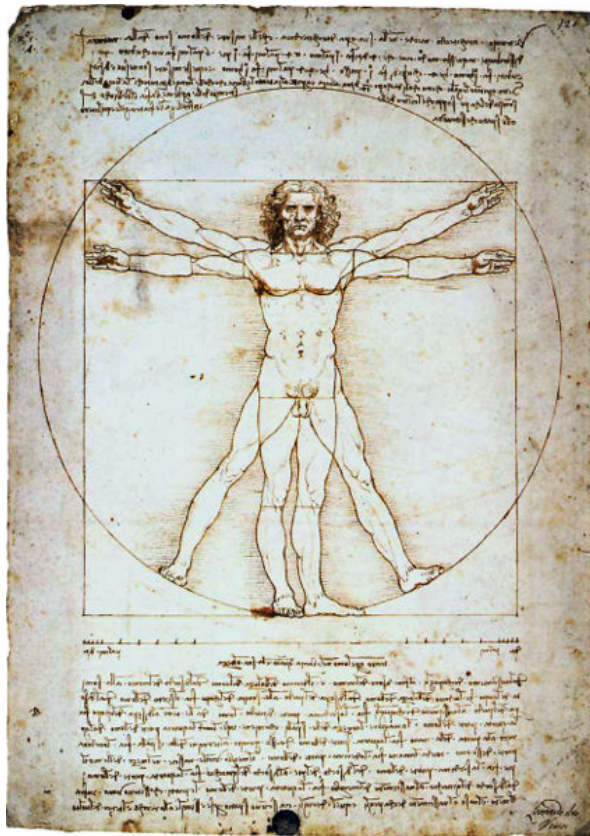


Group Care: operating manual for group education of patients with type 2 diabetes



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PREFACE

These teaching modules for group treatment are the result of investigations which date-back to January 1996 when we started to investigate whether it was possible to substitute the traditional one-to-one doctor-patient approach with group sessions for non-insulin dependent and non-insulin treated diabetic patients in order to improve metabolic control and favour the acquisition of new health behaviours. The randomised clinical trial involved 112 patients subdivided between cases and controls. The first group was divided into 6 groups of 9/10 persons whereas the second group continued with traditional one-to-one consultations. Group sessions took place every three months. At each session, all patients were tested for metabolic control (weight, blood glucose, glycated haemoglobin, glycosuria) and once a year underwent screening for complications. Procedures, methodology and on-going group education treatment are described below.

In the section “**General Overview of Procedures**”, the structure which characterizes each session is outlined together with its various phases and methodological teaching considerations. It is hoped that this will allow for flexibility, clarity and, above all, simplicity. This section describes:

- ✓ formation of groups and room set-up
- ✓ observers’ role
- ✓ rules and norms assumed by the group
- ✓ facilitator’s role and duties
- ✓ patients’ role and duties
- ✓ time-frame and methods – presentation
- ✓ time-frame and methods - helping to make changes, patient participation

A description of each session and subjects covered will be found in the second section, “**Session Programme**”. The “referencing behaviours” or “health conducts” which are the objective of each session are explained at the start of each session. There is both on-going checking for the acquisition of new health conducts (to be explained later in this document) and a final patient questionnaire on “referencing behaviours”

Methodology and procedures are more detailed in this section:

- individual session subject
- presentation for explanation of different goals
- materials used
- methods for communications with patients
- materials for the patients

The programme, methods, procedures and materials have been developed, evaluated and modified over the course of several years of group sessions comparing the results with patients’ glyco-

metabolic data and feedback through questionnaires which test understanding, health conducts (“Condotte di Riferimento”) and quality of life.

Some observations, opinions and comments by the patients themselves form the final part of this manual. It’s only fair that they get a chance to have their say after the experience of these past few years.

So...happy reading and all the best!



GENERAL OVERVIEW OF PROCEDURES

Before describing the various phases which characterize each session, a few words are necessary on the: formation of groups, room set-up and observers if present.

Group formation: Each group is made up of 9/10 participants and, in order to favour group dynamics, the participants should always be the same. In our experience, patients were selected by pure randomisation, that is casually, as we wanted to show that group sessions could be created within mixed-ability populations. Casual selection not only met this objective but also resolved a problem related to inverted snobbery on the part of the organizers when groups were being formed. It was feared that potential participants might be excluded from group sessions if they seemed too different from the rest. Each person has a contribution to make and a preliminary selection would only create senseless exclusions.

Room set-up: the room where group sessions are held should be chosen according to its size and suitability. There should be enough chairs for each expected participant plus one or two chairs for additional persons (family members, observers etc.). The room shouldn't be bare as this creates a depressing atmosphere. It is suggested that the material necessary for each session is prepared and ready before the patients start arriving.

Patients should be seated in a circle and not in rows facing the facilitator. There should be a comfortable space of about an arm's length between each chair so that participants don't feel restricted. There should be a place where coats can be hung up and bags left so that patients are free to actively participate in the session. A circular seating arrangement stimulates discussion as it allows both participants and facilitator to see each other face-to-face. Chairs should be placed so that no patient ends up sitting behind the group in a second row.

Observers: At the beginning, other personnel might be interested in seeing what goes on at a group session. In order to avoid interference with the activity of the group it is important to establish norms of conduct for observers. There are three types of observers: critical, trainees and visitors. The critical observer is a supervisor or another medical professional whose role is to take notes on the session and provide feedback to the facilitator at the end of a session. A trainee observer is someone who is learning or has less experience than the session facilitator. At the end of the session, the facilitator will comment to the trainee on what has happened and answer the trainee's questions as precisely as possible. A visitor observer is a colleague who attends no more than two or three times to see what can be learnt. A true observer stays completely quiet throughout the session, week after week, for as long as he/she is invited to remain present. If a patient actually addresses the observer, the observer should reply courteously and clearly but not encourage the patients to be included in their conversations. If observers are present, they should be formally introduced to the

group by name and with reference to the organization they represent and their relationship to the facilitator: “X is my supervisor/boss”, “X is here to learn”, “We have been working together for some time and he/she wants to see what we are doing here.”

Suggestions: Facilitators might find the following check-list useful in order to improve group management or iron-out trouble spots within the group:

- ✓ Start sessions on time. Delays are irritating for everyone and you risk losing unhappy participants.
- ✓ By speaking slowly and clearly, everyone understands better.
- ✓ Avoid being too direct: “Do this”, “You, be quiet.”.
- ✓ At the same time, don’t be patronizing or condescending.
- ✓ If surnames with the appropriate titles are used, the patient feels more motivated and it is easier to hold his/her attention.
- ✓ Avoid saying things like “What’s the matter with you lot?...haven’t you got anything to say?” which obstructs the aims of the group (making this kind of accusation is the best way to make sure the group doesn’t function!). Don’t worry that everything will come to a halt in a session as programmes are designed in such a way to avoid this. Keep these notes in front of you and follow them!
- ✓ Even if we are saying things which we think are important, we must be prepared to let patients interrupt and speak too. This attitude helps the facilitator understand if the patient has understood what is being said (If patients ask questions which are off-topic, it means that they are not following the thread and you must begin again, preferably using other words).
- ✓ If patients anticipate what is going to be said it is important to gratify the patient saying things like “That’s a good observation and we will be talking about that later on.”.
- ✓ If simple terminology is used patients understand better.
- ✓ Whenever we note correct attitudes it’s good to stress them as an example for all group members.
- ✓ Individual blood glucose and glycated haemoglobin results can only be brought to the group’s attention by the patient concerned.
- ✓ Whenever a patient demonstrates positive behaviour because, for example, he or she has lost weight, this should be brought to the group’s attention, with the patient’s consent of course (the patient is usually more than happy to give it!).
- ✓ Break up the pace occasionally with a joke or silly remark because it helps relax the group and re-gain attention.

