Received: 2 August 2021 | Accepted: 11 January 2022

DOI: 10.1111/dme.14790

DIABETIC Medicine

RESEARCH: EDUCATIONAL AND PSYCHOLOGICAL ASPECTS

'I need someone to believe in me and walk the journey with me': A qualitative analysis of preferred approaches to weight management discussions in clinical care among adults with type 2 diabetes

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Funding information
RG is supported by a Deakin University Industry PhD Scholarship, in collaboration with AstraZeneca Australia (unrestricted educational grant). AstraZeneca was involved in planning workshops that informed the design of the 'Your Story...' survey and data collection. The funding source had no role in the selection of the current research question, data analysis or interpretation of the study findings or in the decision to submit the manuscript for publication.
JS and EHT are supported by core funding of The Australian Centre for Behavioural Research in Diabetes (ACBRD) provided by the collaboration between Diabetes Victoria and Deakin University. SG is supported by an unrestricted grant to the ACBRD from Diabetes Australia.

Abstract

Aims: To explore the preferences of adults with type 2 diabetes regarding the approach to weight management discussions in clinical care.

Methods: Online survey of Australian adults with type 2 diabetes, recruited via a national diabetes registry. Three open-ended questions explored participants' experiences and ideal approach to discussing weight management with health professionals. Data subjected to inductive thematic template analysis.

Results: Participants were 254 adults, 58% aged 60+ years, 52% women and 35% insulin-treated. Five themes were developed to categorise participants' preferences for, as well as differing experiences of, weight management discussions: (1) collaborative, person-centred care: working together to make decisions and achieve outcomes, taking personal context into consideration; (2) balanced communication: open, clear messages encouraging action, empathy and kindness; (3) quality advice: knowledgeable health professionals, providing specific details or instructions; (4) weight management intervention: suitable modalities to address weight management and (5) system-wide support: referral and access to appropriate multi-disciplinary care.

Conclusions: Participants expressed preferences for discussing weight management in collaborative, person-centred consultations, with quality advice and personalised interventions across the health system, delivered with empathy. By adopting these recommendations, health professionals may build constructive partnerships with adults with type 2 diabetes and foster weight management.

KEYWORDS
communication, comorbidities, person-centred care, type 2 diabetes, weight management

1 | INTRODUCTION

Weight management is central to the optimal management of type 2 diabetes. A 5%–10% reduction in body weight is recommended by Australian clinical guidelines for management of type 2 diabetes for those living with overweight or obesity,[1] with physical activity and healthy eating being the most common approaches to achieving this outcome. International standards of care for obesity management in type 2 diabetes make similar recommendations for weight management recommending between 3 and 15+% weight loss depending on personal circumstances.[2] Healthful behavioural changes have direct positive impacts on blood glucose, blood pressure, lipids and general health.[3] However, they can be difficult to implement and maintain due to multilevel and interacting barriers, including limited capacity, opportunity or motivation within the context of an unsupportive environment (e.g. socioeconomic disadvantage, obesogenic food system).[4] Ironically, weight management among people with type 2 diabetes may be further complicated by the use of some pharmacological therapies which are associated with weight gain.[5]

Health professionals play a central role in supporting people with type 2 diabetes to adopt and maintain healthy behaviours. However, previous research suggests that, in practice, people with type 2 diabetes perceive a lack of understanding from health professionals about the difficulties in managing diabetes, including weight management.[6] Other research has found health professionals do not prioritise weight management discussions even in those with weight-related chronic conditions such as type 2 diabetes, leaving the person wondering whether their weight is an issue worth discussing or treating.[7] When discussions do take place, research has found there is a need for additional instructive support beyond the prescription of weight loss.[8] Prior qualitative research exploring how weight management is approached in the consultation has shown clinical discussions to be an important element of whether the person feels supported. The research highlights two distinct viewpoints emerging from the experiences of people with type 2 diabetes. Some viewed direct communication (e.g. bluntly providing information or directives) as unhelpful or offensive[8] and felt there to be a lack of empathy and emotional support from health professionals[6]; others viewed the direct style of communication favourably and found it persuasive and motivating. Furthermore, people with type 2 diabetes also report stigmatisation by health professionals, including being judged and shamed for their weight and efforts to manage their weight and their diabetes.[9]

