A Concordance Therapy to Help Older People Effectively Self-Manage Type 2 Diabetes

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Introduction

Self-management in Diabetes

Diabetes is an increasingly common long-term condition that individuals have to live with and actively manage. Additionally, patients diagnosed with diabetes have to accept that 'even perfect long term therapeutic intervention will not eliminate diabetic complications, only reduce the risk of developing them' (Mulhauser & Berger, 2000, p. 823). However, research has shown that in type 2 diabetes even small improvements in glycaemic control can reduce the risk of developing long-term complications (Goudswaard, Stolk, Valk, & Rutten, 2003). Furthermore, when maintaining tight glycaemic control, diabetic complications are significantly decreased (Gaede et al., 2003).

Many patients do find it difficult to maintain adequate glycaemic control (Harris, 2001), which may be the result of various factors including the progressive nature of the disease, non-attendance and non-compliance with medication (Goudswaard et al., 2003). Therefore, the current intervention (described below) is designed to enhance individuals' self-managing behaviours in type 2 diabetes, by targeting areas of concern for each individual. It is not possible to target one specific area of diabetes management as its very nature necessitates a highly complex self-care regime.

It is anticipated that patients will discuss a variety of problems, which may include; medication regimes, regular blood sugar testing and lifestyle changes, such as taking regular exercise, changing diet and eating regularly. Some patients may feel unable to carry out diabetes related tasks (testing their blood sugar or adjusting their insulin dose); others may have concerns about their medications and potential side effects. Here, all aspects of diabetes management are encompassed in the concept of 'self-management'. This term, along with the terms 'self-care' and 'lifestyle changes', is referred to frequently throughout the manual as a general reference to the diabetes regime.

The focus of the intervention is to enable individuals who have type 2 diabetes and are currently not managing the condition sufficiently well (as indicated by consistently high blood sugar readings) to change their self-management routine. Although not always explicitly mentioned, it is assumed that patients will have adopted some form of management strategy, albeit sometimes not a medically appropriate one, as a means of living with diabetes.

Background to the Intervention

Concordance Therapy was developed and tested in the context of medication adherence of older people with depression (Higgins, Livingston & Katona, 2004). It was adapted from Compliance Therapy a psychosocial intervention designed to help people take antipsychotic medication (Kemp et al., 1996). While the terms compliance, adherence and concordance are sometimes used interchangeably in the research literature, their meaning is not equivalent. Compliance refers to the extent to which patients take medicines as prescribed; adherence refers to the extent to which patients follow through with an agreed course of action to produce a therapeutic result; and concordance refers to the extent to which patients are effectively supported in decision making (Horne et al., 2005; De las Cuevas, 2011). In Concordance Therapy patients are considered to be consumers able to make reasoned choices that are most suited to them; collaboration between the patient and therapist facilitates a shared understanding of the best way to achieve agreed outcomes; different views and opinions are acknowledged and respected (Scott & Tacchi, 2002). Concordance Therapy draws on both cognitive-behavioural therapy and motivational interviewing. The basic tenets of these approaches shaping Concordance Therapy are outlined below:

Cognitive-Behavioural Therapy

Concordance Therapy is influenced by cognitive-behavioural therapy in several key aspects:

- Therapy is **time-limited** and **focused** on a specific area of behavioural change in the here-and-now.

- The first session develops a **formulation** of the patient's stance towards self-management and indicates target problems needing to be addressed.

- The sessions are **structured** and **directive**, with their nature and purpose outlined to the patient at the start.

- The relationship between patient and therapist is envisaged as being a **collaborative** one. All aspects of the therapy are made explicit by the therapist. The process should be one of guided discovery for the patient in exploring their views. A didactic, lecturing stance from the therapist should be avoided.

- Inductive methods are used; the patient is encouraged to see their views about self-management as hypotheses to be tested rather than irrefutable facts.

- In line with cognitive-behavioural research methods (Hawton et al., 2000), Concordance Therapy is described below in **operational** terms and will be evaluated in this study using reliable and objective measures. Specifically, the outcomes measured will be the patients' glycaemic control, depression, self-efficacy, health related quality of life, and illness perceptions.

