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Working effectively with clients who self-injure using a solution focused approach

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Abstract In Australia, the most common service used by self-injurers is the emergency department. Even though nurses are the key clinician available to such patients, nurses have usually received no special training to identify and address the needs of these clients. Building on the knowledge that emergency nurses feel ill-prepared, lack clear frameworks for practice and are thus vulnerable to subtle discourse tensions such as managing versus caring, and diagnosing versus understanding, an intervention was conducted and evaluated to enhance understanding and build proactive nursing skills. It was centred on a nursing philosophy known as solution focused nursing (SFN) – a model of care developed by author to orient care away from a deficit model. Deficit models tend to be reactive and centred on presenting problems. SFN is designed to move nurses' perspective towards a proactive, strengths orientation, the aim of which is to assist them to instill hope in the client and motivate him/her to take the next steps needed for change and recovery. Nurses in two Australian emergency departments completed questionnaires before and after participating in SFN training focused on working with complex clients who self-harm. A comparison group of nurses also completed questionnaires. Results indicated some benefits of the intervention; there were improvements in participants' perception that nursing is strengths oriented and in nurses' satisfaction with their skills. Yet, there were no significant improvement in nurses' reports of their professional self-concept. There is merit in: broadening access to the intervention, so that more nurses in other contexts can learn a strengths model of care and apply it to their practice; and extending the research to measure sustained learning outcomes and improvements to practice.
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Introduction

Intentional self-injury, especially among the young, has emerged in recent years as a major public health concern in Australia. Defined as the deliberate destruction or alteration of one's own body tissue, self-injury can occur with or without suicidal intent but, of particular concern, early research in the field indicates that a person who has self-injured is at higher risk than the general population of completed suicide (Gunnell and Bennewith, 2005). Risk of repetition and consequently of suicide is believed to be highest during the first two years after an initial episode of self-injury although risk does persist over many years (Jenkins et al., 2002). Whereas research on the efficacy of prevention intervention is still in its early stages and formal scientific evidence is currently lacking, there is, ''a reasonable basis to believe that the quality of acute health services (emergency medical and mental health) provided to young people has the potential to reduce the risk of completed suicide in at least some cases'' and to reduce the risk of further episodes of self-harm (Cook and Hamilton, 2000, p. 1).

As emergency departments are the preferred service for clients who self-injure, nurses in emergency departments are very likely to be providing direct care at some stage to the estimated 138,230 Australian adolescents who self-injure on a regular basis (Steenkamp and Harrison, 2000). However, nurses working in emergency care contexts frequently feel under-prepared and often feel unable to effectively care for clients with mental health problems generally (Clarke et al., 2006; Vahey et al., 2004) but most particularly clients who have deliberately self-injured (McAllister et al, 2002a; McCann et al., 2006). Indeed, recent research shows that emergency nursing attitudes towards self-injury are generally negative and most nurses, even those with mental health qualifications, have had no specialised preparation to respond to self-injury (McAllister et al, 2002b). Such situations are likely to negatively impact on nurses' individual and collective capacity to provide effective and timely clinical care, and on client outcomes, thereby exacerbating distress and possibly triggering further episodes of self-injury.

Reviews of the Australian National Youth Suicide Prevention Strategy (1994—1998) show that innovative prevention programs, especially those that improve skills in health professionals, promote community awareness and improve accessibility of services, are beginning to impact upon mortality statistics (Martin, 2007). Indeed incorporating mental health promotion practices into primary and secondary health care is explicitly emphasised in the third Australian National Mental Health Plan.

Several education intervention studies indicate how improvement in clinicians' attitudes and confidence might best be achieved (Evans, 2000; Holdsworth, 2001; Patterson et al., 2007; Samuelsson and Asberg, 2002). The common approach is to emphasise knowledge development, improving factual knowledge about self-injury, but it has been less common to focus on expanding the proactive role that an emergency nurse could take with clients.

