# Using Solution Focused Recovery to Counteract the Nocebo Effect in Mental Health Care.


**Buchanan, G. and Smith, S.**

**Abstract**

***Aim:*** *This study aimed to establish a proof of concept that training mental health nurses in a solution focused recovery approach can enhance the provision of recovery focused care and thereby reduce the iatrogenic effect inherent in much of contemporary mental health care.* ***Methods:*** *A solution focused recovery training programme was devised and delivered to nurses working in an acute in-patient setting. Feedback was sought from participants.* ***Results:*** *Participants reported favourably on the training programme and saw it as promoting a culture change in their clinical practice.*

***Conclusion:*** *The evidence supports the concept that training in a solution focused recovery approach can enhance the provision of recovery focused care.*

**Introduction**

This paper reports on a proof of concept study undertaken to explore whether training mental health nurses in a solution focused recovery approach might enhance the delivery of recovery focused care in acute in-patient settings. The study is based on the premise that much of contemporary mental health care has an, inadvertent, negative effect on patient's sense of self, agency and hope (the Nocebo Effect) which insidiously detracts from recovery focused care.

**Literature Review**

For many nurses, and indeed for most other health care professionals, the nocebo effect is an unknown concept. First identified over fifty years ago, Kennedy (1961) hypothesised that a series of non-specific pharmacological side effects observed in patients participating in drug trials

represented the opposite response that one might see in the *placebo effect*. He coined the term Nocebo from the Latin "I will do harm" (as opposed the Placebo "I will please"). Data-Franko and Berk (2013) define the nocebo effect as the,

> "non-pharmacodynamic, harmful, unpleasant, or undesirable effects a person experiences after receiving an inactive treatment. Like the placebo effect, this additionally has the potential to impact on active therapy."
>
> (p.617)

Several important implications of the nocebo effect have been identified. Cohen (2014) highlights the dilemma whereby the disclosure of potential side effects of a given medication may, in itself, cause pain, stress or harm to occur to the patient. However, that is not to suggest that the negative outcome is purely a psychological response, 'all in the patients head' as it were. Colloca and Benedetti (2007), exploring the impact of the nocebo effect in hyperalgesia, note that the patient's expectations not only produce an emotional response (fear) but also a physiological response (the activation of cholecystokinin) which, in turn, facilitates pain transmission. Sidharth et al (2015. p.242) suggest that a contemporary understanding, or definition, of the nocebo effect would define it as "the occurrence of adverse effects to a therapeutic intervention because the patient expects them to develop". Dietsche and Davies (2007. p.9), in exploring the impact on women of waiting for an appointment with a gynaecologist after having had an abnormal Pap test result, spoke of the "iatrogenic, unintended, harmful consequences" as a nocebo effect. They concluded that,

> "The nocebo effect was not the result of any intentional act on the part of individual health professionals. Rather it was caused in part because the clinician was either unaware or felt

> powerless to consider and act on the effects waiting may have on a person's wellbeing."
>
> (p13)

This highlights the, not only unintentional but often unaware, nature of the nocebo effect whereby actions considered by the nurse (and other practitioners) as neutral, or even therapeutic, may be experienced by the patient as harmful. Gots and Hamilton (2001. p.39) argued that clinicians could add "an iatrogenic component to their patients' illnesses through the nocebo effect" as a result of their own beliefs about the patients' condition.

The potential for mental health care to be iatrogenic is well recognised. Warrender (2015) spoke of the iatrogenic impact of unhelpful responses by nursing staff to patient self-harm, and Jordan et al (2009) have discussed the iatrogenic risks associated with commonly prescribed medications. However, the awareness of the nocebo effect allows us to extend our understanding of iatrogenesis to include objectively benign stimulus such as psychiatric diagnosis and problem/deficit oriented treatment plans. Indeed, Van Os (2010) argued that, what he termed the "unscientific and mystifying terminology" associated, in particular, with diagnoses of psychotic illness, created an iatrogenic stigma for the patient.

It is, in part, the iatrogenic nature of psychiatric treatment (and the same principles applied under the more contemporary label of *mental health care*) that led to the emergence of the Recovery Movement. Drawing upon the work of mental health service users/consumers/survivors, such as Pat Deegan, Esso Leete and Joan Houghton in the 1980's, Anthony (1993) linked the concept of mental health recovery to that of recovery in the context of physical illness and disability, arguing that recovery,

> "is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the

> development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."
>
> (p15)

