# Recognizing and Helping

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# Twenty-five years of diabetes distress research

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## Abstract

The term 'diabetes distress' first entered the psychosocial research vernacular in 1995, and refers to 'the negative emotional or affective experience resulting from the challenge of living with the demands of diabetes'. At first the proponents of the concept were hesitant in advocating that diabetes distress was a major barrier to individuals' self-care and management of diabetes. Since then, a burgeoning body of evidence, now including several systematic reviews of intervention studies, suggests that diabetes distress, in both type 1 and type 2 diabetes, across ages and in all countries and cultures where it has been studied, is common and can be a barrier to optimal emotional well-being, self-care and management of diabetes. As a consequence, monitoring diabetes distress as part of routine clinical care is part of many national guidelines. The present narrative review summarizes this research and related literature, to postulate the aetiology of diabetes distress, and thus how it may be prevented. The current evidence base for the management of diabetes distress is summarized, and the next steps in the prevention and management of diabetes distress identified.

**Instructions:** Which of the following diabetes issues are **currently** a problem for you?
Tick the box that gives the best answer for you. Please provide an answer for each question.

| | | Not a problem | Minor problem | Moderate problem | Somewhat serious problem | Serious problem |
|---|---|---|---|---|---|---|
| 1 | Not having clear and concrete goals for your diabetes care? | 0 | 1 | 2 | 3 | 4 |
| 2 | Feeling discouraged with your diabetes treatment plan? | 0 | 1 | 2 | 3 | 4 |
| 3 | Feeling scared when you think about living with diabetes? | 0 | 1 | 2 | 3 | 4 |
| 4 | Uncomfortable social situations related to your diabetes care (e.g. people telling you what to eat)? | 0 | 1 | 2 | 3 | 4 |
| 5 | Feelings of deprivation regarding food and meals? | 0 | 1 | 2 | 3 | 4 |
| 6 | Feeling depressed when you think about living with diabetes? | 0 | 1 | 2 | 3 | 4 |
| 7 | Not knowing if your mood or feelings are related to your diabetes? | 0 | 1 | 2 | 3 | 4 |
| 8 | Feeling overwhelmed by your diabetes? | 0 | 1 | 2 | 3 | 4 |
| 9 | Worrying about low blood glucose reactions? | 0 | 1 | 2 | 3 | 4 |
| 10 | Feeling angry when you think about living with diabetes? | 0 | 1 | 2 | 3 | 4 |
| 11 | Feeling constantly concerned about food and eating? | 0 | 1 | 2 | 3 | 4 |
| 12 | Worrying about the future and the possibility of serious complications? | 0 | 1 | 2 | 3 | 4 |
| 13 | Feelings of guilt or anxiety when you get off track with your diabetes management? | 0 | 1 | 2 | 3 | 4 |
| 14 | Not 'accepting' your diabetes? | 0 | 1 | 2 | 3 | 4 |
| 15 | Feeling unsatisfied with your diabetes physician? | 0 | 1 | 2 | 3 | 4 |
| 16 | Feeling that diabetes is taking up too much of your mental and physical energy every day? | 0 | 1 | 2 | 3 | 4 |
| 17 | Feeling alone with your diabetes? | 0 | 1 | 2 | 3 | 4 |
| 18 | Feeling that your friends and family are not supportive of your diabetes management efforts? | 0 | 1 | 2 | 3 | 4 |
| 19 | Coping with complications of diabetes? | 0 | 1 | 2 | 3 | 4 |
| 20 | Feeling 'burned out' by the constant effort needed to manage diabetes? | 0 | 1 | 2 | 3 | 4 |

## Diabetes Distress - Screening Scale (DDS17)

**Directions:** Living with diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 17 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 17 items may have distressed or bothered you **DURING THE PAST MONTH** and circle the appropriate number.

**Please note** Circle the number gives the best answer for you and please provide an answer for each question. If you feel that a particular item is not a bother or a problem for you, you would circle "1". If it is very bothersome to you, you might circle "6".

| | | Not a Problem | A Slight Problem | A Moderate Problem | Somewhat Serious Problem | A Serious Problem | A Very Serious Problem |
|---|---|---|---|---|---|---|---|
| Q1 | Feeling the diabetes is taking up too much of my mental and physical energy every day | 1 | 2 | 3 | 4 | 5 | 6 |
| Q2 | Feeling that my doctor doesn't know enough about diabetes and diabetes care | 1 | 2 | 3 | 4 | 5 | 6 |
| Q3 | Feeling angry, scared and/or depressed when I think about living with diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| Q4 | Feeling that my doctor doesn't give me clear enough directions on how to manage my diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| Q5 | Feeling that I am not testing my blood sugars frequently enough | 1 | 2 | 3 | 4 | 5 | 6 |
| Q6 | Feeling that I am often failing with my diabetes routine | 1 | 2 | 3 | 4 | 5 | 6 |
| Q7 | Feeling that friends or family are not supportive enough of self-care efforts (e.g. planning activities that conflict with my schedule, encouraging me to eat the "wrong" foods) | 1 | 2 | 3 | 4 | 5 | 6 |
| Q8 | Feeling that diabetes controls my life | 1 | 2 | 3 | 4 | 5 | 6 |
| Q9 | Feeling that my doctor doesn't take my concerns seriously enough | 1 | 2 | 3 | 4 | 5 | 6 |
| Q10 | Not feeling confident in my day-to-day ability to manage diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| Q11 | Feeling that I will end up with serious long-term complications, no matter what I do | 1 | 2 | 3 | 4 | 5 | 6 |
| Q12 | Feeling that I am not sticking closely enough to a good meal plan | 1 | 2 | 3 | 4 | 5 | 6 |
| Q13 | Feeling that friends or family don't appreciate how difficult living with diabetes can be | 1 | 2 | 3 | 4 | 5 | 6 |
| Q14 | Feeling overwhelmed by the demands of living with diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| Q15 | Feeling that I don't have a doctor, who I can see regularly enough about my diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| Q16 | Not feeling motivated to keep up my diabetes self management | 1 | 2 | 3 | 4 | 5 | 6 |
| Q17 | Feeling that friends or family don't give me the emotional support that I would like | 1 | 2 | 3 | 4 | 5 | 6 |

