

Doing practice differently: solution-focused nursing

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Submitted for publication 4 April 2002

Accepted for publication 29 November 2002

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McALLISTER M. (2003) *Journal of Advanced Nursing* 41(6), 528–535

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Background. Critical thinking and reasoning take many forms; however, a problem-orientation remains the favoured approach in health care.

Purpose. This paper considers the effects of a problem-orientation and argues that a solution-orientation fits nursing's interests more closely and represents an exciting way forward in both education and practice.

Discussion. Whilst a problem-focus is criticized by some, it remains largely unchallenged as the guiding light for nursing practice. A major reason is that the problem focused approach has strong cultural roots. It is deeply embedded in our thinking, and has become taken-for-granted and not often recognized or debated. Whilst problem-solving has an important place in helping to diagnose disorder and overcome difficulties, nursing needs to move beyond its borders because the role also concerns problem-free issues such as health and well-being. Creativity, imagination and focusing on strengths not problems are also important cognitive processes.

Conclusion. A problem-orientated approach in nursing has had a constraining rather than enabling influence. By refocusing on a solution-focused approach, we could show how we are different from medicine, and how we aim to do nursing differently through using skills such as engagement, resilience-building, community development, primary health care and health education.

Keywords: critical thinking, education, nursing practice, problem-solving, reasoning, solution focus, strengths

Introduction

Most of us will agree that health is more than the absence of disease and that nursing work concerns health just as much as it does illness. We also know that nurses require skills in problem-solving to enable them to think logically and work effectively in the illness paradigm, but are we similarly familiar with the kinds of skills required in the health paradigm? In this paper I will argue that a problem-orientation is no longer sufficient to guide nursing work. Indeed a problem focus is deeply problematic and needs to be used judiciously. Solution-focused Nursing provides a much-needed alternative for nurses aiming to work with clients to restore and maintain health and well-being.

The twentieth Century, with its emphasis on discoveries in science and technology, saw these dominant ideologies

flourish. For example, technical rationalism, empiricism and paternalism as well as economic rationalism are dominant ideologies and each values logic, rationalism, order, individualism, autonomy, efficiency, outcomes and the problem-solving method (Gellner 1992). The problem-solving approach has long enjoyed a privileged status in thinking and knowledge development. To some extent, this is a well-deserved position. Certainly medicine, health care and society have reaped enormous benefits from the contribution that technology and science have made to diagnostic and surgical procedures, drug treatments and devices to assist in rehabilitation from injury and some diseases. But this age of enlightenment, according to many social theorists, also has its dark side (Foucault 1994, Giroux 2000). Technical solutions to social problems have only been partially successful and agendas such as providing equitable services for all,

What is already known about this topic

- A solution orientation increasingly is being used in psychology and business disciplines as providing pragmatic, effective ways to think critically, solve problems and reframe issues in novel ways.
- A solution focus emphasizes resilience, strengths and well-being as an alternative to becoming preoccupied, distracted and constrained by a focus on problems.

What this paper adds

- This paper draws from other disciplines to apply solution-focused theories to nursing practice.
- It argues that, since nursing involves working with people in illness and wellness, it is imperative to explore, understand and harness the positive resources that enable health maintenance and adaptation to health problems.
- It explains specific strategies for nurses to transform their practice by valuing problem solving and solution searching in their everyday work.

promoting justice for marginalized groups, and building strength in communities have been largely overlooked (Greene 1986).

The problem-solving method

Thinking, or cognition, is the mental activity associated with processing, understanding and communicating information and is the subject of much interest and research in psychology (Myers 1995). Problem-solving is a particular cognitive skill that helps us to cope with novel situations and generate suitable responses. Some problems we solve by trial and error and others through logic and pattern-making. Sometimes, we solve problems when an answer just comes to us in a flash of insight.

Also called the scientific method, problem-solving involves some predictable stages and linear, deductive reasoning: A problem is identified and described various solutions are considered, one solution is implemented and tested, and the effects or results are evaluated. The table below, adapted from Friedman (1997) and O'Connell (1998), summarizes the approach a clinician tends to use when they have a problem-orientation (Table 1).

