INTEGRATIVE BRIEF SOLUTION-FOCUSED FAMILY THERAPY: A PROVISIONAL ROADMAP

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Solution-focused therapy (de Shazer et al., 1986; de Shazer, 1991), as any other therapeutic model, runs the risk of being applied in a “one suit fits everyone” way, becoming excessively rigid and formulaic. This paper presents my current thoughts on possible ways to develop a more flexible solution-focused brief therapy. The aim of this paper is to spell out a number of guidelines for an integrative solution-focused practice and to illustrate them with detailed case-examples.

BACKGROUND

My colleagues and I1 work in a clinical center located in the Psychology Department of the Universidad Pontificia de Salamanca, Spain, where a two-year post-graduate program in solution-focused brief family therapy is run. In this center, treatment is free, with clients referred by former clients, medical doctors, psychiatrists, school counselors, and social workers. Clients present for a variety of reasons, including complaints of depression, anxiety, child and adolescent behavior problems, marital and family conflicts, eating disorders, addictions, and major psychiatric disorders. Around 40% of the clients consult for a problem presented by a child or adolescent. The average number of sessions is below five (X= 4.7), and around three-quarters of our cases are successful at follow-up (Beyebach, Rodríguez Sánchez, Arribas de Miguel, Herrero de Vega, Hernández & Rodríguez.

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1The Salamanca team has included different people over this period of time. Alberto Rodríguez Morejón and I worked together for the best of ten years, both in private practice and at the University, and Jose María Rodríguez de Castro joined us during two years also. Nowadays the team includes Margarita Herrero de Vega and me, along with the trainees of the program. Several invited family and brief therapist also participate in our program on a regular basis and have greatly influenced our thinking, among them Steve de Shazer, Michael Hjerth, Luc Isebaert, José Navarro Góngora, Yvonne Dolan, and Matthew Selekman.
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Morejón, 2000; Estrada & Beyebach, 2007). Our usual practice is to have around 45 minutes of conversation with our clients, take a 5-minute break to consult with the team or (if there is no team) to reflect on the session, and then go back and share our thoughts with the clients. This final message usually includes compliments (de Shazer et al., 1986) and homework tasks.

My team was introduced to solution-focused therapy in the late 1980s. After some years of solution-focused "purism," we found ourselves using a number of strategies and techniques that seemed not to fit in with the solution-focused model, and that moved us in the direction of a more eclectic practice (Beyebach & Rodríguez Morejón, 1999). We started to think about it and to research it, trying to move from haphazard eclecticism to systematic integration, as described also by a number of other authors (Dykes & Neville, 2000; Geyerhofer & Komori, 2004; Saggese & Foley, 2000; Selekman, 1993, 1997; Shils & Reiter, 2000).

Following the classical distinction by Norcross and Newman (1992), my team does not intend to integrate models or approaches of psychotherapy (theoretical integration), but simply to enhance the range and effect of our solution-focused practice by introducing some different techniques into our basic theoretical and clinical model (technical integration). More specifically, we include certain non-solution-focused techniques within a constructionist, solution-focused, family therapy framework (de Shazer, Dolan, Korman, Trepper, McCollum, & Berg, 2007). However, importing certain therapeutic procedures might jeopardize the epistemological integrity of the base model, inadvertently leading to the adoption of different premises or of a different therapeutic position vis-à-vis the client (Lazarus & Messer, 1991). Therefore, we prefer to use techniques that come from fields historically and conceptually linked to solution-focused therapy: family systems therapies (Minuchin, 1974; Tomm, 1987), strategic therapies (Fisch, Weakland, & Segal, 1982; Haley, 1976), and narrative approaches (White & Epston, 1989). We also keep the fundamental solution-focused premises and the basic solution-focused approach towards our clients: one based on respecting their world view and language, on believing in and eliciting their resources, and on actively creating conditions for a cooperative therapeutic relationship. On a more abstract level, the basic idea is to stay as simple and as much oriented towards solutions (as opposed to problems) as possible.

Our basic therapeutic scheme is to start any case with a deliberate effort at relationship-building, trying to work out a collaborative therapeutic project with the clients and to clarify their goals for the therapy or for the session. Here we are very likely to use the Miracle Question (de Shazer, 1991) or other future-oriented questions. Once this is done, the simplest choice is to keep on the solution-focused track, working on pre-treatment changes (improvements that take place prior to the first session), exceptions (occasions on which the problem is expected but does not happen, or happens to a lesser degree), and scaling questions (for instance asking clients to rate their improvements from zero—things at their worst—to
ten—goals reached) (de Shazer, 1994). In other words, the idea is more to construct solutions than to solve problems (de Shazer et al., 2007).

