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Current Approaches to Support the Psychosocial Care of African American Adults with Diabetes: A Brief Review

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Abstract

African Americans are disproportionately affected by type 2 diabetes and experience significantly higher age-adjusted prevalence of the disease. Psychosocial support, material resources, and education can have a significant impact on successful diabetes management, particularly among populations with diabetes-related psychological distress such as African Americans. This brief review of the literature identifies and synthesizes current evidence on faith-based, community-based, empowerment-based, strength-based, and culturally competent strategies that may be particularly relevant for social work practitioners supporting African American adults at risk for or diagnosed with Type 2 diabetes. Discussion focuses on multiple influences on the self-determination of clients working to manage their condition

Keywords

Diabetes; African American; Social Work

With the increase in numbers of Americans living with diabetes, specifically among minority populations, clinicians an increase of clients with diabetes and diabetes related complications. Often overlooked is the lack of psychosocial care available to individuals managing a type 2 diabetes diagnosis. Psychosocial care has been described in the diabetes care literature as social, psychological, and emotional support, material resources, and education that helps to reduce stigma, promote social functioning and improve quality of life (Barnard, Peyrot, & Holt, 2012) for individuals with diabetes. Prior relevant literature found that frustration with diabetes self-care routines, feeling overwhelmed by disease-related lifestyle changes, and a perceived loss of control are common among newly diagnosed adults (Roy & Lloyd, 2012; Pouwer et al., 2010). For example, it is not uncommon for an individual newly diagnosed with diabetes to be expected to monitor or address their blood sugar, a new or more intense exercise routine, insulin supplementation and other

medications, and several health care appointments with primary physicians and specialists (Ayalon et al., 2008). There is a growing literature base indicating that African American adults are at increased risk for experiencing psychosocial distress and depression associated with poor adjustment to a diabetes diagnosis and the accompanying lifestyle changes (Spencer et al., 2006); particularly when exacerbated by a lack of family, community, or professional support (Chesla et al., 2004; Kogan, Brody, Crawley, Logan, & Murry, 2007).

A community-based qualitative study of African American adults with type 2 diabetes in Arkansas indicated that helplessness, fatalism, and fear of failure about adhering to rigid diet, exercise, and medication recommendations was a reported barrier to self-confidence about diabetes management (Bhattacharya, 2012). While several studies exist examining the psychosocial barriers facing adults with type 2 diabetes generally, few in recent years address specific interventions or approaches employed with African American patients to improve their psychosocial health in the context of their diabetes care (Steinhardt, Mamerow, Brown, & Jolly, 2009). Thus, the purpose of this review is to highlight successful or promising strategies specifically tailored to African Americans with Type 2 diabetes as described in peer-reviewed literature, as a resource for social work clinicians supporting this population.

Diabetes Epidemiology

Calling attention to effective clinical strategies for working with clients with diabetes is essential given the increasing number of Americans living with diabetes and diabetes related complications. Diabetes is the seventh leading cause of death in the United States and currently 8% of the U.S. population or nearly 26 million people are affected by this condition; the Centers for Disease Control and Prevention (CDC) estimate that by the year 2050, as many as a third of all Americans will be diabetic or at high risk of developing the disease (CDC, 2012). Type 2 diabetes is the most common form of this condition, which is characterized by an inability of the body to produce or appropriately metabolize insulin (Naranjo, Hessler, Deol, & Chesla, 2012). Poor management of type 2 diabetes can result in disabling complications that include a lower life expectancy, increased risk of heart disease, lower limb amputation, kidney failure, and adult-onset blindness (Katzmarzyk & Staiano, 2012), making it critical to highlight and continue to develop clinical strategies for social workers and other health care providers working with this population.

