Type 2 diabetes patients' perceptions about counselling elicited by interview: is it time for a more health-oriented approach?

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Summary

The aim of counselling is to optimise diabetic patients' self-care by increasing knowledge, skills and self-awareness. Patients' resources during counselling have been supported by highlighting health-promoting aspects.

The aim of this study was to describe diabetes patients' perceptions of their coping resources and experiences of counselling by nurses. The ultimate aim was to understand how health-promoting aspects are realised in counselling according to diabetes patients.

We used a descriptive qualitative approach with thematic individual interviews conducted in December 2011 and January 2012. The data were analysed by inductive content analysis.

Study participants comprised 15 adults with type 2 diabetes. Participants considered their coping resources to be an accepting attitude towards the disease, adherence to self-care, knowledge of the disease and supportive relationships. In addition, activities and support by the nurse were mentioned. Participants reported that the content of counselling focused mainly on medication. The form of counselling was individual in a person-centred way.

It can be concluded from the study that resources that have a positive impact on diabetes patients' self-care must be emphasised in counselling guidance. Nurses have the professional responsibility for counselling but also the right to have more knowledge. Nurses giving advice to diabetes patients should receive education based on the health-promoting aspects in order to assist them in providing comprehensive guidance. The findings of the study can be used to develop comprehensive health promotion in nursing.

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Key words

counselling; qualitative study; resources; salutogenic approach

Introduction

It is well known that diabetes is a lifelong disease and needs constant counselling and patients' self-care.[1,2] Patients with diabetes discuss self-care activities with nurses[3] and family members.[4] It has been shown that nurses have a significant role in supporting patients in their everyday lives.[3,5,6]

Generally, self-care behaviours in diabetes are related to exercise, diet and blood glucose self-monitoring,[7–9] foot care and recognition of complications,[7,8] and medication management.[8–10] Self-care also includes preventing hypoglycaemia, weight control, measuring blood pressure,[7] stress management[9] and social support.[11] People must acquire the necessary knowledge, skills and confidence, and engage in particular behaviours.[7]

The aim of counselling is to optimise patients' self-care by increasing knowledge, skills, self-awareness and a sense of personal autonomy allowing individuals to self-manage their diabetes.[11–13] The involvement of these factors can be seen if an individual's health and well-being increase.[11] According to research, empowering self-care counselling increases knowledge about diabetes care, improves glycaemic control and increases motivation towards implementing self-care. The consideration of these factors can affect complications related to diabetes and improve attitudes towards the disease. Additionally, supporting individuals' resources promotes the development of self-care.[7,8,14,15]

Self-care is closely related to the coping resources or efforts of the patient. Coping strategies can be seen as trying to manage a situation or avoid the anxiety it causes.[16] Coping resources can also be characterised by problem solving and social support. Support from family members has been recognised as vital for positively adjusting to diabetes. Constructive support from health professionals and frequent consultations with health care providers also influence the well-being of people with type 2 diabetes.[10,17,18] Professional support is a powerful coping resource influencing the way the individual both adapts to and manages the

disease.[18] Positive images, humour and increase in the knowledge about the disease are also among the coping resources.[17]

However, there is awareness of the fact that patients often find it difficult to achieve effective self-care and maintain healthy life choices, even though it is well known that care relies on self-management. Moreover, nurses' role is not always clear and it is also unclear whether counselling is patient-centred or empowering.[6] Therefore, there has been a search for a more holistic way of counselling[19,20] highlighting health-promoting aspects. This aspect is included in the salutogenic theory of Aaron Antonovsky (1970) emphasising that the way people perceive their life has a positive influence on their health.[21] The main question is: 'What creates health?'[22,23] From this standpoint, the salutogenic view implies strengthening individuals' health potential by making good health a tool for a productive and enjoyable life.[24] Currently, this is the core idea in health promotion and counselling. According to Antonovsky,[22,23] the concept of sense of coherence (SOC) includes three dimensions – namely, comprehensibility, manageability and meaningfulness.[25] SOC has also been strongly associated with perceived health and also predicts health.[25,26] In this article, health-promoting aspects, based on the salutogenic approach,[22,23] are connected to the coping resources and promote health by nature, including positive, dynamic and empowering factors.[27] However, we can ask whether these aspects are realised in counselling.

