Stop & Think!

Problem solving therapy for people with personality difficulties

Mary McMurran PhD
University of Nottingham

Version: May 2009

Contents

Section

About This Manual

This manual is for use only by those who have received ***Stop & Think!*** training. It should not be altered, copied, or electronically distributed.

Acknowledgement

Thanks are owed to Stephen Coupe, Consultant Clinical Psychologist, who has co-facilitated many ***Stop & Think!*** training courses. In the course of this joint training, Steve has helped clarify many issues and made a significant contribution to the development of this treatment manual.

Section 1.

Introduction

Stop & think! is a form of social problem solving therapy that may be used with people with personality difficulties to help them improve their social functioning. Based upon the work of North American psychologists Thomas D'Zurilla, Arthur M. Nezu, and Christine Maguth Nezu, my colleagues and I have developed ***Stop & think!*** in the UK for people with personality disorders or difficulties. Here, ***Stop & think!*** is presented as an intervention for people with personality difficulties; that is, they may or may not have a formal personality disorder diagnosis. The purpose of this manual is to describe the rationale for using social problem solving therapy with people with personality difficulties, including evidence for the effectiveness of ***Stop & think!***, and then to describe the principles of ***Stop & think!*** practice.

The essential purpose of ***Stop & think!*** is to teach participants a method for solving problems that, once learned, they can use independently. ***Stop & think!*** does this by working on people's current concerns. People's current concerns are 'hot' topics, and working towards a solution has real meaning in the here and now. If ***Stop & think!*** proves effective in ameliorating current problems, then not only has a real problem been addressed, but the effectiveness of the ***Stop & think!*** approach to solving problems has been demonstrated to the participant. This should encourage the participant to try ***Stop & think!*** with other problems he or she is facing. ***Stop & think!*** is therefore designed not only to help people tackle problems that they are currently experiencing, but also to help them practise and assimilate the skills of problem solving so that they can use these independently, without professional help.

The ***Stop & think!*** manual is less highly structured than some other treatment manuals; it does not describe a series of discussions, exercises, and role-plays that make up a session. Because the programme works on people's current concerns rather than tackling problems in the abstract, the programme uses a semi-structured approach. There is a prescribed sequence, but within this there is considerable latitude regarding how facilitators might respond to participants' problems. Because of this, facilitators need to be both experienced professionals and adequately trained to implement ***Stop & think!***

Supervision and support are also highly important with ***Stop & think!*** As with all interventions addressing people's problems, the professional approach is to have regular

supervision and support to permit reflection on what is happening in sessions and to address any problems that may be arising. The less structured approach of ***Stop & think!*** makes supervision and support all the more relevant to prevent programme drift and to deal with any practitioner anxieties. This has been taken into account in the development of training for ***Stop & think!*** facilitators, where there is an expectation that supervision is provided to enable staff skill competencies evidenced during training to be developed further as their experience of delivery extends.

Section 2.

Personality disorder and personality difficulties

Personality disorder is defined in the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* as 'an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment' (p. 629). The personality disorders and their key characteristics are listed in Table 1.

Table 1.

Personality disorders

Personality disorder	Key characteristics
Cluster A	
Paranoid	Distrust, suspiciousness
Schizoid	Socially and emotionally detached
Schizotypal	Unusual perceptions, odd beliefs, socially anxious
Cluster B	
Antisocial	Disregards the rights of others
Borderline	Unstable mood, relationships, and self-image
Histrionic	Excessively emotional, attention-seeking
Narcissistic	Grandiose, lacks empathy, needs admiration
Cluster C	
Avoidant	Socially inhibited, feels inadequate, oversensitive
Dependent	Clinging, submissive
Obsessive-compulsive	Perfectionist, inflexible

In psychiatric diagnostic systems, if these features are present to a certain degree, then a personality disorder diagnosis may be made. However, this diagnostic cut-off point is

somewhat arbitrary and often excludes people who have difficulties. Instead of diagnostic cut-offs, personality difficulties can be looked at as existing on a continuum, where the problems are experienced by the person concerned, or others in his or her social world, to a greater or lesser degree. So, personality difficulties would be said to exist where a person has 'a history of emotional problems and problematic behaviour that leads to distress, difficulties in relating to other people, and poor social functioning'.

How might someone with personality difficulties that could benefit from ***Stop & think!*** present him- or herself? Some examples are presented in Box 1.

Box 1. Examples of how people with personality difficulties may present themselves

¤ When criticised or challenged, they may lose their temper quickly, even to the point of violence. Your point of view will be dismissed as worthless.

¤ They will say they want to change antisocial ways, settle down, and lead a trouble-free life. However, they show a lack of depth and persistence at working towards new life goals and become easily frustrated when things don't go their way. This can lead to repeated relapses to behaviours that either express or blot out the frustration (e.g., substance use, aggression).

¤ A passive approach to life's problems may be evident. They may seem to take advice about tackling their problems, but when encouraged to become independent they are likely to react in ways that show they still have serious problems. This may include self-harm, substance use, and threatening harm to others.

Section 3.

Social problem solving

Definitions

What is social problem solving? Social problem solving is: "*the self-directed cognitive-affective-behavioral process by which an individual attempts to identify or discover solutions to specific problems encountered in everyday living"* (D'Zurilla & Nezu, 2007, p. 11). Social problem solving involves thoughts, feelings and behaviour.

What is an effective solution? An effective solution is: *"one that achieves the problem-solving goal (i.e., changes the situation for the better and/or reduces the distress that it produces), while at the same time maximizing other positive consequences and minimizing negative consequences .. to others as well as oneself"* (D'Zurilla & Nezu, 2007, p. 13). Thus, a solution that disregards the welfare of other people is not an *effective* solution.

Good problem-solving skills consist of the ability to recognise problems when they arise, define the problem clearly, set goals for change, produce a diversity of possible solutions, anticipate outcomes, devise effective actions plans that have stepwise stages, and carry out those action plans to solve problems effectively.

Theoretical roots

Social problem solving therapy has its roots in a stress-coping model (Lazarus & Folkman, 1984). In this model, stressors are seen as part of everyday life. The level of an individual's stress response (i.e., psychological and even physical distress) is determined not only by the seriousness of the stressor but also by how the individual appraises the stressor and the skills the individual possess to enable him or her to cope with the stressor. So, an everyday problem, such as a car breakdown, will affect people differently depending on how they *appraise* the problem and how they are able to *cope with* the problem. Consider how people with personality problems might appraise a car breakdown: Someone tampered with it (paranoid); I can't cope with it (dependent); The damned car is a useless piece of tin (antisocial). Also consider how a person's abilities to cope impact upon the stress response. Coping depends in part upon the individual's ***social competence***, that is the ability to interact effectively with others. Social competence is a personal resource that protects against

psychological distress. In the car breakdown example, a socially competent person will be able to summon and ask for help effectively.

There is no doubt that a person's physical capital, human capital, and social capital also play a part in determining the stress response. For instance, a person who can afford to be a member of a breakdown service (physical capital), or who knows how to fix cars (human capital), or has a friend who is a mechanic (social capital) is likely to be less stressed by a car breakdown. However, here we focus on social problem solving as it contributes to social competence.

Is poor social problem solving associated with personality disorders?

Poor problem-solving skills are associated with a range of psychological and behavioural problems, including anxiety and depression (Cassidy & Long, 1996; Kant & D'Zurilla, 1997), substance abuse (Herrick & Elliott, 2001), and hostility and aggression (Keltikangas-Järvinen & Pakaslahti, 1999; Matthys, Cuperus, & van Engeland, 1999). These are common problems amongst people with personality problems.

Poor social problem-solving is also associated with personality disorders. We have used the Social Problem Solving Inventory – Revised (SPSI-R; D'Zurilla, Nezu, & Maydeu-Olivares, 2002 – see Section 4 for more details) to compare the problem solving abilities of personality disordered adults, personality disordered offenders, prisoners and mature students (Hayward, McMurran, & Sellen, 2008; Huband, McMurran, Evans, & Duggan, 2007; McMurran, Blair, & Egan, 2002; McMurran, Egan, Blair, & Richardson, 2001). The data presented in Table 2 show that people with personality disorders are more negative, impulsive, and avoidant and less rational in their approach to problems compared with better functioning groups. Herrick and Elliott (2001) found poor problem solving in personality disordered substance abusers, especially in Cluster A, the so-called 'eccentric' personality disorders (i.e., paranoid, schizoid, and schizotypal) and Cluster C, the 'anxious' personality disorders (avoidant, dependent and obsessive-compulsive). Furthermore, vulnerable prisoners are poor at social problem solving (Hayward et al., 2008) and poor social problem solving has been shown to be associated with distress and depression in people detained in a secure setting (Biggam & Power, 1999a,b).

Table 2.