Most studies examining the preferences and satisfaction of people with type 2 diabetes regarding communication in clinical consultations have focused on overall diabetes management.[10] If examining a certain aspect of care, studies concentrate typically on medication preferences.[11–13] Most of the evidence on approaches to weight management focuses on the perspectives of health professionals and how they can better achieve the goal of optimising self-management among people with type 2 diabetes, for example, with motivational interviewing.[14,15] Given the pivotal impact of how weight management is raised and discussed, it is important to recognise the potentially unique needs of people with type 2 diabetes and ensure clinical care is evidence based and leads to satisfactory and positive outcomes. Yet, with limited research exploring the preferences of adults with type 2 diabetes on how to engage with the topic of weight management, there is currently an incomplete understanding of these complex issues.

The aim of this study is to qualitatively explore the preferences of adults with type 2 diabetes about how their main health professional engages with them regarding weight management.

What is already known?

Health professionals play a crucial role in supporting effective weight management, but limited research has explored how best to engage with the topic of weight management within clinical diabetes care.

What this study has found?

This qualitative study explored preferences for discussions about weight during clinical care among adults with type 2 diabetes. We examined free-text survey responses, developing five themes. The need for person-centred care was pervasive across themes.

What are the implications of the study?

Adoption of preferences may enable more supportive, productive clinical care.

2 | METHODS

2.1 | Study design

This qualitative study is a secondary analysis of the 'Your Story: Type 2 Diabetes and Weight Management' study, an online cross-sectional survey conducted July to August

2015. The aim of the Your Story study was to give people living with type 2 diabetes an opportunity to voice their experiences of weight management, positive or negative, and how these experiences affected them. Respondents were also asked about their preference for how health professionals should approach weight management discussions, the focus of this manuscript. This study received ethics approval for the Deakin University Human Research Ethics Committee (DUHREC: 2015-074).

2.2 | Participants and recruitment

Eligible participants were adults (aged ≥18 years) with type 2 diabetes living in Australia, who could read and understand English. They were recruited via the Australian National Diabetes Services Scheme (NDSS) register. The NDSS is an initiative of the Australian Government, administered with the assistance of Diabetes Australia (national diabetes charity), to enhance the capacity of people living with diabetes. A random sample of $N = 5000$ registrants with type 2 diabetes (stratified by geographical state) received an invitation letter by mail-out. Those invited had previously consented to being contacted for research purposes. The letter described the study as an opportunity for people with diabetes to share the story of their experiences with weight management. The letter disclosed the organisations conducting the research together with researchers' contact details. The letter included a link to the website where the survey could be accessed. All participants were offered entry into a prize draw to win an iPad mini.

2.3 | Survey procedure

The survey was written in English and hosted online using SenseMaker™ software. Participants provided informed consent, completed eligibility questions and were directed to the survey (if eligibility criteria were met). The survey included fixed response and free-text, study-specific questions, which were informed by two, three-hour workshops, each with 20 people living with type 2 diabetes. The main survey item of interest to the current study invited participants to provide a free-text response to the following question: '*In an ideal world, how would your main health professional broach the topic of weight management with you?*' Respondents were also asked to relay an experience relating to the statement '*An important aspect of managing type 2 diabetes is to maintain a healthy body weight*' and '*Is there anything else you would like to tell us about your experiences with type 2 diabetes and weight management?*' Demographic and clinical data (e.g. age, gender, diabetes duration, treatment type, desired weight loss) were also self-reported. It was estimated that the survey would take approximately 20 minutes to complete.

