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5

Developing skills in solution-focused interactions

Steve Smith

Chapter contents

Introduction

This chapter discusses solution-focused inter-actions, a specific approach to communication which is based on 'solution-building' (as opposed to 'problem-solving'), which you can utilize across all fields of nursing and implement within your clinical practice. It will explore the theory and skills of solution-focused interactions and provide an understanding of how they can be used. The chapter will draw on examples from various fields of nursing, including from a public health con-text, to demonstrate the strength of this approach across a range of settings. In addition it builds on the core skills from the previous chapter.

This chapter is relevant to the following Nursing and Midwifery Council (NMC) competencies.

Domain 2: Generic standard for competence

1 All nurses must build partnerships and thera-peutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.

4 All nurses must recognise when people are anxious or in distress and respond effec-tively, using therapeutic principles, to pro-mote their wellbeing, manage personal safety and resolve conflict. They must use effec-tive communication strategies and negotia-tion techniques to achieve best outcomes, respecting the dignity and human rights of all concerned.

5 All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relation-ships, and must always respect professional boundaries.

6 All nurses must take every opportunity to encourage health-promoting behaviour through education, role modelling and effec-tive communication.

We begin with a case study which will help to illus-trate the communication skills and approaches required to understand and adopt a solution-focused approach to nursing care.

Case study 5.1: Mark and Janeczka

Mark is 24 and suffered a traumatic amputation of his lower left leg in a motorcycle accident. He also sustained a complicated fracture of his left wrist. His girlfriend, Debbie, was killed in the accident. He is currently being cared for in a surgical ward, as his stump wound is infected and failing to heal. Mark is frequently verbally aggressive and abusive towards nursing staff; at other times he complains of extreme pain in his wrist and phantom pains in his leg. He does not get on with other patients and is being nursed in an individual room.

Janeczka is a nurse working on the surgical ward where Mark is being cared for. On this particular morning she is re-dressing Mark's stump wound. She is aware that he is 'difficult' to work with; today he has sworn at her several times, complained she is causing him pain, and insulted her East European heritage. Janeczka is on the verge of walking away from Mark, casting the experience off as 'just another failed attempt to help him'; however, in desperation and frustration she suddenly asks him, 'What is wrong with you?' The following conversation ensues while Janeczka gathers together the equipment used for Mark's dressing.

M: What do you think's wrong with me?

 J: I don't know; there are so many things that could be wrong with you, I can't begin to imagine. But if I don't know what it is, I can't do anything to help.

M: Yeah, and what are you gonna do?

 J: I don't know what I can do.

M: Exactly; just more goody-goody claptrap. Just leave me alone, I don't need your help.

 J: If there was something I could do, just one thing, what would it be?

M: I don't know!

 J: Suppose you did know . . . what would you say?

M: [pause] Bring Debbie back . . . that would be it.

 J: How would that help?

M: It would just be . . . I feel so guilty. I've never seen her mother . . . I wouldn't know what to say to her . . . just her face . . . would kill me. She always said Debbie shouldn't ride on the back; she never liked the bike at all. 'If Mark had an accident, he could be injured and you could be killed' she used to say, and we laughed, 'How come Debbie was always the one that got killed and I only got injured'; that seemed funny at the time . . . Now who's got the last laugh? Nobody, nobody's laughing now . . .

 J: What difference would it make if Debbie was here now?

M: I'd have something to get better for, I'd have a reason to get out of here.

 J: Hmmn . . . what else?

M: I'd be looking forward to seeing her, and getting out, and doing things.

 J: What sort of things?

M: I dunno, just getting out, getting back on a bike, getting . . . I don't know . . . just getting back to normal; maybe yeah, getting back on a bike someday, or going to rallies, or just doing stuff . . . going to the pub, y'know, normal stuff.

 J: Yeah. What else would be different?

M: I wouldn't feel so guilty all the time.

 J: What would you feel?

M: Determined . . . Strong. Like I was gonna get out of here.

 J: What would be different about you? What would I see different?

M: Oh, I don't know. How do I know what would be different?

 J: Okay, yeah. Let me ask you this though. How close are you to feeling like that? Say '10' stands for you're feeling strong and determined, and ready to fight your way back out of here, and '0' is sort of the exact opposite; you're just gonna surrender and give in to everything. Where are you just now, between '0' and '10'?