Mean scores and standard deviations on the Social Problem Solving Inventory-Revised for UK male samples

SPSI-R	Personality disordered offenders (N=72)	Personality disordered community adults (N=80)	Vulnerable prisoners on special location (N=68)	Prisoners on normal location (N=47)	Mature students (N=70)
Positive Problem Orientation	9.29 (4.63)	6.36 (4.38)	10.30 (5.43)	12.26 (5.03)	12.82 (4.14)
Negative Problem Orientation	22.33 (8.65)	25.35 (8.34)	23.48 (11.07)	15.53 (12.22)	10.95 (6.79)
Rational Problem Solving	29.19 (18.08)	24.20 (17.53)	38.43 (20.33)	37.49 (17.17)	44.78 (12.60)
Impulsive/ Careless Style	23.32 (8.88)	19.64 (9.00)	21.65 (10.44)	15.02 (10.03)	10.97 (5.84)
Avoidant Style	15.25 (6.48)	14.56 (6.31)	14.73 (7.27)	10.45 (7.62)	8.25 (5.42)
Social Problem Solving	8.52 (3.57)	7.92 (3.41)	9.36 (3.83)	11.78 (4.11)	13.39 (2.51)

Evidence exists to suggest that poor social problem solving mediates the relationship between personality traits and psychological and behavioural problems. A mediator is a variable that explains how one thing has an effect on another. In this case, certain personality traits are more likely to lead to psychological or behavioural problems in people who have poor social problem-solving abilities. In our research, we have found social problem solving to mediate between trait impulsivity and aggression in both men and women (McMurran, Blair, & Egan, 2002; Ramadan & McMurran, 2005). That is, impulsive people are more likely to be aggressive if they have poor social problem solving skills. Social problem solving also mediated between trait impulsivity and heavy drinking in men (McMurran, Blair, & Egan, 2002). This suggest to us that improving social problem solving through therapy might lead to reduced aggression and heavy drinking in impulsive people for whom these behaviours are problematic.

Other research that we have conducted shows that an impulsive/careless problem solving style is associated with borderline, histrionic, and narcissistic personality traits, and a

negative approach to problems is associated with avoidant and dependent personality traits (McMurran, Duggan, Christopher, & Huband, 2007). Based upon this research, we have proposed a model of personality difficulties in which the concept of social problem solving is central to adaptive functioning (McMurran, Egan, & Duggan, 2005). This is outlined in Figure 1. We postulate that innate temperament is the developmental start-point for behavioural patterns. Certain temperaments limit and bias information processing, interfering with the acquisition of good social problem solving skills and consequently lead to dysfunctional ways of operating in everyday life. Interpersonal dysfunction causes distress, experienced affectively in a number of ways including anxiety, depression, and anger. Distress further impairs problem solving abilities and may also lead to problematic stress-relieving behaviours, such as substance use, which still further impair social problem solving abilities and also potentially create additional interpersonal problems. Persistent dysfunction leads to a negative approach to life's problems and the development of maladaptive self-schemas that have a further deleterious effect on information processing and social problem solving.

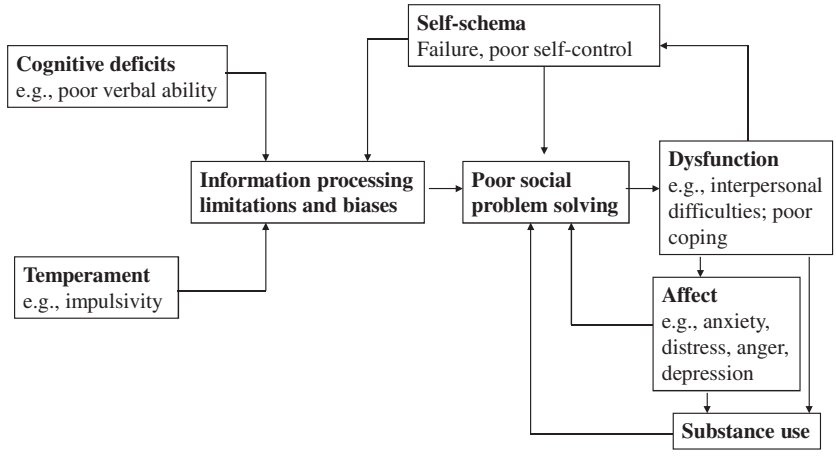


Figure 1. *Social problem solving model of personality difficulties*

In summary, this proposed model indicates the importance of targeting social problem solving skills, not only to assist in finding solutions to current problems, but also as an important means of tackling other emerging difficulties that an individual might experience.

Poor social problem solving may be at the root of interpersonal difficulties and poor coping in the social world, but, furthermore, the distress caused by these problems can be debilitating. Dysfunction and distress can lead to damaging coping behaviours, e.g., substance use. If this maladaptive pattern persists over time, then the person's builds up negative beliefs about him or herself (see Box 2). Distress, damaging coping behaviours, and negative self-beliefs, all interfere with social problem solving in a negative feedback loop.

Box 2. Expressions that indicate negative beliefs about the self

"We've had another argument. It was all my fault. I always screw up in relationships."
"I just cannot control my temper – never could, never will."
"There's no point discussing problems with people – it gets you nowhere."
"People will take the piss if you let them. It's human nature. You have to get them before they get you."
"I'm an easy-going person. It's so much easier to let other people have their own way than to argue about things or get into debates."

Section 4.

Does *Stop & think!* work?

The model described in the previous chapter suggests that social problem solving deficits may contribute to problems that typify personality disorder. The next step is to see if there is evidence to suggest that problem solving therapy might benefit people with personality difficulties.

Problem solving therapy (or problem solving skills training) aims to teach people the skills for solving life's problems, and has been used successfully in the treatment a range of problems, including depression (Biggam & Power, 2002; Townsend et al., 2001), aggressiveness in children (Frey et al., 2000), self-harm (Salkovskis , Atha, & Storer, 1990), and offending (Friendship, Blud, Erikson, Travers, & Thornton, 2003). A meta-analysis of 31 randomised controlled trials of problem solving therapy for a range of psychological and health problems found that overall problem solving therapy was more effective than no treatment or treatment as usual, and as effective as other active treatments (Malouff, Thorsteinsson, & Schutte, 2007). Problem solving therapy may have advantages over other therapies in its acceptability, brevity, and relative ease of implementation. Two important findings in this meta-analysis were that problem solving therapy was more effective when: *a) It included problem-orientation training, and b) homework exercises were assigned.* These findings have been incorporated into the delivery of ***Stop & think!***

Given that people with personality disorders show social problem solving deficits, and given that problem solving therapy is effective with problems relevant to personality disorder, it is reasonable to suppose that problem solving therapy could benefit people with personality difficulties (McMurran, Nezu & Nezu, 2008). We have begun to test this out.

The Social Problem Solving Inventory-Revised

In our research, the measure we used to examine social problem solving skills was the Social Problem-Solving Inventory -Revised (SPSI-R; D'Zurilla, Nezu, & Maydeu-Olivares, 2002). Because we need to refer to this, a description of the scale is useful here. The SPSI-R is a self-report questionnaire where respondents rate their adherence to items on a 5-point scale, with values from 0 to 4. This provides scores on five scales as well as a total score. There are

long (L = 52 items) and short (S = 25 items) of this questionnaire, but both measure the same scales. The scales of the SPSI-R are as follows:

Positive Problem Orientation (PPO; L, S = 5 items). This is a 'cognitive set' (i.e., a person's perspective) where there is a constructive approach to problems, with problems seen as a challenge rather than a threat. There is optimism about the solvability of problems and a belief in one's own personal ability to solve problems. There is an understanding that problems take time and effort to solve.

Negative problem orientation (NPO; L = 10 items, S = 5 items). This is a cognitive-emotional set where problems are viewed as a threat to well-being. Problems are viewed as unsolvable and there is a low expectation of one's own ability to solve problems. When confronted with problems, people become frustrated and upset.

Rational Problem Solving (RPS; L = 20 items, S = 5 items). This is a systematic approach to solving problems that includes problem definition, goal setting, generation of alternatives, thinking o the consequences, and forming an action plan.

Impulsivity/Carelessness Style (ICS; L = 10 items, S = 5 items). This is where attempts to solve problems are impulsive, hurried, and careless. Insufficient information is gathered in defining the problem, achievable goals are not set, only a few options are generated, the consequences of each option are incompletely thought through, and the effectiveness of the action plan is not monitored.

Avoidance Style (AS; L = 7 items, S = 5 items). This is where problem-solving is deferred. There is a hope that the problem will solve itself or that other people will solve it.

Social Problem Solving (SPS). This is a total score derived by averaging each scale and reversing the scores of the negative scales (NPO, ICS, and AS).

Stop & think! groups were first piloted with nine mentally disordered male patients (six with a classification of mental illness but also with personality problems, and three classified as personality disordered) in a regional secure unit for mentally disordered offenders (Arnold Lodge, Leicester, UK). Using the SPSI-R, we found that only six weekly sessions of 1½ hours' duration produced statistically significant improvements in patients'

overall problem solving scores, and significant reductions in impulsivity and negative problem orientation (McMurran, et al., 1999).

The effectiveness of ***Stop & think!*** was then examined further with personality disordered offenders treated in Arnold Lodge's Personality Disorder Unit (PDU). After three months in treatment, personality disordered offenders (N=14) showed positive change on all scales of the SPSI-R except PPO (McMurran, Fyffe, McCarthy, et al., 2001). More recent data show that these changes are sustained, even after discharge (see Figure 2).

