Solution-Based Therapy with Drug & Alcohol Problems

This article describes the work of The Solution-Based Family Service, which is part of the North-West London Mental Health NHS Trust. The service began in 1983 following a research grant offered by central government. A group of clinicians at St Marys Drug Dependency Unit, Paddington began to look at the effectiveness of Family Therapy within the Substance Use Service. Their findings were positive and in 1989 the Regional Health Authority allocated funding for Family Therapy. Shortly afterwards the team began to develop a Solution-Focused Brief Therapy approach, and moved to its current premises in London W10. The therapy team is currently made up of individuals from a variety of clinical backgrounds, including Family Therapy, Hypnotherapy and Personal Construct Psychotherapy. The teams ethos is founded on the work of Steve de Shazer, Bill OHanlon, Milton Erickson, Michael White, Richard Bandler and John Grinder, and others associated with the development of brief therapeutic ideas. The team currently comprises

Client population

All referrals to the service must have, as part of the overall presenting difficulty, some issue to do with drugs (illicit or prescription) and/or alcohol. The person being referred need not be the user of the substance, but may be someone who is affected by another persons substance use. Sessions may be attended by individuals, couples, families and any other concerned parties whose attendance the client feels would be helpful. This can include another professional worker, as well as a partner, family member, or friend of the client.

The therapeutic relationship

From the outset we aim for a collaborative therapeutic relationship with our clients, in which we seek to validate their current position while at the same time opening up new possibilities for the future. We present ourselves as co-workers in the process of change, rather than coercive or prescriptive experts. The client is viewed as the person best informed on his or her own life, while the therapists expertise lies in asking useful questions, clarifying goals, uncovering resources, and surfacing assumptions. In order to respect the clients experience and desires, it is important that the goal of therapy is co-constructed between client and therapist; clients are more motivated to achieve goals which they have identified, and are therefore more likely to accept responsibility for the change process. All interpretations or suggestions are offered tentatively, and checked out with the client, to see if they make sense or are considered useful.

One aspect of the therapeutic relationship that is specific to substance use work centres around the issue of clients who turn up for appointments in an intoxicated state. Rather than sending them away, we work with such clients by focusing on the future and how the next session could be more useful to them. For example, we might ask the question: what would tell you that you were making satisfactory progress the next time we meet? We draw attention to the fact that, in spite of being intoxicated, the client had enough self respect to turn up to the session and focus on the next step in the therapeutic process. The feedback we have received from clients in subsequent sessions suggests that this strategy makes them feel accepted and validated in spite of their problem, and the consequent boost to their self esteem can have beneficial results. There are, of course, cases where this strategy is not appropriate or useful, such as when a client persistently attends in an intoxicated state and does not appear to be taking the therapeutic work seriously. In such cases we undertake a review of their therapeutic goals as an initial first step.

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From problems to solutions

For drug and alcohol users, the past is often described in problem-saturated terms, resulting in a fixed diagnosis and identity (alcoholic, addict, failure, etc) being carried into the present and projected into the future. Brief Therapy offers such clients the opportunity to re-author their lives and their relationships according to alternative stories that have preferred outcomes (White, 1990 pp.38-41). Clients are often surprised to find that therapy does not consist of an exploration of their problem and its origins, and that we are more interested in whats working in their lives: our presupposition that clients are resourceful and competent naturally leads us to ask questions about their existing coping responses; exceptions to the problem pattern; previous successes in solving problems (of any kind); past or present strengths and abilities; and pre-session change.

Case example: *Bill was drinking 8 pints of beer a day and experiencing low self esteem and depression. Asked to describe the last time you resisted the urge to lose control of your drinking, he said that a few days before he had been about to drink a third pint, when I got an image in my head of the real me - a deeper, more sensitive and stronger self. The therapist then questioned Bill to develop this image of his real self as an alternative to the drinker identity which could be drawn on as a source of strength.*

As well as exploring alternative stories about their past and present experience, much of the therapeutic dialogue consists of future-oriented solution talk. Through structured questioning, we ask clients to describe their goals in detail, so that they have definite criteria with which to identify any success. They are encouraged to address, positively, the actions and supporting beliefs that will emerge once they have reduced, controlled or eliminated drug use. We do not assume that specific solutions are always available to clients; however, we make it clear that the eventual aim of therapy is to have clients engage in new and productive behaviour.

