Helping Your Patients with Diabetes: Optimizing Your Approach
Engagement and Communication Strategies for Patients with Diabetes

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Diabetes Overwhelmus

- Foot exams
- Ketones
- Hypoglycemia
- UMACR
- A1c
- Eye Exams
- Blood Pressure
- Injections
- Pills
- Meters
- Exercise
- BMI
- Test Strips
- Lancets
- Diet

Non-Adherent patients
Why Won’t Your Patients with Diabetes do What You Tell Them to do?
Starting Point: No One Wants Poor Control, No One Wants Diabetes Complications – So You Can Rule That Out as the Reason

• Other reasons
  • Perceived Worthlessness
    • *Pointlessness/futility* (what good does it do?)
    • *Hopelessness*
  • Too Many Personal Obstacles
    • *Diabetes Distress*
    • Depression
    • Medication Misperceptions/Fears
    • Lack of education and Self management skills
    • Environmental (“Life”) – time, costs, competing priorities
      • Patient Context /“Needs and Circumstances”
  • The Absence of Support and Resources
    • Diabetes slips to the background (serious but not urgent)
    • Infrequent supportive interaction with HC team (“touches”)


Diabetes Distress

• Diabetes Distress is part of the experience of diabetes for many patients;
  • 48% in the 3D Study met criteria for high distress over 18 months
  • Even at low levels, diabetes distress is significantly related to glycemic control and behavioral management – but DD also occurs in people with “good control”

From: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797979/
Diabetes Distress (DD)

• Diabetes distress is not clinical depression — It is emotional distress that captures:
  • The worries, concerns and fears among individuals struggling with a progressive and demanding chronic disease such as diabetes including
    • The emotional burden of self-management,
    • Threats of complications and potential loss of functioning

The 7 major sources of DD
• 1. Powerlessness (hopelessness-pointless)
• 2. Negative Social Perceptions (negative judgments of others)
• 3. Physician Distress (don’t get help I really need)
• 4. Friend/Family Distress
• 5. Hypoglycemia Distress
• 6. Management Distress
• 7. Eating Distress
Antidepressants are Not the Answer for DD

• Some patients have misperceptions or unrealistic expectations
  • They might think the need for more medication/higher dose means they are failing (vs. their beta cells failing)
    • Or misunderstand the need to “titrate” dose from starting dose or to adjust dose to cover more carbs or stress/illness (misperception that “more is worse”)
  • They might think all other people with diabetes do it better, easier – (showing them that other people with diabetes also struggle can help some)
  • They might expect that their BG should remain steady at 90 or 100 and any fluctuations are “bad”
  • They might assume they need to “avoid all sugar” (fruit, dairy, etc.)—unrealistic, not desirable
  • They might have perfectionistic tendencies and be reluctant to try things that they might not succeed at
Antidepressants are Not the Answer for DD (con’t)

• They might feel judged – feel like a “bad person” (the scarlet letter)
  • If stress or infection raise their BG, they feel like they did something wrong or bad
    • or health care workers ask, “what did you eat to make you blood sugar so high?”
  • The “going to the principal’s office” (punishment) sensation of diabetes care
    • “nonadherence is not doing what the doctor/care team wants you to do”
• Or just the stigma of diabetes....
  • lots of blame and shame
What is Your (or Your Team Members’) Mental Model of Diabetes?

• A mental model
  • Provides the filters through which the user see the world
  • Is based in belief as opposed to being a factual concept
  • Is an explanation of someone's thought process about how something works in the world – how they perceive the world
What is Your Mental Model of People With Diabetes?

• Are any of these familiar?
  • “Many of those who have diabetes are noncompliant and don’t take care of themselves.”
  • “People with diabetes cause themselves to become ill, lose limbs, and disregard their medication/diet regimen.”
  • “Diabetes is a disease of gluttony and sloth – they bring it on themselves”
  • “They don’t do what they are supposed to – they are not even trying to get better”
  • “They just don’t care...their noncompliance, nonadherence, whatever it is, is so frustrating, why don’t they just do what I tell them to do?”

• These are often “taught” or passed on to us in our training or practice.

• What do you think the effects or impacts are of these mental models?
What is Stigma?

• A set of negative and often unfair beliefs that a society or group of people have about something – a negative stereotype
  • Something that takes away from one's character or reputation.

• Stigma is a mark of disgrace which results from the judgment by others.
  • When an individual is labelled by their illness, they experience judgment and prejudice.
  • Stigma brings experiences and feelings of shame, embarrassment, distress, hopelessness and reluctance to seek or accept help.