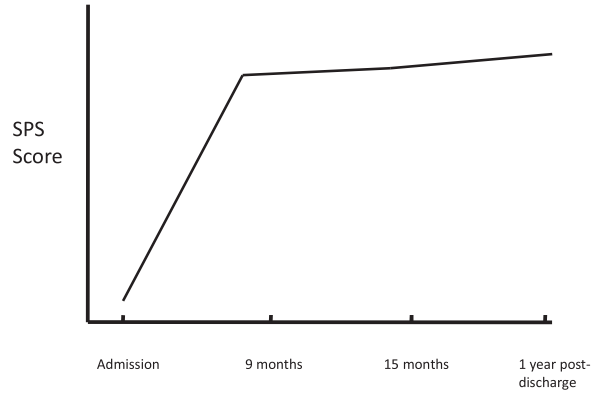


Figure 2. *SPSI-R total SPS scores over time for 11 PDU patients (data from annual report).*

More recently, the effectiveness of a combination of ***Stop & think!*** along with a psychoeducation component, which teaches participants about their personality problems, was examined in a randomised controlled trial (Huband, McMurran, Evans, & Duggan, 2007). Participants were 176 community-dwelling men and women with personality disorder in several sites across the East Midlands of England, who were randomly allocated to either treatment or a wait-list control. The treated group received, on average, 9 group sessions and a further 3 individual support sessions. The primary outcome measure was the Social Functioning Questionnaire (SFQ; Tyrer et al., 2005), which measures functioning in the domains of home, work, leisure, and relationships. Social functioning has been empirically identified in several studies as integral component of personality disorder (Nur, Tyrer,

Merson, & Johnson, 2004; Seivewright, Tyrer & Johnson, 2004; Skodol et al., 2005). Hence, improving social functioning is an important aspect of treating personality disorder *per se.* In the trial, there was a significant difference between the treatment and wait-list controls on the SFQ, with the treated group scoring better (d = 0.25). The treated group also scored better on the SPSI-R (d = 0.56) and on anger expression, as measured by the State-Trait Anger Expression Inventory (STAXI-2; Spielberger, 1999).

Further examination of the data revealed that, for 93 people who completed treatment (i.e., including some of the wait-list controls), pre- and post-treatment changes were positive on all SPSI-R scales and on the SFQ (McMurran, Huband, & Duggan, 2008). In regression analysis, after controlling for pre-treatment SFQ scores, change on the SPSI-R total score predicted change on the SFQ. Of the SPSI-R subscales, change in Negative Problem Orientation was the sole predictor of change on SFQ. This study supports the hypothesis that, when social problem solving therapy for people with personality disorder works, it does so by improving social problem solving ability. Specifically, social problem solving therapy may be effective by reducing Negative Problem Orientation and thereby improving social functioning.

Comments on the psychoeducation plus ***Stop & think!*** treatment trial expressed support for its inclusiveness (i.e., people with any personality disorders were eligible), its delivery by non-specialist staff, and its brevity (Crawford, 2007; Paris, 2007). In addition, a survey of patients' views about ***Stop & think!*** showed that the intervention was perceived as useful (McMurran & Wilmington, 2007). Here are some of their observations: *Very relevant; It's been very useful;* ***Stop & think!*** *helps people realise that there is a solution to problems; The more you do it, the better you get.*

Section 5.

Stop & think! assessment

All services should design an assessment protocol. In doing this, the various purposes of assessment need to be considered:

- Client selection
- Measuring treatment outcomes
- Measuring progress in treatment
- Service audit

Preparing the client for *Stop & think!*

The client assessment process must be linked to the treatment offered and indeed should be part of the preparation of the client for commencing groupwork sessions. In the evaluation by Huband et al. (2007), ***Stop & think!*** was preceded by individual psychoeducation sessions, in which personality assessments were conducted, feedback was given, and a discussion about problems was held. Importantly, the problems clients wanted to work on in ***Stop & think!*** groups were identified.

At the start of the assessment stage, the potential participant will need to know what he or she is being assessed for. An information leaflet about ***Stop & think!*** is presented in Appendix 1. The assessments should be described and, when the results are available, feedback should be given. This will form the basis of a dialogue aimed at identifying the problems the client could focus upon in the ***Stop & think!*** groups. Further information on pre-group preparation is given in Section 8.

Client selection: personality disorder

One selection criterion is that the person should have personality difficulties. This raises the question of whether a formal assessment of personality required. Assessing personality is a complex business, often using tests or interview schedules that require specialist training. The advice given here is to conduct a common-sense assessment of personality difficulties. However, if you think assessing personality is important, then you should involve a chartered psychologist or a psychiatrist in selecting people for your service.

Assessing change in personality as a result of treatment is not appropriate. ***Stop & think!*** does not purport to change personality, but rather to teach people how to cope better with life's problems and to improve functioning with regard to relationships, work, and employment.

You may decide to select men and women with personality difficulties who are not formally diagnosed. Personality difficulties are usually detected by the types of problems people present, including aggressiveness, antisocial behaviour, drinking and drug use, emotional instability, self-harm, and overdosing. Less obvious are the problems of people who are socially withdrawn, avoidant or dependent, since they are less likely to complain or be complained of by others, however such people are eligible for ***Stop & think!***

How do we know that these problems relate to personality difficulties and not to other kinds of difficulties? The first step is to eliminate other obvious problems. If the person has an acute mental illness, has serious drug or alcohol dependency, is suffering from the effects of brain injury, or has a developmental disability, then he or she is not suitable for ***Stop & think!*** groups. This is not to say that such people could not benefit, but their particular needs make them unsuited to a group intended for people with personality difficulties. Also, there is no clear evidence that people with Cluster A personality disorders (i.e., paranoid, schizoid, and schizotypal) respond to ***Stop & think!*** – they have not presented in sufficient numbers in our treatment trial for us to be sure that they benefit.

Those whose problems are related to personality difficulties will have had these difficulties from an early age, including: impulsive behaviour and conduct disorder; difficulties getting along with other people by being either dominant and hostile, or submissive and passive; low self-esteem and poor sense of identity; having fixed, inflexible views of the world; or having difficulties seeing matters from another's perspective.

Measuring treatment outcomes

Using validated psychometric tests, two areas of functioning can be measured both at the start and the end of ***Stop & think!*** to see if changes are evident: (1) Social problem solving, and (2) Social functioning.

Social Problem Solving. ***Stop & think!*** aims to improve social problem solving. We use the Social Problem-Solving Inventory-Revised (SPSI-R; D'Zurilla et al., 2002), a test which was described in the previous chapter. This test is helpful in examining change over the course of

treatment, but two issues must be considered: (1) user qualifications, and (2) cost. The SPSI-R is under copyright, and so it cannot be reproduced here. It is available to appropriately qualified professionals (i.e., those who have completed a graduate level course in tests/measurements) from :

The Cognitive Centre Foundation, 1st Floor, 34 Cardiff Road, Dinas Powys, Vale of Glamorgan, Wales, CF64 4JS www.cognitivecentre.com

The SPSI-R gives an indication of the person's strengths and weaknesses. Mean scores for UK populations against which an individual's scores may be compared were presented earlier in Table 2. Remember, that good functioning is indicated by ***higher*** PPO, RPS, and SPS scores, and ***lower*** NPO, ICS, and AS scores.

Social functioning. ***Stop & think!*** aims to improve social functioning. In the randomised controlled trial of ***Stop & think!*** (Huband et al., 2007), we used the Social Functioning Questionnaire (SFQ; Tyrer et al., 2005). This is reproduced, with permission, in Appendix 2. This short questionnaire, which is in the public domain, asks respondents to rate how they have been recently in 8 areas: I complete my tasks at work and home satisfactorily; I find my tasks at work and home very stressful; I have no money problems; I have difficulties in getting and keeping close relationships; I have problems with my sex life; I get on well with my family and other relatives; I feel lonely and isolated from other people; I enjoy my spare time. Each item is scored 0 to 3, with a total score in the range 0 to 24, the higher the score indicating *poorer* functioning. A score of 10 or more indicates poor social functioning, and a reduction of 2 points on this scale is likely to be clinically significant.

Measuring progress in treatment

Assessment is also important for monitoring progress in treatment. There are several ways to do this. First, over the course of treatment, it would be expected that the participant would show improvements in his or her willingness and ability to use the ***Stop & think!*** procedure. The paperwork associated with the process contains a wealth of information that may be used to assess engagement and progress. This may be used to garner the following information:

- A simple count of the number of problems tackled using the process (both in groups and independently)
- Change in the number of options generated as possible solutions to a problem (participants usually become more creative over time);
- Change in the quality of the action plans produced (participants' plans usually become more appropriate and realistic over time); and
- An assessment of the implementation of the action plan and its constituent parts.

Second, a staff rating scale could be of value in measuring change. A rating scale that could be used in the early days of treatment and again at the end of treatment is given in Appendix 3. Finally, it is important to find out the participant's opinion of ***Stop & think!*** A post-intervention interview is given in Appendix 4.

Final report

At the end of ***Stop & think!***, even with no specialist input, you will be able to report changes on the SFQ, changes in the problem solving process, changes in staff ratings, and the participant's self-evaluation.

Service audit

Additionally, client data can be aggregated to give information about the effectiveness of the service overall (see Box 3 for suggestions).

Box 3. Service evaluation suggestions

How many people are referred?

What is the profile of people referred (e.g., sex, age, type of problem)?

What proportion is selected?

What is the profile of those selected (e.g., sex, age, type of problem)?

How many complete the treatment?

What reasons do non-completers give for leaving?

What improvements are made by completers?

What are clients' opinions of the treatment?

Section 6.

