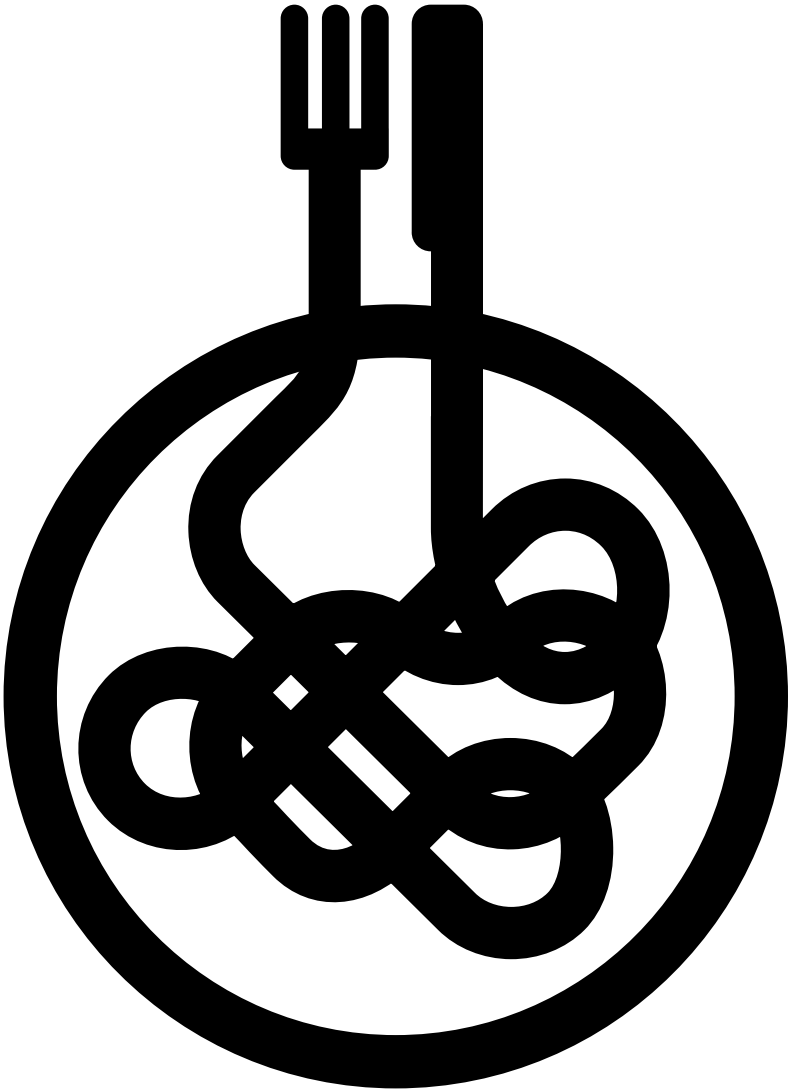
# Solution Focused Recovery from Eating Distress

Frederike Jacob



First published June 2001
Published by BT Press
17 Avenue Mansions, Finchley Road, London NW3 7AX



Design by Alex Gollner



ISBN 1 871697 76 X

# Contents

# Foreword

Frederike Jacob has written a milestone book both for solution focused brief therapy and the field of eating disorders. Solution-focused brief therapy is a generic "all purpose" approach and eating disorders are seen as a very specialist subject. As the title of the book asks: Can the two be reconciled? Frederike Jacob clearly thinks so and argues her case well. She provides a succinct description of solution focused therapy alongside an equally succinct description of the variety of forms an eating disorder might take. The matter-of-factness of these descriptions reduces the mystique of both: solution-focused brief therapy is seen as a perfectly logical and straightforward process and eating disorders are seen as ways of behaving that can be changed.

On the other hand, the potentially fatal consequences of an eating disorder are not ignored and throughout the book close attention is paid to clients' safety and to ways the professional might promote and safeguard this. It is this responsible attitude towards the client's health and safety that creates the real possibility of developing a non-medicalised form of treatment. For many struggling with eating problems this development will open new possibilities for a better life.

Frederike Jacob's practical approach to her subject is no better demonstrated than in the descriptions of her work with clients. In these the problem, the process, the thinking and the outcome are all clearly spelled out, some in the form of word by word transcripts. Case by case, a way to do solution-focused brief therapy unfolds.

