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Case Report

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Solution Focused Counseling with a Substance Abusing Client

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Abstract

Substance abuse counseling is typically offered from a cognitive-behavioral or 12-step based approach. Solution-focused theory can offer counselors with an alternative perspective for working with clients with drug abuse issues. In this article, a case report is presented in which the author utilized a solution-focused approach with a client experiencing co-occurring anxiety and severe alcohol use. Solution-focused theory is briefly described and techniques for use with the model are detailed. The effective use of exception and coping questions are described in the case report and outcomes of these interventions are presented. The article concludes with a discussion on the need for further research and suggests specific areas for additional investigation.

Keywords: Solution-focused counseling, Addictions counseling, Addiction case report, Exception questions, Co-occurring disorders

Introduction

Substance abuse counseling is typically offered from a cognitive-behavioral or 12-step based approach. Solution-focused counseling (SFC) can provide addictions counselors with an alternative approach to disease-based and CBT models. Several theorist and clinician were instrumental in creating solution-focused counseling including Milton Erickson, the Mental Research Institute's Brief Therapy Center, the brief family therapy movement, and de Shazer and Berg's work at the Brief Family Therapy Center [1-3]. In this article, the SFC approach will be described and its application will be detailed utilizing a case report format.

Solution-focused counseling is based on constructivist thought [2,4]. Constructivist approaches have as their basis the idea that there is no single objective truth. Instead, reality is thought to be a subjective construction based on a person's interactions with the world, meanings made of life experiences, and personalized interpretations of ambiguous stimuli and events [5,6].

Berg and Miller (1992) assert that, consistent with the constructivist orientation, "the solution-focused approach makes no assumptions about the 'true' nature of a client's presenting problem" (p. 7). Instead, the approach focuses on the personalized constructions that the client creates about his or her unique experiences and how the client defines their problem based on those experiences. Applied to SA counseling, this constructivist foundation challenges the notion that there is one true pattern of addiction. As Berg and Miller state, "the solution-focused counselor treats many [addictions] – a different type for each client that is treated" [7]. Accordingly, SFC counselors work to understand each client's personalized construction of their addiction and assist the client to construct different meanings about their substance abusing behavior.

The most notable difference between SFC and other forms of SA counseling is a focus on solutions rather than problems [2]. As mentioned, SFC counselors do not adhere to the idea that problems have one objective definition or cause. Further, SFC counselors do not believe that having an understanding of a client's presenting complaints is necessary in order to change their problems. Solution-focused counselors further state that a problem and its solution may not even be related. Accordingly, SFC counselors focus on the positive aspects of clients' lives and seek to expand on them [4]. This strength-based approach assumes that change is constant. As a result, SFC counselors assist clients in directing naturally occurring change, identifying strengths, creating new perspectives on problems, and finding practical solutions that work [7,8].

Several authors have documented the effectiveness of SFC in counseling intrinsically unmotivated clients [7,9-17]. Others have described the successful use of SFC with court-mandated domestic violence offenders, a population that is generally described as being resistant to counseling [13,18]. Solution-focused interventions have also been described for use with unmotivated and resistant clients in SA treatment [9,14,19].

Solution-focused counselors use numerous techniques to assist their clients in creating solutions. Counselors adhering to a SFC approach describe the careful use of language and questions as a central to their interventions with clients. In SFC, individual questions are viewed as interventions in and of themselves [2,4]. As a result, SFC counselors advocate for the use precise language when creating questions for their clients. Solution-focused counselors generally utilize three types of questions to elicit change in counseling; (a) scaling questions, (b) miracle questions, and (c) exception and coping questions [7].

Exception and coping questions are of particular relevance to the present case report. In exception and coping questions SFC counselors inquire at length about times when the client's presenting problem is not occurring and the ways in which clients are coping with their current issue [20]. Solution-focused counselors note that, when presenting for counseling, clients are often solely focused on their problems and are not aware of times in when the problem is under control [4,7,9,]. Solution-focused counselors therefore use exception questions to define times when the problem is not occurring and, in conjunction with the client, work to identify what the client does to create problem free points of their day, week, or month. For example, a SFC counselor may inquire, "tell me about times when the problem is not occurring." Similarly, when using coping questions, SFC counselors work to help clients identify examples of times when they are coping effectively with the problem. A sample coping question is, "Given that the situation is so bad, how come it is not worse?" Out of these conversations and interventions client strengths are recognized, and positive solutions are created.

