

# Awakening the sociological imagination of the DSN

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## Introduction

If wellbeing and social adaptation are central concerns of a person with a chronic condition, then it is important for the health professional caring for such a person to have an understanding of social psychology. This article examines the sociological perspectives regarding concepts of health, illness behaviour and lay beliefs and explores the relevance of these when applied to the diabetic population, to a chronic disease such as diabetes, and to the role of the DSN.

Sociological enquiry often questions existing and assumed definitions of events and situations (Bond and Bond, 1994). In order to participate in sociological thinking a person needs to reflect on his/her own personal values and beliefs. This process can increase the capacity for empathic understanding, which is a basis for critical reflective practice (Glen et al, 1996). It is therefore important to reflect on the terms to be discussed.

## Concepts of health and illness

Many concepts of health exist (Table 1). For most people, health does not consist purely of physiology or the absence of disease, but incorporates social and psychological wellbeing. Illness is a person's subjective experience of ill health. In the author's experience this is equally difficult to define within the diabetic population. Each individual may view their diabetes very differently according to their unique attitude to health, illness and diabetes. These views would also be framed within that individual's experience of diabetes. Diabetes may be viewed as a condition, an illness, or a disease, and because of the chronic nature of diabetes this view may change with time. A recent literature review reveals no recent research into perceptions of health and diabetes. Nearly 50 years ago, Parsons (1951) offered a concept of the sick role (Table 2). However, this description may be more relevant to acute episodes of

sickness than to a condition such as diabetes.

People with diabetes may not consider themselves ill until, for example, they start to experience problems coping with their career or social life as a result of hypoglycaemic episodes. Thus health/illness does not have a purely medical explanation, but can be better explained from a social/behavioural model (Taylor and Field, 1997). This explanation may be attributed to the extended concept of health as wellbeing, rather than to a more traditional biomedical view of health as the absence of disease.

## Biomedical model

The importance of the medical management of diabetes is undisputed (UKPDS, 1998). Like most modern Western medicine, diabetes care rests upon a biomedical model. The criticism of this approach is that it can isolate the body from the person and lead to neglect of social and material causes of disease. The sociology of illness and health offers an alternative way to interpret medicine, health and healing.

## Psychosocial model applied to diabetes

Managing diabetes care requires involvement and participation from the client in terms of monitoring blood glucose levels or urine testing and administering medication. Self-care also involves changing behaviours in the form of dietary, exercise and social activity and reviewing health behaviour in

## ARTICLE POINTS

- 1 Reflecting on personal values and beliefs can increase empathy and understanding with clients.
- 2 Psychological and social factors are related to diabetes management.
- 3 The diabetes experience values a concept of wellbeing.
- 4 Understanding lay beliefs can help in getting across effective messages.
- 5 Health promotion and support needs to be given over the long term to sustain health behaviours.

## KEY WORDS

- Social psychology
- Health concepts
- Illness behaviour
- Lay beliefs

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**PAGE POINTS**

**1** Psychological and sociological factors are related to self-management of diabetes and may form barriers to changing health behaviours.

**2** The extended concept of health as wellbeing requires knowledge of social, psychological, political and economic processes.

**3** To understand the experience of having diabetes from the client's perspective research would need to focus on the lived experience.

**Table 1. Official definitions of health**

Positive	Negative
<ul style="list-style-type: none"> <li>● Health as an ideal state</li> <li>● Health as physical or mental fitness</li> <li>● Health as a commodity</li> <li>● Health as a personal strength or ability</li> <li>● Health as the basis for personal potential</li> </ul>	<ul style="list-style-type: none"> <li>● Absence of disease or bodily abnormality</li> <li>● Absence of illness</li> </ul>

*Adapted from Angleton (1990)*

terms of attendance and acceptance of the preventive nature of diabetic checks.

Psychological and sociological factors are related to self-management of diabetes and may form barriers to changing health behaviours. Overemphasis on the collective management of health behaviours, such as weight reduction, blood glucose monitoring and dietary management, may simplify the impact that lay beliefs, illness behaviour and attitudes can have on these behaviours. Within the constraints of waiting lists and clinic times it may be easier to apply a collective approach and advice, but these may fail to address the complexity of that individual's needs.

Arguably the most important starting point is to try to understand the experience of being diabetic from the client's perspective, drawing on sociological and psychosocial theories related to the sick role, lay beliefs and illness behaviour. The extended concept of health as wellbeing requires knowledge of social, psychological, political and economic processes (O'Brien, 1995).

**Insider's perspectives**

To understand the experience of having diabetes from the client's perspective research would need to focus on the lived experience. Such perspectives may promote understanding of how clients cope with diabetes, what it means for them, and how it affects their everyday lives. Data would need to be collected from a variety of individuals to be able to produce a concept of the experience of living with this condition. In contrast, Parsons' (1951) framework of the sick role can be classed as an outsider's perspective of illness. An outsider's

**Table 2. Summary of the sick role**

<ul style="list-style-type: none"> <li>● Patient separated from everyday activities until regaining health and reintegrated into the social system</li> <li>● Patient absolved from fulfilling certain responsibilities such as work and family</li> </ul>
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*Parsons, 1951*

perspective may ignore or minimise the reality of the lived experience. Therefore to use existing concepts may cloud understanding of the subjective experience of living with illness or a chronic condition. It is also important to take those experiences out of the context of the client role, which may be only one small part of the illness experience for that person.