2.4 | Analysis

The de-identified demographic and clinical data were exported from the online host site to a secure local server for analysis via IBM SPSS Version 26, along with the qualitative responses, which were imported into NVivo V.12 to facilitate data coding, retrieval and analysis. Qualitative data were examined using thematic template analysis[16] with an inductive approach. Analyses were conducted primarily by two authors: RG has training in psychology, exercise science and public health; SG is a practicing psychologist. All members of the research team have training in qualitative research methods and health psychology.

Two researchers (RG and SG) read and reviewed the survey responses to develop an initial coding framework, with major iterations reviewed by all authors. After modifications, the final coding framework was piloted by RG and SG, who coded 10 participant responses collaboratively to ensure agreement on coding rules and then undertook independent coding of an additional 50 responses (approximately 20% of the data set). Intercoder agreement was determined by summing the percentage of content identified by both coders and the percentage of content identified by neither coder. A mean agreement rating of 99% was achieved for the 50 transcripts indicating a high level of consistency in coding decisions. Minor discrepancies were resolved through discussion and RG then coded the remaining transcripts independently. The content of each code and the relationships between codes were examined by all authors to determine if some codes could be subsumed by others due to overlapping content. Themes were developed (and agreed by all authors) from the broad coding patterns and what was represented by the content of the codes. Quotes are presented including participants ID number (#), gender, age bracket and if the quote relates to a preference or experience.

3 | RESULTS

In total, 254 adults with type 2 diabetes responded to the survey, an eligible consenting response rate of 5%. Of these, 52% ($n = 132$) were women, 58% were aged 60+ years, 41% had been living with type 2 diabetes for more than 10 years, and 35% reported managing their condition with insulin. The vast majority (92%, $n = 234$) of respondents reported that weight loss would make a difference to their lives, with 39% ($n = 100$) reporting a

desire to lose more than 10kg. Full sample characteristics are detailed in Table 1.

In total, 689 qualitative responses were provided across the three open-ended questions; with 239 (35%) stemming from the initial question asking about preference for health professionals' approach to the topic of weight management. Coded responses to the remaining two questions (65%) provided insight into participants' experiences of discussing weight management with health professionals.

Respondents' preferences for, and experiences of, how health professionals should approach weight management discussions in a clinical setting were captured by five underlying themes and multiple sub-themes. A full list of themes and sub-themes, including their descriptions, together with example quotes from participants, is provided in Table 2.

3.1 | Theme 1: collaborative, person-centred care

While respondents appreciated the role and expertise of health professionals, they reported a desire for joint decision-making in their weight management (sub-theme 1.1: *collaboration*). There was a range of suggestions for achieving this, highlighting the differences in how people prefer to collaborate. Most wanted their health professional to ask them how they feel and what they want from their care (sub-theme 1.2: *information seeking*). Questioning that enabled insights into their personal context and experience was preferred, so that health professionals could be *responsive to their current status (s*ub-theme 1.3). In some examples given of experienced care, missed opportunities were described for appropriate and tailored management because health professionals did not ask questions that would aid understanding of the individuals' needs or wishes.

Respondents varied widely in their preferences for the level of attention health professionals put on weight management, both in terms of monitoring and discussions (sub-theme 1.4: *weight-centred care*). Although some found it useful, necessary and motivating, others found it intimidating and confronting, underscoring the need for truly person-centred care. For example, whilst one man described his embarrassment at being weighed, another woman expressed a preference for using weight gain as pretext for questions to discover more about her situation and how to help.