Psychology has explained that two cognitive tendencies often interfere in problem-solving, and these are confirmation bias and fixation (Myers 1995). Confirmation bias is the tendency to search for information that confirms our ideas

Table 1 The problem-orientation. [Adapted from Friedman (1997) and O'Connell (1998)]

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- Asks what is wrong and why
 - Explores historical causes and present difficulties in order to find a remedy
 - Searches for underlying issues to expose the 'real' problem
 - Elaborates on the experience of the client, rather than others in the social world
 - Assumes that clients (and their bodies) are somehow deficient, resistant, misguided or naïve
 - Labels and categorizes clients in problem-saturated ways
 - Views nursing and allied health as assisting medicine to provide treatment or remediation
 - Focuses on assessment of clients' problems and providing interventions
 - Privileges the health carers' voices and expertise
 - Uses specific professional jargon
 - Tends to be directive, strategic and sometimes mysterious
 - Asks: When will this problem be resolved?
-

more than we seek evidence that might refute them. Fixation is the inability to see a problem from a fresh perspective. An example of confirmation bias is confidence in medical diagnoses rather than any other framework to 'explain' all human health experiences. An example of fixation is continuing to see health behaviours in terms of pathology even when this provides no resolution or comfort.

One further issue about cognition is that the ability to use flexible thinking becomes even more difficult in times of stress and tension (Janis 1988). During personal crises, thinking often becomes rigid. If one agrees that nursing is in a particularly noticeable state of crisis (Fagin 2001), then it is understandable why familiar ways of thinking and behaving, no matter how ill-fitting they may be, tend to persist.

Limitations of a problem-orientation

While a problem-orientation is sometimes useful in helping to isolate problems, target areas of change, and apply interventions dispassionately and rationally, these actions are not always appropriate. Constantly searching for problems may prevent appreciating the things that are going right for a person. It may also be that some problems may never be resolved completely, and a focus on the negative is inherently pessimistic. Problem-centredness has also been roundly criticised by postmodern theorists as no longer relevant in a posthumanist age (Welton 1995). A posthumanist age is one that no longer believes that the tenets of humanism completely explain or are relevant to diverse groups of people (Foucault 1994). That people can be assisted to reach the pinnacle of human potential, known as self-actualization, if

they are simply allowed to be free is also seen to be untrue. This naïve view does not recognize the layers of constraints placed on various cultural groups that prevent them from existing and achieving on the same plane as other groups (Hooks 1994, Giroux 2000).

Post-humanism is also deeply suspicious of those who profess to have the answers and is ready to redeem the poor and unfortunate amongst us (Greene 1986). Universalizing or totalizing discourses are dangerously redemptive, colonizing and paternalist. They actually remove power from groups who function differently from the mainstream. A problem-centred approach is one of these totalizing discourses and means that problems are seen to be at the centre of human existence, rather than incidental. Problems and difficulties become the main concern, rather than feats and achievements, and are seen as something to be overcome rather than simply tolerated. Thus many people become distracted from appreciating simplicity and from living happy, peaceful and connected lives. Furthermore, as many worldwide health crises and insoluble issues have shown (e.g. HIV/AIDS, famines, plagues, multiorganism resistant antibiotics), a preoccupation with problems is not necessarily liberating or enabling.

In health, problem-orientation supports the ongoing, but unrealistic, position of the health care provider as omnipotent and omniscient. It is only the health provider who is active in solving the problem and the client is necessarily inactivated and has power removed from them in the process. Being the problem-solver is also characteristic of paternalism and, whilst many might be aware of the dangers of this ideology (Arras & Dubler 1995), it will continue to be reproduced unless we also recognize the dangers of its solipsism. Paternalism does little to address the significant social and cultural problems that affect health (Arras & Dubler 1995), and does not activate or empower clients; rather it produces passivity and docility. Thus, to continue to act for clients, rather than work with them to build capacity, is at best inefficient and shortsighted and at worst amoral.

Further, contemporary health care has a formal and increasingly practical commitment to health promotion and illness prevention. Thus a problem-orientation is becoming ill-fitting, as it is inherently reactive, when what is required is a proactive approach. In the problem-solving orientation, action is only taken on an issue when it has developed into a problem. As Linstead (1997, p. 1117) explained, the trouble with the problem-solving orientation is that it:

tends to address such issues only when they emerge as problematic, and those approaches which seek to identify and surface potential problems are often accused of creating needless difficulties for practitioners.

