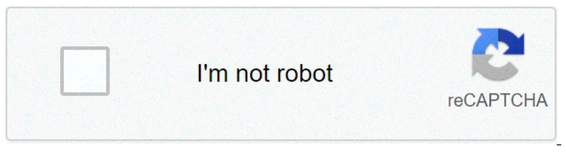

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Cognitive problem-solving skills training pdf

INTERPERSONAL COGNITIVE PROBLEM SOLVING (ICPS) Principal Investigator: Myrna Shure Level of Intervention: Universal Target Population: children age 4-5 (similar program available for older elementary ages) References: Shure & Spivack (1982, 1988); Shure (1979, 1988, 1997) Theory (Risk & Protective Factors Targeted): ICPS is based on a theory of cognitive problem solving ability as a significant predictor of social adjustment and interpersonal competence. ICPS is intended to prevent both internalizing and externalizing disorders by reducing early aggression and antisocial behavior, impulsivity and inhibited behaviors associated with deficiencies in cognitive problem solving ability. Description of Intervention: ICPS is a 12 week interpersonal cognitive problem solving program which uses games, didactic discussion and group interaction techniques to teach children communication and problem solving skills and the thought process necessary for good decision-making. The program consists of 8 weeks of daily 20 minute lessons combined with teacher (or parent) training in "problem solving dialoguing," an informal style of communication meant to foster the exercising of newly-learned problem solving skills. The core skills of ICPS are the ability to generate multiple solutions to interpersonal problems, the ability to consider consequences to one decisions or actions, and the ability to consider others' perspectives as a consideration in decision-making. Research Subjects: The study was conducted with 219 low SES, African-American 4 and 5 year olds. The group consisted of 113 treatment subjects (47 boys, 66 girls) and 106 controls (50 boys, 56 girls) in the first year (preschool). Treatment and control subjects were comparable in gender, age, IQ, ICPS test scores and behavioral characteristics. In the second year (kindergarten) 69 of the 113 original treatment subjects were available and were further divided into 39 subjects who received the intervention for a second and 30 who became 2nd year controls. Of the 106 original control subjects, 62 were available in kindergarten. Research Design: A quasi-experimental design was used with treatment subjects grouped into 2-year treatment (tt), 1st year treatment – 2nd year control (tc), or 1st year control – 2nd year treatment (ct) and compared to a no-treatment control group (cc). Data were collected pre, post, 6 months, and 1 year, with measures including the Preschool Interpersonal Problem Solving Test (PIPS) to measure alternative solution thinking, the What Happens Next Game (WHNG) to measure a child's ability to identify multiple consequences to actions, and the Hahnemann Preschool Behavior Scale (HPBS) to measure teacher-rated interpersonal behaviors (impatience, aggression). Outcomes: The intervention group experienced a significant improvement in interpersonal cognitive problem solving skills (as measured by the PIPS and WHNG) after the first year of training. Even intervention subjects initially rated as impulsive or inhibited improved significantly over the control group. At the end of the second year of intervention (for the tt group), significant effects again favored the intervention group on the PIPS and WHNG measures, with significantly more intervention children rated as behaviorally adjusted on the teacher rated HPBS. Further analysis indicated a strong mediating linkage between cognitive skill improvement and behavior gains, in which students with higher PIPS scores experienced the greatest behavior gains. In followup analysis, with the exception of the PIPS measure at 6 months, all gains were maintained at 6 months and 1 year. A clear dose-response association was found, with children trained two years improving significantly more than those trained one year, who in turn showed significantly greater improvement (whether trained in preschool or kindergarten) than the no-treatment control group. Strengths & limitations: ICPS is a classroom-based universal preventive intervention aimed at providing elementary-age children with structured training in interpersonal cognitive problem solving skills. The program's goal is to teach children "how" to think in interpersonal situations and to come up with multiple potential solutions. The program focuses primarily on the individual, though it has become a core component of a number of more comprehensive approaches since its pioneering research. The study referenced above used a quasi-experimental design with a non-equivalent control group and non-random assignment, and attrition was relatively high. It is unclear what effect pretest differences or attrition may have had on the outcomes. The sample was fairly homogeneous and no information was provided on measurement of implementation fidelity. ICPS has been widely replicated and several independent studies have supported the cognitive and behavioral gains of students trained in the curriculum (Aberson, 1987; Callahan, 1992; Weddle & Williams, 1993). In addition, Shure reports findings from an unpublished longitudinal study in which ICPS skills and behavior gains lasted through grade 2, and after disappearing in grade 3, reemerged at the end of grade 4 (Shure, 1997). back to text back to table of contents external links to program contact investigator RIS EndNote Mendeley BibTeX APA MLA HARVARD VANCOUVER