Brief intervention: reducing the repetition of deliberate self-harm

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ABSTRACT


Deliberate self-poisoning is one of the most common reasons for admission to hospital in the UK and up to 15 per cent of patients who poison themselves eventually kill themselves. The government has set targets for the reduction of suicide rates in Saving Lives: Our Healthier Nation (Department of Health, 1999) and the National Service Framework for Mental Health (DoH, 1999). Many studies have looked at the factors that indicate the risk of suicide, and leading researchers have expressed the opinion that there is a need to target high-risk groups, such as people who deliberately self-harm (DoH, 2002).

It is difficult to find proven therapies to prevent repetition of deliberate self-harm (DSH). Those therapies that do show promise are intensive and must be done over an extended period of time. However, an intervention known as solution-focused brief therapy (SFBT) has the potential to help people who self-harm after just one session. With this in mind, the liaison psychiatry team (LPT) of Tees and North East Yorkshire NHS Trust decided to investigate the effect of SFBT with patients who presented to a local general acute hospital following an act of DSH. This article describes the implementation of the SFBT research project and how it has altered the way nurses and social workers perform their risk assessments.

The team

The LPT was set up in 1996 and is based at St Luke’s Hospital in Middlesbrough. A consultant nurse and consultant psychiatrist, both specialising in liaison psychiatry, lead the team, which includes three RMNs, two social workers, a specialist registrar, a staff grade doctor, one secretary and two administrative workers.

The team’s aim is to provide a timely, quality biological, psychological and social assessment of patients who present to the local general acute hospital with DSH. The team also assesses inpatients who have mental health needs in conjunction with a physical illness.

The risk assessment process

Prior to the SFBT project, the team had developed a risk assessment document that identified suicidal intent, repetition factors and included scientific tools to support the assessment process. The document was based on contemporary evidence (House et al, 1992).

Using the risk assessment tool allowed a summary and a care plan to be identified and an appropriate action to be recommended, for example:

■ Referral to secondary mental health services;
■ Inpatient admission;
■ Referral back to GP;
■ Referral to voluntary services.

The tool had the traditional medical model slant, which encouraged patients to highlight and discuss problems with little in the way of therapeutic dialogue.

Although the traditional model provided the necessary risk assessment, the highly motivated team of nurses, social workers and medics wanted to provide an intervention that was more than just an assessment.

Solution-focused brief therapy

Solution-focused brief therapy was developed in the early 1980s by de Shazer et al (1985), who discovered that clients were helped more effectively by talking about the future rather than going over their problem-saturated pasts.

The model sits well with the contemporary practice of empowerment and partnership and is, by definition, sensitive to differences of culture. Consequently SFBT is more concerned with helping patients describe what they want in their lives as opposed to exploring the reasons that problems developed or are maintained.

Bowles et al (2001) describe SFBT as both a system of communication and a set of assumptions about how best to motivate individuals to change, adapt and grow. They suggest that the key difference between SFBT and other models is its orientation towards strength. They argue that being solution-focused requires a shift of attention from a problem-dominated, deficit or pathology perspective to a positive, solution-orientated perspective. Solutions are developed through two processes:

■ Defining achievable goals;
■ Elaborating on existing strategies that have worked in the past.

The therapy introduces the patient to an achievable future with the confidence of knowing what has and what will help them.

SFBT and the LPT

The team discovered SFBT by accident during a course that promised ‘short intervention of therapeutic value’. They were eager to provide follow-up to deliberate self-harm that was meaningful and would not drain staff resources. There was also a far more pressing agenda to try to engage those young men who often avoid services and who are most at risk of self-harm and suicide attempts. Experience showed that males generally preferred ‘doing’ therapies to ‘talking’ therapies.

Team members agree that therapy is about helping people connect with a sense of hope and possibility that they may have lost. Often therapy has become a place where people talk about and hear things that discourage them, such as ‘They don’t really want to change...’ and ‘They can’t change’. The LPT believes therapy is about acknowledging and validating clients’ experiences and
ideas about their lives while ensuring that possibilities for change are discovered and amplified (O’Hanlon and Beadle, 2000).

Description of the study
For the purpose of this study a sample of patients with no previous history of DSH or a history of an attempt more than five years ago were identified. The five-year cut-off was used as research had shown that repetition rates usually occur within this timeframe, particularly when there have been previous episodes (Centre for Reviews and Dissemination, 1998). The median time of repetition among those with a history of self-harm is about 72 days (Gilbody et al, 1997).

Adapting the assessment tool
The team examined the traditional assessment tool, adapted it and integrated specific solution-focused questions. These were contained within three broad bands:
- Exception questions that enquire about times when the problem did not affect the person (or was not as bad, or when the problem did not exist);
- Outcome (or hypothetical solution) questions that use projective techniques to invite the person to explore the future by imagining and describing what will be different – for example, a preferred future or ‘miracle’ question;
- Scaling questions, which are useful for identifying baselines, coping strategies and goals.

Interview process
Therapy does not always begin when the interaction occurs; valuable thought and/or behavioural processes often occur within the person before they meet a therapist. Prochaska and DiClemente (1983) recognised the benefit of ‘consciousness raising’ as an integral part of the process to move from ‘precontemplation’ to ‘action’. Therefore, the team introduced a booklet that would guide them to ask the question slowly and with pauses for the patient to think and reflect. The therapist also encouraged the patient to consider missed personal attributes (often through other people’s eyes), by asking questions such as ‘What does your partner admire in you?’ The themes of the questions aim to elicit exceptions and orientate the patient towards coping.

