

# PROBLEM SOLVING

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## JFK: We choose to go to the moon



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## Houston, We have a Problem!

- Problem-solving is a key intervention in multiple evidence-based therapies
- Deficits in problem-solving occur across diagnoses
- Goal: Review use of Problem-solving in therapies including PST, Motivational Interviewing, DBT, CBT, IPT, CRT and FBT
- Discuss Problem-solving approaches in specific cases including suicidal patients

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## History of Problem-solving

- Problem solving: complex mental process, solution evaluation, learning, goals
- Short and long term tasks or goals involve problem solving
- Early studies focused on behaviorism: what is observed directly, stimulus-response
- 1940s: Gestalt psychology shifted focus to identifying the structure of the problem
- 1960s: Cognitive psychotherapies: problem focused, practical, inner experience and external reality
- 1960s-70s: Problem solving therapy, developed as a stand alone therapy

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## Problem-solving in psychotherapy

- Problem solving is a focus of treatment for managing emotional and life problems in many therapy approaches including: PST, Motivational interviewing, DBT, CBT, IPT, FBT, CRT
- Problem solving is an intervention for behavior change connected to specific goals
- Based on findings of deficits in problem solving in many psychiatric conditions
- 4 different streams contributed including research on creativity, rise of a positive approach to clinical interventions, recognition of the importance of cognitive processes and self-control in behavior therapy, and Richard Lazarus' s relational model of stress (identifies negative cognitive appraisals and coping deficits as major causes of stress and stress related disorders)

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## Definitions

- Problem-solving: cognitive-behavioral process, self-directed, to increase probability of selecting the most effective solution from various alternatives
- Social problem solving: social refers to natural social environment, learning process
- Problem: situation or task demanding a response for adaptive functioning
- Solution: situation-specific coping response, the outcome of problem-solving(effectiveness)
- Problem-focused coping skills: involves strategies to change nature of situation and of the emotional response: skills to minimize distress
- Problem-solving coping: more general process of dealing with stressful situations

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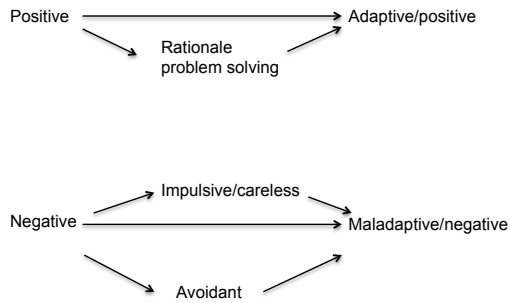
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## Social Problem-Solving Process



D' Zurilla, Nezu, 2007

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## Measures of Social Problem-Solving Ability

- Process and outcome measures
- Problem-Solving Inventory (PSI): appraisal
- Social Problem-Solving Inventory (SPSI), Revised (SPSI-R): orientation, skills, problem-solving style
- Means-Ends Problem-Solving Procedure (MEPS): thinking of steps, anticipating obstacles, time, process and outcome measure
- Others: Negative Problem Orientation Questionnaire, SPSI-Adolescents, Modified Problem-solving Inventory, Perceived Modes of Processing Inventory, Interpersonal Problem-Solving Assessment Technique, Adolescent Problems Inventory, Inventory of Decisions, Evaluations, and Actions, The Diabetes Problem-solving Self Scale Report

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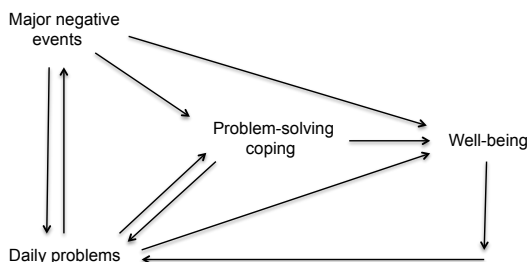
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## Relational/Problem-Solving Model of Stress and Well-Being



