



CDAPP Sweet Success Guidelines for Care

Chapter 9

Behavioral and Psychosocial Components of Care



*Sweet
Success*

California Diabetes and Pregnancy Program

California Diabetes and Pregnancy Program Sweet Success Guidelines for Care

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Behavioral and Psychosocial Components of Care

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9 Behavioral and Psychosocial Components of Care

INTRODUCTION

This section addresses the importance of behavioral and psychosocial components and provides suggestions for effective interventions in assisting pregnant women. While pregnancy is often thought of as being an emotionally fulfilling time and therefore protects against any potential psychiatric issues, research has actually proven this is often not the case.¹ Pregnancy presents a critical time in women's lives with its own challenges to mothers and their families. The quality of a mother's attachment to her child critically affects neurodevelopment of her infant's brain and has far reaching consequences for all aspects of the child's emotional, social and cognitive development and the woman's ability to care for herself.²

CHANGES IN PSYCHOSOCIAL CARE OF PREGNANT WOMEN WITH DIABETES

There has been a major shift in the psychosocial research related to diabetes care which challenges long held beliefs and training about the nature of relationships between providers and patients. How comfortable are providers following the patient's lead, noting her readiness for change, and guiding her through the rigorous regime of diabetes care? Can providers make the shift from "being the expert" to "having expertise" about diabetes and truly seeing the pregnant mother as a collaborator in care?

PATIENT EMPOWERMENT

Current literature supports the patient empowerment philosophy of diabetes care. The empowerment approach conflicts with the more traditional method of care that is compliance-oriented.^{3,4} This paradigm shift to a philosophy of patient empowerment recognizes the woman as a co-provider of her care.⁴ As such, she reshapes her lifestyle within her family system and home.

Beyond focusing on psychosocial risk factors, current research addresses the impact of a woman's:

- ❖ Pregnancy concerns
- ❖ Attachment behaviors
- ❖ Therapeutic relationship with providers
- ❖ Guiding techniques for motivation
- ❖ Degree of emotional well-being and how that contributes to effective diabetes care during pregnancy

To support women in their self-care for their diabetes, pregnancies, and ultimately themselves, providers must recognize that a major part of patient care occurs in the patients' home, not in a hospital or clinic setting. Providers need to establish relationships with patients that encourage empowerment, self-efficacy, and a readiness to embark on what is often an incredibly complex regime affecting all areas of their lives.⁵⁻⁷ Providers should offer effective interventions which include behavioral and psychosocial components.

Pregnancy generates biological, psychosocial, and financial demands on a woman and her support network. Medical complications in pregnancy, such as diabetes, magnify these demands, increase psychosocial risks, and place increased adjustment and adaptation demands on a woman, her inner resources and external support system.⁶ For some women, this will result in symptoms of anxiety and depression which may not be readily apparent, but need to be addressed.

PROFESSIONAL PSYCHOSOCIAL SERVICES

Professional psychosocial services are an essential component of the care provided by CDAPP Sweet Success diabetes care providers.⁸ These services are directed toward engaging the woman in understanding and managing the biological, emotional, and social stressors of a pregnancy complicated by diabetes. The Behavior Medicine Specialist (BMS) is an integral part of the diabetes care team whose goal is to enhance a woman's ability to manage her diabetes, make necessary lifestyle changes, and care for the well-being of herself and her child.

SELF-EFFICACY AND PATIENT PROVIDER RELATIONSHIP

In actuality, the mother is her own health care provider. Among her other pressing responsibilities is learning about and treating her diabetes daily in her own home and reshaping her lifestyle. Because diabetes care has to be integrated with other social, cultural, psychological, and demographic priorities of a woman's life, blood glucose control is only one element of self-care. This presents a major challenge for providers trained in an acute care model stressing patient's compliance with the treatment plan.

Providers do not have control at all over what happens when the woman leaves the brief clinic session. In fact, caring for diabetes is better suited for a chronic care model which stresses the importance of partnerships between patients, families, community, and providers in ensuring a successful outcome.

