UNIT NO. 5

PROBLEM WORK. PATTERN WORK

A/Prof Cheong Pak Yean, Dr Ong Chooi Peng, A/Prof Goh Lee Gan

ABSTRACT

In this Unit we describe the first 2 types of intervention arising out of the extended consultation. In Problem work, the basic idea is to determine whether the patient's behavior is a maladaptive response to antecedent stimuli, or the result of cognitive bias. We use counter-conditioning and contingency management to deal with maladaptive response. We use cognitive therapy to trace cognitive distortions that give rise to NATs and take steps to counter them. The problem approach is integrated as Cognitive Behavioral Therapy. The SMART solution to problems is deployed when there is no maladaptive behavior or cognitive bias at play. In pattern work, the salient life experiences of the patient which are selectively stored as narratives are examined. Such narratives may reflect a negative life pattern of thought and feeling. This is the problem-saturated story. Patients can be helped to change their pattern of thought and feeling and thus store their life experiences as preferred positive stories. The 4Rs – Re-membering, Re-framing, Re-authoring and Re-telling – help us to construct the new stories. When we do this consistently, the pattern work creates present and future stories of hope for the sufferer.

Keywords: Problem work; Counter-conditioning; Contingency Management; Negative automatic thoughts; Cognitive behavioral therapy; Pattern work; Problem-saturated stories; Preferred positive stories.

SFP2018; 44(1) : 15-18

INTRODUCTION

We have four strategies to manage psychosocial distress — Problem work, Pattern work, Presence work, and Positive work. Which one to use for a patient depends on the usefulness of the strategy and the confidence of the therapist in it.

PROBLEM WORK

When Can Problem Work be Used?

This is useful where behaviour is unhealthy or maladaptive. It is about intervening to change the patient's unhealthy behaviour in response to a situation, to one which is preferred. The basic assumption is that we all learn how to behave in certain ways in response to certain stimuli. Hence, we can be taught to develop different ways of behaving in response to the stimuli. Another assumption is that our thoughts and our behaviour are connected. Therefore, if we change how we think about something, we can change behaviour[1].

If the problem behaviour is not due to defective responses or thoughts, the intervention is more straightforward. Problem-solving strategies can be applied to achieve goals which should be specific, measurable, achievable, realistic, and time-delimited. We can conveniently remember this as using SMART measures to solve a problem. Behavioural and cognitive work are often combined.

BEHAVIOURAL TOOLS

Behavioural tools fall into two broad categories — counter-conditioning and contingency management.

Counter-Conditioning

Counter-conditioning is based on the work of Pavlov (1849–1936) and Wolpe (1915–1997). It is based on stimulus control and the assertive response. There is a third counter-conditioning technique, namely reciprocal inhibition.

Stimulus control

By this we refer to the strategy of avoiding an undesirable response by avoiding the inciting stimulus. For example, a patient who is on a diet can plan to avoid the sight or smell of food, and hence avoid his food-seeking behaviour and inappropriate eating.

Assertive response

We can coach our patient to respond to certain stimuli in a way he would not usually do. In this way, he can increase the number of his possible responses to a situation. He can be coached to acquire a new, assertive behavioural response.

Let's say we have a diabetic patient who will be attending a buffet dinner. We can coach him to visualise the range of food on offer and to decide what he will choose to eat.

Reciprocal inhibition

This technique starts by identifying the stimulus that produces the problem behaviour, as well as another stimulus that produces an opposite, or contradictory response. Take an example of the smoker who is trying to quit. Instead of having a meal at the coffeeshop during the weekend with his buddies, an activity which he associates with an after-dinner smoke, he is encouraged to meet them for a jog instead. In this way, the smoker gradually

CHEONG PAK YEAN
Adjunct Associate Professor

ONG CHOOI PENG
Senior Consultant

GOH LEE GAN
Senior Consultant

Division of Family Medicine, University Medicine Cluster,
National University Health System

stops associating his buddies with cigarettes.

Contingency Management

Contingency management is built upon the principle that behaviour is strengthened or weakened, contingent upon the consequence. This consequence can be positive or negative. The response to the stimulus is **reinforced** by adding a positive consequence or reward, or by removing the negative consequence. On the other hand, the response will be **weakened** if we remove the positive, or add a negative consequence.

