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**PROBLEM-SOLVING TREATMENT FOR PRIMARY CARE (PST-PC):
A TREATMENT MANUAL FOR DEPRESSION**

MARK T. HEGEL, Ph.D.

Dartmouth Medical School

PATRICIA A. AREÁN, PH.D.

University of California at San Francisco

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FOREWORD

This treatment manual is the result of approximately 10 years of effort from a number of persons. An initial manual was produced by Laurence Mynors-Wallis and Dennis Gath in the UK for their research with depression and other emotional syndromes in primary care. As a result of the efforts of the John A. Hartford Foundation and the John D. and Katharine T. MacArthur Foundation, under the leadership of James Barrett, PST-PC was imported to the United States. Mark Hegel and colleagues conducted the first wave of modifications and elaborations to the manual for a series of studies with minor depression in primary care. For project IMPACT, jointly funded by the John A. Hartford Foundation and the California Healthcare Foundation, and under the able leadership of Jurgen Unützer, Hegel and Patricia Areán have now further modified and elaborated the intervention for study with older populations with major depression and/or dysthymia in primary care. Each step along the way has been informed by working with the wonderful therapists and depression clinical specialists from each of the studies. At this point we have trained many PST-PC therapists, but they have also challenged us to continue to refine our teaching trade. This reciprocal process has led to what we hope is an informative and useful treatment manual.

One important point deserves to be made before beginning to read this manual. The treatment manual is a starting point to training, and only a starting point. Having read the treatment manual does not qualify the reader as a PST-PC therapist. Reading and doing are two different things, and we have found that merely understanding the principles and procedures in this manual is not sufficient to allow the reader to practice PST-PC in a competent fashion. The following section (The PST-PC Training Program) outlines the PST-PC training program used in

our research and with other persons and organizations working with us for training. If the reader determines, after having read the manual, that they would like to proceed to full certification for PST-PC administration, then we encourage them to contact us at the locations indicated in the following section.

THE PST-PC TRAINING PROGRAM

The PST-PC training program has two parts:

Part I. Treatment Manual and Workshops: PST-PC trainees receive a PST-PC Treatment

Manual that has been designed, evaluated and revised in the context of controlled effectiveness studies in primary care. Trainees attend an eight-hour workshop (or two four-hour workshops on consecutive days) at one of our training centers under the direction of a certified PST-PC trainer. During the first half of the workshop trainees will receive didactic instruction in PST-PC theory, efficacy data and Session 1 introductory procedures. They will view a demonstration videotape and then have an opportunity for supervised role play of Session 1 introductory procedures. During the second half of the workshop trainees learn the additional PST-PC treatment procedures, view a demonstration videotape of these procedures, and then role-play treatment sessions. Workshops must be taken in sequence, either individually or together.

(CME Credit: 4 hours for each Workshop)

Part II. Learning Case Supervision and PST-PC Certification: After completing the

workshop(s), trainees go on to complete two to five Learning Cases (number to be determined by the trainer prior to training and based upon the trainee's experience level and requisite skill level) at their home clinic. Trainees audiotape or videotape two sessions from each Learning Case. These tapes are reviewed by the certified PST-PC trainer and phone supervision is provided. All Learning Cases must be completed within 6-months of completing the workshop.

(CME Credit: 6 hours)

PST-PC Certification:

Upon satisfactory completion of this two-step training program trainees receive certification as a PST-PC Therapist. Trainees may receive credit for either half of the Workshop (4 hours each), taken in sequence, either individually or together, but the Learning Cases cannot be started until the entire Workshop is completed.

Target Audience: Psychologists, Nurses, Physician's Assistants, Social Workers, and Physicians.

Nurses and PA's must have at least two years of clinical experience following their terminal degree.

PST-PC Training Program Goals and Objectives:

Goals: Participants will learn the background scientific basis and the practical application skills for PST-PC.

Objectives: At the end of this program the participants will be able to:

1. Describe the theoretical and scientific basis for PST-PC.
2. Demonstrate the specific procedures of an introductory PST-PC session.
3. Describe the specific stages of a PST-PC treatment session.
4. Demonstrate the specific procedures of a PST-PC treatment session.

Tuition and Other Expenses:

Participants are responsible for their expenses for travel, lodging and meals. Information on local lodging and transportation options is available upon request.

For more information contact:

Mark T. Hegel, Ph.D.

Problem-Solving Treatment and Training Center

Department of Psychiatry

Dartmouth-Hitchcock Medical Center

One Medical Center Drive

Lebanon, NH 03756

Phone: (603) 650-7539

Fax: (603) 650-5842

[Email: mark.t.hegel@dartmouth.edu](mailto:mark.t.hegel@dartmouth.edu)

or

Patricia A. Areán, Ph.D.

Department of Psychiatry

University of California, San Francisco

401 Parnassus, Box F-0984

San Francisco, CA 94143

Phone: (415) 476-7817

Fax: (415) 476-7719

[Email: pata@lppi.ucsf.edu](mailto:pata@lppi.ucsf.edu)

Chapter 1.

Support for Problem-Solving Treatment from Empirical Research

The Need for Psychosocial Treatments for Depression in Primary Care

Mental disorders, particularly depression, are common in primary care (Barrett, Barrett, Oxman & Gerber, 1988; Coyne & Bellavance, 1997; Katon & Schulberg, 1992; Shepherd, Cooper, Brown & Kalton, 1966). Most cases are first identified in primary care and the majority of treatment (60 %), if it occurs at all, takes place in primary care settings (Regier, Goldberg & Taube, 1978). These disorders primarily involve symptoms of depression and/or anxiety, and although often clinically less severe than those seen in the psychiatric setting, have a high prevalence and account for a significant degree of morbidity (Broadhead et al., 1990; Hays et al., 1995). These disorders are usually treated by the primary care physician or other medical professionals such as physician's assistants and nurse practitioners. Treatment typically consists of medications, reassurance, and some form of brief counseling (Schulberg & Burns, 1988).

The prognosis for these patients however, is not always promising. Several studies have shown that perhaps greater than one-third of patients with emotional symptoms are still significantly symptomatic from six months to five years following initial diagnosis (Cooper, Fry & Kalton, 1969; Goldberg & Blackwell, 1970; Mann, Jenkins & Belsey, 1981). Although medications are the first line of treatment, primary care patients often do not adhere well to drug regimens due to side effects, their fear of becoming drug dependent, and their belief that symptoms are due to life circumstances, which will not be alleviated by medications. When patients are reluctant to take medication, or fail to respond satisfactorily, there is a lack of effective counseling strategies available in the primary care office, and patients are often

unwilling to accept specialty mental health referral for psychological treatment. Recent cost-effectiveness analyses have indicated that quality improvement efforts in primary care, specifically by adding effective counseling and antidepressant medication regimens, may be the best method to improve the overall value of care (Sturm & Wells, 1995). Therefore, there exists a clear need for a psychosocial treatment alternative which is designed specifically for primary care settings.

The Rationale for Problem-Solving Treatment in Primary Care

Research has shown that minor life events or problems are strongly associated with psychological symptoms, in particular depression, possibly even more so than major life events (Nezu, 1987). Problems are defined as any situation in which an immediate and easily recognizable solution is not apparent. The degree of impact of these events upon psychological functioning is moderated by personal attributes related to coping ability. For example, the appraisal of problems as challenging versus threatening, and the perception of the self as possessing adequate coping resources (e.g., sense of control, self-efficacy), serve important functions in buffering against the negative effects of life stressors. Evidence has also linked weak problem-solving abilities to the etiology and maintenance of psychological disorders (D’Zurilla, 1986, 1990). Problem-solving is defined as the process by which a person attempts to identify, discover, or invent effective or adaptive coping responses for specific problematic situations encountered in everyday living.

