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Development of a care model that enables people with diabetes and their spouses to unite as a couple in diabetes education

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Abstract

The purpose of this study was to develop a care model that unites people with diabetes and their spouses by stimulating mutual sympathy through diabetes education. The participants in our study were 11 voluntary diabetes education nurses and 27 marital couples with one diabetic partner. A qualitative approach utilizing phenomenology, theoretical discussion and focus group interview was used in development of this model. We found that the care model we developed stimulated mutual sympathy through diabetes education, enabling the couples to work as a team when dealing with the disease. The care model consisted of a couple interview composed of six components. The necessary knowledge and skills for the nurses practicing this care, the nursing care employed, and outcomes of the care were also highlighted. The care model, which encouraged marital couples to unite, was designed to evaluate the marital role of each partner in daily life, helping the couples become aware of the importance of mutual sympathy and encouraging them to adopt more effective diabetes management. After the couple interview, the nurse does not refer back to the topics discussed. Therefore, this care model was designed to be provided in a scheduled manner rather than during ordinary nursing care. The care model developed suggests that in planning diabetes education of married couples with diabetes, nurses can help encourage mutual support.

Key words

diabetes, diabetes education, care, marital couples, family nursing

Introduction

Our previous qualitative study revealed that the status of marital couples when one partner has type 2 diabetes could be distinguished on the basis of factors related to the level of control of the disease[1]. We additionally showed that in the case of well-controlled diabetes, the care provided by nurses within the framework of diabetes education was able to stimulate mutual sympathy between the patient and their spouse. Moreover, this experience was utilized by the couples in daily support. As a care technique, nurses at a university hospital in Japan conducted an interview of individuals who have diabetes with their non-diabetic spouses, producing dramatic changes in the attitudes and actions of the couples in daily management of the disease. This method of addressing the spouse as well as the patient is unique and has not been reported before. It is expected to help couples be more effective in diabetes management at home and attain better control of the disease, though it is yet to be used in conventional diabetes education.

Diabetes education is at the heart of good diabetes self-management. Individuals with diabetes are taught about nutrition, exercise, medication, monitoring, and adjusting emotionally to the disease[2]. Implementation of the various tasks of diabetes self-management can

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leave people with diabetes feeling isolated from other members of their family, making them feel alone with their illness. On the other hand, family members might begin to feel that their life-styles are being controlled by the person who has diabetes, a disease that it is hard to understand if you are not a sufferer[3]. In the past, there have been arguments about the importance of considering the entire family in the setting of diabetes management[4]. However, how the role of these family members should be reflected in diabetes education has yet to be shown.

Some investigators have stated that the importance of a diabetic regimen that includes a significant other is a stronger predictor of behavioral intent than the health beliefs of the person with diabetes[5]. The most likely significant other of an adult with diabetes is a spouse. In a previous study of marital couples composed of a person with diabetes and his/her non-diabetic partner, it was concluded that the spouse's beliefs in the importance of blood glucose control predicted control better than the patient's beliefs[6]. It has also been shown that the quality of marriage is related to adaptation of the patient to diabetes[7,8] and that conflicts within a marriage are often acted out in daily diabetes management[9].

To facilitate the continued self-management of diabetes by marital couples when one partner has diabetes it is therefore necessary to develop a means of diabetes education that stimulates cooperation and effective management of the disease as a couple. In the context of family nursing, Moriyama[10] proposed the importance and necessity of an approach in which people with diabetes and their spouses are viewed as a unit (a couple) and education is provided accordingly to stimulate better support from family members. Toima et al.[11] attempted to improve communication between people who have diabetes and their non-diabetic spouses with an approach based on family nursing, and reported that this attempt led to therapeutic improvements. However, in our previous study we learned that individuals faced with the facts about marital couples when one partner has diabetes often don't fully understand the implication of these facts or nature of issues related to living with diabetes that can be intertwined with other unrelated issues[1]. Therefore, diabetes education is limited if it focuses solely on providing explanations of the conventional concepts of family nursing.

