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A thematic analysis of the experience of UK mental health nurses who have trained in Solution Focused Brief Therapy

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Accessible summary

What is known on the subject?

- Solution Focused Brief Therapy (SFBT) is an effective model of brief psychotherapy.
- Evidence suggests that nurses can be trained to deliver SFBT with only a few days training.
- It has been argued that SFBT reflects the core values of nursing practice, but no empirical research has been undertaken to validate this assertion.

What does this paper add to existing knowledge?

- This is the first time the impact of such training on nurses' sense of professional and personal identity has been explored.
- Drawing upon data derived from twenty interviews, this paper explores the key themes reported by nurses in relation to their personal experience of training in SFBT.
- This paper extends our understanding of the lived experience of mental health nurses and facilitates discussion on the preparation and practice of their role.

What are the implications for practice?

- Training in SFBT can provide a framework for nurses to empower their clients/patients to take control of their own recovery in a shared and trusting relationship.
- Training in SFBT can enhance nurses' sense of trust in their clients.
- Training in solution-focused *interactions* may provide a framework for many nurses to provide the type of collaborative, patient-led care they aspire to.

Abstract

Introduction: SFBT is a psychotherapeutic model that aims to 'build solutions' rather than 'solve problems'. It has evolved into a structured communication framework utilized across a range of disciplines, focusing on the future, as opposed to the past, and on participant's strengths and abilities, as opposed to their problems and deficits. There have been no studies exploring the experience of training in SFBT from the perspective of the nurses being trained. **Aim:** This study sought to explore the experience of nurses who had completed a six-month training course in SFBT. **Methods:** Using a qualitative methodology, 20 nurses who had undertaken SFBT training were interviewed at various locations across Scotland. **Results:** Five main themes emerged from analysis of the 20 interviews. Many of the participants reported increased trust in their clients and enhanced role satisfaction. **Implications for Practice:** Training in SFBT provides nurses with an alternative model of practice

to the dominant 'medical' and 'psychological' models of contemporary practice. The experiences of the participants in this study suggest that SFBT can be a useful intervention in nursing practice and that nurses can easily incorporate SFBT into their practice.

Background

Solution Focused Brief Therapy (SFBT) is a psychotherapeutic model that aims to 'build solutions' rather than 'solve problems' (Iveson 2002, Popescu 2005). It differs from most other psychotherapies in this respect; rather than attempting to develop an in-depth understanding of the complexity, and history, of the presenting problem, SFBT looks to the future and focuses on the times when the problem is not experienced by the client (exceptions). The therapist aims to help the client create rich descriptions of what their life will be like when the problem is gone, and to scale their progress towards experiencing that state (Trepper *et al.* 2006). The theoretical and practical underpinnings of SFBT have been outlined and discussed elsewhere (De Shazer *et al.* 1986, Iveson 2002, Macdonald 2011, Bavelas *et al.* 2013, Bliss 2014) but can be summarized as:

- The resources for change are in the client: she/he is the expert on their own lives and hopes
- 'No problem can be solved by the same kind of thinking that created it': solution building utilizes a different mindset to that of problem solving.
- The therapist does not need to know anything about the facts and circumstances of the problem: see the first point above.
- The role of the therapist is to help the client recognize where exceptions are occurring in their life and to do more of the things associated with these events.

Thus, unlike other briefer, but problem focused, therapeutic approaches such as cognitive behaviour therapy (CBT) or interpersonal psychotherapy (IPT), the therapist does not take a theoretical position on the formation and/or maintenance of the client's problem, but makes a pragmatic acceptance that there *is a problem* and then works with the client towards building a solution, rather than *resolving the problem*. Analogous to this distinction is the scenario where one is getting wet in a rain shower; it is easier to put up an umbrella (building a solution) than to stop it from raining (resolving the problem). SFBT has evolved into a structured communication framework utilized across a range of disciplines, focusing on the future, as opposed to the past, and on participant's strengths and abilities, as opposed to their problems and deficits. Outcome studies have shown SFBT to be at least as effective as other forms of psychotherapy, particularly other briefer therapies such as CBT and IPT (Kim 2008, Gingerich *et al.* 2012, Trepper & Franklin 2012) and to typically achieve successful outcomes in an average of between 2.9 and 10 sessions (Johnson & Shaha 1996, De Jong & Berg 1998, Knekt *et al.* 2011, Macdonald 2011, 2016).

