MOTIVATION IS AN ISSUE IN SFBT

• Motivational Interviewing
• Motivational Enhancement Therapy
• Evoking self-motivation
• Asking open-ended questions
• Stages of change model
EVOKING SELF-MOTIVATION

Questions to ask

- What things make you think that this is a problem?
- What do you think will happen if you do not make a change?
- What are the reasons you see for making a change?
- What makes you think you need to make a change?
EVOKING SELF-MOTIVATION

• What makes you think that if you decided to make a change, you could do it?
• What do you think would work for you, if you needed to change?
• How much does your use concern you?
OPEN-ENDED QUESTIONS

- What brings you here today?
  - So you are here to talk about quitting.
- In what ways are you concerned about your marijuana use?
  - Do you use marijuana too much?
- What do you think you want to do about your use?
  - When do you plan to quit?
STAGES OF CHANGE MODEL

• Precontemplation
• Contemplation
• Preparation
• Action
• Maintenance
PRECONTEMPLATION

Task - to increase discrepancy

- Educational confrontation
  - How many joints do you smoke?
  - Use progression models
  - Accurate information about disease
  - Educational model
PRECONTEMPLATION

Good and less good aspects

• Invites defensiveness
• Narcissistic defense

Broad based assessment

• Alcohol and drug history
• Psychosocial history
• Psychiatric evaluation
• Medical evaluation
CONTEMPLATION

Task - tip the decisional balance scale

• Normalize ambivalence
  • I know many other clients who felt the same way as you and they succeeded.
  • You are the best judge of which way to go.
• Use reframing
CONTEMPLATION

What are the options?
  • Move from external to internal motivation
    • Real from perceived
  • There are many problems
    • Deal with first other issue
    • “Natural link”
  • Quit drinking for a week
  • Take meds for a month
CONTEMPLATION

List of concerns
• “Pro’s and con’s”
• Questions
  • It’s up to you……
  • What do you plan to do next?
  • What is most important reason to change?
  • Where do we go from here?
  • How would you like for things to turn out?
PREPARATION

• Identify and assist in problem solving re: obstacles
• Help client identify social support
• Verify that client has underlying skills for behavior change
• Encourage small initial steps
ACTION

- Practicing new behaviors
- Focus on restructuring cues and social support
- Bolster self-efficacy for dealing with obstacles
- Combat feelings of loss and reiterate long-term benefits
MAINTENANCE

• Continued commitment to sustaining new behavior
• Plan for follow-up support
• Reinforce internal rewards
• Discuss coping with relapse
RELAPSE IS EXPECTED IN THE CHANGE PROCESS

Resumption of old behaviors: "Fall from grace"

- Evaluate trigger for relapse
- Reassess motivation and barriers
- Plan stronger coping strategies
STAGES OF CHANGE (SINGLE ATTEMPT)
THE SPIRAL OF CHANGE (MULTIPLE ATTEMPTS)
STAGES IN WHICH PARTICULAR CHANGE PROCESSES ARE MOST USEFUL

Time = Temporal Distance of Behavior

Behavior Intention

Precontemplation | Contemplation | Preparation | Action | Maintenance

Behavior

Time = Duration of Behavior
Problems

Solutions
SOLUTION-FOCUSED BRIEF THERAPY (SBFT)

Developed by Steve De Shazer and his colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin.

In solution-focused brief therapy, the emphasis is placed on building exceptions to the presenting problem and making rapid transitions to identifying and developing solutions intrinsic to the client or problem.
IF YOU CHANGE NOTHING, NOTHING WILL CHANGE
HIGH LIGHTS OF SOLUTION-FOCUSED BRIEF THERAPY

- Focusing on competence rather than pathology
- Finding a unique solution for each person
- Using exceptions to the problem to open the door to optimism
- Using past successes to foster confidence
- Looking to the client as the expert
- Using goal-setting to chart a path toward change
- Sharing the responsibility for change with the client
THE GOLD RULES OF SOLUTION-FOCUSED BRIEF THERAPY

• "If it ain't broke, don't fix it!"
• Once you know what works, do more of it!
• If it doesn't work, then don't do it again – do something different!
Why a Solution Focused Approach?

Change happens all the time; You’re job is to identify and magnify useful change.

There is no one right way of seeing the world.

A detailed understanding of the problem doesn’t translate into a solution.

The solution’s clues are there in front of you; You just have to see them.

Intelligent small changes can have bigger impacts later on.

It is important to stay solution focused, not solution forced.

“Find out what works and do more of it.”
WHAT IS SOLUTION-FOCUSED BRIEF THERAPY (SBFT)?

Solution-Focused Brief Therapy:

• Helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related their exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality.

• Thus clients find their own way to a solution, based on their emerging definitions of goals, strategies, strengths, and resources.

