Box 4.1. Task analysis of Problem-solving Training 1. Consider the characteristics of the youth that may impact his or her problem- solving abilities, such as developmental, motivational, and family factors, as well as skills deficits affecting the solution's implementation. 2. Provide a rationale for problem solving. a. Introduce it as a coping skill. b. Distinguish between adaptive and maladaptive styles, using the provided example. c. Emphasize the importance of a positive problem-solving orientation. 3. Define the problem. a. Problems are typically either an obstacle to a goal or the presence of com- peting goals or demands. b. Generate a list of current problems, and select one to define. c. Help the youth define the problem clearly and objectively. 4. Set a goal. a. Determine what the youth would like to have happen. b. Goals should be realistic, attainable, and defined using observable out- comes. 5. Generate alternative solutions. a. Use the "brainstorming" method to help the youth come up with as many solutions to the problem as possible. 6. Select the best solution. a. Help the youth engage in systematic decision making (e.g., discard unrealis- tic solutions, identify potential consequences, weigh pros and cons). 7. Implement the solution. a. Consider whether the youth has the skills needed for implementation. b. Help the youth make a plan for implementation. c. Identify and discuss any potential pitfalls. d. Have the youth implement the plan in the natural environment. 8. Evaluate the effectiveness of the solution. a. Help the youth determine whether the goal was achieved. b. If so, praise and reward him or her (or have the youth self-reward). c. If not, either modify the existing plan or return to Step 6 and select a new solution or consider moving back to an even earlier step if needed (e.g., gen- erate more solutions to choose from or a new problem definition or goal). 9. Help the youth recognize the benefits of problem solving, and apply these to additional problems, encouraging increasing levels of autonomy for the youth in the process. go through all the steps. Third, through early identification, remedial efforts can target any major skills deficits (e.g., social skills deficits) that might impede solution implementation later on in the process. Lastly, the family plays a crucial role in PST with youth. Parents should be willing to give up some control and allow the youth to make choices (Manassis, 2012). Taking time to provide a rationale for PST helps with motiva- tion and sets a foundation for the importance of adopting a positive problem orientation (Step 2). Problem solving is introduced as a set of coping skills that will help the youth address difficulties and reduce stress. Recognizing problems and taking action is emphasized. As a starting point, the therapist can ask the youth to describe his or her typical approach to solving problems. Using the youth's response, the therapist can contrast adaptive and maladaptive styles. Depressed and anxious youth are more likely to endorse maladaptive styles marked by avoidance and see their problems as unsolvable, threatening, and overwhelming (Chorpita et al., 1996; Nezu, 1987). The therapist coun- ters negative thinking and reinforces the importance of adopting an adaptive approach to problems. For example, in the Taking ACTION Program (Stark & Kendall, 1996), youth are told, "Life is full of bumps in the road and you can either look at them as bumps or nothing more than problems to be solved, or you can look at them as insurmountable mountains. We are going to work on looking at them as problems to be solved" (p. 20). If the cognitive distortions are severe enough to impede progress, the therapist may need to target them with additional cog- nitive restructuring before continuing with PST (see Chapter 3). The therapist then provides a very brief overview of the major problem- solving steps. Defining the problem is the third step. The youth must first learn to recognize problems, which might be

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quite a challenge for those with histories of avoidance. The therapist should help normalize having problems for the youth and offer a basic problem definition, such as being blocked from achieving a goal or having competing goals, and some examples (e.g., cannot find something, conflict with a peer). For youth with internalizing difficulties, experiencing negative feelings may actually be the problem. Anger, sadness, or fear can also serve as cues that a problem exists. Now better able to recognize problems, the youth is ready to make a list of current problems and choose one to define. It is best to select an easier problem to start. Problems should be defined as clearly and objectively as possible. The youth is instructed to ask questions and gather information (e.g., What is the problem?Where does it occur? When does it occur? Who is affected?). Using this information, the therapist helps the youth put the problem into words, rephrasing and reframing as needed. With a clearly stated problem in place, the therapist then helps the youth set a goal for problem solving in Step 4. Goals should focus on changing the situation and alleviating the problem. They should be realistic, attainable, and concretely defined in observable outcomes. If the problem situation is one that cannot be changed, the youth can instead focus on his or her reaction to the situation. As part of the ACTION intervention (Stark et al., 2007), youth are taught four things to consider when answering the question "What is my goal?": "Ask yourself what you want to have happen. Ask yourself what is the best thing that could happen. Avoid negative thinking. Open yourself to the positive and try to focus on the desired outcome" (p. 39). Next comes the generation of alternative solutions (Step 5). Solu- tions are things the youth can do to change, or better cope with, the problem situation. Using the "brainstorming" method, the youth is asked to come up with as many different solutions as possible. Cre- ativity is encouraged, and evaluation is discouraged. In the CWD-A course (Clarke et al., 1990), the following rules are discussed with the group: "List as many solutions as you can. Don't be critical, all ideas are allowed. Be creative. Begin by offering to change one of your own behaviors" (p. 246). Negative thinking can make this step particularly difficult for youth with internalizing problems. If the youth has trouble coming up with ideas or perseverates on reasons why ideas would fail rather than succeed, the therapist can use prompts or suggest alterna- tives for the youth. In Step 6, the youth then decides on a best solution. In reaching this decision, the therapist helps the youth engage in a systematic pro- cess that involves carefully considering the potential consequences of each generated solution. First, it is helpful to remove any solutions that clearly do not make sense or that are not feasible. The youth is asked to think about the possible short- and long-term consequences of each remaining solution. Using a poster board or form that lists each solution and provides a space for comments (both pro and con) along with a rating can help structure the process for the youth. Pessimism can derail the decision-making process for depressed youth, and the therapist can help by pointing to the positive features of solutions and the limitations or self-defeating consequences of others (Stark et al., 2006). Reminders that even small changes can make a big difference are also helpful. The therapist can address rumination or avoidance byencouraging the youth to write down only the most important advan- tages or disadvantages, setting a time limit, or reframing the process as a learning opportunity with no wrong choices (Manassis, 2012). It is now time to implement the chosen solution (Step 7). Before developing an action plan, the therapist should consider whether the youth has the requisite skills (e.g., social, academic). For example, a lack of conversation skills might get in the