D' Zurilla, Nezu, 2007

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## PST Goals

- Increase positive problem orientation
- Reduce negative problem orientation
- Improve rational problem-solving (effective problem-solving skills)
- Reduce impulsive-careless problem solving
- Prevent avoidance of problem solving
- Improve solution implementation skills

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## ADAPT

- A: Attitude Before attempting to solve the problem, adopt positive attitude toward problem and own problem-solving ability
- D: Define problem, obstacles, specify realistic goal
- A: Alternatives. Find a variety
- P: Predict both positive and negative consequences of each alternative
- T: Try out the solution in real life and monitor its effects. If effective, self-reinforce. If not, back to step A

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## Negative Problem Orientation

- Blame self for causing problem (“stupid, bad”)
- Perceive problem as a significant threat to well-being that should be avoided or attacked immediately without any plan. Minimize positive benefits of solving problem and exaggerate harm or loss from failure to solve problem
- Low expectations of coping with problem effectively
- Believe a competent person should be able to solve problem quickly without much effort. Failure=incompetence

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## Positive Problem Orientation

- Perceive problems as normal, ordinary, inevitable events in life, not necessarily indicting something wrong with themselves. See transient personal factors rather than attributing global stable personal defects
- Problem = challenge or opportunity for personal growth or self-improvement
- Believe there is a solution and that they are capable of finding it on their own
- Realize that solving problem may take time and effort, resist urge to respond impulsively, persist, think, accept

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## Understanding nature of the problem

- Correcting distortions or misconceptions that may interfere with accurate definition of problem
- Identifying why a given situation is a problem: what present conditions are unacceptable (what is), what changes or additions are demanded or desired (what should be).
- Common distortions that impede accurate definition: Arbitrary inference, Selective Abstraction, Overgeneralization, Magnification or Minimization, Misattribution

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## Problem-Solving Training Manual Solving Life's Problems

- 13 Modules including assessment, obstacles, orientation, alternative solutions, decision making, solution implementation and verification, guided practice, rapid problem solving, communication and interpersonal problem solving
- Behavioral Marital Therapy and Integrated Couples Therapy: Principles and strategies for collaborative problem orientation, communication ground rules, conflict resolution training, promoting acceptance and tolerance

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## Problem-Solving Therapy

- Problem-solving therapy (PST) teaches how to find solutions for problems: interpersonal conflicts or the pursuit of goals.
- Best results when treatment includes problem orientation/ addresses taking a positive attitude in approaching problems
- Short term: 4-16 sessions, multiple formats
- 3 types of problem-solving therapy: social problem-solving therapy, problem-solving for primary care settings, and self-examination problem-solving therapy, which focuses on major goals, evaluating and solving problems that are blocking goals, with acceptance of uncontrollable problems.

Cuijpers, van Straten, and Warmerdam (2007)

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## PST in medical conditions

- Diabetes
- Post-Stroke
- Geriatrics
- Stress reduction in Breast Cancer
- Treatment of Depression in Primary Care

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## Steps of Problem-solving in PST

1. Identify problem
2. Generate multiple alternative solutions
3. Selecting the best solution from the alternatives
4. Develop a plan
5. Implement the problem solving tactic
6. Evaluating the efficacy of problem solving

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## Deficits in Problem-solving: Depressive Disorders

- Deficit in social problem solving has been described as core feature
- Means-end problem-solving test (MEPS): patients presented with social problem situations with a defined beginning and end. Task is to develop a strategy (means) that would lead to the presented end.
- Depressed subjects produced less effective solutions than controls
- Marx EM, Williams JM, Claridge GC, 1992

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## Deficits in Problem-solving: Depressive Disorders

- Deficits in problem-solving at baseline associated with worse prognosis at 3 and 6 month follow-up in patients treated with medication alone (Garland et al., 2000)
- Research with children and adolescents indicates that deficits in problem-solving are associated with increased risk for depression and suicidality

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## Deficits in Problem-solving: Depressive Disorders

- Treatment for Adolescents with Depression Study (TADS)
    - Avoidant problem-solving style predicts depression severity and suicidality
    - Impulsiveness/carelessness problem-solving predicts suicidal ideation
- Becker-Weidman et al., 2010