• Even in cases where clients come to use outside resources to create solutions, it is the clients who take the lead in defining the nature of those resources and how they would be useful.
TENENTS OF SOLUTION-FOCUSED BRIEF THERAPY (1)

- It is based on solution-building rather than problem-solving.
- Therapeutic focus should be on client’s desired future rather than on past problems or current conflicts.
- Clients are encouraged to increase the frequency of current useful behaviors
- No problem happens all the time. There are exceptions – that is, times when the problem could have happened but didn’t – that can be used by client and therapist to co-construct solutions.
TENENTS OF SOLUTION-FOCUSED BRIEF THERAPY (2)

• Therapists help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within clients’ repertoire or can be co-constructed by therapists and clients.

• Differing from skill-building & behavior therapy interventions, the model assumes that solution behaviors already exist for clients.

• It is asserted that small increments of change lead to large increments of change.

• Clients’ solutions are not necessarily directly related to any identified problem by either client or therapist.

• Conversational skills required of therapist to invite client to build solutions are different from those needed to diagnose & treat client problems.
Major Tenets of Solution-Focused Coaching

- If it isn’t broken, don’t fix it.
- If it works, do more of it.
- If it’s not working do something different.
- Small steps can lead to big changes.
- The solution is not necessarily directly related to the problem.
- The language for solution development is different from that needed to describe a problem.
- No problem happens all the time; there is always an exception that can be utilized.
- The future is both created and negotiable.

"More Than Miracles", de Shazer pp. 2 - 3
INTRODUCTION TO SOLUTION FOCUSED APPROACH

You are looking to move the client from where they are now to where they would like to be.
KEY CONCEPTS OF SOLUTION-FOCUSED BRIEF THERAPY

• Therapy grounded on a positive orientation - people are healthy & competent
• Past is downplayed, while present & future are highlighted
• Therapy is concerned with looking for what is working
• Therapists assist clients in finding exceptions to their problems
• There is a shift from “problem-orientation” to “solution-focus”
• Emphasis is on constructing solutions rather than problem solving
The question that matters: How can you get this smidgeony teensy bit further?

What “perfect” would be

Don’t worry about this area at all!

You got this far

A teensy bit further

(The 1st question: How did you get even this far?)

Approach with Solutions Focus (Delta Method)
BASIC ASSUMPTIONS OF SOLUTION-FOCUSED THERAPY

• The problem itself may not be relevant to finding effective solutions
• People can create their own solutions
• Small changes lead to large changes
• Client is the expert on his or her own life
• Best therapy involves a collaborative partnership
• Therapist’s not knowing affords clients an opportunity to construct a solution
Stop worrying about what you have to lose and start focusing on what you have to gain.
QUESTIONS IN SOLUTION-FOCUSED BRIEF THERAPY

• Skillful questions allow people to utilize their resources
• Asking “how questions” that imply change can be useful
• Effective questions focus attention on solutions
• Questions can get clients to notice when things were better
• Useful questions assist people in paying attention to what they are doing
• Questions can open up possibilities for clients to do something different
3 KINDS OF RELATIONSHIPS IN SOLUTION-FOCUSED THERAPY

- **Customer-type relationship:** client and therapist jointly identify a problem and a solution to work toward.

- **Non-compliant relationship:** a client who describes a problem, but is not able or willing to take an active role in constructing a solution.

- **Visitors:** clients who come to therapy because someone else thinks they have a problem.
TECHNIQUES USED IN SOLUTION-FOCUSED BRIEF THERAPY

1. **Pre-therapy change** (What have you done since you made the appointment that has made a difference in your problem?)

2. **Miracle question** (If a miracle happened and the problem you have was solved while you were asleep, what would be different in your life?)

3. **Scaling questions** (On a scale of zero to 10, where zero is the worst you have been and 10 represents the problem being solved, where are you with respect to __________?)

4. **Taking "time-outs"** Suggesting to the client "While I step out, I want you to think of the next smallest step you could take that would bring you to the next number on the scale."
5. **Affirm client competencies** (e.g., tell the client, "I am impressed you are sitting in that chair again after what you just went through"). Many of these clients have never had this success acknowledged before.

6. **Task assigning**: Suggest tasks that the clients can perform to improve their situation (e.g., ask them to do something achievable that would provide useful information or move them closer to the "miracle" they has chosen).

7. **Exception questions** (Direct clients to times in their lives when the problem did not exist)
1. Problem talk
2. Separating the person from the problem
3. Miracle question
4. Exceptions
5. Scaling questions
6. Goals / feedback
7. Compliments
8. Task setting
Deliberate and Random Exceptions to Substance Abuse Behaviors

• **Deliberate exceptions** are situations in which client has intentionally maintained a period of sobriety or reduced use for whatever reason. For example, client who did not use substances for a month in order to pass a drug test for a new job has made a deliberate exception to his typical pattern of daily substance use. If he is reminded that he did do this in the past it will demonstrate that he can repeat the behavior.

