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Self-Management Decision Making of Cuban Americans With Type 2 Diabetes

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Abstract

Purpose: Although researchers have studied how individuals manage type 2 diabetes, none have examined how Cuban Americans do so. This article explores how Cuban Americans make self-management choices and examines whether an empowerment framework is viable for informing interventions. **Design:** A qualitative descriptive study was conducted (n = 20) with Cuban Americans with type 2 diabetes. Individual interviews were analyzed with content analysis. **Results:** Motivation and temporal factors, such as knowledge of symptoms and the ability to plan ahead, positively affect self-management. Cultural factors, such as access to cultural foods, negatively affect self-management. Empowerment formed a comprehensive lens through which self-management decisions were acted on. **Conclusion:** Given the cultural context, empowerment and unique barriers and facilitators can affect diabetes self-management in this population. Strategies to promote healthy decisions must take into account the strengths of this community as well as its challenges.

Keywords

diabetes, other methods/designs, type 2 diabetes, Cuban Americans

Introduction

Recent research has supported the idea that the most successful management of diabetes is a combination of lifestyle adjustments, regular monitoring of physiologic markers, such as A1C and body mass index, and medication administration in the context of competing priorities (Ward, Stetson, & Mokshagundam, 2015). To be successful, however, diabetes management strategies must also be tailored to specific populations; this is especially important for those with health disparities. Unfortunately, strategies for resolving disparities in diabetes care for some of the less studied Latino subgroups, Cuban Americans, in particular, remain unclear. Few studies have been conducted on specific disease processes in Cuban Americans and no culturally tailored diabetes intervention studies have been designed for and tested with Cuban Americans. To develop appropriate interventions, it is necessary to distinguish differences because of migration patterns, culture, gender, economics, and political realities of each Latino subgroup in order to establish more specific guidelines for diabetes care (Davila, McFall, & Cheng, 2009). To date, health care providers lack the information needed to develop effective culturally tailored interventions to aid Cuban Americans in their diabetes self-management.

Self-management in type 2 diabetes (T2DM) is complex and demanding and it can be lifestyle restrictive and expensive (Garber et al., 2013). Fundamentally different from simple health behaviors that are easy to adopt, such as the use of seat belts, diabetes self-management involves making healthy lifestyle choices, as well as self-monitoring blood glucose levels. Self-management is an important factor in achieving glycemic control (García, Brown, Horner, Zuñiga, & Arheart, 2015). Yet how a person views his or her health in the presence of diabetes may influence adherence to important self-management recommendations. It may be the case that self-management of T2DM can be fostered if viewed within a sociocultural context so that health-related decisions are culturally appropriate and made easier, thus improving glycemic control (Razee et al., 2010). The qualitative descriptive study reported here explored the decisions made by a sample of Cuban Americans diagnosed with T2DM regarding their day-to-day self-management behaviors, in order to uncover key practical information inherent in their "everyday" diabetes self-management decisions and examine whether an empowerment framework would be viable for informing self-management decisions.

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Empowerment Conceptual Framework

Like any self-management of chronic illness, the self-management of diabetes involves decision making. Paolo Freire's empowerment construct has been advanced as a useful framework for diabetes self-management (Wallerstein, Yen, & Syme, 2011). Freire's (1973) approach maintains people are to be subjects of their own learning and to be active participants in their understanding of the world through reflective decision making and political action. At the patient level, empowerment is described as the decision-making process in which patients take control of their disease management (Tang, Funnell, Brown, & Kurlander, 2010). With this approach, patients are able to decide their learning needs and identify challenges as well as strengths/barriers to developing and attaining their goals. The actual utility of the empowerment model for minority populations remains unclear, however, because the model assumes that (a) the patient is able and willing to take on the responsibility to become an equal partner in his or her health care and (b) health care providers want to shift from the traditional medical model and participate in a process in which patients are equal partners in the treatment of their disease (Hoffmann et al., 2014).