Nursing

A number of authors (Webster 1990, Montgomery & Webster 1994, Hillyer 1996) have argued specifically that the approach is congruent with the values underpinning nursing practice. Montgomery & Webster (1994) argued that solution-oriented approaches provided a framework to promote a paradigm shift, from a cure-orientation to a care-orientation, in health care, and particularly in nursing. They argued that brief therapeutic approaches could enable nurses to re-engage with their clients, concluding that working within a caring paradigm nurses can,

> respond to their [clients'] vulnerability rather than their pathology. Instead of diminishing our clients with the mystique of our own power and knowledge, we can give them a sense of their own power and help them rediscover their resources. (p. 296)

Hillyer (1996) argued that the concepts underlying SF questions were consistent with nursing values,

> which emphasize supporting clients' strengths, focusing on health rather than pathological condition, and respecting clients' abilities to arrive at answers that are meaningful to them. (p. 8)

These develop the argument advanced by Webster in 1990, who had argued that SFBT offered a framework for practice that was congruent with nursing, and feminist values. However, despite such early positive response, there has been little further work exploring the relationship between the practice of SFBT and the ontology of nurses and nursing practice. Indeed, there has been no empirical work undertaken to validate these early theoretical assumptions. Since 2000, nursing research in the field of SFBT has focused more on how readily nurses can learn the basic skills of SFBT in practice. Bowles *et al.* (2001) evaluated the impact of solution-focused training, delivered in four sessions over 8 weeks, on nurses' communication skills and concluded that SFBT was a useful approach in

teaching communication skills, noting that it was 'harmonious' with the nursing values of empowerment, increased patient responsibility and participation in care (p353). Stevenson *et al.* (2003) carried out a multifaceted study to assess the outcome of a SFBT training course on nurses and clients in an acute psychiatric setting, concluding only that both clients and nurses found the approach useful. Hosany *et al.* (2007) reported on a pilot study into the outcomes of a two-day course training a group of mental health nurses in solution-focused therapy techniques. They reported a significant positive shift in terms of participants reducing their focus on clients' problems ($P = 0.001$), and a positive, but nonsignificant, shift in terms of focusing on clients' current strengths and resources. Smith (2010), in a pilot study for the current project, explored the experience of eight nurses who had undertaken an earlier cohort of the 150-hour training course reported on here. He concluded that training in SFBT may enhance the therapeutic and professional role of nurses, but acknowledged that further research was necessary. Finally, Chambers *et al.* (2013) discuss an evaluation of a four-day training course (1 day per week for 4 weeks) combining Heron's six-category intervention analysis (days 1 and 2) with SFBT (days 3 and 4) and concluded that participants had found the training useful and that it had helped to increase participants confidence in their ability to work in a therapeutic manner. However, in general, the research findings are ambiguous and/or vague and relate only to very brief training experiences. Nothing is said about why these nurses found SFBT techniques 'useful', or why their confidence is increased, let alone the process by which the experience of SFBT training may have changed the nurses' outlook and/or practice. That nurses are better able to ask solution-focused questions after a brief training experience should not be surprising, that is simply a technical acquisition; what is of greater interest (and is the focus of this particular study) is the affective changes that nurses may, or may not, experience in the context of that training and the manner in which that may enhance their therapeutic relationships with clients. This deeper aspect has never been explored in this context before.

Aims

The aim of this paper was to explore the experience of nurses who had undertaken a prolonged (150 h) period of training in SFBT. A prolonged period of training was chosen as it was assumed that a longer training period would produce a more discernible change in the nurse's practice and that this, in turn, would aid discussion of any changes that had occurred. This assumption is, however, returned to in the conclusions section.

