

# Solution-focused therapy for children with diabetes and their families

Coming into a solution-focused (SF) service from a problem-focused acute community mental health service has been a journey of empowerment, re-learning and doing more of what works. Working within an acute mental health service consisted of the professional supporting a patient in a self-defined crisis using a “biopsychosocial screening tool”. This tool acted as a “script” for the professional, inviting exploration of a patient’s historical and current problem(s) in depth, while also under time constraints.

Outcomes from using this screening tool were aimed at prescribing a “quick fix” for the patient’s crises. Each time a patient contacted the service, the screening tool would be completed, inviting rehearsal of the problem. The service followed a medical model of an “expert” assessing a patient’s problem and matching them to an outcome or “fix”.

Outcomes prescribed by the “expert” in this process were signpost/referral and psychoeducation informed by Dialectical Behaviour Therapy (DBT) and Cognitive Behaviour Therapy (CBT). Both DBT and CBT only teach individuals “crisis coping skills”, such as emotional regulation, distress tolerance and managing self-harming behaviours (van Goethem, 2015). Upon reflection, such an approach would lead patients to solely believe that the way they think/feel/behave in response to crisis, is a dysfunctional problem that needs to be fixed.

Illness/pathological models asserts to how people make sense and respond to threatening experiences, traumas or challenges with self-worth, identity and meaning in life and these are to be labelled as “symptoms”. As such symptoms and diagnostic labels given as result of these, people see themselves as blameworthy, weak or “mentally ill”, as imposed by society and archaic mental health practices.

In contrast to such medical models, the Power Threat Meaning Framework published by the British Psychological Society (Johnstone and Boyle, 2018) asserts that professionals need to move away from asking “what is wrong with you?” to “what has happened to you?” (Harper and Cromby, 2022). This framework can be used as a way of helping people to create more hopeful narratives about their lives and the difficulties they face.

## The benefits of a solution-focused model

Working from a SF model, it encourages the implementation of this framework, by taking the time to hear someone’s story, how they made sense of it and what strengths the person already possesses to survive and “keep going” (Burns, 2006). By drawing on resources someone already owns, behaviour is more likely to change, as opposed to an expert instructing the person what to do to fix a problem. The behaviour change will be meaningful, motivated from within and be part of the individual’s preferred future that they want for themselves.

Upon reflection, the approach I have worked from previously has led patients to solely believe that the way they think/feel/behave is the dysfunctional problem that needs to be changed, and that healthcare professionals are the experts to tell them how to make these changes.

## Solution-focused therapy in paediatric diabetes

Now working within a paediatric diabetes team, I have noticed that the SF model is a whole team approach with SF conversations happening between consultant paediatricians, specialist diabetes nurses, diabetes educators and dieticians, not just Psychologists. The SF way of working gives the young person and their families the



**Liana McCaffrey**  
Assistant psychologist and  
trainee health psychologist

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“expert” role, hence, empowering them. It has struck me that, by recognising that the young person and/or family member is the diabetes expert, it allows them to identify ways they have coped before, the strengths this brings to them as a person/family, and how they can work together to be their own solution to live better lives.

The professional is highly skilled as being the active listener to the young person/family’s story, inviting them to notice times when things have gone well, when diabetes is always with them, and how they would like things to be better, despite diabetes. I feel this leads young people and their families to feel empowered in their own lives, particularly in managing/coping with diabetes, without the clinician dictating patient outcomes and the patient “complying” to such outcomes.

Personally, I feel I have had to make a significant transition coming into this role and working with a SF approach. I feel I have had to consciously step back from being the “expert problem fixer” and to take more time to be quiet and listen to the story of the patient as they are the expert of their own condition. I have needed to acknowledge that instead providing advice or guidance through invitation only puts the autonomy on the patient which is empowering for them in the therapy room. This empowerment allows the patient to feel they are in control or

more of their condition and that despite the challenges, they can live the life they want to, without their condition controlling them. To make this transition it has taken me to unlearn the medical model approach I previously followed. I have recognised that my role is not to tell people what is good for them, but to invite patients to recognise what is already good for them and to do more of what works.

### Role of the family

Noticing the strengths that the family around the children can bring can aid the building of a life lived well, despite diabetes. In consultation, by having the family present and involved in SF conversations, family members can identify the abilities and strengths that they see the child possess. The family can highlight the assets they admire in the child, and how these skills can support living well with diabetes. ■

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