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## Deficits in Problem-solving: Anxiety Disorders

- Subjects with various anxiety disorders also showed deficits on MEPS
- Ineffective problem solvers report more anxiety than effective problem solvers
- Problem-solving as a mediator between negative life events and anxiety

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## Deficits in Problem-solving: Eating Disorders

- Cognitive inflexibility (poor set shifting): primarily studied in AN but present across eating disorder diagnoses
- Set shifting involves the ability to move flexibly back and forth between tasks and allows for the adaptation of behavior in response to changing demands within the environment.
- Cognitive inflexibility manifests as concrete and rigid approaches to problem solving and rule-bound behaviors.
- Problems with set shifting may be a risk factor for eating disorders.

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## Deficits in Problem-solving: Eating Disorders

- Weak central coherence is a prominent cognitive feature in anorexia nervosa
- Central coherence: natural tendency to process incoming information in context, integrating features to derive a gestalt.
- Weak central coherence: information is fragmented as opposed to integrated. Processing occurs at the level of detail as opposed to the whole.
- Difficulty seeing the forest for the trees.

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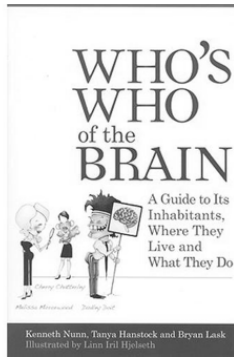
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## The Brain

- Who's Who of the Brain by Nunn, Hanstock and Lask
- Goal-oriented behavior is the key function of the frontal lobes: reconciling internal emotional states with external demands
- Orbitofrontal cortex connected to the temporal lobes and amygdala via the uncinate fasciculus, and to speech centers, cingulate gyrus

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## Cognitive Remediation Therapy in AN

- Neuroimaging suggests primary dysfunction in regions critical for information processing
- Neuropsychological testing, such as the Ravello Profile (Davies et al, 2011), shows common and significant cognitive deficits:
  - Visual-spatial information processing & memory
  - Set-shifting (cognitive flexibility & inhibition)
  - Planning & Prioritizing
  - Central Coherence
- CRT aims to remedy the underlying neurocognitive deficits, in a similar way to its use in brain injury (Samuel et al, 2008), schizophrenia (Wykes et al, 2007) and dyslexia (Broom et al, 1995). Lask 2011

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## CRT in AN

- Toolkit versus manual, typically 10 sessions, individual, group or family formats
- Goal is to think about thinking, (metacognition) increase flexibility
- CRT Guided questions, collaborative discussion during puzzles, games, optical illusions, story problems, central coherence and set-shifting tasks

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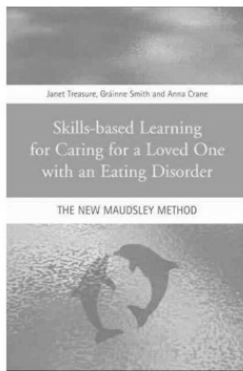
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## Problem-solving in Motivational Interviewing

- Directive, patient-centered technique that includes focused reflective listening and development of discrepancy, with gentle negotiation in which that patient identifies benefits and costs
- Collaborative process to tackle the problem together

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## Problem-Solving in Motivational Interviewing

- Increase the importance of change
- Increase confidence in change
- Balance of acceptance and drive for change
- Confrontation associated with higher levels of resistance
- Patient-centered approach reduced opposition
- <http://www.motivationalinterview.org>

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## Problem-solving in Motivational Interviewing

- Basic principle: people hold a range of representations about their problematic behavior and symptoms.
- Readiness to change depends upon importance/conviction and confidence/self-efficacy
- Problem-solving in Motivational Interviewing helps patient put into words these dimensions

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## Problem-solving in Motivational Interviewing