Motivational Interviewing

Motivational interviewing is an approach developed to help change addictive behaviours such as drug and alcohol use (Miller & Rollnick, 1991). Central to this method is the importance of recognising one's natural ambivalence towards addressing problems and changing behaviour. Exploring this ambivalence affords an opportunity to think through the issues involved in order to move forward.

The stance of the professional in this approach is again that of a partner, exploring with the patient their concerns and considering the advantages/disadvantages of alternative courses of action. Techniques employed include **open-ended questioning, reflective listening, summarising** and **reinforcement of adaptive attitudes and behaviours**.

The confrontation and stalemate of some conventional doctor-patient interactions is actively avoided.

For use in Concordance Therapy motivational interviewing has been modified in the following areas:

- A more active therapeutic stance is taken. There is less reliance on self-generation of material from the patient. In motivational interviewing the arguments for change are left to the patient. While this is ideal, a patient who has not been effectively managing their diabetes is likely to need possibilities suggested to them.

- The session lengths are more flexible. Frequent, short sessions will be used if necessary to counteract any problems with other health ailments or poor memory. It is envisaged that most patients will require three sessions but session number is likely to range between two and six depending on the individual.

- The educational component has been increased. Information is provided about diabetes and the role of the individual in managing their condition. In diabetes this includes: managing weight by eating a balanced diet and keeping physically active; self-monitoring blood sugar levels; checking feet, attending clinics for blood tests (e.g. cholesterol, long-term blood sugar, and kidney function), blood pressure, foot and eye examinations; and taking medicines as prescribed.

- A more structured approach to the sessions is planned using a defined hierarchy of goals to be worked through, as shown in Table 1 below.

Table 1: Goals of Concordance Therapy in Type 2 Diabetes

1. Willingness to discuss current problems.
2. Understanding the concept of diabetes in others.
3. Understanding the concept and accepting of diabetes in self.
4. Understanding the importance of self-managing in long term illnesses.
5. Understanding the importance of self-managing in relation to own health.
6. Understanding of the potential of self-management to increase quality of life.
7. Accepting the need to continuously self manage diabetes.

The intervention has been divided into three phases to achieve these goals:

- **Phase 1: To elicit the patient's stance towards self-management.**
- **Phase 2: To explore the patient's ambivalence towards self-management.**
- **Phase 3: To highlight to the patient the need to maintain effective self-management.**

Techniques to be used are summarised in Table 2 and described in more detail in the following sections. Progress through these stages may not be linear. Readiness to change attitudes or behaviour can be thought of as a continuum; people's commitment to change often fluctuates and may be influenced by other factors, including mood or change in circumstances (such as going on holiday or developing other health problems).

Table 2: Principles and Techniques of Concordance Therapy

Key Principles in Concordance Therapy
Non-blaming Atmosphere
Emphasis on personal choice and responsibility
Development of self-efficacy
Key Techniques
Reflective Listening
Regular Summarising
Inductive Questioning
Expression of Empathy
Exploration of ambivalence: the good and the bad things about self-management
Development of discrepancy between present situation and broader goals
Use of normalising rationales
To be Avoided…
Lecturing or preaching
Insisting on a rigid management programme
Turning session into a debate

Detailed description

Phase 1: Eliciting the Patient's Stance towards Self-Management

Initially, the patient's illness history will be reviewed with them. Their perception of diabetes will then be explored, using the 'common sense model' (CSM; Leventhal, Dienfenbach & Leventhal, 1992) as an explanatory framework. The purpose of phase 1 is to clarify patients' views about diabetes self-management and elicit their current concerns and priorities. Any 'denial' (avoiding the problem or denying it exists) being used as a coping strategy may begin to emerge at this stage.

The Common Sense Model

According to Leventhal, Dienfenbach and Leventhal (1992) when faced with a health threat people form cognitive and emotional representations that guide subsequent attempts at coping. Cognitive representations include perceptions of the illness identity (disease label, diagnosis, and symptoms), its cause and consequences, timeline (beliefs about the course of the illness), curability and controllability (beliefs about personal control over the illness and effectiveness of treatments). Emotional representations incorporate reactions such as anger, fear and sadness. Level of concern about the illness and illness coherence (understanding of the illness) are also important determinants of coping (Broadbent, Petrie, Main & Weinman, 2006).

