A solution-focused approach to diabetes-related distress

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Article points

1. Diabetes-related distress (DRD), or diabetes-specific emotional distress, refers to the unique psychological difficulties resulting from the challenge of managing diabetes.
2. Despite the high prevalence of DRD among people with diabetes, there remains a lack of evidence demonstrating the effectiveness of psychological treatment.
3. Solution-focused therapy supports healthcare professionals to take an individualised and holistic approach to the problem of DRD and encourages small steps for a better future.

Key words

- Diabetes-related distress
- Solution-focused therapy

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Diabetes is a uniquely demanding health condition, the management of which can cause emotional distress. This diabetes-related distress is a psychological issue, distinct from depression and is commonly reported by people with both type 1 and type 2 diabetes. Despite its high prevalence rates and association with a number of negative outcomes, including glycaemic control and depression levels, there appears to be a lack of evidence demonstrating the effectiveness of psychological interventions as a treatment. Solution-focused therapy (SFT) is a psychological approach that is being applied in a number of different health areas and may offer hope for the treatment of the emotional burden diabetes can cause. The eight tenets of the therapy support health professionals to take a holistic, individual view of the person with diabetes, help them look for exceptions to their difficulties, explore alternative changes and encourages them to take small steps towards a better future. Solution-focused practice uses specific language and questions that can be used by any health professionals in their consultations. This article describes SFT and gives some useful examples of ways in which nurses can encourage positive change in their patients with diabetes.

Diabetes-related distress (DRD), or diabetes-specific emotional distress, refers to the unique psychological difficulties resulting from the challenge of managing diabetes. Both type 1 and type 2 diabetes are chronic and demanding health conditions impacting on daily life. Living with diabetes can be frustrating at times and people can feel overwhelmed and discouraged by the treatment (Polonsky et al, 2005; Fisher, et al, 2009).

Defining the issue

The prevalence of DRD has been reported to be between 18–48% and is persistent over time (Fisher et al, 2008; Fisher et al, 2012; Nicolucci et al, 2013). Researchers and clinicians have been urged to ensure that they distinguish DRD as a unique construct, separate to depression (Fisher et al, 2014). This is in part because DRD has been shown to have a different, distinct relationship with glycaemic control and disease management in both type 1 and type 2 diabetes (Fisher et al, 2007; Fisher et al, 2008; Fisher et al, 2010; Strandberg et al, 2014).

High levels of DRD have been significantly associated with glycaemic control (Polonsky et al, 1995; Welch et al, 1997; Fisher et al, 2010; Strandberg et al, 2014), anxiety and depression

(Fisher et al 2010; Papelbaum et al 2010), self-efficacy (Kim et al, 2015), drug or diet treatment regimens (Delahanty et al, 2007), BMI, length of diabetes and complications (Karlsen and Bru, 2014) and social support (Tang et al, 2008). However, the direction of causality of these associations is unclear and some factors may act as both moderator and influencer. For example, Baek et al (2014) reported that the relationship between diabetes burden and distress was moderated by social support.

The desire to accurately define DRD and ascertain its relationship with other biopsychosocial constructs is clearly ongoing. Perhaps partly due to this lack of clarity, there also is a paucity of effective interventions for DRD. Berry et al (2015) provide a comprehensive review of DRD and highlight how treatment to date has mostly been developed with the primary aim of improving diabetic management, not reducing DRD. The relationship with social support has led some researchers to encourage services to focus on developing constructive healthcare support, paying particular attention to emotional issues and non-clinical factors, such as family support (Thorne and Paterson, 2001; Karlsen and Bru, 2014). However, the structure and framework for this has yet to be detailed. It could also be suggested that psychological treatments for other mental health difficulties, such as low self-esteem, might produce an improvement in DRD given the associations between them. However, there is no evidence to support this at the moment.

