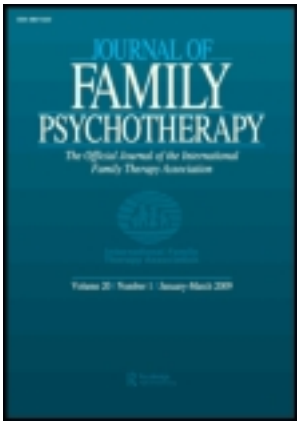

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The Bruges Model

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The Bruges Model: A Solution-Focused Approach to Problem Drinking

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ABSTRACT. This article offers a program description of a new approach to the treatment of problematic drinking developed at St. John's Hospital, Bruges, Belgium. The program is based on Solution-Focused Brief Therapy, and is offered in both an inpatient and outpatient setting. Four-year follow-up telephone interviews were conducted for 118 inpatients and 72 outpatients who had completed the program; 84% of the inpatients and 81% of the outpatients reported maintaining their goals of either abstinence or controlled-drinking four years after completion of the program. The benefits of using a Solution-Focused Brief Therapy model for the treatment of problem drinking are discussed.

KEYWORDS. Alcoholism, alcoholics, alcohol treatment, Solution-Focused Therapy, Solution-Focused Brief Therapy, group therapy, inpatient, outpatient

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Alcohol abuse treatment programs have been traditionally plagued with high recidivism and low success rates. For example, a now classic study of alcoholism treatment (Polick, Armor & Braiker, 1980) found that only 7% of the participants were abstinent four years following the standard traditional treatment in which abstinence was the only goal.[1] In other words, treatment failed in 93% of the cases. Buried among the "failures" cited in the Polick, Armor and Baiker study, however, were some interesting exceptions: 22% had become "non-problem" drinkers in contrast to the 54% who were considered to have continued to be "problem" drinkers. Furthermore, 10% of the problem drinkers were drinking without negative social consequences. In contrast to the 44% of problem drinkers who had symptoms of dependency and/or family and social problems, this might also be viewed as an improvement. It is these *exceptions*, and others like them, that are of interest in the solution-focused therapy approach for the treatment of problem drinking.

THE SFBT APPROACH

Solution-focused therapy is a goal-directed, future-oriented developed-inductively approach based on over 30 years of clinical practice. Although SFBT (Berg & Miller, 1992; Berg & Reuss, 1997; de Shazer, 1985, 1988, 1991, 1994) began to develop at the Brief Family Therapy Center (BFTC) in 1980, and was given its name in 1982, research into the approach beyond BFTC's own exploratory, experimental, model building and theory construction projects and follow-up studies has only recently begun to grow (Gingerich & Eisengart, 2000). While this research is still in its infancy, the results evidenced in programs like those of St. John's, to be described, as well as continuing follow-up by current members of the BFTC team (e.g., Berg & DeJong, 1996),[2] indicate that the approach definitely merits further research.

Unlike most other therapeutic approaches, SFBT is not a problem-solving approach , but rather a solution-constructing approach. The primary tasks of SFB therapists include helping patients develop a clear picture of what they want to be different as a result of therapy (their *goals and the consequences of achieving those goals*) and helping the patients identify the existing and available resources (*means*) such as strengths, thoughts, interactions, relationships, behaviors, attitudes, and perceptions that will help them achieve their goals. This typically involves the clients/patients describing times when the problem is absent from their life (*exceptions*). For example, when the alcohol abuser de-

scribes instances in which he does not drink or drinks less, these instances are identified as exceptions.

Throughout the SFBT process, emphasis is consistently placed on clear and specific goals derived from the client's vision of how life will be at some point in the future when the problem that brought them to therapy is gone. Because these goals are based on actual details of the client's description of the behaviors, thoughts, feelings, interactions, and relationships that will be present when the problem is solved, they are typically very practical and concrete.

Over the years, SFBT therapists have observed that in the first session, the majority of clients/patients report exceptions–that is, times when the problem does not happen–when their life is similar to how they want their life to be once the problem is gone. Thus, many times, the process of solution-construction can be seen as having already begun before the patient came to therapy.

This phenomenon leads SFBT therapists to use "scaling" questions to help clients/patients assess their progress towards achieving goals. For example, 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 session, 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.