| Item | Not a problem | A slight problem | A moderate problem | A somewhat serious problem | A serious problem | A very serious problem |
|---|---|---|---|---|---|---|
| 1. Feeling overwhelmed by the demands of living with diabetes | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Feeling that I am often failing with my diabetes routine | 1 | 2 | 3 | 4 | 5 | 6 |

* The DDS2 is a two-item diabetes distress screening instrument asking respondents to rate on a six-point scale the degree to which the two items above caused distress. An average score of <2 indicates little or no distress, a score between 2 and 2.9 indicates moderate diabetes distress and ≥3 indicates high level of diabetes distress.

# Is Diabetes Distress clinically important?

## Diabetes distress is more strongly associated with HbA1c than depressive symptoms in adolescents with type 1 diabetes: Results from Diabetes MILES Youth–Australia

Virginia Hagger [1] [2], Christel Hendrieckx [1] [2], Fergus Cameron [3], Frans Pouwer [4], Timothy C Skinner [5] [6], Jane Speight [1] [2] [7]

Affiliations + expand

PMID: 29383803   DOI: 10.1111/pedi.12641

## Abstract

**Background:** Glycated hemoglobin (HbA1c) is higher during adolescence than at any other life stage. Some research among adolescents indicates that depressive symptoms are associated with suboptimal HbA1c. However, research among adults suggests diabetes distress is a stronger predictor of HbA1c than depressive symptoms.

**Objective:** To determine the relative contributions of depressive symptoms and diabetes distress to explain the variance in HbA1c among adolescents with type 1 diabetes.

**Participants and methods:** Diabetes MILES Youth Study respondents aged 13 to 19 years completed questionnaires assessing depressive symptoms (Patient Health Questionnaire for Adolescents: PHQA-8), diabetes distress (Problem Areas in Diabetes-Teen version: PAID-T), and self-reported socio-demographic and clinical variables, including their most recent HbA1c. Stepwise hierarchical multiple regression was conducted to examine the contributions of depressive symptoms and diabetes distress to HbA1c.

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Clinical Care/Education/Nutrition/Psychosocial Research
BRIEF REPORT

## The Relationship Between Diabetes Distress and Clinical Depression With Glycemic Control Among Patients With Type 2 Diabetes

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LISA A. STRYCKER, MA[3]

**OBJECTIVE** — To clarify previous findings that diabetes distress is related to glycemic control and self-management whereas measures of depression are not, using both binary and continuous measures of depression.

**RESEARCH DESIGN AND METHODS** — Four hundred and sixty-three type 2 patients completed measures of diabetes distress (Diabetes Distress Scale [DDS]) and clinical depression (Patient Health Questionnaire 8 [PHQ8]). PHQ8 was employed as either a binary (≥10) or continuous variable. Dependent variables were A1C, diet, physical activity (PA), and medication adherence (MA).

**RESULTS** — The inclusion of a binary or continuous PHQ8 score yielded no differences in any equation. DDS was significantly associated with A1C and PA, whereas PHQ8 was not; both DDS and PHQ8 were significantly and independently associated with diet and MA.

**CONCLUSIONS** — The lack of association between depression and glycemic control is not due to the use of a binary measure of depression. Findings further clarify the significant association between distress and A1C.

*Diabetes Care* 33:1034–1036, 2010

Recent studies have drawn a distinction between major depressive disorder (MDD) and diabetes-related distress (DD) among patients with type 2 diabetes (1,2). These studies have generally shown that DD is significantly associated with self-management variables and glycemic control whereas MDD is not (3,4).

MDD has been assessed primarily by a binary diagnostic indicator using a structured interview (e.g., Comprehensive International Diagnostic Interview [CIDI]) (5), whereas DD has been most often assessed by a continuous questionnaire scale score (6). Binary scores contain less information and are less powerful than continuous measures. These differences in measurement may account for

why continuous DD scores are associated with diabetes markers and binary scores of MDD are not when both are included in the same or in separate analyses (2). Also, many studies assess depression using symptom inventories not tied to DSM-IV criteria for MDD. Thus, it is difficult to link scores from these measures to well-defined clinical conditions like MDD. We address both problems by assessing MDD with a continuous and a binary questionnaire score tied directly to DSM-IV criteria for MDD, the Patient Health Questionnaire (PHQ) (7), and evaluating the relationship between both MDD measures and continuous Diabetes Distress Scale (DDS) scores on disease management behaviors and glycemic control.

