The role of problem orientation and cognitive distortions in depression and anxiety interventions for young adults

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Abstract
Interventions that aim to improve social problem-solving skills can significantly reduce the severity of anxiety and depression symptoms in young people. Anxious and depressed individuals often have a negative orientation to problem solution which acts as a barrier to implementing problem-solving skills. Research with older adults suggests that symptoms impair problem-solving abilities through cognitive processes associated with the development of anxiety and depression. In this study we extend previous investigations by assessing the extent to which specific cognitive distortions and symptoms of anxiety and depression are associated with negative problem orientation (NPO) in a sample of 285 young adults aged 18–25 years. Results found that cognitive distortions and depressive symptoms were strong predictors in a regression model that explained approximately half of the variance in NPO. Results also found that the relationship between cognitive distortions and NPO was strengthened as depressive symptoms became more intense. The distortion ‘You think you know what the future will bring; you expect disaster and gloom’ had the strongest individual association with NPO and depressive symptoms. Implications for enriching prevention and early intervention initiatives for young adults are discussed.

Keywords: interventions, anxiety, depression, cognitive distortions, young adults

Approximately 1 in 6 young Australians aged 16–24 experiences an anxiety disorder and 1 in 16 experiences an affective disorder within a 12-month time period (Australian Bureau of Statistics, 2008). The highest prevalence of severe disorders is experienced among those with an affective disorder, followed by those with an anxiety disorder (Reavley, Cvetkovski, Jorm, & Lubman, 2010). The consequences of not intervening when the signs and symptoms of these disorders first appear can affect social, educational and vocational outcomes and, in many cases, can have detrimental effects that last a lifespan (Kessler, Foster, Saunders, & Stang, 1995).

Numerous studies have found that deficits in social problem solving are associated with anxiety and depression symptoms and disorders (e.g., Klein et al., 2011). Interventions that aim to improve social problem-solving abilities can both protect against the development of anxiety and depression (e.g., Bell & D’Zurilla, 2009; Fitzpatrick, Witte, & Schmidt, 2005; Ishikawa, Togasaki, Sato, & Sato, 2006) and significantly reduce the severity of anxiety and depression symptoms in young people (e.g., Eskin, Ertekin, & Demir, 2008; Lerner & Clum, 1990; Rudd et al., 1996). In this study we examine the associations between variables that are known to interfere with treatment effects by acting as barriers to the use of effective problem-solving skills. Our study extends previous research by assessing the extent to which specific modifiable cognitive distortions interact with anxiety and depression symptoms to predict a negative problem orientation (NPO) in a sample of young adults.

Social problem solving is the self-generated cognitive–affective–behavioural process through which an individual attempts to identify, discover or invent effective or adaptive strategies for coping with everyday problems in a social environment (D’Zurilla, 1986, 1990; D’Zurilla & Nezu, 1999). Strong social problem-solving abilities reduce the morbidity associated with anxiety and depression by aiding young people to control and modify their health behaviour (Frauenknecht & Black, 2003), and are of key importance in...
managing emotions and well-being (Siu & Shek, 2010). According to Black and Frauenknecht (1990), social problem solving in young people comprises two complementary sub-processes. The first is the automatic informal process where young people respond to problems by doing what has been done in the past, often by what is easiest. The second is the formal evaluation process that is implemented when the automatic process provides no apparent solution or benefit.

The evaluation process includes two complementary dimensions: problem orientation and problem-solving skills (e.g., Black & Frauenknecht, 1990; D’Zurilla & Nezu, 1999). Problem orientation is the motivational aspect of the social problem-solving process. It is underpinned by cognitive, affective and behavioural schema that result in ‘orienting responses’ – the individual’s cognitive, affective and behavioural responses to a problem that has no immediate solution or has not been faced before (Frauenknecht & Black, 2003). Depending on these responses, problem orientation will either activate or inhibit a young person’s initiation of problem-solving skills, the amount of time and effort they invest in problem solving, their emotions generated by the process, and the efficiency of their problem-solving performance (D’Zurilla & Sheedy, 1991, 1992).