This literature has led the counseling and mental health communities to develop Problem-Solving Therapy, a cognitive-behavioral therapy approach that treats depression by teaching patients how to systematically solve psychosocial problems (D’Zurilla, 1986; Nezu, Nezu & Perri, 1989). Regaining a sense of control over life’s problems is probably the most important

factor for resolving depressive symptoms (Seligman, 1975). The problem-solving intervention has been found to be effective in treating depression in younger adults (Nezu, 1986), older adults (Areán, et al., 1993; Alexopolous, Raue and Areán, in press), and persons with mental retardation (Nezu, Nezu & Areán, 1990). Problem solving training has been found to be an effective component of treatment for a variety of other behavioral disorders, including schizophrenia (Lieberman, Eckman & Marder, 2001; Medalia, Revheim & Casey, 2001), childhood autism, attention deficit and oppositional disorders (Barkley et al., 2001; Bernard-Opitz, Sriram & Nakhoda-Sapuan, 2001; Webster-Stratton, Reid & Hammond, 2001), self-harming behaviors (Townsend et al., 2001), and substance abuse (Zanis et al., 2001). Problem solving has also been found to be an effective component of intervention with caregivers of medically and cognitively impaired elders (Teri et al., 1997; Roberts et al., 1999; Grant et al., 2001). In addition, recently the problem solving approach has been successfully implemented with medical problems, including diabetes (Cook et al., 2002), cancer (Schwartz et al., 1998; Allen et al., 2002; Sahler et al., 2002), and chronic pain (Ahles et al., 2001).

The original problem-solving treatment model was created at a time where the delivery of mental health treatment was always assumed to take place in specialty mental health settings by mental health practitioners. Thus, earlier models of problem solving therapy were meant to be delivered in one-hour individual meetings or 90-minute group meetings, over a ten to twelve week period. Early models also included attention to procedures aimed at reducing cognitive negativity. Although the attention to cognitive processes is not as intensive as is found in other cognitive-behavioral therapies, attention to these processes requires some specialization that non-mental health professionals tend not to have. Finally, skills are taught sequentially, rather than in one sitting, so that the patient can acquire mastery over the skill before learning the next step in

the process. Earlier versions of problem solving therapy, then, are most applicable to settings in which providers have the time and training to teach skills slowly over time, and to patients who are willing to spend time improving coping skills, even though problem resolution will take longer. Thus, these models do not fit well in many primary care practices, where time is tight and providers are not mental health specialists, nor many primary care patients, who are seeking quick resolution to their problems and their symptoms.

A problem-solving treatment model for primary care was originally developed by a team of researchers at Oxford University (Catalan, Gath, Anastasiades, Bond, Day & Hall, 1991). The treatment was designed for application in busy and time constrained primary care settings. It was also designed so that non-mental health specialists in the primary care setting, such as nurses and physicians, could be trained to administer the treatment. In addition, this group of researchers emphasized model of treatment in which patients could rapidly apply problem-solving skills in their everyday life. Rather than building problem-solving skills in stages across treatment sessions as in the traditional model of treatment, the skills are introduced beginning in the first session and reinforced en masse across subsequent sessions.

In order to distinguish this primary care version of problem-solving treatment from the traditional mental health model we refer to it as “Problem-Solving Treatment for Primary Care” or “PST-PC”. The table below summarizes some of the important distinctions between PST-PC and the mental health model of problem solving therapy.

PST-PC Versus Traditional Problem Solving Therapy

Domain	PST-PC	Traditional PST-PC
<u>Therapists:</u>	Broad range of providers (general medical, nursing, mental health, etc.)	Behavioral Therapists Typically doctoral level
<u>Treatment Model</u>	Taught in entirety in Session 1 and reinforced across subsequent sessions	Taught in stages across treatment sessions
<u>Session Length:</u>	Session 1: 1 Hour Other Sessions: 30-Mins	1 1/2 – 2 Hours for all Sessions
<u>Treatment Duration:</u>	4 - 8 Sessions	10-20 Sessions
<u>Total Treatment Time:</u>	2 1/2 – 4 1/2Hours	15 – 40 Hours

The Effectiveness of PST-PC

The effectiveness of PST-PC in primary care and community settings has been evaluated with a number of randomized controlled trials. The results of these studies suggest that PST-PC is an effective and feasible brief treatment for major depression, minor depression, dysthymia and mood disturbance. A review of these studies is provided below.

PST-PC for General Emotional Distress

In an initial study from the UK, Catalan and colleagues (Catalan, Gath, Anastasiades, Bond, Day & Hall, 1991) assessed the effectiveness of PST-PC in treating emotional distress

(depressive and anxious symptoms) in primary care patients identified as having a poor prognosis (i.e., those patients still significantly symptomatic at four weeks following initial case identification). Of 113 initially referred patients, 47 met the poor prognosis criteria and were randomly assigned to either PST-PC or general practitioners' usual care (typically a combination of medication and emotional support, or "watchful waiting"). In this study, four sessions of PST-PC were provided by a research psychiatrist. Results showed that while both groups improved significantly, the PST-PC group showed a significantly greater improvement in symptoms and general health scores than the standard treatment group. These differences were maintained at a 28-week follow-up assessment.

Another study from the UK went on to examine the effectiveness of PST-PC when delivered by community nurses (Mynors-Wallis et al., 1997). In this trial, nurses without any specific psychiatric skills were trained in PST-PC. Patients in this study were identified by general practitioners as having emotional distress (again, primarily depressive and anxious symptoms) of at least one-month duration. PST-PC was then compared with the usual care from general practitioners. Results from this study showed no significant differences in depressive symptoms between the two groups at eight and twenty-six week follow-up. However, PST-PC was associated with fewer disability days (i.e., days when the patient was unable to carry out usual activities) and fewer sick days in those patients who worked. While cost analysis indicated that PST-PC was more expensive to administer than usual care, when loss of functioning at work was included, PST-PC resulted in significantly greater socioeconomic performance.

PST-PC for Major Depression

The same group of investigators went on to examine the effectiveness of PST-PC for the treatment of major depression (Mynors-Wallis, Gath, Lloyd-Thomas, & Tomlinson, 1995). This

study sought to determine whether PST-PC was a) as effective a treatment as antidepressant medication and more effective than placebo in the treatment of major depression, b) feasible in a primary care setting, and c) acceptable to patients. All patients met research diagnostic criteria for major depression. Ninety-one patients were randomly assigned to PST-PC, amitriptyline (a tricyclic antidepressant medication), or placebo. Treatment in all conditions was given in six visits over the course of twelve weeks. Amount of time spent in contact with the treatment provider was held constant in all treatment conditions.

Results from this study showed that at 6- and 12-weeks into treatment PST-PC was as effective in treating depression as amitriptyline and was significantly more effective than placebo (Mynors-Wallis et al., 1995), as was amitriptyline. Similarly, when patients were categorized as recovered or not based on a cut-off score on a standardized measure of depression, 50 % and 52 % of patients receiving PST-PC and amitriptyline, respectively, were recovered, while only 27 % of patients receiving placebo recovered.

As noted above, this study sought to not only assess whether PST-PC was effective in the treatment of depression, but whether it was feasible and acceptable to patients. PST-PC was administered in this study by two general practitioners and by a psychiatrist. Results indicated that there was no difference in patient outcome between the general practitioners and the psychiatrist. Furthermore, PST-PC was associated with a lower drop out rate than for the antidepressant medication (only 7 % of the PST-PC sample versus 19 % for the amitriptyline sample) and was rated as “helpful” or “very helpful” by 100 % of patients receiving it (versus 83 % of the amitriptyline sample).