Method

Aim and Design

Because few studies have examined the self-management beliefs of Cuban Americans with T2DM, a qualitative descriptive method was especially appropriate for this study because it provides a useful first stage of investigation when the goal is to determine the views of a specific group (Sandelowski, 1998). Qualitative description as a method is not without philosophical or disciplinary background and is not atheoretical (Thorne, 2008). It can contain supporting or sensitizing frameworks from other philosophical disciplines such as grounded theory or phenomenology (Sandelowski, 2010). For this study, empowerment theory was used and served as the background in the analysis of self-management for Cuban Americans with T2DM because this approach attempted to maximize self-management knowledge, skills, and self-awareness though a reflective decision-making process (Paterson & Brewer, 2009). The following research questions guided the study: How do Cuban Americans with T2DM describe the day-to-day self-care decision making related to managing diet, activity, glucose monitoring, and medications? What influences the decisions Cuban Americans make regarding factors such as diet, activity, and so on? What amount of control and advice do Cuban Americans with T2DM want or expect?

Participants and Setting

This study used purposive sampling. Participants were invited to participate via a local Cuban American organization in Central Texas and also by personal invitations. Eligible participants were self-identified as Cuban Americans, 40 to 65 years of age, diagnosed with T2DM for at least 2 years to ensure they had ample diabetes self-management experience, able to speak and understand English, and immigrants to the United States within the past 30 years. The number of participants was not preset but determined by data saturation. The final sample consisted of 20 Cuban Americans with T2DM, all living in Central Texas, with interviews taking place in community settings chosen by the participants (homes, offices, etc.).

Data Collection

Following approval by the institutional review board, participants were sent a description of the study, a consent form, and a request for the participant to read a short scenario ("paradigm case") regarding decision making in diabetes self-management, which would be discussed during the interviews. This paradigm case was informed by Freire's literacy training method, in which participants are asked to describe a situation and then use that situation as a basis for reflection and learning (Freire & Macedo, 1987). Follow-up interviews were scheduled within 1 or 2 weeks of receipt of the paradigm case. Consent was obtained prior to conducting the interviews.

The open-ended semistructured interview, contained descriptive, probing, and opinion questions and was conducted by the first author (Kvale & Brinkman, 2009; Seidman, 2006). The researcher/author is a member of the Cuban American community and has had experience conducting qualitative interviews in minority populations. Before the study was conducted, the interview questions were pilot tested with two Cuban Americans with T2DM who lived in the Central Texas area. The first area of questioning included descriptions of self-management decisions, to determine any common elements. Participants were also asked to discuss the paradigm case and consider what other types of decisions they felt were important in T2DM self-management. This initial discussion enabled the use of terms that reflected the participants' own frames of reference during the rest of each interview as well as to use classifications that were meaningful to them. The second field of questions focused on the most prominent influences on self-management decisions. The third area of inquiry focused on aspects of empowerment/decision control that participants sought in their day-to-day management. The interviews averaged 1.5 hours each.

Data Analysis

The audiotaped interviews were transcribed verbatim by the principal investigator, and the transcripts were compared with the audiotapes for accuracy and then examined using content analysis. Interviews were coded by two independent reviewers and compared for consistency. Immersion in the

data were encouraged through the process of transcription and reading/coding of the data. The content analysis followed these steps: (a) the data were read repeatedly to obtain a sense of the whole; (b) the data were read word-for-word, highlighting text that appeared to capture key thoughts and concepts; (c) codes were derived from the key concepts; and (d) codes were categorized according to their relationships and linked and grouped into meaningful clusters (cross-case analysis; Miles & Huberman, 2013).

Results

The participants' mean age was 53 years (range: 45-65 years) and the average duration of their diabetes was 4.5 years (range: 2-8 years). Most were married (70%), all had at least a high school education, and all spoke English. All but one participant had health insurance, and 50% had attended a diabetes education class at some point since diagnosis. Their A1C levels were self-reported, $M = 7.49\%$ (10.4mmol/mol); $SD = 1.27$; range: 5.8% to 10.4% (7.2-16.6 mmol/mol), and their most common comorbidity was hyperlipidemia (80%), followed by hypertension (30%).

Empowerment/Decision Control

Empowerment/decision control infused all of the participants' conversations during the interviews. Control of diabetes was attributed to some degree to external influences as well as to personal factors such as responsibility and self-discipline. When participants used the term "control," they were asked to clarify whether they were referring to blood glucose control or personal control over day-to-day diabetes self-management decisions. Part of the discussions about control centered on the desire for an external locus, someone else who would "fix things" or take control of participants' diabetes management. One summarized it thus,

> There's really nothing I can do to control things. My decisions, sure, but there's so much else going on I feel like I'm totally out of control and I can't control my actions. Someone else needs to do all this stuff for me.