We anticipated that the key to effective education of marital couples is to focus on achieving mutual sympathy between the individual with diabetes and his/her spouse. Such a care model will help nurses plan an effective education programme for married diabetic patients and couples in which one partner has diabetes. The present study was therefore undertaken to develop a care model that includes both the individual with diabetes and his/her spouse, and stimulates mutual sympathy between both members of the couple. In developing this model, we found that care that stimulates mutual sympathy between a husband and wife encourages both partners to unite in dealing with diabetes as a couple.

Procedures

Development of a care model involved the following four phases: (1) investigation of the care presently implemented; (2) theoretical analysis of care; (3) preparation of a draft model for effective care; and (4) evaluation of the draft model.

Phase 1. Investigation of the care presently implemented

The care model we attempted to develop in this research was derived from the care currently provided by nurses within the framework of diabetes education with emphasis on the need to help patients and their spouses practice management of the disease more effectively through mutual sympathy. The efficacy of this care was evaluated previously as follows[1]. When one partner of a marital couple has diabetes, receiving nursing care means the chance for both partners to improve the quality of control of the disease. Patients undergoing this care are able to receive periodical checkups as recommended by their physician and are helped to control blood glucose levels for 6 months or longer. At the same time, this care gives medical staff involved in diabetes education an idea of how well the patient and his/her spouse are working together.

Two questions were addressed in this study: why marital couples begin showing mutual sympathy after this type of care and how such sympathy is stimulated by the nurse? We thus adopted a qualitative approach

to clarify the type of care that stimulates mutual sympathy in a marital couple when one partner has diabetes. Research using a qualitative approach is applicable to various events such as those based on human thoughts or senses of value, sensory events and social events[12]. In qualitative research, qualitative data are collected and analyzed subjectively. Although subjectivity is avoided in quantitative research, it is actively utilized in qualitative research and it is therefore important to show how it is treated in the design of the research[13]. In the present study, subjectivity was dealt with from the standpoint of Husserl's phenomenology, which considers the meaning attached when recognizing experience and phenomena, and requires review of one's consciousness and reservation of self-decision distant from common sense[14].

1) Participants

Five nurses and 27 marital couples (one partner of each with diabetes) participated in phase 1 of this study. All nurses were involved in diabetes education at a university hospital, and were experienced in stimulating mutual sympathy through care in marital couples composing one partner with diabetes. The marital couples were between 40 and 79 years of age, and in 17 of the total of 27, the husband had diabetes. At the time of the study, the individual with diabetes was a regular visitor of one of the above university hospitals (Department of Internal Medicine) as an inpatient or was receiving ambulatory care at an outpatient internal medicine clinic because of poor blood glucose control (hemoglobin A1c over 8%).

2) Data collection

Data were collected between 2002 and 2004 through participant observation and focused interviews[12]. A total of 27 interviews of the patients and their spouses (hereinafter referred to as "couple interviews") was conducted by the nurses; one of the authors was present in each couple interview as an observer.

Verbal and non-verbal expressions of the nurse, patient and spouse during the couple interview as well as the time course of each interview were recorded. In view of the possible influence of the observer's attendance on the couple interview, records were taken immediately after the end of the interview, not during. These records were taken based on memory and transcribed verbatim as faithfully as possible. The couple interviews were conducted in a conference room within university hospital and lasted for about 60 minutes. It has been demonstrated that records of an interview lasting this length of time can be adequately taken on the basis of memory and that it favorably affects the interview if the observer does not take notes during but rather records the interview later[15]. Not only objective data of the couple interviews but also the observer's feelings were recorded.

Focused interviews of the nurses who performed the couple interviews were also conducted before and after each couple interview. About 30 minutes before the planned start of the couple interview, the researcher contacted the nurse in charge of the planned interview and after confirming that he/she was ready to start interviewing the couple, conducted a short interview, focusing on his/her thoughts. After completing each couple interview, the nurse was interviewed again to confirm that the records taken of the interview were correct and to seek his/her opinions. Noteworthy phrases spoken by the nurse during the focused interviews were recorded.