3.2 | Theme 2: weight management intervention

Most preferences for weight management intervention focused on personalised physical activity and diet

TABLE 1 Demographic and clinical characteristics ($N = 254$)

Variable	Total *n* (%)
Gender: Women	132 (52)
Age group (years)	
18–29	7 (2.8)
30–39	13 (5.1)
40–49	19 (7.5)
50–59	67 (26.4)
60–69	103 (40.6)
70+	45 (17.6)
Relationship status: Married/Defacto/Partnered	182 (71.7)
Australian born	178 (70.1)
Education	
Completed year 12 or less	76 (29.9)
Trade training or diploma(s)	76 (29.9)
University educated	102 (40.2)
Employment	
Employed	82 (32.3)
Unemployed	31 (12.2)
Retired	120 (47.2)
Other	21 (8.3)
Household income (per annum)	
Up to $40,000	86 (33.9)
$40,001–$60,000	40 (15.7)
$60,001–$100,000	39 (15.4)
$100,001 or more	43 (16.9)
Don't know/prefer not to say	46 (18.1)
Type 2 diabetes mellitus duration	
≤12 months	15 (5.9)
1–5 years	68 (26.7)
6–10 years	67 (26.4)
11–19 years	81 (31.9)
20+ years	23 (9.1)
Main diabetes treatment	
Diet and physical activity only	40 (15.7)
Oral medication and/or non-insulin injectable treatment	126 (49.6)
Tablets and insulin injections	66 (26.0)
Insulin injections only	21 (8.3)
Insulin pump therapy only	1 (0.4)
Diabetes-related complications: >1 complication[a]	46 (18.1)
Amount of weight loss perceived to make a difference to their life	
0–2 kg	14 (5.5)
3–5 kg	50 (19.7)
6–10 kg	70 (27.6)
11–15 kg	46 (18.1)

TABLE 1 (Continued)

Variable	Total *n* (%)
More than 15 kg	54 (21.3)
Weight loss will not make a difference to me	4 (1.6)
I do not need to lose weight	16 (6.2)

[a]Retinopathy, neuropathy, peripheral vascular diseases, nephropathy, sexual dysfunction, heart disease, stroke.

recommendations, including specific suggestions for healthier alternatives to usual food choices (sub-theme 2.1: *behavioural intervention*). Some participants wanted their health professional to explore other behavioural interventions, such as personalised time management and scheduling issues, where they believed this was impacting their ability to manage their weight.

Medical interventions or information (sub-theme 2.2) also commonly featured in discussions, including potential weight-loss medications, or bariatric surgery. Participants expressed interest in additional *diabetes education* (sub-theme 2.3) regarding the impact that weight management can have on progression of diabetes and its complications.

Intersecting with the *Weight Management Intervention* theme were aspects of the *Balanced Communication* theme. 'Blunt or direct' communication style was typically preferred when discussing weight management interventions, with respondents wanting their health professional to be forthright or honest about the need for weight management interventions.

Participants also reflected on unsatisfactory experiences of discussions regarding weight management interventions, which occurred when approaches to weight management discussions conflicted with preferences. For example, one woman, who was vegetarian, expressed her disappointment in a dietician's recommendations for meat replacement options, which she perceived as unhelpful and obvious.

3.3 | Theme 3: balanced communication

There were varying preferences for the communication style adopted by health professionals during weight management discussions. Some participants preferred a *blunt or direct* approach (sub-theme 3.1), which they believed to be effective for themselves, while others emphasised the importance of *empathic* (sub-theme 3.2: *empathic*) communication from their health professional.

However, participants noted that their desire for direct communication does not mean wanting to be treated without care and consideration. When experiences were relayed, respondents noted the consequences of their preferred communication style not being met, which could be traumatic. For example, one woman described being reduced to tears and feeling worthless for not losing as much weight as her health professional had suggested.

Some participants also expressed a need, or appreciation, for encouragement regarding weight management, which signified health professionals taking a supportive rather than a judgmental role (sub-theme 3.3: *encouraging*).

3.4 | Theme 4: quality advice

Although few respondents commented on health professionals being knowledgeable about weight management, several relayed perceptions that health professionals lack knowledge (sub-theme 4.1: *expertise*). Predominantly, such comments related to advice received from dietitians about sugary foods and dietary practices, such as fasting, that were perceived by some participants as inappropriate, outdated or incorrect. Some participants attributed the low-quality advice to the health professional's attitude and level of engagement. For example, for one woman, her health professional was perceived as self-oriented, rather than person-centred, and uninformed after discussing their own health issues in the consultation.

