RELIGION, FAITH AND THE EMPOWERMENT PROCESS: STORIES OF IRANIAN PEOPLE WITH DIABETES

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Empowerment concerning people with diabetes is well researched. However, few researchers specifically focus on the barriers to and facilitators of empowerment in Iranian people with diabetes. Understanding the factors could help health professionals facilitate self-empowerment more effectively. This study aims to determine the barriers to and facilitators of empowerment in Iranian people with diabetes. A qualitative exploratory study was conducted using in-depth interviews to collect the data from 11 women and men in 2007. Themes were identified using constant comparative analysis method. Common barriers to empowerment were similar to other chronic diseases: prolonged stress, negative view about diabetes, ineffective health-care systems, poverty and illiteracy. Diabetes education, fear of diabetes' complications, self-efficacy and hope for a better future emerged as being crucial to empowerment. Facilitators specific to Iranians were: the power of religion and faith, the concept of the doctor as holy man, accepting diabetes as God’s will, caring for the body because it was God’s gift and support from families especially daughters. Empowerment was strongly influenced by cultural and religious beliefs in Iran and the power of faith emerged as an important facilitator of diabetes empowerment. The findings will help health professionals understand how Iranian people with diabetes view life and the factors that facilitate empowerment.

Key words: empowerment process, faith, religion.

INTRODUCTION

Diabetes is a chronic condition and a global health problem\(^1\) with an estimated global prevalence of ~230 million people\(^2\) and the prevalence is increasing at an alarming rate\(^3\) especially in developing countries.\(^4\) Moreover, Azizi
reported an Iranian diabetes prevalence of 3.5 million adults with diabetes in Iran, which is estimated to rise to ~5.1 million by 2025.

Diabetes is a lifelong condition and due to the chronic complications, which occur if blood glucose is constantly elevated. It has a significant impact on the person’s quality of life as well as that of the family resulting in an exorbitant cost burden to the person with diabetes and society. Meetoo and Gopaul suggested that, although living with diabetes affects all aspects of a person’s life, it is possible for the person to lead a normal life. For this to occur, the individual needs to understand they have diabetes, make important choices about their health management and adopt a healthy lifestyle to control their disease based on their culture and life situation. Thus, they need to develop a range of competencies that will enable them to take greater control over their condition: that is, to become empowered.

Empowerment is becoming increasingly important in diabetes care and is frequently discussed in the chronic disease literature. Empowerment originated from the Latin verb for power, potere, which means ‘to be able’. Its prefix ‘em’ means ‘cause to be or provide with’. Empowerment is a positive and dynamic phenomenon that focuses on people’s strengths, rights and capabilities.

Rappaport defined empowerment as a process by which people gain mastery over their affairs. Most studies show empowered people with diabetes have a better quality of life and fewer complications. Despite general agreement about the benefits of patient empowerment, many Iranian people with diabetes do not achieve metabolic control, continue to suffer health problems and have low empowerment levels similar to other countries.

The existing literature focuses on the role of health professionals in patient empowerment, especially the role of nurses. However, there appear to be many barriers to and little information about how nurses can enhance patient self-empowerment, particularly in Iran.

Information is needed about which specific barriers present the greatest obstacle to people with diabetes achieving empowerment so that practical and cost-effective empowerment strategies can be developed. Therefore, nurses need to know how to help patients become empowered by recognizing their needs, preferences and abilities and understanding their relationships, social contexts and world views. Wahlin et al. suggested the people involved must describe the strategies most likely to achieve empowerment; currently, there is little literature about how Iranian people with diabetes become empowered.

**Aims**

The purpose of the current study was to determine the barriers to and facilitators of empowerment in Iranian people with diabetes.

**METHODS**

A qualitative exploratory study was conducted between February and July 2007. The advantage of using a qualitative approach was that it enabled people’s real life context and world views to emerge and encouraged participants to freely describe their feelings, experiences and actions. In addition, it enabled the researchers to gather in-depth information about and insight into the barriers to and facilitators of empowerment in Iranian people with diabetes.