- Key interventions focus on the process of change
- Training with supervision and practice improves adherence
- Even with intensive training, therapists differ in outcomes
- Strong predictors of effectiveness: empathy of the therapist, ability of the therapist to shift flexibly between acceptance and change, and to communicate belief in patient's ability and judgment, with respect for the patient and potential for goodness

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## Problem-solving in Motivational Interviewing

- Motivational interviewing developed separately from the model of stages of change by Prochaska
- Motivational interviewing is helpful for people in the early stages of change and focuses on resistance
- Views resistance to change as connected to the conceptualization of the problem or with the patient-therapist relationship, resulting in feelings of being coerced and oppositional responses

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## THE PROS AND CONS OF CHANGE

Reasons to stay as I am:                      Reasons to change:  
-If I change...  
-If I change people will think that...

### Looking ahead 5 Years

Reasons to stay as I am:                      Reasons to change:  
-If I change...  
-If I change people will think that...

Conclusions:  
I want to...(specific goal) because...

“Taking the Plunge”

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## Stages of Change

1. Pre-contemplation: not ready to think about change seriously
2. Contemplation: ready to think about change
3. Determination: preparing to make plans for change
4. Action: implementing change
5. Maintenance: ensuring the change becomes habitual

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## Motivational Strategies in Eating Disorders

- Carer Model Goals: reduce stress and expressed emotion (criticism, hostility, emotional over-involvement)
- Broaching the subject: acceptance, preparation, scripting
- Finding the correct balance of direction and emotion: dolphin and St. Bernard
- Communication skills: motivational interviewing
- ABC functional analysis

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## The Problem of Suicide

- Working With Suicidal Patients: What's New and Why It's Important
- Thomas E. Ellis, PsyD, ABPP
- The Menninger Clinic
- Baylor College of Medicine
- 2011 Texas Suicide Prevention Symposium June 16, 2011

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## The Problem of Suicide

- Close to 1 million suicide deaths worldwide per year (more than homicide and war combined)
- More than 30,000 deaths per year in U.S. (3 per hour)
- 11<sup>th</sup> leading cause of death in U.S.
- 50% more suicide deaths than homicides
- 50% more suicide deaths than AIDS
- Approx. 1.1 million suicide attempts/yr in U.S. (2 per minute; SAMHSA, 2009)

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## Suicide Risk

- Suicide is associated with psychiatric disorder in at least 90% of cases.
- About half of people who die by suicide are in treatment.
- SMR (Standardized Mortality Ratio) for Psychiatric Disorders

Major depression	20
Anorexia nervosa	23
Schizophrenia	9
Anxiety disorder	8
Prior suicide attempt	38.4

Harris & Barraclough (1997)

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## Warning Signs

- Severe anxiety
- Panic attacks
- Global insomnia
- Alcohol abuse (moderate-recent onset)
- Agitation
- Severe anhedonia, social withdrawal
- Having a plan

Fawcett, J. et al. (1990). *American Journal of Psychiatry*. Vol 147(9), 1189-1194.

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## American Association of Suicidology

- Know the Warning Signs
- **How do you Remember the Warning Signs of Suicide?**
- Here's and Easy-to-Remember Mnemonic:  
**IS PATH WARM?**
  - I** : Ideation
  - S** : Substance Abuse
  - P** : Purposelessness
  - A** : Anxiety
  - T** : Trapped
  - H** : Hopelessness
  - W** : Withdrawal
  - A** : Anger
  - R** : Recklessness
  - M** : Mood Changes

<http://www.suicidology.org/web/guest/stats-and-tools/warning-signs>

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## Empirically Supported Interventions for Suicidal Patients

- Problem-solving Training
  - Dialectical Behavior Therapy (DBT)
  - Rudd and Joiner's CBT
  - Beck's Cognitive Therapy for Suicidality
  - Mentalization-based Therapy
  - Collaborative Assessment and Management of Suicidality (CAMS)
- From Ellis, 2010

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## No-Suicide Contracts?