- ✓ Group sessions should last no more than one hour as everyone (patients and facilitator) get tired. Sessions are timed to last between 50 and 60 minutes. If we talk too much or let patients talk too much, the impression is that the **group** is an excuse for us, as facilitators, to climb on a pedestal or, for patients, to indulge in idle chat.
- ✓ Experience has taught us that the presence of too many observers upsets the whole group, patients and facilitators alike.

Description of phases

A description of the different phases helps explain and characterize some parts of group teaching. There are various types of teaching with specific names and characteristics which are relatively different from the reality in which we are applying them. In our situation, we are trying to help the diabetic patient towards as much autonomy and independence as possible by giving him/her the ability to make choices and acquire new health behaviours.

Each session or meeting is subdivided into four phases:

- **Welcome**
- **Didactic activity**
- **Real life situations**
- **Summing up**

The point of this subdivision helps with group formation and effective planning for each session.

Welcome:

This is a key phase for the group as it defines the whole project in terms of reciprocal understanding and acceptance. It gives the doctor the opportunity to explain his/her role within the group, to outline the programme and state the objectives. This is when the patient feels truly involved and not just a member of the group.

This phase is of particular importance in group education treatment methodology. At the first meeting it is important to draw the patients' attention to some of the rules which will be adopted by the group in order to work together. These might be:

- Explaining why the group method has been chosen;
- Presenting the subjects to be covered at each session;
- Describing how each session will evolve and who will lead it;
- Explaining that a group session does not mean that individual patients no longer have one-to-one access to a doctor;
- Letting patients know that test results will be evaluated and placed in the patient's file (show them the file);
- Explaining that the subjects to be covered will help them understand diabetes better and learn to be more independent.

These may seem like a lot of rules but they do, in fact, help make group work more cohesive and provide continuity for successive sessions.

In our experience we are able to confirm that this “statement of intent and procedure” is appreciated by patients as they feel immediately involved in a project which concerns them.

Other rules might be:

- ✓ Don't all talk at once (patients and facilitator);
- ✓ Refrain from discussing highly personal clinical aspects.

During successive sessions in the welcoming phase it is necessary to:

- ✓ Individually greet each patient, explain the subject for that session and how it will be approached;
- ✓ Collect in “homework” assigned at the previous session;
- ✓ Explain what patients can expect to learn (clarification, better understanding, support for coping with their diabetes).

This explanation doesn't have to last a long time but it is important as it focuses attention as a way of introducing the subject of that session. A climate of sincerity and respect helps to identify what patients want and need to learn.

Didactic Activity

The main part of every session is an integration of several recognizable teaching methods. It is also the point at which the subject of the session is presented to the patients. To ensure that the concepts are understood within the context of the patients' condition we have attempted to respect the fact that each person learns differently with particular emphasis on:

- **Active participation:** not a lecture, so technical and scientific terminology is avoided in favour of a more simplistic language in order to stimulate group discussion;
- **The right to be wrong:** every error is important and must not be viewed negatively; when wrong behaviours surface, which patients mistakenly believe to be right, they are corrected;
- **Feed-back:** this is reciprocal, as it gives the facilitator and each group member immediate information on what is wrong and what is right.
- **Patients learn at their own pace:** the group is made up of individuals who are all different and this is what gives the group energy and motivation. No person, even at group level, loses his/her identity, thereby enriching both personal understanding and that of others .
- **Respect for learning styles:** each person learns according to their own cognitive, affective and social abilities. Group members learn the same thing in their own way and at their own pace. The techniques and methodologies used allow for these different learning styles.

Methodology

The methodologies used to facilitate presentations and learning are: **Cognitive ability** (simulations, discussions, role play) and **Psycho-motor ability** (hands on practice, small groups)

Such as: flip chart drawings which develop from discussions (e.g. daily meal plans), small group assignments, discussions on a specific subject, role play (simulations: imagine you have to: go out to dinner/prepare a meal; imagine you're at the supermarket; imagine you have to buy a pair of shoes), demonstrations, i.e. figures and images to understand a subject. In this case the word becomes the support for the image (patients can choose images which they believe to be correct and then give reasons; helpful support for illiterate patients; activities described in sessions 3, 4 and 5 are done in smaller subgroups. Metaphors and symbols (cognitive) to create favourable learning conditions; explaining concepts without resorting to technical or scientific language helps to reinforce the message. Individuals can understand concepts using images, colours and situations.

Real-life situations

This is a process which takes place within the group and gives patients a chance to talk about themselves. It needs time because each person decides how and when to talk about himself. This phase is not really separate from the previous one. Patients must be able to speak about themselves and their own experiences at any point during the session. With this type of approach, **the social aspect** of the disease is taken into consideration, when patients recount their individual condition both in relationship to themselves and others. The subject can vary from one time to the next but the patient is the one who activates and shares his or her first-hand experience with the group. It is important that real-life situations told by patients are used by the facilitator as either positive or negative examples for other group members without being overtly judgemental or critical. Dismissing the real-life experience of an adult is the same as dismissing the adult.

By knowing about a patient's real-life experiences, habits and behaviours we can learn to see how the patient behaves and, above all, correct what is wrong and find solutions together.

So that patients can express their experiences, the following points should be taken into consideration:

- **a relaxed atmosphere**; patients must not feel judged and must be able to explain their thoughts in peace; avoid saying things like "You must do this....".
- **no lecturing**; the facilitator should not do all the talking
- **every example is important** so long as it is relevant; this must be emphasized
- **remind the group** if the discussion veers off topic, this **stimulates discussion**
- **gently cut short those patients who talk "too much"** and in the same way encourage those who "never speak"
- **the information transmitted must be concise, comprehensible and easy to remember** (too many words or too many examples can sometimes be confusing)
- **there's no such thing as a stupid question**: every question is another opportunity to learn

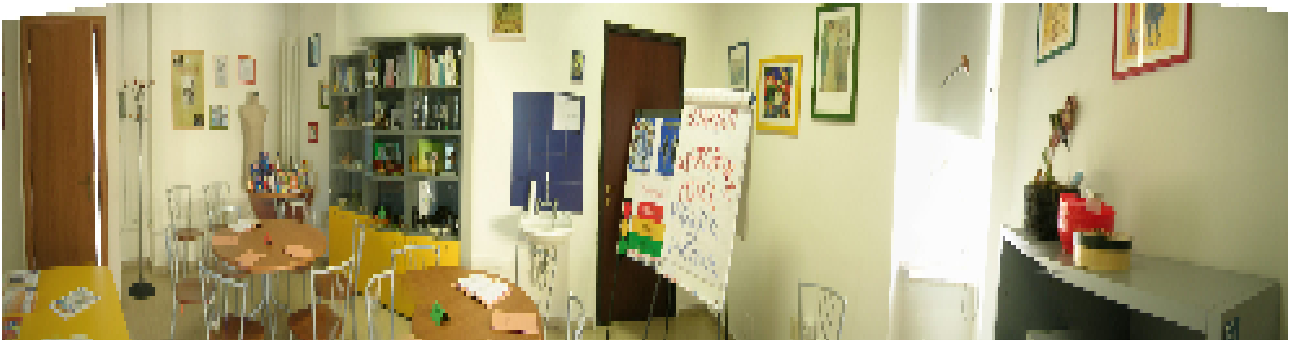
Summing Up

The session subject should be briefly summarized, patients reminded of the next group session and the **homework-assignment** distributed. It is important to remember that if something has not been understood it can be revised and discussed again in order to clear up any misunderstandings. In our practice, after having informed patients of the date of the next meeting, the physician/diabetologist stays on to meet personally all those patients who require a one-to-one consultation or ask to see the doctor.

...something to think about

“...knowing how to lead a group of learners requires very specific knowledge and ability which should be part of the professional training for public health providers and especially for those who will end up involved in public health education.

