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Solution-focused therapy in an Emergency Room setting: Increasing hope in persons presenting with suicidal ideation

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Abstract

- *Summary:* One-third or more of persons presenting to Emergency Rooms (ER)/ Accident and Emergency departments in psychiatric emergencies report experiencing suicidal ideations. A critical task for hospital-based practitioners is to assess the lethality of the situation to determine whether the person should be hospitalized. Practitioners often employ standardized assessment instruments to assist in determining the suicidal risk factors, yet such measures often fail to recognize or consider the following: 1) the relative importance of the therapeutic process in creating meaningful therapeutic change; 2) the quality of the therapeutic encounter in the ER; and 3) follow-through with the community referral process.
- *Findings:* This article proposes the use of the actual ER encounter between client and practitioner to work with suicidal risk factors that are amenable to immediate therapeutic change. Using a therapy approach that can positively impact a client's level of hopelessness and allow for the assessment of suicide risk can work to ensure that an appropriate hospitalization disposition is reached.
- *Application:* This article details how the use of solution-focused therapy provides one avenue for assessing suicide risk and how the therapeutic intervention, which has not been subjected to the scrutiny of empirical research, can serve as an opportunity for increasing hope.

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emergency room, risk, social work, solution-focused therapy, suicide

Introduction

Hospital based Emergency Rooms (ER)/Accident and Emergency departments in the United States are increasingly becoming a place of help for persons experiencing psychiatric emergencies and one significant sub-population of persons coming to ERs in psychiatric crisis are those reporting with suicidal ideation. One-third or more of persons who present to ERs in psychiatric emergencies report experiencing suicidal ideation (Allen, 1999). The fundamental decision facing ER practitioners working with clients in psychiatric emergencies, including those who present with suicidal ideation, is whether the psychiatric emergency is significant enough to warrant hospitalization (Segal, Egley, Watson, & Goldfinger, 1995).

In 2005, suicide rates were 11 per 100,000 persons in the USA and 6.7 per 100,000 persons in the United Kingdom (World Health Organization, 2008). According to the American Association of Suicidology (2003), each suicide directly or indirectly affects at least six other persons. Making an incorrect decision regarding hospitalization of persons presenting to an ER with suicidal ideation could be devastating for them and their family and friends. Not hospitalizing someone who should be hospitalized could result in the death of the person presenting to the ER. Hospitalizing someone who should not be hospitalized (i.e. someone who is not an imminent risk for self-harm) will not result in the person attempting to take his/her life, yet other potential problems could emerge. For example, the incorrect hospitalization of a person could lead that person to develop a sense of stigmatization (Stroul, 1988) or identification with the role of being mentally ill (Scheff, 1984), which translates into the person developing a devalued sense of self. Therefore, making a correct decision regarding hospitalization is critical.

Several key clinical ingredients are missing in the common routinized methods of suicide assessment that primarily focus on assessing suicide risk factors in persons. These include the relative importance of the therapeutic process in creating meaningful therapeutic change; the quality of the therapeutic encounter in the ER; and follow-through with a community referral process (Loneck, Banks, Way, & Bonaparte, 2002). These three factors can have a positive effect on the person's return to the community (Segal et al., 1995).

Frontline ER practitioners, including social workers and nurses, are charged with assisting admitting psychiatrists in making decisions regarding hospitalization of persons who present with suicidal ideation. While the decision to hospitalize a person with suicidal ideation is ultimately the reasonability of admitting psychiatrists, frontline practitioners (here after referred to as practitioners) are those individuals who are initially engaged in the assessment of suicidality and provide the admitting psychiatrist with recommendations regarding hospitalization. Therefore, the practitioner is in an ideal position to positively affect the quality of the therapeutic encounter.

