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Counselling in Diabetes

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INTRODUCTION

The day-to-day management of diabetes includes appropriate use of medication, monitoring of blood or urine glucose levels and lifestyle issues such as exercise and diet. These self-care behaviours are all determined by the patient. Effectiveness of treatment will therefore be limited by the patient's actions.

The current culture of patient training tends to be strongly influenced by the medical model, an issue that was first raised in dietetic training in 1987. Evidence highlighted dissatisfaction with this method and non-compliance (1). This predominant style is still often used by both dietitians and other health professionals to advise patients on diet. This model assumes that patients are ready and motivated to change because a credible professional has told them to. The traditional educational strategies employed have relied on the health professional's perception of what the patient with diabetes needs to know. A didactic process of persuasion is then entered into, in which the health professional attempts to persuade the patient to change his or her diet. The conversation is one-sided and based on information gathering to help the health care professional determine what the patient needs to be told to do. In practice this method of communication is only likely to work for a small number of patients, and this type of expert-led, confrontational counselling style could lead to resistance and a poor outcome (2,3).

Information overload is another common practice, and relates to the fear that the patient may not attend another session and hence must be given all the

information necessary in case this occurs. By doing this however there is a real danger of overloading the patient with information and thus demotivating them with the sheer volume of change that is required (4). It also carries the risk that the health care professional's own health beliefs and priorities will be involved in the changes dictated. This is unrealistic and counterproductive as patients' concerns are very different from those of health professionals, and unless we take these into account we will fail to meet their needs (5). The end result is frustration both on the part of the health care professional, who labels the patient as non-compliant or a failure, and on the part of the patient, who feels their needs are not being met (6).

The way we deliver our message therefore needs to change. If something is not working it is clearly ineffective to continue to practise in the same way. Most studies tend to review knowledge as an outcome, but there is ample evidence to indicate that although essential, knowledge alone is not sufficient to change behaviour or establish healthy eating (2,7–9). The information-giving and instructional aspects of dietary counselling must therefore be extended to incorporate motivational and behavioural components (9,10).

Reviews of available data on educational and psychosocial interventions for adults with diabetes, and other chronic illnesses, indicate that a 'patient-centred' approach is more effective in enhancing patient communication and their subsequent health (11–13). For example, interventions designed to increase patient participation and autonomy have resulted in improvements in self-care behaviour and glycosolated haemoglobin (HbA_{1c}) (14,15). Some studies however fail to clearly define what is meant by 'patient-centredness'. In diabetes care we can take the definition of 'patient-centredness' to mean a process that involves the health care professional being open and responsive to the concerns and needs of patients, including needs for information and participation in decision making (16). This definition encompasses the basis of the majority of counselling models currently used in behaviour change for diabetes care.

It has long been recognised that changing behaviour takes more than a directive approach of telling people what to do. Whole person care is important, and this involves identifying psychological issues which may influence how patients respond to the disease and its treatment. By identifying these issues we can help patients to find ways of coping more effectively with their diabetes. The ultimate aim is to improve the level of knowledge and health locus of control of the patient, as well as trying to help develop a positive attitude to active self-care (17). Not everyone with diabetes will require formal counselling, but exposure to the theories and ideas behind counselling can help everyday diabetes education (18,19).

To practise, we require a range of skills, which involve being able to give information where appropriate, teaching, counselling and advising (20). To practise effectively we must also review our basic skills in communication,

