

Do you ever ask about mood in your diabetes reviews?

Deadlines for my next editorial always seem to creep up on me and coincide with other pressing commitments. My intention was to write this editorial on my way northbound to the 18th Scottish Conference of the PCDO Society being held in Glasgow. Regrettably, the ensuing 12-hour, standing-room-only saga did not allow for this, although I did manage to have an interesting conversation with a fellow passenger about the pros and cons of statins, cardiovascular risk and GLP-1 receptor agonists. Best laid plans and all that!

It was nonetheless a wonderful day of diabetes education at the conference, where my colleague Nicki Milne and I were asked to deliver a session on “What we don’t ask in diabetes reviews”, focusing specifically on mood, male and female sexual dysfunction, and contraception. Quite a tall order in just 40 minutes, allowing time at the end for questions!

I’m sure we all strive to offer a holistic, person-centred, individualised approach to diabetes management, but in practice this can be challenging and, inevitably, certain aspects must be prioritised. Ultimately, our goal is to support people to reduce their risk of developing diabetes-related complications through lifestyle interventions and an ever-expanding choice of pharmacotherapies that target hypertension, dyslipidaemia, dysglycaemia and, often, excess weight. There is a plethora of targets to aim for, but ultimately diabetes is a self-managed condition and we cannot ignore the impact of all this on a person’s quality of life.

Living with any chronic health condition puts additional stress on a person and those around them. Diabetes imposes numerous additional burdens, which can include glucose testing, medications, daily decisions about food and drink, and injections of insulin. It’s not possible to take a “diabetes-free” day; for many people the worry over both short- and long-term complications is always there, and it can really take its toll on a person. Often our focus

is on the physical impact of diabetes, but this is a condition that can have a profound impact on emotional wellbeing.

I tackled the mood section of our presentation, and it made me think about what may cause a person living with diabetes to feel stressed. This is the list I came up with:

- Feelings of guilt around the diagnosis (linked to stigma and discrimination).
- Steep learning curve (so many new things to learn about and remember).
- Worry about impact on current/future work, home life, relationships, etc.
- Having to pay close attention to diet and food choices.
- Greater focus on weight and body image.
- Having to take medication, give injections, monitor blood.
- Fear of hypoglycaemia.
- Disappointing or worrying results (e.g. high HbA_{1c}).
- Worry about long-term complications.
- Life’s stresses making diabetes harder to manage.

People with diabetes are twice as likely to have depression and 20% more likely to experience anxiety disorders (Rotella and Mannucci, 2013). Feelings of sadness, hopelessness or lack of motivation are common among those struggling with the condition. One in four people with type 1 diabetes have high levels of diabetes distress, as do one in five people with type 2 diabetes. For some, this can lead to diabetes burnout, a point of emotional exhaustion with diabetes where self-management tasks feel overwhelming and, as a result, are reduced or ceased (Stewart, 2025). Once psychological distress is established, it negatively impacts diabetes management through reduced motivation and an increase in stress hormones, and changes in behaviour and diabetes self-management.

It seems unlikely that the targets we aspire to will be achieved if these issues are not



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Diabetes UK's practical guide to diabetes and emotional health. Click on the thumbnail to access.

acknowledged and addressed. So why don't we routinely ask about a person's emotional health? I posed this question to the audience in Glasgow, and this is what we came up with:

- Time constraints and time-limited appointments.
- Not part of our "core services"/not funded/not measured (e.g. in QOF).
- A relatively new concept – many of us are not aware of it.
- Lack of confidence – we may not feel we have the right skills to open a conversation about emotions and diabetes.
- Don't know how to support or to access additional support/services.
- Lack of availability/limited access/long waiting times for psychological support services.
- Assume people would not want to be asked such a personal question.
- Reluctant to "open a can of worms".
- We may underestimate the importance.

In my presentation, I discussed the 7As model, a useful framework for assessing and addressing common psychological issues, which is described in detail in Diabetes UK's [practical guide to emotional health](#), (Hendrieckx et al, 2019). Ultimately, the key messages are to be aware of the impact of diabetes on emotional wellbeing, ask about mood and emotional health, assess it (tools are available to facilitate this and can help start conversations), offer support, recognise our scope of practice and refer to other healthcare professionals who can offer the specialist support we can't. The Diabetes UK [Information Prescription on mood](#) is a helpful resource to generate conversations.

Finally, a top tip from Dr Rose Stewart: ask the magic question, **"what's one thing about your diabetes that's really getting to you at the moment?"** (Stewart, 2025). This will communicate that you're open to hearing about a person's stresses and worries without inviting them to offload everything on to you.

More resources to help us support people with diabetes distress are expected soon. The European Association for the Study of Diabetes (EASD) launched the draft of its first evidence-based clinical practice guideline on diabetes distress at its Annual Meeting held in Vienna in September.

The final publication is expected in early 2026, and the draft guidance can be [viewed here](#).

In this issue

In addition to the draft diabetes distress guideline, drug therapies for obesity and diabetes featured strongly in the EASD meeting programme, as you might have predicted. The programme included studies of familiar agents used in higher doses, including the STEP UP trial of subcutaneous semaglutide 7.2 mg, in which titration from 2.4 mg to 7.2 mg produced additional weight loss minimal increases in gastrointestinal side effects, but there were higher rates of dysaesthesia (described as tingling, burning or itching). Results from the OASIS 1 and 4 studies, using semaglutide 25 mg and 50 mg doses, were also presented, as were the initial findings from the phase 3 SURPASS-PEDS trial of tirzepatide in children with type 2 diabetes. We summarise the top-level findings in our [Conference over coffee](#) meeting report.