Within the context of mental health promotion, prevention and early intervention, a positive problem orientation can be understood as a protective factor that facilitates the initiation of proactive problem-solution skills to manage or minimize early signs or symptoms of psychological distress. A NPO – a dimension of problem orientation that is related to, but different from, positive orientation (Maydeu-Olivares & D’Zurilla, 1996) – can be understood as a barrier to active problem solution and, consequently, an important barrier to managing or minimizing early signs or symptoms of psychological distress (D’Zurilla & Nezu, 1999). Problem-solving skills are the cognitive goal-directed tasks that must be successfully completed for effective problem solution (D’Zurilla & Nezu, 1999). These include: (1) problem identification; (2) alternative solution generation; (3) consequence prediction; (4) strategic solution implementation; (5) progress evaluation; and when necessary, (6) solution strategy reorganization (Frauenknecht & Black, 2003).

To improve mental health outcomes, it is important that active components of effective interventions are harnessed to establish how these interventions work (Sutton, 2007). Intervention components that act as barriers to successful treatment outcomes must also be identified and minimised (Rickwood, Deane, Wilson, & Ciarrochi, 2005). It is noteworthy that anxiety and depression symptoms have the strongest association with a NPO above all other aspects of the social problem-solving process (e.g., Chang & D’Zurilla, 1996; Chang, D’Zurilla, Sanna, 2009; Haugh, 2006; Siu & Shek, 2010). It is also noteworthy that success in reducing symptoms of anxiety and depression appears more strongly predicated on the absence of NPO than the presence of positive problem orientation per se (Chang et al., 2009). Clearly, a NPO is an important barrier to symptom minimisation that must be better understood. These findings also suggest that universal and selectively targeted interventions to reduce anxiety and depression among young people might be enriched by content and delivery strategies that minimise variables that strengthen a NPO.

**DEPRESSIVE SYMPTOMS AND REDUCED COGNITIVE PERFORMANCE**

Studies with older adults have found that symptoms or syndromes of depression, which include anxiety symptoms, are associated with reduced cognitive performance (Browner, 1999), resulting in poor problem-solving outcomes (Yen, Rebok, Gallo, Jones, & Tennstedt, 2011). In the first study of its kind, Yen et al. (2011) examined the relationship between depressive symptoms and everyday problem solving in a sample of 2,832 older adults (mean age 74 years). The study found that depressive symptoms and impaired cognitive function act together to reduce problem-solving ability in older adults. Whether similar associations predict problem-solving ability in young people is yet to be assessed, but emerging research lends support to the possibility. For example, in another study first, Hermens et al. (2011) assessed
neurological clustering in a sample of 109 young depressed outpatients and found that almost one in three showed a global cognitive performance deficit. Since most research suggests an association between symptom severity and reduced cognitive performance (see Hermens et al., 2011, for a review), such results raise a question of whether there are modifiable cognitive processes that precede or co-occur with early symptoms of depression and anxiety among young people. It also needs to be ascertained whether these processes interact with early symptoms of depression and anxiety to strengthen a NPO.

Cognitive distortions and negative problem orientation

Cognitive distortions refer to the different types of distorted cognitive processes that produce automatic negative thoughts, which in turn, evoke or strengthen early symptoms of psychological distress and emotional and/or behavioural disorders (Leung & Poon, 2001; Najavits, Gotthardt, Weiss, & Epstein, 2004). Individuals with a NPO are likely to perceive a problem as a serious threat to their well-being, respond with strong negative emotions (e.g., anxiety and/or depression), and avoid or postpone dealing with a problem (D’Zurilla & Nezu, 1999). Cognitive distortions in general, or some types in particular, may have an important role in evoking or strengthening an individual’s negative orienting responses.

Examples of the major types of cognitive distortions are: external attribution (i.e., blaming negative events on an external source), personalising (i.e., taking excessive responsibility for negative events), and catastrophising (i.e., dwelling on the worst possible outcome in any situation) (Najavits et al., 2004). It is possible that different types of cognitive distortion have a stronger association with NPO than other distortions. If some types of cognitive distortion, but not others, can be related to NPO, it would suggest that prevention and early intervention initiatives that focus on improving social problem-solving may be further improved by directly targeting these prominent cognitive distortions. Our review of the literature has found no published research that has examined this possibility.

Impact of anxiety and depression symptoms

Social problem solving is underpinned, at every level and in every aspect, by complex interactions involving a number of cognitive abilities that can be affected by psychological distress. Symptoms of psychological distress can themselves act as important barriers to engaging in behaviours to manage or minimize the development of mental disorders (see Wilson, Bushnell, & Caputi, 2011, for a review). Just as deficits in social problem-solving ability can lead to anxiety and depression, pre-existing symptoms of anxiety and depression can also generate deficits in cognitive function that impair social problem-solving abilities and outcomes (e.g., Cole, Martin, Peeke, Seroczyński, & Hoffman, 1998; Leung & Poon, 2001).