**RESEARCH DESIGN AND METHODS** — Data were part of the preintervention assessment of a new Internet-based diabetes self-management education study of patients with type 2 diabetes. Patient characteristics included age, sex, ethnicity (white/nonwhite), education (years), and use of insulin (yes/no). A1C was gathered from recent clinical records. PHQ9 is a 9-item questionnaire tied to DSM-IV criteria for MDD (8). One question, suicidal ideation, was excluded (PHQ8) in keeping with non-clinically based studies (8). Items were scored 0 ("not at all") to 3 ("nearly every day") and were summed to create a total score and a binary score (≥10) for MDD (8). DDS is a 16-item scale (α = 0.92) that assesses diabetes-specific distress (6). Six items from the regimen-distress subscale were included. Summed items were scored on a 6-point scale from "not a problem" to "a very serious problem," with a score of ≥3 as the cut point. This subscale was selected because it is directly related to health behaviors and is highly correlated with the scale total (6).

The Community Healthy Activities Model Program for Seniors (CHAMPS) questionnaire (9) assessed physical activity (PA), which was calculated as weekly caloric expenditure (10). Diet was assessed by the 7-item Starting the Conversation scale (11), which assesses the frequency of consumption of sugary beverages and fast food. It is sensitive to change in assessing healthy eating patterns (11). Adherence to medications (MA) was assessed by the Hill-Bone Compliance Scale (12) that identifies how often and why respondents miss taking medications. The study was approved by the Kaiser-Permanente, Colorado Institutional Review Board.

**RESULTS** — Of 463 patients, the average age was 58.8 years (SD = 9.1), 51.5% were female, mean BMI = 34.8 kg/m²

# Adults With Diabetes Distress Often Want to Talk With Their Health Professionals About It: Findings From an Audit of 4 Australian Specialist Diabetes Clinics

Christel Hendrieckx, PhD 👤 ✉ • Jennifer A. Halliday, BHealthSci (Hons) •
Sienna Russell-Green, BBiomedSc, BHealth&MedSc (Hons) • ...
Alicia Jenkins, MBBS, MRCP MD, FRACP, FRCP • David O'Neal, MD, MBBS, FRACP • Jane Speight, PhD •
Show all authors

## Abstract

### Objectives

In an unselected clinical sample, we aimed to: 1) investigate the willingness of adults with diabetes to talk with their health professional(s) about their feelings and experiences living with diabetes, 2) assess the prevalence of impaired general emotional well-being and severe diabetes distress and 3) examine whether willingness to talk related to general and/or diabetes-specific emotional well-being.

### Methods

Unselected adults with type 1 diabetes (T1D) or type 2 diabetes (T2D) attending 4 Australian specialist diabetes clinics completed surveys about their experiences of, and preferences for, talking with their diabetes health professional(s) about their feelings and personal experiences of diabetes. They indicated preferred topics to discuss from a list and completed validated measures of emotional well-being (World Health Organisation-5 Well-being Index) and diabetes distress (Problem Areas In Diabetes scale).
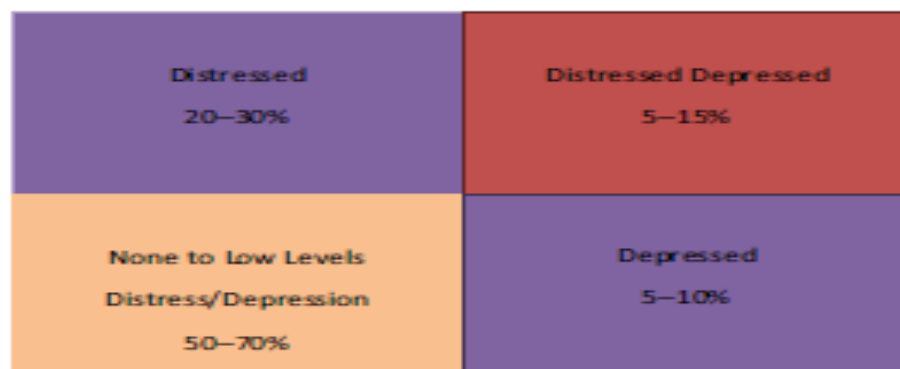
FIGURE 1 Estimated distribution of prevalence of depression and distress in people with diabetes. Estimates derived from meta-analysis, systematic reviews, narrative reviews and empirical studies of self-reported instruments, for distress and depression [2,5,7,15,28,30,31].
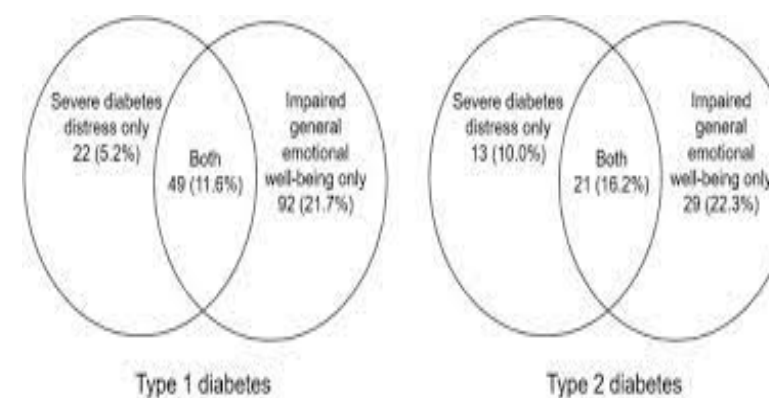
# Intervention resistance...

