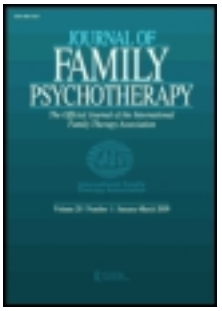

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Solution and Resource-Oriented Addiction Treatment with the Choices of Abstinence or Controlled Drinking

Agnes-Christine Nelle

ABSTRACT. The NIK-Ambulanz in Bremen is the first German solution focused model project in outpatient addiction treatment to be financed by the insurances. The Bremen therapeutic concept is based on solution focused assumptions and techniques and the Bruges Model's approach in alcohol-addiction treatment aiming to restore the clients' ability to choose and allowing controlled drinking as a possible goal. The Bremen concept fits the German insurances recent development to favour shorter therapies, outpatient treatment and to make treatment programs more attractive in order to reach more people with alcohol problems. The article includes a case example of a client who chose controlled drinking and first results of the project.

KEYWORDS. Solution focused brief therapy, outpatient treatment, alcohol addiction, Bruges Model, controlled drinking, pathology of choice, restoration of choice, resources, miracle question, exception, relapse management

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MODEL PROJECT "NIK-AMBULANZ" IN BREMEN, GERMANY

The Northern Germany Institute for Brief Therapy, NIK, has been practicing the solution focused brief therapy approach for more than 15 years in psychotherapy, supervision and consulting.

The NIK is founding member of the European Brief Therapy Association EBTA, Paris.

The NIK-Ambulanz opened in September 2000. It offers outpatient treatment as individual and group therapy for people with alcohol, medicament or multiple addictions. It is the first insurance financed addiction treatment in Germany that is based on the solution focused approach and includes the choice of controlled drinking.

As a 3-year model project of the federal pension insurance our therapeutic work is combined with continuous scientific research: the clients use a questionnaire at the end of every session and after 6 and 12 month after the end of therapy to give feedback concerning the usefulness of their treatment.

According to the standards set by the federal insurance the NIK-Ambulanz team consists of two social workers and a psychologist, all trained solution focused therapists and a doctor. All team members work part time for the NIK-Ambulanz.

The treatment is paid for by the federal pension insurance, health insurance or the city welfare department. Clients who are not insured by any of these, e.g., self-employed persons or civil servants pay for themselves if they decide for our program. There is an outpatient treatment program in Bremen financed by the insurance for civil servants using a traditional approach, but often these clients want to take part in our program and decide to pay for their treatment. Because of this development since 2002 their insurance has increasingly approved to pay for the treatment at the NIK-Ambulanz in "individual cases."

Our concept is basically founded on solution focused brief therapy developed by Steve de Shazer and his team in Milwaukee and the "Bruges Model" by Luc Isebaert. The Belgian models' many years of exceptional success in addiction treatment were the main reason for the German insurances to support our project.

SOLUTION FOCUSED BRIEF THERAPY

This therapeutic approach of Steve de Shazer and the team of the Brief Family Therapy Center in Milwaukee has been applied very im-

pressively in working with people with drinking problems by his wife and colleague Insoo Kim Berg.

In times of decreasing financial resources solution focused therapy is becoming more and more attractive for insurances. The relatively small number of sessions makes it an interesting alternative to traditional long term therapies, which might be similarly effective, but cause much higher costs. In this context it is very important to stress the point, that solution focused therapy is not brief in order to save money. Rather this approach is based on certain assumptions that lead to fewer sessions.

Based on the belief that clients have all the necessary resources to solve their problems, solution focused therapy concentrates on identifying and activating their strengths and abilities. Solution focused therapists take their clients very seriously in the choice of their goals, the choice of the steps they want to make to achieve their goals and their definition of enough improvement. The therapist does not expect the client to agree on the therapists understanding of the problem or to work on a certain insight, e.g., "I am an alcoholic," before therapy can start and does not try to convince the client of a way how to solve the problem. Instead solution focused therapists support their clients in finding individual goals and solutions that fit the client's resources. They use the kind of motivation the client offers and extends it by appreciating the client's ideas and progress.