We also attended 17 nurse meetings aimed at discussing the conducted couple interviews; one of the authors attended these meetings as an observer and noted the exercises conducted by the nurses in the couple interviews. During these meetings, findings related to identification of the essential elements of the couple interviews were recorded.

3) Data analysis

When analyzing the data, we referred to the following six-step phenomenological method and physiology reported by Spiegelberg[16]:

(1) Direct investigation, analysis, and description of the phenomena under study, keeping as free as possible from preconceived expectations and presuppositions.
(2) Perception and probing of the phenomena for typical structures or essential features, and for the relationship among structures.
(3) Analysis of how the phenomena appear in different perspectives or modes of clarity.

(4) Exploration of the way in which the phenomena establish themselves or take shape in consciousness.
(5) Suspension of belief in existence.
(6) Interpretation of concealed meanings in the phenomena that are not immediately revealed during direct investigation, analysis, and description.

We repeated the cycles of data collection and analysis until we were able to explain the phenomena identified in the couple interviews and their significance in light of the questions set at the beginning of this research.

4) Ethical considerations

The Medical Ethics Committee of Kanazawa University School of Medicine reviewed and accepted the design of this study. The objectives of the study and method of participation were explained to participants both in writing and orally, and those candidates who gave consent were enrolled. Voluntary participation and the right to quit the study anytime were assured. Anonymity and confidentiality were guaranteed by ensuring that no data would be used for any purpose other than the current research, that it would be managed in a strict manner, and that adequate care would be taken to avoid identification of the participants.

5) Findings

Eight nursing steps were identified for use in the model. Of these, six were included in the interview; the couple interview was therefore composed of six components. It was found that as the nurse cared for the marital couple, these components led on from one another naturally, encouraging the marital couple to unite.

The couple interviews were started in 2000 on a trial basis by a nurse involved in diabetes education. At this time, it was very rare for nurses to arrange interviews of persons with diabetes and their spouses within the framework of diabetes education. The nurse reported why she began the couple interviews as follows:

I intended to prevent members of a family with diabetes feeling isolated. If a partner has diabetes, the relationship with his/her spouse tends to be disturbed, and this trend is particularly evident in devoted couples. I expected that interviews of the patient together with his/her partner might allow nursing practitioners to help the patient more effectively by making use of the dynamics unique to couple interviews. I thus decided to attempt this method of interviewing (Taken from field notes obtained after a focused interview with the nurse).

The couple interview was therefore deemed as a valid model.

Phase 2. Theoretical analysis of care

This phase was aimed at analyzing, with existing theories, the nursing care for marital couples unveiled in Phase 1, the components of the couple interviews, the outcomes of the model and the processes resulting in these elements. The analysis theoretically endorsed that nurse intervention through care can stimulate mutual sympathy in couples by encouraging them to unite in dealing with diabetes, leading to facilitation of effective home treatment. The analysis additionally clarified the theoretical basis of the knowledge, skills and philosophy needed by nurses practicing nursing care.

Phase 3. Preparation of a draft care model

In implementing care models, it is paramount that the nurses involved fully understand the aims to be addressed. In addition, we paid special attention to the necessity of highlighting the knowledge, skills and philosophy required by nurses practicing the type of care illustrated in phase 2. Combining the results of phases 1 and 2, we prepared a draft care model. With our care model, an essential factor in stimulating mutual sympathy in a marital couple is that the couple is united through the nurse's interventions. That is, our model enables people with diabetes and their spouses to unite as a couple with diabetes through diabetes education.

Phase 4. Evaluation of the draft model

We evaluated the validity[12] of the draft care model prepared in Phase 3 by means of a focus group interview[17] and trial application.

