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Using Solution-Focused Questioning to Facilitate the Process of Change in Cognitive Behavioural Therapy for Food Neophobia in Adults

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Abstract. Food neophobia is a specific phobia of trying new foods. Its treatment in adults has been rarely described. The only paper that related a therapeutic intervention for food neophobia in adults reported a time-consuming effort for both clients and several staff involved. This paper provides a case example of using solution focused brief therapy questioning techniques to facilitate the process of change in a young adult with this diagnosis. It aims to explain how solution focused techniques can be used and in what way those techniques differ from more traditional cognitive-behavioural therapy approaches.

Keywords: Food neophobia, adults, cognitive behavioural therapy, solution-focused brief therapy.

Introduction

Food neophobia is a condition whose treatment has been rarely described. Some studies describe its development and treatment in children, but so far only one has addressed therapeutic interventions for this particular problem in adults (Marcontel, Laster and Johnson, 2003). The latter authors describe a cognitive-behavioural treatment (CBT) intervention in a male aged 23 and a female aged 27. Both subjects did well and reported continued improvement at one-year follow-up. However, the intervention had been rather laborious and possibly not very cost effective. The male subject received 20 individual psychotherapy sessions, 14 relaxation/preparation sessions and a further 14 exposure sessions with a dietician over 7 months. The female subject underwent 20 individual psychotherapy sessions plus 12 each of the relaxation/preparation sessions and the exposure sessions over 7.5 months' time. This case study will give a description of psychological treatment of food neophobia in a young man, using just over one hour of time distributed over three sessions in five weeks.

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Case presentation

John (not his real name) was an 18-year old man, who had consulted his general practitioner (GP) about his difficulties eating new foods. On the GP's request, he had kept a food diary for 2 weeks, which indicated he ate mainly peanut butter sandwiches, cakes, chocolates and crisps with very little else. The problem had been present since he had been 3 or 4 years old. There was no significant medical history that could explain his difficulties and he reported no history of weight concerns or self-induced vomiting. He denied any mood disturbance or experience of significant anxiety, but was happy to be referred to the first author, who worked as a chartered psychologist in primary care (the therapist).

On further assessment, John related an experience of "feeling sick" and a fear of vomiting at the idea of eating unknown food. His distressing thoughts about vomiting could be considered to be "catastrophic thoughts" in CBT terms. He realised that his fear of new food was irrational and he had consulted the GP on his own accord after realising that his difficulties were becoming a hindrance in the development of his independent adult social life. The therapist considered his symptoms to fulfil the diagnostic criteria of a Specific Phobia of new foods (APA, 1994) with no co-morbidity.

Intervention

The current evidence for treatment of a specific phobia favours a cognitive behavioural approach (Antony and Swinson, 2000). Hence, the therapist considered a course of action following that model of therapy. Unhelpful cognitions were identified, after which behavioural techniques were suggested to help John overcome his fears. The rationale for behavioural experiments was explained to him and possible difficulties in carrying them out were discussed. John reported that the main obstacles to building a regular routine of having healthy meals would be "feeling sick" and "feeling hungry between meals" (followed by him eating his sandwiches rather than waiting for the family food to be ready. This could spoil his appetite and make it even less attractive to try new food). The therapist used solution-focused questioning to help John overcome the fear of vomiting on ingestion of new food.

In solution focused brief therapy (SFBT), it is assumed that each person has the skills and resources to find solutions to their own problems. It aims to work with the person rather than the difficulties that bring him or her to therapy. It looks for resources and skills rather than deficits and treats clients as experts in all aspects of their lives (George, Ratner and Iveson, 2000). Individual sessions aim to bring out such information and the therapist's main task and challenge is to select the right questions to do so. The questioning style is largely Socratic, helping clients become aware of their own resources and skills through guided self-discovery. SFBT then formulates solution-focused continua, through which the client charts out his current levels of skill and his improvement on a 0-10 scale (see Figure 1 for examples applicable to this case).

The therapist asked John questions that helped him look for "exceptions" in his avoidance behaviour. Typical examples are:

- Tell me about the times that you *did* manage to eat something else?
- When was the last time you felt *a bit more confident* that you could overcome this difficulty?
- What about the times that you *refuse to let this problem rule you life*?

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Ability to resist avoidance behaviour: 0 ----------|---------- 10
today

Ability to eat X: 0 -------|---------- 10
today

Confidence in trying out new foods: 0 ----------|---------- 10
today

Examples of corresponding questions:

- What are you doing that tells you your rating is as high as that?
- What will you be doing that tells you have reached one point higher on this scale?
- What will your mother see you do that tells her you have reached there?
- How will moving up on your "confidence" scale affect your rating on your "ability to resist avoidance behaviour" scale?