In contrast to the brief therapy tradition of working only with the most motivated clients, and influenced by the family therapy tradition (Carpenter & Treacher, 1989; Pinsof, 1995), we try to have as many members of the client system as possible participating in the sessions. For my team, this means having potentially more resources and solutions to tap into, and often translates into having the nuclear family present in the first interview.

Although, if possible, we stay on the solution-focused track during the whole therapy, we often use some other, non-solution-focused techniques. In this case we try to go back to the solution-focused strategy as soon as possible, for instance consolidating client gains by using “positive blaming” (Kowalski & Kral, 1989) when there are improvements. In the next three sections of this paper, I will try to spell out more clearly three different types of “maps” that help us to integrate non-solution focused techniques in our solution-focused practice.

**GETTING MORE COMPLEX WHEN SOLUTION-FOCUSED THERAPY IS NOT WORKING: SEQUENTIAL INTEGRATION**

When in a given therapy the solution-focused strategy seems not to be working, the first thing my team does is to re-examine our client’s and our own goals, asking ourselves what the clients want. Sometimes this re-examination leads us to reposition ourselves within the solution-focused approach; maybe we had been leaving someone or something out, maybe we need to renegotiate goals, or we are simply working in the wrong direction. However, if we are confident enough that we do have a shared therapeutic project and that the goals are achievable, small, and specific, and even so we are making no progress, we believe it is time to introduce some different techniques.

There are a number of therapeutic procedures we usually consider introducing, usually moving from the more simple, straightforward interventions to increasingly complex ones:

- Externalization of the problem (White & Epston, 1989).
- Interventions designed to interrupt the problem-maintaining attempted solutions, usually involving a quite radical shift in the basic interactional pattern (Fisch et al., 1982; Shoham & Rohrbaugh, 1997).
- Use of a reflecting team format (Andersen, 1987).
- Psychoeducational interventions (for instance, Kuipers, Leff, & Lam, 2002), directed at providing a cognitive framework in order to reframe and change the interactions around the problem.
- Structural interventions (Minuchin, 1974; Minuchin & Fishman, 1981), aimed at re-organizing the family system.
What kind of technique we import in any given case depends of course on the particulars of that case, the position of our clients, and our own creativity as therapists. However, there are certain guidelines that inform our decision-making process:

- We try to stick to the idea of staying as simple as possible. Therefore, if a small change in part of the problem pattern could be enough, we will not try to reverse the whole attempted solutions system. Or, if we can produce enough change by interrupting the main client attempted solution, we will not go for a broader re-organization of the family system.
- We tend to go from the simpler to the more complex progressively. Only if one type of intervention proves not to be working, we will move on to the next, more complex one. In fact, the techniques listed above are ordered in terms of increasing complexity.
- We use interventions that allow us to maintain a coherent position in therapy. For us, it would not make sense to, for instance, start by doing solution-focused therapy (a constructivist, non-normative model, where the therapist tries to adopt a non-expert position), move on to structural family therapy interventions (that come from a realist, normative model, with the therapist in the role of an expert), then use a reflecting team format (again constructivist and non-normative, diluting expertness in a multiplicity of voices), and then take on some psychoeducational ideas (again normative).

Of course, one delicate decision is whether change is or is not happening, and if it is or is not going “fast enough.” We often face this dilemma: should we keep on the solution-focused track, or is it time to start doing something different? Factors like the seriousness of the situation (suicide or violence risk, risk of medicalization) or the chronicity of the case tend to make the decision more difficult. However, we have found out that the easiest way to evaluate if the pace of change is adequate is to simply ask our clients. If they do not see changes, or if they perceive that things are moving too slow, the time is ripe to make a change. In our experience, the best way to get our clients’ view on progress is to ask them the solution-focused progress scaling question. As a rule of thumb, if things do not improve on the scale over the first three sessions, we shift gears. This decision is supported by our own research (Herrero de Vega, 2007), and is coherent with some researchers’ recommendations for therapy in general (Lebow, 2006; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001). The following case is an example of our decision-making processes in sequential integration.