• **Random exceptions** are occasions when client reduces use or abstains because of circumstances that are apparently beyond her control. The client may say, for example, that she was just "feeling good" and did not feel the urge to use at a particular time but cannot point to any intentional behaviors on her part that enabled her to stay sober. This type of exception is more difficult for the therapist to work with but can also be used to help client perceive her own efficacy. In such instances the therapist can ask client to try to predict when such a period of "feeling good" might occur again, which will force her to begin thinking about behaviors that may have had an effect on creating the random exception.
All problems have exceptions. Exceptions are those times when the presenting problem could have happened but somehow it did not. Looking for these exceptions is critical to building further solutions.

Insoo Kim Berg & Therese Steiner
SO HOW DO YOU ASK THE “MIRACLE QUESTION”

Language of the intervention may vary, but basic wording is: “I am going to ask you a rather strange question [pause]. The strange question is this: [pause] After we talk, you will go back to your work (home, school) and you will do whatever you need to do the rest of today, such as taking care of the children, cooking dinner, watching TV, giving the children a bath, and so on. It will become time to go to bed. Everybody in your household is quiet, and you are sleeping in peace. In the middle of the night, a miracle happens and the problem that prompted you to talk to me today is solved! But because this happens while you are sleeping, you have no way of knowing that there was an overnight miracle that solved the problem. [pause] So, when you wake up tomorrow morning, what might be the small change that will make you say to yourself, “Wow, something must have happened—the problem is gone!”
BENEFITS OF USE OF MIRACLE QUESTION

• What clients are able to co-construct with the therapist in answer to the miracle question can usually be taken as the goals of therapy.
• With a detailed description of how they would like their lives to be, clients often can turn more easily to building enhanced meanings about exceptions and past solution behaviors that can be useful in realizing their preferred futures.
In therapy with couples or families or work groups, the miracle question can be asked to individuals or the group as a whole.

If asked to individual members, each one would give his or her response to the miracle question, and others might react to it.

If the question is asked to the family, work group, or couple as a whole, members may “work on” their miracle together.

The SFBT therapist, in trying to maintain a collaborative stance among family members, punctuates similar goals and supportive statements among family members.
USE OF SCALING QUESTIONS IN SFBT

SFBT therapists use “scaling” questions to help clients/patients assess their progress towards achieving goals.

A progress scale is usually constructed in the first session with “10” standing for how the patient imagines life will be when the problem miraculously disappears and “0” signifying how things were at the point the patient arranged for therapy to begin.

In each subsequent sessions, the patients are asked to use this scale to assess their progress.

- Additional individualized versions of this scale are then developed as needed throughout the therapy process to help the clients further assess changes and concretize progress in the specific areas of their lives they have targeted.

(de Shazer and Isebaert, 2003)
In SFBT inpatient treatment, clients are encouraged to keep a daily log form about their cravings and what they do instead of drinking or using drugs. This log contains the following information:

1. How strong was the urge to drink or use drugs? (0-10)
2. Where did this occur?
3. With whom?
4. How come?
5. How did you stop this urge?
6. How difficult was it to stop this urge? (0-10) (de Shazer and Isebaert, 2003)
ON DISCHARGE LOG KEEPING USING SCALING QUESTIONS

Once clients are sent home and on their own they are encouraged to keep a daily log to bring back into outpatient individual or group counseling and asked to respond to the following:

1. What day and hour did they drank some alcohol or use some drug?
2. What kind?
3. How much?
4. With whom?
5. How come?
6. Where?
7. How did they stop drinking or using drug at the point at which they stopped?
8. How difficult was it to stop drinking or using drug at that point? (0-10)  
   (de Shazer and Isebaert, 2003)
SETTING GOALS IN SFBT – GOALS MUST BE:

- Salient to the client rather than the therapist or treatment program.
- Small rather than large.
- Described in specific, concrete & behavioral terms.
- Described in situational & contextual rather than global & psychological terms.
- Stated in interactional & interpersonal rather than individual & intrapsychic terms.
- Described as the start of something rather than the end of something.
- Described as the presence of something rather than the absence of something.
- Realistic & immediately achievable within the context of the client’s life.
ARE YOU HAPPY?

YES

CHANGE SOMETHING.

NO

DO YOU WANT TO BE HAPPY?

YES

KEEP DOING WHATEVER YOU'RE DOING.

NO
Solution(s) to the problems that a client brings into treatment may have little or nothing to do with those problems. This is particularly true in the treatment of problem drinking, where any of a variety of life experiences or actions on the client’s part, which have little to do with his or her use of alcohol, may result in a resolution of the problem.