Methods

This study employed a narrative research design, within a qualitative methodology, in which a paradigmatic analysis (Polkinghorne 1995) of interview transcripts was conducted to generate an inductive understanding of the individual experience. Thematic analysis allowed the emergence of key common themes across the group experience to be identified.

Participant selection

The study population was a convenience sample made up of former students who had completed the SFBT course at Robert Gordon University (RGU). Participants were invited to take part in the study via an online professional support group for SFBT practitioners, all of whom had completed the above training course. In all, 75 potential participants were contacted with an information sheet about the project, a copy of the project proposal and a link to a dedicated web page on the RGU web site, and 31 (41%) responded. Of these 31, due to actual availability of respondents to be interviewed, 20 interviews took place at various locations across Scotland.

Setting

The majority of interviews lasted between 45 and 90 minutes and took place in the participant's workplace, although a small number took place at other locations convenient for the participant. All interviews were carried out in private with only the participant and researcher (SS) present and were digitally audio-recorded.

Data collection

All 20 interviews followed a semistructured format (see Figure 1 for a schematic representation of the interview process), allowing the researcher to respond to participants' responses and develop emerging themes as appropriate. The initial question, 'What has changed since you commenced the course?' allowed participants to choose how best to reply in relation to their experience. To help expand on the initial question, several anchor questions were developed. These sought to break down the temporal boundaries of the emerging narrative into convenient sections. The anchor questions used were as follows:

- How would you describe your practice before you commenced the course?
- What were your expectations when you applied for the course?
- On a scale of '0' to '10', where '10' is 'all your expectations were fully met and you got what you wanted from the course', and '0' is 'you got nothing from the course, it was a complete waste of time', to what extent were your expectations met?

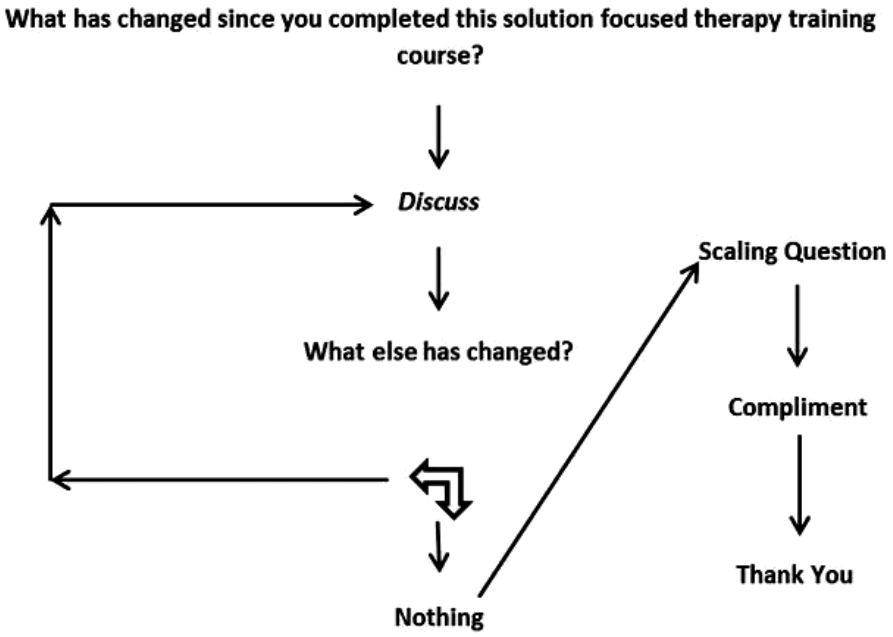

Figure 1
Schematic representation of the interview process

- What would have made your experience '1' point higher?
- How would you describe your practice since you have completed the course?

This, then, followed a chronological structure of pre-SFBT training, expectations on applying for the course, experience of training and post-SFBT training experience. This approach to data collection had previously been tested in a pilot study (Smith 2010). Audio recordings were transcribed by SS after all interviews had been completed.