- Quick

- Within your skill set

- Does not require additional training

- Effective
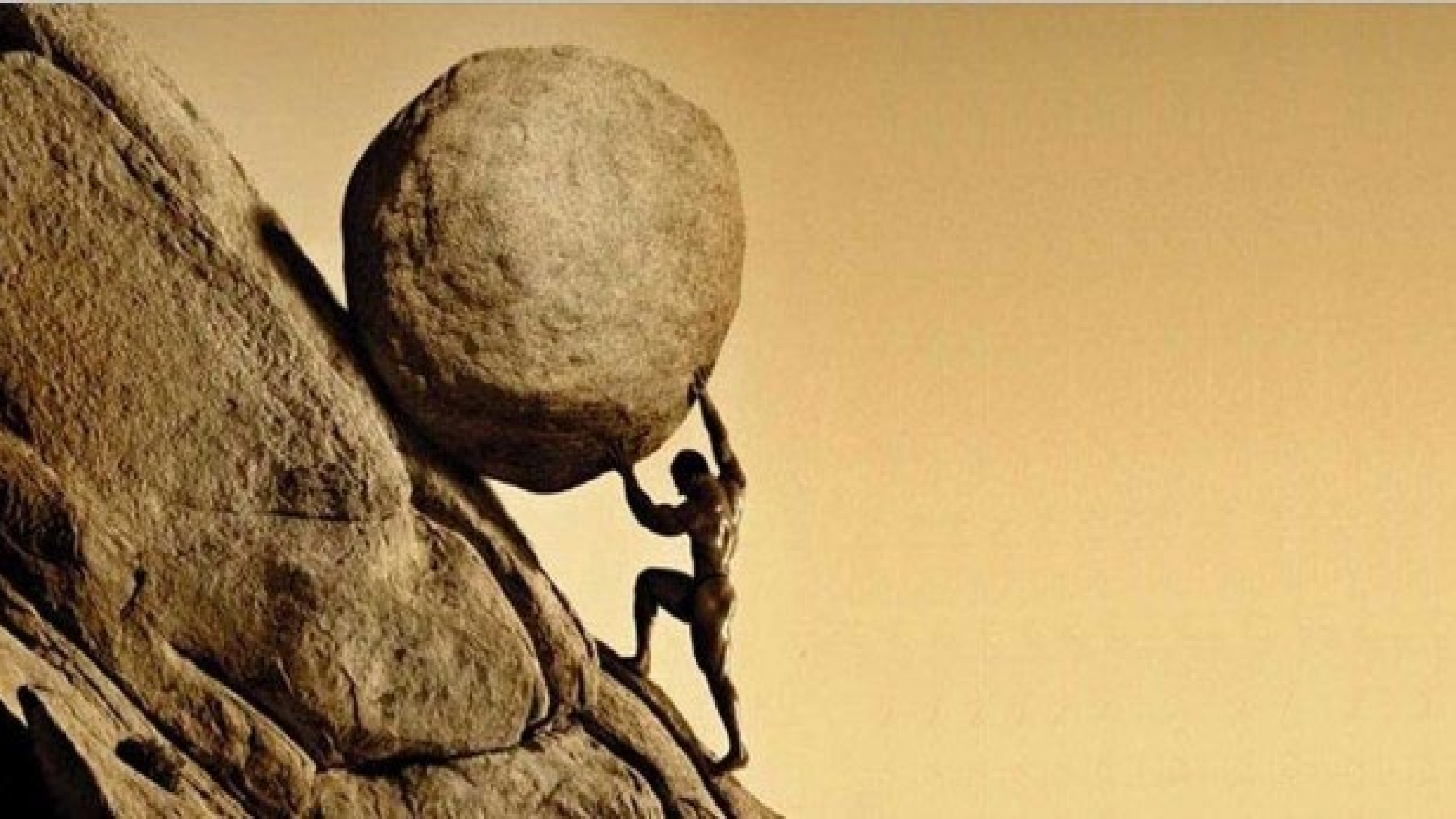
# WHY SHOULD I?

Part of a child's development is asking questions and learning about themselves. With amusing pictures and simple text, this book shows the importance of listening – at home and school.

This book contains notes for parents and teachers to help them use this book most effectively.

## TITLES IN THE SERIES

WHY SHOULD I Protect Nature?

WHY SHOULD I Recycle?

WHY SHOULD I Save Energy?

WHY SHOULD I Save Water?

WHY SHOULD I Eat Well?

WHY SHOULD I Help?

WHY SHOULD I Listen?

WHY SHOULD I Share?