The principles of problem solving therapy

Problem-solving therapy is not a way of changing personality; it is a way of teaching people to deal effectively with problems. The task is to introduce systematic problem-solving skills to those who have never learned them, or retrain people who have fallen out of the habit of systematic problem solving. Teaching people social problem-solving skills can be compared to teaching people to drive a car. Some have never learned, and need to start from scratch. When learning to drive, they have to think about every move, which is laborious. As drivers become more experienced, their driving becomes more automatic. This makes them more efficient, as long as they are using the safest techniques. If they are not, then they have to start thinking again about what they are doing and correct bad habits. Re-training requires us to bring skills back temporarily from automatic processing into conscious processing for correction. In problem solving therapy, people are taught to address their problems systematically in an explicit step-by-step approach. If repeated often enough, this systematic approach will become automatic, and people will become effective problem-solvers. Facilitators do not solve people's problems, but rather they teach people a strategy by which they can solve their own problems independently.

Social problem solving skills

Social problems solving consists of a range of skills, including:

- Problem awareness
- Problem definition
- Information gathering
- Distinguishing fact from opinion
- Goal setting
- Alternative solutions thinking
- Consequential thinking
- Decision-making
- Formulating an action plan in means-end steps
- Behavioural enactment of the plan

These skills are contained within the problem-solving approach of Thomas D'Zurilla and colleagues (D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1999, 2007), who describe seven separate steps for successful problem solving. These seven steps, along with a brief description, are:

1. Orientation. Problem recognition is the first step to effective problem solving. This consists of recognising unpleasant feelings and seeing these as a cue to begin the problem-solving process, rather than as an unpleasantness to be endured. This requires a positive problem orientation, that is the understanding that problems are a normal part of life and that problems can be solved with a bit of effort.

2. Problem definition. The ability to define a problem clearly and accurately is important to effective problem solving. An accurate definition requires information gathering and an ability to get the facts straight, not relying on inferences or suppositions. The ability to disentangle large, unmanageable problems into smaller, manageable ones is also important.

3. Goal setting. The next step is to decide upon the desired outcome. If you do not know what you want, you cannot work out a plan to achieve it and you won't know when you have got it!

4. Generation of alternatives. The creative generation of multiple possible ways of achieving the goal is important. Among the list of potential solutions is likely to be one or two that will work. It is important not to censor potential solutions at this stage, but instead to encourage creativity. Weeding out the imprudent, antisocial, and illegal options comes later.

5. Decision-making. Each potential solution is examined in relation to its likely consequences -- the advantages and disadvantages. This enables a decision about which options to choose as potentially effective, and which to reject as ineffective or too costly in terms of harm to self or others.

6. Action. One or more of the viable options are selected into an action plan. This action plan should consist of specific tasks that can actually be carried out. Vague intentions are not helpful here. Each solution should be arranged in a logical means-end sequence leading up to the specified goal. Then, of course, the action plan has to be carried out.

7. Evaluation. After the action plan has been attempted, the outcomes should be evaluated. If the goals have been met, then praise is due. It is important to recognise success in shaping behaviour. If the plan was not successful, then the reasons for this need to be

identified. What were the obstacles? How can these be overcome? Would it be useful to try the problem-solving process again with a different focus? Would skills training help?

Addressing negative problem orientation

The main challenge of social problem solving therapy is to encourage people to adopt a positive approach to solving life's problems. Instead of viewing problems as insurmountable obstacles that get in the way of happiness, problems are to be seen as a normal part of life and, with a bit of effort, they can be tackled successfully. **This is important.** In the meta-analysis of treatment trials by Malouff and colleagues (2007), encouraging people to become less negatively oriented and more positively oriented to problem solving was a strong predictor of positive outcome in treatment. In our own research, a reduction in SPSI-R scores on Negative Problem Orientation was the significant predictor of improvements on the Social Functioning Questionnaire.

In addressing problem orientation, it is important to know what you are aiming to change. A **negative problem orientation** is a cognitive-emotional set where problems are viewed as a threat to well-being, they are viewed as unsolvable and there is a low expectation of one's own ability to solve problems. Hardly surprising, then, that people become frustrated and upset when confronted with problems. By contrast, a **positive problem orientation** is a cognitive set (i.e., a person's perspective) where problems are seen as a challenge rather than a threat, there is optimism that problems can be solved, there is a belief in one's own personal ability to solve problems, there is a constructive approach to problem-solving, and a willingness to devote time and effort to solving problems. A positive problem orientation is realistic: you don't expect people to be *glad* that they have problems or feel *pleased* that they need to buckle down and solve problems. Think of it more as a kind of "Damn this problem .... Oh well, I suppose I'd better crack on and do something about it".

How do you change a person's orientation from positive to negative? A person should be encouraged to realise that **problems are normal** – we all have them a lot of the time – and that **problems can be solved if you tackle them constructively**.

Helping a person to **experience success in problem solving** is important. A person may be helped to tackle less difficult problems first to give them a good chance of experiencing success. Alternatively, he or she could tackle a big problem which would be very rewarding to solve. In therapy, can the person be supported in the problem solving process to the point of

solving a problem and feeling better about it? This will require giving the person **support in persisting with efforts to solve problems.** In ***Stop & think!*** participants are offered optional individual support sessions about once a fortnight. These sessions focus on helping people carry out their problem-solving action plans. Throughout therapy, **identify the client's strengths.** Some people just do not know when they are good at something; if you point out and reward a person's strong points, they will feel more competent and will likely use this skill more often. It is important to **identify problem-solving successes.** Often people do not take time to recognise when they have achieved something – successes just kind of slip by. Also, it is important to **praise approximations to success**; if a person gets one step nearer his or her goal, that's worth noting. Recognising success when you get there is important reinforcing feedback. When problem-solving has not been successful, **frame lack of success as a learning opportunity.** The aim is to steer people away from self-criticism and feelings of failure into a more positive approach of enquiry: Why did that not work? How can I do it differently? All of this means that you must **follow up the problem solving action plans** – do not fail to do this, or your clients will think you are not really interested in whether or not they solve their problems.

Encouraging a positive mind-set is important, but people also need to improve their specific problem solving skills. There are variations in the way that problem-solving therapy or skills training may be applied (McGuire, 2001). The method described in the next chapter is called ***Stop & think!***

Section 7.

Stop & think!

Stop & think! is a semi-structured treatment programme, which means that there is a prescribed procedure for each session but the content of the session varies depending upon the particular problem the participant chooses to work on. This semi-structured nature of ***Stop & think!*** provides an important level of flexibility to allow a focus on participants' current problems, thus potentially enhancing the relevance and usefulness of the treatment programme as a whole. However, this flexibility comes with the risk of drift away from the original objectives of the treatment, and so training and supervision are crucial to good quality delivery and its maintenance over time.

The steps identified by D'Zurilla and his colleagues can be translated into six key questions that guide the problem-solving process in clinical practice. The six key questions are:

Feeling bad?

What's my problem?

What do I want?

What are my options?

What is my plan?

How did I do? or How am I doing?

The six questions fit in with the seven steps as outlined in Table 3. This Table also shows the range of issues targeted in the problem-solving process.

In practice, the six key questions are used every time, without variation. The aim is to teach people a ***strategy*** for solving problems. By using the procedure repeatedly, it is more likely to stick in a person's mind, and thus it becomes more likely that that person will use the strategy him/herself when problems arise. Working through the questions may seem contrived and repetitive for a while, but once the new style of problem-solving is learned it should become automatic.

Table 3.

The problem-solving process

Question	*Stage*	*Skills*
Feeling bad?	Orientation	Recognition and understanding of feelings Countering impulsivity
What's my problem?	Problem definition	Information gathering Assessing quality & relevance of information Breaking down large problems
What do I want?	Goal setting	Identification of needs Setting targets
What are my options?	Alternatives	Creative thinking
What's my plan?	Decision making	Challenging dysfunctional beliefs Challenging antisocial attitudes Anticipation of outcomes Forward planning
	Action	Interpersonal skills
How did I do?	Evaluation	Recognise and reward success Recognise and address obstacles

The six key questions

Feeling bad?

Recognition of an unpleasant feeling is the cue to start the problem solving process. At first, identifying the experience of an unpleasant feeling is more important than giving the feeling a precise label, and expressing feelings in the vernacular is acceptable, e.g., fed up, pissed off, gutted. Once a feeling has been identified, it can be helpful to examine the physical and psychological experiences in greater depth so that people begin to learn to attend to their feelings. For example, anger may be associated with agitation, sweating, muscle tension, and an inability to focus on anything other than the source of anger. Depression may be associated with lethargy, lack of appetite, and an inability to concentrate. Feelings are important as the signal that there is a problem and that thinking and planning needs to begin. In the next stage, feelings can be analysed more precisely to inform the problem definition.

What's my problem?

An accurate and workable definition of the problem is important. First, it is important to dismantle large, overwhelming problems. "Life is awful" is too large to handle, and the component problems should be disentangled, for example no relationship, no job, and a horrid flat. Each may then be tackled separately. Second, it is useful to recognise the feeling and own the current problem. This is not to say that other people have not contributed to the client's problems, but it helps the client to focus upon how he or she can take action to change any problematic situation. Examples are: "I feel angry and neglected because she has not written" as opposed to "She is a selfish cow who has not written to me" and "I am scared of men and angry with everyone because of my abuse" rather than "He was a bastard and he's ruined my life".

What do I want?

Without a goal it is impossible to devise an action plan. One analogy is baking. Unless you decide what you are going to bake, you cannot make a shopping list, buy the appropriate ingredients, mix them in the right proportions, choose what baking tins to use, and bake the at the correct heat for the optimum length of time. Also, without a goal you will never know if you have reached it or not. This can be very depressing because you never seem to achieve anything at all (even though you do achieve things really).

What are my options?