The association between anxiety, depression and cognitive distortions among young adults is well established, and suggests that as levels of anxiety and depression intensify, cognitive distortions also intensify (e.g., Brent, 2001; Lennings, 1994; Marton & Kutcher, 1995; Mobini, Pearce, Grant, Mills, & Yeomans, 2006; Najavits et al., 2004). With important implications for prevention and early intervention initiatives, these findings raise the possibility that young adults’ ability to use effective social problem-solving processes might be impeded by the severity of the very symptoms they need to manage. The results also suggest that cognitive distortions may have a role in the relationship between symptoms and the social problem-solving process.

Study aims

The aim of this study was to investigate the role of cognitive distortions in NPO, and the implications of this for the treatment of depression and anxiety. It was hypothesized that higher levels of cognitive distortion would be associated with a stronger NPO, as well as higher symptoms of depression and anxiety. Cognitive distortions were expected to be a stronger predictor of NPO than depression or anxiety symptoms, although the presence of anxiety or depression was hypothesized to increase the strength of the relationship between cognitive distortions and NPO. Finally, the effect of specific cognitive distortions on NPO.
Interventions focused on depression and anxiety

METHOD
Participants
A total of 285 participants with a mean age of 19.65 years (SD = 2.00 years) were drawn from first year psychology classes of one regional Australian university. Two-hundred and thirty-four participants (82.1% of the total sample) were aged between 18 and 21 years. Fifty-one participants (17.9%) were aged 22–25 years. Sixty-two participants were male (21.8%) and 223 participants (78.2%) were female.

Almost all the sample described their culture as Australian.

Procedure
Approval was obtained from the University’s Human Research Ethics Committee. Participants were recruited through the School of Psychology student research participation scheme and completed an anonymous online self-report survey.

Measures
Negative problem orientation was measured by the 10-item NPO scale of the Social Problem-Solving Inventory-Revised (SPSI-R; D’Zurilla, Nezu, & Maydeu-Olivares, 2002). Each item is rated on a 5-point scale (1 = ‘Not at all’ to 5 = ‘Extremely true of me’, 3 = ‘Moderately true of me’). Items are averaged to create a scale score and higher scores indicate stronger NPO. The NPO has shown good reliability and validity across a number of samples (D’Zurilla & Nezu, 1990; Hawkins, Sofronoff, & Sheffield, 2009; Maydeu-Olivares, Rodriguez-Fornells, Gomez-Benito, & D’Zurilla, 2000).

Anxiety and depression symptoms were measured by the 21-item version of the Depression Anxiety Stress Scales (DASS-21; Lovibond, & Lovibond, 1995). The DASS-21 consists of 21 statements that measure symptoms of depression, anxiety and stress that are experienced in the past week (seven statements per scale). Only the depression and anxiety scales were used in this study. Statements included in the depression scale have an emphasis on mood (e.g., feeling blue, feeling that life is meaningless, loss of enthusiasm), while statements included in the anxiety scale have an emphasis on somatic and behavioural symptoms that are associated with autonomic arousal (e.g., trembling, feeling agitated, finding it hard to wind down, heart pounding). Each statement is rated on a 4-point scale (0 = ‘Did not apply to me at all’, 3 = ‘Applied to me very much, or most of the time’). Scores for each item are summed to indicate participants’ levels of depression or anxiety, and can range from 0 to 21 per scale. The DASS has shown good discriminant and concurrent validity, and sound convergent reliability with other measures of depression and anxiety such as the Beck Depression Inventory and the Beck Anxiety Inventory (e.g., Antony, Bieling, Cox, Enns, & Swinson, 1998; Lovibond & Lovibond, 1995). In studies with clinical samples, the DASS has shown excellent clear factor structure that supports the independent use of each scale (e.g., Antony et al., 1998).