The study

Objectives

In the current study, an educational intervention was designed to provide relevant, practical skills to assist emergency nurses to take a more proactive role with clients. The skill development was based on principles of solution focused nursing (SFN) (McAllister, 2003, 2007) and was directed at helping nurses to manage challenging patients, especially those with significant mental health problems like self-injury, in more proactive and confidence-building ways. More specifically, the aims were to improve nurses' knowledge of SFN, to increase their expectations that they could be proactive in their nursing role, to increase their feelings of competence when working with challenging patients, and to broaden clinicians' health promotion skills by assisting them to both acknowledge patients' health seeking behaviour and intervene with patients to motivate change (Nutbeam, 2000). Outcomes of the intervention were investigated, including assessing changes in nurses' knowledge, perceived skills, professional identity, and perceptions of their roles.

Participants

Emergency nurses working in two major Departments of Emergency Medicine (DEM) and acute care areas in South East Queensland were invited to participate in the study. Seventy-one nurses entered the study (44% participation rate). ED one is in Queensland's third largest hospital, serves a population of 400,000, and has a nursing complement of about 90 shift workers. ED two is smaller, serving a population area of 145,000 and has a nursing staff of about 70. Nurses were allocated to either an intervention or control group. The participating

nurses were representative of all nurses working in these two DEMs.

Design

The outcomes of the education program were tested using a pre-test/post-test design and compared to a group who did not receive the intervention. The intervention group ($n = 36$) was given a SFN-based educational intervention and intervention participants were compared at post-test to pre-test ($n = 27$ completed the pre-test and post-test), and compared to nurses who received no intervention ($n = 35$). Qualitative data were collected and findings are reported in a companion paper (McAllister et al., in press).

Measures

Nurses completed questionnaires to measure their nursing self-concept, knowledge of SFN, and their perceptions of their nursing skills and purpose. Measures included the Perceptions of Nursing Scale (PNS; McAllister et al, 2006) and the Professional Self Concept in Nursing Inventory (PSCNI; Arthur, 1995). Nurses in the intervention group completed all measures prior to and following their participation. The comparison group of nurses completed questionnaires on a single occasion.

The PNS included 34 items and 7 subscales. All scales had adequate reliability as assessed with Cronbach's α, with the exception of the 2-item subscale that assessed perception of a clear role of nursing. The subscales included the following: (1) a belief in the distinctive role of nursing (4 items, Cronbach's $\alpha = .65$), (2) the perception that nursing is problem oriented (8 items, Cronbach's $\alpha = .53$), (3) the perception that nursing is strengths oriented (3 items, Cronbach's $\alpha = .59$), (4) satisfaction with skills (3 item, Cronbach's $\alpha = .77$), (5) perception of a need for more skills (2 items, Cronbach's $\alpha = 74$), (6) belief in a social role of nursing (2 items, Cronbach's $\alpha = .69$), and (7) the perception of a clear purpose with the nursing role (2 items, Cronbach's $\alpha = .44$). After reversing some items, subscale scores were formed by averaging appropriate items. Response options for each item ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Eight additional items assessed a range of other perceptions and were maintained for analyses. Two items were not analysed as they were not directly relevant to this study.

The PSCNI included 43 items with response options ranging from 1 (*disagree*) to 4 (*agree*). After reversing appropriate items, the inter-item correlation of this scale was good indicating high reliability of the scale, Cronbach's $\alpha = .84$. Items were averaged to form a single score.

The education intervention

SFN Philosophy. The educational intervention centred on a nursing philosophy known as solution focused nursing, SFN (McAllister, 2003, 2007). Essentially this model shows nurses their role in making change at three levels: with the client, with nurses themselves and in society. It is designed to develop communication skills to engage the person in care and develop team-work skills that are strengths oriented, proactive and strategic. In these ways, the intervention is aimed at extending the nursing role beyond illness-care towards facilitation of illness adaptation and recovery and towards clarifying a unique nursing identity and social role.

Traditionally, clinicians have been trained to be problem-focused, and many studies have identified the limitations in this orientation — it tends to give clinicians a reactive role limited to illness-care (McAllister, 2003; McCabe, 2004), and clinicians in some contexts lack strategy in their questioning, clinical reasoning, and health promoting strategies (Polaschek and Polaschek, 2007). Bowles et al. (2001), Webster et al. (1994) and Vaughn et al. (1995) found that the introduction of solution focused therapy required nurses to rethink their philosophy of care and to develop more strategic approaches to client-communication. Instead of looking for causes to problems, they focused on helping clients construct their own solutions to present difficulties.