Once the educator understands the how's of group education, he/she isn't at risk of putting everyone to sleep with academic babble or putting them off because of a too rigid or aggressive style ...”



SESSION PROGRAMME

1ST SESSION

“THE BACKPACK AND THE BASIN”...OR BODY WEIGHT

2ND SESSION

EATING OUT...TALKING ABOUT FOOD

3RD SESSION

THE BEST AND THE WORST MEALS...MORE TALK ABOUT FOOD

4TH SESSION

LET’S GO SHOPPING...FOOD CHOICES

5TH SESSION

GLYCATED HAEMOGLOBIN...HOW IS YOUR DIABETES? CONTROL AND CONTROLS.
PHYSICAL ACTIVITY.

6TH SESSION

WHICH IS THE BEST TABLET? DEALING WITH HYPOS.

7TH SESSION

EYES, HEART, BLOOD PRESSURE, KIDNEYS, FEET. PREVENTING COMPLICATIONS.

1st Session - “THE BACKPACK AND THE BASIN”...OR BODY WEIGHT

Aim: Help patients to discover the relationship between eating and diabetes. The health conduct references relate to:

- **regular weight checks**
- **calories**

PLAN

Two “metaphors” are introduced and demonstrated

- the backpack – or bodyweight
- the basin – how we fill up when we eat

1.Welcome

The facilitator greets the group members, asks them to introduce themselves to each other using both first name and surname, say how long they have been attending the clinic, whether or not they have participated in another diabetes education group (see Introduction: first meeting, Welcome).

2.Why a group?

The facilitator explains the criteria by which patients are enrolled in groups (T2DM treated by diet alone or tablets) and explains the reasoning behind group methodology.

3.Bodyweight...or the backpack! (Teaching activity)

This demonstration uses a backpack filled with sand-filled bags up to a total weight of 20 kilograms (**3 stone**) as an example. You may start by saying: “As you know, every time you attend the diabetes clinic, a few minutes are spent taking about weight. This is because weight is an important factor in patients with diabetes. If you weight too much, it is much more difficult to keep your diabetes under control. This backpack weighs a lot. Go ahead and feel how heavy it is. Would you like to try to lift it, Mr. Smith? Would anybody try to guess its weight?”

Some of the patients try to lift the backpack and we let everyone comment as they see fit.

“Now let’s put the backpack on our shoulders while we go upstairs, out to the shops or around the corner to the newsagent’s. The sensation of being weighed down and tired out, as you imagined, is the same as if you weighed 3 stone more. When someone puts on weight it goes on a little at a time but the end effect on the body is the same. But we can also remove weight from the backpack ...”

4.So how is it that we gain weight? A typical day? (teaching activity)

From the backpack we move on to the example of the “basin”. You’ll have prepared beforehand a LARGE, SEE-THROUGH container (we use a 3 liter laboratory beaker) together with several smaller containers (glass jars, small glass or plastic bottles) which should be filled with water in

advance so that the amount in each of them is proportional to the caloric content of a food item which will be simulated during the demonstration. The lab beaker should be placed in a basin/washing up bowl to catch any overflow of water.

Once again, you may say: “Imagine that this container is your body. In order for the body to function in normal circumstances, you need an average of 1500-1800 calories each day. You’ve all heard of calories but it’s difficult to explain what they are. Only physicists really understand what calories are. In very simple terms, the human body is like a car and calories are like the petrol which you need to make the car run. Usually, when we fill up the car we buy as much petrol as we need and no more. There are two reasons for this: the first is that petrol is always going up in price and we want to save money; the second is because you can only put a certain amount of petrol into the tank. The human body is slightly different, however, in that it can store more petrol than gets used or burnt by transforming it into fat – you know, that “spread” which we all carry, some more and some less, around our hips. And, what is more, usually we put more petrol into the tank than we normally need. Now let’s go back to the lab beaker. Once again, it represents your body or, more to the point, the petrol tank which we have to fill it up for a day’s work.”

DEMONSTRATION: “Let’s see, now...start the day with a good breakfast and you begin pouring in the fuel, pouring the water from each smaller container into the beaker as you go along ... (The examples are based on Italian food, ingredients, meals and habits but can be adapted easily to other cultural backgrounds)

a caffelatte and small bread loaf	130 calories
or 5-6 slices of toast	120 calories

Before we know it, it’s time for lunch and we tuck into...

pasta with tomato sauce	270 calories
... a portion of roast meat	330 calories
... some salad	25 calories
bread: ... a tiny ciabatta	120 calories

Since we’re still feeling peckish, how about... (keep pouring water as before)

... just two slices of salami or a small piece of cheese	80 calories
... some more bread, of course	100 calories
... fruit: an apple or an orange	50 calories
... and wine, half a glass	50 calories

The afternoon whizzes by and next thing you know it's dinner time.

By now the beaker should be full but you keep pouring in water, even though it starts overflowing from the beaker into the basin underneath.

What about a good risotto?	420 calories
... some chicken	250 calories
... pan-cooked spinach	150 calories
... a small ciabatta	120 calories
... half a glass of wine	50 calories
... fruit	80 calories
... coffee and, after that, grappa	90 calories

Good grief, I nearly forgot! I ran into a friend this morning and we walked into a café for a snack. Nothing too drastic for the waistline...

An orange squeeze	60 calories
... and a toasted sandwich	270 calories

All in all, you may not feel that you have really overeaten, but you have consumed 2800 calories, almost double what you need. And all the calories which have fallen over the edge aren't lost. All those calories in the basin will be turned into fat. And only fat. And it's fat which **MAKES YOUR BLOOD GLUCOSE GO UP AND MAKES YOUR DIABETES WORSE.**

Therefore: in order not to get fat you must not put too much fuel in the tank, i.e. eat only what you need. To slim down you have to eat less than you need so that the missing calories get taken from the fat deposits.

6.Real life situations

Time for discussion according to questions individual patients may pose. It is important to ask if the example was clear and fully explained.

7.Final summing up

Assign homework task: weigh yourself once a week until the next group session and learn to observe any variations in weight. Group members are given simple forms on which to write down their weight (weight self-monitoring). Remind them of the date of the next group session and say good-bye.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

Comments: Usually almost all the patients are struck by the backpack demonstration because it is so immediate and functions as an “ice-breaker”! This initial demonstration is fun, gets patients talking to each other and starts to create group cohesion.

As for the basin demonstration, patients maintain that they don’t eat so much in the space of a day. Obviously the demonstration is exaggerated because it shows that everything we eat contains calories which get added to what we’ve already eaten. We have noticed that patients start by asking if individual foods can be eaten or not (e.g., strawberries, kidney beans, bananas, carrots etc.). At this early stage, it is important to remember that the questions may seem very general because this is only the first meeting. Don’t worry because patients will have time to reflect on the two demonstrations which are immediate and memorable.



The backpack

2nd Session - EATING OUT...TALKING ABOUT FOOD

Aims: to help patients discover the relationship between eating and diabetes. The behaviour references relate to:

- Regular weight self-monitoring
- Calories
- **Choosing foods**
- **Individual food needs**

Plan

Three metaphors are focused on:

- The backpack...or bodyweight
- The basin...how we fill up with food
- The menu...choosing foods

Comments: this session lets the patient refresh on concepts that were presented during the previous session and lets the facilitator check whether messages have been correctly perceived.

1. Welcome

The facilitator quickly revises the subject of the previous session (backpack and basin), collects the weight self-monitoring forms which had been distributed and introduces the subject for this session. Place the backpack where all the patients can see it.