Rocío, age 16, and Damián, age 12, came in with their parents, Rosa and Pepe. Rocío had been two years in treatment for what had been diagnosed as anorexia nervosa, but things had not improved, and she was still eating little and vomiting at least twice a day. Rocío was medically controlled, but had dropped out of the three psychological treatments she had started. In despair, her mother had decided to seek some different professional help.
In the first session, I spent some time clarifying what exactly the family wanted from my team, and what they wished us to do differently from the other professionals they had been involved with. Rocío stated that she wanted to find her way “out of anorexia,” but that she thought it would be very difficult, “almost impossible.” She also explained that neither individual nor group therapy had worked for her, and that maybe having some conjoint family sessions would help her more. Of the psychologists that she had met before, the only one she saw as having been helpful was one who had been “hard” on her, and had not limited herself to listening and agreeing. The mother and the father added that they wanted help for the whole family, as the past two years had strained them so much. Damián simply stated that he wanted us to prevent his sister from dying.

As the family did not see any pre-treatment changes, I asked the Miracle Question, and the conversation kept on that track for more than half an hour. The family was very good in giving a detailed account of all that they wanted to be different, including both changes in Rocío’s behavior and in the behavior of the whole family. After the break, I presented the compliments of the team and asked the family members to secretly pretend that the miracle had happened (de Shazer, 1991) two days per week, and try to guess what days the others were pretending.

In the second session, some parts of the miracle had happened indeed: the family members felt more relaxed, there had been less fights around food and vomiting, and there had been more conversations between them and more “good moments” instead. I amplified the changes and tried to understand how they had achieved them. Pepe had made an effort to avoid useless arguments with his daughter about food, and the mother had been able to “forget about the problem” for some moments. Rocío stated that she had been thinking about the eating issue, and that she really wanted to be “normal” again. There were no changes as far as food or vomiting were concerned, but Rocío expressed her willingness to do something about it. After the break, I complimented everybody about their changes on behalf of the team, and encouraged them to keep on doing what was useful. I also expressed our curiosity about the new changes they might report in our next session.

However, in the third session there was nothing new. As Rocío had kept on vomiting twice a day, the changes in the family interaction had back-slid. The general mood was worse, and Damián had even refused to come to the session. After talking with the family conjointly, the team decided to change gears: I would see Rocío separately and try externalization of the problem. In the conversation with her, Rocío expressed her wish to defeat “anorexia,” but also her doubts about whether that was or not possible. We discussed how the “voice of anorexia” used to demoralize her, and after the break asked her to pay attention to any occasion when she was able to disregard the voice or to counter its arguments. We encouraged the parents not to give up and to watch for any positive changes in Rocío’s eating behavior.

In the fourth session, things had improved again. Rocío had found herself bleeding from the throat one day; as the medical consequences of the vomiting had become much more evident for her, she had been able to stop it for some days. The parents were very happy with these developments, but also afraid that Rocío would go “back to anorexia” as soon as her fear had disappeared. After discussing in detail how Rocío had been able not to vomit for three days in a row, we identified several helpful things: Rocío and her mother would go for a slow walk after lunch, Rocío would play with her brother instead of brooding about her weight, and the father would encourage her to go on and keep talking in a “soft voice.” Rocío was finding more convincing arguments to defeat anorexia, and also
improving the relationship with her friends. After that, we discussed some ways to keep the changes going. As a final message, the team complimented everybody on the progress they were making, asked them to continue with their changes, and to pay attention to how they overcame the “bad moments” that might lie ahead.

Over the next two sessions, I kept on having conjoint conversations with the whole family, but taking some time alone with Rocío to discuss ways of fighting back against anorexia. Rocío and her family were able to keep the changes going, although she was not able to have more than three “vomit-free” days in a row.

In the seventh session it became clear that, although Rocío was engaging more and more in social activities, felt happier and more relaxed, and was even eating “normally,” the vomiting pattern persisted: after one or two days without vomiting, Rocío’s fear of getting fat would get too strong and she would “have to” vomit again some days. Her parents and Damián were reacting and contributing positively to Rocío’s changes, but worried about the risks that vomiting posed. The team had a long discussion, and we finally decided that we had to change gears again, as the cognitive work with Rocío and the more positive interactions in the family were not translating into changes in the eating-vomiting pattern. Therefore, we decided to work more from a structural perspective. We would put the parents in charge of their daughter until Rocío was ready to change (Minuchin, 1974; Haley, 1976; Eisler, Dare, Hodes, Russell, Dodge, & le Grange, 2000).

I discussed the situation with the family and it was agreed that Rocío needed more “intensive” help in order to prevent the vomiting: the mother would stay with her daughter at least two hours after lunch and after dinner to make sure that she resisted the urge to vomit. Pepe would extend the surveillance to the way to school, and Damián received the paradoxical task to keep on misbehaving as a way to distract his parents. Rocío, after some hesitation, accepted the deal. We also discussed possible difficulties that might arise and the strategies anorexia might use to prevent the family from working as a team.