Creative thinking is a vital component of ***Stop & think!*** Rather than persevering with one or two ineffective solutions, a whole range of possibilities is generated. Although some of these may be impractical, imprudent, or illegal, it is important at this stage to reward the creative generation of options. The more options generated, the more likely the list is to contain useful and effective solutions. Each option must be analysed to determine the likely consequences. The 'pros and cons', 'fors' and 'againsts', 'positives and negatives', or 'good and bad outcomes' are thoroughly examined (pick your preferred words to describe the 'advantages' and 'disadvantages'). Then each option is reviewed and either selected or eliminated. Those selected form the action plan.

What is my plan?

It is important to realise that the ultimate aim of ***Stop & think!*** is the formulation of an ***action plan***. That is, we are aiming to help people move on from expressing concern to taking action to solve problems. Although ***Stop & think!*** teaches thinking skills, the only way that the effectiveness of rational problem-solving can be tested is by checking if the action plan derived through ***Stop & think!*** actually works. The key question "What's my plan?" should lead to an action plan consisting of specific (not vague) tasks; that is, action plans should consist of items that people can actually ***do.*** Several items may be chosen from those generated in response to the question "What are my options?", and these should be listed in a logical sequence, for example, the goal 'To make contact with someone' may have the following steps: (1) Think about what I want to say in a letter, (2) Write a rough version, (3) Ask John to look it over, (4) Write it out properly, (5) Send it first class, (6) Phone after three days to see what the reaction is.

Items on the action plans must be SMART:

S - specific and significant

M -measurable and meaningful

A - attainable, acceptable, and action-oriented

R - realistic, relevant, and rewarding

T - time-based and trackable

It is worth checking the action plant against the original problem and the original feelings. Will this plan solve that problem and make you feel better?

Action

Taking action is important. Obviously, problems don't get solved by just thinking about them; action needs to be taken. Also, in the meta-analysis of treatment trials by Malouff and colleagues (2007), assigning 'homework' was a strong predictor of positive outcome in treatment. Action plans can be supported in extra individual sessions. The input in individual sessions may be to help people cope with feelings of anxiety, giving practical advice on taking the actions, or helping a person break the plan down into even smaller steps.

How did I do?

Reviewing the action plan is important for knowing whether the problem has been successfully dealt with or not. If it has, then praise and satisfaction are due, both of which raise self-esteem and self-efficacy. If the problem has not been solved, then it is important to approach this with a spirit of enquiry: Was the action plan actually carried out? If not, why not? Identifying and addressing obstacles to implementing change is crucial. If the plan was carried out, why was it not effective? Has a new problem been identified in the process? Does a new problem solving procedure need to be implemented? Is skills training or other therapy required?

In this section, the process of ***Stop & think!*** has been described. Next, some of the practicalities of running ***Stop & think!*** groups will be addressed.

Section 8.

Running *Stop & think!* groups

Pre-group preparation

Prior to starting ***Stop & think!*** sessions, participants are individually introduced to the principles of problem solving and the rationale behind ***Stop & think!*** (see Assessment section). The duration and number of pre-group meeting(s) will be dependent upon the person's cognitive abilities. The person is introduced to the problem-solving process, specifically the six key questions and the paper work, in order that they become familiar with the principles of ***Stop & think!***

The following issues need to be addressed during preparation:

1. What are the person's personal aims and perceived gains in attending ***Stop & think!*** Make sure these are consistent with the aims of the therapy.
2. Has the person had previous experience of problem solving therapy, either in groups or individually? If so, care should be taken to assess any differences in approach between previous therapies and this one to avoid confusion.
3. Provide the person with an overview of the ***Stop & think!*** rationale, the operation of sessions, the paperwork involved, and reporting procedures.
4. Show the patient the six key questions and work through an example.

***Stop & think!* groups**

Stop & think! should be run with groups of 6-8 participants. Sessions are 2 - 2½ hours long and the recommended frequency of delivery is that sessions are held once or twice a week. Evidence tells us that people experience the benefits within 12 sessions/3 months. The ***Stop & think!*** work-through is written on a flip chart in the session, and the content of this should be transcribed onto a worksheet (Appendix 5 – see worked example in Appendix 6) either by the participant after the session or by a co-facilitator during the session. Some facilitators take laptops into sessions and type up the ***Stop & think!*** work-through ready for printing out at the end of the session. Participants are expected to keep all written work together in a file.

Individual support sessions

In addition to groupwork, individual support sessions may be offered. In the randomised controlled trial (Huband et al., 2007), individual support sessions were optional. These individual sessions should augment group sessions, assisting participants to complete any unfinished work on their problems, using the ***Stop & think!*** procedure, or offering support in carrying out action plans. Frequency can be decided dependent on participant need, but a recommended frequency is one individual session for every two group sessions. Group facilitators may also wish to review a person's work from time to time, to ensure that action plans are realistic and achievable, and that participants do not accumulate too many different plans to work on.

Independent working

Participants should also be encouraged to work independently on their problems, using worksheets (Appendix 5). This fosters generalisation of the procedure.

***Stop & think! s*ome practical tips**

- **Set non-negotiable group rules in the first session.** These rules will relate to confidentiality, respect, and attendance. Pin these up at all sessions so that a person may be called to account for any rule deviations.
- **Set non-negotiable group rules in the first session.** They may also cover domestic matters, such as the provision of breaks and refreshments.
- **Start on time.** Do not wait for latecomers before starting the group. Those who have come on time simply get bored hanging around, and waiting does not encourage punctuality.
- **Keep an up-tempo pace.** It helps to keep a brisk pace, involve participants in discussion with each other, and have a laugh occasionally.
- **Reward, reward, reward.** When people participate well, remember the key questions, present prosocial views, and give advice to others, make something of it. We want to encourage the desired behaviours.

- **Involve everyone.** Make sure everyone in the group is involved in discussion. Ask questions of named people, e.g., “What do you think, Bob?”, “Do you ever feel like this, Bill?”, “What would you do, Barbara?”
- **Defining the problem.** Sometimes it is hard to capture a person’s problem in so many words. Ask group members to have a go. Agree the best brief definition.
- **Flipping charts!** Get the participants to do the writing on the flip charts. This keeps them involved (and improves spelling!).
- **Watch out for the chatty one.** Avoid an exclusive one-to-one dialogue with the most vocal group member. Be aware of this as a trap that is easy to fall into -- it can be easier for a group leader to talk to the chattiest person to the exclusion of others.
- **Participants as teachers.** When a visitor or newcomer joins the group, ask the participants to explain the ***Stop & think!*** process. Explaining what it is about will help the participant learn.
- **Normalise.** It helps if participants learn that problems are the stuff of everyday life for all of us not just a symptom of a mental health problem. We can let participants know that sometimes we fall out with people, lack confidence, or screw things up.
- **Concrete examples.** It helps to illustrate points by using concrete examples. Baking, for example, illustrates the importance of goal-setting. You need to know what you want to make in order to devise an effective action plan. For instance, you need to know you want to make pancakes in order to buy the right ingredients, mix them in the right proportions, and cook them in the right way.
- **Group problems.** Problems experienced in the group can be the focus of ***Stop & think!*** For example, if people are reluctant to speak for fear of others breaching confidentiality, this can be worked through by the group.
- **Big problems are lots of little problems wrapped up in one.** Some problems are too big to handle in one go. They need to be broken down into manageable chunks.
- **“Talk to someone” is not the solution to every problem!** We are trying to encourage independent thinking, and so we discourage over-reliance on “talk to someone” as the universal solution to all problems. We ask people to be more precise about what they need from their helper, e.g., assistance with writing a letter, a friendly critic who will allow you to rehearse a difficult conversation, or someone to provide some information about a subject.

- **Please expand on that.** Ask people to expand their reasoning. After all, we are trying to teach people *thinking* skills.
- **Recognising emotions.** You may have to work on getting participants to identify unpleasant feelings and so cue in to the problem-solving process. Try focusing on a specific unpleasant feeling and asking for a description of the feeling. Depression, for example, may make people tearful, sleepy, apathetic, and grumpy.
- **Anxiety and worry.** Having a problem and not knowing what to do about it is a worry in itself. Having an action plan for solving a problem can reduce anxiety and worry.

The biggest threat

The biggest threat to the integrity of ***Stop & think!*** is applying it in a mechanistic fashion. Remember, you are working on real problems that deserve serious consideration. It is important to give time and attention to the problem. Using the ***Stop & think!*** procedure does not make clinical and interpersonal skills redundant.

Suggested timing

Time (in minutes)	Activity
0 – **15**	Ask 'How did I do?' - take feedback from last week's action plan
16 – 25	Ask person briefly to summarise this week's problem
26 – 35	Ask 'Feeling bad?' - link this with the problem
36 – 55	Ask 'What's my problem?' – get a clear definition of a specific problem. Use the group to help with the definition
56 – 60	Ask 'What's my goal?' – get a clear goal
61 – 75	Ask 'What are my options?' – get the person and the rest of the group to generate a list of options. In the early stages, the list is likely to be sparse. Later on, you will need to streamline the list by putting similar options together. (Break in the middle of this.)
76 – 90	Break
91 – 95	Finish 'What are my options?'
96 -105	Work through the 'pros' and 'cons' of each option. If the list is very long, discuss all pros and cons but write only one in each box. (Note –if there are no pros or cons to an option, you do not need to fill the box.)
106 -110	Review all the options and make a selection of the most suitable options.
111-120	Ask 'What's my plan?' – reconfigure the options into a logical means-end action plan

Session 9.