- The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative
  - M. David Rudd, *Baylor University*, Michael Mandrusiak, *Baylor University*, Thomas E. Joiner Jr, *Florida State University*....
  - Our primary conclusion is that no-suicide contracts **suffer from a broad range of conceptual, practical, and empirical problems**. Most significantly, they have **no empirical support for their effectiveness** in the clinical environment. The authors [recommend] the commitment to treatment statement as a practice alternative to the no-suicide contract.
- Journal of Clinical Psychology* 62: 243–251, 2006.

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## Menninger Safety Plan

### Safety Plan Form

#### A. Warning signs that problems may be developing:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

#### B. Things I can do on my own to cope:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

#### C. Ways I can reach out for help:

People who can help distract me: 1. \_\_\_\_\_ 2. \_\_\_\_\_

People I can ask for help: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Professionals I can ask for help:

Therapist Name \_\_\_\_\_ Phone # \_\_\_\_\_ Pager # or

Emergency Contact # \_\_\_\_\_

Other Professional Name \_\_\_\_\_ Phone # \_\_\_\_\_ Pager # or

Emergency Contact # \_\_\_\_\_

National Suicide Hotline (free 24/7): (800) 273-TALK Hospital ER \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

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## Management of Acute Suicidal Behavior: DBT

1. Assess Imminent Risk of Suicide or Self-inflicted injury
2. Explore the Problem Now
3. Focus on Problem Solving of Immediate Situation; address immediate environmental high risk factors (reduce avail of lethal means, ...) address immediate behavioral high risk factors including affect
4. Reinforce progress; extinguish suicidal responses

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## Management of Acute Suicidal Behavior : DBT

5. Trouble shoot. Identify Factors Interfering with Productive Plans of Action
6. Commit to a Plan of Action
7. Anticipate (and Plan for) a Recurrence of the Crisis Response
8. Re-assess Suicide Risk

Linehan, for educational use, 2000-2007, Behavioral Tech, LLC  
[www.behavioraltech.org](http://www.behavioraltech.org)

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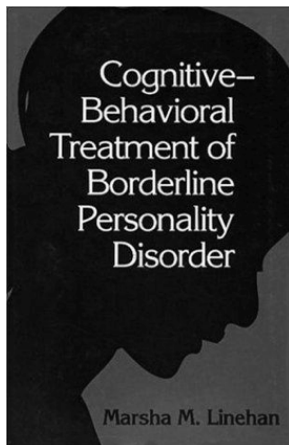
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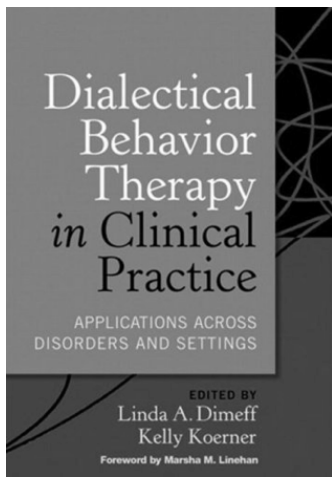
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### DBT: Options for Responding to Any Problem

- Solve the problem: leave, get out of the situation for good, change the situation
- Feel better about the problem: regulate your emotional response to the problem
- Tolerate the problem: Accept and tolerate both the problem and your response to the problem
- Stay Miserable

2005 Linehan, Behavioral Tech, LLC

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### DBT : as Problem Solving

- Behavioral principles and assessments to determine controlling variables for problematic behaviors, develop goals and agreements
- Standard CBT interventions: self monitoring, behavioral and solution analysis, didactic and orienting strategies, contingency management, cognitive restructuring, skills training, exposure procedures
- Micro-orienting due to emotional arousal which may interfere with information processing and collaboration

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## DBT as Problem-Solving

- Collaborative identification of problem behaviors and alternative responses, focusing on emotions
- Behavior chain: analyzing chain of events moment to moment
- Absence of adaptive behavior linked to one of 4 factors in change procedures: skills training, exposure procedures, contingency management, cognitive restructuring, with emphasis on trouble shooting because of generalization with mood dependent behaviors
- Validation strategies, dialectics to emphasize flexibility and balance