2. The menu (teaching activity)

The basin, beaker and smaller containers will be used again. Patients are divided into two subgroups and given a restaurant menu (see attached). One group is asked to pick the worst possible meal for a diabetic person and the other group to choose the best. The two groups are left to make their choices and after the menus are collected and commented upon. Small containers (50, 100, 150 and 200 calories) are prepared to represent the items chosen from the menu. An enlarged copy of the menu with calorie counts for each item (see attached) will be displayed and consulted.

Comments: this exercise lets the patients immediately check the calorie count of the selected menu items.

By repeating the basin, beaker and smaller containers metaphor, calories become less “abstract” and more “concrete” for the patients.

3. Menu or no menu (Real life situation)

Menu choices are discussed together with possible dietary variations on a daily basis, using a calorie exchange table. Hand out a copy of the menu with the calorie count for each dish and suggest it is kept for reference.

4. Summing up

Weight self-monitoring forms are handed out and patients advised of the date of the next session. The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

Comments: the facilitator and above all the patients can begin to understand the choices and amounts of food consumed. In our experience we have met patients who accumulated 1800/2000 calories for one meal alone, all the while believing that they had made the best choice. Patients can see how much they eat and begin to appreciate that quality can substitute quantity by varying foods. Discussions in this session help to improve group dynamics.



3rd Session - THE BEST AND THE WORST MEALS...MORE TALK ABOUT FOOD

Aims: to create an opportunity for patients to better understand the relationship between eating and diabetes. The behaviour references relate to:

- Regular weight self-monitoring
- Calories
- Choosing foods
- Individual food requirements
- **Food exchanges**
- **Planning meals**

Comments: some of the behaviour references have already been presented in the two previous sessions but this does not mean that they cannot be repeated. As in every teaching/learning process, message acquisition is gradual. It is important to revise topics which have already been discussed before.

Plan

BEST AND WORSE MEALS, choosing foods and food exchanges are re-examined through some practical activities.

1. Welcome

Collect the patients' weight self-monitoring forms, quickly revise topics from the previous sessions and talk about the results of weight self-monitoring.

2. How's your weight? Shall we talk about it? (Real life situations)

The discussion centres on the problems and solutions involved in losing weight. In addition, you may talk about clarity (or lack thereof) of the information provided at the previous sessions and whether such information was helpful and fully understood. The facilitator must avoid judgemental comments about the weight of individual patients. It is more useful to encourage them for their perseverance in filling up the weight self-monitoring forms. If, however, some forms not have been completed you should explain once more how to and stress the usefulness of this activity.

The patients and the facilitator then discuss real life situations: what has happened in the past three months, eating habits, things that went wrong, solutions found etc.

3. Let's plan ...(teaching activity)

The patients are again divided into two subgroups and each is given an assignment. One subgroup has to plan the **WORST RESULT or WORST POSSIBLE MEAL**, and the other subgroup must

plan the **BEST RESULT or BEST POSSIBLE MEAL**, to cook at home. Patients will have access to different types of food, grouped according to caloric content.

Real foods, plastic models or photographs of foods, as appropriate and available, are used and divided into:

HIGH CALORIC CONTENT (RED FOODS):

Butter, oil, margarine, processed meats, fatty meats/fish, sauces (mayonnaise etc.), high-fat cheeses, alcohol

Cakes, biscuits, chocolate, pastries, carbonated drinks, sweetened drinks, ice cream, puddings, sweets, dried fruit

MEDIUM CALORIC CONTENT (YELLOW FOODS):

Bread, pasta, rice, cereals, legumes, grapes, bananas, persimmons, fresh figs, white and red meats, fish, low-fat cheeses, eggs, milk

LOW OR NIL CALORIC CONTENT (GREEN FOODS):

Vegetables, fruit, coffee, tea, herbal teas

Each group presents its work. The chosen foods are written up on a board or flip-chart. The two meals are discussed and **red/yellow/green** foods indicated. You can write

- ✓ **R for red,**
- ✓ **Y for yellow**
- ✓ **and G for green**

next to each food.

Next, the facilitator can help the patients to substitute foods so as to avoid an overdose of red foods, Patients learn to make food exchanges in order to accommodate individual preferences in meal planning. Using colours (RED, YELLOW, GREEN) helps patients select foods with ease directing them to foods they can eat and away from those they must be more careful with.

It's a good idea to have a **calorie chart** on hand so that even the strangest requests can be satisfied! It doesn't matter if patients see you consulting your notes to answer their questions instead of reciting calorie counts from memory! Patients perceive this as positive.

It is a good idea to use the metaphor of the **TRAFFIC LIGHT**:

Red = stop	Yellow= proceed with caution	Green = go
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Comments: this session may seem full of material but it should be remembered that in the next session, when we “go shopping”, the same concepts are repeated and discussed again.

You should emphasize the danger of between-meal snacks, drinks, packaged food, junk food etc. which may not seem important but.....

a cappuccino	100 calories
a glass of dry wine	106 calories
a glass of fortified wine	106 calories
a packaged sweet snack	150 calories
a cheese and ham sandwich	210 calories
a proper salami sandwich	380 calories

4. The tray

After asking patients to imagine that they are out at a friend’s house or in a café/snack bar, the facilitator circulates a tray and asks them to pick one of the following foods: Sweets, Chocolates, Salted nuts, After dinner drinks, No sugar-added fruit juices, Coffee, Tea, etc. The patients’ choices are then discussed together.

5. Summing-up

New weight-monitoring forms are handed out and patients told why a “food diary” is a good idea and how to start one. They are asked to write down their food intake only one day each week. Patients are given the appointment for the next session.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

Comments: During this session patients have another opportunity to check the caloric content of different foods. Often during this session some wrong health beliefs or food “taboos” are rectified, e.g. cherries, strawberries and carrots are not “red” foods; eating cold, unheated food does count as having eaten a meal anyway; bitter tasting foods do contain calories (eg certain types of gorgonzola cheese). In our experience, during the discussion phase it emerged how strongly commercial advertising influences food choices. The traffic light approach to categorizing foods has an immediate impact on the patient’s cognitive and sensorial perception where eating, choosing and exchanging foods is done through images and colours. This lets the patient learn to choose and change in accordance with his/her usual eating habits and cultural background.

4^h Session - LET'S GO SHOPPING...FOOD CHOICES

Aims: help patients to fully understand the relationship between eating and good diabetes control.

The behaviour references for this session relate to:

- Regular weight self-monitoring
- **Choosing food**
- Calories
- **Individual food needs**
- Food exchanges
- Meal planning

Plan

The focus of this session is SHOPPING, and the ability to select food (practical activity).

1. Welcome The facilitator welcomes everyone, quickly revises the topic covered over the previous session and collects the weight and eating self-monitoring forms handed out at the end of the previous session.

2. Real life situations

Patients are asked about difficulties they have encountered over the recent period and if the information they have received so far has been clear and helpful. During this phase, try to elicit and highlight the solutions adopted by individual patients. This is also an appropriate moment to talk about weight self-monitoring.

Comments: experience has taught us that:

- initially patients are afraid to reveal their own weight
- provided that there is no negative criticism, over time patients will begin to speak about their weight
- throughout the sessions even minor successes should be highlighted so as to improve patients' confidence
- the situations and experiences of group members are examples and possible solutions which can be used to motivate other group members
- rather than "diets" we speak about healthy eating the message should be "there is no diet for the diabetic patient" but...