Being the problem-solver works to privilege and illuminate the health carer's actions, whilst the work of being a client, struggling to survive, overcome and maintain resilience is overlooked. This in itself can set up and perpetuate a power differential. Focusing on the health carer means that the client tends to be objectified and in the position of recipient of care. This is essentially disempowering and makes difficult the expectation that clients become active consumers of health services. The problem-solving orientation may be essential for understanding issues and for reaching complete solutions, but it is sometimes inadequate for reaching solutions that are partial or able to be tolerated. For many, achieving contentment and ease are far more realistic goals, especially when we must live with an illness or disability from which there is no cure.

Whilst a problem focus may be useful in disciplines such as medicine, it is not as relevant in a discipline such as nursing, which has a strong focus on human relationships and finding strengths and abilities in clients. If nursing students are encouraged to be problem finders and solvers, then they may be unable to function in any other capacity. Such an approach may work to reinforce the very aspects of paternalistic health care which nursing is working so hard to dismantle. Stepping in and taking control too soon, acting as the expert, offering only a passive role to clients, ignoring personal strengths and abilities, and fostering an illness mentality are all aspects of modern health care which need to be replaced.

Issues for nursing

It is apparent that there are several important issues here for nursing. First, in a problem-orientation nurses are ill-prepared to be proactive and preventative. Also, whilst constantly searching for problems, we create for ourselves, and the clients with whom we work, difficulties which need to be overcome. Whilst this is the way nurses are predominantly taught to think, in practice this problem-orientation fits poorly and important practices in nursing are immediately devalued.

The nurse who soothes a patient, telling them not to worry about their problems for a while, or the nurse who gets the job done without planning its approach scientifically, are in a sense traitors to the problem-orientated approach. This kind of nurse, consciously or unconsciously, is being solution-focused, and aware of strengths, the need for adaptation and acceptance. A problem-orientation is more powerful than the unarticulated practices of caring, but it has nevertheless seeped into nursing ideology. The classic evidence for this is the first and second generations of the nursing process, which

were centrally concerned with identifying nursing problems and nursing diagnoses (Pesut & Herman 1999). Clinical nurses were required to integrate nursing diagnoses into their work and this did provide structure for beginning nurses (McHugh 1986). However, there are many who argue that, rather than benefiting skilled caring, ultimately a diagnosis framework competed with it (Tanner 1986, Pesut 1989, Alavi 1997). Writing up nursing diagnoses and action plans became an activity that was added on to a nurse's already busy day. It tended to take nurses away from clients, digging out a trench between theory and practice that has led to unhelpful resentment towards the 'headwork' so necessary to nursing. Generic protocols tended to be applied ritualistically (Tanner 1986), and the individuality of clients and uniqueness of different health and living contexts were overlooked (McAllister 2001a).

Within psychotherapy circles, clinicians have for some time been aware of the limitations of a problem-orientation (Pesut 1989, White & Epston 1990). They argue that clients tend to be consumed by the problem, ruminating over past issues, feeling helpless and despondent, and being unable to identify outcomes because they know too well what it is they do not want, but not what it is they are specifically aiming for. The psychotherapeutic turn towards solutions, aims and personal outcomes has much to offer nursing and to other professions that remain stuck in a problem-orientated paradigm.

If nursing is to prosper, then it needs to change. Not only do we need to *do* nursing differently (Duffy 1995, McMillan 1999); we also need to *teach* it differently (Spouse 1998, McAllister 2001b). We should reorient our focus from thinking problems are at the centre of living towards restoring a healthy balance. Problems are part of life, just as ritual, routine, peace and happiness are. For a full and

happy life to be sustained, three elements must exist in balance: health for the body, harmony for the planet, and peace for the spirit. A return to balance requires that humans develop sustaining and sustainable relationships with others and their habitats. To participate in this rehabilitation is to go beyond scientific practices and to affirm the important role of humans in sustaining the global ecosystem (Rollins 1996).