Participants reported a preference for receiving specific advice, including details on goal setting and action planning (sub-theme 4.2: *specific details and explanations*). For example, two men described separately, their desire for health professionals to provide physical resources on specific foods for weight loss and offer access to established exercise groups, including meeting dates and times.

3.5 | Theme 5: system-wide support

Participants discussed their preference for, and in some instances experience of, coordinated multidisciplinary weight management, such as referrals to diabetes specialists or health professionals from other disciplines (e.g. exercise physiologists) (sub-theme 5.1: *multidisciplinary model of care*). However, barriers to accessing multidisciplinary care following a referral were common due to long waiting lists or the associated costs (sub-theme 5.2: *access to care*).

4 | DISCUSSION

This qualitative study has identified five inter-related themes underpinning the preferences and experiences of

TABLE 2 Theme and subtheme definitions with example quotes from participants

Sub-theme	Description	Example quotes
Theme 1: collaborative, person-centred care: Working together to make decisions and achieve outcomes; and health professionals being aware, and understanding of, the individual's personal context		
1.1 Collaboration	Health professional and person with diabetes working together, in alliance, to achieve weight management or treatment goals	*"[My health professional would say] 'I'm concerned about your current weight, how do you feel and is there something we can put into play to get things on the right track?'"* Participant #98, Woman 30–39 years (Preference) *"I would like to address the issue of my sore knees, but doctors usually dismiss that as an option 'until you lose some weight'. The sore knees impair the ability to actually be as active as I want to be. Doctors don't seem to realise this as an issue"* Participant #163, Man 60–69 years (Experience)
1.2 Information seeking	Health professional asking questions about the individual's current weight management needs/actions and what they want to achieve	*[My health professional would say] "How have you been feeling? Within yourself? About yourself? Is there anything you would like to change?"* Participant #172, Woman 40–49 years (Preference)
1.3 Responsive to current status (context)	Health professional tailoring or modifying their weight management focus or intervention depending on, and in response to, current or evolving needs of the person with diabetes	*"[My health professional would say] nothing because they know I am fully aware of weight management with health and diabetes"* Participant #178, Woman 60–69 years (Preference)
1.4 Weight-centred care	Health professional sensitive to the needs of the person regarding the level of focus placed on weight management	*"Every time I go to the doctor its embarrassing to get on the scales"* Participant #54, Man 50–59 years (Experience) *"[My health professional would say] I can see that you have put on 15kg since we last saw you. What has been happening? How can I help you?"* Participant #45, Woman 50–59 years (Preference)
Theme 2: weight management intervention: Suitable modality of intervention provided to address weight management		
2.1 Behavioural intervention	Health professional focusing on advice relating to the performance of physical activity and dietary behaviours, where appropriate, for the purposes of weight management	*"Discussion regarding what methods of exercise and activity work for me. Discussion regarding finding time in order to exercise and also manage/balance my busy life. Things that I can do on a daily basis to exercise that don't take a lot of time"* Participant #211, Woman 30–39 years (Preference) *"Suggesting alternatives to particular foods in my diet"* Participant #94, Woman 70+ years (Preference) *"As a vegetarian, I am constantly disappointed with the response of dietitians – replace the meat with tofu – thanks, that really helps!"* Participant #239, Woman 60–69 years (Experience)
2.2 Medical interventions or information	Health professional focusing on education or information about the medical aspects of weight management, pharmacological treatments or other interventions	*[My health professional would say] ' "You need to lose weight or your diabetes will never be well-controlled. Here's some appetite suppressants; take them and reduce both your insulin and your food intake."* Participant #251, Man 60–69 years (Preference) *"They would monitor my weight and incorporate discussion about how my medications interact with my weight loss regime"* Participant #206, Woman 50–59 years (Preference)
2.3 Diabetes education	Health professional focusing on an overview of the trajectory of diabetes (including discussion of prognosis, preventing complications, quality of life etc.), and role of weight management in that trajectory	*"Straight up. [My health professional would say] 'You can put a lot of time into testing yourself frequently and rely on medication to manage but consider that your diabetes will get progressively worse. Or you can take control, eat better, exercise more and feel better and live a better life longer'"* Participant #1, Woman 60–69 years (Preference)