When using questions as interventions, SFC counselors do not have as their goal the total elimination of the client's presenting problem. Instead, SFC counselors assume that small changes create a "ripple effects" leading to larger changes [2,4,7]. Additionally, the absence of the presenting problem is only part of the counseling goals. Solution-focused counselors are generally more concerned with what the client is doing instead of engaging in their problem behavior [2]. The SFC approach emphasizes a collaborative and client-centered approach to counseling and assumes that clients bring with them the internal strengths and skills to create lasting change.

Case Presentation

Ted was a 35 year old Caucasian male client. Ted indicated that he began experimenting with alcohol on the weekends around the age of 16. During this time he reported consuming five to six alcoholic beverages on either one or both days of the weekend. Ted stated that around the age of 22 his use pattern began to increase when he began drinking during weeknights, sometimes to the point of intoxication.

By the age of 28 Ted was drinking alcohol daily with his drink of choice being vodka. He stated that he began drinking first thing in the morning in order to control his withdrawal symptoms of trembling, agitation, and severe sweating. Ted maintained active employment during this time as a union-affiliated contractor. He reported that he continued to drink all day during work in an attempt to control symptoms of anxiety related to interacting with customers. Ted indicated that he also used alcohol to address anxiety about his work performance. He stated that he generally assumed that he was going to do a poor job on his work projects and that alcohol helped him to reduce this performance anxiety. Ted stated that he would end every day by finishing off a gallon of vodka and "passing out in his chair for the night so [he] could wake up and do it all again" the next day.

At the age of 32 Ted was found unconscious in his home by a family member. It was unknown how long he was unconscious. The family member called an ambulance and Ted was rushed to the hospital where he remained for nearly two weeks. During his time in the hospital Ted was: (a) medically detoxed from alcohol, (b) assessed and treated for physical squeal related to his alcohol use, (c) assessed and treated for co-occurring psychiatric symptoms, and (d) stabilized with a medical plan and antianxiolytic prescription drugs. Ted was instructed by hospital staff that any further drinking could result in serious health consequences including death.

Upon his discharge from the hospital, Ted was referred to outpatient counseling with the author. He was diagnosed as having a co-occurring disorder of anxiety and alcohol use. Ted presented to counseling of his own volition within a three weeks of his hospital discharge. He reported that he was highly motivated to discontinue his drinking behavior. Upon intake Ted noted that his most pressing presenting issue was anxiety related to a constant craving for alcohol. At the time of his first appointment Ted had not yet returned to work and was spending a great deal of time with his family as he recovered from his physical symptoms.

Discussion

When meeting with Ted the author took a SFC approach to counseling. After working to form a strong rapport with Ted and taking inventory of his drinking history, the author began using the SFC questions mentioned previously. This included the use of scaling, miracle, and exception and coping questions. Ted responded positively to the SFC approach and indicated that he found SFC conversations useful to his recovery.

The use of exception questions proved to be most effective in assisting Ted to cope with his presenting anxiety and alcohol cravings. As mentioned, during his intake session Ted described having constant anxiety related to his cravings for alcohol. In responding to this the author asked the following question; "When are the times of your day or week when you are not experiencing anxiety or cravings for alcohol?" As is common in SFC counseling, Ted first remarked that there were no such times and that his anxiety and cravings were constant. However, after persistent questioning and intentional conversation Ted was able to determine that he did not experience his presenting symptoms during instances where he was spending time with his family, engaging in physical rehabilitation, and watching movies with his friends. Through further discussion Ted was able to realize that the only time of the day that he really experienced debilitating levels of anxiety and cravings were during the evenings when he was alone and after going to bed. This realization helped Ted to recognize that he did have several supports and strengths to address his presenting issue and that his anxiety and cravings were not insurmountable or untreatable. He no longer defined his anxiety and cravings as "constant" and developed a sense of hope that he could overcome his presenting issues, even as he planned to return to work.