Figure 1. Solution focused brief therapy examples of continua

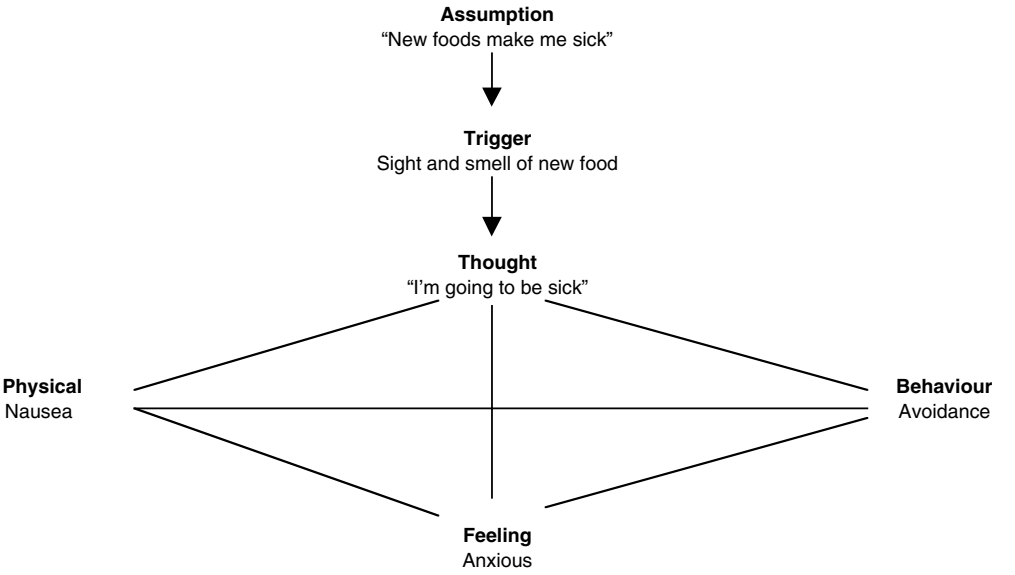

Figure 2. Simplified cognitive-behavioural therapy formulation for John's case

On doing so, it transpired that John had occasionally attempted to eat plain white rice and fish fingers. He had done so in spite of feeling nauseous, using his willpower to counteract the fear. However, he had not pursued that any further and commented to the GP that he did not think he could overcome his difficulties on his own accord. A cognitive- behavioural assessment would have focused on cognitive distortions, avoidance and prediction of failure in trying to overcome his food neophobia (Butler, 1989) (see Figure 2 for an example of a simple CBT formulation for this case). To assess those aspects, the questioning style would need to be problem-focused.

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In contrast, solution-focused therapy assumes that exceptions to the problem are in fact evidence of strength and resources within the client, showing his inherent ability to overcome and solve problems. Hence, the therapist used John's experiences of trying out new foods, in spite of his nausea and fear, to praise him and encourage him to see that as proof of his own capability to help himself. Examples of questions used to do so are again largely Socratic:

- So how did you do that?
- What helped you to achieve that?
- How did you deal with the difficulties you faced in doing that?
- What did you learn about yourself managing to do that?
- What do you think that might have taught others about you?

No questions were asked to retrieve more details about what stopped him from making progress. John responded well to this type of questioning and obviously enjoyed the idea of him being able to help himself. At the end of the first session, he agreed to try again those foods he had eaten before and that he would be satisfied if he managed to do so at least twice a week. This first session lasted about 45 minutes. The second session a fortnight later lasted less than 10 minutes. John had done very well, eating rice cooked with onions, fish fingers, chips and a plain pizza, while trying to eat something new nearly every day. The therapy time was merely used to emphasize this progress and John's courage and strength to push himself beyond his fears. Again, no questions were asked about what had not worked for him. It is assumed in SFBT that clients readily volunteer such information if it is pressing. John left the session beaming with pleasure. The third session, 3 weeks later, again lasted less than 10 minutes. John had been able to expand his range of tried foods, generally eating what appeared on the family table and enjoying most of it. He did still feel a bit sick at times, but he always managed to push himself to at least try the food. He had not vomited once during the 5 weeks since he first met with the therapist and he no longer experienced catastrophic thoughts about the consequences of eating unknown foods. He had started going out with his friends and was looking forward to being able to attend the Christmas festivities at his sports club a few weeks later. John agreed that he did not need to see the therapist again, but was keen to keep the option open "just in case". A year later, he had not requested any further input from the therapist or his GP.

Discussion

There is some debate among cognitive behavioural therapists as to whether solution-focused therapy has anything new to offer. Both SFBT and CBT use an approach that explicitly focuses on behaviour change. However, the difference between them is that SFBT involves no problem deconstruction. There is some evidence that cognitive behaviour therapists are beginning to add solution focused thinking to their repertoire (Mooney and Padesky, 2000), but those ideas still involve deconstruction of unhelpful thinking patterns. It is the authors' view that there is a distinct difference between solution-focused therapy and cognitive behavioural therapy, as the focus in the former is entirely on the client's success. While acknowledging the client's difficulties, SFBT questioning starts with looking at exceptions to the problem behaviour and doing a functional analysis of this deviation from the problem norm. The process of the problem is not explored beyond what the client spontaneously volunteers. Questions asked all focus on his ability to overcome the difficulties.

As mentioned above, based on research evidence, the therapist had considered using a comprehensive cognitive-behavioural intervention to help John overcome his long-standing phobia. However, solution-focused questioning quickly brought out John's own ability to help himself in spite of his initial strong belief that he needed external support to do so. In comparison with more conventional cognitive behavioural approaches to food neophobia, as described by Marcontel et al. (2003), this case example shows that SFBT can greatly facilitate the process of change in such an intervention. It also shows an example of how solution focused therapy techniques can be used to facilitate change within the context of a cognitive behavioural formulation. This could be useful at "stuck points" in therapy when the idea of trying behaviour change techniques or behavioural experiments is very frightening to a client. The brevity of SFBT also has strong economical advantages. Although outcome literature on SFBT is still limited, examples from clinical practice as given here show the potential of incorporating its techniques in more conventional therapy approaches.

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