Chapter 32: Structured Problem Solving and Behavioural Activation

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Introduction

This chapter introduces CBT techniques that have a good evidence basis, are widely applicable and suitable for use in a range of settings; they are well suited to situations in which there is little time available for each session, and in which the total number of sessions that can be offered is relatively small. In general, they are also techniques that may be mastered relatively quickly by therapists without specialist mental health qualifications, and so are particularly well suited to general medical settings.

Problem Solving Therapies (PST) and Structured Problem Solving (SPS)

Problems and challenges are an inevitable part of life, and individuals need effective strategies for navigating them. Being faced with dilemmas and difficulties in life is usually at least somewhat stressful. Whilst emotion-focussed coping (focussing on, and managing, emotional responses) has an important role in self-management, it is also important to be able to take a problem-focussed approach when faced with a potentially modifiable stressor. The ability to effectively problem solve is seen as an important contributor to social competence (D'Zurilla, 1988). Social competence refers to the ability of an individual to function independently and deal with the demands of everyday life; it requires social skills, behavioural competencies and adaptive coping strategies. The ability to solve problems in real-life settings is sometimes referred to as *social problem solving*, which is said to include elements of social learning and self-management, as well as being a general coping

strategy (D'Zurilla, 1988). Problem solving therapies (PST) are an example of problem-focussed coping strategies. There was a rapid expansion of PST in the 1970s and 1980s, with the development of a number of structured approaches, including Structured Problem Solving (SPS).

Rationale for SPS

Numerous studies have shown a link between perceived, or actual, poor problem-solving ability and poorer physical and mental health, as well as a tendency to avoid problems rather than deal with them directly. Conversely, those who perceive themselves as effective problem solvers appear more likely to tackle problems directly, have a greater expectation of success, and have a more positive self-concept. Better problem-solving is postulated to play an important role in both mediating, and moderating, the relationship between stressful life events and well-being (Bell and D'Zurilla, 2009). More effective problem solving may reduce the burden of stress from life problems, but also contribute to enhanced confidence and sense of self-efficacy.

Evidence Base

PST has been shown to be more effective for depression than a treatment that involved discussion of current life problems with a problem-solving goal, but without explicit training in problem-solving skills (Nezu, 1986). The same study found more positive changes in behaviours and attitudes towards problem solving in the PST group, providing support for the view that these skills can be learned. A meta-analysis of 31 studies of PST across all types of mental or physical health problems (Malouff et al., 2007) including depression, dysthymia, obesity, conduct disorder, substance misuse and suicidal ideation, found effect sizes of the order of 1.4 compared to waitlist or no treatment; 0.5 against treatment as usual and attention-placebo; and 0.2 against other experimental treatments. This analysis found that PST that included training in problem-orientation and homework was associated with a larger effect size (Malouff et al., 2007). A meta-analysis focussing on depressive disorders reported equivalence for medication (d = -0.13) and alternative psychosocial therapies (d = 0.17), and superiority to supportive therapy and attention control (d = 0.45). PST in anxiety has been shown to be effective, but to date has generally not been shown to be superior to other forms of treatment (Kendrick et al., 2005; Provencher and Ladouceur, 2004).

Problem Solving

Problem-solving in real-life social settings includes two processes: problem orientation and problem-solving strategies. Problem orientation refers to beliefs and

attributions around problems and problem-solving in general, for example, beliefs about the causes of problems, general views about the likelihood of finding solutions, beliefs about personal problem-solving ability, and locus of control (the degree to which an individual feels they can control events and outcomes in their lives). The major goals of PST are to facilitate a positive problem orientation and enhance problem-solving skills and ability.

Positive Problem Orientation

Aspects of positive problem orientation include perceiving problems as challenges that can be dealt with effectively, seeing a potential to benefit from the situation, having a positive view of one's own ability to problem-solve, and being realistic about the time and effort involved, and about outcomes (for example, it is unlikely that there will be a 'perfect' solution to any problem).

Structured Problem Solving

Problem solving ability can be enhanced by taking a rational and structured approach to problem solving. There are four main problem solving skills taught in PST (D'Zurilla, 1988). These are: problem definition and formulation, generation of alternative solutions, decision-making, solution implementation and verification. These may be further subdivided into the following steps:

1. Problem definition and formulation
2. Generation of alternative solutions
3. Evaluation of pros and cons of each possible solution
4. Choice of solution (or combination of solutions)
5. Planning for and implementing chosen solution(s)
6. Review of the outcome

Problem definition is a key step, as it formulates the issue in a way that is amenable to the problem-solving approach. Many individuals find this difficult, tending to present broad issues, emotional distress or decision-making dilemmas, for example, 'I'm too anxious' or 'Should I leave my job?'. Steps 5 and 6 are also important to focus on: many people can generate ideas about how to tackle their problems, but either fail to make concrete plans, or generate plans that are not realistic. Many people do not review the outcome, and so may miss the opportunity to learn from success, or to fine tune their approach to further improve the outcome. Without a review there is also a risk that individuals may see a suboptimal outcome as final, and fail to appreciate that they can use what they learned from this initial attempt to solve the problem to inform their next cycle of problem-solving. It is important to realise that many problems in adult life are complex, and typically associated with uncertainties such that the first attempt at problem-solving may not achieve an ideal outcome. It does not reflect a failure of the individual or an insoluble problem, but rather realistic challenges.