In a subsequent study these investigators compared PST-PC to an antidepressant medication as well as to a combined PST-PC + medication intervention (Mynors-Wallis et al.,

2000). 151 patients with major depression were randomized to PST-PC provided by either their general practitioner or a practice nurse, antidepressant medication (fluvoxamine or paroxetine hydrochloride), or to PST-PC + Medication. Outcomes were assessed at 6, 12, and 52-weeks consisting of ratings of depression severity and social functioning. The results showed that all treatment groups improved significantly over the course of treatment on all measures and that there were no significant differences in outcome between groups. In addition, for the patients receiving PST-PC, whether they received PST-PC from their general practitioner or from their practice nurse had no effect on their outcome. When the groups were compared on the percentages that achieved a level of improvement associated with a clinically relevant recovery (i.e., Hamilton depression rating scale score of 7 or less) (Hamilton, 1967) again no significant differences were evident between groups at any of the follow-up periods.

Recently, a European multi-site, multi-national community-based study was conducted comparing PST-PC to a psychoeducational intervention (Lewinsohn et al., 1986). Both interventions were compared to a no-intervention control condition in a population with a variety of depressive illnesses (Dowrick et al., 2000). Of the 426 participants randomized to the three conditions the vast majority met diagnostic criteria for either a single episode of major depression (55%) or recurrent major depression (20%), with the remainder distributed among dysthymia (15%) or other depressive syndromes (10%). In this study, standard individualized PST-PC of six visits and approximately four hours duration was compared with a group psychoeducation course of eight or more sessions and 20 hours or greater duration. Interventions were delivered by a range of health care providers including psychologists, nurses and allied health professionals.

The principle outcomes measured included the acceptability of the interventions, their impact on depressive caseness (i.e., whether participants still met criteria for depression), depressive symptom severity and subjective reports of function measured at six- and 12-months post-intervention. Results showed that participants assigned to PST-PC were significantly more likely to complete the intervention than those assigned to psychoeducation (63% versus 44% respectively). Analysis of treatment effects on caseness showed a significant effect for PST-PC at six-months but not for the psychoeducation group, and absence of effects for both interventions relative to the control condition at 12-months. With regard to severity of depressive symptoms, PST-PC showed a significant effect at six-months for depression severity and subjective function, with residual effects for function at 12-months. Similar effects were not observed for the psychoeducation condition.

PST-PC for Minor Depression

Minor depression is typically defined as the presence of at least two but fewer than five depressive symptoms, including depressed mood or loss of interest, during the same two-week period with no history of major depressive episode or dysthymic disorder but with clinically significant impairment or distress (American Psychiatric Association, 1994). Minor depression has been shown to be associated with functional impairment comparable to medical illnesses (Wells et al., 1989) and with increased medical care costs (Johnson, Weissman, and Klerman, 1992). Minor depression is among the most common types of depressive disorders (Broadhead, 1990; Johnson et al., 1992; Williams et al., 1995). This is particularly true in primary care where patients are more likely to suffer from less severe syndromes than in psychiatric settings (Barrett et al., 1988; Regier, 1993).

Lynch, Tamburrino, and Nagel (1997) conducted a preliminary study of a telephone-based problem-solving therapy for minor depression in a family practice clinic sample. They based the intervention on the traditional mental health model (Nezu, Nezu and Perri, 1989) but in practice it appears to have closely resembled the PST-PC model consisting of six 20-minute phone sessions. The intervention was compared to a no-intervention control condition. Patients receiving problem-solving therapy showed a significant reduction in depression severity whereas the no-intervention patients did not. However, the difference between the two groups was not significant. As a preliminary study, consisting of only 11 PST-PC patients receiving post-treatment assessments, the study may be underpowered, and therefore the results should be interpreted with caution.

Williams et al. (2000) conducted the largest study yet for older adults (age 60 and older) with minor depression or dysthymia in primary care, consisting of 415 patients. In this study, PST-PC was compared to paroxetine hydrochloride and placebo plus clinical management over an 11-week treatment trial. Both paroxetine and PST-PC showed comparable effects on depressive symptoms, although only paroxetine showed a modestly significant difference from placebo, partially due to high placebo response rates (averaging 49% across the four study sites). Both paroxetine and PST-PC improved mental health-related functioning in patients at the lowest levels of function compared to placebo.

A companion study was conducted by Barrett and colleagues (Barrett et al., 2001) using the same experimental design with 241 patients aged 18-59 years with minor depression or dysthymia. In this study, again all conditions showed a significant decline in depressive symptoms over the 11-week trial. For dysthymia the remission rates for paroxetine (80%) and PST-PC (57%) was significantly higher than for placebo (44%). However, again, partially due

to a very high placebo response rate for the minor depression sample (averaging 64% across the two study sites) no significant differences were detected for the active interventions in this group. Finally, for patients randomized to PST-PC, treatment attendance was high, with 84% of patients completing all six treatment visits.

Summary and Conclusions

In summary, mental disorders, and particularly depression are common in primary care and if treated at all are most often treated exclusively in primary care. Medications are, and will most likely remain the first line of treatment for depression in primary care. However, many patients do not respond to medications or require or prefer a non-medication approach to treatment. Problems in living are closely related to the onset and maintenance of depression but possessing or developing problem-solving skills can reduce or prevent depressive symptoms. An original problem-solving treatment has been developed and successfully tested in the mental health sector for depression as well as for a variety of other mental health and medical illnesses. A revision of this model has been developed and tested in primary care and we have coined this version “Problem-Solving Treatment for Primary Care”, or “PST-PC”.

Based on the studies cited above it is clear that PST-PC is an effective and feasible treatment for major depression, for more broadly defined emotional syndromes with a poor prognosis, and for dysthymia. PST-PC not only improves depressive symptoms but also improves daily function in a more broad sense (e.g., work, family and social functioning). For minor depression, further research is warranted due to the high spontaneous remission and placebo response rates for this disorder. At this date it is unclear whether treatment, either psychotherapy or pharmacologic, is effective for this disorder.

The studies cited above also suggest that a broad range of health care personnel (e.g., psychologists, general practitioners, nurses, allied health professionals) can effectively administer PST-PC. This bodes well for the potential ability to broadly disseminate the intervention. PST-PC also shows high levels of acceptance and satisfaction with treatment on the part of patients and correspondingly low dropout rates. From a cost-effectiveness point of view, while PST-PC may be more expensive to administer than usual care, it appears that it may be associated with greater savings in indirect costs, such as increased productivity at work and reduced burden from sickness.

In conclusion, PST-PC is an effective treatment for most forms of depression observed in primary care. The largest challenges to its utilization and broad dissemination are the following:

- a. identifying the most likely personnel in a given primary care setting to administer the treatment;
- b. finding ways to adequately train these personnel; and
- c. finding ways to sufficiently fund the provision of this important health care component.

It is our hope that this treatment manual will constitute a step toward resolving these issues.

Chapter 2.

Creating a Therapeutic Relationship and Building the Rationale for PST-PC in Session 1

Creating the Therapeutic Relationship

Volumes have been written on strategies to develop a working and collaborative therapeutic relationship. These writings all stress that the most important elements in creating a trusting relationship are to be warm, empathic and genuine while also promoting an image of self assurance and knowledge about the disorder in question and the methods available to treat that disorder. Most therapies have the advantage of time to help facilitate building a working relationship. In problem-solving treatment, as with in any type of therapeutic relationship, developing a trusting empathic relationship between the patient and the therapist is paramount, yet challenging because of the brief appointment times, limited number of sessions and the need to maintain the structure of a PST-PC session. Given the limited amount of time available in PST-PC, therapists must be ready to develop as much trust and engagement as possible within the first session. If by the end of the first session the patient is not convinced that you or the PST-PC model will be helpful in treating depression, therapists will find themselves struggling to get patients to use the model in subsequent sessions and in the homework assignments. Thus, careful attention must be paid to the first visit so that the patient does not leave the session confused or unconvinced about the efficacy of PST-PC in treating depression.