TABLE 2 (Continued)

Sub-theme	Description	Example quotes
Theme 3: balanced communication: open and clear messages that encourage action, delivered with empathy and kindness		
3.1 Blunt or direct	Health professional is candid, clear and concise in their style of communication about weight management	*"They should be direct with me. Beating around the bush or hinting does not work"* Participant #42, Man 50–59 years (Preference) *"In an ideal world my doctor would be blunt but kind and come to me with a solutions-focussed strategy and plan. They would say 'I know this may be hard for you to hear but this is how I am going to help you'"* Participant #102, Woman 30–39 years (Preference)
3.2 Empathic	Health professional shows consideration, sensitivity and understanding of the person's challenges with weight management	*"They would be kind and say 'I know it's hard to lose weight and that you probably don't like the weight you are. Then we could work together to shed those extra kilos'"* Participant #50, Woman 70+ years (Preference) *"My previous GP had me in tears and feeling like my life was not worth anything because I hadn't lost any weight. I had lost a small amount (3 kilos) and he was not satisfied that I hadn't lost more. I felt useless and unworthy"* Participant #219, Woman 40–49 years (Experience)
3.3 Encouraging	Health professional is positive and supportive regarding weight management	*"I actually found that during my pregnancies due to amazing support and advice from my care team I was able to lose weight."* Participant #211, Woman 30–39 years (Experience)
Theme 4: quality advice: knowledgeable, with an ability to provide specific details or instructions		
4.1 Expertise	Health professional has a good level of diabetes knowledge and provides effective weight management strategies and solutions	*"[I had] an opportunity to visit [a] local supermarket and have a so-called dietitian explanation of things you could or could not eat. […] she had no actual idea what a diabetic could eat or drink, and help lose weight or gain weight"* Participant #118, Man 70+ years (Experience) *"My local diabetes educator spent the entire hour discussing her own health issues and I felt like the counsellor/support. Often times I feel like I'm more informed than they are about the issue"* Participant #39, Women 40–49 years (Experience)
4.2 Specific details and explanations	Health professional provides step-by-step instructions, recommendations or targets to achieve weight management-related goals	*"[My health professional would say] 'I have a group walking around these [names] streets in the morning… walk at your own pace… and go around as often as you feel like… be sure to record your times and results at the starting pace (sic) before you leave. We start at 5.30am…'"* Participant #81, Man 60–69 years (Preference) *"[My health professional would say] 'Because of your medical condition, you need to lose some weight. Here is a guide to healthy eating and suggested food types you may be able use to assist you in losing weight. Simple exercise, such as walking, is also recommended to assist you in losing weight'"* Participant #228, Man 70+ years (Preference)
Theme 5: system-wide support: referral and access to appropriate multi-disciplinary care		
5.1 Multidisciplinary model of care	Multiple health professionals are involved in bringing profession-specific expertise to care and a coordinated approach to weight management is available	*"[My health professional would say] I would like to suggest you visit an endocrinologist to see if there is some way of finding out about your specific hormones and auto-immune issues that may provide some keys to improving your weight management"* Participant #193, Woman 60–69 years (Preference)
5.2 Access to care	Waiting times, expenses, distance, availability of health professionals, consultation times or other access concerns regarding care, in relation to weight management	*"I need to lose weight, e.g. 15–20 kg and change my diet… but I still have not seen the dietician because they are booked out for 2 years… so I have to wait more than 14 months"* Participant #18, Man 40–49 years (Experience)

adults with type 2 diabetes when discussing weight management with their health professionals. The 'collaborative, person-centred care' theme represents participants' preferences for involvement in decision making about their own care as well as for health professionals to be aware of their personal concerns, experiences, capabilities and context. The theme intersected with the issues raised in other themes: 'weight management intervention', 'balanced communication', 'quality advice' and 'system-wide support'.