**Perspectives on diabetes**

Living with a chronic condition can mean that clients have to adapt and manage the continuing challenges of living with diabetes. An individual may have to view his/her health status differently, especially when complications develop (Quackenbush et al, 1996). Clients who have been diagnosed for a longer period of time may perceive more barriers to treatment (Quackenbush et al, 1996), but whether this is related to physical rather than psychological problems is unclear.

The meaning of diabetes and its life impact has been shown by McCord and Brandenburg (1995) to involve a major change in lifestyle, with many clients reporting a sense of frustration and anger at the lack of spontaneity in their life.

However, in contrast, this study also found that clients might view the diagnosis, related treatment, and lifestyle changes as positive changes and an extra incentive to participate in health behaviours.

Within all the health behaviours described, adhering to the dietary regimen appears to be a common theme. Lo and MacLean (1996) found that clients experienced many difficulties in adhering to the diet. These were related to eating out, holidays, food choices and the attitudes of others towards their diet. Unsurprisingly, studies on the social organisation of food have found that the consumption of food cannot be separated from socio-economic circumstances (Nettleton, 1995).

These studies confirm the belief of the diabetes experience as valuing a concept of wellbeing. They also demonstrate how health behaviours may be compromised within a network of choices and restrictions imposed by family, work, diet and leisure.

### Lay beliefs

The illness experience includes perceptions and lay beliefs about the condition and treatment, and can affect the way a person behaves. Calnan and Williams (1996) found that the public did not accept the value and benefits of modern medicine uncritically. Whether this ambivalence was due to socialisation, medical ideology or wider social and economic conditions is unclear.

Understanding our clients' health beliefs and notion of risk may also be important in understanding why some clients take the preventive nature of checks and the adoption of positive health behaviours seriously and others do not.

Class inequalities are particularly marked in preventive services. Clients in manual professions or lower income groups may view health as a matter of luck, often have low health expectations, and make less use of facilities and education programmes (Taylor and Field, 1997). In contrast, middle-class clients tend to get an improved quality service, e.g. longer consultations containing more information, and seek preventive services at an earlier stage.

Taylor and Field (1997) also found a contrast in explaining health. Those in the lower social groups considered that disease

was due to heredity and environmental factors, whereas those from a professional background explained illness in terms of individual actions. Lay beliefs are not shaped by medicine but by the individual's unique environment. This, according to Nettleton (1995), consists of their structural location, cultural context, personal biography and social identity.

### Notions of risk

Modification of lifestyle is associated with ideas about risk, with the concept of risk being in opposition to luck. It is not clear within diabetes management whether some clients know how to take risks without incurring harmful changes in blood glucose levels. More research on risk taking is needed (Joseph and Patterson, 1994). It may be necessary to consider risk behaviour when assessing our client's care. Davison et al (1991) found a marked professional/lay divide regarding explanations and beliefs regarding risk and preventing heart disease. Increased knowledge of lay beliefs within diabetes might reveal a similar divide regarding health behaviours and preventing complications of diabetes. Without reflection and understanding of these lay beliefs, current emphasis on managing these factors may not be successful, as they do not fit with lay beliefs and observation.

It may well be that many clients do not see themselves at risk of the complications of diabetes and thus do not have an incentive to change behaviours. This may mean that they take a calculated risk by being medically 'out of control' by deliberately keeping glycaemic control high to avoid socially disruptive hypoglycaemic episodes (Rajaram, 1997).

### Coping and support

How family and friends support a person with a chronic condition may have an effect on self-care behaviours. Taylor and Field (1997) described this as the creative use of 'lay care' and support. Strategies for coping with anxiety may show gender differences, according to Stenstrom et al (1995), who found that females tend to mobilise their support networks at times of stress. They also found that females focused more

### PAGE POINTS

**1** Health behaviours may be compromised within a network of choices and restrictions imposed by family, work, diet and leisure.

**2** Lay beliefs are not shaped by medicine but by the individual's unique environment.

**3** It may well be that many clients do not see themselves at risk of the complications of diabetes and thus do not have an incentive to change behaviours.

**4** How family and friends support a person with a chronic condition may have an effect on self-care behaviours.

**PAGE POINTS**

- 1 If clients feel that the cause of complications is beyond their individual control this will not encourage self-care behaviours.
- 2 Prescriptive attempts at changing client lifestyle will not be as effective as looking at realistic options within the client's social and economic circumstances.
- 3 Reflecting on the lay/professional divide is an important step in setting realistic targets for clients.
- 4 Health promotion and support need to be continued on a long-term basis in order to sustain health behaviours.

positively on the effect of having diabetes than males. When faced with negative life experiences, men were more likely to be negatively affected.