The solution focus is based on the positive psychology movement, which has used the knowledge gained from studying characteristics of people who survive, overcome and endure stressful situations to provide interventions which will assist vulnerable people to gain strength and resilience (Seligman, 2002; Weiner-Davis and O'Hanlan, 2003). There is now a world-wide movement in health to act preventatively, assess protective factors in individuals and groups, build strengths and resilience and not simply seek to identify difficulties, risk factors and disorder. As Seligman simply states (2002, p. 4) ''Treatment is not just fixing what is wrong; it also is building what is right''.

Solution focused interventions are those that do not place the problem at the centre of activities, but rather emphasise factors that might build strength, resilience and social connection. Where other nursing theories have focused on exploring

the client—nurse relationship (Gordon, 1994; Watson, 1999), the SFN approach is designed to emphasise *two* aspects of nursing work that require re-thinking and changed interventions — the client—nurse interaction and the nurse—nurse interaction (McAllister, 2007). SFN has been evaluated as an effective philosophical model in the educational context (McAllister et al., 2006), and solution focused strategies generally have been rigorously evaluated (Bowles et al., 2001; McAllister et al., 2006; Polaschek and Polaschek, 2007) and shown to be effective, but the SFN approach in nursing clinical contexts had not been researched and hence this study fills this gap.

Building on the insights of Bowles et al (2001), who showed direct positive effects in nurses who were taught solution focused communication skills, SFN is designed to assist nurses to see their roles as strategic and proactive with clients and with each other, rather than reactive to problems. Within SFN, nurses are helped to understand that client care involves relationships (joining), one-on-one work (building) and social reconnection (extending). It is expected that when nurses learn ways of strategically talking to clients, this will improve the nature of the nurse—client relationship, it will give nurses a sense of effectiveness where they have clear aims for interpersonal encounters, and listening and connection will be enhanced (Bowles et al., 2001).

Another aspect of SFN is the focus on nursing itself as an area for change. By having a goal of assisting nurses to become more self-reflective about nursing itself, its place within health care and society, its access to and uses of power, and to see nursing as performing an influential social role, it is expected that nurses will begin to think more critically about (and revise) nursing practices that might be unhelpful or unjust for clients. This is particularly important in the case of self-injury care because clients continue to complain of disrespectful treatment by the very people they are approaching for non-judgmental comfort and care (Jackson and Kroenke, 2001; Thornicroft et al., 2007; SANE Australia, 2004).

Implementation of the intervention. A 2 h interactive discussion was provided on the nature of self-injury, theories for understanding and evidence based treatment techniques, followed by a break and then concluding with 1 h of training in SFN, applied to self-injury. In the latter part of the training, the group explored and discussed brief communication skills that they could use in the context of a busy emergency department. It included practical ways to join with the patient, and learn more about their personal needs — an example was for nurses to use the person's name; to demonstrate respect — an example was for nurses to briefly explain the wait time, and to check that the person felt safe; it explained assessment tools and elaborated on a simple framework within SFN that guides nursing treatment to include: containment, awareness, resilience and engagement strategies McAllister and Walsh, 2003) so that the focus would not simply be on the problem but also emphasise education, strengths, and engagement; and finally, it recommended the distribution of brochures to provide information that affirmed self-harm as a coping strategy but which also aimed to move the client from lack of awareness towards feeling motivated to secure community supports and enact change.

Study procedure

Following ethics committee approval participants were involved in a preliminary 1-h interview to ascertain learning needs and prominent care issues in relation to self-injury. Participants were asked to complete the two 15-min survey instruments at two points in time, one before the intervention, and one after. The comparison group completed the survey one time.