Getting started

Starting a new group requires the usual introductions.

- Introduce staff and group members to each other
- Use a simple ice breaker exercise, for example ask people in pairs to prepare a poster (flip chart) with their name and some key features about themselves on it. Use words, or drawings, or a mixture of both.
- Explain housekeeping issues, for example where the facilities are, when there will be breaks, the arrangements for smoking and drinks.
- Explain any non-negotiable 'ground rules' relating to safety, security, and confidentiality and then ask the group to generate any 'local rules' that they want to agree to work to.
- Give a brief introduction to ***Stop & think!*** along with some examples to illustrate how *avoiding* problems or *acting rashly* can make matters worse rather than better.

Introducing *Stop & think!*

"Some people have difficulties recognising unpleasant feelings, being clear about the problem that is causing those feelings, analysing the problem carefully, and coming up with a solution that will solve the problem. As a result, people either do nothing, or do something without thinking. Often this can make matters worse rather than better. Here are a couple of examples."

Providing examples

Present the following examples, one at a time, written in advance on a flipchart, handout, or slide. Discuss each example, using the questions provided as prompts.

Example 1 ~

> Kerry's brother Lee takes advantage of their mum by treating her like a slave and cadging money off her. Kerry say nothing, buts get more and more annoyed with Lee. Kerry won't speak to her brother, but she does criticise him to their mum. Kerry's mum gets fed up with this and loses her temper with Kerry.

What is Kerry's problem?

Has Kerry solved the problem?

What do you think she could have done instead?

Example 2 ~

> Terry loves his girlfriend Vicky, but they are not getting on too well right now. Vicky goes out for a night with her mates. Later in the week, Terry hears that she was flirting with a bloke in the nightclub. Terry accuses Vicky of being unfaithful. Vicky denies it and gets very angry with Terry for having accused her. Terry then loses his temper, roughly shoves Vicky out of his way, and walks out of the house.

What is Terry's problem?

Has Terry solved the problem?

What do you think he could have done instead?

Devise your own examples if you want to make these more relevant to your participant demographic.

Explain *Stop & think!*

> ***"Stop & think!*** helps people recognise when they are feeling bad; helps people be clear about the problem that is causing them to feel bad; helps people think about possible solutions to the problem; and helps them come up with an action plan."

"Stop & think! follows six key questions ~

Feeling bad?

What's my problem?

What do I want?

What are my options?

What's my plan?

How am I doing?/How did I do?"

These questions are the core of ***Stop & think!*** and it helps to pin the questions around the room, or give participants reminder cards, or both. Here is an opportunity to be creative!

Feeling bad

Explain the importance of the first question, 'Feeling bad?'

> "The first question, 'Feeling bad?' requires people to notice their feelings and label these feelings. Some people have difficulty even realising that they feel bad. Recognising when you feel bad is important because this acts as a cue to start problem solving."

The next step is an exercise to start attuning people to recognising unpleasant feelings. This is essentially a brainstorming exercise, but with fun and creativity added. Draw an outline diagram of a body on a flipchart. Ask group members to name unpleasant feelings, and ask them to draw something on the body that represents the physical sensation of these feelings, for example a butterfly in the stomach (anxiety), a bead of sweat on the forehead (fear), redness on the face (anger), a tear in the eye (sadness). Participants may be given the 'Feeling bad?' worksheet (Appendix 5) for independent work.

In moving through the ***Stop & think!*** problem solving procedure, participants should briefly outline their problem first. Facilitators should then invite the participant to take one step back and ask, 'What were the unpleasant feelings?' The purpose of doing this is to indicate to participants that in future they need to be alert to unpleasant feelings so that they can trigger the problem solving process early on in a potentially problematic situation.

Problem solving

The next step is to work through the problem solving procedure for the first time, using an example. We have found that using a current problem of a soap opera character is both engaging and useful. Alternatively, an example of a commonly experienced problem may be chosen. Again, creativity can be used as to how to present a clear example of an inter-personal problem situation through which the problem solving procedure can be illustrated.

Examples of problems

Angry – Partner doesn't help with the housework

Lonely – No friends

Sad – Fell out with best mate

Worried – Workmate steals from the firm and I might get implicated

Frustrated – My partner won't let me discipline her children

The questions should be worked through in turn right up to 'What's my plan?' At this point, ***Stop & think!*** will end, just as it will in real sessions. The sessions are where the planning takes place, but it is outside of sessions that the action plan is carried out. This is ***crucial*****:** problems mostly cannot be solved on paper without follow-up action. Feedback on action plans – 'How am I doing? – needs to be presented the following week.

Take any questions and then prepare for the next session when a real problem will be tackled. It is important to identify in advance the problem to be addressed in the next session, otherwise you may face an uncomfortable silence. Problem identification may be done in the group, or by facilitators in the individual support sessions.

***Stop & think!* – session 2 onwards**

In the first session that deals with a participant's problem, the ***Stop & think!*** procedure will start at question 1, 'Feeling bad?' and proceed from there. From session 2 onwards, the session will start with feedback from the participant whose problem was the focus in the previous week, that is, 'How am I doing?' or 'How did I do?' Some catch up of action plans from previous weeks may also be appropriate. About 20 minutes of the session

should focus on feedback, and the remainder on new problem solving. Facilitators should be mindful of time, ensuring that the feedback part of the session does not run over and encroach upon the problem solving time.

Types of problem for *Stop & think!*

In theory, all kinds of problems can be processed using the ***Stop & think!*** approach. In therapy, however, we wish to concentrate on personal and interpersonal problems, rather than practical problems. Problems with anxiety, depression, interpersonal friction, family relationships, and offending are all grist to the mill. Practical problems such as finding accommodation, accessing benefits, and looking for work need not be ruled out, since they frequently have an interpersonal component, but they should not form the main diet of group sessions.

Group facilitators' problems

Group facilitators may very occasionally wish to work through issues relevant to a ***Stop & think!*** as a problem of their own. For example, a useful strategy when a group is not going well is for the facilitator to bring this to the group as his or her problem, for example "I'm feeling worried because the group does not seem to be bringing problems up for discussion". This illustrates that everyone can experience problems and ***Stop & think!*** procedure can help solve them, while also getting the group to address its own problems.

Skills training

Stop & think! does not include interpersonal skills training, such as assertiveness or negotiation skills. ***Stop & think!*** can, however, include brief, ad hoc skills training exercises relevant to an individual's action plan e.g., rehearsing a conversation, practising assertiveness, or learning relaxation. More in-depth skills training should be dealt with in other groups dedicated to the purpose. ***Stop & think!*** should be linked with such skills training groups.

Good practice guidelines

Finally, feedback from services that we have worked with has enabled us to draw up good practice guidelines. These are:

Stop & Think! Good Practice Guidelines

- The purpose of *Stop & Think!* is to teach participants a strategy for solving life problems. *Stop & Think!* groups are not for the purpose of introducing patients to working in group
- All *Stop & Think!* staff should operate the same approach.
- Three trained staff should be allocated to each group, of whom two will attend any one session.
- Clients should be referred to *Stop & Think!* group facilitators for suitability assessment.
- Suitability will be determined by motivation to attend groups, ability to benefit from *Stop & Think!* group work, and current group constitution.
- Clients will be informed of the aims, content, and process of *Stop & Think!*
- The optimum is 6 participants per group.
- Sessions to be a minimum of 2 hours duration (including break).
- Groups to run in blocks of 12 sessions.
- Prior to the block of sessions, staff will meet individually with patients to identify problems to be worked on in group and prepare patients for working on those problems in a group. The focus may be on current problems or on more fundamental psychological issues
- Prior to each session, co-facilitators will meet to agree the session agenda.
- The facilitator leads the group, the scribe focuses on writing the flip charts and should not be the lead facilitator.
- The flip charts should be written up after each session and copies made for patient and staff.
- After each session, co-facilitators will meet for debriefing.
- Issues identified in the group session will be taken forward as appropriate.
- Between group sessions, staff will support individuals with action plans in individual sessions.
- After each block, staff will review and rationalise all action plans for each individual.
- After each block, staff will summarise the problems worked on, problem themes, and unmet need identified during the block and write a report for each client's referrer or CPA meeting.
- If appropriate, after each block, staff will identify problems to address in next block of *Stop & Think!*
- All staff will receive supervision specifically related to *Stop & Think!* for a minimum of one hour per block of sessions , e.g., peer supervision, group supervision, expert supervisor.

References

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington: American Psychiatric Association

Biggam, F.H., & Power, K.G. (1999a). A comparison of the problem solving abilities and psychological distress of suicidal, bullied, and protected prisoners. *Criminal Justice and Behavior, 26,* 196-216.

Biggam, F.H., & Power, K.G. (1999b). Social problem-solving skills and psychological distress among incarcerated young offenders: The issue of bullying and victimization. *Cognitive Therapy and Research, 23*, 307-326.

Biggam, F.H., & Power, K.G. (2001). A controlled, problem-solving, group-based intervention with vulnerable incarcerated young offenders. *International Journal of Offender Therapy and Comparative Criminology, 46*, 678-698.

Cassidy, T., & Long, C. (1996). Problem-solving style, stress, and psychological illness: development of a multi-factorial measure. *British Journal of Clinical Psychology, 35*, 265-277.

Crawford, M.J. (2007). Can deficits in social problem-solving in people with personality disorder be reversed? *British Journal of Psychiatry 190, 283-284.*

D'Zurilla, T.J., & Goldfried, M.R. (1971). Problem solving and behaviour modification. *Journal of Abnormal Psychology, 78*, 107-126.