Aim

The aim of this article was to describe diabetes patients' perceptions of their coping resources and experiences of counselling by nurses. The ultimate aim of this study was to understand how health-promoting aspects are realised in counselling according to diabetes patients. Therefore, we focused on: (1) patients' perceptions of their coping resources with type 2 diabetes; and (2) patients' perceptions of the content and form of current counselling.

Methods

A descriptive qualitative approach was used. We found the interview method to be appropriate for data collection regarding coping resources. Interviews were semi-structured.[28] The participants were recruited from a cohort of type 2 diabetes patients from two public health organisations.

Data collection was conducted between December 2011 and January 2012 with the help of nurses from the organisation. The researcher (SN) informed nurses about the study and nurses provided an information letter to patients. Nurses presented the researcher with a list of voluntary participants, and she contacted the patients on the list. Interviews were conducted at the homes of participants or at a health care centre. Participants were interested in freely participating in the improvement of type 2 diabetes care.

Altogether, 15 volunteers participated in individual interviews. The interview themes were based on the health-promoting aspects, and consisted of: (1) patients' perceptions of their coping resources with type 2 diabetes; and (2) patients' perceptions of the content and form of current counselling. We wanted to emphasise that participants personally defined what coping resources meant for them. We did not define all the dimensions of the concept to them, but described them only in a general way in order to find out participants' own perceptions. All interviews were audiotaped and lasted from 20–65 minutes (with a mean of 40 minutes).

Participants, who were Finnish and lived in Eastern Finland, were 58–81 years old, and comprised nine male and six female patients. All had type 2 diabetes and had had the condition for 1–31 years. Six of them took oral medication and nine took both oral medication and insulin.

The data were analysed by inductive content analysis described by Graneheim and Lundman,[29] guided by interview themes.[28] The aim of the inductive content analysis was to find the main categories and subcategories illustrating coping resources. Transcribed data amounted to 120 pages.

During the first phase of analysis, the researcher read and re-read the data several times aiming to get an understanding of the material as a whole. Individual words, word pairs or small word groups and clauses were used as analysis units, and were extracted from the data, condensed and grouped according to the interview themes for sub- and main categories. Analyses were carried out by two researchers, and the final analyses were conducted in agreement with the discussions of all researchers.

Ethics and reliability

Organisational approval and ethical approval were granted by the Ethical Committee of the University of Eastern Finland. All participants gave both oral and written informed consent.[30]

The saturation of the data[28] took place after the thirteenth interview, but two more interviews were conducted to ensure the data. Interview themes were pretested with the first three participants and, subsequently, the order of themes was changed.

