**Over / Under Rated**

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**Over rated: Self-Management**

Our healthcare system is struggling ‘‘*to cope with the demands of acute care, let alone the needs of those with long term health conditions,*’’ (Barlow, Wright, Sheasby et al., 2002. As this struggle has intensified, the phrase self-management has proliferated, particularly in relation to people living with chronic conditions. Sadler and colleagues (2017) define self-management thus:

*“a process in which individuals acquire skills strategies and knowledge to manage the physical, psychological, emotional and social effects of a chronic condition” (Sadler et al., 2017: p1).*

In other words, the idea underpinning self-management is that people who are living with chronic (and sometimes multiple chronic) conditions can be helped to learn to manage their condition(s). If self-management works, it is an empowering idea; it could have a positive impact on people’s quality of life. But it has not yet, in my opinion, been successfully translated from idea to practice. As such, the principle of self-management, is currently over-rated.

If we take the example of chronic pain (an area in which I used to practise as a Health Psychologist), people with chronic pain might be lucky enough to be referred to a pain management programme. High quality pain management programmes are multidisciplinary in nature (the British Pain Society (2013) has published a booklet outlining guidelines for pain management programmes for adults). Typically, participants will have their medication reviewed, receive physiotherapy, occupational therapy and psychological input. They will be taught a variety of coping skills as well as exercises that they can undertake by themselves. Follow-up appointments are made and then participants will be deemed to be on a self-managing pathway and are likely to be discharged from the service.

This all sounds pretty marvellous, and indeed work I have conducted with people who have completed pain management programmes shows that initially, they gain a lot of confidence and benefit from the programmes (e.g. Rodham et al., 2012; 2013). But actually implementing the skills outside of the pain management programme is much harder, and I know from my practice, that patients can very quickly feel as though they have been abandoned, once discharged.

So, the idea of self-management is great. But, and there is a ‘but’, Redman (2011) suggests that there is *‘‘little or no prospect of achieving the intended outcome’’* because many patients whose chronic diseases could be managed by patient self-management are not prepared for, or supported, to take on this role. Indeed, as mentioned at the start of this article, our health system is not set up to provide ongoing care for people living with chronic conditions; Palacios and colleagues (2017: p2) report that “*Coronary Heart Disease patients may only have one scheduled appointment with their family physician or practice nurse each year*”. In other words, professional support for self-management is limited. This to my mind is a false economy.

Think back to when you were learning to ride a bike. I still remember my first proper solo cycle. For quite some time, I had been happily cycling with stabilisers attached to my bicycle’s back wheels. Then Dad decided that it was time to take off the stabilisers. That day, after school, the stabilisers were removed and I cycled (wobbling a lot) while Dad walked behind me holding on to the back of my bicycle seat. Gradually my confidence grew, helped by the knowledge he was close by. Then, he let go without telling me. I was fine until I turned around and saw him standing some distance away. Realising he was no longer right behind me, I had a huge wobble and fell off. He helped me back on and walked behind me again. This time he told me when he was going to let go. I wobbled a bit and probably fell off, and I expect we went through this process a few more times. Then came the time I could cycle without him holding on (but I still needed him to watch over me). Eventually I felt confident enough to cycle without him.

In my mind, the same principle applies when we want to help someone learn to manage their chronic condition. I found that drawing from the ‘Life Thread’ model in my practice offered patients an excellent visual representation of what happens when you are living with a life changing condition (see Ellis-Hill, Payne & Ward, 2008, for further information about this model - developed for people with stroke, but easily applicable to any life changing condition). When the condition ‘arrives’, the life thread (our narrative about our life) is cut. Some threads stay connected, but most are severed and fraying. Some of the remaining threads will need cauterising, whilst it may be possible to tie others back together. It takes time to work out what is possible, what is necessary and what may never happen. It is hard to accept that life as you used to know it has changed, and probably changed forever. Indeed, reconnecting threads in order to be in a position to self-manage is not easy. The following quote from a physiotherapist highlights the importance of working with the patient:

*“In the beginning people are just really low in confidence, they’re like shell shocked. They don’t know what to do, and when we set goals with patients, they often say ‘Oh well, you’re the professional, you tell me what to do’. So they are not ready to self-manage or to take responsibility themselves yet…They very much look at the healthcare professional to guide them.” (Sadler et al., 2017, p6).*

In the same way that I needed reassurance and support when I was learning to ride solo, so too do patients, as they learn to cope with the demands of their chronic condition. It may not be obvious to them how to apply the skills they have been taught, or they may lack confidence or knowledge to apply the skills appropriately. After all, successful self-management necessitates the development of a range of skills including knowledge of the condition and its treatment, maintenance of adequate psychological functioning and the confidence and ability to implement lifestyle changes required when living with a chronic condition (e.g. Clark, Becker, Janz et al., 1991; Redman, 2011). More often than not, this process takes longer than the set number of appointments that the system allows us to offer.

A further part of the problem is that the term ‘self-management’ focuses attention on the individual. It fails to recognise that how we behave, cope and react is intertwined with an array of contextual factors, not least our social network (including friends, family and trusted health professionals). The success (or otherwise) of this ‘intertwining’ is instrumental in our ability to self-manage. Indeed, Dwarswaard and colleagues (2015: p202) argue (my emphasis) that “*in order to self-manage, patients need support from different sources, each with its unique contribution. Health care professionals, relatives and fellow patients all fulfil their own distinctive role*”. The authors go on to state even more starkly: *“People with chronic conditions are not capable of self-management on their own. Significant others are needed to live a good life with a chronic condition”*. Furthermore, Sadler and colleagues argue that for people living with chronic conditions to practice self-management, the development of collaborative partnerships with health professionals is of paramount importance. And this last point leads me to the second part of this article. The issue I consider to be at risk of being under-rated is face-to-face therapeutic interaction.

**Underrated: Face-to-Face therapeutic interaction**

Boulos and colleagues (2014) note that the mobile revolution offers an unprecedented opportunity to provide medical support when and where people need it. They highlight a 2012 estimate suggesting that the number of health-related apps had already reached 40,000 (Pelletier, 2012, quoted by Boulos et al., 2014). These range from basic text message reminders to more sophisticated apps that coordinate the management of a chronic condition. Indeed, as technology capability has grown, it is not surprising that “*interest in Internet delivered interventions for patients with long term conditions is increasing”* (Palacios and colleagues, 2017: p2)*.* In an important paper reflecting on the future of psychological therapies for chronic pain, Eccleston and Crombez (2017, p 4 of 7, my emphasis) suggest that:

*“A frontier of therapy is to embrace the possibilities of technology, not only in augmenting, supporting or replacing the remote delivery of traditional face-to-face treatment, but for novel therapy content.* ***Technology can do what therapists cannot, and can do many things better*.***Technology can accompany the patients, measure multiple aspects of experience, render data into accurate information instantaneously, give immediate access to knowledge, send and receive messages in near real time, and allow discourse anytime and almost anywhere.”*

Of course, technology is useful in the ways outlined in the quote above. For example, wristbands can monitor walking or number of hours slept and this data can provide health professionals with useful information about how their patients’ function in their ‘real lives’. Indeed, to borrow a phrase from Rich and Miah (2017: p 86) technology allows us to *“quantify and know thy post human self”*; the underlying idea being that the more data we have about our bodies (or our patients’ bodies), the more likely we are to be in a position to make informed decisions about health and health behaviour(s).

Ignoring for now the ‘intention-behaviour’ gap (which is well documented in the Health Psychology literature), there is no doubt that collecting extra information can provide greater insights. However, my concern is that we will be strongly encouraged to incorporate digital technology into our psychology practice, or worse, replace our practice with non-face-to-face digital therapy. Why this fear? Not least because of the “*prevailing solution and instrumental approaches to the application of digital technologies to medicine and public health*” (Lupton, 2014: 706), but also, because the rising appeal of digital technology is rationalised against increasing costs, worsening outcomes (e.g. Rich and Miah, 2017) and anticipated shortages of health professionals (Swan, 2012).