The following weeks were quite rocky. After the initial acceptance of her mother’s surveillance, Rocío started to react against it. Suddenly, she became aware of how bad she felt when she could not vomit. We worked with her to help her identify again the tricks and traps of anorexia, and with her parents to keep their strong grip on anorexia, while being kind to Rocío. Then, about one month after the start of the “plan,” things began to go more smoothly again.

We decided to continue using this strategy for a while. In our subsequent sessions together, I worked with the parents alone on how they could keep their strength and not drain their resources, following the ideas about working with overburdened families of chronically ill people (Rolland, 1994). This involved a discussion on how Pepe could look more after his wife, and bring in some members of the extended family to provide respite periods for her. With Rocío, I began to discuss how she would know that the time was ripe for her family’s surveillance to loosen up, and also what her future would look like once she finally let go of the vomiting.

After some sessions, Rocío had almost completely stopped vomiting. Now the task was to go back to a situation were she could be in control of her eating and of her not vomiting. This involved gradually “leaving her alone” for some lunches, then for lunch and dinner one day, then two days, and so forth. In our fourteenth session, more than one year after the beginning of therapy with us, things had finally changed enough to be
rated at an eight on the scale by both Rocío, the mother, and the father. By Damían, they were even rated at a 9.5. We reviewed with the family the video of their first session, and it became evident that most of their goals had been reached and that now they were a “different family.”

We kept on scheduling some follow-up sessions, six and twelve months later, to make sure that the family could successfully manage possible relapses. Things continued to improve steadily. Rocío stayed at a healthy weight, vomit-free, and was no longer concerned with her weight or with food. She thought that the bad time that she had had with anorexia would help her be a good child psychologist, and was planning to study psychology. I asked her to become our consultant, and to write a letter explaining how she had defeated anorexia, and we secured her permission to use it with other girls who were experiencing similar difficulties. In an informal follow-up five years later, I found out that Rocío had indeed enrolled in psychology studies and was about to finish them successfully. There had been no further vomiting episodes, and further therapy had not been needed.

This case illustrates how difficult it may become to adjust the pace in the integration of different therapeutic procedures. My team and I constantly faced the dilemma of becoming too intrusive versus staying too passive in face of the vomiting problem. After starting on a purely solution-focused basis, relying on the cooperation with Rocío, we finally took sides with Rocío’s parents and adopted a strategy borrowed from structural family therapy, where Rocío had less of a say. One might wonder if it would have been more efficient to use a structural strategy from the very beginning. But then, it could also be speculated that beginning with a solution-focused approach created an adequate context of cooperation where the more intrusive approach was later more easily accepted, preventing another dropout. The truth is, we can not know.

The case also provides an example of working out a balance between interventions aimed at the interpersonal, family level and interventions on a more intrapersonal, cognitive level with Rocío. As will be discussed below, working with an eating disorder case creates some further complications, as the medical risks have to be taken into account.

INTEGRATION AS A WAY OF IMPROVING FIT WITH OUR CLIENTS

In my team’s practice, the introduction of non-solution-focused techniques does not mean that things are necessarily going badly or too slowly. There are times when already in the first session we use therapeutic procedures that are not solution-focused, because we think that in this way we adjust better to our clients’ views. Although this possibility can present itself in all kinds of cases and situations, there are three types of situations where my colleagues and I are more likely to depart from the solution-focused road:
Clients Who Demand “Expert Advice”

Sometimes our clients do not want us to help them figure out what might work best, but want to be told explicitly. Of course, this is a rather common situation, probably linked to the medical model so pervasive in our culture. In most cases we are able to renegotiate the therapeutic contract and are eventually successful in avoiding the “advice giving role,” but in other cases the only way we find to cooperate with our clients is precisely to accept the role they want us to play. In that instance, we are more likely to use non-solution-focused techniques, like for instance providing psychoeducation or teaching behavior modification techniques. The solution-focused twist is that we offer these suggestions trying to link them in as much as possible with our clients’ values and past successes, so that they are not perceived as something completely different, but more as something that builds on their strengths.