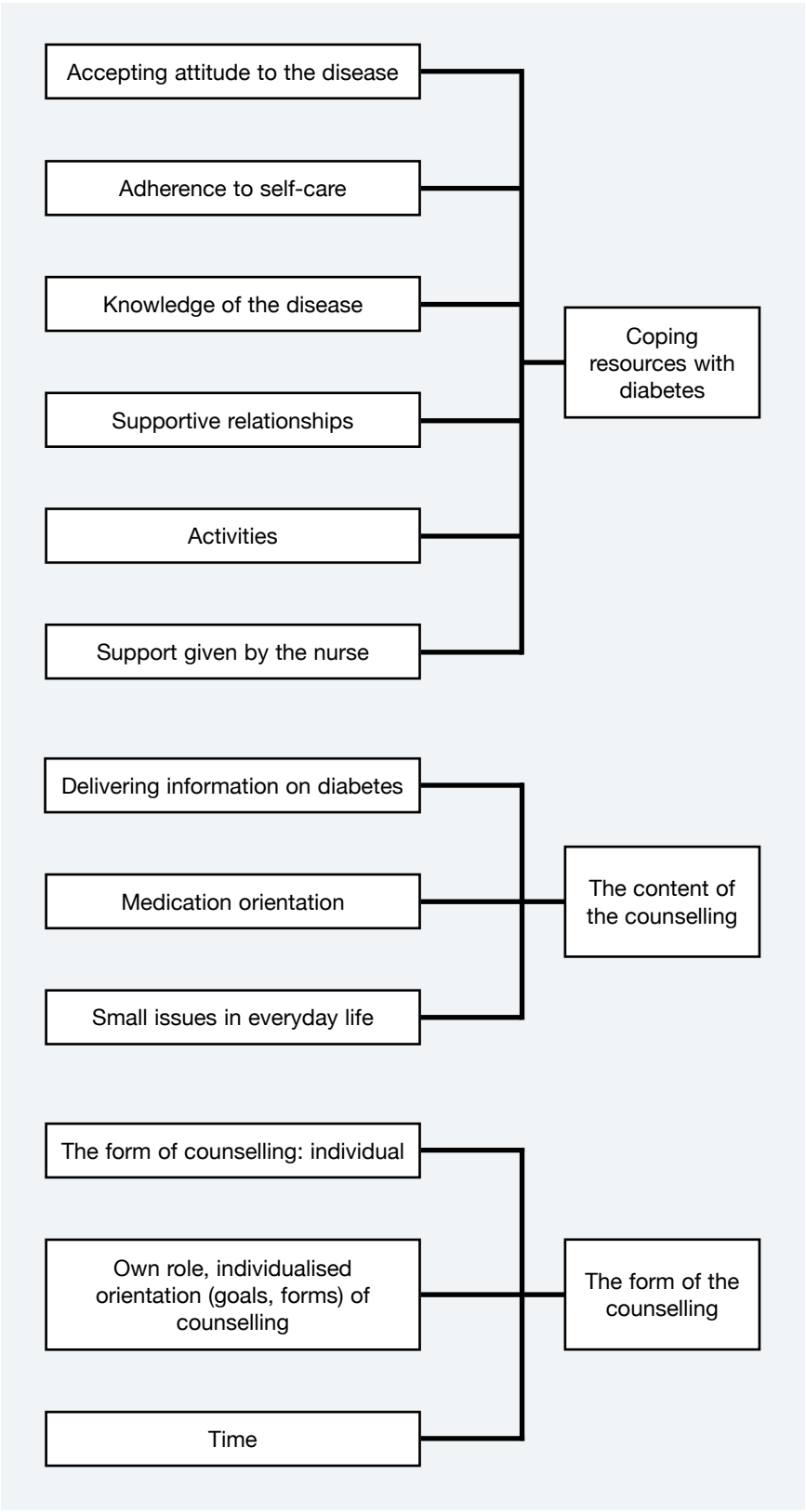

Figure 1. Patients' perceptions of their coping resources with type 2 diabetes and the content and form of counselling

Results

Coping resources with type 2 diabetes

Based on the results, patients with type 2 diabetes described their attitude towards the disease as one of their key coping resources. An accepting and positive attitude is an important coping resource, i.e. treating diabetes as a natural part of life. Participants stated that type 2 diabetes was considered as a practical and manageable matter: while problems should not be created in advance, at the same time care must be taken to treat the illness. In addition, a good-humoured attitude towards care made coping easier. Indeed, one of the participants said: *'It is the best way not to think too much about it* [diabetes]*: if you just sit on the sofa, you will be sitting until the end,'* (interview 2).

Patients' perceptions of their coping resources with type 2 diabetes and the content and form of counselling are outlined in Figure 1.

In addition, patients with type 2 diabetes found adherence to their self-care to be a coping resource. The reasons for adherence included patients' wish to remain healthy and their fear of acquiring disease-related complications. Self-care consisted of medication, nutrition, glucose monitoring, exercise, oral health care and foot care: *'I think that nutrition, exercise and medication are the Holy Trinity of diabetes care,'* (interview 10).

Knowledge of the disease was an important coping resource. Participants described that they were interested in diabetes-related issues from the cell level to their everyday life issues. They felt that they had insufficient knowledge about type 2 diabetes as a disease in general, but had comprehensive knowledge about medication. They received information during appointments with nurses and physicians, but also acquired it based on their own initiative from

different information forums, such as literature and web-pages; as one of the participants said: *'Immediately I got a diagnosis, I went to the library and borrowed a thick book about diabetes mellitus,'* (interview 7).

