Interview

Restoring the client's choice of action

Interview with Luc Isebaert

By Mark McKergow and Anton Stellamans

Dr. Luc Isebaert is a leading Belgian psychiatrist and psychotherapist. He is the founder of the Korzybski Institute. This Bruges-based institute started as a training centre in systemic Ericksonian psychotherapy. After the development of the Bruges Model, with attention to the context of choice for the patient and hence the focus on the goals, resources and exceptions of problem behaviour, Luc Isebaert discovered the work of Steve de Shazer. Recognising the links of the Bruges Model with Solution Focused Brief Therapy, Luc Isebaert subscribed to the tradition of Solutions Focus. Steve de Shazer, Insoo Kim Berg, Yvonne Dolan and others became members of the board of the Korzybski Institute and were regular guests in Bruges. The success of the Korzybski Institute indicates that SF will soon be the predominant model of therapy in Flanders. As a writer and trainer, Luc Isebaert also played an important role in introducing SF in the Netherlands, France, Germany, Switzerland and Spain. He is renowned for his work in the field of the treatment of alcoholism and depression, and is the author of Kurzzeittherapie – ein praktisches Handbuch. Die gesundheitsorientierte kognitive Therapie (Brief Therapy – a practical handbook. Health oriented cognitive therapy, Stuttgart: Georg Thieme Verlag).

You were closely involved with the development of the Bruges Model ...

I was first trained as a psychoanalyst, then got into Minuchin style family therapy at the end of the 70s. I was looking around for what would be helpful in working with adults, and

stumbled across Jay Haley's Uncommon Therapy – one of first books about Milton Erickson. This was extremely interesting – full of Erickson's success stories, and (like others before and after) I couldn't make any sense of it – how did Erickson do this? How did he design the tasks he gave – the book said nothing about this. We started trying to figure it out – this took until about 1982. Then we came up with the idea of thinking about pathology – the difference between ordinary habits and unwanted habits or pathological habits. (As a psychiatrist, this distinction was familiar to me.)

In pathology you have habits which mean thinking thoughts or doing things or feeling things you don't want – but you keep doing them. You are not able to choose any more – your choice is restricted. If I have an elevator phobia, I have to take the stairs. If I am an alcohol addict and the glass is there, I have to drink it. What we saw in Erickson was that he was not addressing the pathology but creating a context where the client could choose again between the pathological habit and the ordinary habit. The task of the therapist is not to get rid of the pathology, but to have the client come to a position where they can choose again. The tasks Erickson used were seldom directed at solving the problem, but at making contact with a place where the client could choose again.

This was the start of the Bruges Model. The first thing we started was looking for exceptions, situations where a client doesn't yet have the pathological habit. This was 1983/84. At that point we started the alcohol clinic – where the client could choose to drink or not. At that time the dogma was that abstinence was the only cure. For us that only replaced one unfreedom to choose with another unfreedom to choose – replacing one lack of freedom with another. In all other situations you want to restore choice. So we thought we had to offer at least these possibilities – including learning controlled drinking. At that time it was just us and one small group in the USA doing that.

There was almost no literature about controlled drinking at that time. There was only one book, which said that the

therapist should decide whether the client could choose controlled drinking or not. We followed these rules for six to nine months. One of the rules was about relapse - if the client relapsed he had shown he could not control his drinking, and therefore had to go into the abstinent group. In about September 1984 we had a client in the abstinent group who had relapsed three times in the previous six months. We thought that he had proved he could not live with abstinence, and therefore he was in the wrong group! So we dropped the idea of telling them which group to enter, and we just asked the clients to choose for themselves.

A few months later, in April 1985, I was the Head of the Department of Psychiatry, and I was called by the Director to discuss our results. The Director told me that over the past few months we had had 25% less occupation of the beds than same period last year. He asked me "What are you going to do?". It turned out that we had admitted the same number of alcoholics, but the relapse rate had fallen by 75%! So we were working with two main ideas at this point – looking for exceptions, and asking the client what they wanted and then helping them to achieve that. "How did you do it on the days you didn't drink or drank less?" was one of our most important questions.

Then in 1989 we discovered SF. Someone drew my attention to a book by Steve de Shazer, perhaps the second one (Clues – de Shazer, 1988), and he seemed to be thinking the same thing as we were. So I wrote to him and invited him to do a training, and we found great congruence in our work – so we decided that what we were doing was SFT. We had not been asking the Miracle Question or using scales up to that point, and we took that over from Steve. That's how the Bruges Model started and how we got onto the SF train.

Once you got onto the SF train, how did relationship with Steve de Shazer develop?

We invited him here every year, sometimes twice a year. He gave a two day workshop for us here in Belgium and in Paris, and we invited Insoo too. I was always with them at their workshops. Steve was always interested in what we were doing in Bruges – up to that point SFT had only been tested in an ambulatory setting (walk-in patients), and we were working with hospitalised clients. He was also interested in the fact that this was clearly a medical setting where people made diagnoses and gave drugs and so on, and SF also worked very well. At that point we were doing group therapy; there had been no application of SF to group therapy up to that time and we did that.

In the end, this led to publication of your work ...

I have always been a clinician, publishing my first book in French in 1989 when I was already 48. I had not been writing articles either, so I was very late in coming to writing. There was one publication (de Shazer and Isebaert, 2003) which was basically written by Steve. The real results will be published in the forthcoming important Oxford University Press book being assembled by Cynthia Franklin. I wrote a chapter on research into alcohol treatment. We get around 75%–80% success rates.

The results seem extraordinary...

They are very good but we are not the only ones. Bill Miller and the motivational therapy people get similar results – and their approach is similar to ours. They say you have to motivate people, we say you have to dig out the motivation that's already there – it's more of a tactical distinction than a real distinction. Those who still impose abstinence have results of 25-30%. Alcoholics Anonymous themselves say they have 15% (but they only count people who live in total

abstinence, so they are probably doing slightly better than that).

