

# Changing diabetes management with psychotherapy

Jacqueline Fosbury

**Diabetes can have a huge psychological impact on the individual. Research has shown that people can experience “burnout” and this can affect the ability to carry out self-care. Furthermore, the global DAWN (Diabetes, Attitudes, Wishes and Needs) study found that 41% of people with diabetes have poor well-being scores. These factors may explain poor outcomes in some individuals and emotional difficulties may cause people to mismanage their diabetes. This article will discuss the various difficulties and will explain how they are treated with psychotherapy, specifically using cognitive analytic therapy. This is a programme of therapy that is tailored to a person’s individual needs and to their own manageable goals for change.**

Although therapies for diabetes are more efficacious and accessible than ever before, outcomes (HbA<sub>1c</sub>, weight and admissions) remain less than optimal. There are three components to this. As healthcare professionals, we can sometimes mismanage the process (Given et al, 2015), people with diabetes can experience “burnout” living with the condition (Polonsky, 1999) and some individuals have pre-diagnosis psychological or emotional difficulties that render regular and reliable self-care virtually impossible, despite high levels of diabetes education and support.

People with diabetes are 2–3 times more likely to have depression than those who do not have diabetes (Barnard et al, 2006). The global DAWN (Diabetes Attitudes, Wishes and Needs) study has shown that 41% of people with diabetes have poor well-being (Nicolucci, 2013). This article will look at how these difficulties are understood and treated in psychotherapy using cognitive analytic therapy (CAT; Ryle, 1990).

## The need for psychotherapy

Jane Milton’s work (Milton, 1989) highlighted how emotional difficulties can cause mismanagement of diabetes. She stated that her patients were not psychiatrically ill in any formal sense but their emotional problems led to an inability to cope with stressful situations and affected self-care. Ryle et al (1993) presented three individuals with diabetes and commented that, despite intensive education, they were “seriously neglectful or self-sabotaging in their diabetes management”. In particular he outlined the differing emotional backgrounds that his patients displayed, including needy, angry, guilty and unconfident. He showed how these emotions led to a range of “procedures”, which led to poor self-care. Over eating and using alcohol to deal with emptiness, unhappiness and to “self sooth” was common. People also reported feeling trapped by others and their diabetes and therefore were resistant to any perceived demands the condition required. Tilden et al (2005) presented a qualitative study

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## Article points

1. Emotional difficulties can occur in people with diabetes and can lead to the mismanagement of their condition.
2. Cognitive analytic therapy is a programme of therapy that is tailored to a person’s individual needs and to their own manageable goals for change, and can be used for people with diabetes who are experiencing difficulties.
3. An individual’s activities are understood as organised sequences of mental and behavioural processes (referred to as procedures) that are repetitive in nature. The therapist needs to make links between the patient’s past and present experiences and their persistent use of procedures that are ineffective or harmful.

## Key words

- Psychotherapy
- Resistance
- Transference
- Unconscious

## Authors

Jacqueline Fosbury is Diabetes Psychotherapist and Supervisor in Psychotherapy, The Diabetes Centre, Royal Sussex County Hospital

### Page points

1. Cognitive analytic therapy (CAT) works more interpersonally than cognitive behavioural therapy (CBT). Although it integrates techniques and understandings from CBT, it is more psychoanalytical in nature. CAT looks at feelings, thoughts and subsequent behaviours, which are usually circular in nature and are causing harm.
2. CAT is a short-term, focused therapy normally involving between 16 and 20 sessions. Patient and therapist will work on jointly identifying any problems and this will involve a clear description of the issues affecting the person using letters and diagrams.
3. As CAT combines a number of approaches, it is a complex treatment used for more complex, resistant problems. It therefore lends itself to comorbid and complex conditions where other therapies have often failed, such as when the patient is uncooperative to their own self-care needs (diabetes and other health conditions).

of one 26-year-old woman, June, who developed diabetes in infancy. Their analysis was that her identity had been overshadowed by a “diabetic identity”, which she rejected and therefore she rejected the requirement for adherence to treatment. Attention from the family only seemed to configure around her diabetes, which June felt was not “good enough”. June wanted to be recognised and valued for herself, not just for her condition. The authors outlined the process of brief, focused psychotherapy (CAT), which showed that June was able to “transform” when she was recognised for herself and not her condition. Further work on CAT has looked at how adolescents might also use diabetes as a vehicle to rebel against parents and staff, who are perceived to be controlling and interfering, and this continues in to adulthood (Fosbury, 1996).

