**QUEEN'S
UNIVERSITY
BELFAST**

Do people with diabetes who need to talk want to talk?

Davies, M., Dempster, M., & Malone, A. (2006). Do people with diabetes who need to talk want to talk? *Diabetic Medicine*, 23(8)(8), 917-919. <https://doi.org/10.1111/j.1464-5491.2006.01892.x>

Published in:
Diabetic Medicine

Document Version:
Early version, also known as pre-print

Queen's University Belfast - Research Portal:
[Link to publication record in Queen's University Belfast Research Portal](#)

General rights

Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

DO PEOPLE WITH DIABETES WHO NEED TO TALK WANT TO TALK?

By:

Dr Mark Davies*, Consultant Clinical Psychologist,
Clinical Psychology Department, Belfast City Hospital

Dr Martin Dempster, Lecturer,
School of Psychology, Queens University, Belfast

Anne Malone, Trainee Clinical Psychologist,
School of Psychology, Queens University, Belfast

*Correspondence: Dr Mark Davies, Consultant Clinical Psychologist, Clinical Psychology Department, Belfast City Hospital, 95 Lisburn Road, Belfast BT9 7AE.

Tel: 02890 263935

Fax: 02890 263915

Email: mark.davies@bch.n-i.nhs.uk

ABSTRACT

Aim To examine whether the people with diabetes who ask for psychological support are those who are experiencing clinically significant levels of psychological distress.

Method In total 300 people with diabetes were asked to complete psychometrically validated questionnaires that assessed subjective need and objective psychological distress.

Results High levels of psychological distress were reported: 25% of the sample reported depressive symptomatology, 41% reported clinically significant levels of anxiety and 51% reported a degree of binge eating behaviour. Participants also indicated a desire to talk to diabetes professionals about various problem areas in diabetes. Chi-square analysis demonstrated that those reporting psychological distress, especially depression, were most likely to indicate a desire to talk to somebody about living with diabetes.

Conclusions Those who want to talk are those who need to talk. Future service development issues should acknowledge the needs and expressed wishes of service users.

Keywords Depression, anxiety, binge eating, service users, psychological support.

(WORD COUNT: 153)

INTRODUCTION

Momentum for the development of psychological support services for people with diabetes has gathered pace recently. It has long been recognised that there is a very high prevalence of clinically significant psychological distress in the population of people with diabetes [1,2,3]. Importantly psychological distress leads to non-compliance, and consequent microvascular and macrovascular complications [4]. However it is perhaps people with diabetes themselves who have been most influential in calling for the development of psychological support. For example in Northern Ireland, recent service development guidelines [5] identified the psychological support of people with diabetes as an area for early action. As part of the process of drawing up these guidelines, patients were consulted, via a postal questionnaire, as to what they perceived to be their service development priorities. In total 2750 questionnaires were distributed to people with diabetes throughout Northern Ireland, and 1314 were returned. The single most requested improvement, cited by 32% of respondents, was access to psychological support [6].

It is not clear, however, whether those who are identifying psychological support as an unmet need are in fact those who are demonstrating the highest levels of psychological distress. South and East Belfast Health and Social Care Group recently commissioned research aimed at establishing the demand for psychological support in their area. As part of this study, people diagnosed with diabetes in South and East Belfast were asked about the services they receive and whether they perceive that their psychological needs are being met. In addition people with diabetes were asked to comment on whether they felt that they needed to talk to diabetes professionals about the practical and emotional

impact of diabetes, and were screened using self-report questionnaires for psychological distress. This short paper explores the relationship between expressed need to talk and psychological distress.

METHODS AND PATIENTS

A convenience sample of 300 people with diabetes, resident in South and East Belfast was obtained from both hospital diabetes clinics and through the diabetes register of general practitioners in the area. Ethical approval was obtained from Queens University of Belfast ethics committee and each participant completed a written consent form. Males and females were equally represented in the sample, 39% of the respondents had Type 1 Diabetes Mellitus and 61% had Type 2. The age of respondents ranged from 16 to 91 years, with a mean age of 55.4 years. The length of time since diagnosis ranged from 1 month to 44 years, with a median of 6 years.