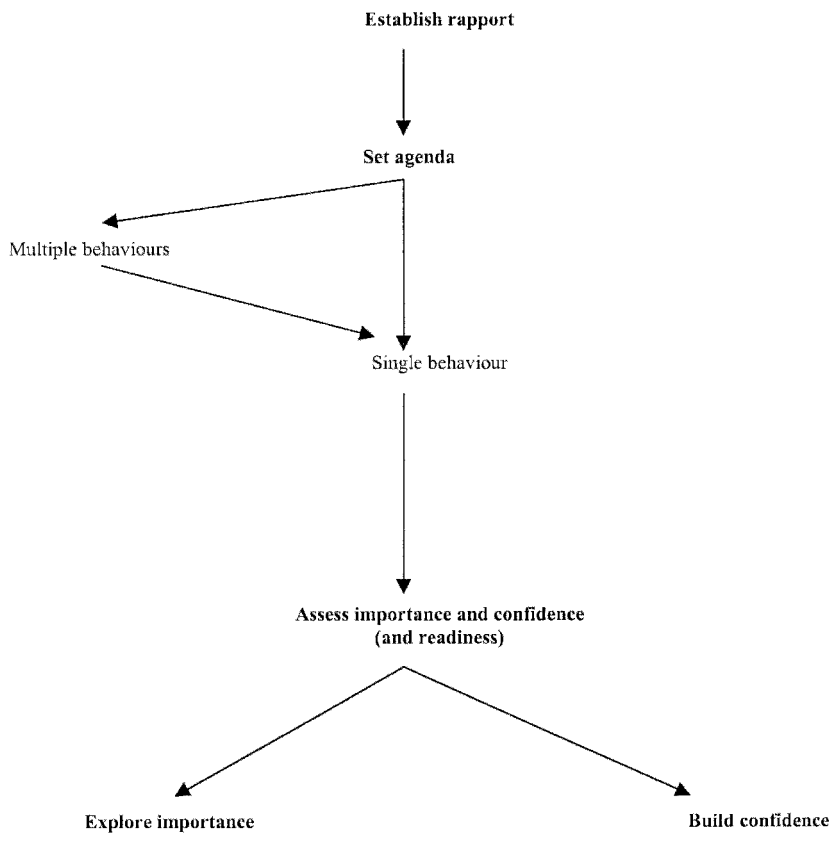


Figure 3.1 Key stages in the consultation
Reproduced from Rollnick *et al.* (21), p.12.

although this would appear to be fundamental as it underpins the majority of the work that we do.

Key stages in the consultation are outlined in Figure 3.1.

ESTABLISH RAPPORT

The discussion should begin with open questions to get patients talking, and is an ideal opportunity to find out what it is they want to know and what they expect from the health care professional. Questions should begin with words like how, what and could you/can you. For example, *‘How did you feel when you were told that you had diabetes?’*, *‘What concerns you most about your*

diabetes?'. Avoid phrases including words such as 'difficulties', 'problems' and 'help' as this implies that you perceive them as having problems when this may not be the way that they see things themselves. Closed questions require a yes or no response; they can be used once discussion has been initiated and are a useful way of checking your understanding of the conversation. '*Did you say that you have tried that diet five times before?*' Another useful opener to establish rapport would be to use a typical day (21). For example, '*Can you take me through a typical day in your life, so that I can understand in more detail what happens?*' or '*Can you think of a recent typical day? Take me through this from beginning to end?*'.

Active listening is an essential skill for this process of communication and counselling to work effectively. It is hard work, as it includes attending to your own non-verbal and verbal behaviour as well as that of your patient. It uses minimal encouragements such as mmm's, aah's, nods and varying degrees of eye contact to encourage people to continue and to let them know that you are listening. Silence can be one of the most useful tools in this arsenal, but for many it proves to be difficult, as the urge to speak and fill the silence is so great. This is a greatly missed opportunity, as it allows patients time to collect their thoughts for a response rather than having them hijacked with your ideas or solutions. This can be very premature as you may not fully understand the real dilemma for the patient. Silence has long been noted to be a difficult tool for health providers, Rollnick *et al.* (21) suggest saying a rhyme to yourself to allow that passage of time before the patient speaks. Silence enables a period of reflection on what has passed and a guide to the direction of the conversation so far, and therefore helps you and the patient move forward.

Once a rapport has been established reflect back comments both to show that you are listening and to check that you have correctly understood what the patient is trying to say. A simple reflection could be '*You've tried many diets then?*'.