One way to conceptualize the use of a therapeutic process in ER assessment of persons with suicidal ideation is to use the actual ER encounter between client and practitioner to work with suicidal risk factors that are amenable to immediate therapeutic change. One of the most significant risk factors is hopelessness (Beck, Brown, Berchick, Stewart, & Steer, 1979; Weishaar & Beck, 1992). Using a therapy approach that can positively impact a client's level of hopelessness and allow for the assessment of suicide risk can work to ensure that an appropriate hospitalization disposition is reached, and can create an environment in which therapeutic change can occur. Solution-focused therapy provides one potential avenue for assessing suicide risk (Sharry, Darmody, & Madden, 2002) while using the therapeutic intervention as an opportunity to increase hope (Greene et al., 2006; Michael, Taylor, & Cheavens, 2000).

Literature review

Suicide assessment: A risk factor approach

The decision to hospitalize a person presenting to an ER with suicidal ideations is often based on the degree to which ER practitioners believe that the person is an imminent threat to him/herself. Studies that have investigated factors associated with hospitalization of persons presenting to an ER in psychiatric crisis have found that persons with higher levels of suicidality and relative symptomology are more likely to be hospitalized than persons presenting with lower levels (Claassen et al., 2000; Marson, McGovern, & Pomp, 1988). In order to determine level of suicidality and symptomology, ER practitioners engage in an assessment process that focuses on identifying the client's relative levels of short- and long-term risk factors associated with eventual suicide (Lambert, 2002). Based on these risk factors, a decision is made about hospitalization. The primary goal of these '... rule-based models is to exclude bias in decision-making processes' (Littlechild & Hawley, 2010). Joiner, Walker, Rudd, and Jobes (1999) provide a detailed description of assessed risk factors. Because correctly identifying potential risk factors among persons who present to an ER with suicidal ideation often relies on clinical judgment, which indicates the subjectivity of the actual assessment process (Way, Allen, Mumpower, Stewart, & Banks, 1998), the assessment of suicidal risk in ERs is turning to routinizing methods of assessment, such as the use of standardized assessment instruments (Brown, Jones, Betts, & Wu, 2003; Rogers, Lewis, & Subich, 2002).

ER assessment as a therapeutic process

While the focus of ER work with clients in psychiatric crisis, such as clients with suicidal ideation, is based on an assessment of the client's risk of self-harm and symptomology (Way et al., 1998), the ER potentially can serve as a location for brief therapeutic intervention. For example, the therapeutic interaction between

client and practitioner can be used to create positive change in the client's life. Segal et al. (1995) found that in addition to client characteristics, like level of suicidality and symptomology, the quality of the therapeutic intervention was associated with the decision to hospitalize. They found that 'an interpersonally sensitive approach to the patient was associated with both improved functioning and release from acute care, even when dangerousness and severity of illness were controlled' (p. 1431). Indeed, qualitative findings suggest that client's place a premium on the relationships they develop with social service works (Huxley, Evans, Beresford, Davidson, & King, 2009). Thus, the quality of the therapeutic intervention may have a positive impact on suicide risk factors that are amenable to therapeutic change. The ER intervention might make it possible for a person who would have been hospitalized for being a risk for suicide to be returned to the community.

Not only can the quality of the therapeutic intervention affect client disposition related to hospitalization, but it may also have an impact on what happens after the client leaves the ER. A study by Loneck et al. (2002) of persons who have a dual diagnosis (i.e. persons living with a severe mental illness and a co-occurring substance abuse disorder) who present to an ER in psychiatric crisis, found that a strong working alliance between the ER practitioner and client was associated with an increase in client following-up with community referrals. Loneck and colleagues defined the working alliance by the following: a) practitioner–client agreement on goals, b) practitioner–client agreement on tasks, and c) practitioner–client bond. Treating the ER intervention as more than assessment, including standardized assessments, and making it a form of therapeutic intervention may create longer-term, positive change in clients' lives.

