CONSEGUENZE

- **Maggior distress psicologico** (Martyn-Nemeth et al., 2016):
 - Attacchi di panico
 - Agorafobia
 - Disturbo d'ansia generalizzata
 - Depressione
 - Conflitti familiari
- **Ridotta qualità della vita** (Martyn-Nemeth et al., 2016)
- **Limitazione della propria autonomia (astensione dall'uso di mezzi pubblici, difficoltà a stare da soli in determinate situazioni, limitazione nell'attività fisica)** (Martyn-Nemeth et al., 2016)
- **Monitoraggio ossessivo della glicemia** (Gonder-Frederick et al., 2011)
- **Disturbi del sonno** (Martyn-Nemeth et al., 2016)
- **Peggior controllo glicemico** (Martyn-Nemeth et al., 2016)
- **Maggior rischio di complicanze** (Anderbro et al., 2015)

LA RELAZIONE TRA IPOGLICEMIA E DISTRESS PSICOLOGICO: Modello ansia-evitamento



Ipoglicemia e distress psicologico

High fear/Low risk	High fear/High risk
Low fear/High risk	Low fear/Low risk

There is not a single intervention to reduce fear of hypoglycaemia *per se*

Educational and psycho-educational interventions that address problematic hypoglycaemia: sintesi

Intervention	Description
BGAT Blood Glucose Awareness Training Programs	8-week psycho-educational training designed to improve individuals' ability to: 1) anticipate extreme glucose levels; 2) detect presence of extreme glucose levels; 3) treat extreme glucose levels; 4) prevent future extreme glucose levels.
DAFNE Dose Adjustment for Normal Eating	5-day, group-based outpatient structured type 1 diabetes education programme , designed to equip participants with the skills required for flexible intensive insulin therapy
HyPOS	Psycho-educational program inspired by BGAT, with focus on avoidance of hypoglycaemia and excluding 'basic' diabetes education content. Includes five weekly 90-min group session.
HypoAware:	4-week programme designed to improve: a) hypoglycaemia symptom recognition, b) prevention and treatment of hypoglycaemia, c) coping with the psychosocial consequences of hypoglycaemia. Includes three facilitated group sessions (2.5 h each) supplemented with internet-based modules including educational texts, videos, exercises, self-assessments, an action plan.
My Hypo Compass	Brief, standardized, 1- to 2-h hypoglycaemia-focused psycho-educational intervention , designed to facilitate reflection on personalised factors associated with hypoglycaemia and formulation of individualized plans to prevent further significant episodes without relaxing HbA _{1c}