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Empowerment and adherence to the therapeutic regimen in people with diabetes

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Abstract

Diabetes mellitus is a chronic disease responsible for complications, which not only limit individuals' lives, but also contribute to a high level of morbidity and mortality. Thus, it is important to enable people to manage their therapeutic regimen appropriately. Promoting empowerment the individuals with diabetes is an enabling strategy which facilitates gains in health and quality of life.

The aim of this study is to examine the relationship of demographic and clinical variables with adherence to therapeutic regimen in people with diabetes and determine the predictive effect of empowerment in the process of adherence.

Most participants scored with high level of empowerment (38.7%). A positive and significant relationship between this and adherence to the therapeutic regimen was found; that is, the higher the level of empowerment, the greater the adherence.

The results show that empowerment and the socio-demographic and clinical variables have a significant relationship with adherence to treatment regimen and should be considered when planning therapeutic interventions and clinical education for people with diabetes.

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Keywords: Diabetes mellitus; *Empowerment*; Therapeuthic, Patient Compliance

1. Introduction

Chronic diseases are considered an epidemic, constituting a serious global public health issue, responsible for 84.0% of deaths in 2008 (World Health Organization, 2011). Diabetes is included in this type of disease, the incidence and prevalence of which have increased worldwide. There are several factors associated with this fact including the following: the aging of the population, increasing urbanization and the adoption of unhealthy lifestyles, including physical inactivity and a poor diet, among others (Temprão, 2006 cited by Ribeiro, 2010). In Portugal as well, there is a growing trend of diabetes. According to the Annual Report of the National Centre for Diabetes, there are 991 000 people with diabetes, which corresponds to 12.4% of the population aged between 20 and 79 years (Boavida et al., 2012).

The percentage of people with diabetes or chronic illness in general, who follow the therapy proposed by their healthcare professional, is much lower than expected. According to the Centre for Diabetes, between 25% and 30% of people with Type 1 Diabetes admit to failing some of their daily insulin injections. Increased physical activity and adherence to a proper diet have even lower percentages (Boavida, 2013).

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For these reasons the need to "educate about diabetes management" has emerged in order to develop knowledge, attitudes and the required skills for individuals to act appropriately and control the disease themselves (Ribeiro, 2010).

Thus, health teams should provide tools for citizens so they can freely become empowered, developing in the person with diabetes greater autonomy and health gains (Pereira, Fernandes, Tavares and Fernandes, 2011).

Adherence to the therapeutic regimen is a type of adherence, defined as "self-initiated action to promote wellness, recovery and rehabilitation, following the guidelines without deviation, engaged in a set of actions or behaviours" (CIPE, 2011, p.38).

Adherence exists when a person's behaviour, in taking the medication, in complying with a diet, and/or lifestyle changes, coincide with the recommendations of a health care provider (WHO, 2003 cited in Dias et al., 2011).

"The term adherence should avoid judgment, so as not to make the patient guilty, the prescriber or the therapeutic regimen and involves an agreement, negotiated over establishing treatment and the care to follow, between the person and the caregiver" (Pinto & José, 2012, p.1639).

2. Problem Statement

Diabetes Mellitus is responsible for complications that not only limit the individual's life, but also contribute to a high rate of morbidity and mortality. Thus, adherence to the therapeutic regimen through empowerment, i.e. acquiring more knowledge/skills that influence therapeutic behaviour, is important. The concept of empowerment reflects a process of acquiring knowledge and skills and enables individuals with the resources required to make informed personal decisions about their own care (Silva, 2006 cited in Pinto and José, 2012). Empowerment can be considered a process, which promotes greater power and control over patients' lives, provided by a cumulative gain of knowledge and the development of skills, which allow them to make decisions and effectively participate in their own health project. People must be educated, giving them the tools and skills to manage their own illness, promoting their autonomy and their ability to make decisions about the difficulties in managing their situation (empowerment). Nevertheless, continuous availability of professionals is obviously essential for health monitoring (Boavida, 2013).

3. Research Questions

The evidence is clear: most of the time people know how to do what should be done and want to do it, but simply do not (Boavida, 2013).Thus, we sought to produce knowledge in order to support people with diabetes in resolving issues that are important and relevant to their empowerment.

The aim of this study, therefore, is to answer the following central question: What are the determinants of adherence to the therapeutic regimen in people with diabetes?

Its aim is to contribute towards better understanding the phenomenon of adherence to the therapeutic regimen and to foster the promotion of empowerment in people with diabetes. In order to improve adherence, health professionals should establish a bond with patients through active listening, empathy and knowledge of their sociocultural characteristics, thereby intervening in educating, teaching, instructing and training them (Machado, 2009).

Non-adherence is related to several factors related to the health professional, the treatment, the pathology and the patient. This can also be classified as intentional (when the patient knows the treatment, but fails to comply) and unintentional (when the patient does not understand the information provided by health professionals). We shall consider that there is adherence when at least 80% of prescriptions are completely followed (Leite and Vasconcelos, 2003 cited in Dias et al., 2011).

"There is not an ideal model that can be followed by everyone and for everyone to promote adherence, but there are strategies that can and should be adopted depending on circumstances, individuals and their individual characteristics as well as the health professional characteristics'" (Dias et al., 2011, p. 217).

4. Purpose of the Study

To analyse the relationship of socio-demographic and clinical variables with adherence to the therapeutic regimen in people with diabetes; determine the predictive effect of empowerment on adherence to the therapeutic regimen in people with diabetes.

5. Research Methods

The data collection instrument included: A socio-demographic and clinical questionnaire; The Adherence to the Therapeutic Regimen Scale "Self-Care Activities with Diabetes", translated and adapted by Bastos (2004) consisting of 21 items, divided into six dimensions: general nutrition, specific diet, physical activity, blood glucose monitoring, foot care, therapeutic administration and smoking habits. The scale is parameterized in days per week, on a 0-7 point Likert scale, corresponding to the behaviours adopted in the last seven days, with zero (0) as the least desirable and seven (7) the most favourable situation, except in the dimension of specific diet, in which the values are reversed. The score for each dimension corresponds to the average number of days of the items that constitute the dimension, i.e. the higher the score, the better the adherence to the therapeutic regimen (Bastos, Severo & Lopes, 2007).

- The "Diabetes Empowerment Scale" translated from the original version "The Diabetes Empowerment Scale" (Anderson , Funnell, Fitzgerald & Marrero, 2000), includes 28 questions and is presented in the form of a 1-5 point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree, respectively). The average for each subscale is obtained as well as the average for the global scale. This scale consists of three subscales, which assess the management of psychosocial aspects of