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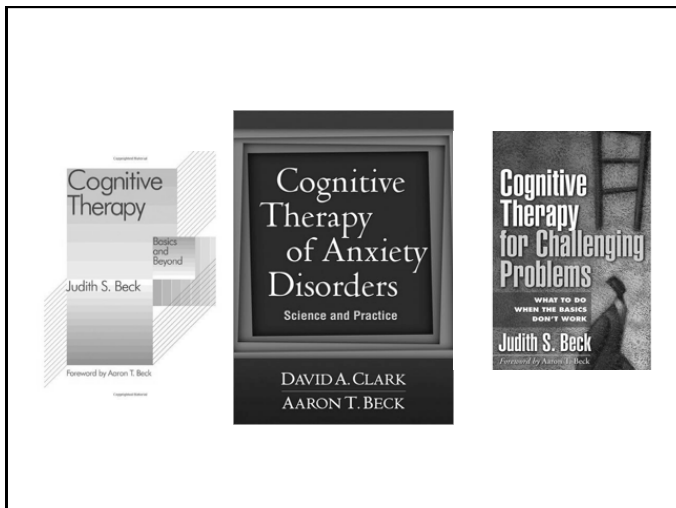
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## Cognitive Model of Depression

- Developed by Aaron T. Beck in the 1960s as a structured short-term, present-oriented psychotherapy for depression
- In depression, dysfunctional thoughts about self, world and the future, with helpless, unlovable, or worthless core beliefs
- Directed toward solving current problems, modifying dysfunctional thinking and behavior
- Extensively tested with meta-analyses since the 1980s, extended to multiple disorders, 100s of outcome studies

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## Problem-solving in CBT

- Therapist creates a problem list, and translates these into positive goals
- Encourages patient to add problems to the agenda in each session
- Encourages patient to do active problem-solving.
- If patient lacks skills, therapist gives direct instruction: 1. specify problem, 2. devise solutions, 3. select solution, 4. implement it, 5. evaluate it's effectiveness.
- Help test dysfunctional beliefs that impede problem-solving
- Therapist teaches advantages-disadvantages analysis for problems with decision-making

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## Steps in CBT for Anxiety

1. Recognize automatic thoughts when feeling anxious
2. Record to challenge and increase tolerance
3. Develop strategies to test thoughts and beliefs
4. Discuss results of test
5. Role playing

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## Problem Solving Worksheet from CBT (modified version of Dysfunctional Thought Record)

1. Problem
2. Special meaning: Automatic thoughts and beliefs
3. Response to special meaning
4. Possible solution(s)

Judith Beck, 1993

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## Transdiagnostic Cognitive Model of Anxiety

- Centers on the idea of vulnerability
- Heightened appraisals of threat and helplessness
- Overestimates, secondary elaborative reappraisal, amplification, misinterpretations
- Inhibitory processing of safety information
- Impaired constructive or reflective thinking
- Automatic processing, Avoidance
- Self-perpetuating via heightened self focused attention
- Cognitive primacy: generalizes and mobilizes defenses
- Cognitive vulnerability to anxiety

Clark and Beck, 2010

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## Faulty Appraisals: Content Specificity Hypothesis

Specific Negative Interpretations of Anxiety Associated with Each of the Anxiety Disorders

<b>Anxiety Disorder</b>	<b>Focus of neg. interpretation</b>
□ Panic Disorder	arousal, specific body sensations
□ GAD	subjective experience of worry (worry about worry)
□ Social Phobia	somatic and behav indicators of anxiety in a social situation
□ OCD	anxiety with unwanted thought, impulse or image
□ PTSD	specific arousal with trauma related mental intrusions

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## Recommended structure of initial session in CBT

- Setting the agenda (and providing rationale)
- Mood check, including objective scores
- Briefly review presenting problem and obtain update
- Identify problems and set goals.
- Educate patient about the cognitive model
- Eliciting the patient's expectations for therapy
- Educating the patient about her disorder
- Setting homework
- Providing a summary
- Eliciting feedback

Modified if patient is hopeless or suicidal: crisis intervention takes precedence if danger to self or others.