M: [sigh] . . . I dunno . . . about '2' I'd say.

 J: Okay . . . how have you managed that?

M: I dunno, I just block the whole thing out my mind sometimes.

 J: And that helps?

M: Well, for a little while . . .

 J: What else have you done?

M: Nothing, I don't think . . .

 J: So you've just got to '2' by blocking things out for a while and letting things happen?

M: Yeah, I guess.

 J: How will you know when you've got to '3'?

M: I dunno . . . I'll be able to think about it without blocking it out.

 J: What will you do instead . . . instead of blocking it out?

M: I dunno, just accept it, accept that it's happened.

 J: And would that help?

M: Yeah, I suppose it must. [pause]

 J: Is that what you're doing now?

M: Yeah, I suppose it is . . .

 J: How have you managed to do that?

M: I dunno, just you asking these questions . . . I don't want to do this . . .

 J: What do you want to do?

M: I dunno, I suppose I have to . . .

 J: So . . . if you're thinking about this just now, and accepting how it is . . . is this you at '3' at the moment?

M: Yeah, I suppose it is. [looks vaguely surprised at this]

 J: Well done. '3'.

M: Hmmn!

 J: Look; if you want to talk again, give me a shout. In the meantime . . . what would '4' look like?

Activity 5.1

Consider how you might have responded to Mark's initial outburst in the conversation above. If you were in Mark's position, what do you think '4' would look like?

Analysing the conversation

In the above conversation there are several points where Janeczka may have regretted getting into the conversation, and felt like running away from Mark's pain. Having taken the plunge and asked Mark, in realistic terms, what was wrong with him, Janeczka could easily have been swamped

by the enormity of his answer. Given his situation, where would she begin to list his potential problems? However, Janeczka did something that nurses (and most other health professionals) rarely do: she admitted that she 'didn't know'. We are, as a profession and as professionals, 'trained to know'. Our knowledge base is the root of our professional identity, and as professional practitioners it is the application of our knowledge to a given situation that defines our practice. So it often goes against all we have been taught, and all we have learned from practice, to say 'I don't know'. Which is unfortunate, because in most situations (or at least in most situations involving subjective experiences) we don't know what our patients are experiencing. So, in this situation, Janeczka admitted that she 'didn't know', which was not only an honest response, but invited Mark to continue in the conversation.

Key learning !

- By adopting a 'not knowing' position in our conversation we can often encourage patients to give us more information, and in greater detail, about how they are feeling and what they are thinking, than if we assume that we know what they mean.
- 'Not knowing' is a technique used by skilled practitioners to enable patients to explore their own thoughts and feelings; it doesn't necessarily reflect what the nurse actually knows or understands about a particular situation.

Again, Janeczka may have felt overwhelmed when Mark asked her directly what she was going to do to help him. Given his list of potential problems, where could she begin to help him? In light of this (so far) brief interaction, Janeczka might well have felt that Mark's derisive comments were justified, and again felt some regret at rushing into this conversation. However, she

knows that she is not offering to 'solve' Mark's problems, she's only asking 'what she would have to do' to solve his problems; in other words, her question is a hypothetical one aimed at discovering what it is Mark wants. Mark, naturally enough, finds it very difficult to answer this question, and so Janeczka, bearing in mind the hypothetical nature of the conversation, encourages him to use his imagination, to 'think outside of the box'.

Sometimes, gently asking someone, 'Suppose you did know?' allows them to think things they have not been allowing themselves to think about previously; sometimes it's just such a strange question that prompts the person to look afresh at the situation being discussed; either way, it can gently encourage someone to look beyond 'I don't know'.