The best way to develop a working relationship with patients is to present a confident, knowledgeable, and professional image and to maintain appropriate professional boundaries. Presenting a knowledgeable and confident image can be accomplished by being familiar enough with PST-PC theory of depression and the rationale for treatment that the therapist can discuss

these issues flexibly with the patient and at a level the patient can understand. A professional demeanor is accomplished by setting and respecting the boundaries of the relationship. For instance, the patient should always be referred to by their surname (e.g., Mr., Mrs., or Ms.) unless the patient gives permission to do otherwise. Some therapists may prefer to use the surname until the patient spontaneously invites them to call them by their first name. On the other hand, it is acceptable to ask the patient to indicate what name they prefer the therapist to use.

The patient should always be made to feel comfortable to discuss any matter that is important to them and can be encouraged with direct statements from the therapist to this effect. In addition, maintaining good eye contact (without staring), orienting the body in the direction of the patient, and emitting supportive vocalizations (such as “mm-hmm”, “tell me more about that”, “I can see this really bothers you” or “I can see this is very important to you”) along with head nods to facilitate continued discussion are all helpful strategies. The therapist should avoid body signals that indicate disapproval or disinterest, such as arms crossed or excessive amounts of time looking down while taking notes.

To facilitate a partnership attitude with the patient the therapist should take care to express themselves in a manner that communicates a collaborative interactive approach rather than an authoritarian or paternal relationship. Frequent use of phrases such as “We will work together to. .”, “I will help you to. .”, or “As a team we will try to. .” will help to communicate this message. The therapist should avoid statements that communicate a one-sided view of the relationship, such as “You are seeing me so that I can treat your depression”, “If you do what I teach you, you will get better”, or “I can only cure you if you cooperate with the treatment.” Likewise, in order to efficiently join the patient in the collaborative treatment process the

therapist should always strive to match their vocabulary to the intellectual level and manner of the patient's vocabulary. This includes adopting terms that the patient commonly uses and refraining from using terms that are obviously overly technical or intellectually advanced. A good rule of thumb is to limit word use to two syllables and sentence length to 10 words until a clear sense of the patient's intellectual/educational level is achieved. The therapist should always endeavor to find alternative expressions for technical medical or psychological terms.

On the other hand, PST-PC is a highly focused and brief therapeutic intervention. To conduct PST-PC properly it is not feasible to allow much digression from relevant discussion. Patients may unwittingly occasionally divert the structure of the session to other more general types of discussion. To allow them to do this unchecked usually results in too little time to focus on PST-PC skills training, and both therapist and patient will feel rushed when they finally do focus on solving a problem. The therapist should develop tactful methods for limiting digressions. First, therapists should indicate early on in treatment that it is very common for people to begin talking about their problem in general terms, rather than staying on the PST-PC task, but that it is very important to stay focused on the problem being solved so that they can learn the problem solving skills. For example, we introduce these boundaries to older patients by saying, "Often people are not used to talking about their problems in such a structured way, and you may find that as we begin solving one problem, you will want to talk about other similar problems. While it is important that we talk about different problems as they arise, it is also very important that we focus on one problem at a time, so that you can learn how to use these problem-solving skills on your own. Also you will find that focusing on one thing at a time is far less overwhelming than trying to solve all the problems at once. So, you may find that while working together, I will interrupt you to refocus on the task at hand. I only mean to do so to

make sure we make the best use of the limited time we have together. What do you think about that?"

Second, a clear articulation of the amount of time the patient has for PST-PC at the outset of every session is important. Statements at the start of the session such as, "Okay, we have 30 minutes together, let's see what we can accomplish" help to set the tone for a focused interaction. Further into the session statements such as "Okay, in the 10 minutes we have left, let's pick a solution and agree on a homework task" are useful for getting a wandering patient back on track. Casually holding up a hand to interrupt the patient, and saying "this line of discussion is very important, and I want to be sure to return to it, perhaps next session, but right now we need to establish the homework tasks for this week" is often very effective in redirecting the patient without offending them. When the patient has been adequately educated about the nature of the treatment (primarily during Session 1) and a supportive collaborative relationship has been established, they will rarely if ever object to such redirection interventions.

Building the Rationale for PST-PC

The nature and rationale of treatment sessions should be explained thoroughly at the beginning of treatment. In our research we have found that treatment outcomes are better for patients who understand the rationale for PST-PC and demonstrate an ability to apply it in early treatment sessions (Hegel, Barret, Cornell & Oxman, 2002). For depressive disorders six sessions is the typical number of visits for adequate resolution of symptoms, although this may vary (as few as four sessions or as many as eight sessions) depending on the patient's education level, age, and depression severity. The first two sessions should be close together (about a week apart) to ensure that the techniques have been understood and correctly applied. The first session lasts about an hour because it includes an explanation of the rationale for PST-PC and collection

of an initial problem list, as well as a full problem solving session for one of the patient's problem areas. Subsequent sessions last about 30 minutes. It is desirable to apply the full problem-solving technique for at least one problem area per session.

There are seven key topic areas to address during the first half of the initial, hour-long session. These topics should be covered during the first thirty minutes of the visit in order to allow an additional thirty minutes for the first full problem solving session. A full Session 1 narrative can be found in Appendix 1 and a checklist to use during the visit can be found in Appendix 2.

1. Explain the structure of PST-PC treatment.

After introducing yourself, explain the basic framework for treatment. For example: "We will be starting the problem-solving treatment today. We will meet for a total of six sessions including today's session. Today's session will last for one-hour because I will be explaining the rationale for the problem solving treatment to you, we will create an initial list of your current problems, and then we will tackle one of your problems using the problem solving technique.

We will meet for 30 minutes during sessions 2 through 6. We will meet again in one week from today, in order to make sure you understand the treatment procedures correctly. For the remainder of treatment we will meet every two weeks. So we will meet for a total of six sessions over the course of nine weeks and we will apply the full PST-PC strategy for at least one problem each session. After the visit you will leave to go home with a number of tasks to work on that are related to the problem, "homework" tasks if you will. Some problems will be resolved fully, often within the time between two visits. Other problems, usually the more complex problems, will require more than one session and may even require continued efforts on

your part after the end of treatment. The overall goal of problem-solving treatment is to teach you the problem solving skills so that you will be able to use them in the future and hopefully avoid becoming depressed again. Do you have any questions about this?"

With elderly patients, you may also want to follow-up with questions such as, "Do you have any questions about the treatment I am talking about? How about the homework, do you understand what we will be doing there?" Often, older clients will be somewhat overwhelmed with information and thus having them think about each issue raised in your discussion will help to solidify the expectations of treatment. Clients from poor educational backgrounds may balk at terms such as homework and lessons. It may be best to instead refer to the homework assignments related to solution implementation as the last part of problem-solving: "Now that we have come up with a plan, the last thing that needs to happen is for you to act on the plan – when do you think you can start?" In this statement, there is no mention of homework. To encourage people to practice using the problem-solving sheet, therapists can say, "Why don't you pick another problem to use this sheet on yourself. That way, we can solve as many problems as we can in the time that we have together. If you don't finish it, that's OK, what is important is that you try to do this on your own, too."

