Health psychology: supporting the self-management of long-term conditions

Using health psychology to help patients: supporting self-management of long-term conditions

Abstract

In the latest of this series on how health psychology can support nursing practice, we consider how knowledge of health psychology can help nurses to support patients to manage their long term conditions (LTC). The concept of 'self-management' is defined and the need for self-efficacy – the patient's confidence in their ability to manage - and social support is highlighted. Patients' "illness perceptions" or beliefs about the nature of their condition also impact on their self-management. This is discussed in particular in relation to adherence to treatment. A distinction between intentional and non-intentional non-adherence is made. Understanding of the many factors, other than lack of knowledge, which influence self-management success will help nurses and patients to work together to develop an effective self-management plan.

Key Points

- LTCs are common, impact negatively on the patient and their families and are costly for the NHS.
- Supporting self-management involves educating patients and empowering them to take an active part in their own care,
- Nurses can intervene to promote a patient's self-efficacy and use of social support, both of which contribute to successful self-management.
- Patients' "illness perceptions" or beliefs about the nature of their condition also impact on aspects of their self-management, including their adherence to treatment.
- Nurses can address unhelpful beliefs about medications which may be influencing adherence. They can also attend to external factors impacting on adherence such as lack of access to a pharmacy or inability to use treatments correctly.

The management of long term conditions are a key priority emphasised in the NHS Five Year Forward Plan. The Plan outlines that healthcare professionals will need to develop new models of care for working in partnership patients, and provides several models of good practice (NHS England, 2014). Around 1 in 3 adults in England have a LTC (Department of Health, 2012), such as diabetes, coronary heart disease, arthritis, chronic obstructive respiratory disease or a mental health condition, for example chronic depression or psychosis. Effective management of LTCs is important since LTCs are common, impact negatively on the patient and are costly for the NHS. The burden for

the patient may include painful symptoms, reduced quality of life, loss of function and independence, strain on personal relationships and psychological distress (Moussavi et al, 2007). There can also be a significant economic burden on individuals, who may not be able to work, or meet their full potential at work. Disease burden and complexity increases when the individual has more than one LTC, which is increasing common. Rates of 'multimorbidity' are expected rise from 1.9 million in 2008 to 2.9 million in 2018 (Department of Health, 2012). Management of LTCs accounts for around 70% of total health and social care spending (Department of Health, 2012).

Self-management aims to reduce symptoms, slow progression and improve quality of life. It also aims to prevent or delay the onset of additional LTCs with shared risk factors, for instance prevention of coronary heart attack through management of hypertension. To achieve this, nurses must support patients in a range of self-management activities. Vassilev and colleagues (2013) divide these activities into 'illness work', (for example, taking medications, recording vital signs, making appointments), 'everyday work' (housekeeping, childcare, shopping), and 'emotional work' (managing depression and anxiety). Making lifestyle changes such as stopping smoking, eating more healthily and increasing physical activity will also be important. This involves considerable burden for the patient and their carers who it is estimated may spend at least two hours a day on LTC-related activities (Jowsey et al, 2012).

Supporting self-management involves educating patients. Patients need to know how to self-manage and need to have the right skills. Alongside this, they also need to be empowered to take an active part in their own care (Department of Health, 2009). A range of self-management education programmes, which may be led by healthcare professionals or 'expert patients' (trained individuals with lived experience of the relevant LTC), have been developed to do this (Foster et al, 2007).

The Role of Self-Efficacy in Self-Management

The Health Foundation has conducted a systematic review of over 550 high quality studies of a range of interventions to support self-management (de Silva, 2011). This review indicated that building 'self-efficacy' is key. Self-efficacy is an individual's confidence in their skills and ability to successfully manage a particular situation. In studies where patients' self-management related self-efficacy increases there is usually a concurrent positive effect on clinical symptoms and outcomes. As self-efficacy improves so does attitude, behaviour, quality of life, and use of healthcare resources. Unfortunately, the best strategies for increasing self-efficacy are not yet known (de Silva, 2011).

However, health psychology research has identified how self-efficacy may develop and knowledge of this can be used to inform interventions and nursing practice. Self-efficacy theory proposes that

performance accomplishments, physiological and emotional responses, role modelling and social support are all important (Bandura, 1977; Schwarzer, 2014). We discuss each of these in turn:

1) Performance accomplishments, or 'mastery experiences', are considered the strongest predictors of self-efficacy. These are experiences of achievement or success in relation to a specific task or situation. Repetition of success reinforces the individual's belief that they will succeed similarly in future. By prompting patients to recall past successes, nurses can help promote performance accomplishment. For instance, if a patient with depression is struggling to leave the house, the nurse could gently prompt them to remember a time when they were going out more regularly, asking how they managed to do this, what they were doing differently then and how it felt.

2) Physiological and emotional responses. An individual's interpretation of emotional, cognitive or bodily response to a self-management task will also impact on their belief in their ability to achieve the task. For instance, cardiac patients maybe reluctant to engage in appropriate physical activity that would reduce the likelihood of a future event because they fearfully interpret normal bodily sensations of discomfort from exercising as a sign of a heart attack. Nurses can help patients to increase their self-efficacy for by normalising such fears, providing clear explanation of what bodily sensations the patient is likely to experience, the benefits of exercise, and by providing reassurance around specific fears, perhaps in the form of written information or patient examples .

3) Role modelling. Self-efficacy theory also highlights how others are involved in building an individual's self-efficacy. Role modelling, or 'vicarious experience', is where individuals learn through watching others manage similar situations to their own. Watching others succeed increases an individual's expectation that they too will be successful. This is the rationale which supports expert patient or peer-support programmes (for examples visit http://selfmanagementuk.org).