Paraphrasing is another method to use, and is a way of summing up the essence of the conversation and providing more concrete information than simple reflection. It conveys to patients that you are with them, crystallises comments, checks accuracy and gives direction. It is aimed more at content rather than feeling. '*It sounds as if you have tried lots of diets in the past, one of which you found particularly good for you as it resulted in the 2 stone weight loss that you were after.*' Paraphrasing should always be applied tentatively to show that you are checking your understanding of the conversation so far. It is a way of clarifying the conversation for both of you, and can be a useful way of highlighting good and positive aspects of a patient's situation which can often be overlooked (22). For example, '*It sounds like you were really pleased with the way that you dealt with that hypo.*'

Being able to keep the conversation to the point is an essential skill when using this approach, and clarifying questions and paraphrasing concisely can

help. *'It sounds as if you have a number of concerns about your eating and weight. Which would you like to talk about, or shall we talk about these one by one?'* Vague solutions to vague problems will never be effective, so clarify statements; *'You say that "it", that is the diet, always makes you feel bad'*. By drawing out these emotions and feelings it is possible to clarify exactly what the patient is trying to say. It is important to identify their concerns about diet, health, weight and diabetes as these will influence both their behaviour and outcomes, and determine the agenda for the discussion.

Reflecting feelings is important and needs to be dealt with as they arise. Recognising signs, verbal and non-verbal, will help with this. Watch out for giggling, tearfulness, fidgeting, wringing of hands, crying, etc. Feelings must be acknowledged and labelled; *'you seem to be angry with the way events have gone'*, ... *'I sense you're frustrated with your diabetes'*, ... *'it sounds like you felt let down'*, ... Acknowledging feelings as they arise is another way of indicating that you have heard what the patient said, and are able to empathise with the feelings that a certain situation or event has caused. It shows understanding and demonstrates active listening is taking place.

Open discussion provides valuable insight into the attitudes, beliefs and lifestyle that have influenced patients' eating behaviour. They may have encountered different messages, approaches and attitudes towards diabetes, weight and eating in the past. These will have influenced their behaviour and need exploring (23). While information-giving can improve confidence and reduce anxiety, be clear why information is being given, find out what the patient already knows, ask patients' views before giving your own (20). Patients need to be given the opportunity to talk and the environment should be conducive towards this. Acknowledge the patient's expectations and allay their anxieties. The key to any good discussion is an understanding of the patient's current situation. How are they coping with the diagnosis, are they ready to make changes, and what is the level of personal responsibility for the management of their diabetes (24)? These factors will determine the type of responses that are required, as well as the type of strategies that may be used (24,25).

In summary, to start the consultation:

- Use open questions
 - to establish rapport
 - to identify patients' concerns
 - to examine patients' beliefs, attitudes, values and understanding of diabetes, weight, eating and exercise
 - A typical day can help to open discussion
- Use closed questions to clarify points.
- Use silence to allow thoughts to be gathered.
- Reflect content to check understanding.

- Acknowledge and reflect emotions as they arise.
- Paraphrase and clarify points as they arise.

EXPLORING PROBLEMS WHICH PATIENTS PRESENT

Eating habits are intensely personal and are a result of nutritional, emotional and social components such as family pressures, lifestyles, beliefs about food and diet (26). Successful management means considering all of these factors. If only the nutritional component is taken into account, poor dietary compliance may be the result of a failure to adopt a comprehensive educational model that considers emotional and social dimensions (27–29).

Past problems may need exploring to enable patients to examine their understanding of previous events and help them identify what was difficult about the task that they had been set and how it could have been made easier. This is an essential step if they want to avoid similar pitfalls in the future. We learn from our mistakes and from our own life experiences, not from other people telling us what to do. This is probably the hardest lesson for health professionals, as we want them to get it right all the time. Letting go can be difficult.

Concreteness can be a way of interrupting long vague stories, with clarifying questions, concrete paraphrases and reflections. *‘What happened exactly . . . what did you say . . . How did you react . . . Have I got this right, on the one hand you have had all these difficulties that have prevented you from doing the things that you want to do, and equally you have discovered an amazing ability to cope and get on with things?’*

Emotions experienced by the patient need to be explored and expressed by the patient. They form an important part of the picture of how the patient is coping in relation to food, weight and diabetes, and as such provide valuable insight. They can help to explain why people eat when they are not hungry.