Theories supporting a solution-orientation

A solution orientation represents an exciting way forward for nursing. A solution focus is based on the positive psychology movement which has advanced knowledge of the characteristics of people who survive, overcome and endure stressful situations (Seligman 1991, 1995, Jackson & McKergon 2002). Using insights from this psychological movement as well as advances made by nursing theorists who have long argued the place for creative, nonrational thinking processes in clinical reasoning (Pesut 1991, Tanner 1993, Pesut & Herman 1999), the solution orientation will now be explained and applied to nursing.

Unlike a problem-orientation, a solution-orientation does not simply identify and reveal difficulties. It also does not place the problem at the centre of nurse–client interaction. A solution-orientation acknowledges problem-solving as part of nurse–client work, but foregrounds the presence of both problems and strengths. Like the problem-solving approach, it is a form of clinical reasoning. But a solution-orientation involves logic and creativity, deductive and inductive thinking, imagination and reason, problem-solving and solution-searching. A solution-orientation also works with what is going right with an individual or group, and seeks to maximize potential by building on strengths, achievements and capacity (Table 2).

Table 2 Differences between problem-solving and solution-orientation methods for clinical reasoning

Problem-solving	Solution-orientation
<ul style="list-style-type: none"> • Health problems are central to the concerns of nurses and clients • Aims to use the problem-solving method to understand and treat clients' problems • Chooses problems rather than strengths • Logic and deductive thinking • Rationality • Remedial • Corrects deficits in lifestyle • Diagnoses the problem • Motivates by giving plan of corrective action to follow • Generates protocols and processes • Health providers work on patients • Providers prescribe conventional treatments 	<ul style="list-style-type: none"> • Health problems are as important as healthy adaptation • Aims to understand problems and strengths, to promote resilience and health progression • Values both problems and strengths • Deductive and inductive thinking • Imagination and reason • Creative • Reinforces present healthy lifestyles • Reframes problems to see them anew • Motivates by building on strengths, achievements, and capacity • Generates personal plans and outcomes • Health providers and clients work together • Both take reasonable risks to test creative solutions

While we know that illness often involves a temporary loss of control over one's life and body and that fear, anxiety and powerlessness are common responses, much has been learned from studying people who have endured long-term hardship and illness. We now know that surviving trauma can make a person feel stronger, more alive, committed and a better human being. By carefully observing how the trauma of illness has affected people, the positive psychology movement has highlighted five key characteristics of the person likely to adapt to stressful situations such as illness. They are hardiness, internal locus of control, resilience, hope and social support (Fortinash & Holoday-Worret 2000).

Hardiness and internal locus of control

The concept of hardiness is used to describe a personality component that aids in mastering or controlling life events. Psychological research has shown that some people have the ability to overcome adversity, recover from illness against all odds, and survive tragedies without negative consequences. To these 'stress hardy' people, stress is perceived as a challenge and an opportunity for growth, rather than a problem. It is also thought that stress hardiness may be the moderating factor in survival rates for people with cancer, lowering blood pressure and delaying conversion to acquired-immunodeficiency syndrome (AIDS) in people with human immuno-deficiency virus (HIV) (Fortinash & Holoday-Worret 2000, p. 718).

People who have an internal locus of control believe themselves to be capable and share responsibility in managing their lives. Such people have been found to be better at minimizing risk factors that affect health and disease. Without it, people rely on others to manage well-being and thus have a reactive stance, often seeking help when illness has already emerged, overlooking prevention and failing to share responsibility for recovery work. Clients with an internal locus of control tend to be more active in their own health maintenance, and have higher levels of self esteem, perception of life purpose and lower levels of anxiety (Kozier *et al.* 1997).

Resilience

A simple definition of resilience is the ability to bounce back. Research into resilient people has shown that they appear to have what is called 'protective factors' – factors that protect them against illness development and assist them to overcome adversity – such as effective problem-solving strategies, adaptability to situations that the person cannot control or change (Rapp 1989).

A number of self-perceptions are characteristic of resilient people. Even when they are experiencing a terrible event, they know that they have goodness within themselves. They are able to picture the self in a good place, where rest and peace prevails. They value being and doing good for others, have moral commitment, feel connected with others and are able to put some conscious distance between the problem and the self. They are able to access cultural resources such as ritual, ideology or religion, reject a victim position, reject a negative view of the self, and see the self as 'an overcomer' and not just a survivor (Glantz & Johnson 1999).