In clinical practice SPS can be conducted with a patient in one long session, which is likely to require 45-60 minutes. This will only be possible where all the necessary information is to hand – sometimes there is a need to obtain further information to assist in generating options or weighing them up. In a community setting, including general practice, a series of 15 minute appointments based around each problem solving step, with 'homework' for the patient between visits, can work well.

Clinical Example

Tahlee is a 26 year old single mother with two boys aged 2 years and 4 years. She presents to her GP in distress asking: *'What should I do? I don't know whether to move to Gosford or stay in Sydney!'* Tahlee presents the problem as though it is a decision-making dilemma with a choice of two options. Exploration is important in order to define and formulate the real problem.

Doctor: "*Can you tell me about why you are thinking of moving?*"
Tahlee: "*My mother lives in Gosford. She could help with the children.*"
Doctor: "*What kind of help do you need with the children?*"
Tahlee: "*I want to get a job. There's no-one to care for the kids while I would be working.*"
Doctor: "*So getting a job is a priority for you?*"
Tahlee: "*Yes! But I need childcare to do that.*"
Doctor: "*It seems like getting a job and finding childcare are both problems. Which would you like to focus on as the main problem?*"
Tahlee: "*I think finding childcare is my main problem.*"

The problem is now more clearly defined and more amenable to problem-solving. Tahlee can now be introduced to the principles of structured problem solving, and the doctor can support her in working through the steps. It is most helpful if Tahlee can generate as many options as possible. In achieving this, the doctor should avoid making suggestions. Patients can be asked to canvass others for ideas, or to imagine what others might do. These tasks can be set as homework between sessions. It is then important for Tahlee to be realistic about the pros and cons of each option. For example, her list of possible solutions might look like this:

1. Move to Gosford to be closer to Mum.
2. Ask ex-partner's mother if she can help.
3. Find out more about eligibility for government childcare subsidy.
4. Start a family day care business so I can work at home.

5. Look for other ways to work from home or be able to have the kids with me.
6. Wait until the kids are a bit older.

Tahlee's GP encourages her to consider the pros and cons of each possible solution in turn. For example:

1. Gosford

Pros	*Cons*
Mother happy to babysit	Very few jobs available
Cheaper to live in Gosford	Don't know anyone up there except Mum

2. Ask ex-partner's mother to help

Pros	*Cons*
I get on quite well with her	Don't really want to see more of ex-partner, though he doesn't live there
She has offered to help before	
Can stay in Sydney where there are more jobs	

And so on, until all options are considered. The health professional has an important role in supporting patients to be realistic in their assessments. Once all options have been assessed, the patient chooses the best option or combination of options and makes a specific implementation plan, covering aspects such as 'who, what, when, where, how'. In the example above, Tahlee might choose to approach her ex-partner's mother for help, but find out more about the government childcare subsidy at the same time. In the medium term she might also explore options around ways to work from home.

In the final step, a review is undertaken, either by the patient alone or supported by the health professional. How well did the option work? Is there a residual problem to be addressed? It will sometimes be the case that the problem may be partially resolved and could benefit from another cycle of problem solving.

The long-term aim is for patients to develop independent problem-solving skills. Along the way they may encounter more problems with which they need support to apply this technique. The health professional's attitude of faith in the individual's ability to solve their own problems, together with avoidance of telling

them what to do or giving advice, will promote the acquisition of this skill and confidence in using it.

Behavioural Activation

Behavioural activation (BA) is designed as a brief, time-limited intervention to increase activity and engagement in behaviours that are associated with positive emotional consequences. It is most often employed in depression, since depressed individuals particularly have been shown to engage in less positively reinforced behaviour but also to employ avoidance behaviours, and strategies such as rumination and complaining that have been described as escape behaviours (Moulds and Kandris, 2007). However, BA may be of value wherever inactivity and withdrawal have become prominent problems.