The therapeutic questions focus on the improvement the clients make, on what should be maintained and has proved useful: How exactly did you do that? What did you do to make that happen? What should you keep on doing to maintain the improvement? By using these questions even very small success can become visible und repeatable. Small fleeting solutions become actions that the client can actively decide to apply again. And exactly this "slow" proceeding makes solution focused therapy brief: clients become independent from therapy much faster than in problem focused approaches, because they learn that they can trust in their abilities.

A typical solution focused question is the miracle question. It is useful in helping the client create a very detailed and personal description of her or his goals: "Imagine, after this session you go home and spend the evening the usual way, maybe you eat something, maybe you watch television and finally you go to sleep. And while you are sleeping a miracle happens. And the miracle is that all the problems that brought you here are solved–just like that. But because you were sleeping you don't know the miracle happened. When you wake up in the morning, what

will be the first small things that tell you the miracle happened? How will other persons notice without you telling them?"

Another characteristic aspect is the emphasis on positive exceptions: "What was the last time you remember when things were a little like the day after the miracle? What did you do differently? And what else?" or working with scales, e.g., "10 standing for how things are the day after the miracle and 0 how they were when you made this appointment. What would you say where are things right now? What is the difference to 0? What did you to reach 3? And how will you know you reached 4?"

All these questions are based on the belief that the client can find a solution without exploring the problem. Solution focused therapists think that by putting the problem into the centre of the clients attention she or he will become an expert for problem behaviour, the problem can be kept up or even worsened and therapy can be unduly prolonged. Or like Albert Einstein said: "You can not solve a problem with the same way of thinking that has caused it."

THE BRUGES MODEL

The other important basis of the NIK-Ambulanz concept, the Bruges Model has been increasingly noticed in addiction treatment in Germany and is discussed controversially. This treatment model has been developed in the St. Jans Hospital, a general clinic in Bruges, Belgium. It is applied in stationary, day-clinic and outpatient treatment. It is based on the solution focused approach and defines addiction as a pathology of choice: the client is able to choose if she or he drinks alcohol or not only in an extremely restricted way. Addiction treatment subsequently aims for the restoration of the ability of choice.

Addiction treatment according to the Bruges model distinguishes between perception and behaviour: while perceiving reality a human being continuously influences reality by behaviour. This model works on the surface between the individual and reality. The first thing we do when we perceive reality is to give meaning to it. For somebody suffering from addiction alcohol can mean relaxation, comfort or sociability. In any case she or he almost automatically chooses alcohol to generate those feelings. The addicted person can't really choose, because alcohol has acquired the meaning of something irresistible. The last thing we do before we react to reality is to decide on a certain kind of behaviour. Somebody with an alcohol problem can't choose at this point of the pro-

cess. Because the meaning of alcohol is something irresistible only one choice makes sense: to drink it.

Therefore, in addiction treatment restoration of choice contains

- to be able to give new and different meanings to alcohol, e.g., something pleasant but also avoidable
- and to be able to act differently concerning alcohol, e.g., to leave it, to tip it away or to drink something else.

The client has successfully reached the goal of the therapy when the ability to choose is restored. This can be achieved by abstinence or controlled drinking.

Because the Bruges model is a solution focused one the therapist does not tell the client, which will be the "right" goal and does not force the client into the treatment-given the client is fully capable of judgement. During detoxification this capability can be missing. In general the Bruges therapists concentrate on supporting the client, to find out what goal is attractive for her or him and which solutions are useful. The respect paid to the clients own ideas leads to a treatment that gives the choice to the client: do you want to live abstinent or learn controlled drinking?

CONTROLLED DRINKING

Above all others the aspect of the NIK-Ambulanz concept offering the choice of controlled drinking to alcohol addicted people has caused intensive discussion among therapists and self help groups in Bremen. Like in Bruges our clients who are interested in learning controlled drinking are informed, that for most people with alcohol problems it is much easier to live abstinent and that it is usually very hard to control yourself every time you drink alcohol. We explain that somebody who has developed a habit of drinking too much alcohol will be endangered to relapse into this behaviour for the rest of her or his life, because a behavioural pattern once learned can never be erased from the brain. Even after establishing controlled drinking as an additional pattern a conscious choice has to be made every time.