1) Focus group interview

Focus group interviews allow individual members to ask the opinions of other members, while bearing in mind their own practices[17]. We conducted a focus group interview of six nurses (different to those who participated in phase 1) practicing nursing care aimed at encouraging marital couples to unite in dealing with diabetes. This interview was aimed at evaluating the fitness, accountability and clinical applicability of the model. Fitness was evaluated on the basis of assessment of fitness to couple interviews by individual members. Accountability was evaluated by checking the extent to which the model could explain the care provided satisfactorily using the data obtained in Phase 2. Regarding the clinical applicability of the draft model, a number of nurses proposed that some of the illustrations used be improved to make the model more user-friendly. We adopted this proposal and partially modified the draft model to make it more extensively applicable.

2) Trial application of the draft care model

The modified model was presented to three nurses for clinical application. Applicability was confirmed by analyzing data from 19 couples. Patients undergoing this care model became to receive periodical checkups as recommended by their physician, control blood glucose levels, and cooperate with their spouse.

Results

Fig. 1 illustrates our proposed care model developed as a result of the 4 steps mentioned above. Our care model was designed to help marital couples, consisting of one partner with diabetes, become aware of the importance of mutual sympathy and guide them to adopt more effective daily diabetes management. To this end, the model evaluates, in detail, the feelings of the diabetic and non-diabetic members of each couple. This model was designed to be implemented in a scheduled manner after assessment of the individual with diabetes during diabetes education, rather than during ordinary nursing care.

The care model is based on the assumption that the nurse providing the care is equipped with knowledge and skills related to human relationships as well as a sense of humor. It is paramount that the nurse is familiar with the interviewing method and holds in his/her mind an image of a loving marital couple. Thus, the nurse needs to be on the same level as the couple being interviewed. In an attempt to unite the couple, each care step is provided when deemed the best timing, with each component of the model proceeding naturally from one to the next. It is assumed that during this couple interview, the couples will undergo a pop-up phenomenon[18]. In the pop-up phenomenon, memory of past episodes, particular scenes or circumstances will suddenly be remembered under sensory stimulation using words or emotions. For example:

> *When the nurse presented a phenomenon that likely happened to the diabetic partner and explained its meaning, the non-diabetic partner became tense, and the diabetic spouse, who had been looking in the other direction, turned the spouse's gaze toward partner. It seemed as if the couple were suddenly remembering one past event after another, possibly thinking that if this event can be so viewed, how about that occasion or that such case (Taken from field notes obtained after a couple interview).*

By experiencing the pop-up phenomenon and reviewing its meaning, the aim is to modify the thoughts and feelings of the marital couple, causing a fluctuation in their feelings and consequently spontaneous responses resembling self-organization[19]. According to the principle of self-organization, a molecule in equilibrium sees only a neighboring molecule, while a molecule in disequilibrium sees the entire system and undergoes resonance, resulting in a change to a new more suitable system. Therefore, if the nurse notices the expected response in the couple, he/she should judge that the couple has begun to change. At this time, the nurse should avoid re-confirming or attaching meaning to the current diabetes management adopted by the couple. In this respect, the nurse is expected to provide care that can alleviate tense circumstances through humor while refraining from referring to events revealed during the couple interview at later times.

> *I make it a rule to complete a couple interview with a humorous statement. After completion, I*