Virtually every mother wants a healthy baby, as do all in her family and circle of support. By empowering the patient to be central in her care, education and guidance can enhance her ability to make informed

choices about her and her baby's health and diabetes. Within the context of the woman's life, the provider will coordinate with her on:

- ❖ The clinical management of diabetes
- ❖ Skills for behavior change
- ❖ Communicating with the health care team so that her concerns are understood
- ❖ Continuing reassessment of realistic treatment goals

READINESS FOR CHANGE: MOTIVATIONAL INTERVIEWING

Providers often assume that a woman is ready to begin a treatment regime when she arrives for her first appointment. Certainly the team is ready, but assessing a patient's readiness for change is the first step before determining how to motivate and guide her through essential segments of successful treatment.⁹ Remember, the woman may have difficulty articulating and resolving her ambivalence about diabetes treatment.

Motivational interviewing (MI) uses both directive and non-directive solution-focused counseling styles to encourage behavioral changes that help patients analyze and overcome any hesitancy to treatment.¹⁰ Once the provider learns to use MI, they establish a partnership between provider and patient which is more effective than traditional advice giving, without consuming more time.¹¹ MI is especially effective with the management of diseases such as diabetes, which requires major lifestyle changes. MI helps resolve differences between the expressed treatment goals and actual management, and helps to strengthen the provider-patient relationship. This assists providers to work with the mother in designing intervention strategies and setting up a working plan. The MI approach offers providers with tools to manage the diabetes, sharing the responsibility, and avoiding the provider's perception, "the patient's not compliant" to "I wonder what she needs or how she understands this?" When a woman is asked questions that imply her concerns, feelings and even disagreements with us as providers are respected and listened to; a collaborative relationship is being built which sustains the rigors of the treatment regime ahead.⁹⁻¹¹

"STAGES OF CHANGE" MODEL

The "Stages of Change" model crafted by Prochaska, DiClemente and Norcross shows that change occurs gradually and often advances in a non-linear spiral progression.¹² Our perception of resistance to treatment recommendations may simply reflect a patient being at an earlier stage of change and not yet ready to actively participate in her own care. With skills in applying stages of change, providers do not get stopped at the barrier caused by belief that the patient is "noncompliant," but instead, begin asking questions that expand rather than constrict their understanding.

There are 5 stages in this model, however, Prochaska et al note that individuals may experience a relapse in their behaviors. He refers to this natural progression of change as “Relapse or recycling.”¹² For simplicity, we are briefly listing these stages with examples of patient behavior and provider questions. These “Stages of Change” are adapted with permission from the American Psychological Association¹²:

Pre-Contemplation

- ❖ Patient behavior: Patient denies or does not recognize that there is a problem and is reluctant to discuss the problem. Patient may not follow up on treatment recommendations.
- ❖ Provider questions/responses: What does having diabetes mean to you? What warning signs would let you know there was a problem? What have you already heard?

Contemplation

- ❖ Patient behavior: Patient is ambivalent, but discusses the problem and weighs the pros and cons of initiating change.
- ❖ Provider questions/responses: What makes it hard for you to change at this time? What might help you with this? How would you like me to assist in caring for you and your baby?

Preparation

- ❖ Patient behavior: Patient understands that change is needed and begins to commit to goals.
- ❖ Provider questions/responses: What is realistic for you to do today? This week? How can I support you in reaching this goal?

Action

- ❖ Patient behavior: Patient is taking steps to change behavior and implement that change into her lifestyle.
- ❖ Provider questions/responses: You made so many changes for you and your baby. What did you do to make that happen? What else would help you?

Maintenance

- ❖ Patient behavior: Patient perseveres and sustains new behaviors with less effort. Patient is aware of high risk situations.
- ❖ Provider questions/responses: You have consistently done so well. What have you learned are your high risk areas?

Lapse/Relapse (Stage of Change added by CDAPP Sweet Success)

- ❖ Patient behavior: Patient’s personal distress or events interrupt change with a resulting temporary loss of progress.
- ❖ Provider questions/responses: Change takes time; this is expected. What can you learn from this to help you in the future?

Within these questions are the themes of accentuating strengths and self-efficacy, providing support, and openly discussing obstacles to change. With the addition of Lapse/Relapse, consider change as a six step process where patients may move forward or back in relation to life events, stress and resources.