The outcome questions
The outcome (or hypothetical solution) questions were asked in the document in a number of ways. ‘How will you know this session has helped you (besides feeling better)?’ and, of course, the ‘miracle question’. This invites the patient to be future-orientated, to describe, as clearly as possible, what life would be like once all the problems have gone or can be managed better.

The question, devised by de Shazer (1988), follows a standard formula: ‘Suppose, after we finish here today you go home, do your chores, watch TV et cetera, and then go to bed and sleep. While you are asleep, a miracle happens, and the problems that brought you here today are resolved, just like that! But this happens when you are asleep, so you cannot know what has happened. Once you wake up in the morning how will you discover that this miracle has occurred? What will be the first signs? What will you be doing that would be different?’

Of the whole process this proved the most difficult for the team to embrace. This was due to inexperience in drawing out patients’ preferred futures. The miracle question can help them to clarify goals and ways of achieving them without being burdened with a language of what has stopped, or is stopping, them. The question encourages existing, sometimes forgotten, coping mechanisms and resources to be highlighted.

The miracle question is not intended to describe a fantasy, it aims to bring a detailed, practical description of a life without the problem. The imagery format gives the patient permission to rise above negative, limited thinking and develop a picture of the solution (O’Connell, 1998). As part of the supervision process, team members were guided to ask the question slowly and with pauses.

Reference


so that the patient could enter into the spirit of the question. If patients gave unrealistic answers to the miracle questions, the therapist responded with ‘and what else?’ This description is critical as it provides quality and concreteness to their future plans.

Scaling questions
Scaling questions were used throughout the document. They included questions scaled in the patient’s dimensions on:
- Current feeling states;
- Confidence;
- Miracle attainment;
- Motivation.

Given the complexity of human communications, we frequently fail to grasp the other person’s meaning. When words fail, numbers can come to the rescue. De Shazer and Berg (1992) recognised that clients could use scales to express a concept of change that may have been difficult to describe in other forms.

The team used a scale ranging from nought to 10, with nought describing the worst/lowest/smallest and 10 being the day after the miracle/best/most confident. These scales help the person set identifiable goals, measure progress and establish priorities. They can be used to elaborate on ‘What’s worked to help you move from three to four?’

Time to think
A core component of the new assessment was the ‘think break’. As the assessment came to a close the therapist asked the patient’s permission to take a few minutes to gather his or her thoughts – in reality the thinking is done alongside the doing. The therapist reflected on what he or she had learned about the person during that session and prepared for the feedback.

The patient was given an empathetic statement of appreciation. The patient was then invited to share what they had learned, or to reflect on things they would share again in the future, and an objective statement, based on their description, of strength. A doing and noticing task was then negotiated and the usual follow-up appointment arranged.

Unfortunately due to the small team and the high volume of inpatients the LPT is unable to offer any further SFBT follow-up. Ideally SFBT should involve greater follow-up. This type of intervention is more effective after three to four sessions because this allows solutions to be revisited and evaluated.

Study update
The study of 40 patients began in February 2002. All consented after being given both verbal and written information on the study. The trial ended once the final patient was seen in November 2002. With the help of the hospital audit team, blind to the trial, the team checked presentations for DSH from this cohort over a six-month period from initial presentation. The results indicate that of the 40 patients seen only one repeated DSH within this six-month period.

Limitations and follow-up
On the wider scale we know that repetition is approximately 16 per cent (NHS CRD, 1998), indicating the need for wider research in this area. This was only a small study, which began as an interest but which may have the potential to impact on self-harm presentations in the reduction and prevention of DSH and suicide. This would in return have cost and resource implications to the NHS.

As a result of this piece of work, regional interest has been generated from other liaison teams who are keen to join forces to look at the possibility of a future multicentred, random-controlled study. In June 2003 the LPT raised further funding supported by the primary care trusts to extend the use of SFBT for a maximum of six sessions in follow-up of patients who perform DSH.

Conclusion
For patients who are used to professionals concentrating on problems, the experience of SFBT must be different. A therapy that recognises problem behaviours but also relays optimism, reliance and hope increases confidence and trust in the person.

This shift was highlighted by students shadowing the team who noticed a visible ‘weight taken from patient’s shoulders’. This reflects the team’s own experiences. The patients demonstrated this positive attitude in the rating scales – a postsession change was identified by 78 per cent of those assessed. In addition patient satisfaction surveys, completed by 26 of the group, revealed that 96 per cent felt that the service was more than satisfactory.

There are weaknesses, however. This is a patient participation therapy and patients need to be motivated or in the precontemplation stage of change. Many are sent for therapy because someone else thinks it is a good idea, making the responsibility someone else’s. SFBT acknowledges the person’s part in problem formation but also recognises his or her role in its solution.

The team feel that the quality of assessments matched the outcomes. The team started at the same level of expertise to enhance competence and knowledge under the supervision of a practice development nurse. It is important that the therapist possesses clear self-awareness and engages in the aforementioned supervision process.

Prior to the SFBT project the team brought an array of expertise and approaches combined with a consistency in beliefs of empowerment and necessary change.

Discussions of SFBT and team training on the subject allowed staff to look at the process through a different set of lenses. Adapting the one approach, focusing on one approach, receiving supervision for the one approach and using the language of the one approach helped to provide support, strengthen belief and enhance the motivation to embark in SFBT.

The assessment process has become more communicative as a result of the increase in open-ended questions and the patient has to participate more. The session does not become saturated by problems or hopelessness: watching the patient develop is enjoyable and in turn provides the team with a lower level of burn-out.