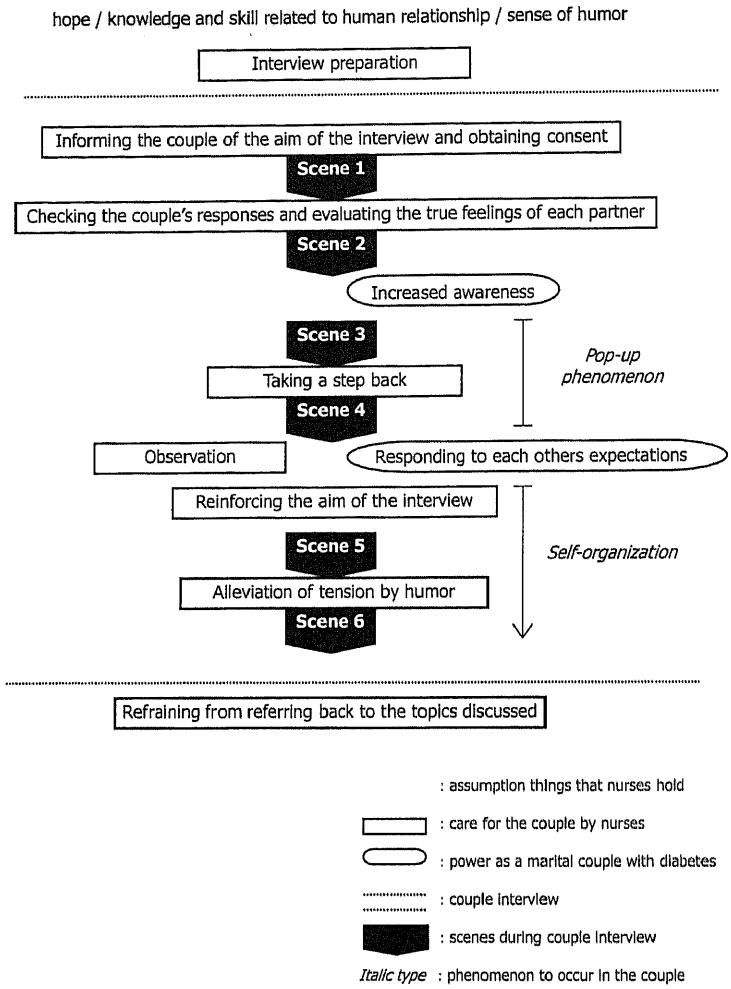

Fig. 1 Care model that enables people with diabetes and their spouses to unite as a couple

never refer to the couple interview when caring for the patient or talking with the spouse. That is, I intentionally refrain from doing so. We can judge the success or failure of a couple interview by watching how the couple leaves the interview room upon completion. If the couple are seen speaking gently to each other when leaving the room, without looking back, it often means that the interview was successful. The aim of this interview is therefore to change the daily behaviors and attitudes of the couple. It is thus important to refrain from referring to the interview again. (Taken from field notes after a focus group interview)

Table 1 shows steps conducted by the nurse in the care model. The care that a nurse used in this care model was divided into eight types: interview preparation, informing the aim of the interview and obtaining consent, checking the couple's responses and evaluating the true feelings of each partner, taking a step back, observation, reinforcing the aim of the interview, alleviation of tension by humor, refraining from referring back to the topics discussed. The components of couple interview in the care model are showed Table 2. The couple interview consisted of six components which began from the patient and spouse to a joint interview with the nurse to help them understand how they should lead their daily lives with diabetes. Table 3 shows the expected outcomes of participating in the care model. The outcome brought by the couple who received this care model was shown by reaction of increased awareness and responding to each others expectations.

Discussion

We developed a care model that enables people with diabetes and their spouses to unite as a couple through diabetes education. In the following, we