The increased prevalence of diabetes and diabetes related complications among African Americans requires more attention be given to calling attention to and developing clinical strategies in this population. African Americans are disproportionately affected by type 2 diabetes and experience significantly higher age-adjusted prevalence of the disease [including diagnosed and undiagnosed cases] compared to non-Hispanic Whites (Katzmarzyk & Staiano, 2012); with nearly 13% of all African Americans over the age of 20 diagnosed with diabetes compared to just 7.1% for non-Hispanic whites (Castro, Shaibi, & Boeh-Smith, 2009); and an additional 7% of African Americans have undiagnosed diabetes (Naranjo et al., 2012). In addition, African American adults are between two and four times more likely to experience blindness, amputations, and renal disease as a result of their unmanaged diabetes than whites of the same age (CDC, 2012), and 20% more likely to die

of those diabetes-related complications than their white counterparts (Naranjo et al., 2012). As a result of the disproportionate impact of diabetes on African Americans, the following focuses on and overview of clinical strategies within this population.

The present paper is a mini review of effective psychosocial clinical strategies for working with clients with type 2 diabetes. A systematic literature review was conducted using PubMed, Cochrane Library, and Scopus from 2000 to January 2012 in order to assess the current status of psychosocial clinical strategies for working with persons with type 2 diabetes, specifically African Americans. While the literature base on psychosocial strategies specifically targeting African Americans with diabetes is somewhat limited, we feel that the scope of time chosen for this review strikes the appropriate balance of recency and attention to the changing landscape of knowledge and interventions for diabetes care. Studies were identified using the following headings and search terms alone and in combination: diabetes, clinical, program, intervention, adult, Black, African American, self-management, self-care, utilization, and health care use. To the author's knowledge, no other literature review exists that focuses on identifying effective clinical strategies for social work practitioners working with persons with type 2 diabetes. The authors conducted a critical review of the literature. The following offers an overview of psychosocial strategies in diabetes care and concludes with directions for future research. As stated previously, the purpose of this paper is to review effective clinical strategies in diabetes care specifically tailored to African Americans with type 2 diabetes, as described in peer-reviewed literature, in an effort to assist social work clinicians working with this population.

An Overview of Psychosocial Strategies in Diabetes Care

As previously discussed, receiving emotional, social, psychological, material, and educational support (i.e. psychosocial care) can have a significant impact on successful diabetes management, particularly among populations with high rates of psychological distress related to diabetes diagnoses and management such as African Americans. While we know that social workers can play a critical role in providing services and support to individuals with diabetes, the literature on psychosocial interventions designed or delivered by social workers in this area is scant. The following discussion covers a range of multi-disciplinary strategies that highlight trends in diabetes-related psychosocial care of African Americans with diabetes. While each of these strategies are not exclusively social work-focused, they are particularly relevant for social work practitioners supporting individuals at risk for or diagnosed with Type 2 diabetes.

Predominant psychosocial strategies for diabetes care include the empowerment, faith-based, cultural competence and community-based approaches. The empowerment approach has been used to assist persons with diabetes to engage in diabetes self-management (Two Feathers et al., 2007). Anderson & Funnel (2002) state that the empowerment approach involves three principals that integrate "the psychology of behavior change" to promote successful diabetes management. The principles include: 1) an acknowledgement that a majority of diabetes care relies on action by the patient making the patient the locus of control and primary decision maker in regular diabetes self-care activities; 2) identifying health care teams primary tasks as providing psychosocial support, be a resource for

diabetes education in order to ensure clients can make informed decisions regarding diabetes self-care; and lastly 3) requiring health care professionals keep in mind that behavior change is more likely to occur when clients engage in change behavior that is salient on a personal level. Diabetes lifestyle interventions that have utilized the empowerment approach as described by Anderson and Funnell (2002) by providing psychosocial support and diabetes education in a way that empowers the client and engages them in the decision process, have resulted in increased diabetes self-management in at-risk populations (Two Feathers et al., 2007). Social work practitioners working with individuals with a diabetes diagnosis can utilize the empowerment approach to help clients achieve successful diabetes self-management.