Identifying problem areas at this stage will direct the focus of Concordance Therapy. For example, if a patient indicates that their treatment is not effective for controlling their diabetes, the therapist will explore what this means to the patient and what steps may be taken in order to maximise the chances of bringing their diabetes under control.

Table 3: Eliciting the Patients' Stance using Illness Perceptions

Therapist/Patient Dialogue
Therapist: *You have reported that you do not understand your diabetes - can we talk about that?*
Patient (with type 2 diabetes): *Yes. I don't understand why my blood sugar is still high even though I try to eat healthily. I know I'm overweight, but I can't seem to lose any weight even though I've cut out sugar.*
Therapist: *You also mentioned that the consequences of diabetes are severe; could you tell me more about this?*
Patient: *I've had to have laser treatment to my eyes which they told me was because of diabetes retinopathy.*
Therapist: *And you feel that the medication you are taking is not effective at controlling your diabetes?*
Patient: *Definitely. It does not matter if I take the tablets exactly as I was told to or not - my blood sugar levels are still way too high.*
Therapist: *So, if I have followed you correctly so far, you have been finding it difficult to fully understand your diabetes, you have experienced negative consequences as a direct result of your diabetes and you feel that your treatment does not control it?*

Open-ended questioning, reflective listening and motivational interviewing are used in this exploration of the patient's views. These techniques allow the patient to describe what they feel is important. Reflective listening involves the therapist reflecting back as a statement the essence of what the client is communicating. This process of clarification ensures the therapist has correctly understood the patient. In addition, by selective reflection the therapist can emphasise certain aspects of what the patient has said – particularly any self-motivational statements around the potential benefits of self-management.

Table 4: A Hypothetical Dialogue Illustrating Reflective Listening & Motivational Interviewing

Therapist/Patient Dialogue
Therapist: *So, if I have understood so far, you feel that your symptoms are quite unpredictable and you have very little control over your diabetes.*
Patient: *Yes. There's not much I can do to make a difference. I suppose I feel worse when I do not eat regularly – then I start to feel very tired and I sometimes get stomach pains.*
Therapist: *So, you feel that your diabetes is worse when you have not carefully planned your eating times?*
Patient: *Yes, but even when I eat on time I still can't have my drop of brandy and I still suffer from the pain of the nerve damage that was caused by the diabetes.*
Therapist: *So, looking back, it seems that you have had some negative experiences with your diabetes, but you feel that planning your meals might help you feel less tired and avoid stomach pains. So, that might be something to work on.*

Points to note:

- Reviewing a patient's illness history in detail reminds the patient of troublesome symptoms; it will be these that are the focus for treatment. Even if the patient digresses with personal history details, concerned attention should strengthen rapport and may also provide clues to views of self and health care influencing concordance (e.g. "Dieting never helped me").

- Reviewing previous experiences of self-management will suggest likely barriers to concordance needing to be addressed.

- If a relationship between previous lapses in self-management and diabetes symptoms (e.g. Getting out of routine when on holiday and becoming unwell with high sugar readings) becomes apparent this will be explored in detail and reinforced as a key point for consideration.

- Patients may report feeling no change in their symptoms or even report feeling worse, despite maintaining good blood sugar control. It is useful to link effective management/HbA1c levels (long term blood sugar) with diabetes related complications, such as eye problems or stroke and consider how this would affect everyday life (e.g. driving or walking the dog).

Formulation of the Patient's Stance

At the end of phase 1 a formulation of the patient's stance towards diabetes and its management is made such as:

Jack was diagnosed with type 2 diabetes 11 months ago. He was prescribed tablets by his GP but has never taken them or followed the self-care advice provided; rather he takes action when he feels unwell (such as doing gentle exercise and trying to eating more fruit). Jack feels that his symptoms are a normal part of getting older and there is no need to change his routines or take medication. Jack reports that he gets extremely thirsty and has to get up many times in the night to go to the toilet; he agrees that this is unusual for him.