Jesús, 15, and his mother came to see us because the boy, who had a learning disability, was doing badly at school, which created a lot of tension between him and his parents. Both Jesús and his mother wanted some help to change this situation. The mother asked for some advice on how to handle her child, and Jesús wanted some “study techniques” so that he could concentrate better and be more efficient in preparing for his exams. The Miracle Question helped to clarify what Jesús felt his mother could do to help him: instead of being on his back all the time, she would keep at a distance and offer help only on his request; she would also stop going to talk to the teachers almost every month, which Jesús felt embarrassed about. As for the “study techniques,” the negotiation of goals and the discussion of exceptions did not help to work out a good “recipe”; indeed, it became evident that both the mother and the son wanted us to teach Jesús the “right way” to concentrate and prepare for his exams efficiently. So we made a separate appointment and one member of the team, who happened to be an education counselor, provided some advice and suggested some exercises. In our therapy sessions, I would ask Jesús what difference the new techniques were making, what effect this had on the rest of his days, what his mother was noticing different, and so on.

A related reason for assuming a more directive role as an expert is that sometimes our clients are very confused and what they want is some “outside” clarity. Again, a possible approach would be to help them achieve some clarity about their goals, about what to do, and so on, but if the situation is really chaotic we feel it pays off to provide some clarity ourselves, as the following case illustrates:

Roberto and Lara, ages 43 and 39, came to us asking for advice on how to communicate to their six and 10-year-old children their decision to get a divorce. I explored their thoughts about this by asking the following solution-focused questions: “What is your hope of the best possible outcome of this conversation with your children?”; “How would you like the conversation to be?”; and “How did you succeed in the past when you had to tell them something difficult?” The couple had great difficulty answering my questions. They had too many doubts and fears and wanted to have a clear guideline about how to behave. Therefore, I took a break and consulted with the team. We decided to explain to the couple...
some ideas as to how to communicate to children about this type of parental decision. I gave them each a handout summarizing these ideas and discussed with them how to implement them. They came back reporting that it all had gone well and that their children had accepted the break-up of the family with surprising ease. We had some more sessions with the family in order to help them adjust to their new situation.

**Clients Who Wish to Explain their Problem History in Detail**

A common experience of most solution-focused therapists is that some clients seem to be much more interested in explaining the history of their problem than in exploring goals or exceptions. This is why the successful co-construction of a solution-focused conversation requires a certain level of technical skill, self-discipline, and persistence (de Shazer et al., 2007). Sometimes this includes opening some space so that the client can tell the problem story and feels listened to. There are occasions, however, when our clients seem to feel that this is not enough, and very clearly demand to tell us in detail and in length their problem (hi)story. This is common in cases where clients have been subject to violence or abuse. On other occasions, it is simply that clients have a very clear agenda that includes telling their problem story in detail. This is why in these cases we prefer to honor these stories and listen respectfully to them, giving support and showing empathy and respect.

Pedro was in a way a special client. He was in the last year of his psychology studies, and had a clear idea of what “good therapy” involved: a detailed account of the history of the problem and specific information about its causes so as to evaluate correctly and develop the “right” therapeutic interventions. So when I asked him in our first meeting how we could help him best, he told me that he wanted to overcome his panic attacks, and that for this purpose he had brought a detailed list of the most important dates in the evolution of this problem. He wanted us to listen to his account and then we could go on to look for specific solutions. I decided to follow his advice and I spend the whole first session listening to the history of the problem, to Pedro’s struggles and sufferings with the panic attacks. In the final message, the team and I complimented him on the accuracy of his perceptions and his great ability for insight and self-observation, and gave him the Formula First Session Task (de Shazer, 1988). In the second session, I felt that it was okay to go back to using solution talk with him. I began the interview by asking him: “What’s better?” and pursuing this line of questioning the remainder of the session. I especially highlighted the improvements that involved exposure to anxiety-arising situations. The rest of the sessions were straightforward and solution-focused, and it was easy to involve Pedro as a co-therapist who would use his knowledge of psychology to “heal himself.” In the sixth session we decided to end therapy, as Pedro felt that he had enough control over his anxiety and was not having any panic attacks. We had two more follow-ups on his request.

The solution-focused twist in listening to the problem history is that we still look out for the resources in our clients’ story and, if possible, highlight them by sum-
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Marizing or asking about them. Coping questions like “How were you able to survive that?” or “How did you know that was the less dangerous thing to do?” are a useful way to entertain an alternative storyline within the client’s discourse. Another good therapeutic option to talk about problems in a useful way is to externalize the problem (White & Epston, 1989). In this way, we meet the demand of the family to discuss the problem but at the same time create new options and pave the way for exploring exceptions. This can be especially useful in working with child-presented problems, as it enables both the parents and child to participate in the conversation (Dykes & Neville, 2000). In any case, the information gathered in the process of listening to the problem story may provide ideas for problem pattern interventions and reframes.