• Patients are influenced by stigma (expectations impact behavior) leads to guilt, shame, blame, embarrassment, futility, isolation
  • Higher BMI
  • Higher A1C
  • Higher self-reported blood glucose variability (more fluctuations up and down)
Antidepressants are Not the Answer for DD (more)

- The demands of self-management might exceed their capacity
  - Diabetes adds several hours per day of an unasked-for “job” per day:
    - No pay, no vacation – this adds a lot extra to balance with life, especially when there are additional life demands (competing priorities)
    - They might not know or understand why or how to do some of the expected self-management
    - Not everyone has the same capacity for self-management and the necessary skills
Addressing Diabetes Distress

• Attention to this emotional distress should be included as part of ongoing comprehensive care for all patients with diabetes
  • Not addressed as a separate co-morbid ‘condition’
• Even minimal, inexpensive interventions can lower levels of distress and improve disease management
  • Can take place as part of traditional diabetes education and/or as part of a standard clinical encounter
  • Does not require Behavioral Health referral (but in severe cases, this might help)
  • Antidepressants are not the answer to DD but if coexisting clinical depression – then needs appropriate level of treatment (use of depression assessment tool)
  • Does require awareness, sorting out, addressing
Addressing Diabetes Distress (con’t)

• Diabetes Education can help (...but it is not the not entire story)
  • Ensure necessary skills (how to xxx) – teach back (“show me how you…”)
  • Assess numeracy skills
    • “Many people tell me they aren’t good at math, how comfortable are you with math? – how are you with adding, dividing...?”
    • “Do you have any questions about what all the numbers mean?”
  • Explain what is normal
    • Normal blood glucose range, fluctuations
    • Normal pancreas adjusts the amount of insulin for what we eat, for stress, illness, etc. – we want to mimic the normal pancreas (“think like a pancreas”)
      • Stress hormones make everyone need more insulin/more insulin needed to help fight infection
  • Explain expectations
    • “Diabetes gets worse even if you do everything right” – beta cells “wear out” over time and make less insulin [from inside] (key message – “it is not your fault”)
    • Therapeutic heterogeneity – not every treatment works the same for every person – need to find what works for any individual (precision medicine)
    • For safety need to start with small dose and gradually increase – the starting dose is not the “right” dose that was expected to do the job
Help with Diabetes-related Numeracy

Nearly 36% of adults in the U.S. have low health literacy
~ 50% have poor numeracy skills

We need better ways to help people with numeracy issues – diabetes is full of numbers:

• A1c numbers (%)
• Blood glucose numbers (mg%)
• Carbohydrate counting numbers (grams)
• Insulin dose numbers (units)
• Formulas for calculating meal-time insulin or correction-dose insulin or both
• Titration algorithms for adjusting basal insulin (e.g., if FBS is 120-140 add 1 unit to bedtime dose of insulin glargine, if FBS is 141-160 add 2 units ....)
• Dosing instructions (e.g., take one time daily, take 3 times per day, take twice daily, etc.)
• Ranges: e.g., goal blood glucose is 70-120 before breakfast (how many people understand range?)
Study Assessing Diabetes-related Numeracy

Provided three problems from the validated Diabetes Numeracy Test (DNT):

1. Determine insulin dose based on glucose level (use a correction formula, e.g., 1 unit for every 40 over 150 or BG-100/40)

2. Determine insulin dose based on algorithm (“sliding scale”) [e.g., if BG 150-200 give 5 units, if BG 201-250 give 6 units, etc.]

3. Determine insulin dose using an insulin-to-carbohydrate ratio (e.g., 1:10 or 1 unit for every 10 grams of carbs)

Only 28.3% did all three problem calculations correctly
33.3% did two correctly
28.3% did one correctly
10% had no correct answers

Diabetes Technology can help –
• Smart Insulin Pens
• Insulin pumps
  • calculate dose of mealtime insulin
  • “closed loop”- adjust insulin

Diabetes is hard
Perception vs. Reality — Ensuring Patients Really Understand & Can do What They Need to do

• Proper insulin dosage and administration study (Trief P. et al Clinical Diabetes winter 2016)

• Most of the surveyed patients with diabetes believed that they were taking their insulin correctly, whereas the evidence suggests otherwise
  • These data reinforce the need not only to ask patients what they are doing related to insulin delivery, but also to ask them to demonstrate their techniques and knowledge. (“show me how you ---”)
  • Need to reassess frequently (i.e., have patients perform “show and tell”), especially when patients are experiencing hypoglycemia, wide glycemic excursions, or otherwise poor glycemic control.
Reality Checking & Support (“Anchoring”)

• Teach back method (want it in the patient’s own words – not a “playback”)
  • “I want to be sure I explained it clearly, using your own words can you tell me what you are supposed to do”
  • “How will you explain this to your family/significant other?”