Hopelessness, hope and suicide

Hopelessness has been defined as 'negative expectancies incorporated in a stable schema' (Weishaar & Beck, 1992, p. 180). In other words, a hopeless person consistently has a negative perception of his/her future, which leads the hopeless person to consider death as the only way out of his/her current pain (Beck, Rush, Shaw, & Emery, 1979). Hopelessness has been associated with eventual suicide in both psychiatric inpatient (Beck, Brown, & Steer, 1989) and outpatient populations (Beck et al., 1990). In both of these populations, Beck and his colleagues (1989, 1990) were able to predict, through retrospective analysis, roughly 90 percent of those people who eventually committed suicide by knowing their scores on the Beck Hopelessness Scale. Knowledge about a client's sense of hopelessness is more strongly related to suicidal ideation than is knowledge about a client's level of depression. Unlike other suicide risk factors such as past suicide attempts and past histories of abuse, hopelessness is one risk factor that is amenable to therapeutic intervention (Beck et al., 1979; Weishaar & Beck, 1992).

If the presence of hopelessness represents a suicide risk factor, than the presence of hope may represent a potential protective factor from eventual suicide.

According to Snyder (2000), hope is hypothesized to consist of three interactive components: presence of goals; pathway thinking; and agency thought. The first component of hope is the presence of a goal or goals. Goals are the object of hope; what the hopeful person wants to achieve. Without goals there is no hope. Pathway thinking is the second component of hope and is a person's ability to conceptualize multiple strategies towards reaching a goal. The more pathways a person can conceive, the more options she has for reaching her goal. More pathways also mean fewer barriers will stand in the way of achieving her goal. Pathways thinking comes, in part, from a person's past experiences with different methods of achieving goals. Agency thought is a person's belief that she will be able to achieve the goal. Agentic thought comes from a person's past experiences with achieving goals. Past success increases a person's sense that she will be able to reach a stated goal. Therefore, a hopeful person is a person who can conceptualize a goal, can think of multiple pathways towards a goal, and can perceive herself as able to move down a path towards that goal (Snyder, 2000). Working with a client on defining a goal, of considering pathways towards the goal, and of thinking herself as capable of reaching the goal, represents one way of helping a client become more hopeful.

Solution-focused therapy and the suicidal client

Solution-focused therapy (SFT) (de Shazer, Berg, & Lipchik, 1986) is one therapeutic approach that can be adapted to work with persons who present to an ER with suicidal ideation by increasing their sense of hopefulness. SFT has been discussed in terms of crisis intervention (Greene, Lee, Trask, & Rheinscheld, 2005), including clients experiencing psychiatric emergencies (Booker, 1996); clients with depression (Lee, Greene, Mentzer, Pinnell, & Niles, 2001); persons presenting with thought disorders (Hagen & Mitchell, 2001); and clients experiencing suicidal ideation (Hawkes, Marsh, & Wilgosh, 1998; Rowan & O'Hanlon, 1999; Sharry et al., 2002; Softas-Nall & Francis, 1998). SFT techniques have been found to increase hope in clients (Greene et al., 2006; Michael et al., 2000), and have been used to assess a client's current level of suicidality (Sharry et al., 2002). SFT represents a non-pathological, goal oriented approach to therapy that focuses on solution construction rather than problem formation (Walter & Pellar, 1992). The positive focus of SFT is in stark contrast to the more medically oriented models of suicide assessment, such as the model of assessment posited by Joiner et al. (1999).

SFT is based on a set of assumptions that govern its use and provide the context in which the specific techniques of SFT can be used to create positive change in clients' lives (Hawkes et al., 1998; Walter & Pellar, 1992). Three of these assumptions warrant further exploration in order to understand how SFT can be used within an ER setting to increase hope in clients. First, SFT believes that clients are resourceful (Walter & Pellar, 1992) and full of strengths and potentials that often go unnoticed by the client (De Jong & Miller, 1995). Second, SFT holds that exceptions to problems lead to the construction of solutions (Walter & Pellar, 1992). Problems and exceptions to problems occur in every person's life and