Clients Who Seek Understanding of their Problem(s)

It also happens that clients explicitly demand from therapy some understanding of their problem situation. Here again, our first reaction is to test if we can keep the solution-focused track, by asking questions like: “Okay, you would like to understand the roots of your problems. Would it be okay with you if we first help you to solve them, and then go back and try to understand them?”; “Imagine that you fully understood the causes of these problems that have been plaguing you. What difference would that make for you?” However, there are times when clients really want to understand more than to solve or overcome something. In these cases, cooperation will be easier if we adjust to our clients’ views. One useful thing to do is to work more in a narrative way, talking about values, personal qualities, and meanings in general. One can also explore in detail the explanations that the clients have given themselves by asking “why” questions (Furman & Ahola, 1992). Another option is to gather some historical information first and to offer one or several possible explanations for the problem situation; depending on the position of the client, we may either give an “expert verdict” or use the reflecting team format (Andersen, 1987). Sometimes we simply refer the case to a psychodynamically oriented colleague.

NON-SOLUTION-FOCUSED “SHORTCUTS”

So far, we have discussed situations where our departures from the solution-focused model occur in response to the feedback from clients, related to how therapy is progressing or to what would enhance cooperation. There are also, however, some situations where our decision to use non-solution-focused practices is taken in relation to the situation or the problem we are presented with. On that basis, we are likely to consider certain lines of action more than others. In other words, in these cases we use some “preferred shortcuts.”
“Shortcuts” in Certain Clinical Situations

There are certain clinical presentations that incline us to start working outside the solution-focused track:

- It is not infrequent to start therapy without an important part of the client system: maybe the wife comes in complaining about her husband, who refuses to attend; or the parents, worried about the drug taking of their teenage kid, are unable to get him to the session. In these cases, it is useful to follow solution-focused ideas about how to work in “complainant-type therapeutic relationships” (de Shazer, 1988), focusing on goals and exceptions and giving observation tasks. But we are also more likely than in other cases to make an effort to get our clients into doing something different with the person they are complaining about, usually suggesting some problem-pattern interruption tasks (O’Hanlon & Weiner-Davis, 1989). In other words, when we are doing “family therapy with individuals” (Weakland, 1983), we find it more useful to use problem-focused, M.R.I. style interventions, and to use them earlier.

- In other cases, the situation is the opposite, as the person described by others as the problem is in the session with us, but does not really perceive having a problem—a “visitor type relationship” (de Shazer, 1988). Maybe the adolescent has been forced to come in by his parents, or s/he is under the threat of suspension from school, or the family has been put under pressure by their social worker; or someone has been court-ordered to undergo therapy. In these cases, we look for other goals the client might indeed want to go for—maybe s/he acts as a visitor in relation to one goal, but is interested in another one. Besides this solution-focused strategy, it can also be useful to resort to other approaches in order to move the therapeutic system so that the client sees a problem (complainant-type relationship) or even asks help to do something about it (customer-type relationship). Motivational interviewing procedures (Miller & Rollnick, 1991) are a good option to this purpose: discussing the problem and its effects with the client, and working more on what these authors call client “ambivalence.” This often translates into explicitly discussing with the clients the pros and cons of change from a very neutral position, avoiding to be perceived as pushing towards change. In this process, we may use the Miracle Question together with the “nightmare question” (Berg & Reuss, 1998) in order to draw distinctions; invite clients to work on “decisional balances” (Miller & Rollnick, 1991); or project them into different futures at different points in time. Often, this leads very naturally into the “go slow” or the “dangers of improvement” stance so typical of M.R.I. therapists (Fisch et al., 1982). In some rare cases, we might even use a full-blown prescription not to change. In any case, we find the “one step at a time” stance of solution-focused therapy is a useful starting point.
Over the last years, an increasing number of our clients have come to consult with us after having had a number of previous treatments. In these situations, we think it is important to take some time in the first session to discuss these experiences (Selekman, 1993), and to explore both what helped and what did not. We see this not only as a story of which treatments were more or less successful, but also as a way to understand our clients’ very personal decision-making process in choosing, continuing, and discontinuing different therapies. This allows us to find better ways to cooperate with our clients, and also gives us some indications as to what pathways to pursue and which ones to avoid. Sometimes this means taking a non-solution-focused approach as a way to maximize differences with previous (solution-focused) treatments; or to choose a conjoint format as a way to make a difference with a previous individual therapy, etc. If clients not only had treatment before, but are currently in treatment, we make a special effort to clarify what precisely they want from us, and to make clear what our role is in the situation. Also, we are likely to invite our clients to think about how their lives will be once they get rid of all the professionals (including us) they are currently involved with. Once improvements occur, we promote that credit is shared with all the helpers involved (Furman & Ahola, 1992).