True to the SFC approach Ted and the author were able to generate solutions to address his evening and bed time symptoms. The most effective of these were reading and listening podcasts. While some of his readings and podcasts were therapeutic in nature, others were for pleasure. He learned that he enjoyed reading mystery novels

and learning about science. After four weeks of practicing these solutions Ted indicated that his anxiety and alcohol cravings were considerably reduced and that he no longer felt as if his problems were intractable.

Conclusions

Solution-focused counseling can be an effective form of SA treatment [7,9,10,11,17]. In this case report the author described the successful use of SFC with a client experiencing co-occurring anxiety and alcohol use disorders. Solution-focused counseling offers an alternative to other widely practiced forms of SA counseling such as cognitive behavioral therapy and 12-step based approaches. While some counselors may be tempted to utilize individual SFC interventions, effective use of the model requires a strong theoretical understanding of the theory's underpinnings, consistent adherence to the model, and intentionally careful use of language during counseling conversations [2,4]. While some research has been conducted in this area, further study of the use of SFC with SA clients is needed. Particularly, it is recommended that such research include investigation into ways in which SFC can be used in a complimentary fashion with 12-step based mutual help groups. Many clients in SA counseling also attend 12-step groups and generating methods for utilizing SFC in conjunction with mutual-help group attendance can further advance the creation of effective approaches to SA counseling.

References

1. Becvar DS, Becvar RJ (2000) Family therapy: A systemic integration (4th ed.). Worldwide: Allyn & Bacon.
2. De Shazer S (1985) Keys to solution in brief therapy. New York: Norton.
3. Mason WH, Chandler MC, Grasso BC (1995) Solution based techniques applied to addiction: A clinic's experience in shifting paradigms. Alcoholism Treatment Quarterly 13: 39-49.
4. O'Hanlon WH, Weiner-Davis M (2003) In search of solutions: A new direction in psychotherapy. New York: Norton.
5. Nichols MP, Schwartz RC (2004) Family therapy: Concepts and methods (6th ed.). Worldwide: Allyn & Bacon.
6. White M, Epston D (1990) Narrative means to therapeutic ends. New York: Norton.
7. Berg IK, Miller SD (1992) working with the problem drinker: A solution oriented approach. New York: Norton.
8. Miller G (1999) Learning the language of addiction counseling. Worldwide: Allyn & Bacon.
9. Berg IK (1996) Solution-focused brief therapy with substance abusers. In A. Washton (Ed.), Psychotherapy and substance abuse: A practitioner's handbook 223-242. New York: Guilford.
10. Taleff MJ (1997) Solution oriented and traditional approaches to alcohol and other drug treatment: Similarities and differences. Alcoholism Treatment Quarterly 15: 65-73.
11. Aambo A (1997) Tasteful solutions: Solution-focused work with groups of immigrants. Contemporary Family Therapy 19: 63-79.
12. Banks V (1999) A solution focused approach to adolescent group work. The Australian and New Zealand Journal of Family Therapy 20: 78-82.
13. Lee M, Sebold J, Uken A (2003) Solution-focused treatment of domestic violence offenders: Accountability for change. New York: Oxford.
14. Pichot T (2001) Co-creating solutions for substance abuse. Journal of Systemic Therapies 20: 1-23.
15. Schorr M (1995) Finding solutions in a relaxation group. Journal of Systemic Therapies 14: 55-63.
16. Schorr M (1997) Finding solutions in a roomful of angry people. Journal of Systemic Therapies 16: 201-210.
17. Zimmerman TS, Jacobsen RB, Macintyre M, Watson C (1996) Solution-focused parenting groups: An empirical study. Journal of Systemic Therapies 15: 12-25.
18. Linton JM, Bischof GH, McDonnell KA (2005) Solution-oriented treatment groups for assaultive behavior. Journal for Specialists in Group Work.
19. Pichot T, Donlan Y M (2003) Solution-focused brief therapy: Its effective use in agency settings. Worldwide: Haworth.
20. Roes NA (2002) Solutions for the "treatment resistant" addicted client: Therapeutic techniques for engaging challenging clients. New York: Hawthorn.