Ethical considerations

Ethical approval for the study was granted by RGU Research Ethics subcommittee prior to commencement of the study. The primary ethical consideration related to the dual roles of SS, as Course Leader on the SFBT training course and as researcher into the experience of trainees on the course, and the potential of this dual role to result in researcher bias. The advantages and disadvantages of conducting such practitioner research are well recognized. Lunt & Fouché (2010) synthesize the major arguments, suggesting that the heightened potential to build collaborative, contextually rich understanding between researcher and participant is balanced against the risk of role blurring and a potential reduction in the ability to be self-critical. However, Mccormack (2009) argues that practitioner research is no different to any other research approach, in that it requires the same methods of rigorous and systematic enquiry, clearly linking methodology, method and analysis. The methods by which this was undertaken in the present study included the use of peer debriefing, member checking, the use of a reflexive diary and production of an audit trail (see Table 1) and are described in full detail elsewhere (Smith 2015).

Table 1
Process of data collection and analysis.

Stage 1 75 potential participants identified and contacted by email.
Stage 2 31 (41%) participants agree to be interviewed.
Stage 3 20 interviews (64%) actually carried out (no internal factors involved in determining inclusion).
Stage 4 Transcript of interviews.
Stage 5 Analysis of transcripts using adaption Colaizzi's (1978) seven-step formulated meaning model.
Stage 6 Member checking
Stage 7 Analysis of data.

Analyses

Thematic analysis was carried out using an adaptation of Colaizzi's (1978) seven-step formulated meaning model, whereby significant statements were parsed into discrete statements of articulated meaning, and were then identified using a recursive analysis, as contributing to emerging themes. All data were analysed by SS, supported by a three-person, doctoral studies supervisory team led by CM. A random sample of three transcripts and analyses were shared with the team, who carried out their own analysis and found these to be congruent with the analyses carried out by the researcher. Data were managed manually to allow the researcher to emerge himself in the narratives

participants had provided. In all cases, themes were identified from the data. Analysis was carried out after all interviews had been conducted to minimize the potential for the researcher to consciously or unconsciously favour one narrative over potential others and thus 'pattern' data for survival (Bateson 1972) at the expense of nonpatterned data, i.e. to 'see' the expected at the expense of the unexpected.

Results

Participant features

Participants were predominately white ($n = 19$) and female ($n = 18$). The majority of the participants ($n = 17$) worked in some form of an autonomous role, usually in a community setting, while three participants worked within a team setting (two participants worked in a ward setting and one in a clinic); this apart, there were no distinguishing features of the sample group. Participants were recruited from across several sites in Scotland, had trained in SFBT across eight cohorts delivered between 2007 and 2010 and had a broad range of chronological experience, from recently qualified to approaching retirement.

Themes

Five key themes were identified from a paradigmatic analysis of the data. Transcripts were thematically analysed using an adaptation of Colaizzi's (1978) formulated meaning model. (Table 2). Extracts of participant's statements are reported below.

Client Empowerment

The first of these themes echoes the theme of 'Trust in Clients' identified in the pilot study (Smith 2010). There was a sense within this theme of participants being able to recognize that clients, given the chance, were often able to develop their own solutions to problems and that the practitioner's role was to facilitate that process rather than provide the client with answers. This appeared to represent a significant shift in outlook for the participants, from one in which the participant typically provided solutions for the client, to one in which the participant took on a more empowering or nurturing role.

Some participants (participant's names have been changed to protect their anonymity) reflected that as completing their training in SFBT, they were now more likely to use SF questions to help their clients find their own solutions and, while this might take several sessions, the client was more likely to carry out an action that they themselves had generated. Other participants spoke of how they saw the client taking more responsibility for the therapeutic outcome, in the sense that they were empowered to take a less passive role in the therapeutic relationship. This was a position alluded to by several participants that clients who had typically 'not taken responsibility' for their well-being were now doing so. However, it could be argued that this position of 'not taking responsibility' is the only position open to the client when the nurse (or other practitioner) adopts a position where they 'are responsible' for the client's improvement and well-being, such a position as that described by Judy below.