Cognitive distortions were measured by seven items selected from the Cognitive Distortion Scale to represent those most often associated with common mental disorders (Najavits et al., 2004): (1) ‘You have a list of how the world should work. When the rules are violated, you feel angry’ ['should’ statement]; (2) ‘You magnify all the negatives in a situation, and ignore all the positives’ [disqualifying the positive and focusing on the negative]; (3) ‘Things are black or white, good or bad. You have to be perfect or you are a failure. There is no middle ground’ [‘all or nothing’ thinking]; (4) ‘Because you feel something is true, then it must be true’ [feelings are reality]; (5) ‘You think you know what the future will bring; you expect disaster and gloom’ [fortune telling]; (6) ‘You know what other people are thinking without having to ask them’ [mind-reading]; and (7) ‘You believe that you alone have a particular problem; no-one else could possibly understand’ [uniqueness fallacy]. Participants rated each statement to indicate the extent to which they experience each type of thinking style on a 5-point scale (1 = ‘Not at all’ to 5 = ‘All the time’). Item scores were summed to create a general cognitive distortions score. Higher scores indicate higher levels of cognitive distortions. The full cognitive distortion scale has been found to have acceptable validity and reliability in a range of samples (Najavits et al., 2004).
RESULTS

Preliminary analyses
To examine the overlap between measures, all study items (7 cognitive distortion items, 10 NPO items, 7 anxiety items, and 7 depression items: 31 items in total) were submitted to principal axis factoring (PAF). PAF uncovered four factors with an eigenvalue greater than one that explained 57.59% of the variance, and six factors in total with an eigenvalue of 0.48 that explained 64.10% of the variance in the model (Kaiser-Meyer-Olkin measure of sampling adequacy = 0.931; Bartlett’s test of sphericity: Approximately $\chi^2 = 5626.77$, df = 528, $p < .001$). Using a Direct Oblimin rotation with Kaiser Normalisation and the loading criteria set to .30, all items loaded simply on the six factors. All cognitive distortion items loaded on factors 4 and 6, all problem orientation items loaded on factors 1 and 5, all anxiety items loaded on factor 2, and all depression items loaded on factor 3. There was no cross-loading between items measuring the different constructs. These results confirmed that the items used in this study measured related but distinctly different constructs. The means, standard deviations, and Cronbach’s alpha coefficients for each scale are listed in Table 1.

Main analyses
Bi-variate correlations were conducted to determine the interrelationships among levels of cognitive distortion, symptoms of anxiety and depression, and NPO. The correlations presented in Table 1 show that there were moderate to strong associations revealing that young people with stronger cognitive distortions had more severe symptoms of anxiety and depression and higher levels of NPO.

Multiple regression analysis was used to explore the extent to which NPO in young adults was predicted by cognitive distortions and symptoms of anxiety and depression (Table 2). Cognitive distortions, depression and anxiety symptoms were all significant predictors in the model, which accounted for about 44% of the variance in NPO.

Interaction effects were also hypothesized, and these were tested by including the interaction terms for cognitive distortions and both depressive and anxiety symptoms with the regression model. The interaction term for cognitive distortions and depressive symptoms attained significance ($\beta = -.08$, $t = -2.04$, $p < .05$), but the interaction with anxiety symptoms did not ($\beta = -.06$, $t = -1.47$, $p = .143$). This shows that depressive symptoms had a role in further strengthening the already strong association

### Table 1: Descriptive statistics

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>$\alpha$</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Negative problem orientation</td>
<td>2.29</td>
<td>0.87</td>
<td>.94</td>
<td>.60***</td>
<td>.46***</td>
<td>.58***</td>
</tr>
<tr>
<td>2 Cognitive distortions</td>
<td>14.40</td>
<td>4.48</td>
<td>.75</td>
<td>.45***</td>
<td>.57***</td>
<td></td>
</tr>
<tr>
<td>3 Anxiety symptoms</td>
<td>3.62</td>
<td>4.01</td>
<td>.85</td>
<td>.45***</td>
<td>.57***</td>
<td></td>
</tr>
<tr>
<td>4 Depression symptoms</td>
<td>4.33</td>
<td>4.34</td>
<td>.89</td>
<td>.45***</td>
<td>.57***</td>
<td></td>
</tr>
</tbody>
</table>

***$p < .001$.

### Table 2: Summary of regression analysis predicting negative orientation towards problem solution

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>$\beta$</th>
<th>Partial $r$</th>
<th>Adj $R^2$</th>
<th>F</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive distortions</td>
<td>0.50***</td>
<td>0.07</td>
<td>.38</td>
<td>.38</td>
<td></td>
<td>0.44</td>
<td>56.88</td>
</tr>
<tr>
<td>Depression symptoms</td>
<td>0.06***</td>
<td>0.01</td>
<td>.30</td>
<td>.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety symptoms</td>
<td>0.03*</td>
<td>0.01</td>
<td>.12</td>
<td>.13</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*$p < .05$, ***$p < .001$. 
between cognitive distortions and NPO, but anxiety symptoms did not.