Controlled drinking is different from the way a person who has never developed an addiction can consume alcohol. It is hard work. The reasons for clients to choose this solution rather than abstinence are various and individual, some can be learned from the case example. If a client

decides for controlled drinking, we describe the physical and psychological mechanisms of addiction. The client gets information about the maximum amount of alcohol that the WHO considers within the limits of healthy drinking (max. 2 units = 40g of alcohol per day for women and max. 3 units = 60g for men, at least one day a week without alcohol). They learn that it is not advisable to directly change from the habit of drinking too much to the habit of controlled drinking, but that it is useful to develop the habit of being abstinent first: controlled drinking is only going to work if the client can choose to have a non-alcoholic drink instead of second beer. Clients are advised to practice abstinence for a certain period of time until it has become a habitual pattern before they start experimenting with controlled drinking. The clients determine how long this period has to be and how they want to go about finding out if they are capable of controlled drinking.

The therapists ask for many details of how exactly the clients will behave differently in difficult situations to reach their goal, how their ideas work out and–if they are not useful–what has to be changed. Because not every client who tries controlled drinking is able to succeed, therapists will at some point ask, how long the client wants to go on trying before she or he decides controlled drinking is not possible.

In any case the clients make use of their own experiences and judgement. During this process about 1/4 change their goal to abstinence. Of cause those clients have a much stronger motivation and conviction for abstinence than clients who have been convinced by the therapists or had to choose abstinence to be permitted to the treatment program. It is interesting that offering controlled drinking as a possible goal resulted in a higher number of stable abstinences than in programs without this choice. In the 1999 outcome study the Bruges program showed a stable success with 75,7% of the former patients four years after the end of therapy. Forty-five point four percent lived abstinent, and 30,3% practiced controlled drinking within the limits set for drinking not hazardous to health set by the WHO.

WORKING WITH EXCEPTIONS

Unlike other treatment programs the Bruges and the Bremen models assume that a person with abusive drinking habits does not suffer a total loss of control concerning alcohol. We believe that there is always some ability to choose left and there are always times of successful self-control in the clients life since the problem has developed. For example, cli-

ents experience periods of abstinence or reduced drinking. Some evening the client drinks six glasses of wine, the next she manages to stop after the fourth glass. Usually she starts drinking at eight o'clock, but sometimes she is able to wait until ten. Often those examples of the ability to choose are not in the client's focus of attention; because they are used to see only their problems and consider drinking six or four glasses the same kind of failure. When the therapist focuses on those exceptions, clients start to notice that they have already started to solve their problems and that they are doing things that can be helpful for reaching their goals. Exceptions are very useful, because they are something the client already does. Sometimes the solution is just to do more of it.

RELAPSE MANAGEMENT

In case a client experiences a relapse during treatment the therapists do not concentrate on what caused the relapse but are interested in how the client stopped the relapse. Also the therapists ask in what ways this relapse was different from former ones, e.g., if lasted shorter or the client drank less and how the client managed to do so. The Bruges and the Bremen treatment programs favour relapse management rather than prevention. By using concrete situations the clients describe what they will do if their strong intentions weaken for what ever reason instead of drinking the beer or in order to stop after the first beer. Preparing this kind of management from our experience is more realistic and useful for the client than trying to avoid all "dangerous" situations or the urge to drink alcohol.

OUR EXPERIENCES IN BREMEN

I would like to describe how we managed to put our concept into practical work and what our clients found to be useful about this new approach in addiction treatment in Germany. It took more than one year to convince the federal pension insurance, which finances addiction treatment in Germany, to accept our concept. At first they were reluctant to include controlled drinking, because this meant breaking a taboo. At the same time insurances were dissatisfied with the results of traditional long term stationary programs and the extremely small number of people with alcohol problems (2%) who were reached by these pro-

grams. Insurances nowadays support outpatient treatment and programs that attract people who refuse to join the traditional programs. Using the results of the Bruges model we were able to convince the insurance that the NIK-Ambulanz would fit those ideas.

