Self-management: How can we increase our success?

Jill Rodgers

As health professionals, we strive to help people manage their diabetes better, but equally we are aware that many people with diabetes often do not achieve target HbA_{1c} levels, and instead over time they develop diabetes complications. This article will address why self-management is so important, the challenges we face in improving self-management, what the ideal situation might be, and how we could move towards that ideal situation.

Standard 3 of the National Service Framework for diabetes (*Table 1*) focuses on empowering people 'to enhance their personal control over the day-to-day management of their diabetes' (Department of Health [DoH], 2001). This is in recognition of the fact that diabetes impacts on almost every aspect of a person's life, and that apart from a few hours per year in contact with health professionals, people with diabetes manage their own condition (DoH, 2002).

The challenges we face

Despite the national agenda outlined above to increase self-management, we as nurses often raise concerns that if people with diabetes are allowed to make their own decisions, they may choose options that are detrimental to their health. We therefore feel more comfortable making choices for people about which path they take, and part of the reason for this is our training as nurses and the organisation and focus of our health service. We are trained to deliver acute care: diagnose the problem, make decisions about what treatment is needed, inform people with diabetes what to do and expect them to comply with our decisions. We then judge how successful people are in managing their diabetes by how well they have managed to adhere to our recommendations – in other words, how compliant they have been (Funnell and Anderson, 2004). There has been a move away from the word 'compliance' in recent years, with substitutes such as 'adherence' or 'concordance' being used instead. Anderson and Funnell (2000) argue that terms which label people with diabetes in relation to whether they follow any recommendations made in a consultation are a way of blaming them for the helplessness and frustration we feel in not being able to control their diabetes for them. We have been both trained and socialised to feel responsible for the people we see in our consultations, and spend valuable time trying to persuade and cajole people to carry out self-care behaviours that are consistent with our knowledge about improving metabolic control and also long-term outcomes. These attitudes and beliefs, as in other areas of our lives, are built on our training, our years of experience and the influence of our colleagues, and they are difficult to change.

What would the ideal situation be?

An ideal scenario might be for our diabetes clinics to be full of people who are knowledgeable about their diabetes, working hard on improving their lifestyles, monitoring

Article points

1. Apart from a few hours a year in contact with health professionals, people with diabetes manage their own condition.
2. Concerns are often raised that if people with diabetes make their own decisions, they may choose detrimental options.
3. To increase positive behaviour changes in people with diabetes, we need to use more effective consultation strategies.
4. Using the empowerment model will leave both the nurse and the person with diabetes more satisfied with the consultation.

Key words

- Self-management
- Decision-making
- Empowerment
- Consultation

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Table 1. Standard 3 of the *National Service Framework for Diabetes: Standards*.

Empowering people with diabetes

All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

their blood glucose levels and acting on the results. But even if this were the case, we might still feel some discomfort if they decide to alter the dose of tablets they take without consulting us, and we are also capable of seeing them as abnormal if they appear to spend a lot of time on managing their diabetes (we might even label them as 'obsessive' and try to encourage them to do less). Again, we are trying to get them to manage their diabetes in the way that we have decided is best. In reality, one of the cornerstones of self-management is that people with diabetes are already making their own day-to-day decisions about their diabetes – we may prescribe tablets or suggest a footcare routine to follow, but they will make their own minds up as to whether they take the tablets or follow our advice.

Our role in self-management is to help the people we see to develop their own goals and plans to care for their diabetes that will enhance their health, based both on knowledge about diabetes and on what will fit with their own lifestyles. To do that, we not only have to provide information about diabetes, but we also need to help people reflect on their own circumstances and have insight into their own values and beliefs, so that they can then make informed choices about their self-care (Feste, 1992). This does not mean that we lose sight of the ultimate goals of diabetes care.

How can we achieve better self-management?

Simply providing information about diabetes in a consultation or a group setting is unlikely to result in behaviour change. Part of the reason for this is that there is great variation between the recall of health professionals and that of people with diabetes regarding what information has been provided, what discussions have taken place and what goals have been set, even when checked immediately after a consultation (Page et al, 1981; Parkin and Skinner, 2003). Hampson et al (2000) identified that one way of increasing the effectiveness of a consultation is to use a consultation model, such as an empowerment model, motivational interviewing or the stages of change model. This helps to structure the consultation and means that we work through a defined process, which has greater potential of resulting in behaviour change. Also, working in a way which supports people making their own decisions about their care, as these models do, helps to increase people's motivation to look after their diabetes (Williams et al, 1998). It also helps to improve glycaemic control, which suggests that the behaviour changes people choose to make, with our support, are beneficial rather than detrimental to their health.