3. Going shopping (teaching activity)

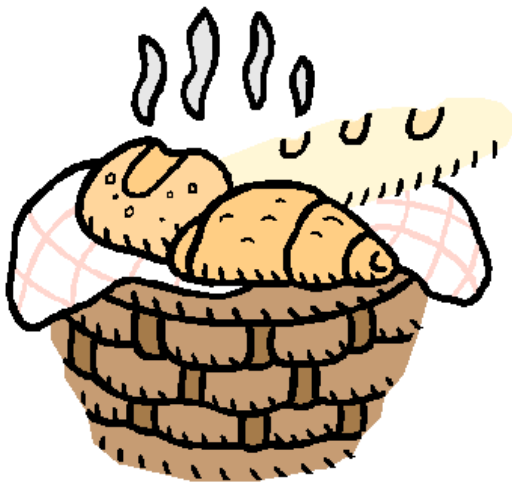
This is a new exercise. Two or three patients will be asked to "go shopping". They will have access to the models and pictures of food used during the previous session (you may have prepared a table in a corner). The foods selected are written up on the flip chart by the facilitator and then

commented on by the whole group. The foods are then classified again by colour: RED, YELLOW, GREEN.

The food pyramid will be explained using a large poster:

The bottom consists of a wide green strip, the middle coloured yellow and the smallest top part coloured red. This way the predominant COLOUR in the SHOPPING activity stands out. As the activity revolves around selecting foods, every selected item can be classified according to whether the foods “purchased” are Red, Yellow or Green.

The discussion should cover the possible choices of bread, condiments, fruit and vegetables, cheese, and learning to read labels on the packaging, in particular finding out about sugar, fat and protein in purchased foods



In addition to these practical activities, a suggestions and advice pamphlet like the one below can be discussed and commented on. This pamphlet is not just about “how to shop” but can be helpful in summarizing the content of the sessions relating to eating and shopping:

Eat well to feel well

Dear Madam/Sir

Here are some suggestions which may help you reach and maintain over time the right body weight. We have listed some “instead of food” activities, considerations that apply when eating out or at home and what to do when you go shopping. Happy reading!

ACTIVITIES

- Do not eat between meals. Go for a walk, read the newspaper or chat to your neighbour instead.
- Eat at set times (no snacks or appetizers).

- Keep food out of sight
- Don't leave bowls of sweets around the house
- Don't keep left-overs. Learn to prepare the amount of food you need for each meal.
- Unless you're preparing fresh vegetables, don't eat while you're cooking.
- TV and meals don't go together. If you watch TV instead of your plate you'll eat more than you intended and be completely unaware of doing so!
- Don't keep at hand foods you should not eat. If they are not in the house, you cannot eat them!

HOLIDAYS AND GET TOGETHERS WITH FRIENDS

- Don't drink alcoholic or sweetened drinks
- Bring a piece of fruit or a carrot as small snack to eat when you go out for a meal so that you do not feel starving by the time you finally start eating.
- If they keep offering you food you can always say "No, thank you."
- Don't be afraid to ask the waiter how the food is prepared
- Stay away from fried foods
- Even if a bigger portion looks better, it isn't worth the extra calories or fat

SELF-CONTROL DURING A MEAL

- Don't eat quickly. By eating slowly, you eat less and appreciate it more.
- Put down your fork between one mouthful and the next
- Chew for a long time before swallowing
- Prepare only one dish or portion at a time
- Take the amount you need once and no second helpings
- Don't help yourself to food from other peoples' plates
- Think before you drink. Alcohol contains a lot of calories, has no nutrients, helps store fats and increases the temptation to eat the wrong foods

GOING SHOPPING

- Don't go shopping on an empty stomach. You will be tempted to buy everything you see
- Write out a shopping list and stick to it
- At the supermarket stay away from the foods you are supposed to stay away from
- Learn to read the labels on the packaging
- Do not buy more food than what you realistically need
- Do not buy ready-made foods as they often have high calorie and fat contents. If you don't purchase something, you can't eat it.

SOME STRATEGIES TO HELP YOU...

- Get your family involved
- Use the results of your weight self-monitoring and self-control as a reward
- Remember that your new attitude towards food will help you keeping healthier and feeling better.

Comments: this suggestion and advice pamphlet was compiled over the course of several group sessions. Some of the suggestions came from the patients themselves and others evolved from discussions. We decided to compile all the ideas and suggestions and present them to the patients in pamphlet form with accompanying illustrations.

4. Summing Up

At the end of the session, forms for weight and eating self-monitoring are handed out to the patients and the appointment for the next session is confirmed. Patients are asked to bring along the packaging (containers, boxes, tins, bags) of the food which they will have purchased while shopping.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.



5th Session - GLYCATED HAEMOGLOBIN...HOW IS YOUR DIABETES? CONTROL AND CONTROLS. PHYSICAL ACTIVITY.

Aims: to create the conditions and opportunities for patients to reinforce/discover relationships between eating, physical activity, pharmacological treatment and metabolic control.

The behaviour references for this session are related to:

- Regular weight monitoring
- Choosing food
- Calories
- Individual eating needs
- Food exchanges
- Meal planning
- **Blood glucose (in normal conditions and emergency situations)**
- **Physical activity**

PLAN

Two demonstrations take place:

- HBA_{1C} (container, plasticine balls, white table sugar)
- The bathtub...or physical activity

1.Welcome: The facilitator greets the group and collects in the weight self-monitoring forms.

2.HBA_{1C} Demonstration with two containers...a lot of sugar and a little sugar. To explain the concept of HbA_{1c}, you may proceed as follows:

“How can you tell if your diabetes is well controlled or not? Fortunately, glycated haemoglobin can tell you!” Two red salad bowls containing white sugar are shown to the patients: one with a small amount of sugar and one with much more, as a way of showing different concentrations of glucose in the blood. Some plasticine pellets are placed in the containers representing red cells circulating in the blood vessels (the bowls). By rolling the bowls, you mix the plasticine pellets and make them stick to the sugar. This is how you can demonstrate what happens to the red cells in the presence of a little or a lot of blood sugar and, consequently, how glycated haemoglobin can vary. Then, you can go on to discuss ways to improve HBA_{1C}, in addition to healthy eating.



Comments: Patients always like the glycated haemoglobin metaphor because they are able to understand what the test actually means and why it is important for diabetes control. Usually, after this demonstration, patients start asking a lot of questions about diabetes control.

3.Real life situations

Patients are asked in which way they participate in regular physical activity: going for a walk, longer walks, climbing stairs instead of taking the lift, etc... The basin used in the first sessions is presented again and additional ways for “emptying” it are discussed. Patients’ ideas and suggestions are written up on the board and discussed together.

The facilitator should find out:

- If patients do any physical activity
- How much exercise they take
- If there are physical restrictions to exercising
- If anything else prevents them from exercising (lack of time, lack of interest...)

The image of the car should be displayed (poster sized drawing) and patients reminded that no petrol is consumed if the car stands still. They are then given suggestions in an illustrated pamphlet.



GET MOVING A BIT/GET A BIT OF A MOVE ON!

Some ideas to help get you physically active:

- ✓ Before starting any physical activity ask your doctor if there are any problems which might limit your activity
- ✓ A 30 minute walk each day is important. Besides, walking requires no special ability!
- ✓ Use the stairs instead of the lift
- ✓ When you're going to work get off the bus one stop early and walk the rest of the way. If you travel by car, park it a few blocks away from your place of work.
- ✓ Household chores, gardening and washing the car are all excellent forms of exercise
- ✓ Find time in your daily household routine to go for a walk. You'll feel relaxed and it will help you round out the day.
- ✓ If you go to a gym make sure the activities are right for you and your level of physical fitness. Don't get into a situation where everyone else is in better shape than you. Is the gym staff aware of your particular needs?
- ✓ Don't say "I'm too old to do that." or "I can't do that." It's not true and it's never too late.
- ✓ Don't rush into doing things. Every physical activity must be started gradually.

Summing Up

Patients are given the weight self-monitoring forms and the date of the next session.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

Comments: the suggestions for physical activity evolved from discussions with patients while giving advice to each other within the group. Any material handed out to patients should be read out and explained to them. When handing out information to patients it is a good idea to reinforce any piece of information which has already been talked about.