When Mark does look again at what would help, his answer could well have left Janeczka stuck in her tracks. Bringing Mark's girlfriend back to life is an understandable response, but one that is clearly beyond Janeczka's power to deliver, and one that conveys some of the enormity of his loss and grief. Janeczka is able to 'hold' Mark's grief for a moment, because she knows that she doesn't have to 'sort it out'; instead, she continues to ask Mark what difference that would make. In all of this, Janeczka is asking rather than telling, and in the asking she is enabling Mark to begin to describe the world as he would like it to be. Clearly, Debbie is not going to come back, but there may well be a time at some point in the future where Mark begins to feel more able to confront the world and begin to move forward. This is in essence what Mark is describing – a future in which things are more positive. Note that in all of this conversation, Janeczka only makes three statements; everything else she says is a question. By asking 'not knowing' questions, Janeczka encourages Mark to explore his own solutions, rather than those which she might try to offer up to him in response to her understanding of his problem. Because the focus of this type of communication is on the patient's description of

their solution (rather than their problem) it is often described as a 'solution-focused' conversation.

Activity 5.2

Watch Insoo Kim Berg, one of the founders of the solution-focused approach, working with a teenage girl and her parents via the video link given below. Notice how she listens to the mother using only minimal 'not knowing' questions, and changes the focus of the conversation from Sarah's deficits to her assets by asking what she has 'going for her' at the end of the first session. You can access the video on YouTube at: http://bit.ly/YDyR8L.

The background to solution-focused interactions

Solution-focused interactions developed out of the work in solution-focused brief therapy (SFBT) of a husband and wife team, Steve De Shazer and Insoo Kim Berg, and their colleagues at the Brief Family Therapy Centre in Milwaukee, Wisconsin (De Shazer and Dolan 2007). De Shazer and Berg's background was in problem-solving; however, they came to realize that the people they were working with made quicker progress the less they spoke about their problems. In other words, less time spent talking about problems, and more time spent on talking about what people wanted out of life, made for more effective communication. Where the typical number of sessions required for other forms of therapy was between 12 and 20 (and sometimes many, many more) the average number of sessions required by the team at the Brief Family Therapy Centre was less than 5 (De Shazer *et al.* 1986). Although SFBT originated in family therapy, it was quickly adopted by other practitioners in a variety of fields. It has been utilized in settings as diverse as couples therapy, substance misuse, sex therapy, individual coun-

selling work, group work and self-help books, as well as settings such as social care, education, prison populations and business systems (Iveson 2002; Trepper *et al.* 2006; Walsh 2006).

In particular, nurses quickly recognized the potential benefits from this approach and began to incorporate solution-focused interactions in nursing practice (Webster 1990; Wilgosh *et al.* 1993; Montgomery and Webster 1994; Iveson 1995; Hillyer 1996). Webster (1990) argued that SFBT provided a framework that was congruent with both traditional nursing values and feminist ethics. Montgomery and Webster (1994) developed this further when they argued that solution-focused approaches provide a framework to promote a shift from a cure-orientation to a care-orientation in health care, and particularly in nursing. They argued that brief therapeutic approaches enabled nurses to re-engage with their patients, concluding that working within a solution paradigm, nurses could respond to their patients' vulnerability, as opposed to their pathology, and could reduce 'the mystique of our own power and knowledge', in order to 'give them a sense of their own power and help them rediscover their resources' (p. 296). McAllister (2007) takes this further, and argues that solution-focused nursing represents a 'practical philosophy' emphasizing the importance of exploring solutions as well as problems, a focus on strategies for working with patients and not on them, and the need to be cautious of dominant ways of thinking. Bowles *et al.* (2001) found that nurses working in a solution-focused way experienced less stress and anxiety, and reported being more confident in their work. Similar outcomes were reported by Boscart (2009) for nurses working in a continuing care setting, and by Neilson-Clayton and Brownlee (2002) and Smith *et al.* (2011) for nurses working in cancer care and surgical care respectively. In all these papers, nurses utilizing a solution-focused style of communication were able to care for their patients in a less authoritative manner, giving patients more opportunity to take responsibility and make decisions about their health care.

Values and principles of solution-focused interactions

Some of the values and principles which underpin solution-focused interactions are:

- sensitivity to individual and cultural differences;
- maintaining human dignity;
- promoting self-care;
- recognizing and enhancing patients' strengths;
- a health, rather than illness, focus;
- endeavouring to reduce pain and discomfort;
- reintegrating patients into helpful social systems;
- emphasizing the pragmatics;
- promoting a safe environment;
- mobilizing patient hope and agency.