Faith-based psychosocial approaches to diabetes care have also been utilized with successful results, particularly in the African American community (Boltri et al., 2005). Faith-based psychosocial approaches involve engaging community members in church-based settings and integrating aspects of faith into diabetes self-care, such as beginning diabetes education classes with prayer and administering intervention components before or after church services (Boltri et al., 2005; Hoyo et al., 2004). Faith-based settings can provide the ideal setting for helping communities engage in diabetes education, prevention and self-care particularly because of the existing social networks and support, the potential history of other health-related programs and because the African American community is already at greater risk for the disease (Campbell et al., 1999; Oexmann, Ascanio, & Egan, 2001). It is important for social workers to emphasize the integration of faith-based strategies for certain populations in order to ensure successful diabetes prevention and management.

Culturally competent psychosocial strategies can also enhance the promotion of diabetes self-care within diverse populations (Brown, Garcia, Kouzekanani, & Hanis, 2002; Whittemore, 2007). Culturally competent diabetes care integrates the cultural characteristics of the targeted population with standard diabetes self-care practices (Brown et al., 2002), such as delivering care accessible community-based locations, using the client's native language, engaging in self-care activities that are culturally relevant (i.e. integration of culturally tailored diet regimens) and utilizing community members and/or leaders to deliver diabetes education (Brown et al., 2002; Whittemore, 2007).

Community-based (or population-based) approaches to delivering diabetes-related care can lead to increased knowledge, and preventive behaviors (such as adherence to physical activity and dietary guidelines) (Satterfield et al, 2003; Two Feathers et al., 2007). A goal of community-based care is to assess community strengths and integrate cultural characteristics into diabetes care and to deliver care in the community setting. One such technique, Participatory Action Research (PAR), involves researchers working with and supporting the community to develop strategies to best engage in diabetes-related care in a culturally relevant way (Harris & Zinman, 2000; Green & Novick, 2001; Minkler, 2000). Social workers should engage in community-based approaches to more effectively deliver care to at-risk populations.

Below offers a more in-depth discussion of these psychosocial strategies, specifically, empowerment and cultural competence perspectives, and faith-based, and community-based approaches.

Trends in Diabetes-Related Psychosocial Care of African Americans

Empowerment and Strengths Perspective in Psychosocial Care

Two prominent strategies employed in psychosocial interventions with various client populations in social work practice are the empowerment and strengths perspectives. Empowerment practice in social work can be defined as “a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life” (Wallerstein, 2002, pg. 73). Empowerment practice speaks to the value orientation that each individual and family brings unique experiences and resources to the table and has at their disposal, personal values, beliefs, identities, and strengths to draw upon for improving their situation or outcome (DeCoster & Dabelko, 2005; DeCoster & Dabelko, 2008). Likewise, a strengths-based perspective speaks to how social work practitioners view clients and their innate abilities to accomplish desired change. Strengths-based perspectives require that the social worker foster hope within the client by focusing on what clients have done successfully in the past (even if very little) and uses those previous successes as building blocks for future change and growth (Labonte, 1994). Strengths perspective also promotes seeing the client as the expert on their problems, and avoids stigmatizing labels of the client that promote the clinician as expert (Labonte, 1994).

Empowerment practice has specifically been used in working with clients with diabetes to promote self-management and mastery of the, often burdensome, medical regimens that accompanies a diagnosis of diabetes. For example, DeCoster and Dabelko (2008) suggested over forty social work practices that promote the empowerment of older patients with diabetes, some being:

“encouraging older adults to express their feelings about diabetes; recognizing the older adult as the expert [in their care]; accept older adults and avoid trying to change them; recognize the elder in the environment; redistribute power; identify existing strengths, competencies and resources; endorse attainable goals; solicit and support intuitive solutions; focus on the here and now; and foster self-awareness and insight” (pgs. 77–79).