2. Establish that symptoms are related to depression.

At the initiation of treatment it is essential to make sure the patient recognizes that their symptoms represent a depressive mood disorder or else they will not fully appreciate the rationale for the treatment. The therapist must first clarify with the patient that their symptoms, some of which may feel emotional in nature and some of which may feel physical in nature, are

in actuality all related to depression. Many patients begin treatment still not fully convinced they are suffering from an emotional disorder rather than a physical malady

The success of treatment rests upon the establishment of a shared understanding that the symptoms are emotional in origin rather than physical. It is easier for the patient experiencing the common emotional symptoms of depression (e.g., low mood, tearfulness, loss of enjoyment in life, negativism, hopelessness, poor concentration, irritability, and thoughts of death or that life is not worth living) to accept an emotional basis to their symptoms. However, for patients bothered more by physical symptoms (e.g., loss of appetite, tiredness, sleep problems, headaches, malaise, and aches and pains) the connection often is more elusive. We will often begin this discussion by first validating the patient's own experience with the following statement, "It sounds like your sleep is off and you are having trouble remembering things, you're tired all the time and you have no get up and go. I have some ideas as to what may be the cause of those symptoms, given that Dr. Feldman has done a pretty thorough physical exam and has ruled out any known medical illnesses. However, I'd like to know what you think may be causing those symptoms? How do you understand what you are going through?". What do you think?"

Resolving any apparent lack of congruence with the very foundation of the treatment model should have high priority at the beginning of treatment. In doing so, it is useful to explain a "mind/body¹ model" of human functioning to the patient. For example, the therapist might say:

¹ We prefer to use "mind/body" rather than the more common "psychosomatic" term in order to avoid confusion with the lay interpretation of this term as meaning "all in your head" or "crazy".

“I understand that your symptoms feel to you like you are having a physical illness. Sleep problems and headaches can often be an indication of a physical problem. The first thing you should keep in mind is that your doctor has examined you and is confident you don’t have a physical illness. The other thing you should know is that there really is no such thing as a purely physical or emotional illness. For example, when we feel excited, our body gets excited (our heart beats faster and we have trouble sitting still), and when our body is sick, such as when we have the flu, it is natural for our feelings to be a little low as well. All of our feelings, both emotional and physical, are processed through the brain, so when one is affected, the other is affected as well. So, depression can often feel very physical in nature to some people, and this is so because the depression is actually affecting you physically. But the thing to remember is that the main cause of the symptoms is the depression, and that is what we need to treat.”

The therapist should identify the patient’s depressive symptoms and inform the patient that these will be tracked during treatment to monitor success and identify the relationships between problem resolution and mood improvement. It is not necessary to collect an exhaustive list of symptoms in doing this. A few key symptoms for tracking and review at the start of each session will suffice.

3. Establish the link between problems and depressive symptoms, and explain the rationale for problem-solving treatment.

The success of any therapeutic endeavor is based in part on the degree to which a patient understands and accepts the underlying precepts and philosophy of a given intervention approach. For this reason, it is essential that the therapist provide a complete explanation, in terms the patient can understand, of the rationale for problem-solving treatment. Thus, a direct

link should be forged between the patient's symptoms, their problems in living and the role problem-solving skills can play in their resolution.

The therapist should help the patient to understand that their symptoms are an emotional response to their problems. What is worse is that once the patient is depressed the depression further interferes with problem solving, thus creating a vicious downward spiral of worsening mood and worsening problems. The therapist then explains that by learning problem solving skills the patient can begin to tackle their problems during treatment, and that successful resolution of the problems will lead to resolution of the symptoms

The relationship between problem solving and mood is diagrammed in Figure 1.

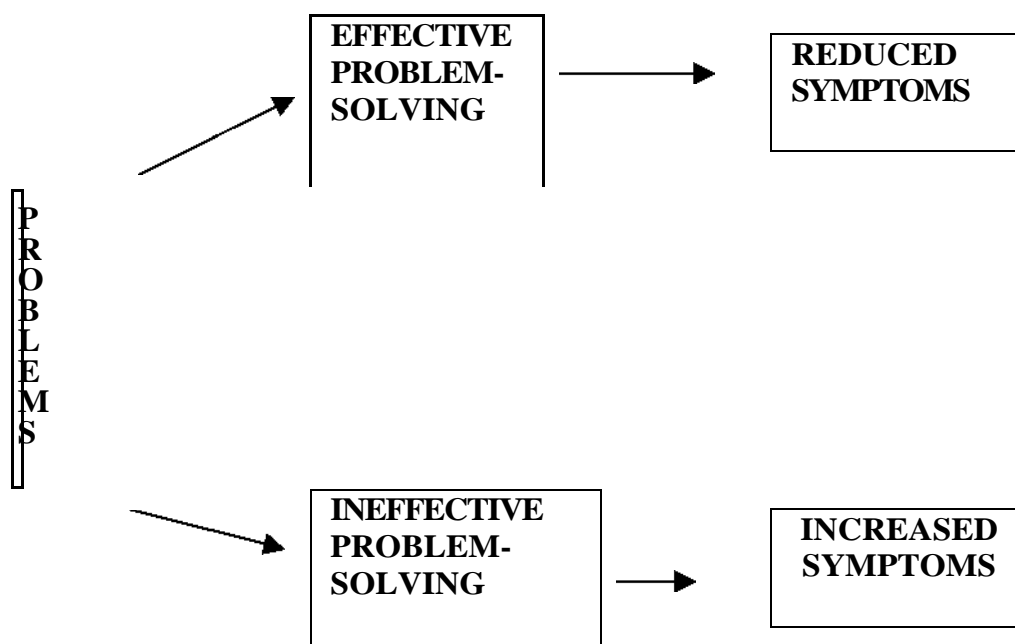


Figure 1. The relationship between problem solving skills and depressive symptoms.

4. Establish an appropriate problem-solving orientation.

Establishing a problem-solving orientation involves providing the patient with a positive and constructive orientation to problems in living and problem solving. The main goal here is to modify the patient's perceptions and beliefs that may interfere with attempts to engage in optimal

problem-solving efforts. A thorough treatment of this extremely important issue is provided in Chapter 5: Facilitating an Appropriate Problem-Solving Orientation for PST-PC, however the main tenets of an appropriate problem orientation are outlined here.

Depressed people frequently feel out of control of their problems and hopeless that they can ever do anything to resolve them. It is important for the therapist to deliver a very clear message that problems are a normal and predictable part of everyone's life; that we face multiple problems within the course of every day. Therefore, problems should be expected as part of our everyday lives. We can have an impact on most of the problems that occur and some degree of control can almost always be achieved. The important implication then is that problems should be viewed as challenges to us as part of our everyday lives; challenges that are best dealt with in a proactive and constructive manner. A negative mood state is usually a sign that some problem area exists in our lives. This negative mood should be treated as a "call to action" to stop and think about what types of problems may be going on and to implement our problem solving skills.

With some patients, a problem-focused orientation is something that may have to be emphasized throughout treatment. Severely depressed patients or patients with a chronic recurrent course may feel particularly pessimistic about their situation and thus will go into earlier sessions thinking that since nothing has worked so far, any new approach is likely to fail. Therapists will want to emphasize in these patients that it is understandable because of their experience that they believe nothing will work. But, it is this very thinking that prevents them from trying some new strategy that may actually work. The therapist should emphasize that even though it feels risky to try something new, you, as the therapist, will be right there with them to figure out the best approach or approaches to handle their problems.

It is important to acknowledge the patient's low mood, but not to reinforce any hopelessness the patient may be experiencing about recovery. The therapist may say "I understand that you are feeling pessimistic about the ability of this, or any treatment, to give you relief from how you are feeling. However, it is important for you to try to suspend your misgivings for a bit and trust what I am saying about the very real possibility of this working for you. We will meet for several visits and we will get a good sense in fairly short order of how things are going. Let's give it a try and hold back our judgments of how well it is working until then." While unrealistic expectations should not be fostered, some optimism should be encouraged in order to motivate the patient. At this point it is important to emphasize that the patient will play an active part in the treatment. The learning that takes place during the session is an important prerequisite for treatment implementation, but acting on the homework tasks between sessions is essential for ultimate success. Strategies for encouraging a problem-focused orientation are discussed in greater detail in Chapter 5.