**Participants and data collection**

A sample of participants with diabetes who were willing to share their experiences was selected purposively from hospitals, diabetes associations, rural health centres in Iran (n = 11). The participants were four men and seven women from different urban and rural regions of Iran, age range 21–73 years, and a range of education levels. Duration of diabetes ranged between 1 and 30 years and most had not received any formal diabetes education. One was single and the reminders were cohabiting.

The data were derived from in-depth unstructured interviews. Unstructured interviews were used because the questions can be changed or adapted to accommodate questions about the interviewee’s responses. Thus, the interviews proceeded in a friendly, non-threatening conversational manner. The initial interview question was ‘tell me your story about living with diabetes’. It was broadly focused to put participants at ease and encourage them to speak freely about their personal experiences of living with diabetes. Each interview lasted between 15 and 150 min. Participants were interviewed more than once depending on the need to clarify or verify data. The interviews were audio-taped and transcribed verbatim before data analysis was undertaken. Field notes were recorded to capture non-verbal information and note the researcher’s reflective processes.
Ethical considerations

Approval to conduct the study was granted by the Ethics committee of Shahid Beheshti University of Medical Sciences in Iran. Potential participants were informed that participation in the study was voluntary and they could withdraw at any time, all information would be handled confidentially and that no specific individual would be identified in any publications arising from the study. After participants gave permission to tape record the interview they choose a time and place for the interview.

Data analysis

Data were analysed using content comparative method. The analysis was carried out manually and simultaneously with data collection. The constant comparison method of data analysis was accomplished by constantly comparing new information from each successive interview with information from preceding interviews. All audio-tapes were transcribed verbatim immediately after each interview. Each transcript was read three times to enable the researcher to become familiar with the data (immersion). The transcript was then re-examined and read line-by-line by the first researcher to identify key codes. Coding is the process by which the researcher identified and named concepts. This involved breaking down and conceptualizing data and started as soon as the researcher has collected the first group of data. It included in vivo coding when the researcher examined the phrases that the participants themselves and researcher coding when the researcher used her interpretations. The researcher generated a great number of codes in the first stage of analysis and then was collapsed, reduced and grouped into categories (categorizing). The researcher noted memos (memo-writing), which helped her think deeply about emerging issues and examine the data and codes in a new way. When all the data had been coded and the categories condensed, each category was assessed and compared to determine whether it was saturated. Saturation occurred when the information received from participants about barriers to and facilitators of empowerment became repetitive and no new code or categories emerged.

Rigour

The researchers used reflexivity to minimize the effect of their interpretation of data on the emerging themes by making their assumptions and frameworks explicit. Rigour was also enhanced by the participants and coresearchers re-examining the transcript and having other researchers independently analyse the data and then compare the themes with those the researcher identified. This process was continued until most of the transcript had been absorbed. The researchers discussed similarities and differences in their coding and compared categories to agree on a preliminary category list. The first researcher reread the transcripts independently to identify data that supported or rejected the preliminary categories. Another round of discussion and comparison resulted in an amended version of the category list. The researchers continued the iterative process of categorization until consensus was reached.

RESULTS

The principal categories indicate some barriers to empowerment are similar to those encountered by people in other countries and those with other chronic diseases. These include prolonged stress, having a negative view about diabetes, ineffective health-care systems, and poverty and illiteracy. Social support, diabetes education, fear of diabetes and its complications, self-efficacy and hope for a better future were emerged as important facilitators of empowerment.

Other factors that appear to be specific to Iran also emerged: some were both facilitators of and barriers to empowerment. These factors were the power of religion and faith, regarding doctors as holy men, believing diabetes was God’s plan for them (God’s will), and that their body was a gift from God, which needed to be respected and cared for. The importance of peer and family support, particularly from daughters, also emerged.

Barriers of empowerment

Prolonged stress

Stress was one of the most important barriers to empowerment in Iranian people with diabetes as it is in other cultures. Almost all the nine participants indicated life and diabetes-related stress and grief made it difficult to cope with diabetes and in time inhibited empowerment. A female 40 aged said:

Stress causes diabetes and increasing blood sugar. When you are happy and relax and enjoy of your life, there isn’t any disease. Disease comes with stress and grief.

