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Solution-Focused Counseling for Eating Disorders

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Eating disorders is a diagnostic classification in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) that includes severe disturbances in eating behavior.

In this article, solution-focused counseling (Guterman, 1996, 1998, 2006; Guterman & Leite, 2006; Guterman, Mecias, & Ainbinder, 2005; Rudes & Guterman, 2005) is presented as an effective treatment for eating disorders. Solution-focused counseling is a comprehensive clinical model that has been influenced by the pioneering work of Steve de Shazer (1985, 1988, 1991, 1994) and his colleagues (de Shazer et al., 1986; Molnar & de Shazer, 1987) at the Brief Family Therapy Center in Milwaukee, Wisconsin. We have found solution-focused counseling to be a fitting model for eating disorders because it is a strength-based approach that emphasizes clients' existing and potential resources. Solution-focused counseling offers an alternative to the prevailing problem-focused treatment approaches for eating disorders that might provoke resistance during the change process. In addition, this model is distinct from the solution-focused approach developed by de Shazer (1985, 1988, 1991, 1994) insofar as it incorporates features of primary importance to counseling, including a multicultural perspective and an eclectic approach (Guterman, 1996, 2006; Guterman & Leite, 2006; Guterman et al., 2005; Rudes & Guterman, 2005).

A limited number of solution-focused approaches for eating disorders have already been developed (e.g., Berg & Steiner, 2003; McFarland, 1995; O'Halloran, 1999). Berg and Steiner (2003) have described using solution-focused therapy for children with eating disorders. O'Halloran (1999) has described using a solution-focused approach for working with a family that included an adolescent with anorexia nervosa. Solution-

focused techniques for eating disorders have also been used in an art therapy model (Hinz, 2006) and a multi-modal prevention treatment program (Stice & Presenell, 2007). In addition, narrative therapy, an approach that is similar yet distinct from solution-focused models, has been applied to eating disorders (e.g., Brown, Weber, & Ali, 2008; Epston & Maisel, 2009; Maisel, Epston, & Borden, 2004). To date, however, no comprehensive solution-focused approach that incorporates important features of counseling (e.g., multiculturalism, eclecticism) is found in the literature.

Due to the relatively high prevalence of eating disorders, it is expected that most counselors will at some time encounter clients who suffer from these conditions. Accordingly, it is important for counselors to develop effective treatment strategies for eating disorders. The purpose of this article is to present solution-focused counseling as a valuable model for the treatment of eating disorders, and to illustrate how its principles can be applied to a variety of therapeutic interactions.

The organization of this article is as follows. First, various issues are described in relation to eating disorders, including etiology, comorbidity, and treatment. Next, the theory and practice of solution-focused counseling is described. Then, a case example that illustrates the application of solution-focused counseling to eating disorders is provided. Finally, implications and recommendations pertaining to the practice and research of solution-focused counseling in relation to eating disorders are discussed.

Eating Disorders

The *DSM-IV-TR (2000)* includes three distinct types of eating disorders: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified. The criteria for anorexia nervosa includes refusal to maintain 85% of expected body weight, intense fear of gaining weight or becoming fat, body image distortion, and amenorrhea in postmenarcheal females (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Bulimia nervosa is described as involving binge eating, recurrent compensatory behavior (e.g., self-induced vomiting, excessive exercise, misuse of medications), and self-evaluation that is excessively influenced by body shape and weight (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). The *DSM-IV-TR* (2000) also includes the diagnosis of eating disorder not otherwise specified for eating disorders that do not meet the criteria for anorexia nervosa or bulimia nervosa. Various conditions are included in the not otherwise specified category, such as recurrent binge eating without compensatory behavior, obesity, purging, and rumination (Machado, Machado, Gonçalves, & Hoek, 2007).