### Why cognitive analytic therapy?

People referred for cognitive behavioural therapy (CBT) may have been diagnosed with disorders, such as anxiety, depression and obsessive compulsive disorder. It has specific, research-proven ways of working with such clients, using different techniques appropriate for their presentation. People who want to work with their therapist on actively changing their problems tend to do well here. However, some patients want to change, but have a number of obstacles to this process. In the Brighton diabetes psychotherapy (CAT) service, patients were recently audited on a range of issues. One issue was previous experience of therapy. Out of 30 individuals, 19 had previously received CBT from the local mental health trust.

CAT works more interpersonally than CBT. Although it integrates techniques and understandings from CBT, it is more psychoanalytical in nature. CAT looks at feelings, thoughts and subsequent behaviours, which are usually circular in nature and are causing harm. It is a short-term, focused therapy normally involving between 16 and 20 sessions. Patient and therapist will work on jointly identifying any problems and this will involve a clear description of the issues affecting the person using letters and diagrams.

One aim is to understand the origins of the individual’s difficulties, normally located in early relationships and experiences. Another important aim is to use the relationship between the patient and therapist to reflect on how those learnt ways of being take place, both in and out of the therapy room.

As CAT combines a number of approaches, it is a complex treatment used for more complex, resistant problems. It therefore lends itself to comorbid and complex conditions where other psychological therapies have often failed, such as when the patient is uncooperative to their own self-care needs (diabetes and other health conditions) and often covertly uncooperative with the therapy (or diabetes education, for example). Understanding resistance is central to treating these cases and is central to a psychoanalytic approach to treatment.

There is an extensive evidence base for the use of CAT in people with mental health problems. With regards to the evidence base for diabetes specifically, Fosbury et al (1997) compared the use of CAT therapy to education provided by a DSN in people with poorly controlled type 1 diabetes. The study found that while there was no statistical difference between CAT and DSN education, the effects of CAT produce a more prolonged effect on glycaemic control. A further study (Shaban et al, 2008) demonstrated that CAT led to a reduction in HbA<sub>1c</sub> from screening to follow up at 2 years.

### Why are people resistant?

Change involves emotional pain, so people are often resistant to it. It involves “letting go” of self-defeating behaviour, such as the comfort of over eating, or of only caring for others (which they may derive self-esteem from), but not caring for themselves. Individuals may have to let go of feelings of guilt when they look after themselves. Therefore, individuals can become unwilling and opposed to this change, even if it is what they desire. This resistance can be revealed to the psychotherapist in a number of ways – in the patient’s obvious discomfort in the room, in their silence or over talking, “did not attend” rates, and making “false promises”. In CAT we refer to these obstacles as “snags”. These

are the “I want to change but...” statements. Another example of a snag is “If I look after myself then others won’t look after me”. These responses are often unconscious and need to be made conscious in the therapy through the process of interpretation. It is the unconscious mind that is the most troublesome as it is anatomically deep and primitive, where we can deny or bury our motivations. It is here we hide our responsibilities for our self-defeating acts, either towards ourselves or others. Problematic unconscious emotions that are not dealt with psychologically often reveal themselves in other ways, via medically unexplained symptoms and the epidemic of mind/body disorders (Sarno, 2006).

**CAT in action**

An individual’s activities, particularly regarding self-care and relationships with others, are understood as organised sequences of mental and behavioural processes (referred to as procedures) that are repetitive in nature. An example is shown in *Figure 1*.

The therapist needs to make links between the patient’s past and present experiences, and their persistent use of procedures that are ineffective or harmful. In people with diabetes this will include procedures that affect other aspects of their lives, not just their diabetes management. As with all psychotherapies, the therapeutic relationship provides the foundation where procedures may be re-enacted with the therapist (transference), and where they may be re-interpreted and changed within the safety of that relationship. At the end of the therapy, patient and therapist write “goodbye letters” to one another, which are discussed at the final session. These aspects are highlighted in the case of Mr P presented below.