While the number of potential solutions is limitless, one example is a problem drinker who stops using problematically when he or she:

- Obtains employment
- Ends or begins a relationship
- Makes new friends
- Relocates

Treatment therefore need not make alcohol the primary focus to resolve the drinking problem. Rather, the focus returns to helping the client achieve the personal goals he or she sets.
CONCEPTION OF SUDS CAUSATIVE FACTORS

Problems with alcohol & other drugs are seen as multidimensional, resulting most likely from a combination of factors both environmental & biological. There is no one alcoholism but many different alcoholisms. The sheer diversity of causative factors & problems resulting from alcohol & other drugs suggests that:

• No one treatment methodology can help all people.
• A diverse package of treatment strategies is needed.
• Treatment strategies should be developed & matched to meet the needs of the individual clients.
CRITERIA FOR USE OF SFBT IN SUDS CASES

- Dual diagnosis issues such as a coexisting psychiatric disorder or developmental disability
- Range and severity of presenting problems
- Duration of abuse
- Availability of familial and community supports
- Level & type of influence from peers, family & community
- Previous treatment or attempts at recovery
- Level of client motivation (brief therapy may require more work on part of client but a less extensive time commitment)
- Clarity of client's short & long-term goals (brief therapy will require more clearly defined goals)
- Client's belief in value of brief therapy ("buy in")
CRITERIA DERIVED FROM CLINICAL EXPERIENCE FOR USE OF SFBT

- Less severe substance abuse, as measured by an instrument like Addiction Severity Index (ASI)
- Level of past trauma affecting client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment (e.g., 7-day average length of stay in county-jail-level correctional facilities; 30- to 45-day limitation in Job Corps program)
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment
Typical themes in solution-focused therapy include:

• The outcome that the client desires from the treatment process.
• Strengths & resources of the client that can be used to achieve the desired outcome.
• Discussion of previous successes of the client.
• Discussion of exception & instance periods.
• Discussion of changes in the client’s life from session to session.
• Exploration of what the client does to achieve those changes.
INITIAL SESSION GOALS IN SFBT

• Producing rapid engagement
• Identifying, focusing, and prioritizing problems
• Working with client to develop possible solutions to substance abuse problems and a treatment plan that requires client's active participation
• Negotiating route toward change with client (which may involve a contract between client and therapist)
• Eliciting client concerns about problems and solutions
• Understanding client expectations
• Explaining structural framework of brief therapy, including process & its limits (i.e., those items not within the scope of that treatment segment or agency's work)
• Making referrals for critical needs that have been identified but cannot be met within the treatment setting
SETTING GOALS IN TREATMENT

Treatment goals should focus on the central problem of substance abuse and may include the following:

• Making a measurable change in specific target behaviors associated with substance abuse
• Helping client demonstrate a new understanding and knowledge of problems and issues related to substance abuse
• Improving client's personal relationships
• Resolving other identified problems (e.g., work problems, support group attendance)
GOALS IN SUBSEQUENT SESSIONS (1)

- Work with client to help maintain motivation and address identified problems, monitoring whether any accomplishments are consistent with the treatment plan and the client's expectations
- Reinforce—through an ongoing review of the treatment plan and client's expectations—the need to do the work of brief therapy (e.g., maintain problem focus, stay on track)
- Remain prepared to rapidly identify and troubleshoot problems
- Maintain an emphasis on the skills, strengths, and resources currently available to client
GOALS IN SUBSEQUENT SESSIONS (2)

- Maintain a focus on what can be done immediately to address the client's problem
- Consider, as part of an ongoing assessment of progress, whether the client needs further therapy or other services and how these services might best be provided
- Review with the client any reasons for dropping out of treatment (e.g., medical problems, incarceration, the emergence of severe psychopathology, treatment noncompliance)
ENDING SFBT TREATMENT

• Leave client on good terms, with enhanced sense of hope for continued change & maintenance of changes already accomplished
• Leave door open for possible future sessions dealing with client’s other problems
• Elicit commitment from client to try to follow through on what has been learned or achieved
• Review what positive outcomes client can expect
• Review possible pitfalls client may encounter (e.g., social situations, old friends, relationship issues) and talk about the likelihood of a good outcome and indicators of a poor outcome
• Review the early indicators of relapse (e.g., depression, stress, anger)
SFBT IN CONJUNCTION WITH OTHER THERAPIES

SFBT can be used with other therapies. One of the original and primary tenets of SFBT – “If something is working, do more of it” – suggests that therapists should encourage their clients to continue with other therapies & approaches that are helpful. For example, clients are encouraged to

1. Continue to take prescribed medication
2. Stay in self-help groups if it is helping them to achieve their goals
3. Begin or continue family therapy.
Finally, it is a misconception that SFBT is philosophically opposed to traditional substance abuse treatments. Just the opposite is true. If clients are in traditional treatment or have been in the past & it has helped, they are encouraged to continue doing what is working. SFBT could be used in addition to or as a component of a comprehensive treatment program.