The lifetime prevalence of anorexia nervosa for women is approximately 0.5% (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). The lifetime prevalence of bulimia nervosa is between 1% and 3% of women (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Research suggests that for males these conditions occur at a rate of about one-tenth of those for females (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), although it has been suggested this is an underestimate because of the societal view that eating disorders occur mostly for women (Crosscope-Happel, Hutchins, Getz, & Hayes, 2000; Oliviarda, Pope, Boroweicki, & Cohane, 2004). Eating disorders often co-occur with other disorders, including anxiety disorders, mood disorders, substance-related disorders, and general medical conditions

(Carbaugh & Sias, 2010; Halmi, 2010). Anorexia nervosa has one of the highest mortality rates among mental health disorders due to related medical complications (Keel et al., 2003). Because of the high incidence of co-occurring problems, eating disorders present unique challenges for counselors that require effective interventions.

Some of the prevailing treatments for eating disorders are cognitive-behavioral (Fairburn, Cooper, & Shafran, 2003), feminist therapy (Carolan, Bak, Hoppe-Rooney, & Burns-Jager, 2010), interpersonal therapy (Tanofsky-Kraff & Wilfley, 2010), neurobiological approaches (Campbell, Mill, Uher, & Schmidt, 2011), and psychodynamic approaches (Ross, 2009). Different treatment approaches have been found to be effective for specific eating disorders and client populations (cf. Fairburn, 2008; Keel & Haedt, 2008; Safer, Telch, & Chen, 2009).

Environmental factors also significantly influence the development of eating disorders, including abuse and neglect (Steiger et al., 2010), peer pressure (Field et al., 2001), and social isolation (Esplen, Garfinkel, & Gallop, 2000). Multicultural factors have also been studied in relation to eating disorders. In particular, it has been suggested that western ideals in the mass media (e.g., perfectionism, thinness) often contribute to the development of eating disorders (Aubrey, 2006). Although eating disorders have been most commonly associated with individuals in Westernized countries, an increasing number of individuals from non-Western cultural backgrounds have also been found to develop this disorder (Cummins & Lehman, 2007). We suggest that solution-focused counseling, by virtue of its strength-based, multicultural, and eclectic approach, is well suited for eating disorders.

Solution-Focused Counseling

Solution-focused counseling is informed by a postmodern, social constructionist framework which holds that problem definitions are cocreated between clients and counselors (Guterman, 1994, 1996, 2006). In solution-focused counseling, a problem implies the existence of exceptions, that is, times when positive coping skills are applied or when the problem is solved. Solution-focused counseling presupposes that there are always exceptions (actual or potential) to a problem. In solution-focused counseling, a clinical problem is formally conceptualized as problem/exception. Solution-focused counseling typically involves five stages which can be applied in many different ways: (a) coconstructing problem definitions and corresponding goals, (b) identifying and amplifying exceptions to problems, (c) assigning tasks, (d) evaluating the effectiveness of tasks, and (e) reevaluating problems and goals (cf. de Castro & Guterman, 2008; Guterman, 1996, 2006; Guterman et al., 2005; Rudes & Guterman, 2005).

During the first stage, the client and counselor collaborate to coconstruct problem definitions and goals. Problem definitions are subsumed by the problem/exception conceptualization. For example, if a client were to define the problem as ineffective coping for anxiety, the problem would be conceptualized as ineffective coping for anxiety/effective coping for anxiety. The change process would involve identifying and amplifying times when the client coped effectively with anxiety. During the second stage, presuppositional questions are used to help clients identify exceptions. For example, the counselor asks, "*When* has there been a time when you coped better with the problem?" instead of "Has there been a time when you coped better with the problem?" The latter

question is a yes-or-no question that allows the client to completely disavow the occurrence of exceptions. The former question carries with it an expectation of exceptions, and encourages the client to re-evaluate their relationship to the problem. Exceptions are amplified by encouraging clients to do more of the behaviors that helped them cope successfully with the problem in the past, to observe times in the present when they are dealing better with the problem, and to ascribe significant and positive meaning to exceptions (de Shazer, 1994; Guterman, 1996, 2006).