Analysis

Data were analysed using SPSS (Statistical Package for the Social Sciences for Windows version 14.0). Both descriptive and inferential data analysis techniques were utilised. Descriptive statistics included measures of central tendency (i.e. mean, median and mode) in addition to measures of variability (i.e. range and standard deviation). Inferential statistical analyses included a series of paired t-tests to examine whether there was improvement from pre-test to post-test among the intervention participants. In addition, independent group t-tests were used to compare the intervention group at post-test to the comparison nurses.

Results

Demographics of participants

A description of participants in each group is provided in Table 1. The intervention group had a somewhat higher level of education and was slightly older than the comparison group. There was no significant difference in the proportion of females in each group.

Table 1 Description of intervention and comparison group participants

	Intervention	Comparison	χ^2 or t	p
N	36	35		
Female, %	72.2%	68.6%	0.1	.74
Education			8.5	.04
Hosp cert	13.9%	8.6%		
Degree	41.7%	74.3%		
Post-grad	30.6%	8.6%		
Other	13.9%	8.6%		
Age, *M*	38.3	33.1	2.4	.02
Employment, *M* years	5.8	4.0	1.4	.17

Changes from pre-intervention to post-intervention

Among the 27 nurses who completed the intervention assessments at both pre-test and post-test, there was no significant improvement in the global measure of nurses' professional self-concept used in the current study (PSCNI, Arthur, 1995; see Table 2). Nevertheless, there were significant improvements ($p < .05$) from pre- to post-test for two subscales of the Perception of Nursing Scale (*strength oriented* and *satisfied with skills*) (see Table 3). Participants showed increases in their perception that nursing is strengths oriented and they were more satisfied with their skills after the intervention as compared to before the intervention. In addition, there were marginal improvements in nurses' belief in the distinctive role of nursing and belief in the social role of nursing, with small increases from pre- to post-test. There was also a marginal improvement in the item ''my work as a nurse could be more focused at the social level,'' with a decline from pre-test to post-test.

Comparisons of the intervention and comparison groups

There were no significant differences between the intervention groups' post-test scores and the comparison group scores (see Table 3). However, there

Table 2 Comparison of intervention group pre-test and post-test scores ($N = 27$)

	Pre-test		Post-test		Paired $t(26)$
	M	SD	*M*	SD	
Professional self-concept scale	3.24	.27	3.23	.28	.07
Perceptions of nursing scale					
Belief in distinctive role of nursing	3.67	.64	3.86	.64	2.82*
Nursing is problem oriented	3.72	.43	3.76	.29	.23
Nursing is strengths oriented	3.62	.50	3.88	.50	4.58**
Satisfied with skills	3.28	.78	3.67	.67	5.96**
In need of more skills	4.04	.72	4.07	.58	.08
Believe in social role	3.56	.85	3.85	.78	2.61*
Clear purpose	3.50	.42	3.50	.49	.00
Client's problem/dx takes priority	3.30	.91	3.15	.97	.35
Working with clients' strengths not reality	3.48	.80	3.44	.93	.03
Skills in being proactive	3.56	.75	3.74	.76	1.20
Value being person-centred	3.96	.76	3.70	.95	2.23
Nursing's identity hard to explain	3.22	1.09	3.00	1.04	1.30
More focus at social level	3.52	.75	3.19	.83	3.00*
Develop better technical skills	3.74	.90	3.89	.85	1.00
Learn more about solution focused	3.67	.73	3.70	.67	.06

* $p < .11$.
** $p < .05$.

Table 3 Comparison of post-test intervention and control groups

	Intervention ($n = 27$)		Control ($n = 35$)		Independent Groups $t(1, 60)$
	M	SD	*M*	*SD*	
Professional self-concept scale	3.23	.28	3.18	.27	−.68
Perceptions of nursing scale					
Belief in distinctive role of nursing	3.86	.64	3.91	.47	.33
Nursing is problem oriented	3.76	.29	3.73	.35	−.44
Nursing is strengths oriented	3.88	.50	3.85	.50	−.23
Satisfied with skills	3.67	.67	3.62	.49	−.32
In need of more skills	4.07	.58	3.87	.85	−1.06
Believe in social role	3.85	.78	3.67	.67	−.97
Clear purpose	3.50	.49	3.48	.60	−.15
Client's problem/dx takes priority	3.44	1.00	3.63	.94	1.93[a]
Working w/clients' strengths not reality	3.44	.93	3.34	.97	−.30
Skills in being proactive	3.74	.76	3.69	.87	−.26
Value being person-centred	3.70	.95	3.43	1.04	−1.07
Nursing's identity hard to explain	3.00	1.04	3.26	1.04	.97
More focus at social level	3.19	.83	3.03	.92	−.69
Develop better technical skills	3.89	.85	3.60	1.12	−1.12
Learn more about solution focused	3.70	.67	3.51	1.01	−.84