helping people recognize these exception times can aid them in developing strategies that increase the occurrence of solutions. Finally, SFT assumes that changes are always occurring and clients' lives are never the same (Walter & Pellar, 1992). The initial cause of a problem is likely not the same thing that maintains the client's attention on the problem. Based on these assumptions, the SFT approach helps practitioners to help clients recognize their personal strengths and aids clients in recognizing their power to change, which pushes clients towards agentic types of thoughts (Michael et al., 2000). By focusing on clients' strengths, acknowledging and building on the exceptions to problems, and encouraging clients to construct solutions, the practitioner is helping clients to develop goals, consider potential avenues for reaching a stated goal, and recognizing times when clients have been able to reach a goal (Michael et al., 2000). Therefore, a SFT approach encourages the development of hope by helping clients articulate a goal, think of pathways towards the goal, and develop a sense of agency related to meeting the goal.

Believing that change is always occurring provides an additional rationale for SFT as an approach for ER assessment. Instead of working with clients on developing insight into their problems, SFT practitioners work with clients on utilizing changes that are already occurring in their lives (Walter & Pellar, 1992). Because the changes have already occurred, the therapeutic process need not be too long. In fact, one of the axioms of SFT is that the practitioner should treat 'each session as if it were the last session and only time you will see that client' (Walter & Pellar, 1992, p. 40). Because of its brevity, SFT is an ideal approach for working with persons who present to an ER with suicidal ideation.

Although solution focused therapy has been discussed in terms of working with client groups who present to an ER in psychiatric crisis, including those who are suicidal, and has been discussed in relation to the creation of hope among clients, to the authors' knowledge the intersection of Snyder's (2000) hope theory, SFT and the ER has not been discussed. The remainder of the present article will provide a SFT framework for working with suicidal clients in an ER setting to increase hope.

A SFT framework for working with the suicidal ideator in the ER

Solution-focused therapy uses a number of questioning strategies to aid the practitioner in helping clients construct a life separate from their presenting problem. These questioning strategies encourage the client to consider goals, exceptions and solutions rather than focusing on the client's problems and deficits (Walter & Pellar, 1992). Although SFT uses specific questions in the construction of solutions, the approach points the practitioner towards a positive, client-focused, and change-oriented stance in working with others (Hawkes et al., 1998). With the understanding that SFT questions cannot be separated from the underlying assumptions of the approach, the following four SFT questioning strategies will be discussed within the context of working in an ER with persons presenting with suicidal ideation: a) goal questions, b) exception questions, c) scaling questions, and d) relationship questions.

Goal questions

One of the first steps in SFT is to help clients construct well-defined goals (Walter & Pellar, 1992). The presence of a goal provides a direction towards which the therapeutic intervention can, and should, be geared (Hawkes et al., 1998). The key to the development of a therapeutic goal is ensuring that it can be used by the client to construct solutions. Walter and Pellar (1992) state that a well-defined therapeutic goal consists of the following six elements: a) in the positive, b) in a process form, c) in the here-and-now, d) as specific as possible, e) in the client's control, and f) in the client's language. In helping clients define goals the practitioner must insure that these six criteria are met.

The miracle question is one SFT approach to help clients define goals. The miracle question asks: 'Suppose that one night there is a miracle and while you are sleeping the problem that brought you into therapy is solved: How would you know? What would be different?' (de Shazer, 1988, p. 5). Based on the client's answer to this question, the practitioner and client work toward defining the picture of life after the miracle has happened. Additional questions are used to further establish the well-defined goal, such as: 'What is the very first thing that you will notice after the miracle happens' or 'What might your husband (child, friend) notice about you that would give him the idea that things are better for you?' (De Jong & Miller, 1995, p. 731).

Persons who present to an ER with suicidal ideation desire to have something different in their life, which is not often well-defined. They see suicide as the only option toward reaching the goal of something different (Sharry et al., 2002). Helping client's articulate well-defined goals aids in the consideration of potential alternatives to suicide (positive goals), and provides a starting point for the construction of exceptions and solutions. Helping clients articulate a goal, with having a goal being one aspect of hope, can impact clients' sense of hope (Michael et al., 2000; Snyder, 2000).