In practice this can prove a dilemma, as responding to emotional issues and avoiding a problem-solving approach is difficult. Instead of providing answers we need to help patients draw from their own conclusions about how to manage or solve such issues for themselves. Dealing with emotions can be hard, and professionals can find it upsetting, or even frightening, and may worry that they will make things worse if people shout or cry. However, the reality is that people appreciate expressing their feelings or even simply having them labelled. Completely ignoring emotions, or belittling them by saying *‘It’s not that bad, everyone feels that’*, is not helpful but it may serve to make you feel better and safe. Emotions have a major role to play in dietary education, and the link between emotions and eating is well established (28,30–32). So aim to get people thinking through their behaviour and reflecting on past experiences.

Empowerment is a philosophy of diabetes care that uses as its base a four-step counselling approach. Its use in diabetes care has been increasing over the last few years, and it encompasses a lot of the areas discussed in this chapter (33).

Useful questions from this work are '*What part of your diet is the most difficult or unsatisfying for you?*', '*How does that situation make you feel?*', '*How would this situation have to change for you to feel better about it?*'

In summary, to explore the issues raised:

- Use open questions.
- Explore the emotional aspect of issues raised.
- Aim to get people thinking through their behaviour and reflecting on past experiences.
- Clarify by paraphrasing and concreteness to check issues being addressed are the real concerns of the patient.

Agreeing goals

Having clarified a patient's concerns and focused on the emotions behind them it is now necessary to look at self-care management options available to the patient. What self-care behaviour are they willing to make and commit to? Remember that you are still facilitating the process and the patient should be fully instrumental in the decision process, so negotiation is vital (31).

If a patient suggests a change, they are far more likely to follow it through and to understand their responsibility for the solution and ultimate control of the diabetes lies with them. Inflexible advice can be negative as it will lower self-esteem and make the patient more resistant to change (34). By allowing the patient increased autonomy, on the other hand, you can identify those who are poorly motivated and find ways to increase their motivation and alter methods of care appropriately.

Rollnick *et al.* (21) describe two aspects to motivation or readiness to change. These are 'importance' and 'confidence'. Importance looks at the 'why' aspect of change, and confidence looks at the 'how' and 'what' aspect of change (see Figure 3.2). This can help to break down a difficult area of behaviour change by focusing on the aspect that, for the patient, is inhibiting or preventing change. For example, the patient may understand the importance of change but lack the understanding or skills to make the practical changes required. Alternatively, you may have a patient who is confident that they could change their diet as they have done so in the past. They have the necessary information to do this, but they do not perceive the change as important and so action has not been taken.

Decisional balance can also help, as weighing up the pros and cons with patients can assist them to focus on the issues around change. List factors that will support change and highlight how the proposed action will be beneficial.

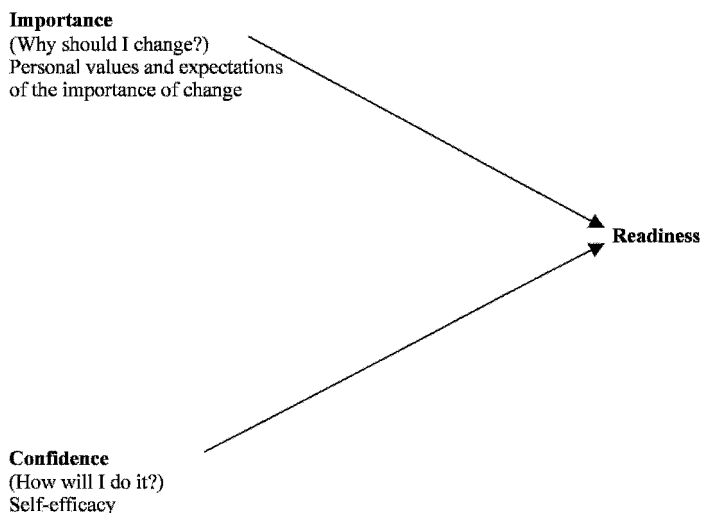


Figure 3.2 Readiness to change
Reproduced from Rollnick *et al.* (21), p. 22.

At the end of the discussion key concerns should have been identified, summarised and key points or individual goals negotiated and written down. A patient-centred personalised problem-solving educational process should have taken place where collaborative goals are set, and both barriers and supports in patients' social environments are identified. Useful empowerment questions to help this process would be:

'Are you willing to take action to improve the situation for yourself?', 'Are there some steps that you could take to bring you closer to where you want to be?', 'Is there one thing you will do when you leave here to improve things for yourself?'