# Actually Mummy...

*The Diary of a Loquacious Schoolgirl*

## Why there is no such thing as stable diabetes

Take a look at this image:
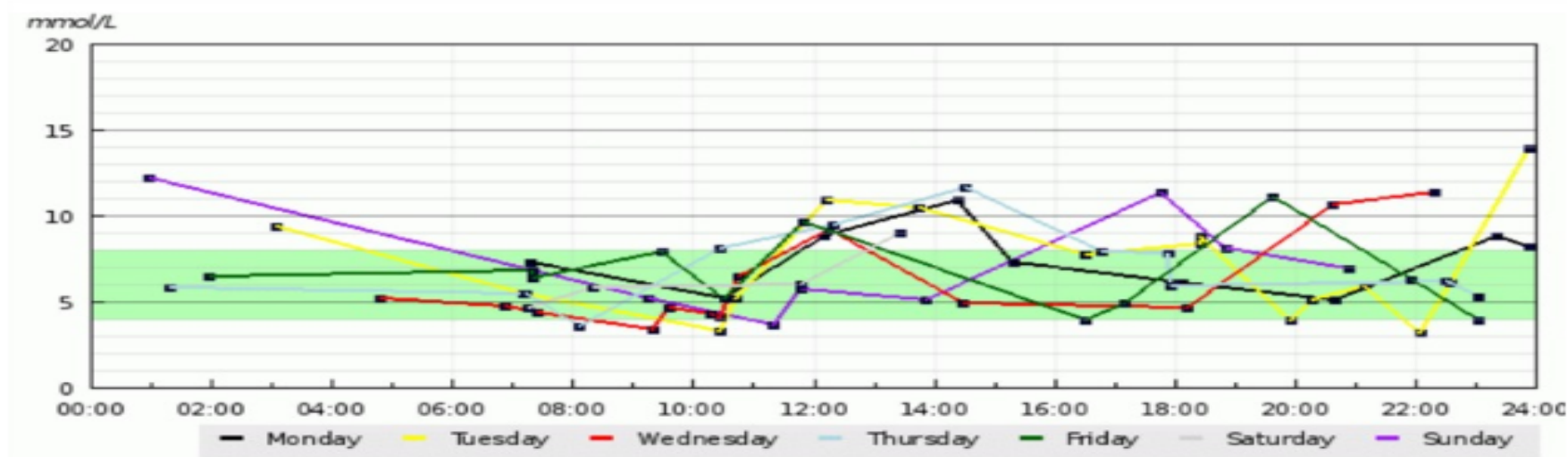


This picture represents a week of blood sugar readings for my 11 year old daughter. She is considered by her doctors to have excellent control, in the top 5% of her clinic. Anything inside the shaded green area (4.0 − 8.0) is in target. Not normal, but normal enough to minimise the risk of complications. The points below 4.0 are hypos, where she has suffered a low blood sugar and urgently needed to consume sugar. The points over 8.0 are numerous, unexpected, and also make her feel pretty rough. She or I worked really hard to prevent them, but they happened anyway.

# Control the Controllable's
## Prepare To Be A Champion

**BOXING**
SCIENCE

## Controllables
- Diet and Hydration
- Kit and Equipment
- Training
- Tapering
- Mental Rehearsal
- Game Plan
- Venue Walk Through
- Self Reflection

## Uncontrollables
- Opponent (Age, Ability, Height)
- Referee
- Coach's Decisions
- Changing Room/Warm Up Area
- Competition Environment
- Media Coverage

These are just a few examples for each section. There are many more factors contributing to success in Boxing

## 10 THINGS THAT REQUIRE ZERO TALENT

1. BEING ON TIME
2. WORK ETHIC
3. EFFORT
4. BODY LANGUAGE
5. ENERGY
6. ATTITUDE
7. PASSION
8. BEING COACHABLE
9. DOING EXTRA
10. BEING PREPARED