New drugs in development for obesity also featured, including orforglipron, a small-molecule, non-peptide GLP-1 receptor agonist which Pam Brown explores in greater depth in [Diabetes Distilled](#). Cagrilintide is another agent we may need to familiarise ourselves with in the future. It is a long-acting analogue of amylin, a satiety hormone involved in food intake, body weight and glycaemia, which affects appetite regulation and may offer a different mechanism for weight loss from GLP-1 receptor agonists.

Case presentations are always a good way to learn because they are so relevant and applicable to everyday practice. This issue, [Lynn Storer](#) highlights the importance of a holistic and multidisciplinary approach to help prevent long-term cardiometabolic complications. Implementing timely, coordinated interventions by a multidisciplinary team is key.

Cardiovascular disease (CVD) remains the leading cause of morbidity and mortality globally, and people with diabetes are known to be at significantly higher risk. A Swedish study, also presented at EASD, compared the risk of CVD, cardiovascular death and all-cause mortality in men and women with type 1 and type 2 diabetes, and those without, and compared risk at different ages. [Pam's summary](#) is a fascinating read.

Early-onset type 2 diabetes is a more aggressive form of the condition, and we have covered this previously in the journal with a [How to guide](#) and an [interactive case study](#), as well as in an on-demand [PCDO webinar](#). Contraception and preconception care are crucial for women of childbearing potential who have type 2 diabetes, in order to reduce risks to both mother and offspring. Choosing contraception is more complex in this group, however, as cardiovascular risk factors, microvascular complications, obesity and history of CVD all place limitations on which contraceptives can be prescribed safely. Our review of [contraception in type 2 diabetes](#), therefore, should be most useful.

National and international guidelines advocate the use of SGLT2 inhibitors early in type 2 diabetes management pathways, based upon an abundance of supporting data from large-scale cardiovascular and renal outcomes trials; however, prescribing hesitancy remains. Several reasons have been proposed, including: “...*confusion concerning their place in the complex therapeutic paradigm, variation in licensed indications [and] safety perceptions/misunderstandings associated with historical data that have since been superseded by robust clinical evidence and long-term pharmacovigilance reporting*” (Seidu et al, 2024).

No drug is without risk, and all medicines have potential side effects; therefore, balancing the benefits versus the risks for an individual must underpin every prescribing decision. With respect to SGLT2 inhibitors, genital mycotic infections are common, and careful counselling is required before initiation (see our [How to](#) and [Prescribing pearls](#) articles). However, a population-based study [described here](#) explored whether men initiated on an SGLT2 inhibitor for diabetes would be at greater risk, not just of mycotic genital infections, but also of phimosis in uncircumcised men and of penile cancer. Perhaps something else we should be discussing to ensure prompt management.

In England, we are fortunate to be able to refer to the [Type 2 Diabetes Path to Remission Programme](#), and several of my patients have done really well on this. However, it will not suit everyone and there are a number of eligibility criteria which exclude people who may still

want to attempt remission. In this situation, it is difficult to know what to do to support a person, so I am delighted to share with you our new [type 2 diabetes remission toolkit](#) for general practice, authored by Roy Taylor and Chirag Bakhai. The toolkit offers comprehensive advice to help us support our patients to achieve remission and outlines the steps to take before and during the low-calorie meal-replacement phase, and then afterwards to assist with food reintroduction and weight maintenance. We also have an [accompanying Q&A](#), in which Professor Taylor answers a host of questions on the practicalities and theory of remission.

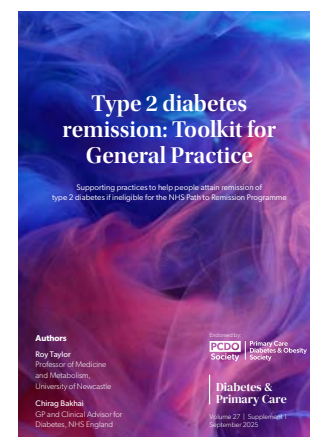
New lipids e-Learning modules

Finally, lipid lowering has become something of a minefield when it comes to pharmacotherapy. You may recall our [At a glance factsheet](#) on the subject. To add to this, the PCDO Society has recently launched a [brand new series](#) of CPD modules on lipid management. It is made up of four half-hour modules covering the following:

- **Module 1:** The different lipid types; lifestyle modification.
- **Module 2:** Assessing and reducing cardiovascular risk.
- **Module 3:** Pharmacological treatment: statins.
- **Module 4:** Pharmacological treatment: other therapies.

Module 5, covering special populations such as familial hypercholesterolaemia, should be published soon. The series is definitely on my to-do list – I hope you find it helpful.

For those of you attending [PCDO Society National Conference](#) on 19–21 November in Birmingham, it would be great to catch up and find out what topics you’d like us to cover in future issues, so please come and say hello! ■



Our new type 2 diabetes remission toolkit for general practice. Click on the thumbnail to access.

References

- Hendriekx C, Halliday JA, Beeney LJ, Speight J (2019) *Diabetes and emotional health: A practical guide for healthcare professionals supporting adults with Type 1 and Type 2 diabetes* (2nd edition). Diabetes UK, London. Available at: <https://bit.ly/4qjyMhw>
- Rotella F, Mannucci E (2013) Diabetes mellitus as a risk factor for depression. A meta-analysis of longitudinal studies. *Diabetes Res Clin Pract* **99**: 98–104
- Seidu S, Alabraba V, Davies S et al (2024) SGLT2 inhibitors – the new standard of care for cardiovascular, renal and metabolic protection in type 2 diabetes: A narrative review. *Diabetes Ther* **15**: 1099–124
- Stewart R (2025) Psychological issues in people living with diabetes. In: Milne N, Thomas T (editors). *Oxford Handbook of Diabetes Nursing* (2nd edition). OUP, Oxford

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