Many of the participants, however, felt that they had at least some degree of control over self-management decisions. There were things beyond their control such as an inflexible work schedule or family obligations, but almost all stated that they still had control over most situations involving their diabetes. Even if a desired self-management goal was not reached (e.g., 30 minutes of exercise), most felt that they controlled that decision (e.g., "I chose not to exercise").

Types of Diabetes Self-Management Decisions

Daily decisions regarding diet, exercise, glucose self-monitoring, and medications were prominently mentioned in the interviews. Participants' decisions involved how each of these self-management behaviors would affect glucose levels. Most participants were aware of what certain foods would do to their glucose levels, and some made decisions accordingly. For example, when Participant 10 was asked to clarify the answer she had given regarding the paradigm case, she said,

> Because I know *pastelitos* and they have sugar in the coating and the dough and when you put those two together it's disaster . . . it's a disaster for the inside of my body because it's not going to do anything good for my sugar.

Diet strategies were based not only on glucose levels, however, but on several factors: the amount of time that the strategy might take; perceptions of appropriate portion sizes; taste preferences, some of which were based on culture; and the desire to make allowances for treats. Exercise, monitoring, and medications were all thought to be important, but because of the cost and time required for each of these activities (e.g., glucose monitoring), some individuals had decided that one or more of these activities were not affordable or were too complex and inconvenient to practice regularly as recommended. Participant 14 said,

> No, I don't check my sugar. I already know it's going to be high and the strips are expensive . . . I checked my sugar in the beginning, when I first got diagnosed, but I don't check anymore. It's always the same. Bad. And I can't afford the pills to fix it.

Motivating Factors

Participants also spoke of the factors that led them to make what they felt were better self-management decisions, such as their symptoms, their experiences with complications, and their knowledge of the physiologic processes of diabetes. The desire to avoid diabetes-related symptoms and complications influenced many participants' self-management decisions. One man talked about the link between diabetes self-management and his symptoms or potential complications:

> I know what's happening to my body. I take that potato and I see it turning into sugar and ruining my eyes. I visualize what diabetes is doing to my body and I get why I need to do the things to be in control, to take responsibility for the decisions.

For most, these triggers to monitor glucose or watch dietary intake of sweets proved to be positive influences on self-management behavior.

Temporal Factors

The trajectory of decisions regarding self-management behaviors followed a common pathway for many participants: success bred success, and, with planning, decisions became easier over time. For example, a few pointed out that exercise made

them feel better and compelled them to do better in the future. As one informant said,

> You know when I cook a good meal and I know I've eaten well and I've enjoyed the food and my husband enjoys it then I want to do more things like that. And also there was a time maybe about three years ago. I mean I certainly wasn't obese, but I had more pounds than I needed . . . which was what started this whole thing, I think, um and so now when I look at the clothes I can wear and the way I feel. I think that's a huge thing.

Cultural Factors

Cultural factors influencing self-management decisions included food preferences and access as well as the perception of Hispanics in the participants' communities. A number of participants expressed a desire for more traditionally prepared Cuban foods, which were difficult to find at local grocery stores or restaurants. Participants were frustrated by this, stating that a lack of traditional, healthier options hampered their making better dietary decisions. The issue of all Hispanic subgroups being considered as the same arose frequently during appointments with health care providers. One man expressed his irritation at a dietician as follows:

> They always assume I'm Mexican. That's fine if you're Mexican. That's great, be proud. Don't assume that because my last name is Spanish, that I'm Mexican. I guess it's hard in Texas. It makes sense. I can't really fault them.

The participants residing in Central Texas, which is not a traditional enclave for Cuban Americans but still has a large Latino population, presented a strain. More than a few Cuban Americans mentioned that health care providers assumed that they were Mexican American or married to a Latino person rather than being a member of another Latino ethnic subgroup or Latino themselves. Thus, diabetes-related recommendations by health care providers did not take into account the cultural traditions and preferences of this specific Hispanic subgroup, which made the recommendations less likely to be followed.

Barriers

Consistently, cost, time, family obligations, and lack of practical advice were mentioned as the things likely to stand in the way of good self-management decisions. Most stated that they were too busy to find the requisite time to shop, cook, and exercise. Planning ahead and setting priorities played a big role in their discussions about time. As one woman said, "If I think ahead of time what am I going to do in this situation, then I have a plan ready and if I don't prioritize those things I'll, you know, give in."