Already during this preliminary process we had introduced our concept to the working group for addiction treatment in Bremen and to the committee of the Bremen senator for health. For our opening we invited professional colleges from different institutions and members of the Bremen self-help groups. Especially the self-help groups were very skeptical of an outpatient, brief therapy approach including controlled drinking.

By making clear the novelty of what we were offering to people suffering from alcoholism we were able to motivate a local TV station to broadcast an announcement about our opening. Because of the great interest it caused two days later they added a detailed report in the evening news. This high publicity led to a steady demand of our program.

In order to establish a good with other institutions and self help groups cooperation it proved very useful not to present our approach as the better way in addiction treatment, but rather–according to the belief in the ability to choose–as an additional one that has been lacking in the traditional treatment. After two and a half years of work our clients' feedback shows that we were able to reach people who had not gone into treatment yet although they felt a need for professional help. They had not been prepared to leave their families or jobs for month of stationary treatment or to accept abstinence as the only possible way to solve their problem. Due to these restrictions of the traditional programs alcohol addicted people often wait until their family and job is gone because of their drinking before the get help. In this way our program can also be viewed as a kind of prevention, because it reaches clients earlier.

CASE EXAMPLE

I would like to use a case example to describe how our program can be helpful to people who would not join a traditional therapy. It is about Mrs. G., a client who chose controlled drinking as the way to solve her problems and to reach her goals. At the end of the therapy I asked Mrs. G. to help me write the final report for the insurance and I will quote from what she wrote in the following.

In October 2000 Mrs. G. made an appointment with me after she had learned about our program from TV. She was 47 years old and self-em-

ployed. In the first interview she told me that for the last five years she had been suffering very much from her increasing regular drinking. She had been in psychoanalytic treatment because of sleeping disorders for more than eight years, which she had recently quit, "because it did not give her ideas what to do different." Right now she was in the middle of an extremely stressful separation and drinking even more. Because of her sleeping disorders she was using a light antidepressant.

For a long time she had been thinking about getting therapeutic help, but a stationary treatment and lifelong abstinence she said "had scared her away." It was important for her to be able to consume small amounts of alcohol on social occasions without falling back into the habit of drinking too much. She said she could not agree on refraining from drinking a glass of wine or sparkling wine with other people, because she would only drink too much *beer* when she was *on her own*.

Mrs. G wanted to start therapy right away and paid for the sessions until her insurance took over the costs a few weeks later. She decided to have a session every week at the beginning of the treatment an then have longer intervals.

For the final report she writes: "When I started therapy in October 2000 I had no emotional strength left and was in a state of nervous exhaustion. I was worried about my habit of drinking six big cans (3 Litre) of beer every evening, I was afraid it would become more. First I had used alcohol to be able to sleep. After the separation from the men, who had been my partner for nine years, I started using alcohol to suppress this problem and my desperation. It was very hard to deal with the situation, because he lives next door to me and works in the same building with me."

Mrs. G. was convinced that she could only succeed in solving her drinking problem if she would also get therapeutic help in dealing with her acute crisis. She writes: "Therapy had two main topics: how to get control over my drinking and how to cope with the separation. For both goals I aimed for stability and responsibility in dealing with crisis, to avoid irreversible relapses."

The therapeutic questions and interventions focused on what was helpful for her to cope with the situation without drinking more and how she would notice that things have become a little less difficult. It became obvious that Mrs. G. had various resources which she began to activate: for example she had a very good friend, who sometimes "gave her a piece of her mind," she loved sewing beautiful clothes, what always had a calming effect on her, and she had always gathered strength

from drawing her "mental state." (She really enjoyed drawing a picture or her day after the miracle.)

When Mrs. G. became more confident in her ability to cope with crisis, we started working on her goal of controlled drinking. I asked her: What do you think would be useful to do in order to reduce drinking? What have you tried in the past that had been useful to drink less or no alcohol? When do think the period of abstinence should begin? How long should it last? How would controlled drinking exactly look like for you?