While there are a range of psychological therapies that could be applied, there is little research examining their use in this area. There is a growing interest in the use of mindfulness-based cognitive therapy (MBCT). The aim of this psychological therapy is to cultivate mindfulness in people, encouraging the self-regulation of one's attention. It supports individuals to develop and maintain an open, curious and accepting outlook on their experiences, thoughts and feelings without judgement by practicing meditation and yoga exercises (Segal et al, 2002). It has been applied to a range of physical health areas, including cancer (Bränström et al, 2010) and back pain (Morone et al, 2008), and a recent meta-analysis reported that, overall, it has demonstrated moderate effects on the reduction of symptoms of anxiety and depression (Hofmann et al, 2010). A randomised controlled trial (RCT) within the diabetes population found that MBCT and cognitive behavioural therapy (CBT) had comparable results, producing a reduction in symptoms of depression and anxiety, as well as a reduction in DRD, when compared with waiting list controls (Tovote et al, 2014). Another RCT comparing MBCT with usual treatment reported that while there was a significant reduction in anxiety and depression symptoms, there were no statistically significant differences between the two groups on DRD, either immediately post-treatment or at 6-month follow-up (van Son et al, 2013; 2014). While MBCT may be a promising treatment, particularly for symptoms of anxiety and depression, research to date has failed to demonstrate consistent positive outcomes on DRD.

Searching for solutions

Given the high prevalence rate of DRD and its relationship with glycaemic control, there is a need to develop affordable and effective treatments, particularly given the rising levels of diabetes (van Son et al, 2013). Solution-focused therapy (SFT) is a trans-diagnostic, brief psychological therapy being used in a range of settings across health, education and social settings.

It was developed in the 1970s, primarily by Steve de Shazer and Insoo Kim Berg from their work in brief family therapy (Connie, 2009). They were interested in identifying the questions, emotions and behaviours that led to increased talk of solutions and progress (De Shazer et al, 2007). The future focus of this approach and use of goal-directed, brief therapy makes it very applicable as a potential treatment for DRD. Rather than solely and directly attempting to reduce the distress, SFT focuses on an individual's competencies, acknowledges them as experts within the process and infuses

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1. Diabetes-related distress (DRD) can influence glycaemic control, anxiety and depression, self-efficacy, treatment regimens, BMI and complications. However, the direction of causality of these associations is unclear.
2. The desire to accurately define DRD and ascertain its relationship with other biopsychosocial constructs is clearly ongoing. Perhaps partly due to this lack of clarity, there also is a paucity of effective interventions for DRD.
3. Given the high prevalence rate of DRD and its relationship with glycaemic control, there is a need to develop affordable and effective treatments. Solution-focused therapy focuses on an individual's competencies, acknowledges them as experts within the process and infuses hope for the future.

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1. The initial task in an solution-focused therapy consultation by a psychologist or other member of the team is to carefully listen to what is being said and identify, with the individual, areas for further discussion or consideration for change.
2. The role of the healthcare team is to encourage the individual to do more of whatever is working for them and not to judge the quality of their solutions, only whether it is effective.
3. If a particular approach is not working, instead of trying to find fault within the individual or current practice, we could encourage a different outcome by changing our behaviour or asking the individual to experiment with trying something different.

hope for the future.

There is a small evidence base for SFT in a variety of settings and it has been found to significantly reduce fatigue in Crohn's disease (Vogelaar et al, 2011). A large controlled study compared SFT with short-term psychodynamic and long-term psychodynamic therapy (Knekt et al, 2008). While the outcomes for depression and anxiety were comparable at 36 months, the number of sessions offered suggests that SFT is a more cost-effective treatment. Participants had, on average, 9.8 sessions in the SFT group, 18.5 in the short-term psychodynamic group and 232 in the long-term psychodynamic group.

SFT may therefore offer a solution to psychological difficulties in diabetes. The tenets of this therapy, how these might be relevant within diabetes and possible helpful questions to ask is discussed below.