One of the models available is the empowerment model, developed at the University of Michigan, which is a staged model that is worked through within a consultation. Research has identified that using the model not only is an effective educational intervention, but is also conducive to improving blood glucose control (Anderson et al, 1995). *Table 2* shows the five stages of this model, with examples of questions and comments that could be used at each stage. It is important to note that putting this into practice involves the use of open questions to elicit the thoughts, feelings and ideas of the person in front of you.

In this model, stages 1 and 2 are helping to define what the issue is from the perspective of people with diabetes (not the nurse), and to help them identify what their thoughts, feelings and beliefs are about this. Stages 3 and 4 involve identifying what the person with diabetes would like the situation to be, and what they need to do to achieve this. An important part of stage 4 is to end the consultation with a very specific action plan, identifying a minimum of the first steps that someone will take after the consultation. Stage 5 helps us to evaluate, with the person with diabetes, how well their plan has worked and what they have learnt. It is important that they see the changes they make as experimental. They may not always succeed – for example, if they have underestimated the barriers that lie in their way – and if they develop a sense of failure, this has potential to reduce their motivation to try again. If it is an experiment, with

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2. The nurse's role in self-management is to help the people we see to develop their own goals and plans to care for their diabetes that will enhance their health.
3. Simply providing information about diabetes in a consultation or a group setting is unlikely to result in behaviour change.
4. One way of increasing the effectiveness of a consultation is to use a consultation model, such as an empowerment model, motivational interviewing or the stages of change model.

opportunities to learn from the experience, this removes the idea of failure and replaces it with the option of revising the original plan if it has not worked.

What barriers do we face?

It is relatively easy to identify ways in which we as nurses can practise to increase the motivation of people with diabetes to self-care, but we may find it more difficult to incorporate these techniques in our consultations. Some of the reasons for this have been explored earlier in this article (we are both trained and well practised in using an acute care model). People with diabetes are also socialised into expecting us to come up with solutions to how they should live their lives, even though those solutions may bear no resemblance to what will in reality fit into their lives. Even if we try to change the way we consult, as with changing any other aspect of our behaviour, we will find it hard, and at times of stress are likely to revert to our traditional way of consulting. This is entirely normal and should be expected, but if we want to be more successful in facilitating behaviour change we need to move away from a culture of blame and criticism and instead adopt a more helpful approach. If we believe in the philosophy of self-management, we must address our own behaviour, beliefs and thoughts about consultations.

Conclusion

This article has discussed the importance of self-management in diabetes, and has highlighted evidence that to increase positive behaviour changes in people with diabetes, we need to adopt more effective consultation strategies. It has also highlighted what strategies can help and the barriers we might face. If we succeed in changing our own behaviour, we should welcome people sharing their ideas with us about how to care for their diabetes, titrating their own medication according to their circumstances, and telling us when they are finding it difficult to self-care. Using a consultation model such as the empowerment model means that you and the people you are consulting with will be able to tackle problems together rather than seeming to come from different angles. This will leave both you and them more satisfied with the consultation, and will also be more likely to result in positive behaviour changes on their part. ■

Table 2. Five-stage behaviour change model (Anderson et al, 1995).

Stage 1: Explore the problem or issue

- What is the most difficult part of your life with diabetes?
- Can you tell me more about that?
- Can you give me specific examples?

Stage 2: Clarifying feelings and meaning

- How does that (the situation) make you feel?
- What are your thoughts about this?
- Are you feeling (describe feeling) because (suggested reason)?

Stage 3: Develop a plan

- What would you like the situation to be like?
- What options do you have to achieve this?
- What might stop you achieving this, and what could you do about this?
- How important is it, on a scale of 1 to 10, for you to do something about this?

Stage 4: Commit to action

- What first steps could you take?
- What exactly will you do, and when?
- How will you know if you have succeeded?
- What is one thing you will do when you leave here today?

Stage 5: Experience and re-evaluate the plan

- What barriers (if any) did you encounter?
- What have you learnt?
- What do you want/need to do now?

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1. It is relatively easy to identify ways in which we can practise to increase the motivation of people with diabetes to self-care, but we may find it more difficult to use these techniques in consultations.
2. If we believe in the philosophy of self-management, we must address our own behaviour, beliefs and thoughts about consultations.
3. Using a consultation model such as the empowerment model means that you and the people you are consulting with will be able to tackle problems together.