In addition, stress inhibited people from accepting they had the disease and taking responsibility and moving forward. A 45-year-old man indicated:
Asphalt can burn a carpet, stress can burn your body like acid. The effect of stress on blood glucose is very negative. If you eat tablets or inject insulin two times in a day, but you have stress, your blood glucose will arise and it seems you don’t do anything.

Fluctuations in blood glucose levels, especially hypoglycaemia, were a significant stressor. Participants who experienced blood hypoglycaemia described it ‘terrible’. In addition, they often needed help to manage their hypoglycaemia, which could be disempowering. A 41-year-old woman stated:

When my blood sugar goes low, I feel like death. I don’t understand anything and need to others’ support.

In addition, chronic complications such as chronic renal failure or limb amputation also caused stress and led to hopelessness, which caused participants to abandon their self-care.

A 73-year-old man said:

Before suffering chronic renal failure, I followed the diabetic diet. However, when I knew I lost my kidneys, I broke the talisman. After that, I eat every thing.

This man’s comment shows that despite complying with doctor’s recommendations (talisman) complications still occur and have disempowering physical and mental consequences including engendering negative connotations of diabetes and abandoning self-care.

Negative view about the illness

One of the strongest barriers to empowerment was people’s negative perception of diabetes. Almost all the participants (nine) had a negative view about diabetes that prevented them from appropriately managing their disease, made them feel their life was out of control and reduced their quality of life. As a consequence, they were more likely to ‘give up’. A 50-year-old woman said:

I’m going to die, sooner or later. Every morning I tell my self why do I sweep? Why do I cook? I’m going to die because I’m a diabetic.

Most participants viewed diabetes as a chronic, devastating disease that represented a bodily defect that was worse than cancer, which people often believe is a death sentence.

A 21-year-old woman said:

Diabetes is worse than cancer. It is a handicap for people that have this problem and this ruins their life. I’m just that person. I tell myself, the illness is a negative point for me.

Beside stress and negative view about diabetes, the healthcare system did not meet participants’ needs, which was another barrier to self-empowerment.

Ineffective health-care systems

Five participants expected their health professionals to provide positive encouragement and timely and relevant information about diabetes. However, most health professionals often struggled to spend time with people with diabetes. For example, nurses are generally engaged in providing clinical care rather than education and counselling. One participant stated:

When I was hospitalized, nurses didn’t teach me any thing. They only took my blood tests, inject insulin and said: eat your diet.

Although participants wanted support and education from nurses as well as clinical care they realized nurses and other staff were constrained by the health system. For example:

Their [nurses] time is very limited. A nurse must care for more patients, how she can educate us. She can only do her routine tasks and tell us follow the diet.

Lack of information about diabetes made it difficult for people to know how to manage their diabetes after they left hospital, engendered stress and was disempowering. In addition to these patient and health professional factors, societal factors such as poverty and literacy emerged as important barriers to self-empowerment.

Poverty and illiteracy

Similar to other studies, our study showed poverty and illiteracy is important barriers to empowerment and was closely linked to negative views about diabetes, stress and dependence. Even when people were informed about appropriate self-care the cost of managing diabetes was a burden. A woman aged 41 years said:
Doctor tells me about diabetic diet, eating fish and chicken. Nevertheless, I must pay too much for 1 kilogram of fish. Therefore I can’t follow my diet.

In addition, illiteracy was common in rural areas of Iran, which six participants found disempowering. A 57-year-old woman said:

I am not able to inject insulin, because I’m illiterate and don’t know how much insulin I must draw.

Further, participants stated that empowerment is impossible without the government’s cooperation. They indicated the government should provide enough suitable health-care facilities, reduce diabetes-related costs, develop diabetes consumer associations and use the multimedia to provide information about diabetes. Significantly, they felt the government could help alleviate poverty and improve literacy. One woman said:

The supportive role of government is very important. Government can develop diabetes associations in all cities and reduce the costs and improve literacy.

The study also showed that beliefs about the role of doctors and God as important factors to overcoming barriers to empowerment.