Emphasis on empathy and establishing collaboration and trust.

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## Coping Cat: Problem Solving Skills

1. Define the problem: What is the anxious situation?
2. Explore potential alternative solutions (be careful not to evaluate yet!): What might someone do to make this situation less fearful?
3. Evaluate the potential alternative solutions: Which solutions are feasible alternatives? Do any NOT make sense or are any NOT feasible?
4. Select the preferred alternative

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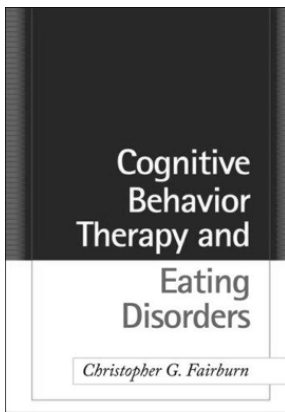
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## 7 PROBLEM-SOLVING STEPS

- Step 1: Identify the problem as early as possible
- Step 2: Specify the problem accurately
- Step 3: Consider as many solutions as possible
- Step 4: Think through the pros and cons of each solution
- Step 5: Choose the best solution or combination of solutions
- Step 6: Act on the solution
- Step 7: Evaluate the process of problem-solving

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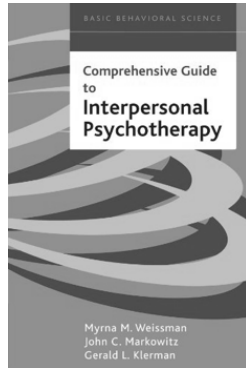
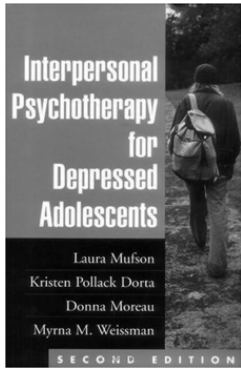
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## Problem-solving in IPT

- IPT was first developed as a time-limited treatment for depression by Klerman and Weissman, with manual in 1984
- Numerous controlled clinical trials support efficacy, and it has been modified for other conditions
- Focus is on finding ways of problem-solving the current interpersonal problems and how these problems impact mood

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## Interpersonal Therapy

- Focus is on the interpersonal context, approaching depression as a clinical disorder
- Assigning the sick role
- Interpersonal inventory of current relationships
- Defining problem in one of 4 key areas: interpersonal role disputes, interpersonal role transitions, grief (complicated bereavement), interpersonal deficits

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## Techniques in IPT

- Exploratory techniques, encouragement of affect, clarification
- Communication analysis involving detailed reconstructions of interpersonal events to identify problems and communication failures
- Common communication problems: ambiguous indirect, non-verbal communication as a substitute for direct, incorrect assumptions of understanding, unnecessarily indirect verbal communications, silence-closing off communications

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## IPT Behavior Change Techniques

- Directive techniques: used sparingly
- Decision analysis: the major action-oriented technique of IPT, explicitly taught for use outside of treatment, and follows communication analysis. Involves helping patient to recognize a broader, less self-defeating range of options, evaluate consequences, and insist that action is held off until each option is adequately explored
- Role playing to facilitate behavior change

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## Problem-solving in FBT

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## TEACHING PROTOCOLS FOR FAMILIES OR GROUPS

- Five Options for Solving Problems
- Combating Self-Criticism
- Seven Steps of Problem Solving
- Pros and Cons of Change
- STOP Technique
- Fairburn Emotion Regulation

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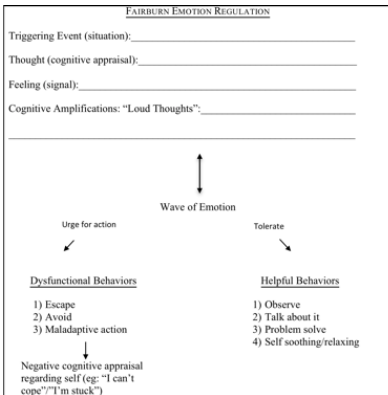
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## Cognitive Model