**Case study**

Mr P was 40 years old when he was referred to the Brighton CAT diabetes service. He had been diagnosed with type 1 diabetes in his early 20s and had always had poor glycaemic control. On assessment he stated he wanted his life to be different but was fearful of what that may mean or involve. He suffered from binge eating

disorder, anxiety and depression.

Mr P had a difficult upbringing. His father was neglectful and depriving in his interest and care for Mr P. He favoured the other children in the family and Mr P stated this was “destructive and cruel”. Being “unfavoured” led to feelings of suspicion and paranoia and as an adult Mr P began “falling out” with family members,

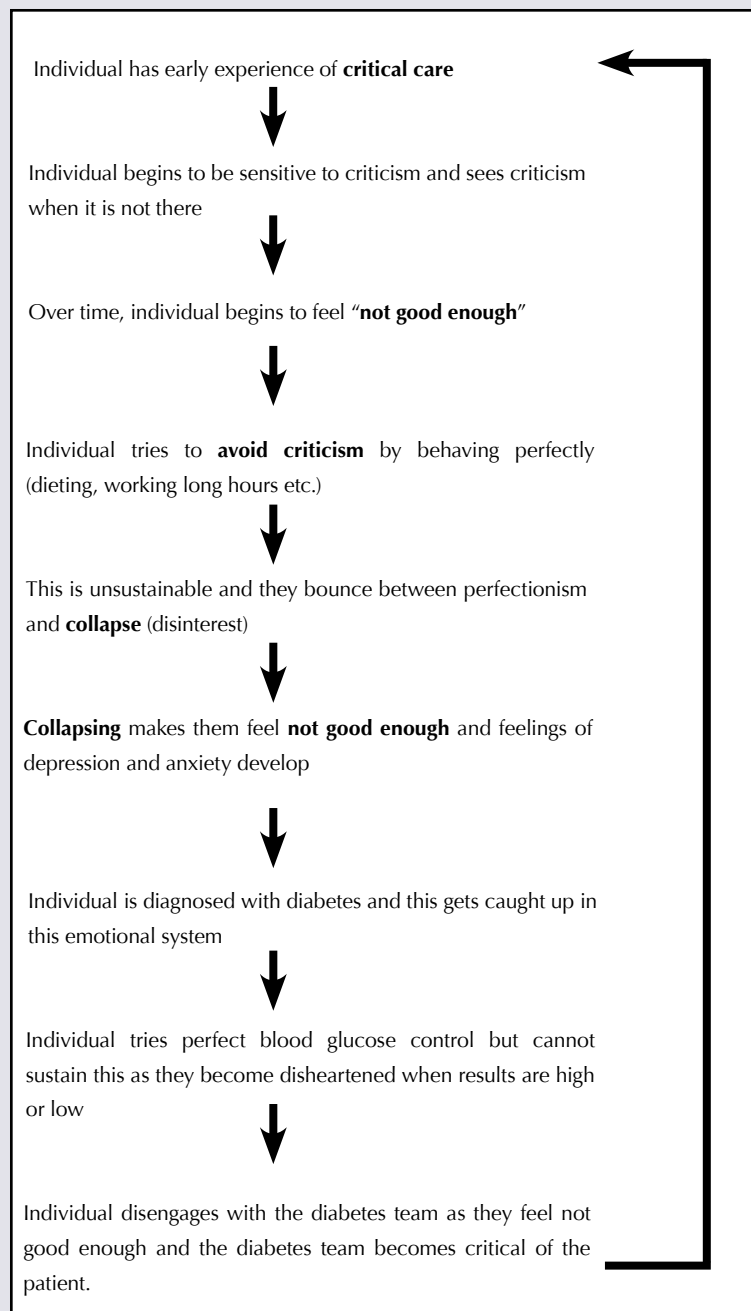


Figure 1. An example of an individual’s sequence of mental and behavioural processes regarding their diabetes.