Exception questions

In addition to helping clients develop goals, the SFT practitioner seeks to help clients find times when their goals are happening, to even the smallest extent, in their lives (De Jong & Miller, 1995). The SFT practitioner uses this type of question to help clients locate past exceptions to their problem, and articulate when the problem is less severe or non-existent. For example, the practitioner might ask the client: 'When over the last few months has the pain lifted even a little bit?' (Sharry et al., 2002). If clients are unable to state a time when their goals have happened or feel that nothing positive has happened in their lives, the therapist can use a coping question. The coping question is a type of exception question that asks clients how they have been able to cope with perceived overwhelming life circumstances (De Jong & Berg, 2002).

In terms of working with persons who are suicidal, exception type questions can be used by the practitioner to increase the client's perception of hope (Michael et al., 2000). Exception questions push clients to consider times when they have been able to meet, even minimally, their goals. By recognizing that they have been successful in working with their problems, as is indicated by the presence of exceptions, clients are encouraged to see themselves as capable of affecting change in their lives; in effect, exception questions aid the client in developing agentic thought (Michael et al., 2000; Snyder, 2000).

Exception questions can also be used to help clients develop pathways thought by helping them to acknowledge alternative avenues for reaching their goals (Michael et al., 2000). In this way, exception questions facilitate the development of pathways thinking in clients and are potentially powerful tools for helping suicidal clients rediscover a sense of hope.

Scaling questions

Scaling questions help clients make different aspects of their life more tangible and useable. These questions ask clients to rate an aspect of their life on a scale from 1 to 10 with 1 representing the worst that the aspect could be and 10 representing the best that aspect of life could be (De Jong & Miller, 1995). Scaling questions can be used for a number of different purposes, such as assessing how clients perceive their current ability to cope; what steps the clients will take to move forward towards their goal, and to assess the clients' motivation and confidence to change (De Jong & Berg, 2002). In working with clients who present to an ER with suicidal ideation, scaling questions provide a way to assess a client's perceived risk of self-harm (Hawkes et al., 1998; Sharry et al., 2002). For example, the ER practitioner can ask: 'On a scale of 1 to 10, how confident are you that you will be able to get through the weekend without attempting to harm yourself, where 1 means you feel you have no change and 10 means you are totally confident?' (Sharry et al., 2002). The client's answer to the scaling question provides the client and the practitioner a sense of the severity of the suicidal ideation.

When used within an ER setting, scaling questions should be asked at several points throughout the intervention to determine if progress is being made towards client safety. If no progress is being made towards client safety, the client may become a candidate for hospital admission (Hawkes et al., 1998). Thus, scaling questions provide a useful tool for understanding a client's current level of suicidality and for helping both the practitioner and client arrive at an appropriate decision regarding hospitalization.

Relationship questions

Relationship questions ask clients to consider other persons', usually significant persons in clients' lives, perceptions about answers to any of the above mentioned SFT questioning strategies (Hawkes et al., 1998). The relationship questions

provide a contextual richness to clients' answers to each of the other questioning strategies as they can be used to help clients further define goals and exceptions that meet the six criteria of a well-defined goal. An example of a relationship question as an adjunct to the miracle question would be 'What would be the first thing that (any persons in the client's life) would notice if the miracle happened?' And with an exception question 'How would (any persons in the client's life) state that you have been able to cope?' And with a scaling question 'Where on the scale would (any persons in the client's life) say that you are in terms of safety.' Each of these questions provides useful information that can be used in the service of further defining goals and solutions.

Disposition after SFT intervention

After the SFT interview intervention, a decision needs to be made regarding the disposition of the person presenting to the ER with suicidal ideation. The basic question is 'Should the person be returned to the community or should the person be hospitalized?' As with the suicide assessment procedure that focuses on identification of suicide risk factors, the SFT approach relies on dangerousness to self as the criteria for hospitalization (Hawkes et al., 1998; Sharry et al., 2002). While the risk factor approaches merely assesses the level of suicidality, the SFT approach works with clients on creating a change in suicidality throughout the course of the intervention. Practitioners using the SFT model work with clients on changing their sense of hope and ultimately changing their self-reported level of suicidality.