When Steve de Shazer, the person most responsible for articulating solution-focused ideas, wrote his first books he was criticised for his "cookbook" style: "You can't learn therapy from books!" was the cry. Yet tens if not hundreds of thousands of therapists all over the world have found a way to make de Shazer's ideas their own. This is a book that follows the de Shazer tradition – it is a book from which the reader can learn. That means it is worth reading.

Chris Iveson
Brief Therapy Practice
London

# Letter to the Reader

Ipswich, 10th December 2000.

Dear Reader,

As I start to write this book, I project my thoughts towards when it is finished and has found its way into your hands and I wonder …

Why did you choose to pick up this particular book?

Were you intrigued by its title, or by the cover?

Are you a professional, trying to support someone in recovery from eating distress? If so, do you find people with eating disorders "impossible to work with"? Maybe you have a friend or relative who suffers, or you may even have (had) difficulties with food yourself.

Or are you simply wondering what solution-focused therapy is all about?

I guess any or all of the above could apply to you and I am aware that I could not possibly do justice to everyone who has a link with eating disorders. Although this book deals with therapeutic interventions in particular, I hope that whatever your background, you will be inspired and encouraged by what you read.

I am a solution-focused therapist with a specific interest in helping clients overcome their difficulties with food. I have worked in this field as an independent practitioner since 1997, and after I presented a workshop in Finland at the European Brief Therapy Conference in 2000, I was invited to write this book.

My way of working has been shaped by carefully monitoring my clients' progress and by doing more of what they tell me is useful and supportive. I did not set out to produce a comprehensive textbook on the intricacies of eating disorders, only to write from my experience as a therapist. The examples I present come from my own practice. They may or may not fit your particular circumstances or therapeutic model, but maybe you will consider and experiment with some of the ideas by moulding them to fit your individual way of working.

I would like to point out that although the techniques and interventions described here are used to combat eating distress, they are in no way restricted to dealing with that problem alone. I find they lend themselves equally well to helping clients overcome a spectrum of problems such as depression, relationship difficulties, anxiety, substance or alcohol misuse and school- or work-related stress.

My aim is to convey a message of hope. Too often books, TV or radio programmes and journalistic articles cover the "down-side" of eating distress. This has resulted in a negative attitude to the problem and towards those who try to recover.

When I am asked what I do for a living, my reply is often met with a sympathetic look or a shake of the head. People say: "Eating disorders…. Gosh, that must be difficult!" or, "Those clients are so resistant, so manipulative, aren't they?" or, "They never recover … what a depressing job you have. You must suffer from burn-out!" My experience is quite the opposite, and this may have something to do with the therapeutic model I work with. Initially, I underwent psychodynamic counselling training, and in such traditional therapy the problem is the central issue. Causes, consequences and maintaining factors are explored in detail. This makes for lengthy – and in my view depressing – therapy, in which many clients report "becoming stuck".

When I was introduced to solution-focused therapy I learned that, in contrast, the therapist is interested in those times the problem is (slightly) less oppressive, and will specifically explore occasions when clients feel they can cope a little better. The therapist is also curious to know how clients envisage a future when the problem has disappeared, or when they are better able to manage it. My colleagues and I have discovered that this motivational way of working moves clients on and creates a sense of optimism. In my experience this not only prevents clients getting stuck, but also safeguards therapists against burning out. These issues will be addressed in more detail later.

I hope this book will help to explode the myth that people with eating disorders are "difficult clients" and I welcome this opportunity to show the courage, integrity, creativity and humour that I have seen as predominant character traits among my clients. To protect their anonymity, I have changed their names and identifiable details.

I am indebted to all my clients for what they have taught me over the years, and am grateful to those who allowed me to share their stories with you.

With best wishes,

F.J.

# Introduction

The 1980s and '90s saw a marked increase in eating disorders, and this trend is set to continue into the new century. We can assume that more people will seek help to overcome such problems. Based on solution-focused principles, this book offers practitioners ideas to promote recovery.

Chapter One briefly explains the solution-focused approach. I have illustrated the techniques and interventions with snippets from sessions with clients, because they are particularly relevant to working with eating disorders. If this is your first encounter with this therapeutic model you may wish to obtain more in-depth explanations of solution-focused therapy (SFT) and how it can be used in other fields. To this end there are some recommendations for further reading at the end of the book.

Chapter Two concerns what is generally understood by the term "eating disorders". Although in most cases expertise is not required, my clients often say that it is helpful when therapists have some understanding of what is happening to them. Alongside this, I think that a broad knowledge of the associated signs, symptoms and, in more serious cases the dangerous side-effects, will make for safer practice.