Facilitators of empowerment

Doctor as ‘holy man’

Most participants (nine) had a strong positive view about their doctors and doctors in general. They expressed absolute faith in their doctors describing them as holy persons (Imam). A 73-year-old man said:

The doctor was my Imam. I consult him for every thing. I’ve faith that he is a good doctor, I believe in him.

Imams are responsible for providing spiritual guidance in the Islam religion, thus participants believed doctors were expert health guides who offered advice and information that helped them manage their diabetes, for example:

I believe in my doctor and his decisions. He knows and guides me to live with diabetes. His decisions always are right.

Participants felt empowered, despite relying on their doctors and not actively participating in management decisions. One woman said:

I believe that my doctor is expert. I rely on his hands. Doctor tells me Do and I only respond yes, I sure it is the best. I follow his prescription; it caused my blood sugar going to low.

In addition to providing support and hope, doctors engendered a positive outlook, which helped participants maintain hope, which was empowering. For example:

Doctors are very important. My doctor tells me we can control diabetes. She gives me hope and positive energy.

Participant’s religious beliefs, in particular God’s will (Inshallah), were closely aligned to the concept of the doctor as Imam. Participants regarded their religion as empowering.

Diabetes as ‘God’s will’

Significantly, religious beliefs strengthened participants to endure diabetes. They regarded the fact they developed diabetes as God’s will and accepted it because they had faith in God and their lives were in God’s hands. Their faith was a form of fatalism that gave them the inner strength to accept with their diabetes. One woman aged 42 years said:

I believe in my destiny, maybe all things are divine tests. Yes, it is a divine examination and God predestinated it for me. I accept his decision.

Once participants accepted they had diabetes and realized they could not change God’s plan for them they began to take care of their bodies, which they regarded as a gift from God. Associated with the gift was the responsibility to look after their bodies. One man said:

God gives me nice eyes, nice ears and nice body. My body is his gift and diabetes is his will. Therefore, I am responsible to take care of myself as God’s gift.

Likewise, a woman aged 42 years said:

I have to accept diabetes as a fact. It is part of my life. I didn’t choose it. It is God’s will and is there. I have to accept it and try to save my body.

In addition, most participants (eight) felt their relationship with God, which encompassed their spirituality, provided crucial support. A 73-year-old man said:

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I have lived with diabetes 30 years and believe only God supports me. My life is in his hands.

Although faith in God provided inner strength and support and empowered participants to take greater control over their lives, they indicated they could not achieve long-term success without visible support.

Social support
All participants described the importance of having supportive family networks and highlighted the importance of having at least one family member who provided constant and ongoing support. Daughters took on the supportive role for many participants and most daughters were willing to shoulder this responsibility. For example, a woman aged 40 years indicated:

My family is the most supportive source, especially my daughter who gives me attention.

In addition to having family support and support from God and their doctors, which gave them inner strength, participants indicated that networking with other people with diabetes helped them realize they were not alone, was a source of practical information about living with diabetes and extended their sense of power over the disease. A woman aged 21 years said:

Communicating with other people with diabetes is very important, because we can share our experiences and understand that we are not alone.

Diabetes education
All participants agreed they needed to have relevant information about their condition in order to effectively manage their diabetes and make informed decisions about their care. Participants indicated that diabetes education improved their knowledge and clarified their beliefs and attitudes about diabetes, which enhanced their self-care capacity. A 51-year-old woman said:

Education is very important. After participating in diabetes classes, I learned many things about diabetes. So, I care for myself.

Participants learned about diabetes complications from their peers as well as health professionals and were afraid they would develop complications and become dependent on other people. Thus, fear of diabetes and its complications was a strong self-care motivator for all participants. A 45-year-old man suggested:

I’m afraid of diabetes complications. If I don’t take care of myself, I will be dependent on my family and others. So, I have to take care of my self.

In order to overcome the fear, people needed to believe they had the requisite self-care skills to manage their diabetes and in their ability to use the skills and inner strength they derived from God. Thus, self-efficacy was an important component of empowerment.

Self-efficacy
One facilitator of empowerment was participants’ belief they could control their disease with God’s help. All participants indicated having confidence in their ability to manage their diabetes and prevent complications as shown by the following quote:

I am able to care for myself. I fight with diabetes for many years, now I’m as good as a doctor.