[a] $p = .06$.

was a marginal group difference on one item that assessed whether the client's problem, or diagnosis, takes priority in the health system, with the control group agreeing with this statement more so than the intervention group at post-test.

Limitations

Recruiting and retaining participants in the study was difficult because of staff movement in the DEM. Thus the sample size was relatively small and there was some attrition from the study. In addition, one study limitation is the use of self report questionnaires rather than observations of nurses' behaviours with clients. Nurses may not have reported changes in their practice that had occurred or, conversely, they may have reported more changes than would have been observed. In addition, future evaluations of SFN should include questionnaire measures to directly assess other key features of the SFN intervention, such as improved ability to empathise, be person-focused, and use questions strategically. Other design improvements would be the use of random assignment and the collection of pre-test and post-test measures for both the intervention and comparison groups, as well as more long-term follow-up of both intervention and comparison participants to assess longer term attitude change.

Discussion and conclusion

Emergency nurses work in a high pressure, unpredictable environment where the need to provide safe, systematic care to a wide variety of clients and their worried families is ever-present and unrelenting. With the advent of mental health reforms in Australia aiming to reduce stigma and enhance equitable, accessible care for all clients regardless of health problem, emergency nurses are now caring for clients with mental health problems on a daily basis. Many of these clients present because they have self-injured and are in crisis.

Whilst nurses genuinely believe these clients deserve the same care as anyone else, they work in a predominantly biomedical treatment context, and this is not a fitting context for clients who self-injure. Furthermore, emergency nurses lack the necessary preparatory knowledge, understanding and communication skills to envision the longer term for the client who self-injures and this limited understanding interferes with their ability to care and for clients' rights in accessing quality care. Most ED nurses are not mental health nurses and thus cannot be expected to provide comprehensive psychosocial care, but perhaps there are ways for mental health clinicians and ED staff to work more collaboratively *and* to apply some of each others' skills in their immediate encounters with clients, such as those who self-injure.

Although this was designed to be a small preliminary study and the improvements found were not as extensive as expected, it is recommended that this trial could be extended in order to overcome some of the limitations in study design. In particular, further research should be undertaken to test the SFN model's effect on a larger group of ED nurses, and to assess impact on clients' health seeking behaviours and further episodes of self-injury. This highlights a limitation of the measures used in the current study, none of which assessed knowledge or perceptions of working with clients who have self-injured. Including measures that ask about these particular goals of the intervention might yield evidence of more positive intervention effects. Additionally, it may be useful to measure other changes in clinicians' behaviours and values towards person-centredness, empathy and how knowledge is used in practice as these are components particular to the SFN model.

In general, further study is needed before the SFN educational intervention is made available to more emergency clinicians as well as to others involved in early encounters with people who self-injure, such as teachers, counsellors, school health nurses and GPs. However, there are many design features of SFN that should provide benefits. SFN embodies a strengths orientation, rather than a deficit approach. That is, it emphasises the value in nurses working with a client's strength, and enhancing those aspects within the individual or the context, that are working well. Although the survey measures used in this small study produced mixed results, there were some indications of positive changes among nurses who participated in the SFN intervention. In addition, this is an intervention that is easily implemented, with a short time commitment from nurses or others and a small budget. If shown in future research to be beneficial to health or other professionals, this makes it a good candidate for widespread dissemination. However, in order to build on this trial, support from administrators is needed. For example, administrators could fund the roll out of a larger trial of the SFN intervention and award Continuing Professional Development Points (CDP) and provide work release time to enable busy clinicians to participate.

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