Table 1 Steps conducted by the nurse in the proposed diabetes care model

Type of care	Description
Interview preparation	Based on information collected in advance from preliminary assessment of the patient, the nurse prepares an explanation of why a couple interview is needed and the message to be presented at the beginning of the interview. The nurse attends the interview bearing in mind an image of a loving couple.
Informing the couple of the aim of the interview and obtaining consent	After showing her name plate, the nurse explains his/her standpoint as a professional in guiding diabetic patients in how to conduct their daily lives, in his/her belief in the mutual roles of patients and their spouses, and in his/her desire to help the couples by providing assistance. The significance of the interview in diabetes education is explained, adding that frank speaking is welcomed. Consent is obtained from each attendant (the interviewer, patient and spouse), allowing the opportunity to exchange views and opinions about events, troubles, discomforts, and so on during daily life as a couple with diabetes.
Checking the couple's responses and evaluating the true feelings of each partner	First, the spouse is interviewed. The nurse assumes a neutral position using phrases such as, "Is that so?" or "What do you think about such and such?". The nurse stimulates both interviewees to express their views, attaching importance not to correctness but to what each partner thinks and whether or not they have understood each others thoughts or feelings. The nurse then frankly tells the couple of his/her impression of the interview. While checking their responses, the nurse depicts an image of the couple. In view of this image, the nurse then discusses the best options for the couple and assesses the true feelings of each partner. This is later utilized as a useful tool, not directly but as a metaphor to encourage the couple to express their true feelings without inviting resistance.
Taking a step back	While approaching the true feeling of the couple, the nurse sets a stage where the couple can reach out to each other. The nurse takes a step back during this process.
Observation	The nurse observes the couple while they remember past events (the pop-up phenomena).
Reinforcing the aim of the interview	As the couple cools down, expressions such as "What can we do?" begin to be spoken. At this point, the nurse once again explains the importance of mutual sympathy and preventing discomfort that is likely to appear in couples with a diabetic member (as referred to earlier in the interview). He/she then confirms that the couple understands the meaning. The couple often asks what they should do. At this point, the nurse proposes a concrete plan suggesting they can "choose between two alternatives" based on the integration of past experiences, expertise knowledge about the daily lives of diabetic patients and what has been learned during the interview. The proposal is first made to the spouse. The patient is then guided to make a selection considering the response of the spouse. In this way, a decision is made between the couple, rather than as a promise to the nurse.
Alleviation of tension by humor	When a decision has been made by the couple, the nurse attempts to change the atmosphere by means of a humorous expression. The nurse takes care to avoid intervening with the couple's decision or referring to the contents of the interview again. She/he waits until the couple appears relaxed before changing the topic with a humorous statement prior to ending the interview. The nurse watches silently as the couple leaves the room.
Refraining from referring back to the topics discussed	After the interview, the nurse should refrain from referring back to the topics discussed. With this model, it is ideal that the issues are settled by one round of interview.

Table 2 The six components of the couple interview in the proposed care model

No.	Contents (indicators)
1	The patient and spouse agree to a joint interview with the nurse to help them understand how they should lead their daily lives.
2	The nurse tries to determine the current roles of the patient and spouse, encouraging them to share their feelings and thoughts.
3	The nurse encourages the patient and spouse to be open with each other.
4	As a result of 3, the couple remembers past events (pop-up phenomena).
5	The nurse encourages the couple to reorganize their daily life patterns as a couple with diabetes (self-organization).
6	The nurse alleviates tension by ending with a humorous statement

Table 3 Expected outcomes of participating in the care model

Outcome	Features
Increased awareness	The components of the couple interview encourage the couple to expose their real feelings. Thus, both members of the couple become aware that their conventional understanding of their partner's behaviors are perhaps incorrect, that they have lost their true feelings, and that the conventional means of support perhaps don't function satisfactorily in the presence of a partner with diabetes, causing miscommunication or troubles. Increased awareness brings the couple closer, encouraging them to review their current way of living with diabetes.
Responding to each others expectations	While remembering past events in light of their increased awareness of each other, the patient and spouse begin to think how they can respond to each other's expectations or play a significant role for the sake of their partner. They also explore ideal ways of achieving mutual sympathy and express their interest in forming an efficient plan for living with diabetes.

will discuss our model from two viewpoints: (1) similarities or differences between our model and existing methods of care for diabetic patients and their families; and (2) the significance and efficacy of care designed to stimulate mutual sympathy in couples within the framework of diabetes education.