THINGS THAT MATTER

THINGS YOU CAN CONTROL
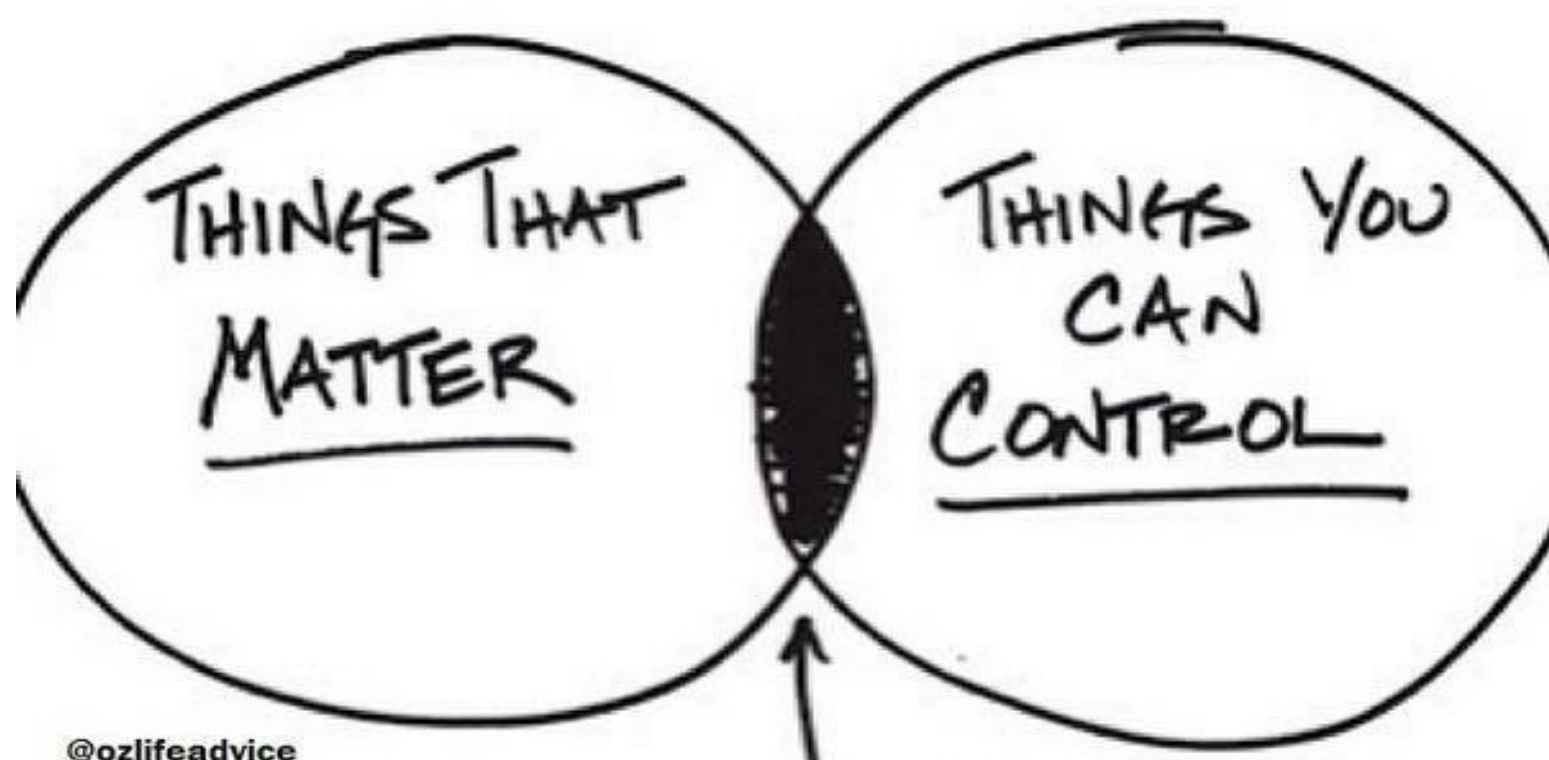
@ozlifeadvice

WHAT YOU SHOULD FOCUS ON

# Misunderstandings about Type 1 diabetes are an additional challenge

## Diabetes Type 2

### Misunderstandings about diabetes

There are 3.5 million people in the UK who have diabetes and yet some people we spoke to said that diabetes was poorly understood by society as a whole (Diabetes UK 2016). Several people expressed the view that they wanted some commonly-held myths and misconceptions about diabetes to be corrected.

The current media portrayal of diabetes as a 'disease of fat people' was said by some people to be stigmatising and potentially damaging to their morale. Several people felt that the links made in the media between 'the obesity crisis' and diabetes was too simplistic. While they acknowledged that obesity was one of several possible contributory causes of diabetes, they said it was wrong for obesity to be portrayed as the main cause of diabetes. Many people said that they knew people with diabetes who were not overweight or obese.

"It's good to be loved, but profound to be understood"

-P. De Rossi

"The single most important lesson I learned in 25 years talking every single day to people, was that there's a common denominator in our human experience. We want to be validated. We want to be understood."

(Oprah Winfrey, Harvard University Commencement Speech, 2013)

# Video clip: https://vimeo.com/539109146

21:21

1 in 5 people with insulin-dependent type 2 diabetes

1 in 6 with Non-insulin-dependent type 2 diabetes

1 in 4 people with insulin-dependent type 1 diabetes

experience Diabetes Distress

Defeat

Denial

Fear

Diabetes Distress

Lonliness

Frustration

Low Motivation
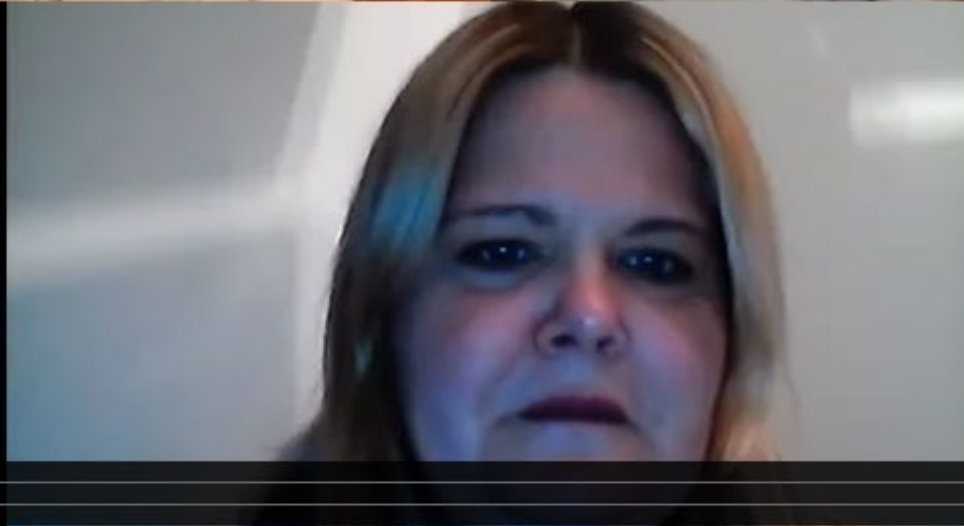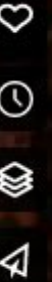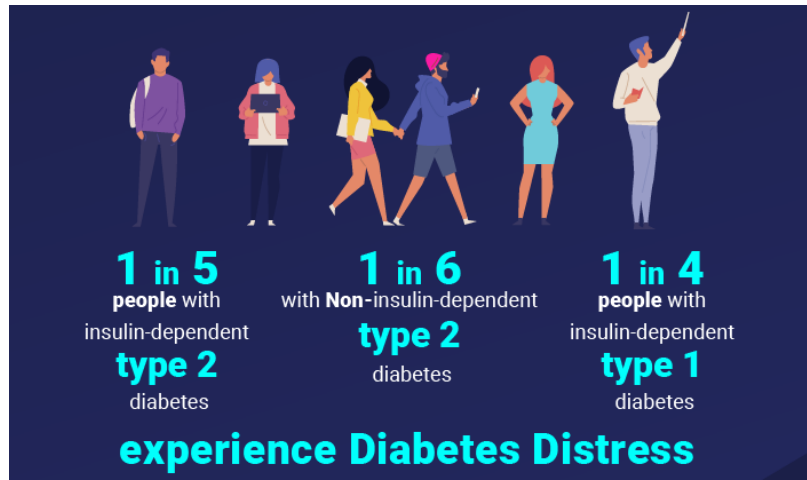
# The Brief Illness Perception Questionnaire