ASKING OPEN-ENDED QUESTIONS

Skill in using open-ended questions strengthens a woman's self-efficacy and offers providers tools to be more successful when meeting obstacles during treatment. Below are a few examples of effective open-ended questions that also reinforce a collaborative relationship:

❖ **QUESTIONS THAT CLARIFY:**

- Does this make sense to you?
- Did I explain it well?
- What seems to not be clear?
- Can you explain what you mean by that?

❖ **QUESTIONS THAT IDENTIFY ISSUES:**

- What seems not to be working?
- What do we need to change?
- What is the toughest part of this for you?
- I do not think this is working. What do you think we need to do?

❖ **QUESTIONS THAT ENCOURAGE PLANNING:**

- What do you see as the first thing to do?
- What do you need from me to help with this?
- What are your next steps?

❖ **QUESTIONS THAT LOOK AT THE TOTAL PICTURE:**

- What have you tried so far?
- When does that usually happen?
- What do you make of this change?

PSYCHOSOCIAL ASSESSMENT

Psychosocial screening should be strongly encouraged for all women throughout their pregnancy, as recommended by American Diabetes Association and American College of Obstetricians and Gynecologists.^{13,14}

Beyond initial screening, additional monitoring is recommended when:

- ❖ A mother's participation in care diminishes
- ❖ She has increased life stressors
- ❖ She exhibits distressed interactions with providers

In addition, the providers should assess the clients for domestic/intimate partner violence which is the most common cause of injury to women in the United States. For more information:

- ❖ www.safehorizon.org
- ❖ www.nlm.nih.gov/medlineplus/domesticviolence.html
- ❖ Domestic Violence Helpline: 800-978-3600
http://www.lapdonline.org/get_informed/content_basic_view/2367_1
- ❖ National Domestic Violence Helpline: 800-799-7233
<http://www.thehotline.org/>

Providers should screen women with sensitivity to their culture, language, and literacy needs. This may require more individualized attention. All communication is held in strict confidence unless otherwise mandated by law.

PSYCHOSOCIAL BARRIERS

Significant barriers and stressors impede a patient's ability to actively participate with providers, and adhere to a treatment regime. Increases in severity and chronicity of the stressors will further diminish a woman's resiliency and coping. Health problems, poverty and intimate partner violence are examples of multiple stressors which can affect her ability to attend to her diabetes care. The providers' ability and skills to interact effectively with their patients can also be an asset or risk factor to a successful treatment plan and birth outcome.

PERINATAL DEPRESSION

Perinatal depression is often under-identified during and after pregnancy. Among low-income pregnant women with diabetes, perinatal depression occurs almost twice as often as among those women without diabetes.¹⁵ Beyond the "baby blues," the prevalence of perinatal depression ranges from 5-25% of women and is one of the most common perinatal complications.¹⁶

Many factors influence maternal mental health including^{15,17}:

- ❖ Family history of depression
- ❖ Hormonal changes
- ❖ Poor environmental factors
- ❖ Intimate partner violence
- ❖ Chronic stressors and trauma
- ❖ Oppression and racism
- ❖ Isolation from adequate social and community support

Some common signs and symptoms of depression include:

- ❖ Sleep and appetite disturbances
- ❖ Anxiety and/or irritability
- ❖ Unexpected weight loss/gain
- ❖ Loss of interest or pleasure in life
- ❖ Hopelessness
- ❖ Loss of energy and motivation
- ❖ Thoughts of harming oneself or another

Providers should keep in mind that:

- ❖ The rates of depression in the second and third trimesters are reported to be as high as during the postpartum period, making this time period assessment important for CDAPP Sweet Success clients. Depression is seen as both a response to the overwhelming psychosocial stressors of a patient's life and also as a result of biochemical changes related to diabetes and its treatment.

Depression and Maternal-Child Attachment

Maternal depression is a multifaceted illness that has varying consequences for a woman's mental health, her functioning as a mother, her family's functioning, maternal-child attachment and her child's development in many ways. For example, postnatal depression can:

- ❖ Negatively impact attachment behaviors, such as an infant's attunement to emotional signals of their mother's voice, gestures, and facial expressions¹⁸
- ❖ Limit breastfeeding duration and success
- ❖ Impede neural development of infants
- ❖ Impair a woman's ability to relate to her infants' needs and increase the risk that she develop negative attitudes toward her children
- ❖ Increase insecure attachment behaviors between infants and their mothers¹⁸
- ❖ Result in children developing fewer positive emotions than children of non-depressed mothers

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) is a simple ten item screening tool for anxiety and depression. It is useful during the entire perinatal period and through the first year of life.¹⁹ As the EPDS is a screening tool and not a diagnostic instrument, it is not a substitute for sound clinical judgment. It does not diagnose depression or anxiety but just screens for symptoms.