1. Similarities or differences between our model and existing methods of care for patients and their families

The couple interview, a key component of this type of care, is characterized by the requirement that the patient and their spouse attend the nurse interview together. In conventional diabetes education for married patients, education of the spouse as a supporter is incorporated into diet therapy or care upon onset of hypoglycemia, but generally, is kept separate from education of the partner with diabetes. Barbara et al.[6] demonstrated that the beliefs of the non-diabetic spouse are sometimes more useful in predicting the prognosis of blood glucose control than those held by the patient. They therefore recommended couple participation in diabetes education and development of programs allowing discussion or emotional expression of the effects of diabetes on both partners daily lives. To date, however, no such program has been applied clinically. In the present study, we developed a care model designed to be applicable to marital couples with one partner having diabetes to help guide them toward effective management of the disease. In the field of clinical psychology, couple therapy was established as a method of counseling for problematic couples in the presence of individual respective partners[20]. This therapy, however, is aimed at identifying problems and is not suitable for use in nursing, which is aimed at caring. In the field of nursing, intervention whereby a family is viewed as a system has been attempted within the framework of family nursing. In recent years, the applicability of findings from such attempts in diabetes education and nursing have been shown[10,11]. However, these attempts are confined to assessment of poor cycles of communication arising in marital couples when one partner has diabetes. The care model we developed is unique in that the care provided by the nurse is aimed at encouraging the couple to make voluntary changes to unite in dealing with diabetes. Whether or not it is possible for a couple to adopt valid and feasible management of diabetes voluntarily can be discussed on the basis of the nursing intervention model designed by Nagato et al. as a means of encouraging agreement in the intentions of family members[21]. The intervention model indicates the possibility that agreement between family members can be facilitated by support and by retaining the family's power in making decisions. This model supports the significance of our care model as a means of stimulating voluntary action. Furthermore, although the nursing intervention model demonstrates the skills required to encourage agreement among family members, our care model is presented as a process of care. That is, our care model makes it possible for nurses to judge what care should be employed at what point.

The care model we developed is additionally capable of assessing the feelings of the person with diabetes as well as those of his/her spouse for utilization in daily care and of alleviating tense circumstances by means of humor once the couple has found a direction for future activities. On employing this model, the nurses refrain from referring to the couple interview once it has been completed. If the goal of nursing care is to guide the family to reach an agreement, it can be achieved by providing care that encourages the family members to take steady steps towards a decision. On the other hand, our care model guides marital couples towards identifying a direction for their future activities on the basis of awareness in their failure as a couple to assess the meaning of their experiences during daily life or misunderstandings of such experiences.

2. Significance and efficacy of care designed to stimulate mutual sympathy in marital couples within the framework of diabetes education

The care model we developed can be characterized by the fact that it is designed to incorporate both the person with diabetes and his/her spouse and that it allows nurses to assist the couple in recognizing the importance of mutual sympathy.

Schafer and Keith[22] demonstrated that the way marriage partners perceive their spouses feelings about them might determine how couples approach and perform their marital roles, interact with each other, and evaluate their marital relationship. However, once a health problem develops in one partner, it can affect the way in which the partner plays his/her role, acting not only on the role expectations of the sick partner but also on recognition of role performance of the healthy member[23]. For this reason, a couple consisting of one partner with diabetes is thought to deviate from their expected roles, leading to unfavorable evaluation of each others behavior towards one another, and thus, negative interactions.

Guiding the couple to become aware of such problems through stimulation of mutual sympathy will help the couple adapt to the presence of diabetes, helping them become more mentally active in coping with the disease in their daily lives. However, even when spontaneous responses are seen in the couple, knowledge on how to judge what acts should be taken is necessary. It is therefore essential that nurses specializing in diabetes education and care, who have expertise knowledge about living with diabetes, present their knowledge and skills while taking care not to suppress the voluntary activity of the couple. The marital role theory[24] emphasizes the need for couples to have and utilize adequate role performance mastery and the individual's and couple's capacity to adapt to marital adjustment. It is therefore necessary to provide adequate education so that the person with diabetes also acquires the capability to create a favorable relationship with his/her spouse and for the spouse to become able to create such a relationship in addition to providing support. Rather than following the existing concept of nursing for couples or families whereby support is provided to help the patients and their family members deal with a given problem, it is more important for nurses to help the couple set their own goal and devise a plan to help deal with any issues. This is an essential point of the care model developed in this study, stimulating the couple to unite in dealing with diabetes.