For the following questions, please circle the number that best corresponds to your views:

**How much does your illness affect your life?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

no affect at all        severely affects my life

**How long do you think your illness will continue?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

a very short time        forever

**How much control do you feel you have over your illness?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

absolutely no control        extreme amount of control

**How much do you think your treatment can help your illness?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

not at all        extremely helpful

**How much do you experience symptoms from your illness?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

no symptoms at all        many severe symptoms

**How concerned are you about your illness?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

not at all concerned        extremely concerned

**How well do you feel you understand your illness?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

don't understand at all        understand very clearly

**How much does your illness affect you emotionally? (e.g. does it make you angry, scared, upset or depressed?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

not at all affected emotionally        extremely affected emotionally

**Please list in rank-order the three most important factors that you believe caused <u>your illness</u>.** *The most important causes for me:-*

1. _____

2. _____

3. _____

# Diabetes distress, illness perceptions and glycaemic control in adults with type 2 diabetes.

Martinez K[1], Lockhart S[2], Davies M[3], Lindsay JR[4], Dempster M[1].

⊕ Author information

## Abstract

The emotional distress associated with adjusting to and living with diabetes has been termed diabetes distress. Diabetes distress is associated with glycaemic control but interventions to reduce diabetes distress have failed to consistently improve diabetes control. Various illness perceptions have previously been linked with both diabetes distress and glycaemic control but interrelationships between these features have not been previously investigated. We hypothesised that illness perceptions mediate the relationship between diabetes distress and glycaemia. Participants with type 2 diabetes attending diabetes outpatient clinics (n = 84) provided demographic and clinical information and completed the Diabetes Distress Scale-17 and the Brief Illness Perceptions Questionnaire. Using regression analysis we demonstrated that the illness perceptions of personal control, regimen-related distress, socioeconomic status and insulin use were significant contributors in the final model predicting $HbA_{1c}$. Higher levels of personal control were associated with better glycaemic control. Conversely, regimen-related distress was associated with hyperglycaemia. Mediation analyses showed that the relationship between regimen-related distress and $HbA_{1c}$ was mediated by personal control. Our work suggests that psychological interventions designed to reduce diabetes distress may be more efficacious in improving glycaemic control if they address an individual's perception of personal control.

# Managing Type 2 diabetes as a couple: The influence of partners' beliefs on diabetes distress over time

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## ARTICLE INFO

## ABSTRACT

*Aims:* Partners and spouses have an important role in supporting healthy self-care in adults with Type 2 diabetes. While evidence has shown that the beliefs held by people with diabetes influence emotional wellbeing, little is known about the long-term impact of partners' illness beliefs on diabetes distress.

*Methods:* Persons with Type 2 diabetes (pwt2d) and their partners completed a questionnaire at baseline (N = 75 couples) and 12 months later (N = 45 couples). Measures included demographic/clinical parameters, the Revised Illness Perception questionnaire, and the Diabetes Distress Scale. A repeated measures ANOVA was used to examine change in measures over time. Multiple regression and moderation analysis were used to explore the indirect influence of partners beliefs on diabetes distress at baseline and follow-up.

*Results:* Illness perceptions and diabetes distress in pwt2d and partners did not change overtime. Partners' beliefs about the controllability, chronicity, and predictability of symptoms of diabetes moderated the relationship between the corresponding pwt2d beliefs and diabetes distress. These indirect effects were observed across both time points.

*Conclusions:* Conflicting illness perceptions about the controllability and chronicity of diabetes, and congruous negative perceptions about diabetes symptoms among couples sustain distress overtime. Targeting the beliefs of couples to improve communication and understanding may reduce diabetes distress.

## Research: Educational and Psychological Aspects

## The effectiveness of an emotion-focused educational programme in reducing diabetes distress in adults with Type 2 diabetes mellitus (VEMOFIT): a cluster randomized controlled trial

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### Abstract

**Aims**   To evaluate the effectiveness of a brief, value-based emotion-focused educational programme (VEMOFIT) in Malay adults with Type 2 diabetes mellitus compared with a programme of active listening to participants' emotional experiences, social support and their opinion on the health clinic diabetes care services (attention control).

**Methods**   Malay adults with severe diabetes distress [Diabetes Distress Scale (DDS-17) mean score $\geq$ 3] were included. VEMOFIT consisted of four biweekly group sessions, a booster session after 3 months and a follow-up 6 months post intervention. The attention control programme consisted of three sessions over the same period. Outcomes included diabetes distress, depressive symptoms, self-efficacy and disease control. Required total sample size was 165.