• Show Me (normalize this in your practice, “I ask everyone to show me …”)
  • “Can you show me how you would draw up [and give injection of] 15 units on your insulin pen/syringe” or other pen (such as GLP-1 RA medication)

• Practice together
  • “Here is the scale you can use at home – let’s be sure you understand how it works - if your BG was 243 how much insulin would you take?”
Addressing Diabetes Distress (more)

• Even minimal, inexpensive interventions can lower levels of distress and improve disease management. Approaches can include:
  • Normalizing the experience of diabetes-related distress as part of the spectrum of diabetes (“most people with diabetes experience DD at some time – often more DD when other things going on, but just dealing diabetes is enough – diabetes is not easy”)
  • Recognizing how other life stressors can affect diabetes management (life demands/priorities/time, other illnesses, etc.) (stress increases BG, also increases DD)
  • Anticipating and acknowledging diabetes stressors over time – including unrealistic expectations and judgement/blame
    • Acknowledge that caring for diabetes does take a lot of extra time and effort vs. not recognizing the demand on their time, energy, skill-set
    • Ensure that the demands/load do not exceed the patient’s capacity (“do you have time to do this; how are you able to ---”)
    • Avoid “bad-good” – use “safe” range/level BG, BP, LDL, etc.
Words Matter: Studies Shows Importance of Language Choices in Diabetes Care

• Health care providers who use "negative terms," such as "nonadherent" or "noncompliant" may create a disconnect leading to negative health outcomes
  • Language choices that place blame can cause patients to disengage with health services and develop diabetes-related distress and sub-optimal diabetes self-management
  • The effects of being referred to as “a diabetic” vs. “a person with diabetes (PWD)”

• Carefully chosen language can have a positive effect
  • Use language to support patients' diabetes self-management and psychosocial well-being – on the same side - fighting for, not against
    • Avoid “bad-good” – use “safe” or “healthy” range/level BG, BP, LDL, etc.
  • Focus on helping PWD stay healthy-provide “evidence-based hope” and strategies
    • “Research shows that with good care, odds are pretty good you can live a long and healthy life with diabetes”
    • “There are things we can do together to help you stay healthy/prevent complications with diabetes” [or prevent from getting worse]
# Examples of Common Jargon or Confusing Wording

<table>
<thead>
<tr>
<th>Problematic</th>
<th>More useful – preferable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic</td>
<td>Person with (who has) diabetes (PWD)</td>
</tr>
<tr>
<td>Control (verb)</td>
<td>Manage – what they are doing</td>
</tr>
<tr>
<td>Control (noun)</td>
<td>Define what is meant (BG or A1c or TIR)</td>
</tr>
<tr>
<td>Test (blood glucose)</td>
<td>Check or monitor your blood glucose</td>
</tr>
<tr>
<td>Good/bad/poor</td>
<td>Safe/unsafe; at, above or below target – numbers, data</td>
</tr>
<tr>
<td>Compliant/adherent</td>
<td>Takes meds about half the time (neutral – numbers, facts)</td>
</tr>
<tr>
<td>“transfer to the floor”</td>
<td>Transfer to the ward (from ICU or CCU, etc.)</td>
</tr>
<tr>
<td>You need to be NPO</td>
<td>You will need to have an empty stomach so stop eating at ...</td>
</tr>
<tr>
<td>Failed treatment</td>
<td>The treatment was not effective, did not improve things</td>
</tr>
</tbody>
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Fear of Complications Leads to Large Contributor to Diabetes Distress

The Language of Diabetes Complications:
Communication and Framing of Risk

Reviewed messaging in magazines for people with diabetes (such as Diabetes Forecast) from American, Canadian, Australian Diabetes Associations

• Majority had loss-framing (e.g., “having diabetes is the leading cause of blindness”) with few if any risk reduction strategies offered (often scare tactics) lead to hopelessness

vs.