Supportive relationships were one of the coping resources. Participants said that they receive encouraging, listening and social support from their private relationships with family members, other next of kin, and friends. In particular, family members' contribution to having a purpose in life was highlighted: *'Without my family and my wife I probably wouldn't be alive,'* (interview 9). Families also had a crucial role in relation to everyday life: *'Since I got this diagnosis, the wife has tried to cook healthier food for all of us,'* (interview 9).

The support from close family members, such as spouse, friends and children, was an important resource in daily living, i.e. cooking low-fat food, participating in the appointments with diabetes nurse and creating shared exercise routines. *'I have friends; just a while ago one called and asked if I wanted to go out and enjoy afternoon coffee. We have this group of men and we talk about everything,'* (interview 4). However, close relationships were sometimes relatively burdensome by nature: *'When my wife became ill, I got tired of looking after my disease,'* (interview 11).

In addition to the above, participants said that activities were also a form of coping. Activities helped to steer thinking away from the illness and gave patients with diabetes alternative ways in which to relax: *'Different activities and culture events, such as going to music concerts, open-air theatres and just walking in the forest help me to carry on,'* (interview 5).

Support provided by the nurse was seen as the final form of coping resources. This was a major resource in coping with diabetes, especially when there was care-related tiredness. Trustworthiness and a shared sense of humour with the nurse were featured in relation to supportive relationships. Regular counselling appointments played a key role, especially during difficult times: *'Support from the nurse is the thing. I wish the nurses would have the strength to empower us and the hurry would go away; today it's important to find a good nurse,'* (interview 15).

The content and form of counselling

The counselling provided by nurses promoted diabetes patients' participation in planning their treatment and in improving their balance of care. There were some implications that the counselling provided did not pay sufficient attention to diabetes patients' resources, which prompted some to consider the use of counselling to be partly inadequate. There were no direct discussions on patients' resources. As one diabetes patient remarked: *'I didn't notice that resources were asked about or paid attention to in any way,'* (interview 8). On the other hand, the diabetes patients themselves did not introduce the matter of resources into active discussion: participants considered that the nurses should have enough courage to ask directly about their coping resources.

Guidance that supported nutritional changes was described as a positive way to change lifestyles. Diabetes patients were motivated to learn from the guidance when they saw the differences – for example, in their blood glucose levels. Guidance was most useful when it was regular. Some diabetes patients felt a sense of guilt when they were unable to obey the nurse's instructions. As one patient said: *'I can't blame anyone else, it has to be me. If I would have been stronger, I wouldn't have relapsed,'* (interview 5). In such cases, diabetes patients felt that it was important to meet the nurse.

Information was the main content of counselling. Participants missed most information on disease-related complications and the disease in general. Gaining information helped them manage the disease better.

Medication was the primary content of the counselling. Participants said that counselling was very extensive and consisted of their own thoughts and wishes on how the medication could be realised. Participants noted this, and small and practical issues were an important content of the counselling.

Individual counselling was the dominant form of counselling. Appointments were organised at health care centres. Participants said that the ideology of the counselling was individualised: they were involved in discussions, and goals for their own care were settled in collaboration with the nurse. The participants were also present when the management plan was made. In addition, they understood that, in the end, they had the responsibility for their treatment, which can be illustrated by the following: *'The nurse asked me when I would like to come again. In two or three months? And the next time we will discuss my medication; whether I have been satisfied or not,'* (interview 5); and: *'I know that I have to take the responsibility* [for the care]*; it's harmful for me if I don't. This is what the nurse also said,'* (interview 5).

Discussion

Based on this study, participants were able to recognise their coping resources. In line with previous studies, patients described that their coping resources include adherence,[11,31] knowledge, supportive relationships,[11] activities[32] and the support of professionals.[5,11,32] The content of counselling was highly traditional, including the 'Holy Trinity' of nutrition, exercise and medication.[14,33] In that sense, our results confirm previous information.