Additionally, Miley and DuBois (2007) encourage social workers to conceptualize empowerment practice as a “social justice contract” between the clinician and society at large; ensuring that social workers practice in a way that ensures “the social participation of individuals and their capacity to contribute to the resource pool of society” (pg. 31). Empowerment-oriented social work practice most often incorporates the strengths perspective. When applied to clinical interventions in diabetes prevention or management, social workers offer a unique care perspective, which seeks to partner with the client, value their expertise, highlight the resources and skill set clients can utilize to solve the presenting problem, and build upon past successes to encourage future growth (Wallerstein, 2002; DeCoster & Dabelko, 2008; Labonte, 1994).

Faith-Based Psychosocial Care

Social workers and other health care providers may be reluctant to integrate aspects of a client's spirituality or religiosity in efforts to promote diabetes education and self-management (Austin & Claiborne, 2011). However, a growing body of knowledge delineates the usefulness of faith-based diabetes interventions, particularly for African Americans who view and value spirituality and religious institutions as significant sources of psychological and social support (Austin & Claiborne, 2011; Kilbourne, Cummings, & Levine, 2009). For example, Austin and Claiborne (2011), in collaboration with the health ministries (i.e. committees or boards) of four predominately African American churches in the Northeast, developed a seven-week educational intervention at each of the four churches focused on heart health, healthy eating, physical activity, and routine health care among congregants of each church who were diagnosed with type 2 diabetes (Austin & Claiborne, 2011). Using a large focus group (n=23) comprised of congregants and the input of church health ministers, investigators of this study emphasized that the key to successful implementation of this study was the integration of spiritual elements in each aspect of the intervention. For example, congregants insisted that each educational session in the intervention began and concluded with a prayer, and that educational sessions included time for extended discussions on how caring for one's body is addressed in their faith and spiritual text (Austin & Claiborne, 2011). These authors concluded that the integration of spiritual practices in collaboration with and physically situated within such a culturally-relevant institution (i.e. church) promoted increased understanding of diabetes-related education and improved specific diabetes self-management behaviors among participants who completed the majority of intervention sessions. Boltri et al. (2005) translated the National Institutes of Health (NIH)-Diabetes Prevention Program (DPP) into a church-based setting focusing on the diabetes lifestyle aspect of the DPP. The DPP is an intensive diabetes lifestyle modification program (Knowler et al., 2002). The study showed that engaging with participants in a church-based setting utilizing conducting blood glucose screening and diabetes education classes, resulted in better diabetes self-management and positive health outcomes (Boltri et al., 2005).

Beyond impacting diabetes-specific outcomes in intervention studies, varied aspects of religiosity have been examined for their protective effects against depression in individuals with type 2 diabetes. For instance, a community-based cross-sectional study of lower-income adults with type 2 diabetes who lived in low-resource communities, two-thirds of whom were African American, found that specific religious practices such as religious reading, attending services, and especially prayer, was inversely associated with depression and other indicators of psychological distress in African American participants (Kilbourne, Cummings, & Levine, 2009). These authors suggested that clinicians screen for depression among diabetic patients and also include discussions of religiosity in initial assessments, particularly among African Americans, so that clients who wish to interpret health challenges through the lens of spirituality can be appropriately matched to resources and support.

Culturally Competent Psychosocial Care

Capable social work practice is built upon an understanding of and responsiveness to how social and cultural patterns influence mental and physical health status. Moreover, individual and collective attitudes and motivations to engage in certain health behaviors are shaped by these cultural influences. Research indicates that diabetes interventions that are closely aligned with African American cultural values and beliefs have been successful in improving selfmanagement of the disease in this population (Betancourt, 2012; DeCoster & Cummings, 2005; Utz et al, 2008; Williams et al, 2006). For example, in a health education intervention study of rural African Americans with type 2 diabetes, Alexander et al (2008) utilized an anthropological strategy called “cultural brokerage.” This intervention was delivered by a nurse liaison who worked alongside participants to bridge divides between the health system, requirements for successful diabetes self-management, and cultural norms which influenced health behavior using what authors characterized as an “insider perspective.”