A provider may be uncertain about how to address a woman's sense of well-being. A simple discussion may begin with stating, "We ask all pregnant women, especially those dealing with diabetes, about how they are feeling. We'd like to know a little about your emotional health, what is important to you and your family, and how you care for yourself."

Barring the rare situation requiring emergency intervention, providers are not required to "fix" the problems of a woman's life. Appropriate referrals may be beneficial in some cases. Often her sense of distress can be reduced by acknowledging her suffering.

- ❖ The use of EPDS screening tool
Staff needs to be trained before screening for anxiety and depression is integrated into care. After being trained, using the screening tool, scoring it and developing an action plan based on the findings, all health care team members should be able to screen diabetic women.

Ideally, providers should screen patients once during the following time periods in order to identify most women who experience perinatal depression:

- The second trimester
- The third trimester
- Six weeks postpartum
- Three months after delivery

Administering and Scoring the EPDS

A woman is provided an EPDS sheet with 10 questions and she underlines the answer that most closely reflects how she has felt during the last seven days. Providers can assist a low literacy woman, but should be careful not to influence her answers. They should also be aware if anyone with her is influencing her responses. Each answer has a number score. A total score of more than twelve points warrants clinical attention.

Modes of Treatment for Perinatal Depression

Key to supporting a women's well-being is to increase awareness and education about stress, depression and anxiety among providers, family members and women themselves. Mild depression and anxiety symptoms benefit from supportive relationships and psycho-educational materials.

Dysthymia (moderate depression), major depression disorder and other psychiatric disorders require careful coordination with a mental health professional and/or a BMS consultation and educational materials for the woman and her family. The following are treatment options:

- ❖ Counseling/Psychotherapy particularly cognitive behavioral therapy (CBT), a treatment that has proven to be effective in reducing depressive symptoms and improving problem-solving skills and interpersonal psychotherapy.²⁰
- ❖ Exercise which is important to maintain blood glucose and enhance well-being and improve their mood.
- ❖ Prescription of psychotropic medication requires a careful risk-benefit analysis, weighing the consequences of untreated depression and the use of medications in pregnancy.²⁰

Knowledge of current research and coordination with psychiatry is critical.

Postpartum Assessment

The postpartum period is a time of heightened emotional and physiological vulnerability. A postpartum assessment should be completed for all women, whether they had positive birth outcomes or experienced losses such as therapeutic or spontaneous abortions, ectopic pregnancies, having a baby with birth defects, still births or neonatal death. The postpartum evaluation should be completed earlier than six weeks if indicated by psychosocial history.

For women who have become attached to the diabetes treatment team, exiting the program may be very difficult. For some, this is one of the few times in their lives when someone has paid attention to their psychosocial needs and provided them with significant support. These women may be more vulnerable to postpartum depression. A woman

who has experienced a high-risk pregnancy and/or difficult delivery is also more vulnerable to depression. She may be experiencing feelings of guilt or loss.^{3,21} She may also feel let down from decreasing the intense energy she has used to adhere to the expectations of the program.

Additionally, this might be the ideal opportunity for the patient to be empowered toward positive lifestyle changes for herself and her family. Spacing future children is essential to a healthy start for her next pregnancy as well as the woman's physical and mental health. Providing women with information on birth control will increase the chances of preconception care.

**RESOURCES AND
WEBSITES -
PERINATAL
DEPRESSION AND
ANXIETY**

All women and their families benefit from receiving written materials which includes community resources, and crisis numbers for services available in their areas.

- ❖ Phones: Hotlines and Warmlines- (English/Spanish)
Postpartum Support International 1.800.944.4773
<http://www.postpartum.net/>
- ❖ Online resources
www.mededppd.org/mothers
<http://www.motherisk.org/women/index.jsp>
www.beyondblue.org.au
<http://ctispregnancy.org/>

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