Sometimes the situation is very volatile or even dangerous: that is, there is a serious risk for suicide or violence; there are clear signs of an impending psychotic crisis; time is running out fast before a legal or academic decision is taken; or the family is facing any other type of acute crisis. Once more, we firmly believe that in these crisis situations the therapist can successfully keep a solution-focused stance, and that maybe especially in times of acute crisis it is useful to avoid automatically falling into the position of “taking charge.” However, sometimes more traditional alternatives are necessary, like, for example, providing the social network of the suicidal person with clear guidelines for surveillance and support, designing an escape plan for the person at risk of violence, or actively persuading the client to consult a psychiatrist.

Research shows that, for certain problems, the likelihood of relapse is especially high (Roth & Fonagy, 2005). For this reason, we routinely put relapse prevention on the agenda from the start of therapy in cases of eating disorders, depression, and addictions. To convey our trust in our clients’ resources, we discuss with them how they will address the problem if they relapse. In the course of these conversations, we use exceptions to promote “alternative habits,” and behavioral and interpersonal contexts in which the problem behavior is less likely (Isebaert, 2005). Problems with a strong biological component call for a close coordination with medical doctors. In these cases, we also tend to slow down the pace of our interventions.
"Shortcuts" for Types of Problems

This is probably the issue where our practice is more at odds with traditional solution-focused thinking. After all, from the solution-focused perspective, problems and solutions are not logically connected (de Shazer, 1991). From this point of view, there is no reason why any specific type of clinical problem should call for any specific type of intervention. In our opinion, this is a useful assumption that reminds us that the person is always more than the problem and helps us to keep on listening carefully to our clients and not just to our pre-conceived theories about them (Duncan & Miller, 2000). However, it should not lead us to ignore the knowledge that decades of psychotherapy research have brought forth (Bergin & Garfield, 1994; Lambert, 2004; Norcross, Beutler, & Levant, 2006; Roth & Fonagy, 2005). It is in the best interest of therapy clients that their therapists are aware of and use this knowledge. And therapists have the ethical duty to keep up with the developments in psychological treatment.

There are a number of more or less well-defined problems that, in our view, merit that we add different concepts and techniques to our usual solution-focused approach (Isebaert, 2005). In all of these cases, there are some theoretical and practical challenges that invite any therapist to get specific training and enlarge his/her frame of reference. Although the list of presenting problems is potentially very long, and a detailed discussion would exceed the scope of this paper, we would like to give some examples:

**Chronic Illness and/or Disability**

Quite often, families present with a chronic physical condition, either as the main concern of the family (for instance, an adolescent depressed after amputation of a leg following a car accident), or as an element that complicates a situation for which help is requested. Medical Family Therapy provides clear guidelines on the impact that physical illness, especially chronic illness, has on the family (Rolland, 1994). Therefore, even if the chronic illness is not the main complaint of the family, we like to take this conceptual framework into account. It helps us to redefine and normalize the experiences of the family, to be watchful of the possible difficulties of the primary caretaker (who is at risk of becoming overburdened and of developing psychological problems), and to actively promote social support for him/her and the family. It also requires that we sometimes mediate between the family and the medical system, and that we have a broader look on how the situation may evolve as family and illness move along their evolutionary cycle. Ex-

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2We are adopting the position of a “general practice therapist,” ready to do therapy with a variety of problems and client populations. It could be argued that, in challenging cases (like, for instance, most cases of schizophrenia and many of anorexia), a practitioner should refer immediately to a specialized unit. However, this is sometimes not necessary and not always possible: specialized units or teams may not be available, financial restrictions prevent their use, or clients dislike them.
ternalizing conversations (White & Epston, 1989) might be useful in this context, especially discussions on how to “put illness in its place” (Rolland, 1994). These ideas are also potentially useful for any chronic mental health problem.

