

Understanding Physicians' Challenges When Treating Type 2 Diabetic Patients' Social and Emotional Difficulties

A qualitative study

ELIZABETH A. BEVERLY, PHD^{1,2}
BRITTNEY A. HULTGREN, BA¹
KELLY M. BROOKS, BA¹

MARILYN D. RITHOLZ, PHD^{1,2,3}
MARTIN J. ABRAHAMSON, MD^{1,2}
KATIE WEINGER, EDD^{1,2}

OBJECTIVE—To explore physicians' awareness of and responses to type 2 diabetic patients' social and emotional difficulties.

RESEARCH DESIGN AND METHODS—We conducted semistructured interviews with 19 physicians. Interviews were transcribed, coded, and analyzed using thematic analysis.

RESULTS—Three themes emerged: 1) physicians' awareness of patients' social and emotional difficulties; physicians recognized the frequency and seriousness of patients' social and emotional difficulties; 2) physicians' responses to patients' social and emotional difficulties: many reported that intervening with these difficulties was challenging with few treatment options beyond making referrals, individualizing care, and recommending more frequent follow-up visits; and 3) the impact of patients' social and emotional difficulties on physicians: few available patient treatment options, time constraints, and a perceived lack of psychological expertise contributed to physicians' feeling frustrated, inadequate, and overwhelmed.

CONCLUSIONS—Recognition and understanding of physicians' challenges when treating diabetes patients' social and emotional difficulties are important for developing programmatic interventions.

Diabetes Care 34:1086–1088, 2011

A recent study reported physicians' awareness of diabetic patients' social and emotional difficulties (1,2); however, whether physicians can integrate this information into their clinical practice is not known. Diabetic patients experience disproportionately high rates of social and emotional difficulties (3–8), which are associated with poor glycemic control (9) and may interfere with the performance of self-care behaviors (10,11). Understanding how physicians perceive the severity and consequences of patients' social and emotional difficulties is important for developing solutions for these problems. We explored physicians' awareness of and responses to social and

emotional difficulties in type 2 diabetic patients.

RESEARCH DESIGN AND METHODS

We used purposive sampling (12) to interview English-speaking endocrinologists and primary care physicians with at least 5% of their practice consisting of type 2 diabetic patients. We recruited physicians from the greater Boston area. The Joslin Diabetes Center Committee on Human Subjects approved the research protocol, and all physicians provided informed written consent.

We devised a structured interview guide and field-tested it for flow and clarity of the questions. Interviews lasted 30–60 min

and were digitally audio-recorded and transcribed.

We performed content analysis (12) by categorizing key words and phrases to identify themes using NVivo 8 (13). This process continued until data saturation was reached. To support credibility/validity and dependability/reliability of the data, we triangulated data sources, methods, and investigators and tracked the decision-making process.

RESULTS—Nineteen physicians (Table 1) participated. Transcript identifiers (identification number, sex) are included with quotations. Qualitative analysis revealed three themes.

Physicians' awareness of patients' emotional difficulties

Physicians acknowledged how the challenges of following multiple self-care recommendations contributed to new or existing emotional difficulties:

Diabetes carries a significant amount of emotional baggage...the work involved, limitations...or perceived limitations on their life, or downright fear about the consequences of the disease...can really be a tipping point for them. I feel bad for them. (Physician 102M)

They also recognized the frequency of social difficulties:

Sometimes they have other things that are higher priority...family, sick husbands, work, or school. Some patients have multiple jobs, they have financial issues...they just can't check their sugars. (Physician 115F)

Some physicians reported trouble detecting patients' difficulties:

It's usually something that I don't think I always pick up on. (Physician 100M)

Furthermore, physicians expressed uncertainty about how or whether they should assess patients' difficulties:

Every single person that I see has a whole lot more to them than I see. And how do you

From the ¹Joslin Diabetes Center, Boston, Massachusetts; the ²Harvard Medical School, Boston, Massachusetts; and the ³Children's Hospital, Boston, Massachusetts.

Corresponding author: Katie Weinger, katie.weinger@joslin.harvard.edu.

Received 7 December 2010 and accepted 3 February 2011.

DOI: 10.2337/dc10-2298

This article contains Supplementary Data online at <http://care.diabetesjournals.org/lookup/suppl/doi:10.2337/dc10-2298/-/DC1>.

© 2011 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. See <http://creativecommons.org/licenses/by-nc-nd/3.0/> for details.

Table 1—Demographic characteristics of physicians

	Means \pm SD (n = 19)	Range
Age (years)	48.2 \pm 9.3	37–63
Years in medical practice	20.8 \pm 10.1	7–34
Percentage of practice with type 2 diabetes	52.4 \pm 25.2	7.5–95
Female (%; n = 8)	42.1	—
Non-Hispanic white (%; n = 15)	78.9	—
Endocrinologist (%; n = 14)	73.7	—

bring it out? And do you necessarily have to bring it out? And would it be better if I did? These are questions I don't know. (Physician 107F)

Physicians' responses to patients' emotional difficulties

Physicians reported few treatment options for patients with social and emotional difficulties. Most described making referrals to mental health professionals; however, some remarked that not all patients were open to referrals:

[I] try to find a way to deal with it in a medical visit and direct them to appropriate treatment, which is hard because there's often resistance to that. (Physician 104F)

Furthermore, physicians noted limitations within their referral system:

I think it's somewhat harder to find therapists. . . I don't know what to tell someone who is [outside the city]. I know there must be people within ten miles, but I'm stuck and we don't have a good identification system. (Physician 108M)

Physicians also suggested individualizing care and requesting more frequent follow-up visits:

For some people it totally shuts them down and they're immobilized. . . I try to understand that and then I tailor my approach so that I don't overwhelm somebody because I think that's the best way to be effective in getting their A1C better. (Physician 114M)

The impact of patients' emotional difficulties on physicians

Treating patients with social and emotional difficulties appeared to take a toll on the physicians. Physicians commented on the stress and anxiety of struggling to adhere to the time constraints of a standard medical visit:

Well it affects me in terms of time. Our appointments. . . are twenty minutes. . . If they go over. . . you get anxious because you want

to cover everything. . . You have to examine the patient. You have to order the labs. So definitely it creates a lot of stress and anxiety on my part. (Physician 113F)

Physicians also described feeling tired and overwhelmed:

When I have people come in, I try to deal with emotions but it may make me tired. . . overwhelmed. . . I think dealing with the emotions is important but it's probably one of the more. . . frustrating and exhausting things that we do. (Physician 112F)

Some physicians felt they lacked the expertise to best support their patients:

I feel inadequate sometimes because I don't have enough of a background to help them. (Physician 100M)

Several considered receiving additional training in psychology:

I even thought semi-seriously of taking some time off and doing a psychology residency. (Physician 108M)

CONCLUSIONS—In our study, physicians recognized the frequency and seriousness of social and emotional difficulties in diabetes care. Many reported that intervening with these difficulties was challenging. Limited patient treatment options, time constraints, and a perceived lack of psychological expertise contributed to physicians' feeling frustrated, inadequate, and overwhelmed. The emotional toll from treating patients with social and emotional difficulties may put physicians at further risk for burnout (14,15).

Similar to our study, the Diabetes Attitudes, Wishes, and Needs (DAWN) study found that physicians recognized that a majority of their diabetes patients had psychosocial problems (1). These physicians also reported a lack of expertise in their abilities to identify and evaluate

patients' psychosocial problems and/or provide needed support (1). These findings, along with ours, highlight the extent of the challenges physicians face in treating diabetic patients with social and emotional difficulties.

In conclusion, recognizing and understanding physicians' challenges are important as a first step for developing programmatic interventions. The development and testing of efficient, brief interventions that physicians can use are necessary but should not replace mental health referrals. Furthermore, medical education and training should address psychosocial difficulties that frequently occur in patients with chronic illnesses. Finally, given the brevity of treatment visits and the amount of medical information that needs to be addressed, physicians may benefit from a multidisciplinary team approach where other team members complement care by supplying assessment and treatment for patients' social and emotional difficulties.

Acknowledgments—The Kathleen P. Welsh Fund supported this study. M.J.A. has received research funding from Pfizer and has provided consulting services to Novo Nordisk, sanofi-aventis, Halozyme, and Merck. No other potential conflicts of interest relevant to this article were reported.

E.A.B. conducted interviews; read, coded, and thematically analyzed the transcripts; and wrote the manuscript. B.A.H. and K.M.B. read, coded, and thematically analyzed the transcripts and reviewed and edited the manuscript. M.D.R. conducted interviews; 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 and can take responsibility for the integrity of the data and the accuracy of the data analysis.

The authors thank the physicians who shared their experiences and perceptions.

References

1. Peyrot M, Rubin RR, Lauritzen T, Snoek FJ, Matthews DR, Skovlund SE. Psychosocial problems and barriers to improved diabetes management: results of the Cross-National Diabetes Attitudes, Wishes and Needs (DAWN) Study. *Diabet Med* 2005; 22:1379–1385
2. Peyrot M, Rubin RR, Siminerio LM. Physician and nurse use of psychosocial strategies in diabetes care: results of the cross-national Diabetes Attitudes, Wishes and Needs

- (DAWN) study. *Diabetes Care* 2006;29:1256–1262
3. de Groot M, Anderson R, Freedland KE, Clouse RE, Lustman PJ. Association of depression and diabetes complications: a meta-analysis. *Psychosom Med* 2001;63:619–630
 4. Anderson RJ, Freedland KE, Clouse RE, Lustman PJ. The prevalence of comorbid depression in adults with diabetes: a meta-analysis. *Diabetes Care* 2001;24:1069–1078
 5. Lloyd CE, Dyer PH, Barnett AH. Prevalence of symptoms of depression and anxiety in a diabetes clinic population. *Diabet Med* 2000;17:198–202
 6. Weinger K, Jacobson AM. Psychosocial and quality of life correlates of glycemic control during intensive treatment of type 1 diabetes. *Patient Educ Couns* 2001;42:123–131
 7. Welch GW, Jacobson AM, Polonsky WH. The Problem Areas in Diabetes Scale: an evaluation of its clinical utility. *Diabetes Care* 1997;20:760–766
 8. Polonsky WH, Anderson BJ, Lohrer PA, et al. Assessment of diabetes-related distress. *Diabetes Care* 1995;18:754–760
 9. Lustman PJ, Anderson RJ, Freedland KE, de Groot M, Carney RM, Clouse RE. Depression and poor glycemic control: a meta-analytic review of the literature. *Diabetes Care* 2000;23:934–942
 10. Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function, and costs. *Arch Intern Med* 2000;160:3278–3285
 11. Lin EH, Katon W, Von Korff M, et al. Relationship of depression and diabetes self-care, medication adherence, and preventive care. *Diabetes Care* 2004;27:2154–2160
 12. Morse J, Field P. *Qualitative Research Methods for Health Professionals*. 2nd ed. Thousand Oaks, CA, Sage Publications, 1995
 13. QSR International. *NVivo 8 Software 8th Edition*. Victoria, Australia, 2008
 14. Thomas NK. Resident burnout. *JAMA* 2004;292:2880–2889
 15. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136:358–367