In summary, when agreeing goals:

- Weigh up the pros and cons of change.
- Explore the patient's motivation, using Rollnick *et al.* (21).
- Allow the patient to identify and set their own goals.

FACILITATING CHANGE

EVALUATING EFFECTS OF DECISIONS AND ACTIONS

When focusing on dietary management of diabetes, discussions of issues other than food will achieve a clearer picture of the events or triggers related to

certain eating behaviours, and allow better understanding of why the patient eats in a particular way. Exploring ‘what if’ situations helps to equip the patient with more life-management skills, especially once they have a greater understanding of their own behaviour. For patients, their real concerns are being listened to and knowing they are learning to cope with their diabetes.

PROFESSIONAL PRACTICE

In order to develop consultation skills effectively we need to evaluate the way that we practise as an individual; to let go of advice giving and let the patient take charge (33,35). Before we can practise differently we need to examine the way that we currently practise. We need to examine our own preconceptions first, and over time develop a less judgmental approach to our care. This means that behaviour change takes time both for the professional and the patient.

Rollnick *et al.* (21) state that all models of education are only as effective as the practitioners who use them. A review of their study on behaviour change in 2000 showed the model of education used, wasn’t as effective as anticipated, as the professionals found it hard to change their behaviour and therefore lapsed into a previous consultation mode. Encouraging patients to make their own decisions and to set their own targets was harder than anticipated, especially when good diabetic control was not being achieved. This posed a number of questions, one of which was ‘Do we need to reconsider the issue and extent of professional responsibility?’ Further, ‘Do we aim for the change in patient behaviour that the professional wants or facilitate informed choice by the patient?’ Not all professionals will behave in the same way, and patients’ perceptions of their condition, their coping strategies and the implications of these on their long-term health status, will also vary considerably (36). So although we may think that we have encountered a situation before, the solution will always vary as the patient’s needs and drive will be different. More research is needed into professional perspectives on chronic care, the strategies used by professionals to manage patients and to cope with their own feelings, and the implications of these strategies for patients (16,37).

If you are trying to change your behaviour to enable you to work more effectively with patients, you need to constantly review the process. It will continuously evolve over time, and within the educational models you will adapt and find certain aspects that work best for certain patients – this is not a process set in stone. It does, however, require a core set of basic counselling skills, as all models require the application of these during their use. Videos of consultations and case reviews are an effective way to enrich and develop your practice and that of others. In Doherty’s study in North Shields the most valuable training methods were individual supervision and

video examples. Videos of consultations can be used as a teaching aid to illustrate certain techniques or as a way to assess current practice. Reflective practice is a vital part of personal development. This is essential in developing and supporting practice, as perceived and actual communication can vary (37).

You could use the following questions at the end of a consultation to reflect on your practice:

- How much was I able to accomplish by just asking questions?
- Was I tempted to jump in with advice and solutions?
- How did the patient respond to my questions?
- Was the session effective?
- Who did most of the talking?
- Did the patient express any concerns with regard to their diabetes and management, and were these acknowledged?
- Who set the agenda?
- Who set the goals?
- Did I listen?
- Do I feel that I understood what motivates the patient?
- Do I know how confident the patient feels to follow through the changes discussed?
- Do I know how competent the patient feels to follow through changes and the impact this will have on their life?

Giving patients a greater role in the management of their own condition corresponds to current views stressing the importance of being more patient-centred and developing an equal partnership with patients with a chronic illness. There is work starting to emerge that suggests behavioural counselling leads to improvements in healthy behaviour. It suggests that extended counselling to help patients sustain and build on behaviour changes may be required before differences in biological risk factors emerge. On the whole behaviours change simply, and it may be unrealistic to expect people to embrace a consistently healthy lifestyle in one fell swoop. Patient-centred empowerment and behavioural problem-solving skills training interventions produce results superior to both usual care and more traditional knowledge-based diabetes education (39). Interventions that help facilitate self-management have been proven to be effective, and sometimes even cost-effective (40).

There is still a need to provide additional strong data to support this work, as many educational models support its ideology but the evidence is sometimes lacking (41,42).

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