> I liked how you could put it more … the kind of responsibility, or what the patient's wanting rather than what you're wanting them to do. They're telling you what they're wanting to do, what they want to happen, as part of the assessment rather than what I think they should be doing … or what level of functioning I think they should have. (Judy)

Table 2
Utilizing adaptation of Colaizzi's seven-step method of data analysis.

Transcript	Meaning	Theme
'I've become a hell of a lot more confident in my job because I've got a structure to follow'.	SFT training gave me a structure to work with, and that has made me more confident in my role.	Confidence in role
'Although I don't use the whole structure all the time, I use bits and bobs of it that are suitable for the individual client, and the clients are responding well to it'.	I choose which parts of the model to use, based on my perception of my client's needs.	Eclectic use of model
'I get, "I'm at a 4 today, Dawn", before I even ask a question; so my clients get it, and they work with it really well'.	My clients now use scaling without a prompt from me.	Client engagement Trust
'It makes me more confident, and the success rate of discharges has increased as well'.	Seeing the model work has increased my confidence.	Confidence in model

Arguably, this new 'empowering' role reflected the growing trust the participant had in the client's ability to find their own solution; indeed, it is difficult to imagine how a nurse can empower a client to develop their solution building capacity in the way described above, unless the nurse believes that the client has the potential to do so.

Fit with Personal Values

The second theme to emerge was a 'fit' (De Shazer 1985) between the underpinning ideas of SFBT and their own personal values. Many participants suggested they found that the underlying principles of SFBT resonated with their own pre-existing world view. For some, such as Lauren, this was simply a pragmatic position in which she preferred to explore potential solutions as opposed to analysing existing problems. Lauren suggested that for her, outside of the therapeutic environment, this was a 'common sense' approach to problem resolution and she was pleased to be able to bring this approach into the therapeutic arena. For others, the attraction of the SF model was that it did not feel like a model. By this, participants described an aversion to working in a formalized style, and a preference for what they perceived as a naturalistic approach.

> If they came with a crisis to do with their kids, we'd look at how they could help that. But, it would be me telling them. It was intuition, I don't like models … You can do it [SFBT] without the client even realising you're working in an approach. It just worked with my instincts. (Dawn)

Success

The connection between Success and Fit with Personal Values was reflected on by Teresa, who implied that she had been unaware of just how dissatisfied she had been with her traditional mode of practice until she began to work in a SF way. It was her experience of satisfaction with both the process and outcomes of SF practice that prompted her to ask why she had not seen these successful outcomes previously, and to question the usefulness of the 'medical model' approach she had previously been trained to work in.

> The medical model doesn't sit well with me; but I don't think I knew that until I started the solution focused stuff. I just thought, 'This is what we're supposed to do', and I just thought 'This is what we're expected to carry out'; and y'know I didn't realise I wasn't happy with that. It was doing the course that made me question, "Is this working?" (Teresa)

Other participants spoke of their surprise at the positive clinical outcomes they were seeing since they began working in a SF manner. Emily spoke of her delight at being able to help people, 'It really, really works, and that's what's changed for me'. The obvious implication here is that Emily's previous mode of practice did not seem to 'work' as successfully for clients and that this was not seen as 'unsuccessful' but rather, represented the norm in terms of clinical outcomes. This experience of success not only led participants to continue using SFBT but helped to reinforce their sense of professional identity, in that they were seeing themselves as 'someone who can make a difference'. Some participants had been able to set up and run a SFBT Clinic (Barbara), while others were simply pleased to 'show off' their newly acquired clinical skills to students and trainees (Janet).

Framework

The fourth theme to emerge was that SFBT training had provided participants with a framework for practice. Where previously most participants had relied on their own intuition to know how to respond to client's problem narratives, SFBT gave nurses a structure around which to build their conversations. Participants spoke about the process of solution building (of coconstructing solutions with clients) and how 'knowing what to do next' removed the burden of having to come up with a solution for the client.