Hope and social supports

People who continue to hold out hope for a better life and who aspire to continuing to reach goals, to endure and to work are more likely to make successful transitions from illness to health (O'Neill & Kenny 1998). Hope, or the endurance of the human spirit, is that which gives meaning and purpose to life and illness. Others might assist hope by displaying attitudes of hopefulness, optimism, that change is possible and likely, that small changes accumulate to make large changes, that the future is different from the past and that all people have intrinsic human value (Littrell 1998). Working this way can have a flow-on effect for others – clients as well as other clinicians. In this way, nurses can actively build workplace optimism, feelings of efficacy and higher morale. A person who has social supports tends also to fare better than those who are isolated. A sense of belonging, of being accepted, loved and valued, helps a person recognize inner strengths, encourages acceptance, and buffers against negative effects of stressful events (Pender 1996). Traditional social supports such as families and peer groups can be incorporated into health service delivery. Changing a clinician's stance to one of acceptance rather than always seeking to change clients is equally important (Linehan 1993).

All of these resources and solutions can be actively developed by nurses in order to facilitate coping and adaptation. Not only can they be developed in the context of illness and recovery, but they are also features that can be developed in healthy people. Thus, nurses have a role in prevention, and in building strengths, connections, coping abilities and wellness in people.

A solution-orientation is at the same time practical as well as theoretical, and outcome- as well as process-orientated, and will benefit both efficiency and effectiveness of health services. It emphasizes creative thinking, and thus moves beyond technical knowledge towards emancipatory thinking. It creates possibilities for new knowledge, pushes boundaries and potentially advances nursing.

Table 3 A solution-orientation [Adapted from Friedman (1997) and O'Connell (1998)]

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- Asks what the client wants to change and how
 - Opens space for future possibilities through a focus on exceptions and resources
 - Invites client to clarify main issues and priorities for health service
 - Continuously channels client and carer towards goals or desired actions
 - Assumes client is competent, resilient and resourceful
 - Views client as unique, and maintains a position of curiosity
 - Views nursing as interaction which opens new possibilities
 - Focuses on a process of collaborative inquiry
 - Privileges the client's voice and expertise
 - Builds on client's ideas and language
 - Seeks to be open, collaborative and respectful
 - Asks: Have we achieved enough to end?
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Becoming solution-focused

The practical applications of these principles of solution-orientation are many. First, nurses can shift their standpoint in relation to clients so that, rather than aiming to do work *on* a client, one aims to work *with* and *for*. Since the hospital system has long encouraged nurses and others to deliver care to patients and to be the experts and active partners, this shift in standpoint requires some practice and can be challenging. However, working alongside clients and negotiating care with them means that the person is more likely to feel understood and cared for. They are also more likely to feel motivated to begin the work involved in changing lifestyle habits, and finding new ways to cope and to thrive in today's world.

For nurses, the new orientation involves some rather significant reframing (See Table 3). Rather than assuming the stance of expert, clinicians can acknowledge that both people in the partnership have expertise. There is much to be gained by assuming clients to be competent, resilient and resourceful rather than needy, weak and unknowing. It is much easier to begin recovery by moving towards the place where a client is, and going on from there (Table 3).

One can begin by being gentle, humble and kind, acknowledging and attending to the person's unique needs, conveying respect and trying not to judge their actions. Try to do less telling and more listening. Get to know the person not the label by asking, for example, 'What do you call what's happened to you?' and use the person's words and not technical jargon (White & Epston 1990). If we agree that change is needed then it is helpful to start with where the client is and not where the nurse wants to take them. Try to work on skills needed in the everyday, using resources that

are at hand. It is also important to prioritize relationships between nurses and clients, rather than nurses' relationships with teams or services (Rapp 1989).

Exploration of a person's problem can be done in such a way as to put some distance between it and the person's identity, so that they begin to see themselves as more than their disorder. Called 'externalising', this strategy aims to give the problem a name of its own, separate from the person, and to find opportunities to talk about times when the problem was not prominent in the person's life (Zimmerman & Dickerson 1994). An example of this might be 'Can we talk about the times in the last week when "confusion" was not around?' Externalizing strategies help to contain and limit undesired aspects of the self and enhance its good parts.