This perspective and the subsequent diabetes education intervention sessions were informed by focus groups of African Americans with diabetes which revealed that: participants preferred to make use of personal narratives and storytelling in the intervention curriculum; the acknowledgement and inclusion of family or significant others was decisive to effective diabetes management; there were barriers to self-care that were unique to the rural environment such as a lack of educational programs and medical specialists; there was a social stigma associated with being diagnosed with diabetes; and spirituality and faith was often utilized as a reference point and source of encouragement during challenges to managing illness (Alexander, Uz, Hinton, Williams, & Jones, 2008). This culturally-relevant knowledge became the guiding framework for how investigators tailored their recruitment methods, the content of intervention materials, the methods of delivering educational content, and the tone of interaction between study participants and their “nurse-broker” (Alexander et al., 2008). Other pilot studies utilizing trained community members as “cultural health brokers” have also been effective in improving diabetes knowledge and self-management among African American adults with type 2 diabetes who reside in low-resource environments (Cadzow, Craig, Rowe, & Kahn, 2012).

The cultural competence perspective also calls for clinicians to be aware of the influence of culture on how health and mental health conditions are interpreted in different communities (Naranjo et al., 2012). A recent study reviewed current evidence on psychosocial outcomes among minority adults with type 2 diabetes and found that satisfaction with the patient-provider relationship was enhanced and medical mistrust was lessened when clinicians expressed a genuine interest in the distinctive diabetes-related experiences of African American and Latino clients (Naranjo et al, 2012). The authors also reported that an important component of psychosocial diabetes care is addressing the potential for depression, emotional distress, and reduced perceived quality of life in a way that is respectful and relevant to clients’ cultural perspective. They recommend clinicians acknowledge how mental illness may be perceived differently some racial/ethnic communities while emphasizing the potential for depression to be effectively treated (Naranjo et al., 2012).

Community-based Psychosocial Care

Community-based participatory strategies are among the most well studied methods of addressing psychological, social, and educational barriers to diabetes self-management in African American communities. For example, the Racial and Ethnic Approaches to Community Health (REACH) program was an innovative intervention study in Detroit, Michigan that targeted 150 African Americans and Latinos with diabetes for a peer-led, culturally tailored lifestyle intervention (Two Feathers et al., 2005). This intervention was structured with significant input from local community members in the form of focus groups and a community advisory board. Not only did the culturally relevant knowledge gleaned from community members result in ten hours of educational sessions, but other local residents were trained as “family health advocates” to deliver the a curriculum focused on stress reduction, depression, health eating, physical activity, and the use of social support to maintain lifestyle changes. Family health advocates were specifically trained to deliver content using an empowerment perspective (Two Feathers et al., 2005). The authors reported that participants experienced statistically significant improvements in blood sugar control (as measured by A1C levels at baseline and post-intervention) as well as improved knowledge about proper diet and self-care (Two Feathers et al., 2005). Hendricks & Hendricks conducted a diabetes self-management education program with 30 African American men with type 2 diabetes with the goal of testing the intervention and testing whether monthly and 3-month follow up influenced patient performance, diabetes-related quality of life and diabetes-related health outcomes (Hendricks & Hendricks, 2000). Participants were recruited from diabetes organizations located in Washington DC, churches and via community advertisement. The educational component involved a diabetes self-management portion administered at a community-based diabetes self-management center. The primary goal of the trainings was to increase diabetes knowledge based on 15 diabetes self-care guidelines provided by the American Diabetes Association (ADA). The trainings included lectures, group discussion and audio and visual aids. Clinicians relied on establishing trust, appealing to men on a personal level and expressing sincere interests in their health in order to motivate men to adhere to treatment regimens. The authors found that the intervention was effective on a variety of diabetes outcome measures and that men who received monthly follow-up versus 3-month follow-up had no significant differences in outcomes.