COGNITIVE TOOLS AND COGNITIVE THERAPY

Cognitive therapy is directed at how we perceive and interpret the stimuli that we are presented with. One important tool here is recognition and management of NATs, or negative automatic thoughts.

Contrary to what we like to think, we do not always react rationally in situations. Sometimes, certain cues from the situation will automatically trigger an emotional response, which may be quite irrational or undesirable. We may not even be aware of the thoughts that triggered these emotions, because these are in our sub-conscious. We just experience a shift in emotions or behaviour. These thoughts are called NATs.

We can often trace NATs to cognitive distortions, which can be thought of as inappropriate ways of perceiving or interpreting the situation. These ways may have been appropriate or useful in the past, but they may not be appropriate when we try to apply them automatically to the present situation.

Examples of cognitive distortions include stereotyping, where we generalise our experience of someone to the entire group he represents; or catastrophising, where we are confronted with a situation and immediately expect the worst to happen[2].

Cognitive Behavioural Therapy

Behavioural tools and cognitive tools can be used together. The combination is then called cognitive behavioural therapy or CBT.

PATTERN WORK

When we use the genogram and the timeline, we may identify events in the patient's life that are imbued with positive or negative feelings. We may notice that the patient has unconsciously or subconsciously authored problem stories by linking together significant negative events with negative themes whilst ignoring the positive events.

Such people are said to indulge in negative patterns of thinking and reacting. Their negative stories are called problem-saturated stories. In pattern work, we get patients to tell their problem-saturated stories as the first step in therapy.

A useful technique in pattern work is to listen with an EAR to the past and an EAR to the future.

EAR to the Past[3]

Examining salient situations and stories

We examine the patient's salient situations for their meaning to him, looking especially for patterns, or themes, that the patient has used to link into the defining stories of his self. We can take apart the stories by helping him to realise that the linkages may not be valid or true by looking for exceptions. This is **deconstruction**.

Sometimes the problem stories are so enmeshed with self and personality that the patient may not be able to talk about them apart from himself. We may need to separate the patient from his problem using the technique of **externalisation**.

Alignment & realignment

We need to actively listen to the situations and stories to understand the themes that align them. Next, we deconstruct the stories by open questioning using CAR-ACE and then re-align them so that the stories lose their hold over the patient. For example, we can make the patient aware that situations may not be the same and should not be linked together. This is done in tandem with the reconstruction tools discussed next.

Reconstructing Preferred Positive Stories

There are 4 reconstruction tools — re-membering, re-framing, re-authoring, and re-telling. These are used to deconstruct the problem-saturated stories and then to reconstruct them into preferred positive stories.

Re-membering involves reviewing the status of past and present significant persons or events, as players in the patient's present life story. In other words, we are trying to assess what they mean now to the patient. If the present meaning is still problematic, the patient can be helped to re-Member so that the past person or event, together with the accompanying pain or hurt, can be dropped out.

Re-framing involves looking at a situation with a different perspective. We try to help our patient see his glass as half-full instead of half-empty.

Re-authoring involves examining at the patient's problem saturated story for discordance, deconstructing the story and re-visiting the events. Then we look for exceptions to the negativity which can be framed into a preferred positive story. The new story is authored by infusing new meaning and plot into the story, which incorporates the exceptions that were previously ignored in the old story.

Re-telling the new story over and over will thicken the story. The telling can first be rehearsed in practice situations, and then executed in social situations.

EAR to the Future[4]

We can also construct stories from finding positive moments in the present, as well as from hopes and dreams for the future. The practitioners of Solution Focused Brief Therapy believe that a fixation on past problematic situations and repeatedly talking about them may be counterproductive. Instead, they help patients to focus on hopes and dreams for a future where the problems do not have such a hold.

Elicit Exceptions

For example, we have a depressed man who keeps talking about how unfortunate his life has been, because of past choices. The therapist notices that the man brightens when the conversation touches on his grandchildren. Instead of letting him brood on, the therapist switches his focus to the present and starts talking to him about his family. The focus is shifted from problem talk to solution talk in the present and the future.