Table 5: Summary of Phase 1

1. Review illness history and current problems.
2. Review the patients' understanding of diabetes and its self-management.
3. Acknowledge any previous negative experiences with diabetes management.
4. Acknowledge the challenges that effective self-managements presents.
5. Suggest advantages of the patient effectively self managing diabetes.
6. Reinforce any self motivational statements.
7. Formulate patient's stance towards continuously self managing diabetes.

Phase 2: Exploring Ambivalence towards Self-Management

In phase 2 the patient will be supported to discuss their concerns about self-management. They will then be guided through an exploration of the pros and cons of self-management for them, in the light of their wider interests and priorities.

Table 6 below highlights potential barriers to engaging in diabetes self-management. If any of these issues have not emerged naturally by this point they will be brought into discussion by the therapist. In the following sections potential approaches are suggested for addressing these barriers.

Table 6: Potential Barriers to Diabetes Self-Management

1. Presence of psychological difficulties, such as anxiety and depression.
2. Perceived negative beliefs of significant others (e.g. Spouse / Close Neighbour/ Employer) about diabetes self-management.
3. Negative beliefs held by the patient about diabetes self-management.
4. Perceived lack of ability to effectively self-manage.
5. Feeling unprepared to take on the demands of self-management.
6. Denying the potential health risks of not self managing.
7. Negative past experiences with diabetes self management.

Presence of Psychological Difficulties

People with diabetes are more likely to experience psychological difficulties (including depression, anxiety and problems with stress and coping) than those without diabetes and this can compromise self-care (NHS Diabetes and Diabetes UK, 2010).

If a patient feels uncomfortable discussing psychological difficulties this will not be challenged directly. Instead the patient will be guided through to recognise in graded steps (as outlined above) the barriers that are preventing them from carrying out self-care behaviours. Information about psychological problems will be provided, emphasising that such difficulties are common in people with chronic conditions and can be treated.

Patients differ in the amount of information they want and find useful. Therefore basic information will be provided and patients will have the opportunity to discuss further. They will be given the opportunity to ask for explanations of anxiety and depression and information about psychological problems in diabetes. The information provided will focus on associations between psychological difficulties, diabetes management and health outcomes (quality of life).

Negative Beliefs about Self-Management

Theories of health-related behaviour change highlight the role of beliefs in carrying out health-related behaviours. For example, the Theory of Planned Behaviour (TPB; Ajzen, 2002) has been used to predict condom use (Bennet & Bozionelos, 2000), smoking cessation (Norman, Conner & Bell, 1999) and participation in health screening programs (Sheeran, Conner & Norman, 2001). According to this theory, health-related behaviours are influenced by beliefs about the behaviour itself (e.g. will the behaviour make a difference to valued outcomes?), as well as beliefs about the individual's ability to carry out the target behaviour (i.e. the degree of control the individual has over the behaviour) and beliefs about the expectations of significant others (i.e. do significant others believe that the behaviour is important?).

For instance, if a person with diabetes perceives self-management to be a waste of time, since it will not cure diabetes or eliminate the risk of complications, then they are not likely to actively self-manage. Similarly, if other family members or close friends hold negative beliefs about self-management and the individual values their opinion they will be unlikely to make any changes to self-management behaviours.

In this instance there could be a discussion about what is meant by the term 'self-management' and what diabetes self-management involves. The patient should be provided with information and have the opportunity to ask questions. The therapist should address any concerns or misconceptions the patient may have. Depending on the individual, the therapist could refer to research that highlights the link between tight control of blood sugar levels and significant reduction in diabetes-related complications. Another aim would be to discuss with the patient potential benefits of better management, even if not directly related to diabetes complications.

On occasions it could be useful to include significant others if they hold negative views about self-management. This would enable the therapist to highlight the potential benefits of self-management and potentially to increase the support for the patient.