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way of a youth's decision to try to make new friends. In such cases, more thorough assessment and targeted skills training (e.g., see Chapter 8) may be needed before pro- ceeding with PST. The therapist then helps the youth develop a step- by-step plan for carrying out the solution. The plan should be detailed, breaking things down into small achievable steps, and should include a time and place for enactment as well as specifics about needed input or assistance from others. Role playing with the therapist is an excellent way for the youth to practice the plan in a safe environment and also to provide added opportunities for instruction, corrective feedback, and assessment. Asking the youth to anticipate potential pitfalls in the plan and come up with a contingency plan is also helpful. The therapist assists the youth in evaluating the outcome in Step 8. The goal is to find out whether the plan has been carried out and whether it is having the desired impact. Reviewing the goal set in Step 4 can provide a context for the youth's self-evaluation. If the goal has been met, the therapist offers praise and perhaps other rewards (e.g., stickers, free time) to the youth (see Chapter 9). Teaching the youth to self-evaluate and self-reward is important for promoting the mainte- nance and generalization of the problem-solving skills. In Coping Cat (Kendall & Hedtke, 2006), children are taught that a reward is some- thing that is given when "you're pleased with the work that was done" (p. 41), and a self-rating is a way to decide whether the child is satisfied with his or her own work. The therapist points out that success leads to rewards, but also that succeeding all of the time is not possible and should not result in punishment. Children are reminded, "All that is asked is that one tries his best" (p. 42). This is an important point.

Even if the problem is not solved, the therapist can help the youth look for any signs—even small ones—of improvement in the situation and offer praise for effort and perseverance (Manassis, 2012). Biased thinking is likely to affect the self-evaluations of depressed and anxious youth. As in previous steps, cognitive restructuring techniques, such as nor- malizing and reframing (see Chapter 3), can be used to counter them. Deciding what to do when an implementation attempt fails is not easy. One option is to modify the existing plan and try again. Another is to83 return to Step 6 to select a different solution. Sometimes it may be nec- essary to return to an even earlier step. For example, more solutions to choose from or a new problem definition or goal may be needed. Once the goal has been met, the therapist has the youth apply the problem- solving steps to new problems (Step 9). The benefits of problem solving are emphasized, and the youth is encouraged to assume more auton- omy in the process. There are a variety of ways to teach the problem-solving skills. These include established behavior therapy procedures, such as verbal instruction, modeling, and reinforcement (see Chapters 5 and 9). Prom- inent among these is cognitive modeling, in which the therapist walks through the steps of solving a problem while verbalizing thoughts along the way (Spiegler, 2016). A coping model—one that allows for making mistakes or struggling at times—is suggested. Acronyms can help youth remember the problem-solving steps. In the ACTION pro- gram (Stark et al., 2007), girls are instructed to remember the "five P's" (i.e., Problem, Purpose, Plans, Predict and pick, and Pat yourself on the back). Another useful instructional approach is to first have the youth apply the steps in hypothetical situations before moving ahead with actual problems. Role plays allow for practice, modeling, and additional instruction. Because maintenance and generalization are so challeng- ing and relatively few sessions are devoted to PST in the manualized treatments, homework assignments are very important. Another

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way to boost maintenance and generalization of PST is to include parents in the intervention. Parents can encourage the use of the trained skills outside of sessions with prompts, provide active instruction, and serve as models. In the C.A.T. Project (Kendall et al., 2002), for example, there are two "meet the parents" sessions. Among the suggestions for parent involvement are fostering independence and confidence, not permitting avoidance, and modeling problem solving in difficult situations. Other programs have more structured and inten- sive parent components. The PEP (psychoeducational psychotherapy) intervention (Fristad et al., 2011) includes one parent and one child ses- sion devoted to PST. The parents learn the steps before the children. They also learn "dos" (e.g., approach child at calm time, empathize with child, ask for child suggestions before offering your own) and "don'ts" (e.g., assign blame, insist on coming up with a solution at an emotional time, choose a parent solution before hearing the child's suggestions) and are given a take-home assignment to identify a problem in the fam- ily related to the child's symptoms and use the steps to solve it. There is a slight difference between treatments for anxiety anddepression in the focus of PST. In the anxiety treatments, PST is used to help youth manage their anxiety. In Coping Cat (Kendall & Hedtke, 2006), for example, children learn to develop plans (i.e., FEAR [Feeling frightened, Expecting bad things to happen, Attitudes and actions that can help, Results and rewards] plans) for handling anxiety-provoking situations. In these plans, physical sensations and negative thoughts serve as cues to employ coping strategies, such as positive self-talk and problem solving, to help reduce anxiety and facilitate exposure to feared situations (see Chapter 2). In depression treatments, PST is used to help youth develop plans for changing situations that lead to negative emotions (Stark, Sander, et al., 2006). If the situation cannot be changed, youth are taught to use coping skills designed to enhance mood, such as distraction, talking to someone, or doing something relaxing. Family conflicts are a common problem source for depressed youth, and PST often targets their interactions with parents (e.g., Clarke et al., 1990; Fristad et al., 2011).

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