If exceptions are identified, clients are helped through various questions to amplify exceptions. Examples of such questions are "How did you make that happen?" "What does this (i.e., the exception) say about you and your ability to solve the problem?" and "What are the possibilities?" If clients are unable to identify exceptions, counselors might encourage them to consider small, albeit positive changes that occurred. If clients still report that there have been no exceptions, then counselors attempt to identify potential exceptions. A question aimed at identifying potential exceptions might be "What will it be like when you are dealing better with the problem?" This question is derived from the crystal ball technique, a method that encourages clients to picture themselves at a higher level of functioning sometime during a hypothetical future (de Shazer, 1978). A similar technique, known as the miracle question, focuses the client's imagination on exceptions in the future: "Suppose that one night there is a miracle and while you are sleeping the problem that brought you into therapy is solved: How would you know? What would be different?" (de Shazer, 1988, p. 5).

During the third stage, tasks are assigned to build on progress made during the previous stages. This stage is aimed at clarifying and building on progress made during previous sessions, including defining problems, setting goals, and identifying and amplifying exceptions. The fourth stage involves evaluating the effectiveness of tasks. During this stage, counselors follow up on tasks given in the previous session. This may involve helping clients clarify the problem, goal, and identify and amplify exceptions derived from tasks that were given in the prior session. The fifth stage, re-evaluating problems and goals, involves clients and counselors examining how well therapeutic progress has matched the attainment of goals. At this stage, counseling is either continued or terminated. If the goals have been reached or clients have made significant progress toward the goals, then the counselor might ask the client if further counseling is needed at this time. Ideally, clients and counselors reach a consensual agreement about termination. If clients indicate further counseling is needed, then problems and goals are reconstructed. The contention that counseling is unfinished indicates that the goals have not yet been satisfactorily constructed or attained. Clients might indicate that a goal has been reached and that there is a new goal. In such cases, it is important to help clients re-examine and clarify the problems and goals. The plan of action might need to be more attainable, more specific, and/or more relevant to clients' problems.

A strategic approach to eclecticism in solution-focused counseling allows for the compatible, systematic, and effective use of diverse theories and techniques within our model (Guterman, 1996, 2006; Rudes & Guterman, 2005). Duncan, Parks, & Rusk (1990) have proposed a rationale for strategic eclecticism by suggesting that "should [a client's worldview] appear congruent with a particular theoretical orientation, the therapist may utilize that content to structure the intervention" (p. 572). Accordingly, if the theories and techniques from another model fit with a client's worldview or if the

client initiates such content, it may be used within the change process of solution-focused counseling (Guterman, 1996, 2006).

The process/content distinction has been used as a metatheoretical lens to describe strategic eclecticism within various models (Duncan et al., 1990; Held, 1984, 1992; Guterman, 1996, 2006; Guterman & Leite, 2006; Guterman et al., 2005; Rudes & Guterman, 2005). *Process* refers to what is done to bring about change (e.g., methods, interventions, and techniques). *Content* is defined as the object of change in any given clinical theory. Held (1992) has also defined two levels of content: formal content and informal content. *Formal content* refers to the counselor's assumptions about problem formation; that is, "explanatory concepts that must be addressed across cases to solve problems" (Held, 1992, p. 27). *Informal content* refers to the client's subjective views about the causes of problems (Held, 1992). The formal content in solution-focused counseling is problem/exception. Similar to other process-oriented models, this formal content is conceptualized in general terms. The problem is not elaborated beyond the model's problem/exception ascription. Instead, informal content is used as the principal metaphor in treatment. Because the formal content in solution-focused counseling is so general, it allows for the incorporation of formal contents of other models as informal contents that are, in turn, subsumed at the formal content level of solution-focused counseling (Guterman, 2006; Rudes & Guterman, 2005).

In solution-focused counseling, multiculturalism is broadly defined to address various domains, including age, ethnicity, family structure, gender, disability, race, sexual orientation, socioeconomic status, religion, and spirituality (Guterman, 2006). Solution-focused counseling stresses the importance of developing self-awareness, acquiring knowledge, and building skills relevant to clients' diverse cultural worldviews (Lee, 2001). It is also important for solution-focused counselors to gain an understanding of how the cultural worldviews of their clients influence the formulation of problems and solutions (Guterman, 2006). Accordingly, solution-focused counselors strive to learn the collective worldviews of diverse cultural groups and, also, the subjective perspectives of individuals within these groups. Further, solution-focused counselors recognize how their own worldviews influence clients and hence make efforts to do so in ways that contribute to cocreating constructive therapeutic dialogues.