Amplify small steps

The miracle question can be suggested to elicit more exceptions. The man can be asked how he would behave if, by a miracle, all his gloom vanishes when he sleeps. When we explore the new imagined situation with him we can generate more positive experiences. Every exception which may seem small to start with, can be amplified.

Rescale, Repeat, then Reconstruct

After going through each small step, the patient will be asked to scale his feelings. If he improves, repeat the step. If not, elicit some other exceptions and amplify again. Once the gloom is dispelled, the focus shifts to reconstructing the preferred positive story.

REFERENCES

1. Beck JS. Cognitive Behavior Therapy: Basic and beyond. 2nd ed. New York: Guilford Press; 2011.
2. Lee D. Using CBT in General Practice. Bloxham, UK: Scion Publishing; 2006.
3. Dulwich Centre: A gateway to narrative therapy and community work. http://www.dulwichcentre.com.au. [Accessed date 20 Dec 2017]
4. Solution-focused brief therapy association. http://www.sfbta.org. [Accessed date 20 Dec 2017]

SOME EVERYDAY APPLICATIONS OF PROBLEM WORK AND PATTERN WORK AND SELECTED READINGS

	Topic	Suggested readings
1	Chronic insomnia	• Harsora P, Kessmann J. Nonpharmacologic management of chronic insomnia. Am Fam Physician. 2009;79:125–30. PMID: 19178064. • Joshi S. Nonpharmacologic therapy for insomnia in the elderly. Clin Geriatr Med. 2008;24:107–19. PMID: 18035235. • Toth CM. The anxious sleeper. J Clin Sleep Med. 2010;6:403–4. PMID: 20726291.
2	Smoking cessation	• Mola A, Lloyd MM, Villegas-Pantoja MA. A mixed method review of tobacco cessation for the cardiopulmonary rehabilitation clinician. J Cardiopulm Rehabil Prev. 2017;37:160–74. PMID: 28448378.
3	Chronic obstructive pulmonary disease	• Osthoff M, Jenkins C, and Leuppi JD. Chronic obstructive pulmonary disease — a treatable disease. Swiss Med Wkly. 2013;143:w13777. PMID: 23592218.
4	Diabetes management	• Williams-Reade J, Freitas C, Lawson L. Narrative-informed medical family therapy: using narrative therapy practices in brief medical encounters. Fam Syst Health. 2014;32:416–25. PMID: 25329755.
5	Cardiometabolic risk reduction	• Dagogo-Jack S, Egbuonu N, Edeoga C. Principles and practice of nonpharmacological interventions to reduce cardiometabolic risk. Med Princ Pract. 2010;19:167–75. PMID: 20357497.
6	Shared decision making in antibiotic use	• Coxeter PD, Del Mar C, Hoffman TC. Parents' expectations and experiences of antibiotics for acute respiratory infections in primary care. Ann Fam Med. 2017;15:149–54. PMID: 28289114.

LEARNING POINTS FOR PROBLEM WORK

- **The basic idea is to determine whether the problem behaviour is a maladaptive response to antecedent stimuli, or the result of cognitive bias.**
- **We use counter-conditioning and contingency management to deal with maladaptive responses.**
- **We use cognitive therapy to trace cognitive distortions that give rise to NATs and take steps to counter them.**
- **The problem approach is integrated as Cognitive Behavioural Therapy.**
- **The SMART solution to problems is deployed when there is no maladaptive behaviour or cognitive bias at play.**
- **Positive psychology can be incorporated into CBT to construct new positive beliefs and behaviours, and to augment existing strengths.**

LEARNING POINTS FOR PATTERN WORK

- **We recognise that salient life experiences are selectively stored as narratives.**
- **Such narratives may reflect a negative life pattern of thought and feeling. This is the problem-saturated story.**
- **Patients can be helped to change their pattern of thought and feeling and thus store their life experiences as preferred positive stories.**
- **The 4Rs — Re-membering, Re-framing, Re-authoring and Re-telling — help us to construct the new stories.**
- **When we do this consistently, the pattern work creates present and future stories of hope for the sufferer.**