Progressing the relationship with patients: an overview

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ARTICLE POINTS

1 One area of neglect in discussions with patients about what they want for themselves and their diabetes is acknowledgement of quality of life.

2 Different approaches to people of different personality types may optimise the relationship between nurse and patient.

3 There is a multitude of evidence to support the idea that the collaborative patient–provider relationship is associated with better outcomes for people with diabetes.

4 The nurse requires knowledge and skills, attitude and self-awareness to enhance her/his relationship with the person with diabetes.

KEY WORDS

- Empowerment
- Relationship
- Attachment style
- Transactional analysis

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Introduction

One of the pleasures of diabetes nursing can be the longevity of the relationship between the nurse and the person with diabetes. Sometimes, however, these relationships may seem unproductive to both patient and provider for reasons that remain unclear. Some of the possible reasons for an unsatisfactory relationship are discussed in this paper. Recent theories suggest that different approaches to people of different personality types may optimise the relationship between nurse and patient. An understanding of the concept of empowerment can help to improve this relationship.

The concept of empowerment in diabetes care was first introduced by Funnell and colleagues in 1991. They stated that:

> ***'Patients were empowered when they have the knowledge, skills, attitudes and self-awareness to influence their own behaviour and that of others in order to improve the quality of their lives'***

However, Gibson (1991) described empowerment as a composite of attributes that relate to:

- The client
- The nurse
- The relationship between the client and the nurse.

Although much of the work of the specialist nurse focuses on the behaviour of the patient, it is important that the nurse also has self-awareness of his/her own behaviours and how they might empower or disempower the patient.

Quality of life

One area that is often neglected in discussions with patients about what they want for themselves and their diabetes is acknowledgement of quality of life. Lip service is paid to this complex construct and despite numerous definitions it is recognised that quality of life is a subjective measure (Everett and Kerr, 2001). A helpful definition includes the domains of psychological state, physical wellbeing, role functioning and social support (Meadows, 1991).

A patient's decision to try to achieve psychological and physical wellbeing can be understood from the following quote (Brown, 2001):

> ***'I always keep my blood sugars high… That way you feel better. See, if you get them just the way they want them – between 4 and 6 – you feel worn out…tired all the time…yawning all day… But if you keep them a bit higher, then that way you feel good….'***

Empowering or disempowering?

It is important to understand that empowerment is not something we can do to others. The concept of empowerment derives from person-centred philosophy, where one of many beliefs of the person-centred practitioner is that human nature is essentially constructive and not destructive (Bozarth et al, 1986) and that so-called destructive behaviour may arise from disempowering people, relationships and events (Brown, 2001).

An understanding of the concept of partnership is important. A recent concept analysis (Gallant et al, 2002) describes key attributes to successful partnership. These include:

- Beginning with the agreement to partner
- Fostering the patient's identification of his/her strengths through listening

- Building trust by communicating respect and being non-judgmental
- Self-reflection
- Respectful merging of patient and nurse information and experience.

Communication

It has long been acknowledged that counselling skills enhance a person-centred communication process between the nurse and the patient (Brown, 1996). However, more recent theories suggest that different approaches to people of different personality types may optimise the relationship between nurse and patient.

Ciechanowski et al (2002) have identified that people with different attachment styles are likely to vary in the way they can access services. Attachment theory states that styles develop depending on the experience of parenting that the individual has had as an infant. Those with dismissing attachment style are more likely to have poor glycaemic control than those with secure attachment style (Table 1).

Ciechanowsi et al have suggested that it may be important to relate in a person-centred but relatively distant manner with those exhibiting dismissing attachment style (potentially 25% of the population), and that these people may benefit from having several different care providers rather than only one.

Recent counselling theory (Joines and Stewart, 2002) suggests that, depending on the personality type and adaptation of the patient, it may be better to either use or avoid questions about thinking, feeling or doing (*Figures 1* and *2*).

Transactional analysis

Another modality that can help the nurse to understand the often unspoken processes that go on in the relationship is a theory of personality and communication called transactional analysis (Stewart and Joines, 1987).

Central to transactional analysis is the theory of the parent, adult and child ego states. These three ego states exist within each of us and communicate with each other (Figures 3 and 4) – sometimes inappropriately.