4) Social support aids self-management, by providing reinforcement that a self-management strategy is valuable and that the patient is able to do this. If appropriate, the nurse could encourage significant others to provide supportive feedback about the patient's progress, as well as providing more formal evaluative feedback during appointments by highlighting positive aspects of the individual's performance in the task. For instance "it's so great how you have managed to go out for a walk every day, despite this bad weather, that's really impressive."

Social support needs to be handled sensitively as not all patients have significant others that are supportive, indeed some may be quite negative to the patient's efforts at self-management. Likewise, many patients are isolated and lack social support. In both situations, the support and encouragement of the nurse can be particularly important, as can other avenues of support. For

example support from self-help groups run by voluntary groups that work with specific conditions. Many of these offer telephone and online support, in addition to the traditional group setting.

Systematic review evidence demonstrates that social support promotes self-management in diabetes, asthma, heart disease and epilepsy (Gallant, 2003). Social support together with practical help, reduces illness-related stress (Armstrong, Birnie-Lefcovitch and Ungar, 2005). In a study of 2,572 patients with Type 2 diabetes, seeing friends and family more frequently was associated with better outcomes and improved self-management (Schiøtz et al, 2011). With this in mind, nurses could ask patients to identify specific individuals who might provide help, bearing in mind that different individuals may be able offer help with the different areas of self-management work. Through helping patients to specify such help, self-efficacy can be promoted and useful resources highlighted.

Building self-efficacy through the components outlined above is clearly important for effective self-management. Health psychology has also highlighted the role of illness-related beliefs and attitudes, or 'illness perceptions'.

The Role of Illness Perceptions

Health psychologists have identified a range of Illness perceptions that can impact on self-management and/or disease outcome, (Leventhal, Meyer, Nerenz, 1980; Leventhal, Brissette, and Leventhal 2003; Moss-Morris et al, 2002).

Illness Perceptions
Cause: What the patient believes caused their condition, for example genetics, lifestyle, a virus, etc.
Identity: The symptoms or impacts that the patients believes are related to their illness
Perceived control (treatment-related and personal): Whether the patients believes they can control their illness or whether they believe it is outside their power.
Severity of illness consequences: Whether the patient perceives their illness as having a significant impact on their life or if it is manageable.
Time line: If the illness is acute or chronic, and if symptoms fluctuate.
Emotional representations: how the person feels as a consequence of both their illness, and the above perceptions.

It is easy to see how these beliefs may impact on self-management and research supports this. For instance, attenders at cardiac rehabilitation compared with poor or non-attenders, were more likely

to believe that they had a greater number of symptoms and that the consequences of their heart disease would be worse; they were less likely to believe that their heart disease had been caused by a germ or virus (Whitmarsh, Koutantji and Sidell, 2003).

Much research has focused on the role of illness perceptions in medications adherence. For example, adherence to inhaled steroids was reduced in children with asthma whose parents doubted their necessity, had a more negative perception of the condition, and had more concerns about side effects (Morton et al, 2014). Similarly, older patients who doubted the benefits of anti-hypertensives were less likely to take them (Rajpura and Nayak, 2014). This work is consistent with the 'Necessity-Concerns Framework', which predicts that medication adherence will be associated with stronger perceptions of necessity for treatment and fewer concerns about adverse effects (Horne and Weinman, 1999). A systematic review (N = 94) of a range of conditions found that for each standard deviation increase in necessity beliefs, the odds of adherence increased by a factor of 1.7 and for each standard deviation increase in concerns, the odds of adherence decreased by a factor of 2.0 (Horne et al, 2013). Nurses therefore need to take time to understand their patients' illness perceptions and to address concerns about the need for, and effects of, medications.

Health psychology research shows us that treatment adherence is not related to disease type or severity, age, gender or socioeconomic status (DiMatteo, 2004, Horne et al, 2006a). That is, there is no such thing as a typical 'adherent' or 'non-adherent' patient. Rather, an individual may be adherent to all, some or no aspects of a treatment regimen and this may vary over time and with circumstances. The 'perceptions and practicalities model' helps to understand this by distinguishing between 'unintentional' and 'intentional' non-adherence (Horne et al, 2006a).

Unintentional non-adherence is where the patient may be willing to adhere to treatment, but they are prevented by factors over which they have limited control. These may be external to the patient (lack of money or difficulties reaching a pharmacy) or internal (memory difficulties, chaotic lifestyles, poor understanding of instructions or physical inability to manage medications, such as poor inhaler technique). Intentional non-adherence refers to the patient actively deciding whether or how to follow a treatment regimen. They may not adhere at all, or may choose to adhere in a way which differs from medical recommendations, for instance by taking fewer doses, stopping a course of treatment early or limiting type rather than quantity of alcohol. Non-adherence in any individual can be both unintentional and intentional, for example deciding to take fewer doses of a medication, and also then not being able to open the packaging.

Conclusion

Many factors therefore influence an individual's ability to self-manage their LTC. These may not be obvious and patients may not volunteer them. It is clear therefore that simply providing information concerning how to manage a LTC will not be sufficient. Nurses need to employ communication skills such as active listening, appropriate use of open and closed questions and rapport development to be able to determine patient needs. A structured approach to consulting with patients such as that described in the Calgary Cambridge model of healthcare consultation (Kurtz et al, 1998) or the Medication-Related Consultation Framework (MRCF) (Abdel-Tawab et al, 2011) can be helpful. These structured approaches to conversations with patients, can ensure that nurses understand patients' illness perceptions, the practical problems which hinder treatment adherence and the patients' own beliefs about their self-efficacy to self-manage. Nurse and patient can then work together to develop an effective self-management plan.

Further information on this topic can be found in Chapter 3 of 'Health Psychology in Nursing Practice' Barley, E. (2016) Health Psychology in Nursing Practice. Sage Publications, London.

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