The "miracle question" is a standard part of solution-focused therapy. Usually it is asked in this form:

"Suppose . . . after we are through here, you go home and have dinner, do your chores, watch TV and whatever else you do, and then go to bed and go to sleep . . . and, while you are sleeping . . . a miracle happens. . . . And the problems that brought you into therapy are gone, just like that! . . . But this happens while you are sleeping, so you can't know that it has happened. . . . So, once you wake up in the morning how will you discover that this miracle has happened? What else?" (de Shazer, 1985). Throughout the therapy process, scaling is used to help the client assess progress towards the goals that reflect this picture of a "miracle"–when the problem is gone.

Because SFBT therapists recognize that clients' goals frequently change during the therapy process, therapy ends at the point when the patient determines that they have made *enough* progress, that is, while

things are not perfect, their life has improved sufficiently for therapy to no longer be necessary.

THE BRUGES MODEL FOR TREATMENT OF PROBLEM DRINKING

The Department of Psychiatry and Psychosomatics at Saint John's Hospital in Bruges, Belgium, has a psychiatric treatment program with a 60-bed capacity, a day clinic with 30 beds, and a large outpatient program. As is the case in most psychiatric wards, a substantial proportion of the patients suffer from problems directly or indirectly related to alcohol and/or medication abuse. St. Johns has developed a modified version of Solution-Focused Brief Therapy (SFBT) for the treatment of alcohol abuse tailored to fit their treatment context.

Typically, patients referred because of problem drinking remain in the hospital for 14 days, in the day hospital approximately two weeks, resulting in an average of 4 1/2 weeks total length of treatment. Most of the patients are admitted in a crisis situation referred through the hospital's emergency services. A smaller number are referred by the outpatient department, and some are brought in by the police.[3] There is almost always at least one family member present when the patient is admitted. The therapists always advise the family members that their cooperation will be essential to treatment. In at least half the cases, these family members are seen again at least once by the therapist responsible for the case.

During the first week of treatment a special detoxification program is used if necessary. The patients are examined regularly during this time for any withdrawal symptoms. Medication (20 mg of diazepam) is started only if symptoms[4] appear. On the average, 25% receive medication and 75% of the patients admitted to the treatment program for problem drinking at St. John's receive no medication during their hospitalization other than B vitamins. Since the instigating of this in 1988, no delirium tremors have been observed.

Upon admission to the program, the psychiatric nurses assigned to be the patient's primary therapists provide extensive information on the biological, psychological, sociological and interactional aspects and impact of alcohol addiction and abuse. After the intake, the nurses, who are trained in SFBT, help the patient along with his or her family, and decide which form of group treatment[5] he or she will join: AB (Abstinence)-oriented or CD (Controlled Drinking)[6]-oriented. Abstinence is

not demanded by the treatment program, nor is it seen as the only way to solve alcohol problems; instead, it is presented as a possible choice. This allows patients who initially chose controlled drinking but are unsuccessful to subsequently change their goal to abstinence without a loss of face.

The therapists at St. John's work to ensure that the patients' family supports any important treatment decision. Patients and families are offered a choice of solution-focused individual, couple or family therapy, or can elect not to have therapy. In addition, family members are invited to weekly Multiple Family Therapy Sessions which they may continue to attend after the patient is discharged. The families that choose to attend, typically do so three times. Patients generally consider the Multiple Family Therapy Sessions to be very valuable.

The patients' initial choices are evenly divided between the two groups, however, about 10% of those who initially chose CD eventually change to AB. Of course, the patient is free to choose to join neither group. Furthermore, the patients can, at any time, change from one group to another or remain in the same group after changing their minds about which approach to take. Also, patients may switch from inpatient to day hospital or outpatient services after one day of hospitalization. About 10% of those patients who initially choose CD (Controlled Drinking) eventually change their minds and switch to the AB (Abstinence) group.

In both groups (AB and CD), while the patient is hospitalized full-time and throughout subsequent treatment as well, the main focus is on identifying *exceptions*. Examples include instances when the patient has an urge to drink but refrains and finding out how the patient overcame the urge to drink. Each patient is asked to keep a daily log form about his or her cravings and what he or she does instead of drinking. This log contains the following information:

a. How strong was the urge to drink? (0-10)
b. Where did this occur?
c. With whom?
d. How come?
e. How did you stop this urge?
f. How difficult was it to stop this urge? (0-10).

Patients in the CD group who decide to switch to the day hospital or outpatient options are asked to record the following additional information:

a. What day and hour he or she drank some alcohol
b. What kind?
c. How much?
d. With whom?
e. How come?
f. Where?
g. How did they stop drinking at the point at which they stopped?
h. How difficult was it to stop drinking at that point? (0-10).