6th Session - WHICH IS THE BEST TABLET? DEALING WITH HYPOS

Aims: to improve conditions and opportunities for patients to better understand the relationship between physical activity and pharmacological therapy and recognize a hypoglycaemic attack..

The behaviour references for this session are related to:

- Regular weigh self-monitoring
- Calories
- Choosing foods
- Individual food needs
- Food exchanges
- Planning meals
- **Blood glucose (in normal and emergency situations)**
- **Physical activity**
- **Taking your own medication**

PLAN

1. Welcome

The facilitator welcomes the group members and collects the weight self-monitoring forms.

2. HBA_{1C} and Tablets (Teaching Activity)

In addition to diet and physical exercise, diabetes can be controlled with medication. Patients will be shown a range of oral hypoglycaemic products available and asked to recognise the one(s) they are taking. Next, the facilitator will elicit from the group the various factors which the doctor takes into consideration when prescribing one type of tablet instead of another. For example:

- A thin patient compared to an overweight patient
- A more physically active patient compared to a more sedentary one
- A patient who has diabetes compared to somebody who has additional problems
- A patient who has had diabetes for a short time compared to one who has had diabetes for a much longer period
- It is important to stress at this point that the doctor's decision to use one medication instead of another is motivated by various factors and chosen for an individual patient: weight, hyperglycaemia, other pathologies. It has to be stressed that tablets do not make up for a healthy diet or physical exercise and that they can have side effects.

Important Messages

- ...this is why each one of you takes different medications and you can't decide on your own to change the tablets you are on.”
- ...you should always check with the doctor instead seeking advice from your neighbours, friends, relatives or “that other lady who has diabetes too” .”
- ...some tablets can make you feel sick. In this case you should speak to the doctor and describe your symptoms.”

3.Side effects? Real life situations

Patients are asked whether after a longer-than-usual walk, working in the garden, doing housework or after taking their tablets, they have experienced any of the following: unexpected hunger, tingling and numbness around the lips, cold sweating, shivering, confusion, weakness, dizziness, fainting and how these were treated.

Pictures illustrating each of these situations have been prepared and will be displayed on the board.

4.Hypoglycaemia

Patients will have had an opportunity to describe their experiences and so the facilitator can introduce the topic of hypoglycaemia:

- ❖ what is it
- ❖ symptoms
- ❖ why it happens
- ❖ what to do when it happens

Sugar, chocolates, sweets and other commonly used remedies. are displayed so as to understand the right solution. The patients choose between: **Do's**: sugar in water; and **Don't's**: milk, sweets, chocolate, alcohol, biscuits, bread and breadsticks, crackers, fruit.

Comments: patients may be confused and not always able to recognize the symptoms of hypoglycaemia. Some patients are frightened by things they have heard about type 1 diabetes or “young people's diabetes”, which may create irremediable “problems” (hypos). Some of them are surprised to learn that sugar can resolve a hypo. Patients must be informed that they should learn to recognize and understand the symptoms they are experiencing.

5.Reinforcing

“Do's ” and “Don't's ” are illustrated one by one and, during the discussion, patients can pick them up and talk about them. A “Do's and Don't's Checklist” is handed out to the patients.

“DO”

- Take your medication properly

- Take the right tablets at the right time
- Eat healthily
- Talk to your doctor before making any change in treatment
- Learn to recognize a hypo
- Know what tablets you are taking, write it in a safe place or get someone else to write it for you
- Remember your next clinic appointment
- Use lifts as little as possible
- Go for a walk with a friend – you’ll feel better and it’s good for you!
- Use an exercise bike if you have one – while watching TV, reading or listening to the radio

“DON’T”

- Take your medication whenever you happen to remember
- Forget to go to your clinic appointments
- Take all your tablets together in order to save time
- Take your friend’s tablet because someone else said you should and because “They’re work really well for him, so...”!!
- Stop taking your medication and looking after yourself...”Diabetes isn’t a problem, I feel fine.”
- Over-react if you feel a hypo coming on

Comments: we decided to simplify correct and wrong behaviours with Do’s and Don’t’s on the basis of our experience. It may sound too simplistic but, as a result, our facilitators became clearer when presenting simplified messages. When talking about tablets, we often discovered that patients change their medication by themselves or taking somebody else’s advice because “they work for him”. Other patients had stopped taking tablets altogether without telling the doctor. This is why it is important to discover these mistakes and try to help patients understand why these conducts are wrong and potentially dangerous. If patients are encouraged to talk about their mistakes, then we can really help them to change.

6. Summing up

Hand-out the weight self-monitoring forms and remind patients of their next group session appointment.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

7th Session - EYES, HEART, BLOOD PRESSURE, KIDNEYS, FEET. PREVENTING COMPLICATIONS

Aims: to help patients discover the importance of measures to prevent complications and which behaviours to adopt on a daily basis.

The behaviour references in this session relate to:

- Regular weight self-monitoring
- Calories
- Choosing foods
- Individual dietary needs
- Food exchanges
- Meal planning
- Blood glucose (in normal and emergency situations)
- Physical activity
- Taking medication correctly
- **Problems resulting from poor diabetes control**
- **Practical solutions for daily life**
- **Patient/doctor roles in managing diabetes**

PLAN

1. Welcome

The facilitator welcomes the patients, collects the weight self-monitoring forms and quickly revises the topics of the previous session before introducing the new topic.

2. How have things been going? Real life situations

As a way of revising the previous sessions patients are asked to talk about difficulties and strategies for coping with regular physical activity, taking medication, sticking to a healthy and correct diet.

3. Complications

To introduce today's topic patients are reminded that only through "good" diabetic control can complications be avoided. It must be stressed that diabetes does not seem to have particular symptoms (when blood glucose is high, your nose doesn't catch fire! And you don't feel bad either). In order to pinpoint serious problems, an Annual Screening is organized by the diabetes clinic staff (Remind patients that this check-up is their right). Ask the group to talk about what happens at the annual screening and the parts of the body which are checked (eyes, feet, blood pressure).

Some of these questions might be then asked:

“Has anyone ever experienced pain similar to having a heavy weight or like being punched in the chest and the left arm?”

“Do any of your friends or family suffer from angina?”

“Has anybody ever had a heart attack?”

“Does anyone ever get cramps in their calves while walking? Enough so that you have to stop, or does it go away if you continue to walk?”

“Have you ever had visual problems?”

EYES (Teaching activity)

Patients are shown some photos of the fundus of the eye. Other materials include a model eye, and a booklet describing how the patient’s eyes are checked (visual acuity, pupil dilation, fundus and possible procedures). It is important to point out that retinopathy **does not produce symptoms** which is why a yearly screening is so important.

FEET (Teaching activity)

We can start talking about feet using a bag of dried beans! Give each patient a bean and get them to roll it around between their fingertips. Then get them to put the bean in a shoe and ask whether they can feel it or not under their feet. The facilitator then explains how we have tactile sensations and why diabetes can cause problems related to the feet. Then make the patients place their feet on plastic mats of smooth and rough textures and ask if they feel the difference.

Patients are asked to suggest strategies if they find:

- ❖ Calluses
- ❖ Cracked skin
- ❖ Overgrown toe nails
- ❖ Small sores or cuts

Patients are asked what to do if they buy:

- ❖ Shoes that are too tight
- ❖ Shoes that are too big

After listening to the various contributions, correcting mistaken information and acknowledging correct strategies, patients are told about the most common causes of foot lesions:

- shoes (different types of shoes are shown-- too tight, with high heels, sandals etc.)
- macerated skin, sweaty feet, prolonged bathing when the skin becomes damp and whitish before cracking...
- lesions resulting from daily foot care (cutting toenails and calluses, using sharp scissors, razor-blades, over-the-counter callus remover preparations)

- improper use of irritating disinfectants, plasters or other items.