Nurses can facilitate resilience in people through providing education on the nature of resilience and helping them to reframe the way they see themselves. It is also a good idea to provide opportunities for people to be helpful so that they can feel a sense of social connection, and moral goodness. Cultural strengths can be built by introducing and encouraging life rituals, which lend comfort and identity. Special events using music, singing, laughter or discussion are also ways to build in social activity and can be organized from time to time. Everyday rituals can be negotiated and encouraged with clients by exploring values and goals.

Generating solutions to problems also requires more than logic and reason. It requires imagination, wishful thinking and the exercise of one's creative mind. Creativity can be developed through play, dance, music, artistic expression, poetry, reading, writing, listening to motivational and inspirational speakers and learning to think metaphorically. Metaphorical thinking helps to link the known to the unknown and is particularly suited to health care work. Health problems that become familiar or seemingly insoluble can be thought about differently and new solutions generated when metaphors are applied (Pesut 1991, Zimmerman & Dickerson 1994, McAllister 1995).

Such concepts lend persuasive arguments for why nurses should move away from a problem-orientation, because there is much that can be learned about how people stay well despite adversity. There is also much to be learned about how people can be assisted to adapt to health problems and diseases without losing their place in life, and by harnessing resources to live meaningful, happy, connected and peaceful lives.

A vision for nursing: (re)turn to relationships

Nursing is well placed within the health system to find space to reclaim human-human relationships because it has as its essence the human qualities of nurturance, care, presence and

connection. It is not sufficient for nurses to react to problems such as illness, stress and social disharmony because this is an essentially conservative act which does not lead to enduring change. They must be empowered to be proactive and prevent problems and maintain health.

In the past, nurses have been taught to develop self-identity in a way that focuses on individuality, separation and autonomy (Glenn 1999). Such a view does nothing to develop connection, tolerance, consideration and mutual adaptation.

A refocus on nurse–client relationships, in which each person works towards achieving a healthy body, social harmony and a peaceful spirit, represents a way of reshaping those forces. By relocating nursing's concern to relationships, rather than to the self, self-knowledge and self-hood are enhanced for both nurse and client in a different way.

Nursing has an identity that is deeply rooted in history and relatively well known by most people. This identity simply needs to be more honoured and proclaimed. In this way nurses, wherever they work, will begin to believe again in a distinct purpose that is separate, different and complementary to medicine, and so begin to change their practice.

Together, nurses can also work to change the practice of caring through good education, good clinical work, good management, and good social action. Good teaching will provide opportunities for students to learn the art and science of wellness as well as pathology. Good clinical environments will support development of helping skills such as empathy, reframing, strengths focus, hope, resilience-building and social connections. Good management will offer an atmosphere of friendliness, respect and dialogue. In this unashamedly moral vision, nurses may begin overtly to honour each other by offering praise and expressing pride. They might also actively work to change public opinion by taking a visible role in public debate and decision-making, and by giving the media rich news stories about nurses' achievements and clients' growing satisfaction.

Conclusion

Whilst medicine continues to enjoy relative stability through having carved out a valued place in health, nursing in the main does not. For many years the health service has privileged medicine and marginalized nursing. All along many of us have failed to recognize that these positions were supported by a culturally embedded but formally unspoken ideology that was ill-suited to nursing: the problem-orientation. We know now, however, that this ideology serves the important purposes of preserving the elite and perpetuating assumed judgements on how best to deliver health care. A problem-orientation has supported

the social and economic status quo, when what we need is system change.

If we are serious about claiming difference from medicine, then there are a number of changes that we need to make in order to shift practice towards being solution-focused. Nursing needs good education – not just training in skills that quickly become outdated and leave clinicians dependent on others for direction – but education that teaches lifelong learning skills and the confidence in oneself to know how to think and search creatively for solutions. Nursing needs to move from valuing skills akin to housework and those of trades-assistants, to practising and developing effective helping skills. Such skills include engagement, resilience-building, community development, primary health care and health education. If we can do this, if we can teach, practise, manage and lead in these ways, then this is how we can aim to do nursing differently.

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