Chapter Three talks about the treatment currently on offer, and places solution-focused therapy within other therapeutic paradigms. It shows how solution-focused interventions can be used to combat eating disorders, and there are several examples that show how it works in practice.

I have a keen interest in finding out what it is that works for clients. At the end of each session we discuss what has been particularly useful, and evaluate our work in the final session. Over the years, this feedback has shaped and developed specific concepts, ideas and ways of working, and some of these are included in this section.

Chapter Four examines a number of case studies to give a more in-depth insight into how solution-focused interventions are used in practice and the final chapter is devoted to answering questions I am most commonly asked.

# 1.

# What is Solution-Focused Therapy?

**How it started**

The solution-focused approach was conceptualised by Insoo Kim Berg and Steve de Shazer in Milwaukee, USA, in the early 1980s. While traditional therapy involved deep explorations into the client's problem-saturated past, practitioners discovered that their clients made significant progress by talking about a "preferred future". Inviting clients to describe how they pictured life once they had overcome their problem resulted in a consistently favourable outcome. The work involved looking for exceptions (occasions when the problem was easier to handle), being future-oriented, and collaboratively devising small, achievable goals. New coping strategies and solutions replaced the problem thinking in which so many clients had become stuck.

With their team at the Brief Family Therapy Center (de Shazer 1998) they subjected their initial findings to rigorous tests. They honed, refined and perfected specific interventions until they came up with a way of working which they named Solution-Focused Brief Therapy (SFBT).

Their practical concepts are now widely used in the therapeutic field, but are found to be equally effective in other settings, e.g. management consultation, career counselling, in schools and nursing, to name but a few.

**A bit of theory**

Solution-focused therapy belongs to the "constructionist" school,† where therapy becomes a dialogue in which both partners construct the problem and the solution. It is a "language game" (Friedman, 1993), in which clients tell and re-tell their stories using language which reshapes the social reality in which they live. In effect, language creates reality.

† Constructionism states that meaning is known only through social interaction and negotiation. We have no direct access to objective truth, independent of our linguistically constructed versions of reality. (O'Connell, 1998)

According to Wittgenstein (Grayling, 1996), whose philosophical thinking supports solution-focused therapy, the language we are "in" provides both *possibilities* and *limitations* for what we can understand and how we understand it. The possibilities lie in the richness of language and its capacity closely to convey personal meanings to others. But alongside this co-exist limitations: we all live according to individual internal belief-systems and experiences. Therefore it is impossible really to understand what goes on within another person's mind. As de Shazer says, the optimum we can work towards is: *"How can I best mis-understand you?"* (Friedman, 1993).

For example, people with eating disorders often hear comments such as, "Why don't you just eat something" (anorexia nervosa) or, "Just leave those chocolates alone and have an apple instead!" (compulsive binge eating or bulimia nervosa). These are classic examples of "missing the point". Were it that simple, there would be no problem, and my colleagues and I would be out of a job!

The *"How can I best mis-understand you"* concept involves saying something like, "I can't possibly understand what it's like to be in your tight spot, and how could I, since I am me and you are you. But you can help me to get as close as I can, so we can join forces and try to get out of it together." This opens the way to the collaborative work that is described in this book

**Problem v solution**

As its name implies, solution-focused therapy concentrates on solutions and preferred futures in preference to problems. We amplify clients' strengths and abilities we believe co-exist alongside their dilemmas and difficulties. We look for evidence in the client's story that proves that however bad the circumstances, he or she is already doing something which prevents the problem worsening. In an empowering exercise, the client is encouraged to do more of what works.

Therapy is still regarded by many as being about an in-depth exploration of difficulties. Traditionalists think that getting to know what's wrong, coming to grips with it and facing up to it are essential stages that need to be completed before clients can move forward. This is thought that to be a "cathartic" process. However, those committed to solution-focused therapy think that problem-focused work may lead to feelings of inadequacy and hopelessness. If you are new to solution-focused therapy, it may be surprising to know that successful work has been done without referring to the problem at all!

The difference between problem- and solution-focused work can be illustrated by imagining the therapy room to be a theatre set, where the leading actors are Problem and Solution. They are supported by Client and Therapist.

