RESPONSE TO COMMENTS ON YOUNG-HYMAN ET AL.

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Thanks to Drs. Kalra, Balhara, Mezuk, Pouwer, and Campbell and Ms. Macdonald for their careful consideration (1–3) of the first American Diabetes Association (ADA) psychosocial guidelines Position Statement (4). Kalra and Balhara (1) note the overlaps and differences in the content of the ADA and Indian position statements, with particular emphasis on the cultural appropriateness and specificity of recommendations. Mezuk and Pouwer (2) question the need for routine screening for depression in persons with impaired glucose metabolism and undiagnosed diabetes based on meta-analytic results (5) and note the need to address disparities in diabetes burden and quality of care. They further suggest the need for action steps for practitioners once psychosocial issues are identified that impact health outcomes. These concerns are echoed by Macdonald and Campbell (3) when identifying that emphasis on compliance can cause blame to be placed on patients through misguided interpretation of the patient-centered paradigm. They suggest that this might be avoided through “long-term” care, by which they appear to mean the relationship formed through long-term follow-through by a consistent care provider.

These authors identify social issues that are not explicitly addressed in the ADA Position Statement: barriers to getting married, gender-based issues, geographically based management challenges, culturally specific intervention strategies for increasing well-being, disparities in burden and quality of care for racial/ethnic minorities, and the need for relationship-based care, i.e., provider understanding of personal needs rather than only reliance on treatment algorithms. The importance of individual needs and cultural context is thereby emphasized. Whether with regard to phase of life, availability of medical resources, and/or broader cultural issues that are endemic and therefore interact with care, no one set of guidelines or recommendations will be applicable to all people affected by this global epidemic. Thus, person-based and contextual factors must always be considered in order to optimize treatment and outcomes (4).

As noted, some content areas such as compassion fatigue of caregivers, provider assumptions regarding burden of care and burnout, and drug addiction were not included in the ADA Position Statement. This first Position Statement was limited to topics regarding psychosocial issues with evidence-based literature that included problem prevalence and effective treatment approaches and that provided support for recommendations. It is our expectation that additional evidence-based reviews and future position statements will address special topics and populations not covered in this first statement. The need for tested interventions to remediate disparities in burden of care, delivery, and quality of care is particularly critical given exponential increases in global diabetes prevalence (6).

Also highlighted were issues addressed in the ADA guidelines but not recommended in European and Indian guidelines: preconception counseling, diabetes distress, fear of hypoglycemia, depression screening for those individuals with prediabetes, etc. The Australian authors (3) also suggest that patient-centered care as actually implemented may increase diabetes distress and that diabetes self-management education and support or psychological treatment may be unable to alleviate diabetes distress (although

Deborah Young-Hyman,1 Mary de Groot,2 Felicia Hill-Briggs,3 Jeffrey Gonzalez,4,5 Korey Hood,6 and Mark Peyrot7

1Office of Behavioral and Social Sciences Research, Office of the Director, National Institutes of Health, Bethesda, MD
2Department of Medicine, Indiana University School of Medicine, Indianapolis, IN
3Department of Medicine, Johns Hopkins University School of Medicine, and Welch Center for Prevention, Epidemiology and Clinical Research, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
4Ferkauf Graduate School of Psychology, Yeshiva University, New York, NY
5Department of Medicine and New York Regional Center for Diabetes Translation Research, Albert Einstein College of Medicine, Bronx, NY
6Stanford University, Stanford, CA
7Department of Sociology, Loyola University Maryland, Baltimore, MD

Corresponding author: Deborah Young-Hyman, deborah.young-hyman@nih.gov.

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the review they cited identifies these interventions as effective strategies). The ADA Position Statement emphasis on patient-centered care may reflect the Western view of health care and individual agency in determining health outcomes, with emphasis on self-management behavior (7) and decision-making (8), but it needs to be implemented within a context that does not engage in patient blaming. An- other important point made by Macdonald and Campbell (3) is the differences between approaches to psychological inter- vention: screening, coping paradigms, and therapies to facilitate well-being and adaption to burden of illness. Although they may be called different things—risk assessment in the case of depression (9), interpersonal or cognitive behavioral therapy—simultaneous medical and psychologi- cal treatment has been shown to potentiate well-being and health for peo- ple with diabetes (10,11). Given that de- pression and other psychiatric disorders are known risk factors for development of diabetes and a significant percentage of those affected by diabetes remain undi- agnosed (9), preclinical screening in vulnerable individuals is justified. Effective care paradigms that include routine screening and improve well-being and health out- comes need to be more broadly adapted and offered. As Mezuk and Pouwer (2) and Macdonald and Campbell (3) note, capacity building of providers and health care systems, as well as actionable pro- vider treatment algorithms, are key to achieving this goal. Provider behavior must also be altered to facilitate shared treatment goals and decision-making. How this is best accomplished has not been systematically studied. Develop- ment of effective collaborative care sys- tems and delineation of provider roles in team care is in its infancy (12). In consider- ing implementation of the ADA psycho- social guidelines, it has been suggested that a systematic review of existing care systems and provider attitudes and roles could be informative.

There are now a number of position statements regarding psychosocial care that represent foundational steps to address these important issues (13). There are vary- ing paradigms for provision of care, with some medical milieus more or less amena- ble to shared decision-making, collaborative care, and long-term care provision. More effort needs to be made to synthesize and learn from implementation of recommenda- tions among diverse populations to help establish best practices that may have greater universality and/or applicability to a variety of cultural milieus.

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References