This has continued to provide a broad-based definition of recovery, one that is endorsed by policy makers across the United Kingdom (Mental Health [Wales] Measure, 2010; HM Government, 2011; Scottish Government, 2012), as well as internationally. The core concepts associated with recovery are the growth of Hope, Agency and Opportunity (South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010). In Scotland, the Scottish Recovery Network (SRN) (2016) identify recovery as being a personal journey, a goal for some and a destination for others, with a focus on what the individual can do as opposed to what they cannot do. This concept of 'being able to live a good life regardless of symptoms or diagnosis' is one that informs much of contemporary mental health policy and legislation, and yet is one that is also widely misunderstood. Kidd et al (2015) point out that for many mental health practitioners 'recovery' remains a concept of cure, or 'recovery from', rather than recovery in the context of living with a condition. McKenna et al (2014) have argued that although recovery,

> "has become a dominant policy-directed model of many mental health care organizations … in older-adult acute mental health inpatient settings, nurses do not have a clear description of how to be recovery-oriented"
>
> (p1938)

Indeed, this goes beyond the arena of older adult care, Kidd et al (2015) note that models of mental illness that exclude a recovery concept remain the dominant models in clinical practice. Milbourne et al (2014) highlight that the experience of engaging with mental health services for many people

with severe mental illness remains one of being within a cycle of surveillance and maintenance where one is a recipient, or consumer, of services rather than being the expert by experience. According to McCauley et al (2015) there is little shared understanding of the concept of recovery across the mental health professions. They state that the psychiatric literature reflects recovery as a prolonged absence of symptomatology, while the occupational health and behavioural science literature projects an understanding of recovery as 'psychiatric rehabilitation', with the mental health nursing literature reflecting an understanding of 'rediscovering the self' and a 'new orientation' (p587).

While recovery is about the individual and their ability to have control and agency in their own life, clearly health and social care mental health services should maximise the individual's potential to achieve this, and not detract from that potential. Many services, while saying they support a recovery model still practice in a deficit orientated approach, focusing on what is perceived to be 'wrong' with the individual and failing to engage with the person's strengths, abilities and positive life experience. This can result in services attempting to respond to the unique experience of the individual with a standardised response, in the name of evidence-based-practice. For us, while the principles of recovery are widely accepted by policy makers and legislators, the practical integration of those principles into mental health care practice is not always evident; for many mental health practitioners and services, *how to* deliver recovery-based care remains unclear.

**Aims**

Having posed the question, 'how can mental health nurses incorporate the principles of recovery-based care into every day practice?' we drew upon our background in solution focused interactions (Smith et al, 2011; Smith and Buchanan, 2012; Smith and Kirkpatrick, 2013) to develop an answer. We recognised that solution focused interactions (SFI) help to promote the core concepts of hope, agency and opportunity that are central to mental health recovery (South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010;

Smith, 2015). SFI is an umbrella term for those techniques and ways of communicating that grew out of Solution Focused Brief Therapy, developed by Steve De Shazer and Insoo Kim Berg (and colleagues) in the 1980's (De Shazer et al, 1986). Some of the key principles underpinning SFI can be seen in Box 1. It can be seen that SFI focuses on the patient's strengths and abilities rather than on deficits and disabilities; in other words, it focuses on 'what is not the problem' and as a result provides the opportunity to foster a sense of hope and agency for patients and clients (Reiter, 2010). Therefore, we hypothesised that practising in a SFI manner would have the effect of promoting recovery-based care in practice. The aim of the study was therefore to test whether this hypothesis would be acceptable to a group of experienced nurse practitioners.

**Strength Based**: Focuses on what the patient can do as opposed to what they can't do. Focuses on patient's abilities rather than deficits.
**Future Focused**: Looks to the future (which is open to change) rather than the past (which cannot be changed).
**Not knowing**: Nurse asks questions of the patient to assist them in finding solution (open conversation)rather than telling the patient what she thinks the solution is (closed conversation).

Box 1: Key Principles underpinning Solution Focused Interactions.

**Methods**

We devised a one-day training course in Solution Focused Recovery (SFR) and delivered it to two cohorts of mental health nurses in order to test the concept of the training initiative. There were thirteen participants in total, seven on the first day and six on the second day; all participants worked in either an Intensive Treatment Unit or acute psychiatric care ward. Twelve nurses were trained and one participant was a Nursing Assistant. The training day focused on introducing participants to the Nocebo effect and then outlined SFI in four key stages, participants then took part in simulated practice scenarios where they were able to try out the SFI communication techniques (see Box 2 for the content of the day). Following a question and answer period anonymous feedback was gathered from participants on how they felt the day had gone for them.

**Results**

Anonymous qualitative feedback was gathered using an evaluation questionnaire which participants were asked to complete at the end of the one-day training event. Evaluation was very positive, with all participants (n=13) rating their experience of the event as 'positive' (see Table 1), and giving an overall mean satisfaction rating of 97.5%. From analysis of written feedback two themes emerged. The first of these is that participants clearly intended to incorporate solution focused interactions into their clinical practice. While some degree of enthusiasm at the end of the training day would be hoped for, 11 participants (85%) specifically stated that they intended to promote solution focused recovery in their ward area, and the remaining 2 participants *implied* a similar position.