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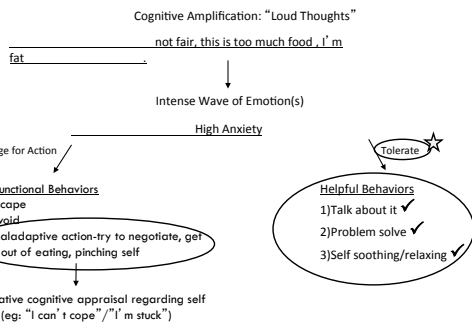
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## FAIRBURN EMOTION REGULATION GROUP EXERCISE

Triggering Event: felt full and found myself comparing my body to someone else's  
 Thought: this might be eating disorder thinking  
 Feeling: scared




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## GROUP EXERCISE

Skit 3: Adolescents sitting in a circle during a snack, comparing what was being eaten and their body sizes.

### Positive Thoughts

- You did the right thing
- You will get home sooner
- You'll be with friends sooner
- You are much stronger
- This is your ED thinking
- You're beautiful
- The tallies are made for you exactly
- You are getting healthy
- You need the nutrition
- Just walk away
- Don't compare, you are better than that

### Negative Thoughts

- You should take replacement
- You need to exercise
- You're fat
- You had way too much to eat
- The others had more choice
- Everyone else gets to stay thin
- Don't eat at your next meal
- You will never be good enough

Conclusions: It's helpful for parents to validate how you are feeling and to remind you that there is something fun to do afterwards.

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## Problem-solving Stance

- De-centered
- Intellectually curious, intellectually generous

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## STOP TECHNIQUE

- S-** I'm starting to feel scared
- T-** I'm having the thought that ...
- O-** Some other thoughts or behaviors to stay on track
- P-** Praise self for coping

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# COMBATING SELF-CRITICISM

\*Fennell, M: *Overcoming Low Self-Esteem*

## What is the evidence?

- Am I confusing a thought with a fact?
- What is the evidence in favor of what I think about myself?
- What is the evidence against what I think about myself?

## What alternative perspectives are there?

- Am I assuming my perspective is the only one possible?
- What evidence do I have to support alternative perspectives?

## What is the effect of thinking the way I do about myself?

- Are these self-critical thoughts helpful to me, or at they getting in my way?
- What perspective might be more helpful to me?

## What are the biases in my thinking about myself?

- Am I jumping to conclusions?
- Am I using a double standard?
- Am I thinking in all-or-nothing terms?
- Am I condemning myself as a total person on the basis of a single event?
- Am I concentrating on my weaknesses and forgetting my strengths?
- Am I blaming myself for things which are not really my fault?
- Am I expecting myself to be perfect?

## What can I do?

- How can I put a new, kinder perspective into practice?
- Is there anything I need to do to change the situation? Even if not, what can I do to change my own thinking about it in the future?
- How can I experiment with acting in a less self-defeating way?

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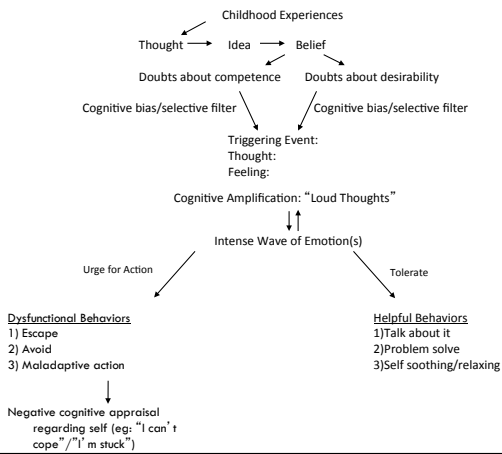
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## Expanded Cognitive Model



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# Questions?

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