In order to work sensitively and competently with clients from diverse cultural backgrounds, relational questions have been developed to identify and amplify exceptions (Berg & Miller, 1992). Questions such as "Who else in your life will notice when you are functioning better?" "What will they say?" and "If they were here right now, what might they say about the times when the problem is diminished?" can help move a client toward identifying and amplifying exceptions while simultaneously allowing the counselor to gain crucial information about the client's cultural frame of reference.

Solution-focused counseling speaks to Paul's (1967) suggestion that outcomes be evaluated in relation to how well they address the question of "what treatment by whom, is most effective for this individual, under what set of circumstances" (p. 117). The multicultural perspective and the strategic approach to eclecticism in solution-focused counseling allows counselors to tailor interventions based on the unique aspects of each client. Any informal content may be used or introduced to frame a problem and solution providing it fits with the client's worldview (Guterman & Leite, 2006; Rudes &

Guterman, 2005). Similar to how solution-focused counseling has been used for a variety of clinical problems, this model can be effectively applied to eating disorders. The following case illustrates the application of solution-focused counseling for clients with eating disorders.

Case Example

Lisa, a 27-year-old single Japanese American female, was self-referred for counseling. During the first session, extensive background information was obtained from the client. The client was a graduate student and worked part-time. She had lived with her parents and younger sister since the family moved from Japan to a medium-sized city in the United States. As Lisa began to make friends in the United States, she experienced increasing conflicts with her parents. It has been suggested that although there is a wide range of diversity within and between Asian groups, there are some values that many Asian groups often follow (Iwamasa, Hsia, & Hinton, 2006). Cultural values shared by many Asian groups include external locus of control, a collective rather than individualistic perspective, and traditional gender and family roles (Smart, 2010). As Lisa became exposed to the dominant culture in the United States, she began to display increasing autonomy. Her autonomy became a constant source of friction between Lisa and her parents.

Lisa reported that she experienced intense confusion about her cultural identity, and had begun to use eating as a way to cope with the stress generated by this uncertainty and her volatile home life. Lisa then began socializing with a circle of acculturated, Asian-American female friends that she met at the university. She participated with these friends in what the group referred to as "puke parties." On Friday evenings, the group would get together to watch movies while binging on food. Toward the end of the evening, each of them would make themselves vomit in front of the group. Lisa soon began to binge and purge on a regular basis when alone as a way to cope with her emotional distress. However, Lisa experienced feelings of guilt following these episodes that, in turn, exacerbated her shame. In particular, she expressed anxiety about the possibility of her parents learning that she was out of control.

On the basis of the presentation, the counselor determined that the client met the *DSM-IV-TR* (2000) criteria for bulimia nervosa. At the end of the first session, the counselor suggested to Lisa that she may be able to come up with alternative ways of coping with conflicts with her parents and herself. The client agreed and expressed motivation to explore ways to break the cycle of her binging and purging.

During the second session, Lisa elaborated that she was uncomfortable dealing with two conflicting cultural identities. She explained, “It’s like I’ve got a foot in two worlds, Japanese and American. I'm on shaky ground with both of them.” The client's understanding of the problem was formally conceptualized within solution-focused counseling’s problem/exception formal content as uncomfortable with cultural identity/comfortable with cultural identity. Toward the end of the second session, the counselor asked Lisa to imagine looking into a crystal ball to foresee what her life would look like when she felt more comfortable with her identity. Lisa stated, “I’d be laughing more when I’m with my American friends.” The counselor then asked Lisa to be “on the lookout” for additional exceptions to her problem.

During the third session, Lisa reported that she had identified two exceptions to her feelings of cultural confusion. Earlier in the week, Lisa received a high grade on a group presentation at the university. This achievement brought pride to both herself and her parents. Accordingly, Lisa and the counselor identified this academic achievement as an exception. Further, Lisa had befriended another Asian American student while working on a group project in another class. When asked what made spending time with her friend exceptional, Lisa explained, "He's really funny. He makes me laugh really easily. He doesn't have any expectations about who I should be like my parents or the girls do." To build on this exception, Lisa agreed to spend time with her new friend at least once before the next session. Lisa also expressed a willingness to be more mindful of additional exceptions.