Thus, the ability to self-care and having diabetes for a long time meant participants developed a great deal of expertise in diabetes and reduced their feeling of being ‘a victim of diabetes’. Participants compared themselves with other people they believed were worse off, which enhanced their self-esteem, whereas their faith in God and their belief in their self-care strategies gave them hope. People with strong belief in their God and themselves were able to sustain hope in the future. A 37-year-old man said:

When I compared my self to other diabetic patients, I understand that I’m an empowered person. Because I’m living well with diabetes and I can control it.

Hope for a better future
Being able to sustain hope for a better future over a long period, as is necessary with diabetes, was important to diabetes outcomes and a key aspect of empowerment. Four participants spoke of their hope a cure for diabetes would be discovered or more effective treatment would be found. One 21-year-old woman said:

Finally [one day] scientists could find a cure for diabetes, especially type 1. I have hope for the future. I wish doctors find a new treatment for diabetes. I never lose my hope.
In addition to placing their hope in doctors finding a cure or better treatment, three participants hoped God would provide a miracle. They believed God could cure diabetes if he wanted to, because all things in the world, health and illness, are in his hands. One man said:

I hope in my God. I believe if he wants that I would be cured.
I always hope in God.

Significantly, participants were able to maintain hope despite the lack of a miraculous cure for diabetes.

Study limitations

The study was carried out in Iran. Thus, caution is needed in generalizing from the findings. Attributing greater strength to the findings will only be justified if/when they are confirmed in the larger study. The small sample size is a limitation too.

DISCUSSION

The study shows Iranian people with diabetes have some similar beliefs to people from other cultures and other chronic disease as well as beliefs specific to Iran that are influenced by its culture, religion, philosophy and art. Participants believed in and derived a great deal of strength from their faith in God. All participants were Muslims and believed God’s will would prevail because God predeter- mined events, including the diagnosis of diabetes.

The belief in predetermination according to God’s will in the Islamic religion could be regarded as a form of fatalism. However, participants’ religious belief gave them the inner strength to take responsibility for their diabetes. Iranian people with diabetes accepted God’s will that they have diabetes because they believed God has knowledge of all things because he is al-Qadir, the Omnipotent, and al-’Alim, the All-Knowing the Omni- scient one. Participants indicated their body was a divine gift from God; therefore, they had an obligation to look after their body by taking control of their daily life and any diseases they acquire. Belief in God’s will is evident in other cultures. For example, Dalal showed that patients in Indian hospitals consistently attributed their illness to karma and God’s will.

These cosmic beliefs influenced patients’ treatment-related decisions. However, there was no consistent association between patients’ illness beliefs and their psychological adjustment. Other researchers suggest religious beliefs give patients the strength to endure suf-fering. Understanding these concepts can assist health professionals in Iran and other countries to support Muslim people with diabetes and other chronic illness and facilitate the empowerment process more effectively for Muslim people.

In addition, the participants in the study indicated that people with diabetes need support from other people, which is consistent with other researchers who showed personal support was vital to achieving personal empowerment. In the study, family especially daughters were important sources of support. Strong support from daughters appears to be rooted in Iranian culture, because Iranian people believe their daughters are more kind and have more pity than sons do. Thus, people with diabetes usually lean on their daughters for support. Nurses and health professionals need to identify supportive family members and help them encourage people with diabetes as part of the empowerment process.

Peer support through groups like the Diabetes Associations of Iran was regarded as beneficial and was popular sources of information and support. Unfortunately, there are only 18 Diabetes Association centres to cater for > 3.5 million people in the main Iranian cities. Participants felt governments need to establish more Diabetes Associations or improve access to existing centres to help people achieve self-empowerment. Peer support also emerged as being important factor in patient empowerment in other studies.