Tenet 1) If it isn't broken, don't fix it

This overarching tenet is extremely relevant within diabetes. Diabetes is a far-reaching health condition and members of the individual's system may hold different opinions around areas needing change. Referrals to psychological support may be received from the multidisciplinary team or other agencies who view the person's diabetes management as sub-optimal, possibly due to different ideas of what constitutes adequate diabetes management. If the individual does not share this view, then they are unlikely to be motivated to make sustained changes to their behaviour.

The initial task in an SFT consultation by a psychologist or other member of the team is to carefully listen to what is being said and identify, with the individual, areas for further discussion or consideration for change. This may be their diabetes self-management, or something unrelated, that is indirectly causing DRD, such as demands at work making it difficult to them to have routines around their mealtimes and medication regimens, or overly high expectations of others for the diabetes management causing them to have low self-efficacy and low self-esteem. If the individual does not feel that there is a need or that they do not perceive any benefit of having psychological therapy, the healthcare team could collaboratively develop an understanding of how the individual can continue to avoid distress and stay well, or how they would become aware of the need for further support in the future.

Helpful questions might include:

- "What would need to happen today to make this a really useful session?"
- "How are you coping with the demands of diabetes?"

Tenet 2) If something works, do more of it

This guideline further emphasises the "hands-off" approach and reinforces the individual as the expert. The role of the healthcare team is to encourage the individual to do more of whatever is working for them and not to judge the quality of their solutions, only whether it is effective.

Services should endeavour to be open and curious in order to support the different solutions that the individual may use to reduce distress. Consultations could focus on times when DRD was minimal or absent, and what was different during this period, by asking questions such as:

- "You've had diabetes for many years, tell me what you've learnt about what improves it and what worsens it."
- "On days where diabetes has felt even a little bit better to manage, what was different?"

Tenet 3) If something is not working, do something different

De Shazer et al (2007) point out that there is a human tendency to often persist with an attempted solution, despite its lack of effectiveness. Instead of trying to find fault within the individual or current practice, we could encourage a different outcome by changing our behaviour or asking the individual to experiment with trying something different. It can be helpful to ask people to pick a day when they are going to imagine and live that day as though they were not experiencing any or reduced DRD. This can be something to try as a healthcare professional if you are worried about an appointment; imagine that you are feeling positive and hopeful about the possibility

of improvement and see how this influences the session. Examples of suitable questions would be:

- "If you were to experiment with doing something different before our next appointment, what might that be?"
- "What could I do differently in this consultation in order to find the positives and exceptions to this person's difficulties?"

Tenet 4) Small steps can lead to big changes

SFT makes use of scaling techniques to help people develop a picture of their "hopes for future" and how they might make small steps towards this (Connie, 2009). If individuals are in an acute stage of DRD, making big changes to their behaviour is likely to be difficult, ineffective or short-lived. For example, encouraging people to test their blood glucose three times a day when they are rarely testing is likely to lead to failure, disappointment and more DRD. Therefore, you might ask:

- "What would be the first small sign that things were a little more 'on track' for you?"
- "Who would notice this and how would they know things were better?"
- "What would be different if you were one step higher on the scale?"

Tenet 5) The solution is not necessarily related to the problem

SFT is different to many other psychological approaches as, instead of examining the problem in the hope of finding a solution, it first elicits a detailed description of what would be different when the problem is resolved. The healthcare professional and individual can then work backwards to develop the small steps needed to bring about this future. There may be very little discussion around the DRD itself and its origin, but rather discussion about what would be different when the distress has lifted.

While it can be interesting, and other approaches might be helpful to examine problems, pathology and dysfunctional interactions, SFT focuses on the present moment and future. It does not dismiss problems or the past, as it is important that the individual feels heard, but the health professional's role is to listen carefully to what is being said and facilitate change. This is particularly relevant if the source of distress is a health condition that will require lifetime treatment and will never disappear.

Examples of these questions include:

- "If you were not feeling overwhelmed, what would you be feeling?"
- "When you are managing your diabetes well, what is different?"