Perceived Lack of Ability / Readiness

Improving the patient's self-efficacy is an important goal alongside improving concordance. Self-efficacy is concerned with 'judgments of how well one can execute courses of action required to deal with prospective situations' (Bandura, 1982, p.122). Self-efficacy theory predicts that the more a person feels capable of both anticipating and coping with problems, the less vulnerable they are to feeling overwhelmed by them (Saddock & Saddock, 2000). Therefore, the more a person feels in control of their diabetes, the more likely they are to persevere with effective self-management. A growing body of research supports associations between self-efficacy and diabetes self-care behaviours including healthy eating, exercise and glucose monitoring (Bean, Cundy & Petrie, 2007).

If the patient does not feel ready to take on the demands of self-management, the therapist will discuss areas of concern and consider ways in which these may be addressed. For example, if the patient reports difficulty remembering to take medications, the therapist could suggest setting an alarm. It will be highlighted to the patient that taking an active role in the management of their diabetes will make them feel more in control and more able to carry out required tasks.

Denial of Potential Health Risks

The use of denial as a coping response to threat may be useful in the short term, but it is likely to be detrimental over longer periods of time. Denial may result in both avoidance of preventive health behaviours (e.g. health eating, exercise) and failure to acknowledge potential health risks.

If the individual is unwilling to discuss problems experienced with diabetes self-management, the therapist will not confront the issue directly. Instead, hypothetical

scenarios will be used to consider the risks taken by other people who do not take an active role in self-management. Once these risks have been acknowledged, the patient will be asked to consider their own position in this light. Alternatively, if this proves difficult for the patient, they may be asked to consider reasons why others (e.g. their spouse) might be concerned about their (i.e. the patient's) health, or why the patient might be concerned about a friend or relative with diabetes or other health problems.

Negative Past Experiences

Reviewing a patient's illness history may provoke a catalogue of negative experiences. Patients with experience of troublesome management are more likely to have negative expectations regarding outcomes of self-management behaviours and less likely to persevere with behaviour change. Negative past experiences need to be acknowledged empathetically. At this point it might also be appropriate to suggest that, in the light of their past experience, it would be preferable for the patient to be more involved in future treatment decisions.

It is important to link any negative accounts to instances where treatment has been useful. For example, if the patient reported experiencing side effects of their diabetes tablets in the past without any discernable benefits, a careful evaluation of their history might reveal that some symptoms had improved. Benefits of medications such as relieving tiredness or thirst should be emphasised.

Negative views about past treatment may sometimes be reflective of the patient's current state of mind and it is unlikely that patients will be able to recall all relevant details. With the patient's agreement, their medical notes could be reviewed to clarify their treatment history.

This highlights an important ethical consideration for the development of Concordance Therapy – **the need to ensure that it is used alongside prescribing practices that are being satisfactorily monitored.**

Considering Pros and Cons of Self-Management

Following discussion of past experiences, the patient will be encouraged to examine any reasons they may have for resisting change to their self-management routine. They will also be invited to consider the possible benefits of effectively managing their diabetes. For example:

"It is difficult to get my partner to change the meals she has always cooked … but I have felt more energetic in the past when I have followed a healthy diet."

"Exercising was a big problem at the start … but it has become so much part of my life now that I hardly think about it."

"I had been lethargic for quite some time before I was diagnosed with diabetes … now since losing weight I have more energy and am much livelier than I have been for years."

In exploring ambivalence, the therapist needs to be mindful of illness behaviours and in particular of the fact that patients can be attached to their symptoms within the context of the 'sick role' (Gelder et al., 1998). Thus being unwell can confer certain benefits, such as relatives being more attentive or placing fewer demands on the patient. The possibility of becoming more independent and subsequently losing these benefits may in some instances feel threatening to the patient.