Finally, to determine which cognitive distortions had the strongest relationship with depressive symptoms and NPO, bi-variate correlations between the individual cognitive distortions, depressive symptoms and NPO are reported in Table 3. The distortion ‘You think you know what the future will bring; you expect disaster and gloom’ had the strongest positive correlation with both depression symptoms and NPO, and was significantly higher than the other correlations.

**DISCUSSION**

This is the first known study to specifically examine the extent to which young adults’ cognitive distortions and levels of anxiety and depression symptoms were, together, associated with a NPO. As expected, we found strong associations between cognitive distortions and NPO, between anxiety symptoms and NPO, and between depressive symptoms and NPO. We also found that in this sample, cognitive distortions and depressive symptoms were strong individual predictors in a regression model that explained close to half of the variance in NPO. Moreover, the relationship between cognitive distortions and NPO was slightly strengthened as depressive symptoms became more intense, and the distortion ‘You think you know what the future will bring; you expect disaster and gloom’ had the strongest individual association with NPO and depressive symptoms.

Negative problem orientation reflects a dysfunctional or maladaptive dimension of the social problem-solving process that can be strategically targeted to reduce or prevent negative psychological functioning (Chang et al., 2009). Becker-Weidman, Jacobs, Reinecke, Silva, and March (2010) hypothesized that young people with high NPO and low positive problem orientation might have difficulty staying motivated and engaged in the demands of solely cognitive or knowledge-based interventions due to dysfunctional schema promoting the belief [set] that ‘nothing will work, they are not capable of solving problems, etc.’ (Becker-Weidman et al., 2010, p. 17). But, young people with low NPO and high positive problem orientation might be more motivated to engage in a knowledge-based intervention, making it more effective for this age group. Our findings suggest that young adults with pre-existing cognitive distortions might be those with the most difficulty engaging in knowledge-based social problem-solving interventions to reduce or manage their symptoms of depression. These young adults may also be those who remain unmotivated by universal prevention initiatives that aim to promote social problem-solving strategies such as seeking help for symptom reduction.

Our results also suggest that NPO might be improved among young adults with co-occurring depressive symptoms by interventions that focus on directly addressing cognitive distortions, specifically aiming to develop optimism and hope.

### TABLE 3: CORRELATION OF COGNITIVE DISTORTION ITEMS WITH DEPRESSION AND NEGATIVE PROBLEM ORIENTATION

<table>
<thead>
<tr>
<th>Cognitive distortions</th>
<th>Depression</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>You think you know what the future will bring; you expect disaster and gloom. (1.67, 1.06)</td>
<td>.59***</td>
<td>.58***</td>
</tr>
<tr>
<td>You magnify all the negatives in a situation, and ignore all the positives. (2.36, 1.09)</td>
<td>.46***</td>
<td>.49***</td>
</tr>
<tr>
<td>Things are black or white, good or bad. You have to be perfect or you are a failure. There is no middle ground. (1.79, 1.08)</td>
<td>.39***</td>
<td>.39***</td>
</tr>
<tr>
<td>You believe that you alone have a particular problem; no-one else could possibly understand. (1.79, 0.97)</td>
<td>.34***</td>
<td>.32***</td>
</tr>
<tr>
<td>You have a list of how the world should work. When the rules are violated, you feel angry. (2.31, 1.11)</td>
<td>.25***</td>
<td>.38***</td>
</tr>
<tr>
<td>You know what other people are thinking without having to ask them. (2.34, 0.97)</td>
<td>.22***</td>
<td>.24***</td>
</tr>
<tr>
<td>Because you feel something is true, then it must be true. (2.13, 0.97)</td>
<td>.22***</td>
<td>.20***</td>
</tr>
</tbody>
</table>

Note: Item mean and SD presented in parentheses, ***p < .001.
about the future, the availability of helpful solution options, and the value of help for problem solution. Problem-solving therapy (PST) is based on social problem-solving theory and is a form of cognitive behavioural therapy (CBT). One of the primary goals of PST is to encourage, and provide the methods for, reducing and shifting from a negative to a positive problem orientation, especially encouraging attendance to and confrontation of an uncomfortable situation instead of avoidance (D'Zurilla & Nezu, 1999). Our results suggest that both in and outside the therapeutic context, action strategies to minimize a NPO might include specific messages about the efficacy of different solution options, such as treatment for depression and anxiety, ways to access different problem solutions (e.g., ways to access professional help), and the benefits of implementing different solutions early (e.g., seeking help early) for symptoms of psychological distress.