But to prioritize daily self-management activities was also thought to be too expensive. Some participants mentioned that they would skip doses of pills or avoid checking their glucose levels at home because of cost. Others, however, did develop strategies to incorporate diabetes self-management despite the cost. For example, one man said,

> It's really different than someone who lives in [an affluent neighborhood] and has a cook and a trainer and a home gym, you know. I mean it's different and so I have to work with what I have.

Again, most participants thought that they were doing the best they could with the options that they had. For the most part, participants attributed the difficulty of their self-management decisions to frequently unavoidable poor food choices as well as the occasionally overwhelming complexity of diabetes self-management itself, and especially to the nutritional principles that it entails.

Discussion

Few descriptions of Latinos' diabetes self-management decision-making processes are to be found in the literature, particularly for Hispanic subgroups such as Cuban Americans. Studies of Latinos in general have shown that they may be less likely than non-Latino Whites to engage in self-management activities, but the interviews conducted with this sample of Cuban Americans illustrate their perceived importance of daily self-management activities. Most of these participants tried to make decisions that would foster glucose control. A review of diabetes self-management programs targeting Latinos identified important tasks and decisions similar to those considered important by the sample in our study (Millan-Ferro & Caballero, 2007). All participants in our study agreed that diet, exercise, glucose monitoring, and medication decisions were central to glycemic control.

Empowerment/Decision Control

Although not all of the findings of this study may align perfectly with Freire's ideas of empowerment and lack his emphasis on political action, the evidence presented here suggests that the aspects of reflective decision making and control in the empowerment framework might still be a useful guide for work with Cuban Americans with T2DM. The cultural context inherent in being a member of an ethnic minority group demonstrates that the group's barriers and facilitators to empowerment/decision control might be unique. Freire (1973) indicated that one's economic, political, and social environment is mirrored in one's experiences of learning. To ignore such contexts is to treat people as passive learners. Reflection and dialogue facilitating disclosure and engagement in problem solving in the medical visit are factors that foster the competence needed for individuals with diabetes to become proficient at self-management.

Motivating Factors

For many of the participants in the present study, self-management decisions were based on symptoms and the interpretation of their cause, on glucose meter results, and on other biomarkers such as A1C. Most of the participants wanted good glucose control, but it was not achieved entirely at the expense of other obligations and expectations. Multiple objectives in the participants' diabetes self-management evolved as they acquired knowledge through living with the condition over time. Diabetes self-management information was used to shape their perceptions of decision control.

Not all self-management decisions made by individuals with diabetes result in glucose control. In the present sample, the mean A1C was well above the recommended 6.5% goal set by the American Association of Clinical Endocrinologists (Handelsman et al., 2015). Of course, it is unrealistic to suggest that any single element of decision making could explain the disconnect between diabetes-related knowledge and acting on that knowledge. The participants' decisions in self-management came about as the result of an interplay between cognitive and affective elements (e.g., my glucose is 235 mg/dL, but I want to eat the donut). Diabetes education is often built on the assumption that if information is offered, if objectives are established, and if barriers are identified, people will change their behavior sufficiently to achieve the A1C goal. That assumption suggests a linear, rational process of decision making, and overlooks the affective component of empowerment/decision control in such decisions experienced by most people.

Temporal Factors

Conflicts between difficulties and the ease of decision making in diabetes self-management were obvious in this sample. Taste preferences, time pressures owing to the preparation of foods or exercising, family priorities, and stress caused by the perceived cost of "healthy living" were mentioned by the majority of the participants as factors that made following dietary and exercise recommendations some of the hardest activities to accomplish. On the other hand, in discussing the easiest decisions, participants voiced a feeling of change or progression in how they managed their diabetes. This is supported by the findings of Paterson and Thorne (2000) and the idea of "transformation" in diabetes. The present study's participants expressed it as a balancing act of diabetes decisions that became easier the more they saw what worked and what did not. Transformation was the process of realizing "who you could be" and taking steps to change practices and beliefs to become that person. For the Cuban Americans in this study, decisions regarding the self-management of their diabetes were initially difficult but evolved into a way for them to achieve better glucose control while maintaining relationships, preferences, and values.