Participants were contacted by post and asked to complete a number of questionnaires including the Hospital Anxiety and Depression Scale (HADS) [7], the Binge Eating Scale (BES) [8], and the Problem Areas in Diabetes scale (PAIDs) [9]. The PAIDs was chosen as it lists problem areas often experienced by people with diabetes, but was modified insofar as respondents were asked if they would like to talk to a diabetes professional about each of the items, rather than indicating the degree to which each item is true. People were asked to respond 'yes' only if they felt they required additional emotional support for that particular issue. One item, relating to satisfaction with diabetes physician, was omitted.

For the HADS, scores for the anxiety dimension and the depression dimension are interpreted as follows: 0-7 normal, 8-10 mild, 11-14 moderate, 15-21 severe. For the BES, scores are interpreted as follows: ≤ 17 mild or no bingeing, 18-26 moderate bingeing, ≥ 27 serious bingeing. Both the BES and the HADS have good validity and reliability [10,11] and have been used previously among people with diabetes [12,13,14].

RESULTS

Evidence of depressive symptomatology was reported in 25% of the sample, and significant levels of anxiety were reported by 41% (percentages were similar for people with Type I and Type 2 diabetes). On the BES, 51% reported a degree of binge eating behaviour, with almost 30% reporting severe binge eating behaviour. Moderate levels of binge eating behaviour was more prevalent among people with Type 1 compared to Type 2 diabetes, whereas severe levels of binge eating was more prevalent among people with Type 2 compared to Type 1 diabetes.

Chi-square tests were used to examine the association between scores on the HADS and the BES (using the mild, moderate and severe classification categories on each of these scales) on one hand and the patients' desire (or not) to discuss problem areas in diabetes (as specified by the PAIDs) on the other (using a dichotomous yes/no response). The results are summarised in Table 1. Problem areas identified in Table 1 are presented in rank order according to the percentage (in brackets) of respondents who wished to discuss the problem. The pattern of results in Table 1 was similar for all the problem areas where statistically significant results were found. In each case, the higher the score on the HADS or the BES, the more the patients wished to discuss the area identified. No

statistically significant differences were found between people with Type 1 and Type 2 diabetes on this pattern of association. Overall, it appears that depression scores showed the strongest association with desire to discuss problem areas in diabetes.

Table 1: Associations between HADS and BES scores and the desire to discuss problem areas in diabetes

	HADS-A	HADS-D	BES
Not knowing if the mood or feelings you are experiencing are related to your blood sugar levels (28.5%)	***	***	***
Feeling constantly concerned about food (18.6%)	**	***	***
Feeling guilty or anxious when you get off track with your diabetes management (17.2%)	**	***	***
Worrying about low blood sugar reactions (16.3%)	**	**	**
Worrying about the future and the possibility of serious complications (15.9%)	*	***	
Not having clear and concrete goals for your diabetes care (15.9%)	***	***	***
Feeling discouraged with your diabetes regime (14.9%)	***	***	***
Feeling depressed when you think about living with diabetes (13.9%)	**	***	*
Coping with the complications of diabetes (13.2%)			
Feeling that diabetes is taking up too much mental and physical energy (12.5%)	*	***	**
Feeling constantly burned-out by the constant effort to manage diabetes (12.2%)	*	***	***

Feeling scared when you think about living with diabetes (10.8%)	*	**	**
Feeling alone with diabetes (10.5%)			
Feeling overwhelmed by your diabetes regimen (9.8%)	**		
Feelings of deprivation regarding food and meals (9.8%)	**	***	***
Feeling angry when you think about living with diabetes (9.2%)	**	***	
Not accepting diabetes (7.4%)	**	***	
Feeling that friends / family are not supportive of diabetes management efforts (6.1%)	***	***	
Uncomfortable interactions around diabetes with family / friends (5.7%)	*	***	*

* $p < .05$; ** $p < .01$; *** $p < .001$; values in brackets refer to the percentage of the sample (n = 300) who reported a desire to talk to someone about the issue.