• Many fewer had Gain-framing (“early diagnosis and treatment of diabetic retinopathy can prevent up to 98% of severe vision loss”) plus strategies – “get annual eye exam” lead to more effective (evidence-based hope – how to stay healthy)
Greater Sense of Futility Among American Indian Patients Even More Critical Role of Messaging for AI/AN People

<table>
<thead>
<tr>
<th></th>
<th>Montana – AI clinics</th>
<th>Montana – non-AI clinics</th>
<th>New Mexico – AI clinics</th>
<th>NM – non-AI clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient sense of futility about health</td>
<td>40%</td>
<td>13%</td>
<td>62.3%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Patient lack of follow-through (with referral to specialty care clinic)</td>
<td>86.4%</td>
<td>65%</td>
<td>78.4%</td>
<td>65%</td>
</tr>
</tbody>
</table>

• Role of historical trauma?
• Role of messaging/perceptions?
• “bad genes/genetics” (doomed) (“everyone in my family….”) – it is a BAD ENVIRONMENT
• Need (counter) messaging: Environment >> Genetics (“Nurture” >> “Nature”) – strategies – hope
Effects of Traditional and Western Environments on Prevalence of Type 2 Diabetes in Pima Indians in Mexico and the U.S.

Abstract

OBJECTIVE—Type 2 diabetes and obesity have genetic and environmental determinants. We studied the effects of different environments on these diseases in Pima Indians in Mexico and the U.S.

RESULTS—The two Pima groups share considerable genetic similarity

- The age- and sex-adjusted prevalence of type 2 diabetes in the Mexican Pima Indians (6.9%) was less than one-fifth that in the U.S. Pima Indians (38%) and similar to that of non-Pima Mexicans (2.6%).
- The prevalence of obesity was similar in the Mexican Pima Indians (7% in men and 20% in women) and non-Pima Mexicans (9% in men and 27% in women) but was much lower than in the U.S. Pima Indians.
- Levels of physical activity were much higher in both Mexican groups than in the U.S. Pima Indians.

CONCLUSIONS—The much lower prevalence of type 2 diabetes and obesity in the Pima Indians in Mexico than in the U.S. indicates that even in populations genetically prone to these conditions, their development is determined mostly by environmental circumstances, thereby suggesting that type 2 diabetes is largely preventable.

- This study provides compelling evidence that changes in lifestyle associated with Westernization play a major role in the global epidemic of type 2 diabetes.
How to Help Overcome Futility & Hopelessness

• Motivational Interviewing will not work well, if at all, unless the patient moves out of the sense of hopelessness, futility, worthlessness
  • If they believe that no matter what they do bad things are going to happen, that they are doomed and nothing they do makes a difference, then why even try... it is all futile

• Be curious, not furious (ask instead of tell...listen ...seek first to understand)

• You may need to invest in providing that “evidence-based hope” – help them discover that their efforts make a difference (not futile)
  • Patients (PWD) often have “Perceived Treatment Inefficacy” – you can help them establish Treatment Efficacy
How to Help Overcome Futility & Hopelessness (con’t)

• Help them establish **Treatment Efficacy**
  • **Discovery Learning** (e.g., *structured BG testing* or professional CGM study) – (“let’s see what happens when you take a walk”; “see what happens if you eat XX vs. YY”; “let’s check how well that insulin dose is working for you”)
    • Structured BG testing: paired SBGM or 7-point data (purposeful) or CGM
  • Uncover **therapeutic heterogeneity** (“let’s find out if (how well) this med/exercise works for you”) – Not all individuals respond or respond the same to every medication or treatment – involve the patient in helping figure out what works for them
    • structured BG testing or CGM
  • Create positive mindset (a sense of control, having input vs. being told what to do) - generating “**ownership**” vs. “**buy-in**”
Ownership vs. Buy-in

• “Ownership” is when you own or share the ownership of an idea, a decision, or an action plan; it means that you have participated in its development, that you chose on your own accord to endorse it. It means that you understand it and believe in it. It means that you are both willing and ready to implement it.

• “Buy-in” is the opposite: someone else or some group of people has done the development, the thinking, the cooking and now they have to convince you to come along and implement their ideas/plans.
Generate & Engender Ownership
Sharing the Decision Making

**Definition: Shared decision making** occurs when a health care provider and a patient work together to make a health care decision that is best for the patient.

- The optimal decision takes into account:
  - Evidence-based information about available options
  - The provider’s knowledge and experience
  - The patient’s values and preferences

- With diabetes and the high dependence on self-management – utilizing **motivational interviewing techniques** and considering **patient capacity and burden** (“How will you work this into your day?, With your arthritis do you think you can do ----”) as part of shared decision making is even more beneficial and critical
  - Ambivalence – want to change but doesn’t want to give up something
My “3 Questions”

1. What is hardest for you (about managing the diabetes)?
2. What are you most concerned about/afraid of/worried about?
3. What are your goals?
   • Diabetes
   • Life
Importance of Shared Decision Making

• In many cases there are several treatment options available.
  • Evidence-based assessments of treatments and interventions often fail to identify one treatment as clearly superior to another.

