The Disease Concept and SFT: Difference in Action

(Problem focused and solution building)

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Type of Audience

Students, workshop participants at any level, supervisees

Clients in individual, group, family or couple treatment

Group Size

Minimum 5 participants.

Experience level

Introductory to advanced; no experience with solution-focused ideas or applications is necessary.

Some experience with substance abuse treatment and the disease concept preferred.

Purpose of the Exercise

As a warm up

To begin right away recognizing the difference between problem focused and solution-focused methods in practice

To recognize SFT methods in a group learning environment

To obtain a range of group interactions and input

To introduce solution building based on clients responses

To practice solution building in a variety of age groups

To practice developing a picture of a more positive future

To enhance "getting out of the box" (this exercise is literally a "warm-up"), gets people moving, thinking, talking, often laughing and connecting as well. The learning process increases when thinking is challenged, and flows more easily. Participants are more engaged when they move their bodies and interact with each other.

As learning tool, to evaluate progress, and change in clients' responses

To involve all training participants

To demonstrate how solution-focused methods can be adapted and immediately applied to a variety of practice settings.

Experiential Level of the Exercise (1-10)

(Instructions aside) this exercise is a 10.

Time Frame for the Exercise, Debriefing

It depends on the size, knowledge, attitudes and beliefs about the disease concept of addiction, experience level of the group (students, experienced clinicians), what they've head about SFT, the number of questions asked, how much furniture has to be moved first.

As an introductory exercise, it can be completed in as little as 15 minutes; 20-30 minutes is more typical.

Instructions

Ask participants break into groups (or you number people off---once you determine the size of each group based on the total number of participants. Once the groups are established have someone volunteer to be "the client". When this person is identified, have the client leave the room. The remaining members of the group are "the therapist". When the client leaves the room, tell the remaining participants when the client comes back in, they are the therapists. As such, they will take turn asking questions, or make statements based on the disease model of addiction. Such questions may include "how many meetings have you gone to", "you need to go to ninety meetings in ninety days", "you are in denial of your disease", "are you ready to make a commitment to abstinence", etc. and to act like they know all the answers, not the client.

You (the trainer) go out and greet the clients and give them a case to role play with the group of therapists they are returning to. Then bring the client back into the room and send them back to the group, and the interaction begins. Once this has gone on for about 5 minutes (you can usually feel the tension in the room), ask the clients to share with the larger group how they feel about the therapists they are talking to. This brings up lively discussion and the reactions from the client include: "Why bother?" "I'm not it denial" even to the point where some say "I'm leaving".

After the discussion, the therapists are then asked how they feel about the interaction (this is usually quite difficult for them) but then a discussion takes place on how a therapist with this mindset, based on the *clients responses*, would document what took place. The language used to describe this type of interaction often includes: the client is "in denial", "resistant", "unable to

accept the disease concept", "hasn't reached bottom yet", "is defiant", etc. More discussion then takes place about how this can often reflect the attitudes of the therapist, not accurate description of the mindset of the client. A discussion then ensues on how this problem focused approach labels the client for failing to agree or accept the lead of the therapist. Discussion then can take place of the culture of the treatment center: the therapist, treatment center, etc. is the authority. The client will not succeed or may fail (not surrender to the disease) unless they do what the authority states (complete abstinence, 90 meetings in 90 days, etc).

At this point the trainees may need to let out a long relaxing exhale (to let the tension out) as a lively discussion about many things has just taken place. Then you ask the clients to stand up and go out of the room for the second half of the exercise. You (the trainer) then go back into the room and tell the therapists this time to give the client their undivided attention. Then one by one each therapist takes a turn asking SFT questions, based on the *client's responses*. The first question they will ask is: *What do you want?* ---and stay there.

This part of the exercise can be challenging, especially for the seasoned therapist who already has in their head what the next question will be---*before the client answers the question.* Pacing is discussed and how a theme they might use to integrate SFT might be: before you make up you mind, open it----getting out of the box and into many possible solutions the client has depending on what they want.

You the trainer in both phases of the experiential exercise can walk around and assist the therapists and clients by offering questions and answers they might offer. This will help

generate the activity in the role plays. Again discussions then takes place on how the client feels with this interaction, and how it would be written up using SFT language:

> Client wants the wife/husband/family to stop focusing on the drinking/substance abuse.
>
> Client is considering attending AA meetings to learn more about how his or her drinking is affecting their life.
>
> Client is willing to cut down on their drinking this week (state how much).
>
> Client states he/she will try different ways to respond to the family when they focus on his/or her drinking such as _______________.
>
> The very first small step the client is willing to try in cutting down the drinking is _________.

Once the exercise is over thank everyone and have them return to their seats. During the rest of the time allotted for this exercise, time is spent exploring what was helpful and useful. Some time is also spent on how this exercise might make a difference with the next substance abuse client they have in terms of the language they will use, and how they may document the interaction.

Handouts

None specific to the exercise; a handout would include samples of SFT questions and the Miracle Method Ready Reference: Principles of the Solution-Focused Approach (Miller & Berg, 1995).

Closing Comments

Used early in the training process, this exercise sets a tone learning to challenge their knowledge, attitudes, and beliefs about substances abusers, and treatment philosophy---instantly. The exercise elicits the skeptic, the judge, is active, and is participatory—it opens their mind and views about addiction treatment in an open supportive forum. This exercise promotes group interaction and encourages exchange of concepts and ideas.

For the as trainer, this experience of hearing and seeing how mind set of the therapist is challenged and put into action is exciting. It opens the door to influencing change in the practice of addiction treatment---offering many solutions and possibilities for the client.