Webster (1990) argues that these same principles underpin traditional nursing values. Given the very close links between the ethics and practice of nursing and the principles underpinning solution-focused interactions, it is not surprising that working in a solution-focused way can be

seen to operationalize some of the NMC competencies relating to communication and interpersonal skills. In particular, nursing from a solution-focused perspective enhances the nurse's ability to ensure that communication is 'safe, effective, compassionate and respectful'. We have seen how Janeczka used solution-focused skills to listen to Mark in an empathic way. This is central to the NMC expectations, and indeed Domain 2, Competency 1 states that all nurses 'must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication'. In the example above, it can be seen that Janeczka's practice met these standards, in that she didn't tell Mark what to do, rather she facilitated a conversation that helped him identify his 'problem' and begin to build a solution to it. This principle crosses all domains of nursing; in the next conversation note how Anne, a children's nurse, enables David, an 8-year-old boy who has Type 1 diabetes, to maintain his sense of independence and engage in the decision-making process.

Case study 5.2: David and Anne

David's previously well managed diabetes has become unstable in the last year. It is thought this is due to his increasing reluctance to follow a regular dietary regime, which he is unable to do as he is spending more time with friends from school than he did previously. While his family are keen to promote normal social interactions, they are worried that David's desire to be 'the same as everyone else' is at odds with his diabetes management.

Anne works in a unit specializing in the care of children and young people with diabetes. David has been referred by his GP to a nurse-led clinic within the unit. Anne begins by talking to David about his life: what he enjoys, his favourite sports and his favourite television programmes. In carrying out this 'problem-free talk' Anne is both learning something about David's wider life, and letting him know that she sees him as more than just a problem or just another case. She then goes on to ask David how he sees the problem. In this period of 'problem talk' Anne listens to David describe how he sees the problem from his perspective. David talks at some length about how his mum gets onto him for not eating the 'right food' at the 'right time' and how it's not fair, because all he wants to do is play with his school friends and it's not his fault about the diabetes. Throughout this period, Anne simply listens and acknowledges that she understands what David is telling her; specifically, she offers no opinions or advice on what David is telling her. In this respect, solution-focused communication differs from other forms of professional communication Anne might employ as a nurse, in which she might provide health education information, or take the opportunity

to explore David's feelings more deeply. Here, she simply listens (T.K., one of my students on a solution-focused training course, described the approach as 'more of a listening therapy than a talking therapy', which I thought very apt). Anne then asks David how she can help him deal with his problem – i.e. how can she help him stop his mum 'getting on to him'. In doing this she is both addressing David's problem (as opposed to his doctor's problem or his family's problem) and using the words that David used to describe the problem to her. Not surprisingly, David doesn't have many ideas how she could do this. Here's an extract from their conversation.

D: You could tell her she doesn't need to worry about me.

A: Would that help, do you think?

D: Probably not.

A: Let me ask you a question then, David. [Anne pauses] Suppose . . . just suppose that later . . . after you leave here and go home and do the things you're going to do for the rest of the day . . .

D: I'm going out to play with Gavin at the park.

A: Right; so you go out to play with Gavin at the park . . . and then you come home . . . and when it get's to bed-time, you go to bed. Now . . . while you're sleeping . . . something amazing happens . . . and the problems you've been telling me all about . . . are gone. Just like that! You don't understand how it's happened, but they're gone. But . . . you're asleep, right?

D: Yeah . . .

A: So . . . because you're asleep, you don't know that this thing has even happened. So . . . what will be the first thing that tells you in the morning that something is different? Can you draw me a picture of what it will be like when things are different, and this problem's gone? [Anne then provides David with paper and a large selection of coloured pencils and pens]

It can be seen here that Anne and David are essentially 'telling a story'; Anne is providing most of the story but readily incorporates the parts David provides. She makes good use of pauses; allowing David time to imagine what that part of the story is like. In asking David to draw a picture of his ideal day rather than describing it in words, Anne is recognizing that it is often easier for young children to use visual communication, as opposed to verbal communication, to express their ideas. This approach can also be used when asking scaling questions (**Figure 5.1**).