Case example: *Bill was asked how he would know that it was time to stop therapy. He replied that he would be drinking less than 7 units of alcohol a week, exercising regularly, socialising with people other than his drinking friends, and feeling better inside.*

Clients goals are not typically achieved overnight, particularly in cases of long-term substance use. For this reason it is important that clients have a sense that the efforts they are making now will result in definite progress towards their desired outcome. Once this outcome has been identified, we ask clients what they can start to do immediately that will start to bring them close to it, and - importantly - how they will know that they are moving in the right direction.

Case example: *Bill identified a number of anti-drinking behaviours he could use to show himself that he was becoming more my old self. These included joining a gym, signing up for a course of study, and being more assertive with his friends when they pressed him to drink.*

Problems as old solutions

A solution focus does not mean that we ignore problems altogether; when a client repeatedly punctuates a conversation about strengths and solutions by returning to the problem (often using phrases such as yes butÖ or its not that easyÖ) then we begin to explore what was once useful or purposeful about the symptom pattern. It frequently emerges that the current problem was once the best available solution to previous difficulties. For example, alcohol helped one client feel more comfortable in social situations; another person found that it helped her sleep better; others have turned to drugs as a means of coping with physical or psychological pain.

By focusing on the perceived benefits of substance use (or other problem-related behaviours) we help clients generate alternatives that can satisfy these needs and align them with the stated goal of abstinence or reduction.

Case example: *Richard presented for therapy when a recent blackout after bingeing on crack and alcohol had made him very concerned about his health. He expressed a strong desire to stay clean but said he could feel the cravings getting too strong for me. He spent much of his time caring for his disabled father; he did not bring this up as an issue, so we did not address it directly, but he did comment that he often found his life drab and unfulfilling.*

Rather than viewing his insistence on the power of the cravings as resistance, the therapist questioned Richard to find out what made bingeing seem so attractive in spite of the fact that its damaging your health and messing up your life; Richard responded that its an escape, but agreed that it had now turned into a dead end and was depriving him of the freedom he wanted. When asked where else he had had a taste of freedom he described his pleasure in playing sport, particularly golf. He was encouraged to take up sport again, and a month later reported that the cravings were much easier to control and he was now confident of being able to beat them for good.

Relationships within a system

The systemic approach adopted by the team means that we view even small changes made by a single individual as impacting on a wider context of relationships with others, with work or home, or with the therapy team. We introduce significant others into the therapeutic equation from the start, either by inviting them into the sessions (when working with couples, families, or other concerned parties) or by discussing the clients interactions with them (when working with individuals).
This systemic perspective can be particularly helpful for a non-substance-using client, whose attempts at helping are often perceived as interference by the user. By focusing on such clients concerns around their own situation, we can help them regain a sense of personal effectiveness. It is often with a sense of relief that the concerned person realises that making a change in his/her own life can also make a difference for the other person(s) involved - not by manipulation or direct intervention, but by taking a step back so that the user can take responsibility for his/her own change process. This can break the pattern of nagging and feeling persecuted that often manifests when one person relies on another to change before things can improve, and reframes concern and care (for the self and others) in a way that is compatible with more constructive behaviours.

Case example: A woman presented in considerable distress over her husbands drinking, which had progressed to the stage where he now lived abroad, and took minimal responsibility for important decisions and caring for their two children, beyond sending them money. She reported that he refused to acknowledge that he had a problem, and felt that she was carrying more than her share of the burden of responsibility. She had tried to discuss these issues on numerous occasions, but he shied away from her questions, with the result that she found herself doing more and more for the family, while he did less and less.

The therapist encouraged her to focus on taking care of herself, and to resist her instinct to go it alone when faced with problems relating to the house and/or the childrens upbringing. She made an effort to ask her husbands advice, and leave things with him to sort out, and stopped trying to raise the issue of his drinking. Two months later, after 3 sessions of therapy, she reported with surprise that he was now taking action to solve the problems she presented to him, and that he had even made a surprise trip home to spend Christmas with the family; during the 3 days he spent with them, he was drinking noticeably less than usual, and was giving more time and attention to her and the children.

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