5. Describe the Seven Stages of the problem-solving process.

Next, the seven stages of problem solving are explained to the patient. It is not essential by the end of the first session for the patient to have memorized all of the stages and the sequence in which they are conducted (although this becomes an expectation as treatment progresses). However, it is necessary for patients to understand that the problem-solving process proceeds in a systematic fashion and that they will be expected to adhere to a particular format of treatment during the sessions. Explaining the stages helps to reduce ambiguity for the patient in terms of what to expect during treatment sessions, and thereby helps reduce their anxiety. Also, it serves to "socialize" the patient to treatment by letting them know what is expected of them.

For example, the explanation lets them know that (1) they will not just be discussing or “venting” their problems at random, but that they will systematically resolve them in sessions; (2) they will be expected to complete homework between sessions; and (3) peripheral discussions not closely tied to the problem under consideration will be minimized; etc. For patients already experienced with different forms of counseling, or for those heavily influenced by exposure to the popular images of counseling seen in movies, TV, or literature, this helps to modify their implicit and often misleading assumptions about the counseling format.

It is also not essential at this point to provide an exhaustive description of each problem solving stage. The patient is not likely to remember the details anyway. A general overview will suffice for now. As the therapist goes on to conduct the subsequent problem solving sessions they will have ample opportunity to describe and reiterate the principles underlying each of the stages. A typical narrative describing the problem-solving stages proceeds as follows:

“We will begin the problem-solving process by exploring and getting a clear description of the problem. The more clearly and specifically you can state the problem, the more directly and effectively you can tackle it. The next step will be for you to set a goal for what you would like to change about the problem. Again, being as objective as possible in the way you describe the goal is very helpful. You need to have a clear understanding of what you would like to see happen because the final solutions will be tied directly to this goal. Next, I will encourage you to develop as many potential solutions for the problem as possible. The more you can come up with the better, because you will want to pick from as many options as possible, and the first idea is not always the best. Then I will encourage you to look at all of the advantages and disadvantages (or pros and cons as we call them) for the solutions, comparing and contrasting them as you go, as a way of deciding which seems the most feasible for you. From this you will

pick the best solution or solutions. Finally, we will work together to identify the specific steps you will need to take to implement the solution. You will want to think of where, when and how you will put it into action. The more detailed you can be about planning your course of action, the more likely you are to follow through on it and for it to be successful. Between our visits you will attempt to put the solution into practice, revising it as necessary using the problem-solving approach, and then we will review your progress next session.”

6. Activity Scheduling.

An important aspect of PST-PC is helping patients to plan pleasurable events in their daily lives. During the course of treatment the importance of having pleasurable activities incorporated into each day will be emphasized. This can be introduced in the following manner: “Depression causes people to stop doing enjoyable things. Unfortunately, once you stop doing things that give you pleasure then you start to feel even worse. The worse you feel the more difficult it is to plan and carry out enjoyable activities. This continues in a vicious cycle of worsening depression and fewer and fewer pleasurable experiences in your day-to-day life. Another vicious downward spiral. Therefore, planning enjoyable activities helps treat depression and we will focus on having you plan some pleasant events in your life on a day-to-day basis.”

A visual depiction of the downward spiral between mood and pleasant activities is provided in Figure 2. In addition, see “The Role of Activity Scheduling in PST-PC” in Chapter 3. A patient handout describing the rationale for Activity Scheduling is also provided in Appendix 4.



Figure 2. The relationship between low mood and reduced pleasant activities.

7. Compile a list of problems with the patient.

Once the outline of treatment has been completed the patient is ready to begin identifying the problems they will choose to work on. The therapist may begin by stating:

“Now that you know what is causing your symptoms and how problem-solving can help, we should actually start to apply the problem-solving treatment so that we can help you start feeling better. Obviously, in order for you to solve your problems we need to get a sense of what sorts of problems you are dealing with and where to begin. Also, I find that I very quickly get to know an awful lot about a person as we review the various problems in their lives. So, what are the problems bothering you right now?”

The next step is to list the patient’s problems. Begin the creating the problem list by asking the patient for a spontaneous report of their problems. This allows for a fairly natural indication of perceived problem priorities in the patient’s life. However, do not assume that the patient will spontaneously list all relevant problems in their life. They may not be conceptualizing certain situations as being problems, or they may be forgetting a particular instance, or they may feel uncomfortable mentioning a situation without encouragement to do so. Therefore, it is helpful to ask about any other possible areas in which the patient may be

experiencing problems. The therapist should use the “Problem List Worksheet” in Appendix 5 to systematically query the patient about potential problems in different areas of their life. For example, the therapist may say: “You mentioned problems with work, family and weight. Are you having any other problems, such as with money, your health, or your husband?” On rare occasions the patient may steadfastly deny that they have any problems at all in their life. In such instances the therapist should first be sure they have reviewed all of the problem domains listed above. If the patient denies problems in any area the therapist should then discuss “Activity Scheduling” with the patient (See “The Role of Activity Scheduling in PST-PC” in Chapter 3).

In constructing the initial problem list it is not the time or place to achieve great clarity and specificity regarding the problems listed. The therapist should obtain enough information to gain a working knowledge of the patient’s problems but leave more definitive exploration and clarification of the problems for the problem-solving sessions that will follow. Place the emphasis on getting a relatively exhaustive but cursory list of the domains of problems in the patient’s life. Once a problem is mentioned and explained to the degree necessary for a cursory understanding the therapist should ask “What other problems are you having?” or “What else?” and move on.

The final thing to accomplish in Session 1 is to actually choose a problem and conduct a full problem solving session for that problem. This should comprise the remaining half hour of this session. The therapist may introduce this task by stating that they would now like the patient to choose a problem to focus on for the remainder of the session, that they would like to familiarize the patient with the problem-solving process and provide them with something to work on between sessions. In other words, the therapist should convey the enthusiastic message,

“Let’s get going!” The actual stages of the problem-solving treatment session are outlined in Chapter 3.

Materials Needed for Introducing PST-PC:

Provide the patient with:

- (1) A completed copy of the session’s PST-PC Worksheet (Appendix 6)
(Completed by the therapist; photocopy for the patient)
- (2) Problem-Solving Guidelines handout (Appendix 4)
- (3) Extra PST-PC Worksheet for independent problem solving between sessions.
- (4) Activity Scheduling handout (Appendix 4).
- (5) A copy of the Problem List Worksheet (Appendix 5).

The Problem-Solving Worksheet

Most of the work during the problem solving treatment session can be recorded on the Problem-Solving Worksheet (See Appendix 6). The worksheet outlines the seven stages of PST-PC and allows enough space to record the various problems, goals, solutions, etc. derived from the session. Early in treatment (e.g. Session 1) the therapist takes primary responsibility for recording the information, with the patient following along with a blank worksheet.

As treatment progresses, the therapist gradually turns over to the patient more of the responsibility for completing the worksheet. For example, during Session 2 the patient fills out their own worksheet along with the therapist and is provided guidance in doing so. During subsequent sessions the patient takes primary responsibility for completing the worksheet, although the therapist may certainly provide guidance and cueing as needed.

It may be necessary to emphasize to patients who are reluctant to use the worksheet that the goal of PST-PC is not to create paperwork for them but to teach them a systematic method to use for solving their problems. The worksheet is a “tool” to help them do this but is not an end in itself. Therefore, extra copies of the worksheet should always be provided to the patient at the end of each session.