• Shared decision making (guided by providers) can help patients understand the benefits and harms of the options and clarify their own values and preferences.
  • Helps promote “ownership” vs. “buy-in”

• Increasing evidence of improved outcomes
  • Improve the patient’s experience of care and satisfaction
  • Improve patient adherence to treatment recommendations
  • Emerging evidence that it can help improve health outcomes – quality improvement
When to Engage in Shared Decision Making

• Engage when your patient has a health problem that needs a treatment decision.
  • Not every patient encounter requires shared decision making.

• Some patients may not want to or be ready to participate in shared decision making.
  • A patient choosing not to participate in the decision-making process is still making a decision.

• Studies suggest that many health providers believe patients are not interested in participating in health care decision making.

• Evidence suggests that most patient want more information than given, and many would like to be more involved in their health decisions.
Exploring Why People With Type 2 Diabetes Do or Do Not Persist With Glucagon-Like Peptide-1 Receptor Agonist Therapy: A Qualitative Study

William Polonsky, Cory Gamble, Neeraj Iyer, Mona Martin, Carol Hamersky

Results: Among continuers (n = 16), the most commonly identified facilitators supporting the decision to continue were the observations of improved glucose control (50%) and weight loss (55%).

Among discontinuers (n = 20), the most commonly identified challenges leading to treatment discontinuation were side effects (55%) and high cost (50%).

Continuers were more likely than discontinuers to receive clinically relevant information from their health care team, including facts about GLP-1 receptor agonist medications, likely treatment benefits, the importance of gradual dose titration, and the need to adjust diet after initiation.

Conclusion: Although cost is a major obstacle to treatment continuation, it can only be resolved through changes in ongoing reimbursement coverage and policies.

However, many other obstacles could potentially be addressed through more collaborative patient-clinician interactions before initiating therapy.
Nine Essential Elements of Shared Decision Making

• Define/explain problem
• Present options
• Discuss benefits/risks/costs (decision-aids/tools can be helpful)
• Clarify patient’s values/preferences
• Discuss patient ability/self-efficacy (often overlooked)
• Discuss doctor knowledge/recommendations
• Check/clarify patient’s understanding
• Make or defer a decision
• Arrange follow-up
The SHARE Approach

The SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each health care option through meaningful dialogue about what matters most to the patient.

• Step 1: Seek your patient’s participation
• Step 2: Help your patient explore and compare treatment options
• Step 3: Assess your patient’s values and preferences
• Step 4: Reach a decision with your patient
• Step 5: Evaluate your patient’s decision

The One Thing: Patient-Priorities Aligned Decision Making

• “The One Thing” – Start with the One Thing the person most wants to focus on first to achieve their most important health outcome goal – “What matters most” – rationale:
  • Helps get started in patient priorities aligned decision-making
  • Simplifies the process – can use serial “trials” of strategies to see if achieve goal
  • Engages patients’ immediately

• Example: The One Thing for patient Z “I want to feel less tired so I can babysit my grandchildren” – Options to try:
  • Taper Lorazepam
  • Reduce or stop Beta Blocker
  • Manage blood sugars to avoid BGs over 250
  • Manage heart failure
  • Trial of antidepressant
  • Progressive exercise program
Why Won’t Your Patients with Diabetes do What You Tell Them to do?

“Non-adherence may be the means by which a patient may express their preferences when their values, goals and preferences are not incorporated into the treatment decisions during the encounter.”

Shah et al, Med Care 2010;48

A few useful terms & concepts

- Diabetes “Overwhelmus”
  - Clinical Inertia
  - Stigma - Expectations
- Diabetes Distress
  - Different than Depression
- Futility
  - Treatment Skepticism
  - Perceived Hopelessness
- Curiosity
- Compassion
- Confidence
- Contextual Care
- Cooperation
- Cohesion
What’s the Answer – Diabetes is Hard

How do I help my patients with diabetes do what is needed to stay healthy?