Patients are shown:

- scissors
- razor blades
- over-the-counter callus remover preparations
- pumice stone
- mirrors
- talcum powder...

Patients are then given a list of **Do's and Don't's for Feet** with accompanying illustrations:

- ✓ don't expose your feet to extremes of hot or cold temperature
- ✓ don't keep your feet in extremely damp or extremely dry conditions
- ✓ keep your feet clean and dry paying particular attention to sores or cracks between the toes
- ✓ check the condition of the skin of the feet both under the plants and between the toes
- ✓ don't pull away or cut pieces of skin or cut away calluses
- ✓ file your toenails rather than clip them
- ✓ don't use callus removal plasters or iodine tincture. Don't use hot water bottles
- ✓ don't wear shoes without stockings
- ✓ don't wear open-toed shoes
- ✓ don't wear nylon stockings for long periods and if you wear boots wear a cotton or wool sock between the skin and the stocking
- ✓ don't go barefoot, not even on the sand at the seaside

BLOOD PRESSURE, Teaching Activity

Ask patients how often they check their blood pressure and what helps to keep it under control.

Re-introduce the importance of healthy eating, regular physical exercise and weight self-monitoring.

How to look after yourself. Hand out the following advice:

- take your tablets as prescribed
- follow a healthy diet
- don't add salt to your food
- keep your weight down
- limit alcoholic beverages
- don't smoke. Stop smoking if you still do
- take regular physical activity
- reduce the fats in your diet

- have your blood pressure checked regularly

Comments: when we start talking about complications we have observed that patients think these things shouldn't happen if they have "maintained good diabetic control over time". Some of the suggestions and advice are health behaviours which everyone should follow in order to stay healthy. Diabetic patients appreciate this approach and it makes them feel the same as other people while they learn to pay greater attention to their specific needs.

4. Summing up

The weight self-monitoring forms are handed out and the date fixed for the beginning of the next two year cycle of structured group care, starting again with Session 1.

The physician/diabetologist meets individually all those patients who do a yearly check for complications, require a consultation because of their blood tests or ask to see the doctor because of symptoms or clinical problems.

...I have learnt to understand what diabetes is and how to live with serenity

Talking about groups....

The comments below come from patients who continue to participate in group care. We asked them: "What are your impressions of group care and what do you remember most from your experience?"

These comments show that patients have started to understand more about their disease and how to live with it.

The patients said:

"The groups are useful because they explain the process, how diabetes works".

"...an exchange of ideas, what someone is thinking. If there are a lot of things you don't know you can learn about them in the groups."

"I like being there. I can't remember everything, I forget easily. By coming to the groups I can remember more."

"Instead of reading ... I don't always understand and I can't read very well ... with the groups I understand more, difficult things become easy and I learn."

"...they explain things well"

"...it certainly helps"

"It's useful for everyday life, eating, what not to do."

"It was useful to cope with the impact of diabetes in a non-traumatic way, laughing and joking about it."

"Sometimes you read that diabetes makes you blind, makes you lose your legs ... here I've discovered that it isn't like that and I can feel well."

"The group makes you live with the impact of diabetes without feeling afraid. You can speak to the organizers and you feel like somebody cares and you aren't a victim. If you had a pain you would get help but it does not help. Within the group you feel cared for, less alone and you learn."

"When I had to come to the clinic before I was always afraid. The doctor spoke, asked me how I was and spoke. I didn't understand anything, came away remembering nothing and I didn't understand why everything was wrong the next visit. Now I understand and, if I don't understand everything, I ask and I know that things will be explained again and I'm not the only one who doesn't understand."

"It's a different kind of help."

"To learn about other people's problems makes us better people."

“Of course, it helps because what I don’t know can be explained to me by someone else.”

“The neighbours or the television can say what they want. I have understood that I have to think for myself if I want to take care of my diabetes.”

“the demonstrations helped: the backpack, the water ... and it was fun too.”

What happens over time....

Over the years we wanted to find out what people with diabetes thought about group care: were they happy, did they find the topics useful, did they like how they were presented. The comments which follow were made by patients who still participate in group care. Their comments have been re-produced exactly as they were made during an interview session which we called:... **I’ve learned to understand what diabetes is and how to live with it.**

Introduction

During a meeting with a group of people with type 2 diabetes not treated with insulin, the concept of empowerment and how it is lived by every patient in their everyday life was dealt with and discussed. The people who participated in the meeting have been following diabetic group visits of therapeutic education in the last four years. The programme of the visits, based on a systemic approach, scheduled 7 visits, one every three months, during a two-year period. The group visits, with 9-10 type 2 patients, are part of the routine diabetic clinical practice.

This education programme aims at helping people with diabetes understand how to reach and maintain their ideal weight, learn how to choose the correct diet and how to do their shopping, learn how to take their medication correctly, to recognize and prevent hypoglycaemias and complications and to take care of themselves. The teaching methodology is centred on the patients and on their active participation in the learning activity.

The caretakers who do the group visits of therapeutic education are doctors, nurses, dieticians and one psycho-pedagogist. Indeed this project was designed to be carried out by the different caretakers involved in diabetes care.

After the first two years of observation the patients participating in the group visits were compared with other patients who had been cared for with a traditional doctor-patient relationship. The former had improved their quality of life and their knowledge of diabetes, and had taken up healthier habits. After two years, the former had better glycated haemoglobin values, BMI, total cholesterol and HDL cholesterol than the latter.

Methodology

Ten patients were invited to the meeting: 4 women and 6 men. They had all type 2 diabetes, were not treated with insulin and had been regularly attending group visits in the recent years. The metaplan technique was used to facilitate discussion and gather exhaustively all the remarks made by the patients. Diabetes patients were handed out cards where they could write their thoughts and ideas. Their task was to write the answer each of them considered appropriate and correct in capital letters with a thick felt pen and a readable handwriting. If a patient had problems writing, somebody would help. With the patients' consent, the meeting was filmed to record statements and attitudes as accurately as possible. To this end, we are reporting the statements and dialogues as they were recorded in the following sections.

Discussion

We started by welcoming the patients and explaining the task and goal we wanted to reach. The first question “**how people with diabetes can learn how to take care of themselves**” gave our work a start and we had a good discussion. The first cards were collected. They contained the following concepts and remarks: **control oneself, knowledge, learn how to live with the disease, correct diet and correct behaviour, understand what is happening and know oneself, be your own doctor, avoid complications, live with serenity, free will and free of shame**. Each patient was asked to explain and clarify to the other participants the meaning of what they had written.

The dialogues you are going to read are created by each person's inborn wish to learn and understand what is happening to them in order to be able to deal with different situations and not be at the mercy of a disease.

The desire to understand and to learn in order to live in serenity was repeatedly underlined:

“it is important to be able **to control oneself and live with serenity**, to learn to understand why your glycemia can be high or low, although it is not always easy.”

Another man added that “it is possible to choose and decide how you want to be cured thanks to **knowledge**”.

Another patient underlined “ I have learnt a lot these years, but although I am attending the groups and learnt, glycemia is sometimes variable, but now I realize it and this is the difference from the past ... now I can **control** my glycemia and understand the reason why it is changing ... Glycemia

is not only a figure but it reflects what we have been through during the day. It is not easy to **understand** all this and you need a strong will power.

After this statement another patient continued and underlined that “each of us can **learn how to know** diabetes and **live with it with serenity without being ashamed** of suffering from a disease.”

Diabetes is a chronic disease that needs continuing health care and repeated education sessions to prevent acute complications and reduce long-term complications.

To treat diabetes we need continuing and structured education sessions for a person to understand the repercussions of suffering from a disease and how to change their way of life. For this to happen it is necessary to help a person be autonomous although in the presence of a disease. We need to create the right conditions for each person to be able to find the most appropriate solutions for their own life.