**Results**   Participants ($n = 124$) were randomized to either VEMOFIT ($n = 53$) or the attention control programme ($n = 71$). Participants had a mean (SD) age of 55.7 (9.7) years, median diabetes duration of 7.0 (8.0) years and mean $HbA_{1c}$ level of 82 mmol/mol (9.7%). The mean DDS-17 level decreased significantly in both the VEMOFIT and the attention control programmes (3.4 to 2.9 vs. 3.1 to 2.7, respectively). The adjusted between-group DDS-17 difference was not significant [$-0.01$, 95% confidence interval (CI) $-0.38$, 0.35]. The proportion of individuals with severe diabetes distress decreased in both groups, from 89% to 47% vs. 69% to 39% (odds ratio 0.88; 95% CI 0.26, 2.90). Other outcomes did not differ between groups.

**Conclusions**   Both interventions decreased diabetes distress significantly. The theory-based VEMOFIT programme was not superior to the attention control programme. The latter approach is a simpler way to decrease severe diabetes distress (Trial registration: NCT02730078; NMRR-15-1144-24803).

Diabet. Med. 35, 750–759 (2018)

Research Article | Original Research

# Association Between Primary Care Practitioner Empathy and Risk of Cardiovascular Events and All-Cause Mortality Among Patients With Type 2 Diabetes: A Population-Based Prospective Cohort Study

Hajira Dambha-Miller, Adina L. Feldman, Ann Louise Kinmonth and Simon J. Griffin

Article    Figures & Data    Info & Metrics    eLetters    PDF

In this issue

## Abstract

**PURPOSE** To examine the association between primary care practitioner (physician and nurse) empathy and incidence of cardiovascular disease (CVD) events and all-cause mortality among patients with type 2 diabetes.

**METHODS** This was a population-based prospective cohort study of 49 general practices in East Anglia (United Kingdom). The study population included 867 individuals with screen-detected type 2 diabetes who were followed up for an average of 10 years until December 31, 2014 in the Anglo-Danish-Dutch Study of Intensive Treatment in People With Screen Detected Diabetes in Primary Care (ADDITION)-Cambridge trial. Twelve months after diagnosis, patients assessed practitioner empathy and their experiences of diabetes care during the preceding year using the consultation and relational empathy (CARE) measure questionnaire. CARE scores were grouped into tertiles. The main outcome measures were first recorded CVD event (a composite of myocardial infarction, revascularization, nontraumatic amputation, stroke, and fatal CVD event) and all-cause mortality, obtained from electronic searches of the general practitioner record, national registries, and hospital records. Hazard ratios (HRs) were estimated using Cox models adjusted for relevant confounders. The ADDITION-Cambridge trial is registered as ISRCTN86769081.

**RESULTS** Of the 628 participants with a completed CARE score, 120 (19%) experienced a CVD event, and 132 (21%) died during follow up. In the multivariable model, compared with the lowest tertile, higher empathy scores were associated with a lower risk of CVD events (although this did not achieve statistical significance) and a lower risk of all-cause mortality (HRs for the middle and highest tertiles, respectively: 0.49; 95% CI, 0.27-0.88, *P* = .01 and 0.60; 95% CI, 0.35-1.04, *P* = .05).

**CONCLUSIONS** Positive patient experiences of practitioner empathy in the year after diagnosis of type 2 diabetes may be associated with beneficial long-term clinical outcomes. Further work is needed to understand which aspects of patient perceptions of empathy might influence health outcomes and how to incorporate this understanding into the education and training of practitioners.

Jump to section

# Quick, within your skills, does not require additional training, effective……

- Type 1

    - Meaningful purpose

    - Control the controllables

    - Get it (understanding)

- Type 2

    - Increase perceived control

    - Educate partners

    - Empathy and understanding

**DIABETIC**
Medicine

# Differences and similarities in the experience of living with diabetes distress: A qualitative study of adults with type 1 and type 2 diabetes

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## Abstract

**Aims:** To explore the lived experiences of diabetes distress (DD) in adults with type 1 and type 2 diabetes, and to identify similarities and differences in these experiences.

**Methods:** We conducted in-depth interviews with people with type 1 ($n = 19$) and type 2 diabetes ($n = 29$). We conducted thematic analysis using NVivo 12 software.

**Results:** We identified three themes: (1) Experiencing Diabetes Distress as a Lack of Control – Similarities: All participants voiced a perceived lack of control with their glucose levels and other peoples' misconceptions about diabetes. Differences: Nearly all type 1 participants described a "lack of control" over emotional reactions to hypo- and hyperglycaemia as opposed to only one type 2 participant. (2) Experiencing Diabetes Distress as a Burden of Constant Management – Similarities: All participants emphasized the nonstop, relentless nature of diabetes management. Differences: type 1 participants described self-care as vital, with life-threatening consequences if not performed, while type 2 participants did not perceive such dangerous consequences. (3) Understanding the Value of Social Support in Diabetes Distress – Similarities: All participants acknowledged the importance of having others recognize the difficulties of living with diabetes. Differences: type 1 participants noted actual experiences where peers and health care professionals acknowledged that burden, whereas type 2 participants expressed a desire for this support that was not present in their lives.

**Conclusions:** Findings revealed subtle differences in perceptions of DD among adults with type 1 and type 2 diabetes, which suggest a need to tailor treatment for people with each type of diabetes.

KEYWORDS
diabetes distress, qualitative methodology, type 1 diabetes, type 2 diabetes

# Diabetes and emotional health

A practical guide for healthcare professionals supporting
adults with Type 1 and Type 2 diabetes

*Slides available from:* mark.davies@belfasttrust.hscni.net