Cultural Factors

Neither acculturation nor biculturalism was included in the interview questions in this study, but participants said during some of the interviews that living in two cultures influenced the availability of resources and the degree of support for diabetes self-management. Cuban Americans as a whole have been considered less acculturated than other Latino ethnic subgroups because the majority of Cuban Americans in the United States reside in Miami, a Cuban American enclave (Portes & Puhrmann, 2015). In such enclaves, immigrants' cultural heritage is preserved so that they can live without interacting with or acquiring the practices and/or values of their host society (Ebert & Ovink, 2014; Perez-Firmat, 2012). These enclaves provide a level of social support and other resources not found elsewhere (Gallo et al., 2015). Acculturation has not been examined in Cuban Americans who live outside traditional areas of settlement, as the present sample did, where the circumstances of living in an area with support from others with similar experiences (migration, Cuban American history, etc.) might be lacking.

Barriers

Socioeconomic status influences diabetes self-management decisions and the same was true for the participants in the present sample (Chang et al., 2015; Huffman, Vaccaro, Gundupalli, Zarini, & Dixon, 2012). In contrast to participants in most studies examining Latino diabetes self-management, this sample had relatively good access to health care (all except one had health insurance), and most were employed. Even so, the cost and time involved in successful self-management was mentioned frequently as a strong influence on decision making, which might lead one to believe, as several participants suggested, that their decisions were a matter of prioritization. There is no discussion of this in the literature as it relates to Cuban Americans with T2DM.

Limitations

The participants in this study were members of a select/specific group of Cuban Americans residing in one particular region and state within the United States. Given that this was a qualitative descriptive study, however, generalizability was not the goal. The sample of 20 men and women was sizable for a qualitative study, and the perspectives of a range of participants, including both genders, were captured. In addition, because participants were English-speaking Cuban Americans, the findings might not reflect the beliefs of Cuban Americans who speak Spanish only. Nevertheless, given that the goal of the project was to provide new insights into the issues under investigation, this design and its findings should enable development of future studies and interventions that meet the needs of this particular understudied population.

Implications for Practice

This study's findings suggest that much work remains to be done to understand the experiences of diabetes self-management decisions for Cuban Americans with T2DM. When caring for Cuban Americans with T2DM, as well as other minority groups including other Hispanic subgroups, one should consider their unique challenges in attempting to balance self-management practices with the responsibilities of everyday life. Strategies that facilitate the integration of glucose monitoring, exercise, diet, and medications need to be developed in a culturally sensitive manner. Strategies to promote healthy decisions must take into account the strengths of this community as well as its unique barriers and challenges. Health care providers need to be aware that persons with diabetes may want to play a more active role in their care and should be encouraged to discuss how decisions and recommendations made during the health care encounter might affect decisions made at home. Future studies on self-management, decision making, and empowerment/decision control for this population are needed.

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References

Chang, A., Kenya, S., Ilangovan, K., Li, H., Koru-Sengul, T., Alonzo, Y., & Carrasquillo, O. (2015). Is greater acculturation associated with increased prevalence of cardiovascular risk factors among Latinos in South Florida? *Medical Care*, *53*, 417-422. doi:10.1097/MLR.0000000000000337

Davila, M., McFall, S. L., & Cheng, D. (2009). Acculturation and depressive symptoms among pregnant and postpartum Latinas. *Maternal and Child Health Journal*, *13*, 318-325. doi:10.1007/s10995-008-0385-6

Ebert, K., & Ovink, S. M. (2014). Anti-immigrant ordinances and discrimination in new and established destinations. *American Behavioral Scientist*, *58*, 1784-1804. doi:10.1177/0002764214537267

Freire, P. (1973). *Education for critical consciousness*. New York, NY: Seabury Press.

Freire, P., & Macedo, D. (1987). *Literacy: Reading the word and the world*. South Hadley, MA: Bergin & Garvey.

Gallo, L. C., Fortmann, A. L., McCurley, J. L., Isasi, C. R., Penedo, F. J., Daviglus, M. L., . . . Carnethon, M. R. (2015). Associations of structural and functional social support with diabetes prevalence in U.S. Hispanics/Latinos: Results from the HCHS/SOL Sociocultural Ancillary Study. *Journal of Behavioral Medicine*, *38*, 160-170. doi:10.1007/s10865-014-9588-z

Garber, A. J., Abrahamson, M. J., Barzilay, J. I., Blonde, L., Bloomgarden, Z. T., Bush, M. A., . . . Davidson, M. H. (2013). AACE comprehensive diabetes management algorithm 2013. *Endocrine Practice*, *19*, 327-336.