> It gives me more structure than I had before … I rarely feel out of my depth now … before, when I'd done the counselling skills course I quite often felt out of my depth at times. But I don't get that so much now. The structure of an interview really helps … just to know what the next question is. (Karen)

This would appear to be the position that many of the participants had found themselves in previously; or rather, they found themselves in the position of doing what they felt they ought to be doing, without necessarily knowing what that was. The provision of a theoretical framework removed the need to 'pluck things out of the air' (Judy) and allowed participants to legitimize their own way of working (Michael, Dawn) and structure their work with clients (Karen, Drew).

CBT-based practice

The majority of participants had some experience of CBT-type therapeutic work, arguably reflecting the near-paradigmatic status this approach has come to have within mental health care. A *Structured Psychosocial InteRventions in Teams* (SPIRIT) course (Williams & Garland 2002) had been delivered across one of the major sites where SFBT training had been delivered (SPIRIT training was delivered before SFBT training) and to selected staff in the other major site; thus, most participants were aware of the approach and many had used it in practice. The

SPIRIT course is designed to enable nurses to promote increased access to CBT-based self-help materials. Experience and opinion of the approach varied, from dislike and avoidance of the approach (Dawn) to acceptance and use (Norman), but rarely with the sense of enthusiasm and personal fit as participants used in relation to SF work.

> I knew that CBT was okay, but it didn't particularly sit with me that well … it didn't suit me that well, although I used elements of it, and it was useful, but I didn't want to go and do CBT therapy or anything like that. (Lesley)

This may be due to the fact that the SPIRIT training (in various guises) was delivered to most participants over a period of 1–5 days, thereby precluding an in-depth understanding of CBT in its own right. Only a few participants had completed a more extended training in CBT; however, while having an in-depth understanding of the model, they continued to describe a closer personal fit with the SFBT model than with the CBT model.

Discussion

The aim of this study was to explore the experience of nurses who had undertaken training in SFBT. The findings suggest that the nurses found training in SFBT had a profound effect on their clinical practice and professional identity. It appeared that the nurses were motivated to work collaboratively with clients but that their training and experience had somehow created a barrier to that genuine therapeutic relationship taking place. The results indicated that training in SFBT provided a means of circumventing that barrier and that once these nurses engaged in a trusting, shared relationships with clients positive therapeutic outcomes often followed. In this respect, one of the most remarkable things for many participants was that SFBT 'worked'! Worked in the sense that clients 'got better' (many of the participants, while recognizing the social constructivist nature of SFBT practice and its congruence with their own personal outlook, continued to utilize medical terminology associated with an illness model), and did so in a remarkably short space of time. Despite the evidence base in the literature (Macdonald 2011) suggesting that typical treatment times were three to ten sessions and, indeed, that SFBT was by definition a 'brief' therapy, this came as a surprise to many participants.

Many of these nurses had a significant amount of clinical experience; however, almost all of them were surprised to note how little they had come to trust and respect (other than at a superficial level) the patients they worked with. The cultural norm that they described was one where patients were 'not to be trusted': not to be trusted with the nurses safety, not to be trusted with their own safety and not to be trusted to *really try* to get better (to take their medication, to adhere to their treatment plan, to *do what they were told)*. Possibly this should not be surprising, Foucault *et al.* (1978) argued over thirty years ago that, since the beginning of the nineteenth century, it is the unpredictability of the behaviour of *the other* that defines the social (and legal) construct of 'madness', by definition – 'the mad are not to be trusted'. This was not, however, a message they had explicitly come across. It implicitly permeated almost everything they did in practice, but was submerged in an explicit message to the contrary, a rhetoric of rights, relationships and recovery. Cleary & Edwards (1999) have discussed some of the explanations given for poor nurse–patient interactions, as has McCabe (2004). The latter noted that while 'nurses can communicate well with patients when they use a patient-centred approach' (p48), healthcare organizations tended not to value the extra effort this entailed, thereby discouraging a patient-centred environment. Altschul (1999) argued that the sheer numbers involved in nurse–patient interactions mitigated against the formation of sustainable therapeutic relationships.