And yes, I know that I could well be accused of worrying about something that hasn’t yet happened (catastrophising: psychologist heal thyself!) and of exhibiting luddite tendencies, but I would argue I am not a luddite because I am *not* ‘engaged in seeking to obstruct progress’ (Concise Oxford Dictionary, 1982), rather I want to ensure that we retain an important part of the therapeutic relationship – the human ability to develop a relationship that facilitates collaborative working. If we were to turn Eccleston and Crombez’s quote around we can see that there is a dualistic paradox in that the opposite can be true at the same time: ***technology cannot do what therapists can***. In short, technology cannot hold a hand, empathise, offer humanity, react to the patient humanely and work with them to foster a relationship that will best help them to move forward. It is the human connection, in my opinion, which should not be underrated.

Lambert and Barley (2001) note that factors such as empathy, warmth, and the therapeutic relationship correlate highly with client outcome. Indeed, removal of the opportunity for social interaction in therapy could be detrimental and increase isolation. This potential negative outcome was recognised by adolescent girls taking part in a focus group study exploring health and fitness apps:

*“They simultaneously critiqued the individual nature of apps for isolating individuals and removing the holistic characteristics of healthy lifestyles they valued; being active in a fun environment, socialising and competing with friends” (Depper and Howe, 2017: p109).*

In other words, the participants felt that health and fitness apps could isolate adolescents and could be detrimental to their long-term engagement in physical activity. If this is the case for apps aimed at increasing physical activity, what might be the impact for those using apps to help them cope with pain, or to reduce their social anxiety for example? Indeed, my experience of working with people living with a chronic pain condition was that in addition to benefitting from meeting other people living with a similar condition (which they found profoundly helpful), they rarely came to the service with one neat issue. My job was to help them unpick the barriers and identify facilitators, to help raise their awareness of the connectedness of their thoughts, actions and behaviours, and in so doing, to help them develop the skills to cope.

In order to work collaboratively and in a patient-centred manner, we need to communicate effectively with our patients. Picking up on, and responding to, the nuances in face-to-face communication is not easy, how would this work in a non-face-to-face technological scenario? This is especially important when you consider that as humans we have an amazing capacity to say one thing whilst meaning another. This alternate meaning can be conveyed by tone of voice and non-verbal behaviour. Bernard Moss (2017) in his book on communication skills highlights this in the following exercise:

“*See how many different tones of voice you can use in saying the words ‘Can I help you?’ You will quickly discover that some tones of voice can contradict the very words you are using, just as a very defensive body posture can have the same effect*.” (Moss, 2017, p6).

He calls non-verbal behaviour the ‘music behind the words’ and argues that it is the music which conveys the real meaning of what is being communicated. ‘*If the listener takes the words simply at face value, the real meaning could be ignored*.’ (Moss, 2017, p6). Online technology removes the human connection, the ability to ‘read’ the patient and potentially silences the music behind the words.

The dualist paradox I mentioned earlier is, I think important. There are things that technology can do, faster and better than humans, but there are also things humans can do better than technology. I am not arguing that we should instigate a blanket-ban on technology, I think that a combination is appropriate. But I do want to suggest that we run the risk of undervaluing the (sometimes intangible) benefits that face-to-face therapy can bring. We also need to be mindful that as Michie and colleagues (2017: p1) note: *“we are still mainly in the age of promise rather than delivery”* where digital technology is concerned.

**Concluding Thought:** To finish, although it was not my intention when I started to write this piece, the two concepts that I have discussed are closely linked. Both refer to our need to ensure we remember to include ‘humaneness’ in our psychology practice as we find the best way to prepare our patients to sally forth confident in their ability to face *and* cope with their current and future problems.

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