Research has suggested that cognitive-behavioral interventions are consistent with some Asian cultural values because of its educational approach (Iwamasa et al., 2006). Accordingly, during the third session the counselor assessed that the formal content corresponding to rational emotive behavior therapy (REBT; Ellis, 2001), one of the most widely practiced cognitive-behavioral approaches, was a good fit with the client's worldview. In keeping with solution-focused counseling's strategic eclecticism, the formal content of REBT (i.e., irrational beliefs) was used as informal content for solution-focused counseling's problem/exception theory. The problem was re-conceptualized as irrational beliefs/rational beliefs. More specifically, the counselor helped Lisa identify and challenge irrational beliefs that occasioned her binging and purging as well as her feelings of identity confusion. The change process was organized around helping the client identify and amplify exceptions to irrational beliefs.

The client was particularly receptive to REBT's concept of unconditional self-acceptance (Ellis, 2001) and during the third session the counselor helped her identify and dispute irrational beliefs that occasioned her feelings of shame. At the end of the third session, the counselor suggested that Lisa obtain and read an REBT self-help book for eating disorders (Ellis, Abrams, & Dengelegi, 1992). Subsequent sessions were organized around reviewing the client's progress at using REBT techniques. Each instance in which the client was effective at using REBT techniques was considered an exception that was, in turn, amplified in keeping with the change process of solution-focused counseling. Lisa also reported that she began to feel more comfortable about possessing a dual cultural identity. She stated, "Before, I felt like both cultures were fighting over me. Now, I'm beginning to feel like there is room for me to function both as a Japanese woman and an American one." Although Lisa was still experiencing some confusion regarding her cultural identity, she reported feeling more accepting of herself despite these discrepancies.

During the fourth session, Lisa reported that she decided to break ties with her friends who engaged in binging and purging. By the fifth session, the client reported that she ceased binging and purging, started a healthy diet, and began to associate with a new circle of friends from the university. By the sixth session, the client reported that she seldom, if ever, felt ashamed about anything. She continued to have some conflicts with her parents as well as within herself, but she felt more prepared to deal with these. At the end of the sixth session, the client and counselor agreed that counseling was no longer necessary. A telephone follow-up with the client one year later revealed that Lisa

continued abstaining from binging and purging and was maintaining a healthy diet. She also reported that her relationship with her parents was significantly improved.

Concluding Remarks

Similar to how solution-focused counseling has been used for a variety of clinical problems, this approach can be effectively applied to eating disorders. In contrast to the prevailing problem-focused treatment approaches for eating disorders, solution-focused counseling emphasizes clients' resources and emphasizes a collaborative therapeutic relationship to enhance cooperation during the change process. In solution-focused counseling, it is crucial for counselors to gain an understanding of how the worldviews of clients influence problem and goal definitions. In the case example, a thorough assessment of the client's worldview and cultural background informed how the counselor conceptualized problems and tailored interventions.

It is especially important for solution-focused counselors to be prepared to develop innovative clinical strategies when working with clients with eating disorders. In particular, we suggest that counselors adopt eclectic strategies within solution-focused approaches to eating disorders. The strategic approach to eclecticism in solution-focused counseling allows for the use of divergent theories and techniques within the change process. An eclectic approach to solution-focused counseling also speaks to the importance of addressing the diversity of clients in a multicultural society. In the case example, although REBT's problem-focused is counter to a solution-focused approach, theories and techniques from REBT were used precisely because it was assessed to fit with the client's worldview.

It is suggested that future research be designed to assess outcome effectiveness related to solution-focused counseling applications to eating disorders. Such studies would contribute to establishing best practices in the area of solution-focused approaches to eating disorders and for solution-focused counseling in general. Finally, although we have described in this article a solution-focused approach specific to eating disorders, we have also effectively used this approach for related problems that are experienced by many clients, including addiction, anxiety, and perfectionism. Accordingly, we suggest that solution-focused counseling holds promise as an effective treatment for various clinical issues that are related to eating disorders and which fall along a continuum of severity and type.

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