With person-centred care principles being at the core of clinical guidelines for type 2 diabetes management,[1] the cross-cutting nature of this theme is unsurprising, but further demonstrates its critical importance. In application, these findings demonstrate that exploring the individual's goals and life context without judgement is essential for providing appropriate, effective care. Research on the impact of person-centred care has shown the importance of attending to a person's psychosocial needs,[6,17] and our findings provide further evidence for the impact it can have. For example, respondents' reports of negative experiences show that a depersonalised approach to care can lead to reduced trust and confidence in the health professional's ability to provide effective support for weight management. This is corroborated by evidence elsewhere that a person's engagement in self-care, their relationship with their health professional, and their clinical outcomes can all be improved by the health professional showing empathy and providing emotional support during consultations.[18–20] Although health professionals report there is a lack of time for person-centred discussions,[21] studies show that person-centred consultations can actually save time.[22,23] Furthermore, when discussing weight management in the context of living with a condition such as type 2 diabetes, research also shows that not prioritising a person-centred approach, for example, tokenistic comments, can send the wrong message about the importance of managing weight.[7]

The findings also demonstrated that 'balanced communication' is at the core of weight management discussions. Participants expressed divergent (but not necessarily mutually exclusive) preferences for communication styles when discussing weight management, which is consistent with other research.[8] The experiences cited offer crucial insights into the profoundly positive and negative emotional impact that certain styles of communication can have, and the considerable individual differences that exist in the extent to which communication needs to be direct and empathic. The overriding implication, which applies across all themes, is that a person-centred approach is vital to discover this context, and to ensure that the communication style matches the person's needs and expectations.

The current study offers new insights through the 'quality advice' theme where there was an over-representation of negative experiences of dietary information and advice being delivered. Evidence of health professionals, including dietitians,[24] being insensitive, unsupportive and/or providing incorrect/outdated advice has been reported elsewhere.[6] However, the specific and disproportionate number of comments necessitates further consideration. In our study, the number of perceived negative experiences regarding dietary information and advice being delivered may be symptomatic of the 'digital age' and the increased access to contradictory information, which only continues to expand, about the effectiveness of various dietary approaches.[25] It also likely reflects the focus of conversation with dietitians versus other health professionals (e.g. general practitioners) who may not discuss diet in any detail. In providing tailored guidance, health professionals need to not only have an understanding of the efficacy of various dietary approaches but also take a non-judgmental perspective about an individual's preferences, so that they can support the person with diabetes to manage their weight with an approach that they can sustain.

Our findings demonstrate the importance of the person-centred care principle of clinical guidelines for type 2 diabetes management.[1,26] Although some respondents reported experiencing person-centred care, this was not a universal experience. This finding is consistent with previous research among adults with type 1 diabetes and type 2 diabetes.[6] Thus, it reiterates the need for timely translation of guidelines to clinical practice, which will likely require a multi-faceted approach, for example, via further training, modelling, incentivisation, environmental restructuring.[27] In addition, people with type 2 diabetes want health professionals to understand their context (e.g. experience, other conditions, other responsibilities etc.) and appreciate its impact on their capability and opportunity to initiate or sustain weight management behaviours, rather than adopting a simplistic misperception that they lack motivation. Enquiries about personal context may also act as a barometer for views and attitudes toward certain diet or exercise trends that may need to be addressed or redressed. By better understanding what is realistic for the person, health professionals can preserve the individual's level of agency over their care whilst also maintaining perceptions of self-identity within acceptable or reconcilable levels.