**Act One**

Client and Therapist stare into the middle of the room where, bathed in floodlights, Problem holds centre stage. Problem is examined closely from every angle, turned this way and that to get a better look. Its origins are excavated and much of the discussion evolves around psychodynamic interactions related to events that took place in childhood and the people who are causing or have caused the client distress. The therapist hypothesises and the client is awe-struck in the presence of this Very Learned Person.

Meanwhile, Problem is basking in all the attention. It puffs up self-importantly, and becomes more real by the minute. Like a magnet it attracts labels, such as Depression, Underlying Pathologies, Systemic Dysfunction, Resistance, Collusion, Psychodynamic Discords, Repression, Denial, Regression, Manipulative Attitudes and so on.

Finally, with hushed voice and grave face, Therapist proclaims his diagnosis.

Client exits. Bent under the weight of Problem, he is even more convinced than before that he is in very grave trouble. The stage is set for long-term therapy.

Curtain down, interval, then back to your seats for Act Two.

Client and Therapist are in conversation while Solution stands in the centre of the stage. The discussion is very different to that of Act One. There is little talk about Problem. What is focused upon instead are the times when Client was a little better able to cope, and who was there to give support. The discussion projects Client's thoughts towards a preferred future, which evolves around what life will be like when Problem has disappeared. Together, Therapist and Client find evidence of exceptions, the times that Problem appears to be less powerful, and Client is already doing something positive.

Solution has magnetic powers too: it attracts evidence of character traits such as hopefulness, confidence, capability, creativity, resilience, staying-power, self-esteem, optimism, assertiveness, self-control. … These enable Client to see that he has some ability to do something to make his problem a little less arduous.

Therapist and Client collaboratively puff up Solution and at the end of the session Client leaves the stage upright, with a bounce in his step, supported and empowered by Solution and also more optimistic, knowing that Problem can be defeated in the shortest possible time.

**How it works**

Solution-focused therapists do not believe that current difficulties can be resolved by identifying "underlying issues", nor by lengthy and in-depth explorations of the problem, its causes, and how it is maintained within interactional patterns. They assume instead that clients become empowered and achieve change more quickly by

constructing and developing solutions.

Another assumption is that in our world nothing is ever constant, so there will be times that the problem is not as bad as usual. These times are called "exceptions", and they are focused upon and amplified in the therapeutic process. Take one of my clients, for example, who exclaimed that she was "constantly vomiting". That statement immediately tickled my curiosity. I wondered aloud, "What … *always*?" Even when you are asleep? Even when you hang out the washing? Even when you walk your children to school? Even while you're in the shower?"

What transpired was that she vomited on average twice or three times a day. It may be tempting to follow up this information with questions such as, "What leads up to those times that you vomit?" or, "What is your relationship like with the people who frustrate you so much that you want to vomit?" But solution-focused therapy would focus on the times that the client did *not* vomit, to highlight a wealth of coping strategies and support structures that are already in place.

Considering language to be the medium for change, meaning is co-constructed in conversation. The therapist will empathise, and closely follow the client's agenda, while the non-pathologising approach helps to create options and possibilities. In a nutshell, there is no need to make interpretations or speculations regarding the role and function of eating, restricting or purging behaviours. Instead, the usefulness of the eating disorder is challenged and solutions are built to move towards the client's preferred future (McFarland 1995).

Many clients initially present with multiple, inter-related problems and it is essential to establish early on what will be the main goal of therapy. Staying focused can be a very tricky business. Yet it is imperative not to get waylaid by unrelated, juicy stories, because in the end these only serve to muddy the therapeutic waters and make for a confusing process. In other words, if the client's goal is to have a more regular eating pattern, it is not much use getting sidetracked into trying to improve her relationship with crotchety great-aunt Agatha. Furthermore, clients report that when positive change is made in one area, other aspects of their lives benefit as well. I have found that as a client grows more assertive in relationship to the eating disorder, the attitude towards great-aunt Agatha will improve too. It is a great economy: two positive changes for the price of one!

Solution-focused therapy can be considered a directional way of working. By asking specific solution- and future-oriented questions, the therapist ensures that problems are not dwelt upon. At the same time, it is commonly accepted that it can be therapeutic for the client to share how bad things have been. Any therapist worth her salt will give the client space to talk about difficulties. But in contrast to analytical therapy, which looks for deficits and hidden pathology, the solution-focused therapist acknowledges the problem and sympathises with how difficult things must have been, whilst amplifying the resources, coping-strategies and strengths which have

enabled the client to survive.