D'Zurilla, T.J., & Nezu, A.M. (1999). *Problem solving therapy: A social competence approach to clinical intervention*. 2nd edition. New York: Springer Publishing Company.

D'Zurilla, T.J., & Nezu, A.M. (2007). *Problem solving therapy: A positive approach to clinical intervention*. 3rd edition. New York: Springer Publishing Company.

D'Zurilla, T.J., Nezu, A.M., & Maydeu-Olivares, A. (2002). *Social Problem Solving Inventory – Revised (SPSI-R): Technical manual.* North Tonawanda, NY: Multi-Health Systems, Inc.

Frey, K.S., Hirschstein, M.K., & Guzzo, B.A. (2000). Second step: Preventing aggression by promoting social competence. *Journal of Emotional and Behavioral Disorders, 8*, 102-112.

Friendship, C., Blud, L., Erikson, M., Travers, R., & Thornton, D. (2003). Cognitive-behavioural treatment for imprisoned offenders: An evaluation of H M Prison Service's cognitive skills programmes. *Legal and Criminological Psychology, 8,* 103-114.

Hayward, J., McMurran, M., & Sellen, J. (2008). Social problem solving in vulnerable adult prisoners: Profile and intervention. *Journal of Forensic Psychiatry and Psychology, 19,* 243-248.

Herrick, S.M., & Elliott, T.R. (2001). Social problem-solving abilities and personality disorder characteristics among dual diagnosed persons in substance abuse treatment. *Journal of Clinical Psychology, 57*, 75-92.

Huband, N., McMurran, M., Evans, C., & Duggan, C. (2007). Social problem solving plus psychoeducation for adults with personality disorder: A pragmatic randomised controlled trial. *British Journal of Psychiatry, 190,* 307-313.

Keltikangas-Järvinen, L., & Pakaslahti, L. (1999). Development of social problem solving strategies and changes in aggressive behaviour: A 7-year follow-up from childhood to late adolescence. *Aggressive Behavior, 25,* 269-279.

Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Malouff, J.M., Thorsteinsson, E.B., & Schutte, N.S. (2007). The efficacy of problem solving therapy in reducing mental and physical health problems: A meta-analysis. *Clinical Psychology Review, 27,* 46-57.

Matthys, W., Cuperus, J.M., & van Engeland, H. (1999). Deficient social problem-solving in boys with ODD/CD, with ADHD, and with both disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 51,* 215-224.

McGuire, J. (2001). What is problem solving? A review of theory, research, and applications. *Criminal Behaviour and Mental Health, 11,* 210-235.

McMurran, M., Blair, M., & Egan, V. (2002). An investigation of the correlations between aggression, impulsiveness, social problem solving, and alcohol use. *Aggressive Behavior, 28,* 439-445.

McMurran, M., Duggan, C., Christopher, G., & Huband, N. (2007). The relationships between personality disorders and social problem solving in adults. *Personality and Individual Differences, 42,* 145-155.

McMurran, M., Egan, V., Blair, M., & Richardson, C. (2001). The relationship between social problem-solving and personality in mentally disordered offenders. *Personality and Individual Differences, 30*, 517-524.

McMurran, M., Egan, V., & Duggan, C. (2005). Stop & Think! Social problem-solving therapy with personality disordered offenders. In M. McMurran & J. McGuire (Eds). *Social problem solving and offending: Evidence, evaluation, and evolution*. Chichester: Wiley.

McMurran, M., Fyffe, S., McCarthy, L., Duggan, M., & Latham, A. (2001). 'Stop &

think!': Social problem-solving therapy with personality disordered offenders. *Criminal Behaviour and Mental Health, 11,* 273-285.

McMurran, M., Huband, N., & Duggan, C. (2008). The role of social problem solving in improving social functioning in therapy for adults with personality disorder. *Personality and Mental Health, 2,* 1-6.

McMurran, M., Nezu, A.M., & Nezu, C.M. (2008). Problem solving therapy for people with personality disorders: An overview. *Mental Health Review Journal,13,* 39-43.

McMurran, M., Richardson, C., Egan, V., & Ahmadi, S. (1999). Social problem-solving in mentally disordered offenders: A brief report. *Criminal Behaviour and Mental Health, 9*, 315-322.

McMurran, M., & Wilmington, R. (2007). A Delphi survey of the views of adult male patients with personality disorders on psychoeducation and social problem solving therapy. *Criminal Behaviour and Mental Health, 17,* 293-299.

Nur, U., Tyrer, P., Merson, S., & Johnson, T. (2004). Relationship between clinical symptoms, personality disturbance, and social function: a statistical enquiry. *Irish Journal of Psychological Medicine, 21*, 19-22.

Paris, J. (2007). Problem-solving therapy improves social functioning in people with personality disorder: Commentary. *Evidence-Based Mental Health, 10,* 121.

Ramadan, R., & McMurran, M. (2005). Alcohol and aggression: Gender differences in their relationships with impulsiveness, sensation-seeking, and social problem-solving. *Journal of Substance Use, 4,* 215-224.

Salkovskis, P.M., Atha, C., & Storer, D. (1990). Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide. a controlled trial. *British Journal of Psychiatry, 157*, 871-876.

Seivewright, H., Tyrer, P., & Johnson, T. (2004). Persistent social dysfunction in anxious and depressed patients with personality disorder. *Acta Psychiatrica Scandinavica, 109*, 104-109.

Skodol, A.E., Pagano, M.E., Bender, D.S., Shea, M.T., Gunderson, J.G., Yen, S., Stout, R.L., Morey, L.C., Sanislow, C.A., Grilo, C.M., Zanarini, M.C., & McGlashan, T.H. (2005). Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive–compulsive personality disorder over two years. *Psychological Medicine, 35*, 443-451.

Spielberger, C.D. (1999) *STAXI-2: State-Trait Anger Expression Inventory-2.* Odessa, FL: Psychological Assessment Resources, Inc.

Townsend, E., Hawton, K., Altman, D.G., Arensman, E., Gunnell, D., Hazell, P., House, A., & van Heeringen, K. (2001). The efficacy of problem-solving treatments after deliberate self-harm: Meta-analysis of randomized controlled trials with respect to depression, hopelessness, and improvement in problems. *Psychological Medicine, 31*, 979-988.

Tyrer, P., Nur, U., Crawford, M., Karlsen, S., McLean, C., Rao, B., & Johnson, T. (2005). The social functioning questionnaire: A rapid and robust measure of perceived functioning. *International Journal of Social Psychiatry, 51,* 265-275.

Appendices

Appendix 1.

Stop & Think!

Stop & Think! is a group programme for people who have problems controlling their emotions or behaviour, to the extent that this makes them unhappy or causes problems with other people in their lives. The problems of people who are eligible for ***Stop & Think!*** relate to personality difficulties. That means that they have traits that sometimes make life difficult. Traits that can cause problems include impulsivity, irritability, aggressiveness, and poor self-worth. ***Stop & Think!*** aims to help people cope with these difficulties and solve life's problems more effectively.

Stop & Think! teaches people a strategy for solving problems. ***Stop & Think!*** involves answering six key questions:

Feeling bad?

Some people have difficulty recognising unpleasant feelings such as anger, depression, and boredom. Either they react without thinking to the unpleasant feelings or they just put up with them. What they don't do is try to identify what the problem is and work out an effective action plan. ***Stop & Think!*** helps you recognise unpleasant feelings and start problem solving.

What's my problem?

You can't solve a problem unless you can say what it is. Some people have difficulty defining their problems clearly and breaking down big problems into smaller, manageable ones. ***Stop & Think!*** teaches you to define your problems clearly and break big problems into smaller chunks.

What's my goal?

To solve a problem, you need to know what you're aiming for, otherwise you'll never know if you've arrived! ***Stop & Think!*** teaches you to set clear, achievable goals.

What are my options?

There are usually a number of ways of achieving a goal. Be creative and think of a lot of options. This gives you more than one way to solve a problem. Creativity is good, but you also need common sense. ***Stop & Think!*** teaches you to be creative in thinking of possible solutions to a problem. Then you learn to think of what would likely happen if you took action, and you weed out the bad ideas.

What's my plan?

The good ideas that you are left with are then put into order as an action plan. This action plan isn't going to be effective if it stays on paper, so you need to carry out this plan.

How am I doing?

Action plans need to be checked to see if they are working. Have you achieved your goal? If so, well done! If not, what got in the way? What can you do next?

Appendix 2.

Social Functioning Questionnaire (Reproduced with permission)

Please look at the statements below and tick the reply that comes closest to how you have been recently.