An important clinical implication of these findings is continuity of care. Continuity of care is reliant on person-centred care and the opportunity to build rapport and develop mutual understanding.[28] Research shows that increased continuity of care is associated with lower mortality rates through multiple mechanisms, such as increased disclosure, responsiveness, optimal tailoring of treatment,

greater satisfaction and likelihood of the individual taking prescribed treatments as recommended.[28,29]

This study is the first to investigate the preferred weight management approach among people with type 2 diabetes and used a novel data collection method (open-ended brief online survey questions) to elicit responses to this sensitive topic from a large sample. The self-completion format of the survey, that is, without the presence of an interviewer, enabled full anonymity for the research participants, which is likely to have impacted positively on their willingness to share their experiences and perspectives. However, a limitation of this approach is it does not allow for the rich and probing style of information gathering offered by traditional semi-structured qualitative methods. Furthermore, although the sample is reasonably consistent with the latest Australian demographic data[30] of adults living with type 2 diabetes (in terms of age and treatment type), the relatively small response rate and lack of diversity (e.g. with respect to education and cultural background) are key limitations, which may restrict the transferability of the results.

4.1 | Future research

This research provides a stepping stone for further work into how weight management discussions can be effectively handled in clinical care for people with type 2 diabetes. Further research on this topic needs to use a research design that will enable greater richness of data, for example, semi-structured interviews, and with participants from diverse cultural backgrounds. Exploring the experiences of younger adults with type 2 diabetes would also be useful, as they were in the minority in the present study and have been shown previously to have unique needs.[24] The present findings offer a framework for which the identified themes could be investigated further using a deductive methodology.

4.2 | Conclusions

To be effective, healthcare practices in type 2 diabetes and weight management need to be informed and shaped by the preferences of those receiving the care. Our findings indicate that while preferences for how weight management discussions are approached by health professionals can vary from person to person, a preference for collaborative, person-centred care, is common across individuals. Adults with type 2 diabetes express a desire for balanced communication about weight management, weight management interventions and quality advice, with access to system-wide multidisciplinary support as needed. Although there are some distinct differences in preference for communication style in interpersonal interactions, weight management discussions with adults with type 2 diabetes need to be individualised by way of a collaborative and person-centred approach to care.

ACKNOWLEDGEMENTS

We thank the adults with type 2 diabetes who participated in the 'Your Story: Type 2 Diabetes and Weight Management' study. We acknowledge Dr Jessica L Browne (formerly of The Australian Centre for Behavioural Research in Diabetes and Deakin University) who was responsible for initial project management, and Emerging Options Pty Ltd who hosted the survey, collated and reported on the initial findings. Open access publishing facilitated by Deakin University, as part of the Wiley - Deakin University agreement via the Council of Australian University Librarians.

CONFLICTS OF INTEREST

No conflicts to declare.

AUTHOR CONTRIBUTIONS

JS conceived of and conducted the Your Story: Type 2 Diabetes and Weight Management' study with Dr Jessica L Browne and the assistance of Emerging Options Pty Ltd and AstraZeneca Australia. All authors contributed to the development of the research questions addressed in the current study. RG and SG conducted the data analyses with contributions to initial analyses from EHT. All authors discussed and agreed on the final themes and contributed to interpretation of findings. RG prepared the first draft of the manuscript. All authors reviewed, contributed to, and approved the manuscript.

The preliminary results of this study were presented at the Australasian Diabetes Congress (Brisbane, October 2020) and published in abstract form. No other results reported in this manuscript are published elsewhere.

ETHICS APPROVAL

Ethics approval for the project was granted by the Deakin University Human Research Ethics Committees (research project number: 2015–074).

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How to cite this article: Geerling R, Gray SM, Holmes-Truscott E, Speight J. 'I need someone to believe in me and walk the journey with me': A qualitative analysis of preferred approaches to weight management discussions in clinical care among adults with type 2 diabetes. *Diabet Med*. 2022;39:e14790. doi:10.1111/dme.14790