Three potential outcomes may result from the application of the SFT approach to working with clients who present to an ER with suicidal ideation. First, persons who come into the ER with high suicidal ideation after the intervention may remain highly suicidal. This type of person is characterized by the inability to formulate goals; no ability to identify coping strategies or exceptions to the problem; has little or no movement on the scaling question related to self-harm; and has little or no increase in hope. The primary concern with this type of client outcome is to ensure client safety. In this type of situation, the client should be seen by an admitting physician for potential hospitalization.

A second outcome is a reduction in suicidality. For example, a person may present to the ER with high suicidal ideation but may have a reduced level of suicidality after the SFT intervention. This type of client outcome is characterized by being able to formulate goals; identify exceptions or coping strategies, move in the positive direction on the scaling question related to self-harm, and have an increase in hope. Although this person initially presented to the ER with high suicidality, the SFT intervention made a difference in reducing the client's suicidal ideation. This type of client outcome indicates a client disposition of return to the community. Community referrals should be made to ensure that the client progress in the ER can continue once back in the community. The client should be linked with the community agency as soon as possible; preferably within 24 hours after being seen in the ER. Further, the ER practitioner may want to provide the client

with some suggestions for how the client can capitalize on the solutions discussed during the ER intervention.

The final outcome is no change in suicidality with the actual level of suicidality at first presentation being relatively low. For example, a person may come into the ER with relatively low suicidality and after the intervention the person's level of suicidality remains relatively low. Such an outcome is characterized by being able to formulate goals; identify exceptions or coping strategies; measuring low on risk of self-harm on the scaling question with no movement in the negative direction on the scaling question throughout intervention; and stability or increase in hope. Because a person with this outcome is considered to be at a low risk of suicidality, this type of person should be returned back to the community. Appropriate follow-ups should be made to insure that the client remains a low or no risk of suicide. Finally, the ER practitioner should provide the client with suggestions for how he/she can use the goals and solutions discussed through the course of the SFT intervention to remain at low levels of suicidality.

Potential difficulties

This SFT intervention for working with clients who present to the ER with suicidal ideation is still under development. To date, no research studies have been conducted to test the approach's effectiveness. It is possible that the use of the SFT intervention will not have a positive therapeutic impact on clients experiencing suicidal ideation. While we are hopeful that this approach would create a strong and hope inspiring therapeutic impact on clients, we cannot be sure that the progress made during the ER intervention would be sustained when the client returns to the community; a client may leave the ER with increased hope and lowered suicidality, but become suicidal once faced with life back in the community and return to the ER for reassessment or attempt suicide. One way to buffer against this possibility would be to develop a seamless connection between community providers, including case managers, and ER personal so that gains made in the ER would be sustained in the community. This might mean developing community mental health approaches that utilize SFT ideas and techniques (Greene et al., 2006).

Conclusion

The ER is one place that persons with suicidal ideation may turn to for help (Allen, 1999). The primary decision made in ER setting with persons who are suicidal is whether to hospitalize the person or return the person to the community (Segal et al., 1995). The decision to hospitalize or not hinges on the client's current level of suicidality as assessed by the ER practitioner (Lambert, 2002). Approaches that focus solely on assessing the risk factors associated with suicidality may miss the

potential positive impact of the therapeutic relationship between the client and the practitioner on the client's actual level of suicidality. Approaches that work with suicide risk factors that are amenable to therapeutic change, such as hopelessness (Beck et al., 1979; Weishaar & Beck, 1992), may help change the client's perceived level of suicidality. SFT is one therapeutic approach to working with persons who present with suicidal ideation that can have a positive impact on a person's level of hopelessness thereby capitalizing on the power of the therapeutic process to create positive change in the lives of clients.

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