Support for multicomponent universal and targeted interventions that include strategies to simultaneously reduce NPO, improve positive orientation, and reduce negative psychological and behavioural functioning is found in both the adult and youth mental health literature (Becker-Weidman et al., 2010; Chang et al., 2009). Within the youth literature, Eskin et al. (2008) found that six sessions of PST, which did not have a focus on problem orientation, were effective in reducing depression and suicidality. It is currently unclear whether an additional focus on problem orientation would improve therapeutic effects. Certainly, more research is needed to evaluate whether interventions that focus on both problem orientation and problem-solving skills achieve meaningful improvements in treatment outcomes among anxious, depressed, and suicidal young people.

In the meantime, targeted prevention or early intervention programs for young adults might go beyond known risk factors for anxiety and depression among young adults (i.e., risk factors based on their family history, individual characteristics such as high pessimism, limited optimism, cognitive style, and current stressors such as workload or social identity pressures), and also address the presence of prominent cognitive distortions and NPO. Consistent with content proposed by Garber (2006), such interventions might include: (1) cognitive and behavioural strategies for responding to early symptoms of depression and anxiety, and promoting well-being; (2) the skills for, and value of, early engagement in purposeful problem solving for depression and anxiety symptoms; (3) interpersonal communication strategies to improve relationships that are likely to be involved in effective problem solving for depression and anxiety symptoms; (4) recognition of one’s own behaviours that might contribute to the development of depression and anxiety; and (5) emotion-regulation strategies that reduce labile reactions to current stressors.

Within a social problem-solving framework, specific actions for each content area might include:

(1) Normalising the experience of psychologically distressing symptoms (statistics can help), teaching young people what different symptoms ‘look’ and ‘feel’ like (use behavioural and mood-based symptom descriptions), and teaching young people to use their symptoms as a trigger to do something rather than nothing about their condition (shift to a positive from negative motivational frame).

(2) Teach young people about different solutions they can choose for managing depression and anxiety symptoms, the costs and benefits of each decision at different levels of symptom severity (e.g., the costs and benefits of receiving professional mental health care versus other options such as talking with friends or family when symptoms are early and mild compared to severe), and ways to make a decision about which solution will be most useful to the young person at different points in symptom development (e.g., discuss the point at which talking with a friend or parent is insufficient and mental health treatment is the solution of choice for managing different symptoms).

(3) Teach young people how to approach others and ask for solution support (e.g., how to seek help), how to talk to others about the details of their problem and their specific solution needs (e.g., teach words to describe different
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behavioural and mood-based symptoms, the severity of symptoms, the length of time symptoms have been experienced), and teach young people how to evaluate whether the solution options they choose are successful.

(4) Teach young people about risk factors that can lead to different symptom types, ways to recognise modifiable risk factors in their own behaviours (e.g., social withdrawal, help-negation for depressive symptoms), and strategies for overcoming these risky behaviours (e.g., ways to engage in social activities even when social connection is unattractive to the young person).

(5) Teach young people strategies for experiencing and tolerating rather than avoiding the discomfort associated with different symptoms. For example, teach young people to: (i) Pretend the feelings are a wave, (ii) Imagine you’re on top of the wave, (iii) “Surf” the wave until the feeling flows away, and (iv) When the feeling dies down … get help! – this and other specific strategies are listed in the Do It Together Kit (The DIT Kit; Wilson, 2008, pp. 139–151).

LIMITATIONS AND CONCLUSIONS

There are several limitations that must be considered alongside these results. The use of a non-clinical university student sample as the only source of data means that we don’t know if these results will generalize to young adults in the wider community or to other age groups. In particular, almost all the sample identified their culture as ‘Australian’, so there was little cultural diversity. Problem orientation in this study was self-rated and there may also be a gap between this and more objective measures of actual response to a mental health problem. Similarly, symptoms of depression and anxiety were self-rated, which may have under- or over-estimated rates of actual symptom intensity in this sample. Data were also collected at one time point, so whether cognitive distortions and depressive symptoms predict future problem orientation is not known.

Despite the limitations, this exploration of the way in which cognitive distortions and levels of depression and anxiety symptoms are associated with NPO in young adults provides a potential focus for improving targeted, selective preventive or early interventions that aim to reduce the symptoms of depression and anxiety in this age group. Future research needs to specifically explore the relationships between individual cognitive distortions, depressive symptoms and problem orientation in samples with different ages and cultural backgrounds. It will also be important to confirm the direction of these relationships in longitudinal studies.

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