In addition, health professional support, especially from doctors, and education about diabetes and its complica-
tions was very important to self-empowerment in the study and is consistent with the literature. The current study showed that Iranian health professionals especially nurses were unable to facilitate patient empowerment, because they provide routine clinical care rather than education and counselling and did not have enough time to listen and educate people with diabetes, and is consistent with the literature. Likewise, Etu-Seppala stated that the health professional support is partly or totally lacking in many developing and some areas of developed countries. For example, rural areas of Iran had fewer services and higher prevalence of illiteracy. It seems increasing the number of nurses, diabetes educators and education programmes to support self-empowerment and using a society-based approach in Iran could assist health professionals to support their patients.

A key finding of the study was the fact that Iranian people with diabetes depended on their doctors and this
finding emerged in other cultures such China. In fact, participants put their care in the hands of their doctors and depended on them for medical care and support, often regarding them as ‘holy men’. The participants commented that doctors were professional people and they preferred to comply with their management recommendation because they thought it best just trust the doctor’s decision as being the right one. However, other researchers suggest patients and their families should be the primary decision-makers and regard autonomous decision-making as key to empowerment. Participants in the study regarded themselves as being empowered even though they relied on their doctors and trusted in God’s will, which suggests empowerment is complex and multifaceted and might be strongly influenced by religious faith, cultural philosophy and individual spirituality.

Bulsara et al. found hope for a better future and belief in self-ability helped people with cancer move away from denial and disability towards empowerment. These findings also emerged in the study where hope for a cure for diabetes or more effective treatment in the future or miracle from God sustained hope in the future. In addition, the current study, like Rubin et al., found people with diabetes were fearful about the disease and its many complications, which was stressful. Rakel and Weiss indicated long-term stress led to ‘diabetes burn-out’. In the study, people took care of themselves out of respect for God as well as a strong dislike of disability and being dependent on other people.

It was apparent from the data that most participants had a pervasively negative view of diabetes but were able to maintain positive attitudes overall. Other researchers suggested negative emotions stem in part from the fact that patients are responsible for many facets of diabetes management. In the study, participants regarded diabetes as a gift from God and a talisman. The negative view could also be due to the bad reputation diabetes has in the general public. Health professionals need to help people with diabetes change this perspective and achieve self-empowerment. Furthermore, introducing empowered people with diabetes via diabetes associations and mass media programmes could be effective.

**Strategies for clinical practice**
The findings highlighted many barriers to self-empowerment in Iranian people, particularly around the role of nurses; the findings could assist nurses and other health professionals to be aware of the various factors that affect the empowerment process in people with diabetes and focus on them in patient assessments and care. The findings can be used to design an empowerment approach to care for Iranian people with diabetes, to provide nurses and other health professionals with a deeper understanding of life with diabetes and people’s sources of strength.

The findings suggest incorporating questions about people’s religious, spiritual and cultural beliefs when compiling patient histories will help nurses understand the individual’s world view and assist the individual to move forward in the empowerment process. Considering the perspectives of people with diabetes will enable nurses and other health professionals to interact with them in a meaningful way to plan care and facilitate growth and learning instead of compliance and passivity. The participants suggested nurses and other health professionals could provide them with support and diabetes education, which would help them become self-caring and empowered. They also highlighted the important role of health managers and planer and other health professionals in the empowerment process. Thus, the findings might contribute to improving nurse education programmes, especially programmes for diabetes educators, developing diabetes associations and diabetes clinics in Iran and the world.

**Conclusions**
The strong faith in God and religious beliefs such as diabetes being predetermined by God and the body being a gift from God played a major role in the empowerment process in Iranian people. People felt responsible for taking care of God’s gift and took steps to manage their diabetes such as asking their doctors and peers for information and acting on the advice.

In time they developed considerable expertise in managing their diabetes, which was empowering. Daughters were important sources of support and most people with diabetes relied on their daughters.

Religion, spirituality and culture play a significant role in the lives of the people with diabetes. Nurses in many settings interact with persons at various points in the empowerment trajectory. Understanding the barriers to and facilitators of empowerment can help nurses provide appropriate care and assist patients to become empowered.

Finally:

*The Moving Finger writes; and, having writ,*

*Moves on: nor all thy Piety nor Wit*
Shall lure it back to cancel half a Line,  
Nor all thy Tears were out a Word of it.\(^5\)

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