Behavioural activation therapy for depression is based on the 'behavioural analytic theory' of depression, a model that proposes that individuals can become depressed when there is an imbalance in reward and punishment in their environment; namely, too much punishment and inadequate reward. Behavioural activation therapy aims to reconnect individuals with sources of positive reinforcement in their environment by scheduling activities into their day that provide them with a sense of pleasure or achievement. The first therapy package developed from this model is attributed to Lewinsohn and colleagues in the 1970s, who developed Behavioural Activation as an intervention aimed at increasing engagement in pleasurable activity. A key consideration of the behaviour analytic model is that the purpose or goal of a behaviour is more important than the form it takes. For example, spending all day indoors reading may be an avoidance behaviour for one individual, a pleasure rarely afforded to another, or a necessity of student life for a third. For the first person, reading functions as avoidance, for the second it is a pleasure in itself, and for the third it is a means to a desired end.

With the advent of cognitive therapy in the 1980s, behavioural activation was deemed inadequate as a treatment for depression as there was no consideration of cognitive factors. However, renewed research interest in behavioural activation found it to be equally effective as a full cognitive behavioural treatment package for depression at post-treatment (Jacobson et al., 1996) and prevention of relapse at 2-years follow-up (Gortner et al., 1998). In a more naturalistic setting of existing clinical services (both general practice and psychological therapy practices), BA delivered by junior mental health workers was found to be non-inferior to CBT delivered by accredited CBT therapists (Richards et al., 2016). BA lends itself well to manualisation, and the principles of delivering this therapy can be mastered quickly. It is therefore an ideal therapeutic intervention for non-specialists. BA typically includes psychoeducation about depression and the rationale for focusing

on activity, identification of activities that bring a sense of pleasure or achievement (or that have this potential), and a diary for planning activities and monitoring the results, for example, rating the sense of pleasure and/or achievement gained. It is important not to limit the focus to pleasurable activities, but also to target those that may bring a sense of achievement. A BA program may also include baseline monitoring of activity and identification of behavioural goals (e.g. (Lejuez et al., 2001)). When using the technique to treat a specific condition, for example, anxiety or depression, baseline ratings of the target symptoms, together with progress monitoring should be undertaken. For example, use of rating scales such as the Depression, Anxiety and Stress Scales (DASS; (Lovibond, 1995)). In most cases, BA can be effectively delivered within eight sessions.

BA may be combined with 'graded task assignment', whereby behavioural goals that are initially too difficult or demanding are broken down into smaller steps that themselves become targets for achievement within a BA plan.

Tips For Clinical Practice

Many patients with psychological problems are highly self-critical and may tend to set perfectionistic goals and targets. A key element of BA is mastery, so a good rule of thumb is to set goals for which there is a 90% likelihood of achievement, in order that the patient predominantly experiences success. Discussion with the patient to assist them to set realistic (rather than idealistic) goals and targets can be an important element of therapy. It is better to set small and easily accomplished goals with the experience of success than to add to experiences of failure. For example, asked to identify a goal that would bring a sense of achievement a patient may nominate 'completing my overdue tax return'. Setting this as a goal may be unrealistic, and it may be better to employ graded task assignment here, by breaking up this goal into a series of smaller and more manageable tasks. This is best negotiated with the patient so it can take into account their specific circumstances, but might include goals such as 'sort through the pile of papers on my desk to identify those that may be relevant for tax', 'see if I have my group certificates', 'obtain group certificates', following which the patient might begin the tax return by completing one page at a time of the online form, or one category of expenses at a time if on paper, for example.

Since lack of motivation and problems with initiating behaviour are the problems that BA aims to treat, the health professional will need strategies to increase the likelihood that the patient will actually plan and complete tasks. This is most likely to be the case when at least some of the planning is undertaken within the session, rather than simply presenting information and advice then leaving the patient to implement it all at home. Taking enough time to ensure the patient has

engaged with the therapy – that is, that they appreciate the rationale and agree that it may have some benefit for them – is also important. This may mean spending more than one session on the introduction to and preparation for BA. See (Lejuez et al., 2001) for an example of this.

A sense of personal achievement and confidence will build motivation, and may be enhanced by supporting the patient to periodically review and acknowledge their achievements. For patients who feel as though nothing brings pleasure, it can also be helpful to sensitively guide them to attend to positive ratings, which might also indicate activities worth repeating. Examples of recording forms may be found on various websites or in (Lejuez et al., 2001).

Conclusions

Problem-solving therapies and behavioural activation are therapeutic interventions that may be mastered by generalist clinicians without specialist mental health qualifications, and which can be implemented over relatively brief time periods. They may be as effective as other psychological treatments and in some cases as effective and better tolerated than pharmacotherapy. They may be used alone or together with pharmacological or other psychological interventions. The selection of therapeutic intervention is best guided by an assessment of the individual's presenting problems.

Further Reading

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