Tenet 6) Language for solution development, if different to the language used to describe a problem

Being aware of the language that is used within teams and consultations is important. Problem talk is often negative, focused on the past and causes a sense of permanence of the difficulties. The language of solutions is usually more positive, future-focused, hopeful and open to the potential for change and improvement. For example, using "when" instead of "if" when talking about positive change and giving meaningful compliments, such as:

- "What special ability/strength (e.g. as a parent or employee) do you have that help you keep diabetes in its place?"

Tenet 7) No problem happens all the time, there are always exceptions

Using SFT effectively requires careful listening skills, as even in the most dire circumstances, there are small exceptions. The role of the healthcare professional is to hear these and use them to build further solutions. Talking to people about the times when their distress was less or when they found the diabetes easier to manage will help identify potential goals by asking questions such as:

- "What changes have you noticed that have happened since your last appointment?"
- "How have you prevented the problem from getting worse?"
- "When are the times when you are affected by DRD?"

Tenet 8) The future is creatable

Maintaining and instilling hope for the future

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1. If individuals are in an acute stage of diabetes-related stress (DRD), making big changes to their behaviour is likely to be difficult, ineffective or short-lived. Therefore, it is important to ask the individual to take small steps to changing behaviour.
2. Solution-focused therapy is different to many other psychological approaches as, instead of examining the problem in the hope of finding a solution, it first elicits a detailed description of what would be different when the problem is resolved. The healthcare professional and individual can then work backwards to develop the small steps needed to bring about this future.
3. A focus on language is important for solution-focused therapy. The language of solutions is usually more positive, future-focused, hopeful and open to the potential for change and improvement.

"Developing a clearer picture of diabetes-related distress and its relationship with other physical and psychological outcomes would be helpful in understanding this issue and designing effective interventions."

is a powerful part of SFT. People often attend services feeling as though they are failing and are unable to see how things might improve. The very nature of DRD is about feeling overwhelmed and frustrated, and this lack of hope is often also felt by healthcare teams and other people within the system. However, the future can be "created" and negotiated. There is the possibility of a future with little or no DRD at least some of the time and people can be equipped with the skills to manage it, if it reappears. It may be helpful to normalise periods of DRD, given the level of intrusion diabetes has on day-to-day life, through peer support.

Hopes for the future

We can use these questions to help think about our hopes for service development and future research. Developing a clearer picture of DRD and its relationship with other physical and psychological outcomes would be helpful in understanding this issue and designing effective interventions. However, we could question whether this is a necessary prerequisite for moving forward. It might be that detailed examination of the "problem" is not helpful and research could do something different. Research could explore what is different about the people who manage their diabetes well or who do not report DRD.

There could also be further experimentation with different treatment options. This could include psychological therapy or other interventions, as the solution may not be related to the "problem". For example, thinking about how employers support people with diabetes, whether more out-of-hours services would reduce stress around attending appointments and the perceived impact of diabetes on daily life.

Similarly, healthcare services can use SFT in developing their hopes for service provision. It is has been suggested that the singular pursuit of ideal HbA_{1c} may be unwise, as it may lead to neglect of the psychological aspects of diabetes (Jones et al, 2015).

Conclusion

As yet, there does not appear to be an intervention type that has consistently proved to have a positive impact on both the physical and psychological aspects of diabetes (Harkness et al, 2010). Services may consider how they can develop a range of potential solutions to meet the differing needs of people with diabetes. The future, after all, is creatable. ■

Further resources

- **United Kingdom Association for Solution Focused Practice** for further information on solution-focused practice, its applications and further training (available at: www.ukasfp.co.uk).
- **Diabetes UK** for peer support (available at: http://bit.ly/1QL7BJD).
- **Social media.** For people who use Twitter and Facebook, there is an active diabetes community that many people with diabetes value. Please use #DOC (Diabetes Online Community) to gain immediate support from others with diabetes.

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