> A little arithmetic is not out of place if one is to consider the significance of nurses' relationships with patients. How many relationships with patients can a nurse be expected to sustain at any one time? … How many therapeutic relationships can a hospitalized patient form with nursing staff? (p.262)

More recently, Thibeault *et al.* (2010) have argued that patients expect and value a positive therapeutic relationship with nurses, but that nurses find it increasingly difficult to provide this in the context of acute psychiatric care. Pazargadi *et al.* (2015) note that the discrepancy between the ideal and actual therapeutic relationship evident in mental health nurse–patient interactions has become increasingly evident and relate this to 'cost-driven, technocratic care environments [which] often reduce the time for establishing an interactional nurse–patient relationship' (p552). Thus, it came as a shock to many of these nurses when they discovered what happened when they did, actually, begin to develop a trusting relationship with the people they worked with. This was a major breakthrough for these nurses; that you could really trust the client's you worked with, and they would respond positively. By *working with* the client, the nurses were able to circumvent the problems of telling the client what to do and, through the adoption of a 'not knowing' stance (De Shazer *et al.* 1986), ask the client what they thought would be helpful and work with the ideas generated by the client. This sense of *joining* with the client in a spirit of *respect* and *genuine interest* was not a new concept to

the participants in the study, what surprised them was that it was only once they had begun to practice in a SF manner that they realized how minimally their practice had endorsed these principles previously.

Limitations

There are a number of limitations to this study. First of all, it could be argued that the study is merely a large-scale course evaluation; however, this would be to miss the point of the study. What is being evaluated here is not the training course *per se*, but the changes in outlook and practice observed by the nurses who have completed the training. While the study is contextualized around one training course, this is not unusual in the literature (Bowles *et al.* 2001, Stevenson *et al.* 2003, Hosany *et al.* 2007, Chambers *et al.* 2013) and in this instance involves several cohorts of trainees across several different sites. Central to this study is the argument that educating someone in a therapeutic approach is more than simply enabling them to deliver a set of techniques; education must in some way 'change' the practitioner in order that they can make a different therapeutic use of self in relation to clients. It is that change that this study seeks to explore. Secondly, the participants in the study were self-selecting, leading to a potential selection bias in recruitment to the study, skewed in the direction of those who had found the training experience worthwhile. For this reason, we do not suggest that training in SFBT is of value to all nurses, but only to some nurses, and indeed, this is the first time this distinction has been made. Thirdly, the study is limited to mental health nurses' own perceptions, and in particular to mental health nurses practicing in Scotland. Further research is required to establish whether the experience described here is similar to the experience of nurses across the domains of professional practice and across geographical boundaries.

Clinical implications

While not all nurses will practice as 'mental health therapists' (not even all mental health nurses will practice in this way), there is potential that the central attributes of training in SFBT – solution focused interactions – can help nurses practise in a manner that is congruent with UK and Scottish Government directives (Scottish Executive, 2006; Department of Health, 2010), professional standards (Nursing and Midwifery Council, 2015) and best practice guidelines (NHS Education for Scotland, 2011; Scottish Recovery Network, 2013) for nursing. More than that, training in solution focused interactions may enable nurses to use their professional skills in a positive manner to the benefit of the patient/clients they are working with, providing them with a practice paradigm that enables them to provide co-operative, egalitarian and concordant care, focusing their attention on the patient's/client's strengths and assets as opposed to their faults and deficits and providing them with a framework to promote a real patient recovery.

Conclusion

A prolonged training in SFBT can have a significant and sustained effect on the practice and professional identity of mental health nurses. Further research is required to explore whether these changes are replicated in other training situations and in other locations. Most importantly, high-quality research is now required to explore the consequence of the changes experienced by practitioners on their clinical practice from the client/patient's perspective. There is also a need for further research to explore whether similar outcomes to those found in this study would emerge from a study being replicated with nurses who have completed a much briefer training experience such as the two- to four-day training events described in much of the literature.

Relevance Statement

This paper argues that training in SFBT enhances mental health nurses ability to work with patients/clients in a trusting, collaborative and concordant manner. It suggests that training in SFBT can have a profound impact on the practice and professional identity of mental health nurses and that this aspect of practice has not been previously explored.

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