**Relating theory to practice:  
Implications for the DSN**

**Effective messages**

More knowledge on lay logic regarding the disease process, development of complications and illness behaviour may help the DSN to find effective messages about the preventive aspects of diabetes care. Some individuals may dwell on the biological cause of diabetic complications rather than looking at the positive aspect of altering behavioural factors. If clients feel that the cause of complications is beyond their individual control, this will not encourage self-care behaviours. Nettleton (1995) has criticised health promoters for presenting simplified and straightforward messages without taking into account the sophistication of lay thinking.

**Knowing the audience**

The association between health and lifestyle increases the complexity of the delivery of health services. Prescriptive attempts at changing a client's lifestyle will not be as effective as looking at realistic options within the client's social and economic circumstances. Concentrating on individual factors has in the past been an oversimplification, ignoring the social context of behaviour, and ignoring factors that may be out of that individual's control (Taylor and Field, 1997). An increased sensitivity and awareness of the language and concepts of the audience is therefore important in health education and promotion (Nettleton, 1995).

**Lay/professional divide**

Reflecting on the lay/professional divide is an important step in setting realistic targets for clients. If diabetes care concentrates solely on glycaemic control and lifestyle factors there is a risk of victim blaming if the client does not heed the advice given. Health professionals may then assume that this behaviour is due to lack of knowledge. Joseph and Patterson (1994) found no correlation between control and knowledge.

Reflecting on this lay/professional divide can help health professionals to refocus their strategies and could lead to improved client outcomes and increased satisfaction for the health professional (Hernandez, 1995).

**Impact on lifestyle**

The impact of diabetes care on lifestyle is a common theme in the literature. It is therefore important that health professionals acknowledge this impact and that treatment regimens offer clients more flexibility in terms of their lifestyle. Health promotion and support need to be continued on a long-term basis in order to sustain health behaviours over a lifetime and realistic goals need to be reviewed as health or cognitive abilities change.

Equally, at diagnosis it is important to assess needs appropriately. Beeney et al (1996) found that needs were misjudged by health professionals who overestimated the threat of complications as of pressing concern and did not recognise the insecurities that may exist around trying to cope with the dietary restrictions. Within the newly diagnosed group, the main concerns were injections and the impact on lifestyle.

The staging of education and support on an individual basis offers the health professional many challenges.

**Conclusion**

Critiques of health promotion have, in the past, concentrated arguments on the collective vs the individual approach, neither offering ideal solutions. The collective approach ignores individual responsibility whereas the individual approach leads to victim blaming. The main lesson to be learnt from this in diabetes care is to analyse what assumptions are being made.

Some clients may be aware of the complications of diabetes, but may not identify the causal links to their behaviour. Health promotion needs to be expanded in diabetes care. Education programmes are often short term and information based. These are not going to be effective in supporting clients and sustaining health behaviours over the long term. This is particularly relevant to the role of DSNs, who must not underemphasise their role in supporting clients psychologically, although

this is intangible compared with information giving and physical tasks.

A greater understanding of lay beliefs and attitudes will allow a DSN to develop more individual and realistic care plans, and should in theory lead to better outcomes. All members of the diabetes team should analyse their philosophy of care, their understanding of health and illness, and how they can support the individual to maintain health behaviours so that there is consistency within the team. ■

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**PAGE POINTS**

**1** DSN should not underemphasise their role in supporting clients psychologically.

**2** A greater understanding of lay beliefs and attitudes will allow DSNs to develop individual and realistic care plans.

**KEY ARTICLE REVIEW**

**INFLUENCE OF PSYCHOLOGICAL FACTORS ON THE SELF-MANAGEMENT OF INSULIN-DEPENDENT DIABETES MELLITUS**

**Aims**

The study investigated the influence of perceived health beliefs, perceived control of diabetes, and knowledge on the practice and outcomes of diabetes self-management.

**Methods**

Data regarding demographic variables, health beliefs, perception of control and knowledge were collected via a postal survey. Data regarding metabolic control and clinic attendance as indices of self-management were obtained from the patients' records for 263 patients.

**Results**

The results demonstrated that the sample members perceived that they were responsible for the control of their diabetes, that the benefits of following treatment were greater than any barriers, and that they were knowledgeable about their diabetes. However, according to multiple regression analysis, these factors were not found to have any practical effect upon diabetes self-management.

**Discussion**

The implications of these results relate to both nursing practice and to future research. Further insight into the strategies used to achieve successful management of insulin-dependent diabetes would be useful to nurses to adapt their educational approaches in the future. The fact that patients perceived that they were responsible for their care indicates that they would wish to be considered as active participants. Education programmes, therefore, must facilitate decision making and empowerment as well as, for example, giving information on diet and injections. Further, rigorous research is needed in this area.

**Conclusion**

Perceptions of control, health beliefs and knowledge were not found to have any practical effect on diabetes self-management behaviour or outcomes. The authors suggest that these are not useful frameworks on which to base diabetes care, and that care should be tailored to individual requirements.

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