Photo by: Lisa F. Young Cognitive problem-solving skills training (CPSST) attempts to decrease a child's inappropriate or disruptive behaviors by teaching the child new skills for approaching situations that previously provoked negative behavior. Using both cognitive and behavioral techniques and focusing on the child more than on the parents or the family unit, CPSST helps the child gain the ability to self-manage thoughts and feelings and interact appropriately with others by developing new perspectives and solutions. The basis of the treatment is the underlying principle that children lacking constructive ways to address the environment have problematic behaviors; teaching these children ways to positively problem-solve and challenge dysfunctional thoughts improves functioning. The goal of CPSST is to reduce or terminate inappropriate, dysfunctional behaviors by expanding the behavioral repertoire (including ways of cognitive processing). The behavioral repertoire is the range of ways of behaving that an individual possesses. In children with conduct disorder , intermittent explosive disorder , oppositional-defiant disorder , antisocial behaviors, aggressive acting-out, or attention-deficit/hyperactivity disorder with disruptive behavior, the number of ways of interpreting reality and responding to the world are limited and involve negative responses. Although CPSST originally focused on children with problem behaviors or poor relationships with others, it has generalized to a variety of different disorders in children and adults (this treatment has the most research supporting its use in children). The therapist conducts individual CPSST sessions with the child, once a week for 45 minutes to an hour, typically for several months to a year. The cognitive portion of the treatment involves changing faulty or narrow views of daily situations, confronting irrational interpretations of others' actions, challenging unhelpful assumptions that typically underlie the individual's problem behaviors, and generating alternative solutions to problems. For example, meeting with a child who has received a school suspension for becoming physically enraged at a teacher, the therapist starts by exploring the situation with the child, asking what thoughts and feelings were experienced. The child might state, "My teacher hates me. I'm always getting sent to the principal and she yells at me all the time." The therapist helps the child see some faulty ways of thinking by asking what the child has seen or experienced in the classroom previous to this incident, thus exploring the supporting evidence for the "my teacher hates me" notion. Questions would be ones that could confirm or disconfirm the assumptions, or that identify the precipitants of the teacher disciplining the child. The therapist tries to help the child shift his or her perceptions so that, instead of seeing the student-teacher negative interactions as something external to the self, the child comes to see his or her part in the problem. This discussion also helps the child to discern opportunities to influence the outcome of the interactions. When the child makes a global, stable, and negative attribution about why the interactions with the teacher are negative—where the attitude of the teacher is the cause of the problems—the child loses the sense of having any efficacy and is liable to show poorer behavior. By changing the child's perceptions and examining different options for the child's-responses in that situation, however, the child can identify ways that changing his or her own behavior could improve the outcome. The behavioral aspect of CPSST involves modeling of more positive behaviors; role-playing challenging situations; and rewarding improvement in behavior, providing corrective feedback on alternative (and more appropriate) ways of handling situations when undesirable behavior occurs. In each session, the child is coached on problem-solving techniques including brainstorming a number of possible solutions to difficulties, evaluating solutions, and planning the steps involving in gaining a desired goal (also called means-end thinking). For instance, if the child in the above example felt that the teacher's accusations were unfair, the therapist would help to come up with some options for the child to use in the event of a similar situation (such as visualizing a calming scene, using a mediator to work out the conflict, or avoiding the behaviors that precipitate a trip to the principal's office). The options generated would be discussed and evaluated as to how practical they are and how to implement them. The child is given therapy homework of implementing these newer ways of thinking and behaving in specific types of problematic situations in school, with peers, or at home. The child might be asked to keep track of negative, externalizing thoughts by keeping a log of them for several days. The therapist would ask the child to conduct an experiment—try one of the new options and compare the results. Typically, the between-sessions work begins with the conditions that appear the easiest in which to successfully use the updated ways of thinking and behaving, gradually progressing to more complex or challenging circumstances. The child would get rewarded for trying the new techniques with praise, hugs, or earning points towards something desired. Although the bulk of the sessions involve the individual child and the therapist, the