Anderson and colleagues (2003) evaluated the effectiveness of personalized follow-up for African Americans diagnosed with diabetes receiving routine eye examinations in free community-based urban clinics; 106 patients received a diabetes eye evaluation and were requested to complete the examination yearly. Participants were randomized to standard follow-up (receiving a letter a month before the appointment) and to the intervention group, which received an ‘intensive personalized’ intervention that involved a personal phone call after reminder letters were sent. During the phone call patients were reminded of the importance of getting the eye exam and addressed any barriers or concerns related to eye health. The study found that individuals who received personalized phone call reminders were more likely to return for diabetes eye evaluations than those who did not.

A separate qualitative study of African American REACH participants sought to explicate the specific components of the intervention, which were effective in participants' estimation. Participants reported that the REACH program provided a non-judgmental environment in which they could address issues with fear and motivation related to managing type 2 diabetes (Heisler et al., 2009). In addition, participants felt that the individual attention of family health advisors, emotional support of fellow participants in the group sessions, and opportunities to practice and reinforce new diabetes management strategies increased their level of comfort interacting with health-providers; specifically in terms of asking questions and requesting medical tests and results (Heisler et al., 2009). A third study of post-intervention results from the REACH study affirmed that using community health workers who are specifically trained in empowerment strategies do facilitate improved self-management behaviors among low-income underserved African Americans with diabetes (Spencer et al., 2011). These findings are significant because they represent promising alternatives to an often impersonal medical model of care, which may not be culturally relevant or accessible to populations with high disease burdens and few resources.

Conclusions

While this brief review of studies addressing the psychological and social needs of African American adults with diabetes is not exhaustive, it is illustrative of recent strategies that acknowledge multiple influences on the self-determination of clients working to manage their condition. Social work clinicians can ascertain from this review that efforts to address the psychosocial needs of African Americans and clients in general, should consider the reciprocal relationship between psychological, social, and environmental factors and the diagnosis and management of diabetes as a condition. For example, we now better understand how the need to actively monitor and comply with a rigorous diabetes management plan can be psychologically disruptive for African American adults. As social work clinicians, it is also imperative to identify how pre-existing mental illness could impede efforts to consistently manage a complex condition like diabetes. Interestingly, no studies were identified for review that addressed the co-occurrence of diabetes with one or more mental health problems; future research should explore this specific and relevant aspect of psychosocial care.

This review was able to clarify the context in which a number of psychosocial interventions have been applied with success. Studies were reviewed that point to the value of assessing participation in religious communities at the outset of therapeutic work, giving clients time and space to express how their beliefs shape and support their health efforts. Drawing on culturally competent psychosocial care, we have identified how clinicians may have opportunities to assess whether recommended diabetes interventions are responsive to the cultural context of their clients. Indeed many social workers are translating the concept of cultural brokerage to practice settings; tailoring teaching and learning styles, bringing cultural relevance to educational content, and uncovering unique barriers to care by using narrative techniques that open communication channels between clients and their health providers. Further, research related to improving psychological and social care in the context of diabetes management for African Americans suggests that utilizing community-based approaches, educating clients on the potential for depressive symptoms in culturally

sensitive way, and acknowledging clients as equal and engaged partners in their own care fosters improved psychosocial and health-related outcomes. Lastly, empowerment practice and strengths perspectives, already prominent strategies in social work practice, were interwoven throughout several interventions across thematic categories; owing to the perspective that clients or patients should be provided with the information, skills, and support to influence their own diabetes care. Embedded within both empowerment and strengths perspectives is the principle of self-determination, a core social work ethic reflected across nearly all of the interventions reviewed.

While the REACH intervention (Heisler et al., 2009) specifically addressed efforts to strengthen the patient-provider relationship and include familial support, we noted a dearth of additional studies in these two areas; future research should give attention to these and other important relational aspects of psychosocial diabetes care. As stated at the outset, we attempted to fill a gap in knowledge on how clinical strategies specifically tailored to African American adult diabetes patients addressed their psychosocial needs. From our review, it is clear that social workers play an important role in helping underserved clients with diabetes to navigate the healthcare system, implement and maintain the lifestyle changes necessary to live with diabetes, and work through psychosocial barriers to health; the strategies pinpointed in this review support and affirm our efforts.

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