Table 7: A Hypothetical Dialogue Exploring Ambivalence toward Self Management

Therapist/Patient Dialogue (part 1)
Therapist: *I find it is often useful to draw up a balance sheet to look at how self-management affects you, both the good and the not so good things about it.*
Patient: *It is good that I feel a bit better and I am able to do a few more things.*
Therapist: *Yes, that certainly comes across. You seem livelier.*
Patient: *It is good to feel better and not to feel so worried about it all.*
Therapist: *And the not so good side?*
Patient: *Well, I had trouble with the new eating plan, but not so much now though.*
Therapist: *Has that been the worst thing about changing your self-management routine?*
Patient: *No, I suppose having to juggle so many things - take tablets, eat well and exercise regularly. It is all a nuisance.*
Therapist: *So, on one hand you've had some problems with making changes to your routines. On the other hand, you are worrying less and it has helped you feel more energetic and more in control.*

Therapist/Patient Dialogue (part 2)
Therapist: *It is often useful to weigh up the benefits and drawbacks of self-management. What do you think might be the good and the bad points of managing your diabetes?*
Patient: *It is hard to say, I feel like diabetes has taken over and runs my life, but I am able to do more things now.*
Therapist: *So, you are more energetic than before you started self-managing?*
Patient: *Yes, but I still don't feel as well as I did before the diabetes. I am still in pain some days, but I suppose that's because of the problems I have had since the operation.*
Therapist: *You feel pain on occasions, which is due to other health problems, rather than your diabetes?*
Patient: *Yes, I think so, changing my lifestyle isn't going to help that.*
Therapist: *So, you feel as though the management plan takes up a lot of your time and you don't think that managing your diabetes will help you to feel less pain. However, on the positive side, you have more energy and you are able to be more active.*

Focus on Target Symptoms

When considering the advantages of self-management, the patient's most problematic symptoms should be reviewed and highlighted as targets for treatment.

Patients with poorly controlled type 2 diabetes may present with fatigue, thirst, passing urine more frequently and irritation from candidiasis (thrush). They often have difficulty maintaining their weight and may develop problems with their vision. Pain or soreness in the feet can be distressing and may be associated with infections. Improved diet and exercise can help to reduce weight, lower blood sugars and reduce symptoms; tablets are usually also required and sometimes insulin. The therapist should emphasise the effectiveness of active self-management and lifestyle changes for improving diabetes-related symptoms.

Difficulties with Tight Control of Type 2 diabetes

Some patients may feel the benefits of active self-management, particularly if they have experienced symptoms due to raised blood sugar (e.g. tiredness). However, others may not experience any noticeable benefits; there may also be an increased incidence of hypoglycaemia. Existing diabetes-related complications (such as painful neuropathy or poor vision) will not improve, although they may progress more slowly. It is important to highlight that good blood sugar control can dramatically reduce the risk of developing further complications, even though there may be no *perceived* benefits.

Indirect Benefits of Self-management

Identifying indirect benefits of active self-management (e.g. increased energy or greater independence) may reinforce the personal relevance of changing self-management routines. Highlighting important indirect benefits might be particularly useful for patients who cannot see any direct link between self-management and symptom reduction.

If the patient has never had a period of active self-management, then indirect benefits could be suggested to them; making changes to their lifestyle could be viewed as a personal experiment for the patient to see whether the changes might help.

Developing awareness of discrepancy

When an individual holds two opposing cognitions (opinions, thoughts or beliefs), they experience a pressing motivation to remove/alter one of the two 'dissonant' cognitions (Festinger, 1957, cited in Bem, 1967). Therefore, if a patient is resistant to the idea of changing their current self-management regime, the therapist will work with them to increase awareness of the consequences of not effectively self-managing. The discrepancy between the patient's resistance to change and their wider interests and priorities will be highlighted in order to develop 'cognitive dissonance'.

Table 8: A Hypothetical Dialogue of the Development of Cognitive Dissonance

Therapist/Patient Dialogue 4
Therapist: *It sounds like you have had a number of health complaints since being diagnosed with diabetes. From your point of view this is not related to your lifestyle, so you don't feel that you need to make any changes.*
Patient: *Well, not really, no. I suppose I could try it for a bit, but I don't think it is for me.*
Therapist: *Why is that?*
Patient: *I've never been the routine type.*
Therapist: *But you feel it might be worth trying?*
Patient: *Well, my doctor thinks I should change a few things and I told him I'd try to, but I don't want to commit to it forever.*
Therapist: *Being able to have independence is clearly important to you. I remember you said you felt too tired to get out of the house much and you're having to rely on your daughter, which you don't like doing.*
Patient: *Yes, well I know I am at the moment. I just don't have the energy to go out to the shops.*
Therapist: *And that got better the last time you made changes to your lifestyle?*
Patient: *Yes, but that wasn't because of the changes …well maybe it had something to do with it.*
Therapist: *So, even though there's a chance that lifestyle changes will make you feel better, you feel being free of routine is too important to take that chance. So you'd rather carry on feeling like you do for the time being and not be able to do things like get out of the house.*