In particular, there is a tendency for a nurse to be in controlling parent mode (nurturing or controlling) and the patient to respond from adapted child mode (rebellious or conforming). This can manifest itself in the form of psychological games which are played out of awareness, and where each individual takes the role

Table 1. Relationship between attachment style and glycaemic control

Attachment style	Proportion
Secure	34%
Preoccupied	39%
Fearful	51%
Dismissing	62%

Personality adaptation		Characteristic
Creative daydreamer	⟷	Strong/placid
Enthusiastic over-reactor	⟷	Shows feelings, pleases others
Playful critic	⟷	Complains/teases
Brilliant sceptic	⟷	Thinks well/critically
Charming manipulator	⟷	Flirts or intimidates
Responsible workaholic	⟷	Perfectionist, gets things done

Figure 1. Types of personality adaptations.

Personality adaptation	Approach
Creative daydreamer	Engage through behaviour, target thinking, avoid feelings
Responsible workaholic	Engage thinking, target feelings, avoid behaviour
Charming manipulator	Engage through behaviour, target feelings, avoid thinking
Playful critic	Engage through behaviour, target feelings, avoid thinking
Enthusiastic over-reactor	Engage through feelings, target thinking, avoid behaviour
Brilliant sceptic	Engage through thinking, target feelings, avoid behaviour

Figure 2. How to handle different personality adaptations.

Parent
Behaviours, thoughts and feelings copied from parents or parent figures. Can be caring/controlling (positive or negative).

Adult
Behaviours, thoughts and feelings that are directly responsive to the present situation.

Child
Behaviours, thoughts and feelings replayed from childhood, e.g. happy or crying or rebellious or sulky or conforming.

Figure 3. The three ego states.

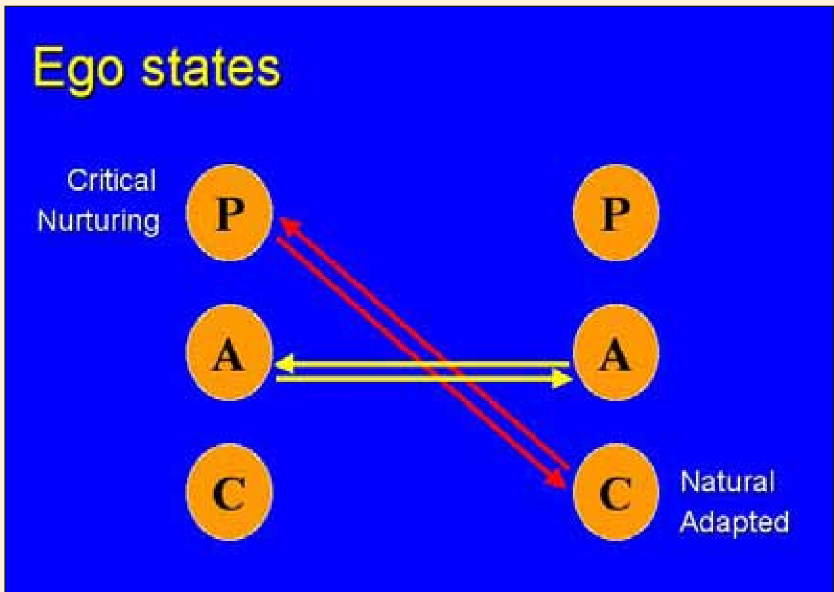

Figure 4. Interaction between ego states (P = parent; A = adult; C = child).

of either victim, rescuer or persecutor. Popular games include 'Poor me', 'Blame others' and 'Why don't you…yes but'. During a game, the nurse might suggest 'Why don't you…? (rescuing role) and the patient says 'Yes but…' (persecutor role).

These roles may switch, with the nurse becoming persecutor as she blames the patient for getting nowhere, and the patient becoming a victim – also for getting nowhere! The good news is that awareness of game playing can allow the players to abort the game!

The empowerment model

Since 1997, there have been empowerment workshops for nurses working in diabetes throughout the UK (Cradock et al, 1999). The 2-day workshops assist people with diabetes (and nurses) to follow four steps towards behaviour change:

- *Step 1 – Identify the issue*
  (What do you want to talk about today?)
- *Step 2 – Explore feelings and values*
  (What is important to you?)
- *Step 3 – Identify goals and choices*
  (What would you like to happen?)
- *Step 4 – Committing to action*
  (When will you start?)

The key to success throughout the four steps is the use of a series of open questions and reflecting on thoughts and feelings.

Conclusions

There is a multitude of evidence to support the idea that the collaborative patient–provider relationship is associated with better outcomes for people with diabetes. The definition for the empowered patient cited above could be applied to the nurse, who also requires the knowledge and skills, attitude and self-awareness to enhance the relationship that she/he has with the person with diabetes. ■

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