John (39), a businessman, had been through a particularly nasty divorce, closely followed by redundancy. This crushed his self-esteem to such an extent that he resorted to comfort eating. He put on a massive amount of weight and at about 140 kilos he was self-conscious and deeply unhappy. He spent the first few sessions pouring his heart out, telling me how bad things had been. I empathised, marvelled at his staying power, and picked up on useful coping strategies he had employed to survive.

By the fourth session he recognised that he had dwelt upon his problems long enough and it was time to start looking forward. When therapy was finished he said that being able to let off steam in those first sessions had been particularly helpful. It had made him realise that he did have a "survival streak" in him which made him feel less victimised by his ex-wife, ex-boss and the eating disorder.

# Solution Focused Recovery from Eating Distress

Frederike Jacob

People trying to overcome eating disorders are often referred to as resistant and manipulative, or even labelled "hopeless cases". Therapists regularly report that working with these clients makes them feel drained or "stuck".

In this book, Frederike Jacob sets out to explode the myth that eating disorders are difficult to treat, while providing the reader with a basic understanding of solution-focused therapy. She describes techniques and interventions that have helped clients, colleagues and carers move on.

The various types of eating disorder – anorexia, bulimia and athletica nervosa, yo-yo dieting, compulsive binge eating and orthorexia – are all anatomised. Their physical, psychological and physiological repercussions are clearly addressed to help therapists provide safe treatments.

A section of the book is devoted to case studies to give the reader a detailed understanding of the therapeutic process, and there is also a chapter of commonly-asked questions.

This is a book of hope, based on the knowledge that clients possess inner strengths and coping strategies that will assist therapists and help sufferers on the road to recovery.

BT Press
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(020) 7794 4495 · orders@btpress.co.uk

£13.50/$20 ISBN 1 871697 76 X

Solution Focused Recovery from Eating Distress. London: BT Press. Janet, P. (1889). Lâ€™automatisme psychologique (Psychological Automatism). Paris: Alcan. Jansen, A., Smeets, T., Martijn, C., Nederkoorn, C. (2006). I see what you see: the lack of a self-serving body-image bias in eating disorders.Â  Dropping out from psychological treatment for eating disorders: what are the issues?European Eating Disorders Review, 8, 198â€“216. Main, T. F. (1957). The ailment. British Journal of Medical Psychology, 30, 129â€“145. Malan, D. H. (1995). Individual Psychotherapy and the Science of Psychodynamics. London: Butterworth. An eating disorder is best described as a chronic condition resulting from the misidentification of food as a threat; and as such it is best situated under the much larger umbrella of anxiety disorders.Â  The HDRM is the set of science-based guidelines for recovery from an eating disorder that are published here on the Eating Disorder Institute website. There have been no controlled trials or independent corroboration and therefore HDRM cannot be identified as evidence-based treatment at this point.Â  â€œRandomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa.â€ Archives of General Psychiatry 67, no. 10 (2010): 1025-1032. 32. Arcelus, Jon, Alex J. Mitchell, Jackie Wales, and SÃ¸ren Nielsen. 5. By focusing on eight keys and how they interrelate, the authors offer a. clear map to recovery. 6. The authors recommend numerous resources so readers can further. explore any interesting concepts. 7. The information offered can beneï¬t not only individuals struggling with. an eating disorder, but also anyone who is besieged by self-doubts, self-. criticism or perfectionist tendencies.Â  Some of the most distressing and problematic eating disorder symptoms. can occur during the late evening and throughout the night. How many of. us who work in the ï¬eld of eating disorders or obesity neglect asking our. patients about their night-time food intake and sleep patterns? I admit that I. was often guilty of that, until I read this fascinating book about night eating. Eating disorders are notoriously difficult to treat. You might be wondering whether recovery is even possible. Let me assure you it is.Â  Let me show you what spontaneous recovery rates look like across each of the main eating disorders after 5 or so years. These figures are based on large, well-conducted naturalistic research studies 1Fairburn, C. G., Cooper, Z., Doll, H. A., Norman, P., & Oâ€™Connor, M. (2000). The natural course of bulimia nervosa and binge eating disorder in young women. Archives of general psychiatry, 57(7), 659-665. . For bulimia nervosa, after 5 years 41% are expected to recover naturally. For binge-eating disorder, after 5 years 35% are expected to recovery naturally. For anorexia nervosa, nearly 45% a