What, then, is the meaning of our results, and what new information is produced by this study? Referring to our ultimate aim to find out health-promoting aspects of counselling, can the results produced be critically considered? The coping resources mentioned in this study are described by patients, are multifaceted and individual by nature, and they highlight patients' physical, mental and social health.

Unfortunately, it can be deduced that the counselling offered to type 2 diabetes patients still represents a disease-centred approach and poorly responds to the coping resources which patients have described: nurses focused on medication instead of individual everyday life or health-promoting and empowering aspects, such as meaningfulness and manageability. This is regardless of the fact that there is evidence that, for example, empowerment-based counselling programmes are effective[33,34] and behavioural goal-setting is a useful strategy to support self-management behaviours.[34,35] However, it is also recognised that lack of resources, time and translating the theory into practice can function as barriers for implementing patient-centred counselling in practice.[36]

Counselling should be evidence based, systematic and intentional. In relation to type 2 diabetes patients' counselling, health-promoting orientation is not a new approach. Since 1970 Antonovsky,[22,23] but also the World Health Organisation[27] since 1986, have pointed out that health-centred personal resources are one of the cornerstones for coping with everyday life, and in finding individual solutions for health issues. However, we know that counselling should be continuous[1,2,11] for type 2 diabetes patients. It is understandable that counselling given at the beginning of diagnosis is more disease centred.[11,12] In this study, patients had had diabetes for a considerable period and, therefore, it was surprising how rarely health-promoting aspects were brought up in the interviews. This is particularly so, as there is evidence that the dimensions of the sense of coherence, meaningfulness, manageability and comprehensibility[22,23] can play a significant role in counselling patients with diabetes.[31,37,38] In this study, individual counselling was mostly used, even though it was known that group or age appropriate education is effective.[35]

Health-promoting aspects are not easy to recognise or quantify, therefore more team work between different stakeholders is needed.[39] In practice, responding to the patients' needs, and especially with regard to health-promoting aspects in counselling, requires more nurse education. A practical example is the situation described by one participant when she/he could not follow the given guidelines and experienced feelings of relapse long after the situation, a matter also described in a previous study by Furler *et al.*[5] Therefore, nurses should have a crucial role in highlighting patients' resources. It is essential to find health-promoting resources in a positive way and to support resources, as well as finding out where each patient has succeeded. It is also important that the diabetes nurse has the means to apply counselling so that it can respond to challenging situations.

Who is responsible for type 2 diabetes counselling? It is noteworthy that the question of the responsibility for care of chronic illnesses, such as type 2 diabetes, is highly topical. The implementation and planning of diabetes care are changing, due to an aging population[40] as well as the need to improve the services.[34,36] The current changes impact on and highlight patients' self-care and monitoring,[1] but also challenge nurses' abilities to adjust to their multifaceted role.[6]

Based on previous studies, patients are motivated and willing to take responsibility for self-care, and this has also been identified as a prerequisite for effective self-management.[11] It is also noteworthy that, according to this study, patients appreciated receiving information about the disease and support, both of which are aspects to which nurses can contribute. Information about aspects related to everyday life was especially appreciated.

In this study, patients highly valued nurses and their work, which was in accordance with earlier studies.[5,31,32] However, we must remember that while nurses have the professional responsibility for counselling,[41] they also have the right to gain more information by being offered education about counselling.[40,42]

Conclusions and relevance to clinical practice

The results of this study demonstrated that the current content of type 2 diabetes patients' counselling focuses on their medication, nutrition and exercise. Interestingly, descriptions of the health-promoting aspects of counselling were sparse. Therefore, in the future, there will be a need to develop nurses' knowledge and practical skills regarding health-oriented counselling, and encourage them to use group counselling. There is also a need for more research on the topic.

We considered it important to use different research methods, e.g. videotaping, to find out about the nature of counselling in order to support effective diabetes counselling.[35] Moreover, we would like to stress the fact that the core values in health promotion are

equity, participation and empowerment. These values are also central elements in patient care and counselling. Therefore, we believe that taking into account health-centred aspects in diabetes counselling will have remarkable relevance to clinical practice.

Declaration of interests

There are no conflicts of interest declared.

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