Note also that Anne doesn't say, 'Can you draw me a picture of what it would be like when things are different', or 'what it will be like if things are different', instead she uses pre-suppositional language to suggest that things not only can be different, but will be different. David then goes on to draw a picture of his family in the kitchen on the morning after his problem is gone.
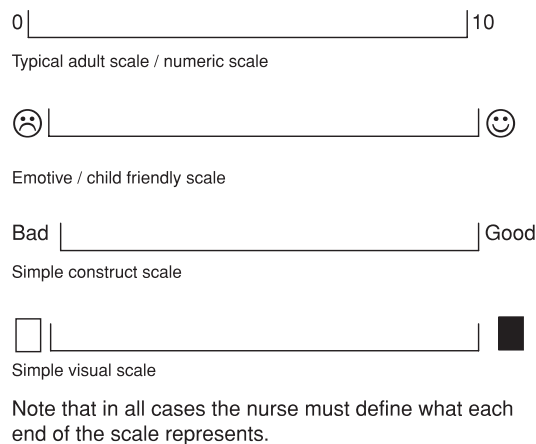

Figure 5.1 Different media for scaling questions

Case study 5.2: continued

A: So, what's here?

D: This is me, sitting in the kitchen, and I've got my football top on.

A: Right, so, what day is it?

D: It's Saturday, 'cause I'm going out to play. I'm going to play football with Gavin and Tom, and we're going to the park.

A: Right. What else?

D: We'll buy sweets.

A: Okay; what else is happening in the picture?

D: The dog's wagging his tail, 'cause he's happy . . . and I'm smiling 'cause I'm happy too. And Mum's smiling, 'cause she's happy.

A: Right! So everyone's happy. What else is happening?

D: I'm having my breakfast, I'm having sausage and eggs, that's the egg there, and I'm having juice to drink.

A: Wow, okay. What else is there?

Anne goes on to get David to describe how this particular story ends and David, knowing the rules about stories, provides a suitable happy ending as he sees it. In doing this, Anne is helping David describe his 'positive future scenario'. The capacity to tell a story with a happy ending is something that is not lost to us as we grow older; we can all describe a positive future scenario given the right encouragement. However, no matter how happy the ending, this is still just a story. Anne continues to encourage David to add detail to his story by asking him what his mum would notice different about him on this day ('I'd be all happy and talking to her') and eliciting detail about this, and what his Dad would notice different about him ('I'd finish my breakfast quick, and clear away the plates'); even what the dog would notice different about him ('Ha ha; he'd get a really big walk and we'd go to the park, and he'd get a bone. He'd know I was happy 'cause I'd give him a big hug'). In every case, Anne elicits as much detail from David as he can provide about what would be happening and what each person (or pet) would notice. In doing this, David creates more and more detail, and his story becomes more and more 'real' as a result. It is though, still a story; which is why Anne then brings the story back to reality.

A: Wow . . . what a great picture. But, I'm wondering . . . have there been any times you can remember when any of that's actually happened? Any time you've all been happy, or you've gone out with the dog, or even given him a big hug?

D: Well . . . we're happy sometimes . . . and the dog's always wagging his tail, and we take him out for walks and stuff.

A: Wow . . . how do you manage to do that? I mean with all these problems you were telling me about; with all that going on, how do you manage to be happy sometimes and take the dog out?

D: Well . . . it's not always like that . . . Mum's not always getting on at me . . . mostly she's okay.

A: How do you manage that . . . how do you get your mum not to be getting on at you?

D: I don't know . . . it's only when I'm messing about with my diet that she gets mad . . .

A: So what do you do to stop her getting mad?

D: Well . . . I just keep to my diet really.

A: Oh right . . . Okay . . . How do you do that?

D: Well, it's quite easy really. I've got a thing here, look . . .

David then goes on to explain his diet regime to Anne. Note that throughout Anne is asking 'not-knowing' questions, using David's words wherever possible, and looking at the situation from his point of view. In doing this she helps David create a meaningful positive future scenario, and then helps him to recognize that *parts* of it are happening already; not only does he not need a miracle to bring about his positive future scenario, but parts are already happening and he wasn't even aware of it! This highlights a basic principle of solution-focused interactions; *it's not our job to change the patient's life*. Our job is to help the patient recognize where change is already happening in their life, and they haven't noticed it yet, and to do more of what has helped bring about that change. Most of the key principles of solution-focused practice can be grouped under four interconnected headings, which we examine in the next section after **Activity 5.3**.