Tasks and Materials Needed for PST-PC Session 1:

Time: 60 minutes.

The following tasks should be completed during this session. Recommendations for the time required to complete each task are also provided.

- (1) Explain the structure of PST-PC Treatment (2 minutes).
- (2) Establish that symptoms are related to depression (2-5 minutes).
- (3) Explain the link between problems and depressive symptoms and the rationale for problem-solving treatment (2-5 minutes);
- (4) Establish an appropriate problem solving orientation (5 minutes);
- (5) Describe the seven stages of the problem-solving process (5 minutes);
- (6) Describe the rationale and importance of activity scheduling (2 minutes);
- (7) Compile a list of problems (10 minutes); and
- (8) Illustrate the problem-solving process by working it through on a specific problem (30 minutes).

Chapter 3.

The Seven Stages of PST-PC Treatment

As noted earlier, PST-PC proceeds through seven stages as the patient and therapist address each problem the patient brings to the treatment session. The following is a detailed description of the principles and procedures for each of these stages. Examples from actual cases are included to demonstrate the practical application of each of the stages. A complete case example is provided at the end of the chapter to give an overview of the process as it takes place over the course of an entire treatment session.

Stage 1: Selecting and Defining the Problem

Stage 1 is typically initiated by the therapist asking the patient to choose a problem area that is important to them. Often this begins by briefly reviewing the problem list generated in Session 1 and asking the patient if they would like to choose one of these already identified problems to work on. Alternatively, particularly during Session 1 it is appropriate to ask the patient if they would like to focus on designing daily pleasant activities (See Activity Scheduling later in this chapter) as a convenient means of introduction to the problem-solving strategy. Typically, it is a good idea that the first problem selected be one that is the least emotionally problematic for the patient. The first problem solved sets the stages for how the process works, and in our experience, focusing on a very sensitive problem can distract the patient from the learning process. If a patient does initially select what seems to be a rather complicated or emotionally challenging problem, it is fine for the therapist to redirect the patient toward a more neutral problem. In doing so, the therapist must provide the rationale for the redirection and assure the patient that as he or she becomes more proficient with problem solving, he or she can

return their focus to this more complex problem. The therapist may also offset initial selection of a complicated problem by turning the problem list into a hierarchy, ordering the problems by how difficult the patient feels the problems are to solve.

In later sessions the patient should always be asked about other preferred problems to focus upon, even when a problem from an earlier session does not seem to have been fully addressed or resolved. When the patient chooses a different problem from one that has not been fully solved, the therapist should inquire about the reasons for the change in focus. It is possible that other mitigating circumstances have developed that make the previous problem less of an immediate priority to address, and the therapist should be ready to change focus in response to the patient's more pressing needs. However, if this is not the case and the patient has simply "given up" on the previous problem, the therapist should encourage some discussion of the problem, and may need to employ the problem orientation strategies discussed in Chapter .

There are four methods for choosing a problem to be addressed: 1) reviewing the problem list and selecting a problem from that same list; 2) working on a problem selected from a previous session; 3) identifying a new problem to be addressed; or 4) designing daily pleasant activities, especially during Session 1. The patient should always be the final judge on which problem to address in each session, albeit with some gentle inquiry from the therapist as indicated.

Once a problem is chosen, three primary steps are followed for guiding Stage 1:

Step 1: Explore and Clarify the Problem

It is practically impossible to conduct an effective and efficient problem solving session without a thorough understanding of the problem to be addressed. The old saying, "Look before you leap," is very relevant here. A thorough exploration of the problem assures that both

the patient and the therapist understand and agree on the nature and specifics of the problem. If the problem is not thoroughly explored prior to developing solutions then the therapist and patient run the risk of generating inadequate, and even worse, irrelevant solutions for it. Alternatively, it often happens that without adequately clarifying the nature of the problem in Stage 1 important facts about the problem do not surface until later in the process (such as while considering pros and cons). In such a case the therapist and patient must then return to Stage 1 to redefine the problem and important time in the session has been lost.

A couple other aspects of exploring the problem deserve mention. By definition, a problem is a situation in which a desired state of affairs is different from the current state of affairs and some obstacle stands in the way of reconciling the discrepancy. Oftentimes a patient raises a situation (such as having a cluttered closet) which they have not addressed but for which there is really no apparent barrier to addressing it (for example, they just haven't gotten around to doing something about it). This does not constitute a problem in the formal manner that is relevant for problem solving intervention. In such a case it may be perfectly appropriate to assist the patient with developing a plan of action designed to address the situation (for example, by using strategies from Stage 6, Implementing the Preferred Solution) but this does not necessitate utilizing the entire problem solving model. Such situations can usually be quickly addressed early in the session while still allowing time to conduct a full problem solving session for a more relevant truly problematic situation.

A final element of problem exploration is to consider the feasibility of the problem. Assessment of feasibility is primarily concerns the degree of control the patient can potentially exert over the problem. For example, the problem of having diabetes is not a feasible problem to work on because there is nothing the patient can do to make the disease go away. However, the

problem of having difficulty adhering to diet restrictions necessitated by the illness, and which may influence the course of the illness, is more feasible in that the patient can potentially modify their diet behavior. Likewise, the problem of having a spouse that drinks too much is not a feasible problem because the patient has no direct control over the spouse's drinking behavior. On the other hand, the problem of not knowing what to do about the spouse's drinking is more feasible because this places the focus back on the patient.

One of the less intentional positive outcomes of problem solving treatment is that it helps the patient learn to differentiate between things that are within their personal control and that are not within the realm of their personal control. Although not an explicit goal of problem solving training, this serendipitous effect can be extremely valuable in helping patients extricate themselves from chronically frustrating and depressing personal situations while at the same time promoting acceptance of what are admittedly undesirable yet ultimately unchangeable life situations. Oftentimes they can learn this simply from the process of problem exploration itself, while at other times they must experience the unsuccessful consequences of their problem solving efforts (sometimes over multiple trials) before they can truly accept that a situation is outside of, or never really was meant to be within the realm of their personal control. Such a learning experience can have a profound impact on the patient's ability to give up longstanding negative coping patterns and proceed with their life in a more productive and ultimately more satisfying manner.

In exploring and clarifying the problem it is helpful for the patient to consider the following questions:

1. What makes this a problem?
2. When does the problem occur?

3. Where does the problem occur?
4. Who is involved in the problem?
5. How often does the problem occur?
6. What have you already tried to solve the problem?
7. Do you truly have control over this problem?

Answers to these specific questions will give the types of specific details necessary to determine whether in fact the situation actually constitutes a problem and for conducting the ensuing problem solving session.

Another important point to clarify for depressed patients is how to differentiate fact from assumption. Often, patients will make assertions about a problem based on their gut feelings, or intuition, as if such feelings were indeed fact. As discussed in the problem orientation phase, the problem with depressed patients relying on their gut and intuition is that they tend to only focus on negative information while discounting any positive information. Thus, it is important to help the patient figure out when, in defining a problem, they may need to go on a fact-gathering mission to better define the problem. We have found that sometimes telling patients to think of themselves as detectives who are gathering all the facts before solving a case can be helpful in this regard. In other versions of PST-PC, patients are taught to use what is called the “Columbo method”. Columbo was a popular television detective in the mid 1970s who was often perceived to be an unintelligent and annoying person because he had to ask so many obvious questions, sometimes repeating the same question over and over until he was absolutely satisfied the answer was consistent each time. However, it was this technique – to question all the information presented to him on a case – that allowed him to solve the mystery so adroitly.