DISCUSSION

Consistent with other studies, high levels of psychological distress were evident in the 300 people with diabetes who participated in this piece of work, though rates of self-reported binge eating behaviour were comparatively high. The results of this study also demonstrate that those who express a desire to talk about issues concerning their diabetes are more likely to experience high levels of psychological distress. It would appear that people with diabetes recognise the impact that living with diabetes has on their mental health. Moreover it appears that ‘talking approaches’ are considered a helpful strategy. Diabetes professionals suggest that psychological support services should be part of the diabetes team (i.e. people should not be referred to separate mental health services) and that diabetes professionals themselves require additional training in psychological issues [15]. However, the opinions of people with diabetes have not been sought into these issues. Nevertheless, these data suggest that people with diabetes who are experiencing high levels of psychological distress wish to engage with psychological support services.

WORD COUNT (excluding references) **1521**

REFERENCES

1. Anderson RJ, Lustman PJ, Clouse RE, de Groot M, Freeland KE. Prevalence of depression in adults with diabetes: a systematic review. *Diabetes* 2000; **49**: A64
2. Grigsby AB, Anderson RJ, Freeland KE, Clouse RE, Lustman PJ. Prevalence of anxiety in adults with diabetes: a systematic review. *J Psychosomatic Res* 2002; **53**: 1053-1060
3. Crow S, Kendall D, Praus B, Thuras P. Binge eating and other psychopathology in patients with type 2 diabetes mellitus. *Int J Eating Disord* 2001; **30**: 222-226
4. Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function and costs. *Arch Intern Med* (2000); **160**: 3278-3285
5. Clinical Resource Efficiency Support Team (2003) *Blueprint for Diabetes Care in Northern Ireland in the 21st Century*. CREST/Diabetes UK: Belfast
6. Clinical Resource Efficiency Support Team (2003) *Blueprint for Diabetes Care in Northern Ireland in the 21st Century: Report of the User Group Survey*. CREST/Diabetes UK: Belfast.
7. Snaith RP, Zigmond AS. The Hospital Anxiety and Depression Scale. *Acta Psych Scand* (1983); **67**: 361-70.
8. Gormally J, Black S, Daston S, Rardin D. The assessment of binge eating severity amongst obese persons. *Addictive Behav* 1982; **5**: 219-226.
9. Polonsky WH, Anderson BA, Lohrer PA, Welch GW, Jacobson AM. Assessment of diabetes-related emotional distress. *Diab Care* 1995; **18**: 754-760.

10. Marcus MD, Wing RR, Hopkins J. Obese binge eaters: affect, cognition and response to behavioural weight control. *J Cons Clin Psychology* 1988; **56**: 433-439.
11. Bjelland I, Dahl AA, Haug TT, Necklemann D. The validity of the Hospital Anxiety and Depression Scale – an updated literature review. *J Psychosomatic Res* 2002; **52**: 69-77.
12. Wing RR, Nowalk MP, Marcus MD, Koeske R, Finegold D. Subclinical eating disorders and glycemic control in adolescents with Type I diabetes. *Diab Care* 1986; **9**: 162-167.
13. Wing RR, Marcus MD, Epstein LH, Blair EH, Burton LR. Binge eating in obese patients with type 2 diabetes. *Int J Eat Disord* 1989; **8**: 671-679.
14. Lloyd CE, Dyert PH, Barnett AH. Prevalence of symptoms of depression and anxiety in a diabetes clinic population. *Diab Med* 2000; **17**: 198-202.
15. Malone A, Dempster M and Davies M. (2005) Assessing the psychological care needs of people with diabetes in Northern Ireland. *Practical Diab International*, 22, 244-248

ACKNOWLEDGEMENTS

Funded by South and East Belfast Health and Social care group. We are grateful for the support and advice of Dr Welby Henry (Consultant Physician, Belfast City Hospital) and Dr Roy Harper (Consultant Physician, Ulster Hospital).