SOLUTION-FOCUSED THERAPY FOR CLIENTS WHO SELF-HARM

This is a summary: the full paper can be accessed at nursingtimes.net

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ABSTRACT Laydon, C. et al (2008) Solution-focused therapy for clients who self-harm. Nursing Times; 104: 9, 30–31. This article looks at developments that have been implemented to improve a service that offers solution-focused therapy to clients who self-harm. These include using follow-up sessions, feedback letters for service users and changes in clinical supervision. Future plans for the service are also described.

INTRODUCTION

In 2002 the liaison psychiatry team in Middlesbrough adopted the solution-focused approach to interventions (see background box). The following year we completed a study exploring the effects of solution-focused brief therapy on reducing repeated incidents of deliberate self-harm (Wiseman, 2003). The results were positive – only 6.25% had repeated self-harm after one year compared with 13.2% of the control group (Fisher’s exact test p=0.3). It confirmed our belief that solution-focused therapy is a feasible and acceptable intervention for clients presenting with self-harm for the first time, and that the initial contact with service users can have a more enduring impact if they are helped to consider more than just their problems, such as hopes for the future.

The study had an impact on our service delivery and a positive influence on the team dynamic. It allowed us to continue with the service and justified our dedication to change.

FURTHER SERVICE DEVELOPMENTS

The assessment document is continually reviewed and revised as more up-to-date practice brings new ideas. For example, we are considering integrating a ‘preferred future’ topic rather than the ‘miracle question’ (see background box), as the team found ‘What would be your idea of a preferred future?’ or ‘What are your best hopes…?’ to be questions that were more grounded in reality and more tangible for clients to work with. We are also offering follow-up sessions to the initial assessment and introducing feedback letters.

Feedback from staff is encouraging. As the experts on what is needed in the sessions, they are encouraged to develop a mutual process.

FOLLOW-UP SESSIONS

We realised the first therapy session often gives the only chance to encourage clients to move from recent past problems and identify constructive hope for the future. The right question can show them a way of relating to life that challenges their depressive view of the world. They can be helped to find a way to move towards healthy change – to literally step out of their negative trance (Griffin and Tyrell, 2004). Solution-focused therapy helps clarify these hopes.

Although the first session could be used to explore clients’ coping strategies – once the problem story has been given appropriate attention – in practice this did not happen. Several factors such as the environment (usually a medical ward); clients’ attitudes (regret, guilt, embarrassment and truculence); their physical state (pain, discomfort, hangover); and staff members’ need for risk assessment, efficiency and safety all tended to focus the session on identifying the problem, which reinforced the client’s reasons for being there. We noticed a shift when the conversation moved to ‘What would you like to happen…?’

During our initial session with clients we felt some would respond to follow-up. They seemed to grasp the concept of the solution-focused approach and were interested in the idea of drawing on their own strengths to move on but the only way we could know that the session was useful was to offer some form of follow up.

When clients accept a follow-up session, some fundamental changes occur. They are seen in a different environment, usually a clinic, which is more relaxed and conducive to proactive and therapeutic dialogue. They have been given responsibility to attend (giving them an active responsibility) and, depending on their mode of self-harm, they may no longer feel physical discomfort.

As the follow-up session may be 2–4 weeks after the initial assessment it is extremely likely clients will also be in a better frame of mind. All these factors help separate the person from the problem and allow for autonomy.

Usually only one follow-up session is required, although we allow for up to four. We are currently auditing the effectiveness
BACKGROUND

● Solution-focused brief therapy was developed in the US. The model’s philosophy is empowering – it emphasises that individuals have unique resources and the potential to find their own solutions to problems.

● Within the sessions, clients are helped to identify the future they want as well as the things they are doing that are helpful in getting there. The problem story is used to identify resources, achievements and survival strategies rather than acting as criteria for diagnosis.

● The ‘miracle question’ involves asking clients to imagine that, while they slept, a miracle occurred and their problems were solved. They should then describe how they would go about discovering that this had happened.

● The extended version of this paper, including full reference list is available for four weeks and then to subscribers only. Log on to nursingtimes.net, click NT Clinical and Archive and then Clinical Extra

and drop-out rate of these sessions. We have devised a tool for second and subsequent sessions to help identify clients’ progress since their initial assessment.

Where clients have encountered setbacks, it is especially important to acknowledge their achievements. We also use present- and future-orientated questions.

FEEDBACK LETTERS

The inspiration to offer written feedback to service users came from two sources. The first, developed from a training workshop run by Mindfields college, highlighted that clients would benefit from seeing their positive attributes written down. In addition, good-practice protocols regarding offering clients a copy of their assessment letters were being discussed in our trust.

After much debate, it was agreed that sending the usual assessment letter (the GP letter) might be detrimental to clients as its narrative structure could cause them to revive and possibly relive negative incidents contributing to their situation and prevent them moving forward. However, we agreed that constructive feedback might be helpful.

We explored the concept of a solution-focused therapy feedback letter, sent to service users following completed assessments. We felt by using headings we could maintain consistency and validate sessions with clients in a reflective rather than reactionary way.

The letter would focus on the client’s skills, strengths, resources, qualities and coping strategies, and offer evidence of what they believe they can achieve, with headers such as:

● Your best hopes for the future;

● Ways you identified what you can do to achieve/work towards your preferred future;

● Qualities you (and others) recognise in you;

● What interests me about you.

The feedback is framed in clients’ language, quoting their statements on what they have done, are doing or plan to do that is helpful, positive or valuable.

Using this type of solution-focused questioning encouraged clients to reflect on their positive attributes and on actions they could take to improve their lives. The questions also served as positive affirmation and helped to ensure healthy coping strategies despite periods of low mood. It was a challenge for practitioners to support clients to identify as many qualities as possible. Each letter is unique and allows us to be creative and respectful to the individuals concerned and leave them a written acknowledgment of their strengths, such as ‘...despite that episode I still managed to...

CLINICAL SUPERVISION

Our requirements of clinical supervision were quite specific. We needed it to:

● Enable us to develop our knowledge base around solution-focused issues in liaison psychiatry;

● Reinforce consistency and continuity of care;

● Enable us to monitor both the process and the progress of the intervention;

● Provide opportunities for learning and appraisal;

● Formalise how we provide care and highlight what works;

● Provide information and outcome studies;

● Reinforce and improve minimum standards;

● Ensure integrity of the approach during research projects (after 2002).

We agreed on a supervision contract that included ground rules, statements of confidentiality, expectations, boundaries and agenda issues and was based on solution-focused values. We adopted Nicklin’s (1995) statement for supervision as we felt its reflective approach and forward movement towards goals fitted the project’s aims.

As the supervision sessions developed, a noticeable change in their focus and content emerged. Initially the team searched for theoretical answers, such as, ‘How should I respond to the client’s reply?’ As time went on, more philosophical questions were posed, highlighting a deeper understanding of their potential therapeutic impact.

At present, clinical supervision takes place fortnightly. As well as reflecting on the process, practical issues are discussed, such as reframing questions on the assessment sheet, outcomes, information leaflets and discussions with ward teams.

FUTURE DEVELOPMENTS

We are planning to undertake a more in-depth follow-up of our original study (Wiseman, 2003) and also plan to continue our progress with follow-up sessions and feedback letters. We will use the model’s perspective that we too are unique experts on ourselves, and our resources will help us move towards a solution to service demands.

REFERENCES