Activity 5.3

- Consider for a moment how solution-focused interactions might enable you to practise in accordance with the NMC competencies within your own area of practice.
- Make a note of a recent clinical situation you were involved in, and think of how you could have applied solution-focused interactions in that situation.
- Make links from this to the specific NMC competencies you would be demonstrating were you to have responded in that way.

Some key principles of solution-focused interactions

If it's not broken, don't fix it

Patients come to us with problems; they are not the problem themselves. We often hear other practitioners (and, truth be told, we sometimes do it ourselves) speak about 'problem patients' or refer to patients using a diagnostic label; in other words, defining patients by what is wrong with them. While there is, obviously, an element of logic to this process, it is very likely to encourage us to see our patients in terms of their deficits, and to focus our attention on what they *can't* do. In solution-focused interactions we make a deliberate attempt to build on what is healthy and functioning about the patient. We see patients as being inherently

competent, and having the necessary resources to change and adapt to whatever problems are occurring in their lives. Therefore we focus on what is going well in the patient's life (while not ignoring their presenting problem) and what they have at the moment that they would like to keep in the future. These are the patient's assets and strengths, and these are the things that they are going to have to rely upon in order to overcome whatever difficulty they are experiencing at the moment.

Activity 5.4

Take a piece of A4 paper and fold it in half. On the left-hand side write down any problems you have been experiencing recently (equally you can note any problems a patient you have been working with has been experiencing); make a list of between three and five aspects of the problem. On the right-hand side of the paper, write down opposite each part of the problem the skills, strengths or attributes which you (or your patient) have brought to bear in dealing with that problem. Now tear the paper in half along the fold you made earlier. Throw away the left-hand panel, and look at the right-hand panel; where did you get these strengths and abilities from? Consider how they have helped you in the past, and think of how they might be useful in helping you in the immediate future. What other strengths, skills and positive attributes do you possess?

If it's working, do more of it

This might seem like a really obvious statement, but very often people respond more to what they think they 'should be doing', rather than what they know to work. In order to know if something is working, we have to know where we are going or what it is that we want to happen. Often, particularly in times of distress, we focus on feelings of 'I don't want this to happen' without necessarily thinking what it is 'I do want' to happen. In Mark and Janeczka's story, Janeczka helps Mark move from what he doesn't want to be happening to what he does want, by asking him 'What would you feel?'. Mark then begins to describe what it is he would like to be happening instead. Janeczka then helps him measure how well his efforts at getting to where he wants to be are working by asking him to scale his progress, and even to identify a 'next step'. Similarly, Anne enables David to describe what he wants to be happening and then helps him to describe what it is he is doing already 'that works'. Again, it is not Anne's or Janeczka's job to tell their patient what they should be doing, it's their job to help their patient identify what they are already doing that works, and then to encourage them to do more of it.

If it's not working, stop doing it

If the previous point seemed pretty elementary, this key principle should be even clearer. However, there are many times when we all continue to do things that aren't helping us, even when we are clear what we want from a situation. Sometimes we are unaware of the connection between what we are doing and a lack of positive change, sometimes we tend to think that we're just not doing what we think will be helpful 'hard enough', and sometimes we just like doing something even though we know it isn't helpful. In all three cases it isn't our role to lecture our patients on what they should, or shouldn't be doing, but rather we can take a 'not knowing' posture and ask them to explain to us how what they are doing is helpful to them. By asking questions like, 'Does that help?', or 'How is that good for you?' we can encourage our patients to explore the impact of what they are doing, and to recognize that if something isn't helping the first time you do it (or certainly by the third or fourth time), it's unlikely to help at all. We can then ask, 'What else can you do that will be helpful?' It's important to recognize that, sometimes, a patient might benefit from permission from a nurse, or other perceived authority figure, to stop doing something that isn't working (e.g. to stop responding to a violent partner, or to stop 'grieving' for a loss); however, the recognition that it isn't working must come from the patient before we can respond to it in a helpful way.