- **Recovery:** Hope, Agency, Identity, Self.
- **The Nocebo Effect**: Do we do harm by focusing on problems?
- **Solution Focused Interactions:**
  - Best hopes
  - Future Goals
  - Scaling
  - Compliments
  - Task
- **Practice Sessions**

Box 2: Core content of SFR training day.

> "Solution focused recovery will be put into practice daily at my own ward to help patients focus on solutions instead of problems"
>
> Participant 3

> "I can utilise this in practice on a daily basis when interacting with patients"
>
> Participant 4

> "I will try and implement it into my daily interactions with others, both patients and peers."
>
> Participant 8

"I would use information at work, and day to day life."

Participant 12

While caution must be exercised in drawing conclusions from brief written statements, it is apparent that the idea that solution focused interactions could help promote recovery based care was acceptable to the participants, and that some of them had already begun to see ways in which this form of communication could be used in other settings.

| | Negative | Neutral | Positive |
|---|---|---|---|
| Please rate your enjoyment of the event | | | 100% (n=13) |
| Please rate the training methods used | | | 100% (n=13) |
| Based on the advert, did the event meet your expectations? (* 1 missing response) | | 7.5% (n=1) | 85% (n=11)* |
| Did you find the event useful? | | | 100% (n=13) |
| Has your confidence in this topic area increased? | | | 100% (n=13) |
| Would you recommend this event to a colleague? | | | 100% (n=13) |

Table 1: Evaluation of training event by participants (n=13).

The second theme to emerge is that solution focused recovery represents a positive shift in the culture of mental health care. Nine participants (69%) suggested that they believed that the introduction of SFR into their ward would be beneficial; some focusing on a specific aspect of care, while some statements were more global.

"I would use this approach as it would feel to the patient like more empowerment and for them to think for themselves"

Participant 12

"SFR will make a positive experience and useful change in culture within ward environment"

Participant 7

"This is a positive move forward with culture change, and it's easy to understand"

Participant 9

"I will use this because it makes sense!"

Participant 10

While the first three statements above suggest the belief that SFR will empower patients, to have their voice heard by staff and that this equates to a positive cultural shift, it is the fourth statement that has the greater significance for us; that our hypothesis makes sense to nurses in clinical practice.

**Discussion**

It can be seen that there was a general approval of the training day from staff who participated, and these nurses appear to support our hypothesis that brief training in solution focused recovery would enable them to deliver care that would promote recovery for the patients they were working with. The key concepts of hope, agency and opportunity were central to that experience. It could be argued that we are claiming quite a significant impact for a simple one-day training experience. However, our hypothesis makes two assumptions. One; that the majority of mental health nurses (and indeed any nurses or other health care workers) want to deliver recovery-based care and promote the experience of hope, agency and opportunity for the patients they work with, and two, that learning how *to do* recovery-based care is not difficult, when the training is provided upon a bedrock of experience and education (almost all of the participants were trained nurses, and the one untrained nurse had a significant history of working with vulnerable people). Indeed, previous research has suggested that the practice of solution focused brief therapy, which underpins the interactions inherent in SFR, can be successfully taught to nurses in very brief training experiences

lasting only a few days (Bowles et al, 2001; Stevenson et al, 2003; Hosany et al, 2007; Chambers et al, 2013).

**Conclusion**

Our primary conclusion is that this test of concept has shown that there is reason to believe that training nursing staff in solution focused interactions can help them to deliver recovery enhancing care. The feedback we received from a small group of experienced nurses leads us to believe that the concept of Solution Focused Recovery based care is a realistic concept for training and clinical practice.

**Implications for practice**

- A brief one-day training workshop in solution focused recovery can help mental health nurses deliver recovery focused care in a meaningful way.
- A solution focused recovery approach helps mental health nurses avoid the nocebo effects of focusing on patient's deficits and problems and allows them to engage with patient's strengths and abilities to build recovery.
- The use of a solution focused recovery approach may enable mental health nurses to engage in communication more meaningful to the patient's needs.

**Acknowledgements**

The authors acknowledge the assistance of Neil Gallacher and Alyssa Bell, both of Stratheden Hospital, Fife, for their support in the wider project from which this paper is taken.

**References**

Anthony, W., A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*; 16: 11 - 23.

Bowles, N., Mackintosh, C., Torn, A. (2001) Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing*; 36(3): 347 - 354.

Chambers, M., Gillard, S., Turner, K., Borschmann, R. (2013) Evaluation of an educational practice development programme for staff working in mental health inpatient environments. *Journal of Psychiatric and Mental Health Nursing*; 20: 362 – 373.