**“CAT works at a deep level with complex, often resistant patients with a high level of emotional need. These patients have often had long-term diabetes education input and other forms of therapy with no change in self-care behaviour.”**

**Box 1. Goodbye letter from Mr P to his psychotherapist following Cognitive Analytic Therapy.**

*To whom this may concern,  
My name is Mr P, I am 41. I suffer with diabetes, cardiomyopathy, disk prolapse, asthma, depression and binge-eating disorder, which was consuming me out of control, making me a physical mess. Since having all these medical predispositions, you would expect a change of determination. People would just be frustrated and say “stop eating!” If only! What this experience has taught me is that I am my mother and father, there is good and bad in that it’s not worth dying for, which incidentally is a real possibility. If you cut me in two like a stick of rock, the dysfunctional upbringing is there for all to see. That will never end. I will take one day at a time. I will have sad times and days of self-pity, but I will have a life worth living. I have reached a point where I can deal with this. Many thanks*

friends and neighbours. His mother experienced her own early traumatic life events and was violent and abusive to all of her children. Mr P became self-abusive, via over eating, and was neglectful of himself. He was often abusive to others. Mr P had no model of reliable, decent care where he felt he was listened to. This had to be modelled in the therapy by his therapist as an antidote to his early experiences so that he did not feel so emotionally deprived and needy. He also began to understand the cause of his self-abuse and the way in which he became abusive to others and felt abused by them.

At the end of the therapy and in follow up, Mr P’s relationship with his wife, his mother and his diabetes began to improve. In relation to food he stated that “I don’t even fancy over eating”. He also began to remember good things about his father who had subsequently died.

The full process of Mr P’s therapy is outlined in his goodbye letter and is presented exactly as written by him (Box 1).

**For more information on CAT visit:  
[www.acat.me.uk](http://www.acat.me.uk)**

**Conclusion**

CAT works at a deep level with complex, often resistant individuals with a high level of emotional need. These people have often had long-term diabetes education input and other forms of therapy, with no change in diabetes self-care behaviour. Unfortunately, there can be no “quick fix” for these individuals. A number of diabetes centres around the UK use CAT for such difficulties and you can ask your local psychology department for details. ■

Barnard K, Skinner T, Pevelar R (2006) The prevalence of co-morbid depression in adults with type 1 diabetes: Systematic literature review. *Diabet Med* **23**:445–8

Fosbury JA (1996) Psychological treatment (CAT) with poorly controlled type 1 patients. *Pract Diabet* **13**: 158–62

Fosbury JA, Bosley CM, Ryle A et al (1997) A trial of cognitive analytic therapy in poorly controlled type 1 patients. *Diabetes Care* **20**: 959–64

Given J, McCay D, Hill A et al (2015) Understanding barriers to commencing injectable therapy in people with type 2 diabetes. *Journal of Diabetes Nursing* **19**: 214–20

Milton J (1989) Brief psychotherapy with poorly controlled diabetics. *Br J Psychother* **5**: 532–43

Nicolucci A, Burns KK, Holt RIG et al (2013) Diabetes Attitudes, Wishes and Needs second study (DAWN2): cross-national benchmarking of diabetes-related psychosocial outcomes for people with diabetes. *Diabetes Med* **30**: 767–77

Polonsky WH (1999) *Diabetes burnout: What to do when you can’t take any more*. American Diabetes Association, Virginia, USA

Ryle A (1990) *Cognitive analytic therapy: Active participation in change*. John Wiley and Sons, Chichester

Ryle A, Boa C, Fosbury JA (1993) Identifying the causes of poor self management in insulin dependent diabetics. The use of cognitive analytic therapy techniques. In: Hodes M, Mooney S (Eds) *Psychological treatment in disease and illness*. Gaskell, London

Sarno JE (2006) *The Divided Mind*. Harper Collins, London

Shaban MC, Fosbury J, Cavan DA et al (2008) Complex problems need complex solutions: A comparison of psychological interventions in type 1 diabetes. *Diab Med* **25**(Suppl 1): 135

Tilden B, Charman D, Sharples J, Fosbury J (2005) Identity and adherence in a diabetes patient: Transformations in psychotherapy. *Qual Health Res* **15**: 312–24