Patient: *I don't know. I do want to feel better than now and definitely not as bad as before.*

Therapist: *So, if I have understood, you would prefer to feel well and to have more energy and independence and not to have to rely on your daughter. Your experience tells you that lifestyle changes might help with this. Perhaps these changes might be worthwhile even if they do involve following some routines?*

Practical Aids to Concordance

Juggling the many complex tasks involved in self-managing diabetes can be difficult. Practical issues surrounding how the patient organises (or intends to organise) their complex regime will be explored together with their current routines (if any) for self-management. Simple strategies to remind them about specific elements of their management plan could be suggested. This could include for example, keeping a calendar in a prominent place to tick after particular tasks have been carried out, using alarms or notes on the fridge. In addition, if appropriate, the involvement of the patient's spouse or other family members could be suggested as a way of supporting the patient to manage their diabetes.

Points to Note

- The aim of this intervention is not to dictate a rigid self-management programme, but rather to enable the patient to find a routine that is most suited to them.
- It will be important to make the discussion of direct personal relevance to the patient; this is likely to be more helpful than talking in an abstract fashion.
- The complexity of the information offered may be varied according to the patient's level of knowledge and understanding.
- In each session a considerable amount of new information may be introduced. Depending on the individual this may be difficult to digest in one sitting. Important ideas should therefore be rehearsed at intervals, while ensuring that the patient has understood what has been discussed.
- To reinforce key information patients will be provided with a printed booklet containing information about type 2 diabetes and its management in older people. Whilst recognising considerable ground has been covered, the therapist will encourage the patient to review this booklet in their own time outside the sessions.

In addition, patients will be offered a summary of key points relevant to them as a quick reminder (e.g. a note to stick on the fridge or a card to carry in their pocket).

Table 9: Summary of Phase 2

1. Consider common barriers to diabetes self-management.
2. Provide information about self-managing diabetes.
3. Guide consideration of benefits and drawbacks of self-management for that individual.
4. Highlight indirect benefits of effective self-management.
5. Cautiously explore any issues surrounding illness behaviour.
6. Emphasise symptoms reported by the patient as targets for self managing.
7. Suggest practical aids to help with self managing, if necessary.

Phase 3: Highlighting the need for maintaining self-managing behaviours

Improving recognition of the signs of poor diabetic control

Diabetes is a progressive disease and it is important that the patient can recognise when their current regime, whether previously effective or not, requires changing. The patient will be helped to identify symptoms they may experience if diabetes is not well controlled including foot ulcers, worsening blood sugar levels, or the emergence of new symptoms, such as neuropathy. Medication doses may need to be altered, which in turn may affect other aspects of the management programme (such as eating times).

Taking a Medium to Long-term View of Self-Management

Although patients may be motivated to make lifestyle changes when feeling unwell, the relevance of continuing when symptoms have improved may be difficult to understand. It will be acknowledged that there is a natural tendency to decrease efforts to maintain health when one feels well, but that long-term maintenance is essential for reducing the risk of health problems in the future.

The concept of maintenance could be introduced using examples of other chronic conditions requiring long-term treatment - for example, hyperthyroidism, arthritis or hypertension (which diabetes patients may also be diagnosed with). The possible consequences of premature cessation of treatment may be discussed. The patient will be invited to think about their future, considering how health problems might interfere with valued goals and lifestyles. It will be emphasised that choosing to actively self-manage in order to minimise potential health risks is a way of taking control of the situation and a positive strategy to enhance quality of life.

