

5th Scientific Spring meeting of the Psycho-Social Aspects of Diabetes (PSAD) study group of the EASD

Dubrovnik, Croatia, April 7-9 2000

Dr Bill Polonsky from San Diego opened the meeting with his invited talk on the concept of 'Diabetes Burnout', which he closely related to a number of other similar terms in the literature, such as 'Diabetes Overwhelm' and 'Diabetes Distress'. This suggested condition was generally described as 'a sense of being overwhelmed and defeated by diabetes and the frustrating burden of self-care'. More specifically individuals with this state will share a set of common beliefs (diabetes is out of personal control, feeling unable to change, minimising diabetes, sense of impending doom), common feelings (anger, frustration, fear about complications, guilt and depressed mood) and common behaviours (cutting back on self-care, especially behaviour that provides feedback or conversations about diabetes e.g. blood glucose tests, visits to health care professionals, and hiding diabetes from family and friends). From work in the USA it was estimated that roughly 25% of individuals with type 1 and 12% of type 2 diabetes feel burned out to some degree by the constant effort of managing diabetes.

Dr Polonsky suggested six strategies for overcoming diabetes burnout; ally and investigate, address mood problems, address health beliefs, negotiate goals, provide support/feedback and problem solving. The first of these strategies involves listening to the individual and making it easy for the patient to be honest about his/her self-care – the barriers to change. At all cost the health care professional (HCP) must avoid stereotyping patients. Next regularly screening for depressed mood was advocated, and where evident this should be treated promptly with medi-

cation and or psychotherapy. The third step was to address the patients health beliefs, which may include misconceptions of doom or a sense of complete invulnerability to complications. Health care professionals need to elicit each individual's health beliefs, in a non-judgmental manner, with a view to discussing these beliefs in detail, especially concerning the actual risks, given the individuals' history, of experiencing complications. Patients frequently overestimate these risks so that they assume an inevitability rather than being potentially avoidable. Following on from these strategies, goals should be negotiated for the behaviour change, focusing on one behaviour at a time, and on goals that are realistic, specific and time-limited. The last two strategies focus on the implementation of these goals. Goals should be reviewed at a future meeting, and provide supportive feedback with encouragement. Even a single attempt at behaviour change maybe better than nothing and should be encouraged and reinforced. However, it is important to expect and prepare for discouragement and difficulties. It is therefore, essential to help the patient identify and work through potential or experienced problems. Help them find a solution, look for previous successes, encourage brainstorming and mindfulness. Following this discussion of strategies a case study was presented showing how these approaches can be implemented successfully. For further information on burn out, and helping patients with behaviour change a number of members of the group recommended Dr Polonsky's book, 'Diabetes Burnout', recently published by the American Diabetes Association.

The programme continued with participants in small workshop groups to consider how 'burn out' is manifested; how can it be assessed; what factors contribute to 'burnout' and how to determine strategies for prevention and treatment. It was clear that the discussion on factors that influence 'burnout' and how to prevent it could be summarised by the statement of one group 'if you feel responsible for something you cannot control, it is a recipe for disaster', this being true for patients and professionals alike.

Other oral presentation sessions included M.Grubic (Zagreb, Croatia), who presented data from a study on the disease-related worries of adolescent and their parents. The greatest concern for both parents and adolescents was that of future complications. Adolescents were also concerned about future employment prospects, whereas parents were more concerned about hypoglycaemia. Overall parents reported greater disease-related worry than adolescents, with greater parental concern associated with poorer metabolic control. M. Thatsum (Aarhus, Denmark) presented results of a survey of 183 adolescents attending diabetes services in Denmark aimed at identifying the nature of services that adolescents would like from their health care system. Over 50% thought that HCP's should be interested in subjects other than just diabetes and wanted to talk to more than one HCP. Patients with the poorest control wanted the consultation to last longer. Although there were no obvious age effects, there were a number of gender differences, leading one attendee to suggest that maybe clinics should be gendered rather than age banded.