The above two log forms help the patients, their therapist and the group members focus on their goals and the means of achieving them, i.e., the specific steps necessary for achieving the goals.

The choice of goals is made by the patients and their families. Interestingly, the actual goals have little or nothing to do with drinking or not drinking. Instead the goals are usually things like saving their marriage, keeping their job, getting back their driving license.

Because this is an alcohol abuse treatment program, and the patient's primary choices are between attempting to achieve total abstinence or achieving controlled drinking, any goals suggested by the patient in response to the miracle question are considered to be acceptable regardless of whether they are directly related to alcohol problems. As a result, many times clients/patients changing their drinking *patterns* becomes a means to achieving other goals identified from their response to the Miracle Question. In this way, the goal of abstinence or controlled drinking becomes part of the larger (and perhaps more personally meaningful and rewarding) context of the patient's highly individualized hopes, dreams, as well as relationships with loved ones, co-workers, bosses, etc.

HOW EFFECTIVE IS THE BRUGES MODEL? THE RESULTS OF A FOUR-YEAR FOLLOW-UP WITH INPATIENTS AND OUTPATIENTS

Inpatient Follow-Up

An attempt was made to contact each of the patients who completed treatment at St. John's during an 18-month period (n = 131) four years prior. These interviews were completed by graduate students in psychology at a local university, none of whom had any connection with the St.

John's Hospital programs. When possible, interviews were also conducted with relatives of the former patients to corroborate self-reports.

Eighty-seven of the patients were male and 44 were female. They ranged in age from 19 to 74, with the average age of 46.2 years old. The patients' mean score on the MALT,[7] given upon admission to the hospital, was 27.39 (maximum possible score is 37). A score of 10 or above is seen to designate "alcoholic." Upon admission, only three of the 131 patients had scored below 10 on the MALT. The standard deviation was 7.82.

Out of the 131 original patients, 13 had died or had moved. Follow-up telephone interviews of the remaining 118 inpatients four years after discharge were conducted. One hundred (84%) of the 118 reported either being abstinent (60, or 50.1%), or had succeeded in continuing to practice controlled drinking (40, or 33.9%). Eighteen, or 15%, reported that they had not reached either their goal of abstinence or controlled drinking.

Outpatient Follow-Up

Although the number of patients was smaller (n = 72) in the four-year follow-up of outpatients (patients who were never part of the inpatient program) treated with the Bruges Model approach to problem drinking, the telephone survey suggested that patients choosing their own goals and approach to reaching these goals was crucial in the successful treatment of problem drinking. Four years after therapy ended, 50% (n = 36) reported being abstinent, and 32% (n = 23) reported success at controlled drinking. Interestingly, only 19 of these 36 people no longer drinking had originally chosen abstinence as a goal; controlled drinking had been the original choice of only 9 (12.5%) of these people. This strongly suggests that having a choice of goals and the ability to change goals makes a big difference in patients' treatment success. It also suggests that the patients' initial choice is not crucial to success, however, that it is important for the therapist to accept and encourage the client's choice.

No statistical differences were found in success rates between: (a) patients with high vs. low MALT scores; (b) patients who chose controlled drinking vs. abstinence; (c) males and females; (d) married or unmarried males or females; (e) patients' who were working and those who were unemployed or on a pension; (f) high and low SES patients; (g) patients who saw their spouses as supportive or non-supportive; or (h) patients who saw their families as harmonious vs. non-harmonious.

DISCUSSION

What could account for the very high percentage of patients reporting a successful outcome? One obvious difference is that patients at St. John's Hospital were given a choice of possible approaches, goals, and types of therapy available, and participate actively in goal-setting and assessment of success throughout therapy. For example, following hospitalization, the patient has a choice of continuing to be an inpatient, switching to day hospital, becoming an outpatient or being discharged. These areas of choice allow the patients to cooperate with the treatment program, and the therapists cooperate with the patients by assuming that the informed patient knows best what is needed in his/her particular case. Another obvious difference between the St. John's Bruges Model approach and more traditional approaches is that changing the patient's drinking pattern is usually merely a part of the patient's larger goal of creating a better life.