Care designed to unite a marital couple with diabetes can induce self-organization. However, the stimulation produced needs to be large enough that it can guide the couple to become aware of the importance of mutual sympathy and responding to each others expectations. It was our aim that the couples who underwent couple interviews during the present study perceived the model as having stimulated mutual sympathy. The point of time when mutual sympathy was stimulated most with this type of care was when the thoughts of each partner were exposed by the nurse. By checking the couple's responses and evaluating the true feelings of each partner, the nurse is able to help the couple open up to one another. This indicates that the marital couples were perhaps previously quite unconscious of the necessity of changing their roles following the onset of diabetes in one partner. It seems very important therefore for couples to become aware of the importance of mutual sympathy. These points endorse the validity of our model for couples unable to understand the meaning of their roles during daily life with diabetes.

Issues for the future

The present study was aimed at developing a care model designed to stimulate mutual sympathy in couples with one diabetic partner on the basis of nursing practices at a university hospital in Japan. The study attempted to achieve the above goal by means of various research techniques, including phenomenological qualitative approaches, theoretical analyses and focus group interview. As a result, a care model enabling marital couples with diabetes to receive enhanced care in a new approach to diabetes education was developed.

In diabetes education, care for both the partner with diabetes and non-diabetic partner is rare. No research method for developing qualitative care models for use in such education has yet been established. Although there are many open questions, the procedures followed in the present study towards the goal of developing a care model for marital couples with diabetes have the potential of progressing into methodology useful in developing skills of qualitative care.

As far as the applicability of this care model is concerned, the scope of application is still limited because the data used in the present study were obtained from only a small number of nurses. Expansion of its application by accumulating data from additional cases, developing methods for assessment of the maturity level of nurses required to practice this type of care, and devising measures to spread this care is therefore necessary. In any event, we believe the care model developed in the present study will contribute greatly to advancing nursing care for people living with diabetes.

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糖尿病教育における糖尿病をもつ人とその配偶者の糖尿病をもつ夫婦としての力を発揮させるケアモデル

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要　　旨

本研究は、糖尿病教育において患者とその配偶者に思いやりが揺さぶられた経験をもたらすケアモデルの開発を目的とした研究である。糖尿病教育看護師11名と片方のパートナーが糖尿病をもつ夫婦27組の参加協力を得て、現象学的立場での質的アプローチ、理論的考察、およびフォーカスグループインタビューの研究手法を活用した。開発途上で、思いやりを揺さぶるケアは糖尿病をもつ夫婦としての力を発揮させるケアであることが見出された。したがって、開発されたケアモデルを“糖尿病教育における糖尿病をもつ人とその配偶者の糖尿病をもつ夫婦としての力を発揮させるケアモデル”と命名した。このケアモデルは、糖尿病患者とその配偶者が同席し6つの場面が展開する夫婦面接を幹に、夫婦面接を実施する看護師に持ち合わせることが求められる知識や技術、夫婦面接の展開に必要な8つの看護ケア、夫婦面接で発揮される2つの糖尿病をもつ夫婦としての力、および夫婦面接において夫婦がもたらす現象で構成された。糖尿病をもつ夫婦としての力を発揮させるケアとは、糖尿病をもちながらの生活における夫婦の心根を見極め、夫婦に思いやりのすれ違いが生じていることへの気づきと効果的な療養行為の自発的な採択を援助することであった。このケアモデルが開発されたことにより、既婚の糖尿病患者への糖尿病教育を企てる看護師に新たな手がかりを与え、片方のパートナーが糖尿病をもつ夫婦への支援を可能とすることが示唆された。