parents are brought into the therapy for a portion of the work. The parents observe the therapist and the child as they practice the new skills and are educated on how to assist the child outside the sessions. Parents learn how to remind the child correctly to use the CPSST techniques for problem-solving in daily living and assist the child with the steps involved in applying these skills. Parents are also coached on how to promote the positive behaviors by rewarding their occurrence with praise, extra attention, points toward obtaining a reward desired by the child, stickers or other small indicators of positive behavior, additional privileges, or hugs (and other affectionate gestures). The scientific term for the rewarding of desired behavior is positive reinforcement , referring to consequences that cause the desired target behavior to increase. In research studies of outcomes, CPSST has been found to be effective in changing children's behavior. Changes in behavior have been shown to persist long-term after completion of treatment. Success in altering undesirable behaviors is enhanced when CPSST is combined with parent management training . Parent management training is the in-depth education of parents or other primary caretakers in applying behavioral techniques such as positive reinforcement or time away from reinforcement opportunities in their parenting. Inappropriate or inept application of cognitive-behavioral techniques such as those used in CPSST may intensify the problem. CPSST should be undertaken with a behavioral health professional (psychologist , psychiatrist , or clinical social worker) with experience in CPSST. Parents should seek therapists with good credentials, skills, and training. While individual results vary, problematic behaviors are reduced or eliminated in many children. Resources D'Zurilla, T. J. and A. M. Nezu. Problem solving therapy: A social competence approach to clinical intervention. Second edition. New York: Springer Publishing Company, 1999. Hendren, R. L. Disruptive behavior disorders in children and adolescents. Review of Psychiatry Series, vol. 18, no. 2. Washington, DC: American Psychiatric Press, 1999. Gilbert, S. "Solution-focused treatment: A model for managed care success." The Counselor 15, no. 5 (1997): 23-25. Kazdin, Alan E., T. Siegel and D. Bass. "Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children." Journal of Consulting and Clinical Psychology 60 (1992): 733-747. Matthews, W. J. "Brief therapy: A problem solving model of change." The Counselor 17, number 4 (1999): 29-32. Association for the Advancement of Behavior Therapy. 305 Seventh Avenue, 16th Floor, New York, NY 10001-60008. (212) 647-1890. Deborah Rosch Eifert, Ph.D. Other articles you might like: Back to Search Family Functioning, Parenting Skills - Training and Enhancement Program/Intervention Description Intervention Target Population Identified (Age Group) 6-12, 13-17 Program Goals/Outcomes QIC Target Group Both Target 1 and Target 2 QIC Adoption/Guardianship Relevance Levels LEVEL 5: Other Human Services QIC level of Evidence LEVEL 1: Effective and proven by Research Intervention Web Site/URL Contact Person/Purveyor Agency/Affiliation Contact Email Contact Phone External Links (Registry/Other Catalog) Attachments Back to Top Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1122-01-00. The contents of this website do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers are encouraged to copy and share it, but please credit Spaulding for Children. What is problem solving skills training? People with severe mental illnesses such as schizophrenia may show impairments in problem-solving ability. Training interventions can help develop problem solving skills, by teaching people strategies for tackling a particular problem, and ideally, teaches skills that can be reapplied in the future. A typical problem-solving therapy approach includes several key stages; linking symptoms to problems, defining the problem, setting achievable goals, generating solutions, and evaluating results. What is the evidence for problem solving skills training? Low quality evidence is unable to determine any benefit of problem solving skills training over routine care, coping skills training or unstructured therapist interaction for problem solving ability, social behaviour, or study attrition. Review authors conclude that there is insufficient evidence to confirm or refute the benefits of problem solving therapy. September 2020 Last updated at: 4:15 am, 14th September 2020 Tags: Therapy for schizophrenia Title Colour Legend: Green - Topic summary is available. Orange - Topic summary is being compiled. Red - Topic summary has no current systematic review available. What is reasoning? Reasoning refers to the ability to logically gather information to form conclusions and solve problems. People with schizophrenia may show impaired reasoning, with bias in the way they gather information, interpret events and develop beliefs. Reasoning bias is usually measured in three ways: "jumping to conclusions" (JTC) is when a decision is made after little information is gathered; belief inflexibility is an inability to change a belief even when presented with disconfirmatory or confirmatory evidence (BADE/BACE); and attribution bias is when available evidence is incorrectly used to attribute negative or positive events to internal or external causes.…

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