At least in part because of the typically low success rate of traditional treatment programs, dealing effectively with alcohol problems has long been viewed by health-care professionals as extremely difficult. The assumption that abstinence is necessarily the *only* viable treatment approach coupled with the fact that only relatively few people succeed at being abstinent suggests that resolving drinking problems is frequently going to be a hopeless task. This is made even more difficult by the commonly held belief that an "alcoholic" can never become a "normal drinker."[8] Thus the very difficult, and oftentimes apparently impossible, remedy of abstinence is seen as the only approach.

When a problem is believed to have only one remedy, failure in an attempt at that remedy is viewed as the individual's fault. Each subsequent failure demands that the individual increase his or her efforts at applying the remedy, that is, doing more of something that is not working. Doing more of something that is not working, in fact, is exactly how problems are defined in brief therapy (Weakland et al., 1974).

Each failure, of course, leads to greater pessimism and guilt on the part of the patient and the people around him or her. Family members and spouses become more and more disappointed with each episode of failure. This sets up an impossible interactional pattern that further contributes to hopelessness. The following questions naturally arise: Is success possible for me? Is failure inevitable for me? Eventually, the individual is lead to the idea that for him or her, a solution is impossible. Therefore it seems perfectly reasonable to stop attempting to apply the remedy.

The results of this follow-up suggest, however, that such pessimism may not be necessary and that at least some optimism is warranted. The situation is entirely changed once a second possible remedy to the alcohol problem is introduced. With two ways to approach the goal, failure at one only means that patients should try the other approach. With two approaches to choose from, the individual is not forced to try to become abstinent. He is not trapped by a situation in which there is no choice. Trying to become abstinent is only one option. Within the context of choice, even continuing to drink is an option. There is a big difference between choosing to drink and believing that you have no choice but to drink.

Therapists using the Bruges Model take the patient's choice seriously, and, as a result, the patient is dealt with respectfully and openly. No matter what the patient's/client's choice (abstinence, controlled drinking, drinking less but still too much, drinking only on weekends, etc.), the therapists will help patients figure out how best to make that approach work for them in approaching and achieving their goals.

Although helping patients change his or her drinking pattern is a major focus of the Bruges Model and is the program's primary measure of success or failure, for the patients themselves their own goals are more important and changing the drinking pattern is usually only a means to some other end. For instance, an individual might decide that changing his or her drinking pattern would help save his or her marriage. For many patients, having a change in the drinking pattern signify a means to an end rather than as an end in itself, makes changing the drinking pattern both more acceptable and more achievable.

The fact that patient choice is central to Solution-Focused Brief Therapy is obvious. Whether in its original form (at BFTC) or as used in the Bruges Model, what patients want from therapy, as described in response to the "miracle question," becomes the focus of therapy. This ultimately affords new and effective options for clients searching for a solution to their drinking problem.

One limitation of this preliminary report is that client and family self-reports via telephone interviews were used rather than standardized or physiologic measures of alcohol use. While this a common method in program evaluation, it does limit the reliability of the findings. However, these findings are clearly suggestive of an important new approach to the treatment of a very difficult problem, and future research should be conducted using a randomized, clinical trial approach to more clearly examine the effectiveness of Solution-Focused Brief Therapy for the treatment of alcohol abuse.

NOTES

1. These results are far worse than can be accounted for by chance. How is this to be understood, particularly in the context of research that tells us that as many as 82% of those people who stop drinking for at least one year do so without any treatment (Sobell, Sobell, Toneatto, & Leo, 1993)? This 93% failure rate strongly calls for, at the least, a total re-evaluation of the standard treatment of alcoholism, the development of new, effective methods of treatment, and a change in the definition of treatment.

2. In this study (n = 138, about half of those BFTC attempted to contact), the success rate was 77% with 45% of the clients saying they had met their goals and another 32% saying they had made significant progress towards reaching their goals. The average number of sessions per case was 3. Race, class, sex, age, economic class, and type of problem had no impact on outcome.

3. Up to 1/3 of the patients are initially "involuntary" referrals. Involuntary status has not been predictive of outcome in the problem drinking program at St. John's.

4. Symptoms of withdrawal that prompt the use of diazepam include rising blood pressure, elevated temperature or pulse rate, tremor of hands or tongue.

5. See Berg and Reuss (1977) for details about using group therapy with substance abusers.

6. Controlled drinking is defined as 3 units of alcohol or less per day, with two days without alcohol per week.

7. This is a standard test used throughout Europe.

8. For an early contrary view, see Davies, 1962; Davies, Scott, and Malherbe, 1969.

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