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Assessment of Emotional Struggles in Type 2 Diabetes: Patient Perspectives

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OBSERVATIONS

Assessment of Emotional Struggles in Type 2 Diabetes: Patient Perspectives

Diabetic patients experience disproportionately high rates of depression, distress, and other psychosocial difficulties (1) that interfere with glycemia and self-care (2). Physicians recognize the frequency and seriousness of patients' emotional struggles (3,4); however, many report that intervening is challenging because of limited treatment options, time constraints, and perceived lack of psychological expertise (4). Diabetes physicians may not feel comfortable or qualified to assess patients' emotional difficulties because they have not received formal training in screening for these difficulties and do not have the resources/referral patterns necessary to provide patients with psychological support (4). Inquiring about patients' preferences for addressing emotional struggles may help guide physicians in providing better support and treatment. As part of a larger qualitative study (4), we conducted in-depth interviews to explore patients' perspectives about how their diabetes physicians approach emotional struggles during a medical visit.

We recruited participants aged 30–70 years who had been diagnosed with type 2 diabetes for 2 or more years, had an A1C ≤14.0%, and were free of cognitive impairment, visual impairment, and severe psychopathology. All patients provided informed written consent. We devised and field-tested a semistructured interview guide. Interviewers asked patients open-ended questions about how their physicians approach and inquire about emotional difficulties. Interviews lasted 30–60 min and were audio recorded and transcribed. Data were collected until saturation was reached. We performed content analysis by independently marking and categorizing key phrases and texts; discrepancies were resolved through consensus.

Thirty-four type 2 diabetic patients (82% white, 41% female; 60 ± 7 years old, 15 ± 2 years education, 12 ± 9 years duration, A1C = 8.0 ± 1.7%, BMI = 34 ± 8 kg/m^2) participated. Fourteen patients reported that their physicians inquired about emotional struggles. These patients appreciated that their physicians inquired and understood the impact these struggles could have on diabetes outcomes. Interestingly, 20 of 34 patients reported that their physicians did not inquire about emotional struggles, and attributed it to the brevity and infrequency of medical visits. All but one of these patients wanted their physician to inquire; the remaining 19 patients wanted physicians to address changes in their emotional status between visits and make mental health referrals when necessary. Further, these patients emphasized the importance of physicians getting to know them and individualizing treatment. Importantly, patients did not expect physicians to treat their emotional difficulties, rather they wanted physicians to inquire about their difficulties and listen to what was going on in their lives.

Inquiring about patients' emotional struggles is necessary in clinical practice to help patients feel connected and help physicians understand how emotional struggles interfere with self-care. Our findings suggest that emotional assessments may not be part of routine diabetes care for all patients. Diabetes treatment guidelines recommend that physicians assess patients' emotional difficulties as part of ongoing care (5); however, assessing these factors during a standard medical visit can be a considerable challenge. Physicians may lack knowledge about specific screening tools and/or the psychological expertise to administer these tools correctly. Further, diabetes management problems and/or complications may take precedence during an already time-constrained visit. Current recommendations, combined with our finding that patients want physicians to address their emotional difficulties, support the need for more efficient strategies to screen for these difficulties.

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E.A.B. and M.D.R. conducted interviews; read, coded, and thematically analyzed the transcripts; and wrote the manuscript. K.M.B. read, coded, and thematically analyzed the transcripts and reviewed and edited the manuscript. M.J.A. reviewed and edited the manuscript. K.W. had the initial idea for this study and wrote the research proposal; read, coded, and thematically analyzed the transcripts; and reviewed and edited the manuscript. All contributors had access to the data. K.W. is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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