I complete my tasks at work and home satisfactorily

Most of the time	□
Quite often	□
Sometimes	□
Not at all	□

I find my tasks at work and at home very stressful

Most of the time	□
Quite often	□
Sometimes	□
Not at all	□

I have no money problems

No problems at all	□
Slight worries only	□
Definite problems	□
Very severe problems	□

I have difficulties in getting and keeping close relationships

Severe difficulties	□
Some problems	□
Occasional problems	□
No problems at all	□

I have problems in my sex life

Severe problems	□
Moderate problems	□
Occasional problems	□
No problems at all	□

I get on well with my family and other relatives

Yes, definitely	□
Yes, usually	□
No, some problems	□
No, severe problems	□

I feel lonely and isolated from other people

Almost all the time	□
Much of the time	□
Not usually	□
Not at all	□

I enjoy my spare time

Very much	□
Sometimes	□
Not often	□
Not at all	□

Scoring:

I complete my tasks at work and home satisfactorily

Most of the time	0
Quite often	1
Sometimes	2
Not at all	3

I find my tasks at work and at home very stressful

Most of the time	3
Quite often	2
Sometimes	1
Not at all	0

I have no money problems

No problems at all	0
Slight worries only	1
Definite problems	2
Very severe problems	3

I have difficulties in getting and keeping close relationships

Severe difficulties	3
Some problems	2
Occasional problems	1
No problems at all	0

I have problems in my sex life

Severe problems	3
Moderate problems	2
Occasional problems	1
No problems at all	0

I get on well with my family and other relatives

Yes, definitely	0
Yes, usually	1
No, some problems	2
No, severe problems	3

I feel lonely and isolated from other people

Almost all the time	3
Much of the time	2
Not usually	1
Not at all	0

I enjoy my spare time

Very much	0
Sometimes	1
Not often	2
Not at all	3

Appendix 3.

Stop & Think! Rating Scale

This rating scale should be used to assess an individual's performance in applying the *Stop & Think!* procedure to a specific problem. The individual's performance in each stage should be rated. This will identify the person's strengths and weaknesses. Rating the procedure at different stages in therapy permits the assessment of changes over time. The problem that was addressed should be recorded and a copy of the *Stop & Think!* worksheet pertaining to that problem should be appended to this rating sheet.

CLIENT'S NAME:_____ ASSESSOR'S NAME:_____ DATE:_____

PROBLEM ASSESSED: _____

_____

UNDER DEVELOPED		WELL DEVELOPED
Feeling bad? An under-developed response shows a lack of awareness of emotions (e.g., 'I don't know'). There is an inability to name (e.g., 'I just feel bad') and own emotions (e.g., 'It's him that makes me feel like this'). A limited range of emotions is expressed. Emotions are not linked to physical sensations or cognitive changes. The focus is on behaviours rather than emotions or feelings, and feelings are described as behaviours (e.g., 'I felt like punching someone').	**0 1 2 3 4 5 6 7 8 9 10**	**Feeling bad?** A well-developed response clearly identifies and owns difficult emotions. This is signified by statements of 'I feel ……'. Emotions (e.g., angry, sad, anxious) are clearly identified and are linked with physical sensations (e.g., tense, heart racing, feeling a lump in stomach) and cognitive changes (e.g., mind racing, focus only on one thing, confusion). There is recognition that these emotions and feelings are linked to the problem. There is recognition that 'feeling bad' is a cue to initiate problem solving.

What's my problem? An under-developed response is a vague, unfocused or global problem (e.g., 'My relationships are terrible'); or a list of problems; or a problem that is historical, although expressing current difficult emotions relating to a past problem is acceptable. Responsibility for the problem is placed elsewhere (e.g., 'They don't treat me fairly'). The problem is not related to the emotions identified. The problem is based on assumptions (e.g., 'I am singled out for unfair treatment').	**0 1 2 3 4 5 6 7 8 9 10**	**What's my problem?** A well-developed response is a description of a specific current or anticipated problem that relates to feeling bad. The description is clear and concise while identifying the crux of a problem. It does not focus on the superficial aspects of a problem, but rather the focus is on problematic issues that are part of a pattern for the individual (e.g., rather than focus on a minor altercation, the focus might be upon a pattern of angry responding when thwarted).
What do I want? An under-developed response is unclear (e.g., 'I want to be better'), unspecific (e.g., 'I want to be happy') and unrealistic (e.g., 'I want to stop feeling angry'). The focus is on what other people should do rather than what the person him/herself should do. The goal is not related to the problem expressed hence it will not solve the problem or ameliorate unpleasant feelings.	**0 1 2 3 4 5 6 7 8 9 10**	**What do I want?** A well-developed response is an important, specific and realistic goal (e.g., 'I want to learn ways to control my anger better'). The goal should focus on changing one's own behaviour and not on the expectation that others will change. When achieved, the goal should ameliorate the identified problem and hence reduce the frequency or intensity of unpleasant feelings.
What are my options? An under-developed response shows few options or options that are all variations of the same thing. The options may be a rehearsed set, with no real thought given to the specific problem under discussion (e.g., 'Speak to staff'). The options are vague (e.g., 'Relax'). There is a predominance of unreasonable options. The options do not relate to the expressed problem. The balance of advantages and disadvantages is not addressed and the effects on other people are not acknowledged.	**0 1 2 3 4 5 6 7 8 9 10**	**What are my options?** A well-developed response shows a diverse range of options. The list can include options that may not be advisable to act upon (e.g., self-harm, violence to others), but most will be potentially useful options. The options will relate to the expressed problem. The major advantages and disadvantages to self and others of each option are identified.

What is my plan? An under-developed action plan is an uncoordinated list of actions that have no clear progression. The plan is a repeat of the list of options generated. The items on the plan are vague (e.g., 'I will improve my self confidence') and outcomes are not measurable. The plan does not include immediately actionable coping strategies or the plan focuses only on immediate coping strategies. There is no reference to the resources needed for supporting the plan. The plan does not relate to the expressed problem. The actions are antisocial or damaging.	**0 1 2 3 4 5 6 7 8 9 10**	**What is my plan?** A well-developed action plan focuses upon a small list of themed actions (e.g., prevention, coping, negotiation). In each theme, a small number of actions should be listed. These should be SMART, i.e., specific, measurable, achievable, realistic, and time-limited. There should be actions with immediate, short-term, and longer-term outcomes. Any support needed to enact the plan is specified. Some plans should be challenging and aim to address the problem's causes. The action plan relates to the expressed problem. There are no antisocial or damaging actions.
How am I doing? An under-developed appraisal is rushed, superficial, and unclear. The plan has not been tackled and no good reasons are given for inaction. Alternatively, there is claim to an immediate and complete success (e.g., 'The first step solved all my problems'). Successes may have been achieved but are not recognised. Failures are viewed as a shortcoming of the plan and there is no commitment to persist with the plan, examine the reasons for lack of success, or find alternative strategies.	**0 1 2 3 4 5 6 7 8 9 10**	**How am I doing?** A well-developed appraisal is honest. It reports on all aspects of the plan and indicates which actions have been carried out and which have not. The success or otherwise of each action is assessed and the obstacles to implementation of the plan are identified. The reasons for lack of success with aspects of the plan are identified and alternative strategies are considered. Success is acknowledged in terms of incremental achievement towards the identified goal. A clear intent is expressed to continued work on the plan.

Appendix 4.

Client Post-Intervention Interview Schedule for *Stop & Think!*

Participant Identification ..... **Date .....**

The purpose of this interview is to gather your views on the *Stop & Think!* group sessions. The *Stop & Think!* sessions were those where you learned a way of tackling and solving problems.

1. **First, I am interested in hearing your general opinions of the *Stop & Think!* sessions. So, before I ask you any questions that might get you thinking about specific things, would you please give me your general opinions of the *Stop & Think!* sessions?**

2. **Please tell me the main things you learned in the *Stop & Think!* sessions:**

3. **Besides gaining knowledge, I am interested in whether you got anything else out of the *Stop & Think!* sessions. Did you benefit in any way?**

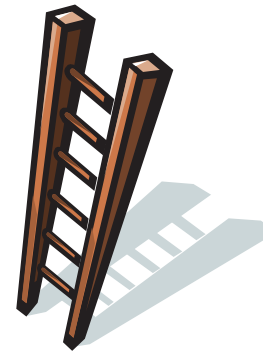
   3a. If you did benefit, could you please try to tell me <u>how</u> *Stop & Think!* had this good effect?

4. **Do you think *Stop & Think!* had any bad effects?**

   4a. If so, could you please try to tell me <u>how</u> *Stop & Think!* had a bad effect?

5. May I ask you to rate how useful you found the Stop & Think! sessions overall?

10 Very useful indeed
9
8
7
6
5
4
3
2
1
0 Not at all useful



6. Do you have any other comments?

Thank you for your help.

Appendix 5. (*Note:* Your version of this will need to offer more space for clients to write in).

Stop & Think!

Bad feelings?

What's my problem?

What do I want?

What are my options?

	Good outcomes	*Bad outcomes*

What's my plan?

Action	*Date*	*Helper*

How am I doing?

Appendix 6.

Stop & think! example

Feeling bad?

Sad, lonely

What's my problem?

My wife dumped me and I can't see the kids

What do I want?

To see my children

What are my options?

Options	Positives	Negatives
Kidnap the kids	I'd see lots of them.	Would distress the kids. She'd get the law onto me.
Speak to my wife and negotiate access	Maybe we could work something out. I could tell her I'm doing something about my problems.	She'd not listen because she thinks I'm unreliable and aggressive.
Write to my wife to negotiate access	Wouldn't have to listen to her criticising me.	She'd tear the letter up.
Ask Social Services if they can arrange access.	Might get a result.	I got banned from seeing the kids because of my drinking and aggression.

What's my plan?

Speak to Social Services. Tell them I'm doing something about my drinking and aggression. Ask them to help me negotiate access with my wife.

Continue to work on my problems. Phone up the Alcohol Counselling Service to make an appointment.

Appendix 7.

Stop & Think!

****

Feeling bad?

What's my problem?

What do I want?

What are my options?

What's my plan?

How am I doing?

Appendix 8.

Feeling bad?