García, A. A., Brown, S. A., Horner, S. D., Zuñiga, J., & Arheart, K. L. (2015). Home-based diabetes symptom self-management education for Mexican Americans with type 2 diabetes. *Health Education Research*, *30*, 484-496. doi:10.1093/her/cyv018

Handelsman, Y., Bloomgarden, Z. T., Grunberger, G., Umpierrez, G., Zimmerman, R. S, Bailey, T. S., . . . Zangeneh, F. (2015). American Association of Clinical Endocrinologists and American College of Endocrinology: Clinical practice guidelines for developing a diabetes mellitus comprehensive care plan-2015: Executive summary. *Endocrine Practice*, *21*, 1-87. doi:10.4158/EP15672.GL

Hoffmann, T. C., Légaré, F., Simmons, M. B., McNamara, K., McCaffery, K., Trevena, L. J., . . . Del Mar, C. B. (2014). Shared decision making: What do clinicians need to know and why should they bother? *Medical Journal of Australia*, *201*, 513-514.

Huffman, F. G., Vaccaro, J. A., Gundupalli, D., Zarini, G. G., & Dixon, Z. (2012). Acculturation and diabetes self-management of Cuban Americans: Is age a protective factor? *Ageing International*, *37*, 95-209. doi:10.1007/s12126-010-9102-z

Kvale, S., & Brinkman, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: Sage.

Miles, M. B., & Huberman, A. M. (2013). *Qualitative data analysis* (3rd ed.). Thousand Oaks, CA: Sage.

Millan-Ferro, A., & Caballero, A. (2007). Cultural approaches to diabetes self-management programs for the Latino community. *Current Diabetes Reports*, *7*, 391-397.

Paterson, B., & Brewer, J. (2009). Needs for social support among parents of adolescents with diabetes. *Journal of Nursing and Healthcare of Chronic Illness*, *1*, 177-185. doi:10.1111/j.1752-9824.2009.01019.x

Paterson, B., & Thorne, S. (2000). Developmental evolution of expertise in diabetes self-management. *Clinical Nursing Reasearch*, *9*, 402-419.

Perez-Firmat, G. (2012). *Life on the hypen: The Cuban-American way*. Austin: University of Texas Press.

Portes, A., & Puhrmann, A. (2015). A bifurcated enclave: The economic evolution of the Cuban and Cuban American population of metropolitan Miami. *Cuban Studies*, *43*, 40-63. doi:10.1353/cub.2015.0010

Razee, H., van der Ploeg, J., Blignault, I., Smith, B. J., Bauman, A. E., McLean, M., & Cheung, N. (2010). Beliefs, barriers, social support, and environmental influences related to diabetes risk

behaviors in women with gestational diabetes. *Health Promotion Journal of Australia*, *2*, 130-137.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*, 77-84. doi:10.1002/nur.20362

Sandelowski, M. (1998). Writing a good read: Strategies for representing qualitative data. *Research in Nursing & Health*, *21*, 375-382.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College Press.

Tang, T. S., Funnell, M. M., Brown, M. B., & Kurlander, J. E. (2010). Self-management support in "real-world" settings: An empowerment-based intervention. *Patient Education and Counseling*, *79*, 178-184. doi:10.1016/j.pec.2009.09.029

Thorne, S. (2008). *Interpretive description: Developing qualitative inquiry*. Walnut Creek, CA: Left Coast Press.

Wallerstein, N., Yen, I., & Syme, S. L. (2011). Integration of social epidemiology and community-engaged interventions to improve health equality. *American Journal of Public Health*, *101*, 822-830. doi:10.2105/AJPH.2008.140988

Ward, J. E. F., Stetson, B. A., & Mokshagundam, S. P. L. (2015). Patient perspectives on self-monitoring of blood glucose: Perceived recommendations, behaviors and barriers in a clinic sample of adults with type 2 diabetes. *Journal of Diabetes & Metabolic Disorders*, *14*, 43-47. doi:10.1186/s40200-015-0172-z