Eating Disorders

As shown in the Rocío case, with eating disorders the solution-focused framework has to be enlarged to take into account the biological aspects of these problems (Jacob, 2000). For instance, the solution-focused premise that “small changes are enough” and will lead to other changes is not very useful in situations where the biology of the client may put heavy constraints on his/her response to changes, or even to his/her ability to change in the first place. Due to the medical risks involved, if the client is not being followed-up medically, the therapist has the duty to refer him/her to a medical doctor so as to check his/her physical health and take appropriate measures. On the therapeutic side, we like to provide the client with as many options and choices as possible (and here again solution-focused techniques provide excellent leverage), but we also take the weight problem into account, even though our client may not have any concerns about it at all. This does not mean that we have to spend all of our sessions discussing food, vomiting, or exercising, but it does mean that changes in other areas (friends, family, college . . .) are welcomed but are only “good enough” if they also translate into weight gain. We also find that the ideas of the “motivational interview” (Miller & Rollnick, 1991) are useful in helping eating-disordered clients make the decision to change, and we often externalize “the voice of bulimia” or “the voice of anorexia” so as to create some space between the client and her eating disordered identity. “Becoming independent from anorexia” or “challenging the tyranny of slenderness” can be powerful themes for more cognitive interventions. If the eating-disordered client is not able to change on her own, we rely more on her parents and put them in control of their child’s eating behavior, following the approach of Ivan Eisler and his colleagues at the Maudsley Hospital (Eisler et al., 2000). Many of these ideas are also useful working with addictions, a field were the solution-focused approach (Berg & Reuss, 1998; de Shazer & Isebaert, 2003) opens a whole new range of possibilities for a more collaborative client and family work.

Psychosis

Psychosis, specifically schizophrenia, is one of the problem areas where research better supports the effectiveness of family therapy. Over the last three decades, a

\[3\text{Biological factors are probably even more important than traditionally assumed by family therapists, as shown by recent research on the interaction between food intake, exercise, and temperature (Gutiérrez & Vazquez, 2001).}\]
great number of teams have been documenting the effectiveness of psycho-educational family therapy for schizophrenia (Falloon, Boyd & McGill, 1984; Kuipers et al., 2002). Although psycho-educational programs are complex, multi-dimensional, and multidisciplinary, there are a number of elements that a solution-focused practitioner may wish to take into account if there are no specialized teams to which to refer the case. One important aspect is the role of maintenance neuroleptic medication in reducing the risk of relapse. In co-operation with the psychiatrist, we promote informed decision-making around the issue, and actively support the taking of the medication by the person with schizophrenia. The other element that research on schizophrenia (but also on other conditions like depression, anorexia, or drug addiction) has shown to be of importance is “Expressed Emotion” (Leff & Vaughn, 1985), a strong predictor of relapse. Therefore, we routinely encourage the reduction of hostile and critical remarks by the relatives. Sometimes we do this providing some psychoeducation to the family members (Kuipers et al., 2002). In other cases, we use structural family therapy techniques (Minuchin & Fishman, 1981) in order to re-inforce interpersonal borders and reduce emotional overinvolvement, one key element of Expressed Emotion. The metaphor of “putting the illness in its place” is also very useful in these cases, both for the patient and for his/her family, who are usually carrying a heavy burden and are in need of respite moments and social support.

**Phobias**

Phobias are probably the best-researched disorders in psychotherapy, and exposure to the phobic stimuli (with and without cognitive restructuring) is the best supported type of intervention (Roth & Fonagy, 2005). This does not mean that we necessarily apply a behavioral exposure program, but that we are ready to highlight and promote any instances where the client, instead of avoiding the phobic situation, exposes himself to it. In other words, the information on exposure procedures helps us to decide what exceptions are more relevant: maybe the phobic teenager felt quite good the day she decided to stay at home instead of going to the mall, but that other occasion when she did go to the mall and was able to cope with her anxiety will be much more useful as an exception. We have found scaling questions and percentage questions (White & Epston, 1989) especially useful in finding out how much control over their lives the clients have and how much they want to regain. It is also usually useful to discuss their readiness to face the phobic situation, their confidence in coping with anxiety, and so on.

As these examples have hopefully made clear, I do not consider the interventions we borrow from other approaches as closed protocols that have to take the center stage in the therapeutic encounter. For us, the foreground is always the interaction of the therapist (Sexton, 2007) with his/her clients and their unique wishes and needs. In that respect, both the techniques we import and the overall therapeutic model get
into the background as a potentially useful tool that might or might not make sense for any given family. As Arthur C. Bohart states, “therapies (...) are not really treatments that operate on clients to change them but rather tools used by clients in their self-healing and problem-solving efforts. Techniques do not operate on clients so much as clients operate on techniques” (Bohart, 2006, p. 223).

REFERENCES


Integrative Brief Solution-Focused Family Therapy