To reinforce the importance of long-term management, scenarios could be described in which the patient paid less attention to their own role in the management of diabetes, only to have increased health complications as a result. The use of analogies such as lifestyles changes as a 'protective layer' or an 'insurance policy' may also be used.

At the end of the therapy time will be spent reviewing topics discussed during the sessions. The therapist will highlight any themes that have arisen which are particularly pertinent to the patient and will emphasise achievements that occurred during the course of therapy.

Table 10: Summary of Phase 3

1. Improve recognition of the signs of poor diabetic control.
2. Encourage a long-term view of self-management.
3. Review topics discussed and highlight problematic areas.
4. Highlight any achievements that happened during the intervention.

Potential Difficulties

The following are potential difficulties that may arise during the course of therapy:

Difficulties with the therapist's role

1. Confusion over the therapist's role
    - Both the role of the therapist and the purpose of the sessions need to be made explicit. The therapist can use the technique of asking the patient what they have understood in this respect to reveal any misunderstanding.
2. The Question-Answer Trap
    - A common trap to fall into in a patient-therapist encounter is the situation of a therapist asking a series of questions and the patient giving short unelaborated responses. Asking Socratic / open-ended questions and using reflective listening should be used to avoid this.
3. The Therapist's Stance
    - This may be too authoritarian, confrontational or in some other way not appropriate for that individual patient. The therapist's stance should remain at all times collaborative rather than didactic, facilitating a process of guided discovery for the patient while respecting their personal experience of diabetes.

Difficulties with the patient's position

1. The patient is too unwell to tolerate full sessions
    - Comorbidity (suffering from one or more acute or chronic conditions) is often evident in type 2 diabetes and may impair the patient's capacity to engage in therapy sessions. Covering too much ground too quickly is likely to compound this problem. Frequent, short sessions should be use if this is the case (e.g. five times fifteen or twenty minute sessions as opposed to three times 50 minute or one hour sessions). Using simple language, summarising regularly and having the patient repeat key points could all be helpful. Interest could also be sustained by keeping the discussion

personally relevant and using plenty of examples. Cue cards may also be used to prompt rehearsal of pertinent material.

- Engagement in therapy may also be effected by depression, feelings of hopelessness and/or negative beliefs about the possibility of improvement with effective management. It is important to reassure the patient that diabetes can be effectively managed and to challenge negative cognitions about the role of self-management. The patient should be encouraged to conceptualise negative beliefs as hypotheses to be tested, rather than irrefutable facts.

2. The patient is not engaging in discussion
    - In this situation more active therapist input may be required, using a sensitive, non-judgemental and empathic approach. Information and ideas could be presented in a low key manner, followed by the question "what do you make of that" or "how does that affect you?"
3. The patient is irritable or hostile
    - With a patient who is irritable it is important to present ideas in terms of choices and to emphasise the benefit of feeling in control of their treatment. If a session appeared at risk of turning into a debate, the response would be to reflect back dilemmas to the patient, rather than argue. Entering into confrontation needs to be avoided.
    - Generally speaking, people are often hostile due feeling worried or concerned. If this appears to be the case, it is important to establish the nature of the patient's concerns. They may have worries concerning self-management or the illness itself; the therapist should review potential difficulties highlighted in phase 2 to ensure that these have been systematically explored.

Patient Refusal to Change their current Management

If a patient remains steadfast in their opposition to changing their current management routine for whatever reason, despite the above, they will be encouraged to keep an open mind for the future. Discussions with the patient in this situation could be focused on encouraging them to reconsider the role of self-management in the event of increased symptoms or a change in their current circumstances. Possible further negative

consequences in the foreseeable future resulting from their symptoms could also be discussed.

Summary

Concordance Therapy is a cognitive psychoeducational intervention to enhance concordance in effectively self managing type 2 diabetes. It is based on an approach that has been demonstrated to be fruitful among patients taking antipsychotic medication and antidepressants. It is intended to be brief, pragmatic, acceptable to patients and applicable in the typical busy clinical setting. Its emphasis on collaboration within a therapeutic alliance is in accordance with a growing interest in user empowerment and patients' rights.

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