The dialogue continued with a man saying “it is important for a person having diabetes to know what it is, because they will also need to explain it to others sooner or later and if you can explain what you suffer from you can be more serene”.

The dialogue continued “when I went to the clinic for my individual visits I did not always understand nor remember what the doctor would tell me. Since I started participating in the groups and we did the visits in this new way I have had the time to **learn and understand, there are examples and things are repeated**. We can even learn from our own mistakes”.

Another lady stressed that “when I first had the disease, diabetes, I could not accept it. The doctor helped me understand what could happen to me and this helped. Since we began with the groups and you (the doctors) changed your visiting methods, we have had more time to learn and understand...”

The discussion continued and all the components of the group participated. We dealt with social life and the repercussions of suffering from a chronic disease. Patients would explain the problems they sometimes had encountered and the solutions they had found.

“... When I’m getting worse and my haemoglobin is getting worse, I feel ashamed, since now I am aware of the mistakes I’m making ... but anyway I know I can improve”.

A man answered that “we must not feel ashamed. We must all socialize and not avoid on people’s company. We should rather **learn to choose what and how much to eat**. Each of us can find new solutions according to our own **daily eating habits**.

A woman added that “Sometimes you can say no to some parties, some other times I’d go and pay attention to what I eat and would not give up on my friends””.

To change a way of life a person needs to learn new strategies, new ideas, new concepts and be supported in their learning path.

At this point the topic is raised and stimulated. Patients recognize how difficult it is to change and are aware that they cannot deal on their own with such changes, which are fundamental for them and their health.

“... You (doctors, nurses, dieticians) have to teach us how to know diabetes and what its consequences are. We are not all the same, we all need different treatments and care.”

This is what a man answered to this statement:

“After **understanding, I am the one who decides**, as a person, and **I take my responsibilities**, ... but I cannot make it on my own and I need our **caretakers’ help**, those people who work in the clinic, to manage to **take control of myself** , be able to **live with the disease** and **learn** how to relax. Knowledge is not enough in itself... we are asked to have different habits for every day... There are moments when you do not feel like doing everything at your best and then caretakers who will remember and stimulate you again help you not to lose your spirits...”

Change does not happen in solitude. Diabetes is really a social disease, since it does not only involve many citizens, but also their families and friends...

“I am the one who decides as a person taking my responsibilities, helped by our caretakers and **our family**. We **valued exchanging experiences** in our groups. We learnt to get to know ourselves and to take control of ourselves and to follow a correct diet knowing how to behave... If we are **helped and supported**, because there are critical moments despite our good will and we must not feel ashamed.”

The disease must not be a label for solitude or social outcasting. Everyone’s life must be valued and used in the classroom as something useful to learn from.

Exchanging and sharing experiences help overcome the anxiety that comes from solitude and feeling “different”.

“I’ve also learnt a lot **from people with which I share and participate in the groups** and I’ve learnt a lot from the people beside me”.

“Every person I met in the groups has given me something, wisdom that comes with age, new solutions, ... there were also those who could neither read nor write but they too have given me so much...”

Knowledge, the ability to learn, the results reached become stimuli to continue learning and we too can become teachers for others... ..

“My husband used to take tablets against cholesterol. He started my diet and taking care of himself, just as I am taking care of myself, and his cholesterol has dropped. You need a lot of will power, we need to acquire strength and be able to make choices in everyday life and take care of ourselves. **This is what I’ve tried to pass on to my husband and I’ve noticed it works...**”

The discussion ended with people analysing and reading the cards pasted on the board. When asked “Anything else to add ...?”, a man answered

“Education is important because it helps each of us **understand and become autonomous**, we are no longer ignorant nor unable to decide we can discuss things with the doctor and ask what is going on. The task to understand and put what we have learnt into practice is ours, their task is to help us understand ... as long as this is done together.”

“Education is a process that enables patients to acquire and preserve abilities and competences to help them live their life with the disease in the best possible way”

WHO 1998.

LIST OF MATERIALS FOR GROUP CARE

(All handout leaflets, self-monitoring forms and printable material can be printed from the CD provided)

1ST MEETING

“THE BACKPACK AND THE BASIN”...OR BODY WEIGHT

Materials:

- ✓ backpack containing four 5 Kg bags filled with sand (the should be strong enough to be frequently moved in and out of the bag without breaking)
- ✓ large, transparent glass container (3L laboratory beaker)
- ✓ 5L capacity plastic basin
- ✓ glass jars, clear plastic bottles with levels indicated by a felt marker equivalent to caloric amounts, also written on the containers and representing different foods used in the “basin” demonstration
- ✓ forms for weight self-monitoring to be handed out to the patients, to be returned properly compiled in at the following session

The backpack should be placed in full view at every session so as to be used for reference. The completed weight self-monitoring forms should be collected at the beginning of each session and new ones handed out at the end of each session as “homework”

2ND MEETING

EATING OUT...TALKING ABOUT FOOD

Materials:

- ✓ More transparent containers labelled with calories (50, 100, 150, 200, 300 and 400)
- ✓ Photocopies of a restaurant menu enlarged on A3 paper
- ✓ Prepare two versions of the menu:
 - 1) one that does not indicate the caloric value of the items, to be used in group work
 - 2) one indicating the caloric value of all items, to be used during the group discussion and handed out at the end of the session

3RD MEETING

THE BEST AND THE WORST MEALS...MORE TALK ABOUT FOOD

Materials:

Different types of food and drawing of a traffic light, which should be left in view

- ✓ Photos of food, preferably pictures of the single food, e.g. only spinach, potatoes, meat, cheese
- ✓ Packages and tins. Pasta, rice and biscuit packages can be used. If you cannot find all the packages you need you can put foodstuffs (pasta, rice, cereal etc.) directly into glass jars. Milk cartons (full-fat, partially skimmed, skimmed), drink tins or bottles, wine bottles, oil containers, butter and margarine packaging.
- ✓ Plastic models of food (fruit, vegetables, cheese, meat, fish, eggs)
- ✓ Table or working surface for teaching activity
- ✓ Blackboard or flip chart for writing patients' choices. If neither is available, you can use large pieces of paper. Choices are subdivided according to the colours of the traffic light.
- ✓ Chalk or large felt-tip pens
- ✓ Tray
- ✓ Calorie chart

4TH MEETING

LET'S GO SHOPPING...FOOD CHOICES

Materials:

- ✓ Different types of foods and drawing of traffic light, which is to be left in full view
- ✓ Flip chart or large piece of paper
- ✓ Drawing of the food pyramid
- ✓ Table
- ✓ Hand-out leaflet "Eat well to feel well"

5TH MEETING

GLYCATED HAEMOGLOBIN...HOW IS YOUR DIABETES? CONTROL AND CONTROLS. PHYSICAL ACTIVITY.

Materials:

- ✓ Two red plastic salad bowls
- ✓ Red plasticine worked in pellets 1-2 cm in diameter
- ✓ White table sugar
- ✓ Large glass container
- ✓ Poster-size drawing of a car
- ✓ Flip chart
- ✓ Hand-out leaflet "Get moving a bit/Get a bit of a move on"

6TH MEETING

WHICH IS THE BEST TABLET? DEALING WITH HYPOS

Materials:

- ✓ Packages of all oral hypoglycaemic agents commercially available
- ✓ Drawings of symptoms of hypoglycaemic episodes to stick up on the board
- ✓ Water and sugar
- ✓ Milk (in container), chocolate, crackers, some fruit
- ✓ Checklist hand-out “Do’s and Don’t’s”

7TH MEETING

EYES, HEART, BLOOD PRESSURE, KIDNEYS, FEET. PREVENTING COMPLICATIONS.

Materials:

- ✓ Model of the eye
- ✓ Color fundus photographs
- ✓ Shoes of different models (including some with stiletto heels and narrow)
- ✓ Foot care items