Cohen, S. (2014) The Nocebo Effect of Informed Consent. *Bioethics*; 28(3): 147-154.

Colloca, L. and Benedetti, F. (2007) Nocebo hyperalgesia: how anxiety is turned into pain. *Current Opinion in Anesthesiology*; 20(5): 435-439.

Data-Franco, J. and Berk, M. (2013) The nocebo effect: A clinicians guide. *Australian & New Zealand Journal of Psychiatry*; 47(7): 617-623.

De Shazer, S., Berg, I. K., Lipchik, E., *et al.* ( 1986). Brief therapy: focused solution development. *Family Process*; 25(2): 207 - 222.

Dietsch, E., and Davies, C. (2007) The nocebo effect for women in waiting. *Collegian*; 14(3): 9-14.

Gots, R., E. and Hamilton, D. V. (2001) Multiple chemical sensitivities: an iatrogenically perpetuated disorder and example of the nocebo effect: symposium on 'alternative' public health threats. *Scientific Review of Alternative Medicine*; 5(1): 39-44.

HM Government. (2012) *No Health Without Mental Health: Implementation Framework*. London, Department of Health.

Hosany, Z., Wellman, N., Lowe, T. (2007) Fostering a culture of engagement: a pilot study of the outcomes of training mental health nurses working in two UK acute admission units in brief solution-focused therapy techniques. *Journal of Psychiatric and Mental Health Nursing*; 14: 688 - 695.

Jordan, S., Jones, R. and Sargeant, M., P. (2009) Adverse drug reactions: managing the risk. *Journal of Nursing Management*; 17(2): 175-184.

Kennedy, W., P. (1961) The nocebo reaction. *Medical World;* 95: 203–205.

Kidd, S., Kenny, A., McKinstry, C. (2015) The meaning of recovery in a regional mental health service: an action research study. *Journal of Advanced Nursing*; 71(1): 181 - 192.

McCauley, C. O., McKenna, H. P., Keeney, S., McLaughlin, D. F. (2015) Concept analysis of recovery in mental illness in young adulthood. *Journal of Psychiatric and Mental Health Nursing*; 22: 579 – 589.

McKenna, B., Furness, T., Dhital, D., Ireland, S. (2014) Recovery-Oriented Care in Older-Adult Acute Inpatient Mental Health Settings in Australia: An Exploratory Study. *Journal of the American Geriatrics Society*; 62(10): 1938 – 1942.

*Mental Health (Wales) Measure 2010. nawm 7.*

Milbourn, B. T., McNamara, B. A., Buchanan, A. J. (2014) Do the everyday experiences of people with severe mental illness who are ‘‘hard to engage’’ reflect a journey of personal recovery? *Journal of Mental Health*; 23(5): 241 – 245.

Reiter, M., D. (2010) Hope and expectancy in solution-focused brief therapy. *Journal of Family Psychotherapy*; 21: 132 – 148.

Scottish Government. (2012) *Mental Health Strategy for Scotland: 2012-2015*. Edinburgh, Scottish Government.

Scottish Recovery Network. (2016) *What is recovery?* [Online] Available from : http://www.scottishrecovery.net/what-is-recovery/ [Accessed 04 October 2016]

Sidharth, S., Kinshuk, S., Rahul, A., *et al*. (2015) Nocebo effect in dermatology. *Indian Journal of Dermatology, Venereology and Leprology*; 81: 242-250.

Smith, S., Adam, D., Kirkpatrick, P., McRobie, G. (2011) Using solution-focused communication to support patients. *Nursing Standard*; 25(52): 42 - 47.

Smith, S., Buchanan, G. (2012) Engaging with the Scottish Government’s Agenda on Health and Social Care. *InterAction: The journal of solution focus in organisations*; 4(2): 26 – 34.

Smith, S., Kirkpatrick, P. (2013) Use of solution-focused brief therapy to enhance therapeutic communication in patients with COPD. *Primary Health Care*; 23(10): 27 - 32.

Smith, S., W. (2015) *BECOMING: an analysis of narratives describing the experiences of nurses who have undertaken training in solution focused brief therapy.* [PhD Thesis] [Online]. Available from: https://openair.rgu.ac.uk/handle/10059/1220. [Accessed 04 October 2016].

South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust. (2010) *Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists*. London: SLAM/SWLSTG.

Stevenson, C., Jackson, S., Barker, P. (2003) Finding solutions through empowerment: a preliminary study of a solution-oriented approach to nursing in acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*; 10: 688 – 696.

Van Os, J. (2010) Are psychiatric diagnoses of psychosis scientific and useful? The case of schizophrenia. *Journal of Mental Health*; 19(4): 305-317.

Warrender, D. (2015) Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: a qualitative study. *Journal of Psychiatric & Mental Health Nursing*; 22(8): 623-633.