• Examine the mental model of care team members
  • Eliminate stigma (shame and blame, disobedience, bad vs. good)
  • On the same side – helping them live with diabetes and deal with diabetes difficulties

• Watch your words
  • Start with “person with diabetes” (PWD) with your care team

• Acknowledge and explore diabetes distress

• Evidence-based Hope and Strategies
  • Avoid scare tactics

• Discovery Learning

• Ownership
  • Shared decision making
Questions, Comments, and Idea Sharing

cgreenlee@westslopeendo.com
References & Resources

• Shared-decision making aids/tools for diabetes: *Diabetes Medication Choice – care that fits*

• Motivational Interviewing for Diabetes – videos – well worth it!!! (“resolving ambivalence”)
  • [https://www.youtube.com/watch?v=ZWmJ15W-FJ0&feature=youtu.be](https://www.youtube.com/watch?v=ZWmJ15W-FJ0&feature=youtu.be)
  • [https://www.youtube.com/watch?v=qGi1uCaljZg&feature=youtu.be](https://www.youtube.com/watch?v=qGi1uCaljZg&feature=youtu.be)
  • [https://www.youtube.com/watch?v=OTCurW9_DPY](https://www.youtube.com/watch?v=OTCurW9_DPY)
  • [https://www.youtube.com/watch?v=DhgGQuMVSBlw&feature=youtu.be](https://www.youtube.com/watch?v=DhgGQuMVSBlw&feature=youtu.be)
References & Resources (con’t)

• Depression & Diabetes booklet  [BDIDepressionBookletFINAL.pdf (behavioraldiabetes.org)]
• [https://cme.ucsd.edu/psychosocialdiabetes/modules.html](https://cme.ucsd.edu/psychosocialdiabetes/modules.html)

• Shared Decision Making
• AHRQ -- [https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html](https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html)
References and Resources for Patient — Priorities Aligned Decision Making

Resources

• Self-directed health priorities identification: [https://myhealthpriorities.org/](https://myhealthpriorities.org/)
• Patient Priorities Care Decisional Guide [http://decisionguide.patientprioritiescare.org](http://decisionguide.patientprioritiescare.org)
• OurNotes (patient agenda setting for encounters) [https://www.opennotes.org/ournotes-professionals/](https://www.opennotes.org/ournotes-professionals/)
• Overview of Patient Priorities Care: [https://patientprioritiescare.org/](https://patientprioritiescare.org/)

References

• Tinetti ME, et al. Challenges and strategies in patients’ health priorities-aligned decision-making for older adults with multiple chronic conditions. PLOS ONE. 2019; [https://doi.org/10.1371/journal.pone.0218249](https://doi.org/10.1371/journal.pone.0218249).
• VA SHARE (and Hypoglycemia) video for patients with diabetes: [https://bcove.video/2OEFZAF](https://bcove.video/2OEFZAF)
• Diabetes_SHARE
Weight Stigma and Diabetes Stigma: Implications for Weight-Related Health Behaviors in Adults With Type 2 Diabetes

Rebecca M. Puhl, Mary S. Himmelstein, Jane Speight

Abstract

There has been little recognition that people with type 2 diabetes are vulnerable to weight stigma and diabetes stigma, and almost no research examining the implications of these forms of stigma for their health and well-being. This study examined health behavior correlates of weight stigma and diabetes stigma in 1,227 adults with type 2 diabetes. Results showed that experiencing weight stigma in health care, experiencing differential treatment from others because of their diabetes, and engaging in self-stigma for diabetes and body weight were each significantly associated with increased frequency of binge eating and eating as a coping strategy to deal with negative feelings. Internalizing weight stigma was also significantly associated with lower levels of physical activity and worse self-rated health. These findings suggest that initiatives to improve the health and well-being of people with type 2 diabetes must consider the potentially harmful roles of weight stigma and diabetes stigma.
Ensuring Patients Really Understand & Can do What They Need to do

• Proper insulin dosage and administration study (Trief P. et al Clinical Diabetes winter 2016)
  • Insulin administration assessment (*survey and “show me”*)
    • Insulin-related behaviors
      • 13.3% sometimes or never took correct dose
      • 21.7% sometimes or never took at correct times
      • 48.3% sometimes or never adjusted for BG level, food or exercise
    • Insulin-related confidence
      • 93.3% moderately or very confident could properly inject
        • Demo by patient: 15 to 82% correct on techniques for pens and syringes
      • 83.3% moderately or very confident could choose correct dose
        • ~20% did not administer the correct dose
  • Skin problems (lipohypertrophy/lack of rotation)
    • 38.3% (T2DM 45% vs. T1DM 15%; Pen users 45% vs. syringe users 19%)