Your results seem so much better – why is this not taken up more widely?

In alcohol treatment there is still the moralistic idea that the alcoholic is doing something he should not do. It's a moralistic stain that is still there. You don't say to a depressed person 'you should not be depressed!' But if you are an alcoholic people still say 'Stop drinking!'. There is no other field in medicine where the evidence is treated with such compunction by the practitioners as alcohol abuse.

And you are still trying to get this idea out there...

In Flanders, the part of Belgium where I live, there is almost no alcohol clinic where at least some of our ideas have not been taken up. It's gaining ground in Holland too.

Let's come back to Steve de Shazer. When he died I asked around about who his real friends were. People said that he had few real friends, but you were one of them.

Yes, we were very good friends. Insoo said we were like two brothers! When we met I had left my first wife, and lived alone in a small house in Bruges. Steve used to come to Bruges and stay with me whenever he had time when he was in Europe. He had his room in the house for when he came over, and sometimes Insoo came too. He could be rather abrasive sometimes, bumptious, but I had no difficulty with that at all. Sometimes he was ill-mannered – he could be very short with people, but he was a very good-hearted person. When he was irritated he showed it, but he was a very kind-hearted person. So we never quarrelled. A regret I have is that at the end of his life we had moved to Oostende, and the house there was very badly insulated and I could not have

him to stay. I made up a room for him and offered it to him, but the toilet was outside in the cold! I also booked him into a hotel, and offered him the choice. He wasn't very pleased because he liked to be with me – he slept in the hotel but stayed the rest of the time at our house.

In my small house in Bruges we would sit there for the whole evening, by the stove, reading books, saying one sentence every 15 minutes or so, and that was a perfect evening for Steve. He hated being invited to restaurants by people when he did workshops because he had to make conversation. Also, we talked very little about therapy – mostly about music and beer!

What kind of music did he like?

Shostakovich was one of the composers we both liked very much, and Gustav Mahler. We discussed Shostakovich's chamber music a lot. And jazz – Steve would talk to me for half an hour about playing the saxophone and how to get three notes at the same time. I didn't understand half of what he was saying about that, but it was very interesting and I learned a lot.

I have an anecdote that Steve told me – when he was young he was not sure whether to choose music or sociology and family systems as a career. At that point he was an understudy in Duke Ellington's orchestra, rehearsing in place of the big soloists before recordings. He told me about an occasion when he was doing this when the guy he was replacing came in and sat there. Steve played the solo and Duke Ellington told the main player – "You hear the kid playing – you should play the same!"

What is the difference between the Milwaukee Model and the Bruges Model?

They are very similar – it's about applying it in different contexts. There are a few theoretical points - we developed this ontology of habits. We moved it a bit closer in thinking

to cognitive therapy. We had been using techniques based on Milton Erickson, and we kept on using them. Steve was more of a scientist than a therapist – he was concerned to use as few techniques as possible, which is a researcher's point of view rather than a clinician's. He didn't disapprove of what we were doing (just as he didn't disapprove of whatever Yvonne Dolan was doing) – he thought you didn't need it.

You have just been involved in setting up IASTI – tell us about it.

IASTI (International Alliance of Solution-Focused Teaching Institutes) resulted from a double conversation – Yvonne Dolan on one side, and Manfred Vogt and Heinrich Dreesen from NIK Bremen on the other side. We were talking about the fact that EBTA (European Brief Therapy Association) has been trying to set up guidelines for certification of training for SF therapists, and it has not really got going. In Holland, Spain, the USA and elsewhere there are people who say they are SF but they are not really – more like problem solving, but they give certifications in 'SF Therapy'. So at least SF is becoming a recognised label, people want to have it. And if we don't do something about certifying this, then someone else will.

So we thought it would be a good idea to create a small group of institutes – either the biggest or the most active in research and so on – internationally – and keep it small so we can move on faster. In a big group everybody has to agree, which slows progress, and in a small group it can move faster. The idea is that we can make a website similar to the SOLWorld ning site (www.solworld.org), where people can get together, post blogs, create groups and so on. Also we want to make criteria for certification of SF therapy training. So I have set up the IASTI website (www.iasti.org), and Michael Hjerth has just started the first propositions for the training certification. We invited BRIEF from London, but they wanted to make it a much bigger association immediately, and we didn't think that would function – we are an

alliance, not an association. After the initial setup is over, we will start inviting other people and institutes to be accredited. That's why we made it so small. It's not that we are excluding people – we wanted to include as few as possible to get things moving to start with.

Can you tell us who is involved?

The Korzybski Institute from Belgium, Michael Hjerth and Caroline Klingenstierna in Sweden, Peter Sundman and Taitoba and also Ben Furman from Finland, NIK in Germany, Mark Beyerbach in Salamanca, Spain, Yvonne Dolan and Terry Trepper in the USA, Michael Durrant in Australia and Debbie Hogan in Singapore.

What are you doing now that enhances the practice of SF therapy?

On the research side we are setting up a follow-up study of our ambulatory (out-patients) programme. I would love to do some research on depressed clients, but it's difficult to set that up now I am retired from the hospital. I am very interested in Matthias Varga and Insa Sparrer's work, as they use very sparing and novel techniques. On the other hand, I think with SF therapy, the conversational aspect of therapy, I don't see how we can get much better with that. There are other things developing alongside it – EMDR, meditation – which are interesting.

Thank you very much.

References

De Shazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.

De Shazer, S. and Isebaert, L. (2003). The Bruges Model: a solution-focused approach to problem drinking. *Journal of Family Psychotherapy*, *14*, 43–52