Mrs. G. had clear ideas about this. She planned to live abstinent for two months from March to May. Until then she wanted to reduce alcohol gradually. It was her idea to thin down beer with mineral water. She also found a special tea with ginger flavour that she liked to drink instead of beer. And she removed the little table next to her sofa, where she used to arrange the six cans of beer for the evening. Now she had to get up and walk to the kitchen if she wanted another can.

She was so successful in reducing her consumption of alcohol that I had to suggest to go slow. She found it very easy to go from six down to five cans and wanted to reduce to only two cans in one step. I asked her how confident she was to be able to do so, and she said 50%. When I advised her to drink at least four cans of beer every evening until the next session she smiled and told me she would be much more confident to reach this goal. In the next session she was very proud to tell me that she only had three cans of beer every evening, except one time when she stopped after the second can. Solution focused therapy avoids putting pressure on the clients to set high goals and thus make a failure more likely than a success. Rather the therapist suggests a smaller step than the client is confident to perform. This way the client is likely to make it or to do even better.

Mrs. G. writes: "For the first three month therapy was very helpful to cope with the desperation and hurt of the separation by activating my strength and resources. After the sessions I felt much better and more confident to be able to solve my problems. I started to develop my own plan to reduce alcohol and prepare for my phase of abstinence."

Mrs. G. followed her plan and did not drink any alcohol for two months. Within this period of time she went on a trekking holiday with a friend and did not drink the usual red wine in the evening but enjoyed her favourite tea instead. To practise her new habits was so much easier than she had expected that she decided to stop taking the antidepressant. Although this meant an additional effort she was glad to notice that she was able to keep up her abstinence and did not even suffer from sleeping

problems anymore. She writes: "Being able to live without alcohol encouraged me to try to learn controlled drinking. Because I did not use the antidepressant anymore I experienced some emotional instability, but I was able to cope with it using the things I had already learned in therapy."

In therapy Mrs. G. worked out an exact plan how to change to soft drinks after one glass of sparkling wine on her birthday party. Instead of drinking more alcohol she intended to hold a little speech and to dance a lot. After her ideas had proved to be useful she started to experiment with her re-established ability to choose. Finally she even managed to have one beer at home in the evening and than change to tea. During the last four sessions which were set once a month she told me that she was abstinent, because now that she had convinced herself she could stop after one beer she enjoyed living without alcohol or medicaments. Medical examination at the end of the treatment program showed a great improvement of her physical condition. The follow ups after six month and twelve month after the end of her therapy told us that she was still abstinent and confident to maintain her progress.

SOME RESULTS OF TWO AND A HALF YEARS OF NIK-AMBULANZ

- Since our opening in September 2000, 52 clients were treated.
- Fourteen female clients and 38 male clients. The youngest is 23 years old, the oldest 69 years.
- Clients came from very different socioeconomic and educational background, e.g., students, unemployed, managers, teachers, manual workers and people living on welfare. One client was in open imprisonment for the most time of his therapy.
- In 50 cases the medical diagnosis was alcohol addiction, one client suffered from medicament addiction, one client from multiple addictions (alcohol and cocaine).
- Forty-one clients chose abstinence, 11 controlled drinking. Two clients changed to abstinence.
- The number of sessions was between 5 and 35; the length of therapy was between 7 weeks and 12 months (the insurance pays for max. 120 sessions within 18 months).
- About 1/3 of our clients pay for themselves. Usually clients whose insurance does not take part in our program yet.

- Most of our clients were not sent by other institutions but came because of information they got from former clients, newspapers or TV. In the last month we have established an increasing cooperation with a new day-clinic in Bremen that sends clients.
- According to the questionnaires we use at the end of the therapy more than 90% of our clients think they got the right treatment and would recommend the program.
- As especially helpful about the treatment they name positive thinking, appreciation of their abilities, transparency and a pleasant atmosphere.

Results regarding the long term stability of the clients' progress will be available when the final evaluation after the three year model period is completed. The positive results were gathered so far make us very confident that the Bremen program will proof to be similarly helpful for people with alcohol addiction as the Bruges program.

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