Big problems don't need big solutions

Most people are pretty good at solving the problems of daily life; we regularly overcome any number of problems on a daily basis. 'Where are my shoes?', 'How do I address this assignment?', 'How can I tell my friend that I can't meet her tomorrow night?': these are all the types of problems that most of us deal with every day. However, the problems that our patients often bring to us are of a different order: 'How can I live my life with the impact of injury, disease, disability and loss?' These are the kinds of problems that can feel overwhelming to us as nurses, and we often resort to 'on the surface' responses that fail to respond to the patient's underlying need for help. However, from a solution-focused perspective we take the view that problems and solutions are not as closely connected as we might think. We don't have to 'solve' the patient's problem; we only have to help them see it in a different way, in order that they can find their own way of dealing with (or solving) their problem. In helping people see things in a different way, encouraging them to make a small change in their lives is often more effective that asking them to make a major change. A small change in the way a person behaves is frequently enough to bring about further changes in their life and in the way people around them behave towards them.

Activity 5.5

The diagram below describes the solution-building process. See if you can link the parts of the process to what you have learned about solution-focused interactions so far.
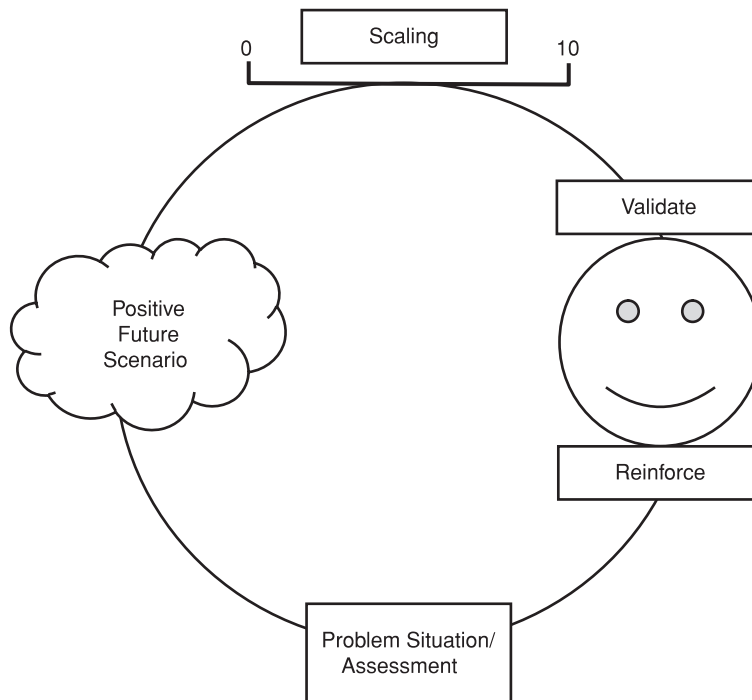

Figure 5.2 The solution-building process

Key learning

!

The process of solution building begins with hearing the patient's account of 'the problem'. We then help the patient describe their positive future scenario, and scale how close they are to achieving that goal. We then validate the steps the patient has taken towards achieving their goal and reinforce the things that are 'working'. In doing this we are guided by the principles of:

- if it's not broken, don't fix it;
- if it's working, do more of it;
- if it's not working, stop doing it;
- big problems don't need big solutions.

Solution-focused interactions in the 'non-clinical' setting

Some of these key principles have been seen in the clinical scenarios presented above. However, solution-focused interactions can also be used in non-clinical situations such as team meetings, staff appraisals and planning meetings. The same techniques of 'not knowing', 'asking rather than telling', 'focusing on assets rather than deficits', and the use of scaling and a 'positive future scenario' can all be utilized in moving professional conversations away from a problem focus to a solution focus. The NMC generic standard for competence in communication and interpersonal skills states that, 'all nurses must use excellent communication and interpersonal skills. Their communications

must always be safe, effective, compassionate and respectful'. This standard does not only apply to communication with patients but equally to professional communications – for example, with members of the multiprofessional team. Solution-focused interactions can provide a framework for engaging in effective communication in a range of difficult situations. Where, increasingly, the registered nurse's role encompasses that of mentor and coach to junior staff, the skills of solution-focused interactions can be utilized to facilitate respectful, yet effective, coaching across the domains of professional practice.