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Moving into adulthood C. Skinner (London, England) presented pilot data on differences between the illness beliefs of ethnic minority populations in South London and the majority Caucasian population. Preliminary data indicated that there were a number of differences in the ethnic minority participants beliefs concerning the cause of diabetes, how long their diabetes will last and the effectiveness of treatment to prevent complications. These differences mediated the relationship between ethnicity and emotional well being, through their influence on coping strategies. E. Matteucci (Pisa, Italy) presented data from a cross section survey of patients prior to an educational intervention. This survey confirmed low levels of patient knowledge. Individuals with type 1 diabetes reported higher levels of depression and anxiety than age matched control healthy participants. Individuals with type 2 diabetes on insulin reported higher levels of anxiety and depression than patients on oral medications.

The remaining two presentations were more methodological in orientation. M. Adriaanse (Amsterdam, Netherlands) presented a paper introducing a large scale study looking at the psychological impact of screening for type 2 diabetes in the general, elderly population. Pilot data indicated that individuals perceive diabetes to be a mild condition that is easily treatable. Many patients seemed ignorant as to the cardiovascular complications of diabetes and the high mortality rates for individuals with type 2 diabetes. The second more methodological paper by C. Bradley (London, England) was on assessing the impact of complications on quality of life. An excellent critique of the measures used in UKPDS was provided which raised some doubt about some the conclusions concerning the impact of therapies in this study. The benefits of using more refined questionnaires which can assess the impact of different treatments and complications on quality of life were discussed, emphasising the need to consider not only diabetes

specific quality of life but the different dimensions of quality of life; in particular the impact of dietary restrictions.

This was an excellent meeting, which provided strong evidence of the increasing quality of behavioural diabetes research in Europe. With the growing interest in this field from psychologists and health care professionals alike, members hoped to plan additional meetings and a symposium at EASD meetings in the future. Our deep gratitude is expressed to Dr Mirjana Pibernik-Okanovic from Zagreb for organising this meeting, showing us the beauty of her country, and the mediaeval splendour of Dubrovnik.

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News round-up from the diabetes world

EUROPEAN STUDY OF IMPACT OF ROSIGLITAZONE ON CVD

GlaxoSmithKline (GSK), the company formed from the recent merger of Glaxo Wellcome and SmithKline Beecham, has announced the launch of a long-term outcome study to evaluate the impact of its thiazolidinedione product, rosiglitazone maleate (*Avandia*), on the development and progression of cardiovascular disease in people with type 1 diabetes. The new clinical trial will be called RECORD (Rosiglitazone Evaluated for Cardiac Outcomes and Regulation of glycaemia in Diabetes). RECORD will be a six-year randomised parallel group study involving 4,000 patients from 300 study centres across Europe, including approximately 50 in the UK. The RECORD Steering Committee Chair is Professor Philip Home from the Department of Diabetes and Metabolism, The Medical School, University of Newcastle upon Tyne, UK.

The trial will compare the most widely used traditional OHA combination therapy, sulphonylurea plus metformin, with a combination of rosiglitazone and sulphonylurea or

rosiglitazone and metformin. The main study outcome will be the number of patients who suffer major cardiovascular events, including myocardial infarction, revascularisation and stroke. The main rationale for the study is that: (1) the risk of CVD is substantially increased in patients with insulin resistance (whether or not they have diabetes); (2) rosiglitazone directly targets insulin resistance; (3) therefore rosiglitazone, by reducing insulin resistance, may impact favourably on the onset and progression of CVD in patients with type 2 diabetes receiving combination OHA therapy.

Professor Home comments: "Avandia improves insulin resistance as well as other markers of cardiovascular risk. Therefore, we would expect Avandia to favourably affect cardiovascular endpoints when used in combination with a traditional glucose-lowering agent."

For further information about RECORD, please contact Siân Boisseau or Becky Down on tel: 0207 3136300.