Conclusion

No single approach can be seen as a panacea for all nursing practice; however, solution-focused interactions are an important addition to the 'tool-box' of knowledge and skills possessed by the contemporary nurse practitioner. Whether practising in adult, children's, learning disabilities or mental health nursing, all practitioners are required to demonstrate competency in communication and interpersonal skills. This requirement not only crosses all domains of practice, but also

crosses communication with patients and clients, relatives, colleagues, and anyone the nurse comes into contact with. Solution-focused interactions provide a framework for nurses to communicate in a safe, respectful, compassionate and effective manner, recognizing the traditional values of nursing and promoting patient independence and well-being. Several examples of the techniques being used in clinical practice have been discussed, and further reading is suggested below.

In summary:

- It can be seen that solution-focused interactions are structured around a process of:
  - hearing the client's definition of their particular problem;
  - helping the client construct a positive future scenario;
  - scaling how close the client is to achieving their goal and their next small step;
  - delivering a solution-focused intervention.
- These questions provide a structure within which we can then address the NMC competencies in relation to communication and interpersonal skills.

Further reading and resources

Connie, E. and Metcalf, L. (eds) (2009) *The Art of Solution Focused Therapy.* New York: Springer.
De Shazer, S. and Dolan, Y. (eds) (2007) *More than Miracles: The State of the Art of Solution-focused Brief Therapy.* London: Routledge.
Hanton, P. (2011) *Skills in Solution Focused Brief Counselling and Psychotherapy*. London: Sage.
MacDonald, A. (2011) *Solution-focused Therapy: Theory, Research and Practice*. London: Sage.
McAllister, M. (ed.) (2007) *Solution-focused Nursing: Rethinking Practice*. Basingstoke: Palgrave Macmillan.

References

Boscart, V. (2009) A communication intervention for nursing staff in chronic care, *Journal of Advanced Nursing,* 65(9): 1823–32.
Bowles, N., Mackintosh, C. and Torn, A. (2001) Nurses' communication skills: an evaluation of the impact of solution-focused communication training, *Journal of Advanced Nursing*, 36(3): 347–54.
De Shazer, S. and Dolan, Y. (eds) (2007) *More than Miracles: The State of the Art of Solution-focused Brief Therapy.* London: Routledge.
De Shazer, S., Berg, I.K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W. and Weiner-Davis, M. (1986) Brief therapy: focused solution development, *Family Process*, 25(2): 207–22.
Hillyer, D. (1996) Solution oriented questions: an analysis of a key intervention, *Journal of the American Psychiatric Nurses Association*, 2(1): 3–10.
Iveson, C. (1995) Solution focused brief therapy: a tool for health visitors, *Health Visitor*, 68(6): 236–8.

Iveson, C. (2002) Solution-focused brief therapy, *Advances In Psychiatric Treatment*, 8: 149–57.

McAllister, M. (ed.) (2007) *Solution-focused Nursing: Rethinking Practice.* Basingstoke: Palgrave Macmillan.

Montgomery, C. and Webster, D. (1994) Caring, curing and brief therapy: a model for nurse psychotherapy, *Archives of Psychiatric Nursing*, 8(5): 291–7.

Neilson-Clayton, H. and Brownlee, K. (2002) Solution-focused brief therapy with cancer patients and their families, *Journal of Psychosocial Oncology*, 20(1): 1–13.

Smith, S., Adam, D., Kirkpatrick, P. and McRobie, G. (2011) Using solution-focused communication to support patients, *Nursing Standard*, 25(52): 42–7.

Trepper, T.S., Dolan, Y., Mccollum, E.E. and Nelson, T. (2006) Steve De Shazer and the future of solution-focused therapy, *Journal of Marital and Family Therapy*, 32(2): 133–9.

Walsh, T. (2006) Two sides of the same coin: ambiguity and complexity in child protection work, *Journal of Systemic Therapies*, 25(2): 38–49.

Webster, D.C. (1990) Solution focused approaches in psychiatric/mental health nursing, *Perspectives In Psychiatric Care*, 26(4): 17–21.

Wilgosh, R., Hawkes, D. and Marsh, I. (1993) Session two and beyond – or, 'what do you say after you say "hello" again?' *Context*, 9: 31–3.