As an example of how this method could be helpful to a patient, a depressed employee may think that his manager is distant to him and does not like him. He may have selectively based this assumption on behaviors he has observed that would confirm the hypothesis and ignored other relevant information. Rather than go on the assumption that this belief is true, it would be beneficial for this patient to weigh more evidence and ask questions. Is the manager distant only with him, or is he a distant person in general? Do other employees feel as the patient does? What other explanations are there for the manager's behavior? Once assumptions are confirmed, or disconfirmed, then the problem is defined specifically and the possibility of developing effective solutions is maximized

Step 2. Break down large problems into smaller and more manageable parts.

Large problems are often comprised of a number of smaller, yet distinct, interrelated parts. In the process of exploring a problem the patient may be unaware of or under appreciate the interconnectedness of these component parts. Failure to differentiate these components leads to an overly vague problem definition that in turn leads to an inefficient problem solving session. For example, a female homemaker reported that she had a problem with "family relations". On further inquiry the therapist established that she actually had several different problems with family relations. First, she was resentful of her husband for staying out four nights a week. Second, she felt criticized by her mother about the quality of her housework. Finally, she had to take care of an ungrateful sister with a chronic medical illness. The therapist and patient reviewed these problems carefully and then the patient selected one specific problem to initially address.

Similarly, patients will often describe a complex problem for which the solution is dependent upon multiple smaller problem areas being resolved. The clarity of the problem

statement is not at issue, but the complexity of its resolution may be great. For example, a middle aged disabled veteran stated that he needed money to buy Christmas presents. This is a clear and specific problem definition. However, further exploration revealed that the lack of free cash was a function of other problem areas. First, his income was low. Second, he had too many expenses. Third, he was paying off back debt. Finally, he lacked agreement with his spouse on where money should be spent. Each of these problem areas was then established as a target for intervention in its own right.

The essential message embedded within each of these scenarios is that problems are best addressed when they are broken down into their essential elements. Doing so allows a more thorough understanding of the complaint, a more specific definition of the problem or problems to be focused upon, and therefore a more effective and efficient problem solving session.

Step 3. State the problem in a clear and objective form.

In PST-PC, all subsequent stages flow from the problem definition. Therefore, emphasis should be placed on stating the problem in a clear and specific manner with objective behavioral referents that lead to objective goals and practical solutions. The importance of this process for guiding later problem-solving stages, such as solution generation, cannot be overemphasized. In the patient's daily life the nature and extent of problems are often ill defined. If consciously defined at all, they are done so in a vague manner, often without clear behavioral referents. For example, the problem definition "My daughter is disrespectful toward me," is vague and provides no indication of what specifically needs to be changed. Whereas the problem definition "My daughter tells me to 'Shut Up' when I ask her to do something" is much more objective and specifies the exact behaviors needing change.

Problems stated in a subjective or unobservable manner are to be avoided. For example, a problem stated as “low self-esteem” is both subjective and unobservable. Low self-esteem is not a term that has a common meaning for two or more people and it is outside the realm of direct observation and measurement. Likewise, being “depressed” is not an objective problem definition. The phenomenon in reference resides “within the person” and therefore cannot be observed by others or measured behaviorally. However, the above problems can potentially be stated differently. Low self-esteem is often associated with avoidance of other people and isolation. A more beneficial restatement of the problem may be that the patient “spends too much time alone” or has “no friends.” Time spent alone is both behavioral and potentially measurable. Likewise, “depression” is commonly associated with missed work and letting home obligations slip. A more productive statement of the problem may be that the patient “is missing too many days at work” or “has let the yard work and garden go unattended.” Again, such a rephrasing of the problem brings it out into an observable and measurable domain.

When patients state problems in a subjective manner it is often helpful to ask them how this problem affects their ability to function in their family, work and social lives. Such questions bring the problem into the realm of “here and now” and uncover practical aspects of the problem that can be directly addressed. Another helpful strategy is to ask the patient to picture the problem in their mind, or to close their eyes and attempt to visualize the problem. One cannot visualize low self-esteem or depression, but we can readily form a picture of a person sitting home alone or looking out their window at an overgrown garden. If you can visualize the problem then it is a pretty safe bet that you have defined it in an objective fashion that is amenable to problem solving.

Sometimes patients will bring up as problems what are typically thought of being more neurovegetative symptoms of their depression, such as problems with energy, sleep, or motivation. Although these symptoms are “problematic” they are not objective life problems and therefore are not the best problems to identify for problem solving. Nonetheless, if the patient insists that they wish to address these, or there are no objective life problems that appear to exist, then a symptom may be chosen as the problem area as long as the functional correlates of the symptom are identified. The problem definition is then constructed in reference to the functional impairment rather than the symptom. For example, low energy may have the function of decreasing the patient’s ability to do housework, and in which case the problem definition becomes “trouble getting housework done”. Likewise, lack of motivation may interfere with going out of the house to visit with friends, and the problem definition becomes “difficulty getting out of house to visit friends.” As the patient becomes more effective in resolving these functional problems their depression will begin to lift and the symptoms of low energy and motivation will improve.

Stage 2: Establishing Realistic and Achievable Goals for Problem Resolution

Once the problem has been properly defined, the next stage is to identify an achievable goal that follows directly from the problem statement. This involves asking the patient what they would like to see changed about the problem. It is often helpful to ask the patient the following question, “If the problem didn’t exist anymore, what would be different?” This allows the patient to project into the future and to envision their life without the problem. Hence, this is their goal. For example, from the above patient scenarios, the homemaker set a goal of spending more time out of the house with friends, and the disabled vet set a goal to decrease outgoing expenditures.

It is important to emphasize to the patient that the goal be achievable with a reasonable amount of effort and time. Therefore, it is important to take into account the balance between the patient's resources and the time frame for its achievement. Initially, goals should be identified that can be achieved quickly, for example before the next session. Mid-term goals can be set early in treatment but attained in stages over the course of treatment. The importance of having made a clear definition of the problem during Stage 1 is apparent here in that vague definitions will interfere with setting realistic and achievable goals. Long-term goals will undoubtedly require continued effort after the conclusion of treatment. Therefore, although they should be identified early in treatment, they should only be addressed via short- and mid-term goals during the course of treatment, and emphasized particularly during the last sessions as planning for post-treatment takes place.

As with the problem definition, emphasis should be placed on establishing a clear goal, which is stated with objective behavioral referents that are within the patient's personal control. For example, a middle-aged female identified the problem of being overweight. The novice PST-PC therapist allowed her to set a goal to "lose five pounds during the next week." Aside from the judgment as to whether this goal is realistically achievable or not, it is stated in a fashion that is not within the patient's control. She has no control over whether or not the weight comes off and it is not stated in a fashion that guides behavioral action. A better goal statement could be "I will find ways to decrease my fat consumption" or "I will increase my activity level." These are goals she has direct personal control. Whether she changes her fat consumption or activity level is completely up to her. Both activities are observable and measurable and she will know whether she met her goal or not.

Another advantage of setting clear behavioral goals is realized during Stage 7 when the success of the solution implementation is evaluated. When the set goal stipulates specific behavior changes for the patient, and they successfully implement those changes, then they have succeeded with their task. Whether their behavior change translated into an effective impact on the problem is not at issue. For the overweight patient, whether or not her increased activity level or decreased fat intake has affected her weight is irrelevant. She has met her goal and she can feel satisfied that she has done so. If her goal were to “lose five pounds during the next week”, a goal not under her direct behavioral control, and she has not done so, then she is faced with a failure experience, which in turn may even exacerbate her depression.

The therapist should be careful that in stating the goal in an objective behavioral fashion that the goal should not be stated in such detail that it actually represents a specific solution and prematurely aborts the next stage, Stage 3 or solution generation / brainstorming process. Otherwise the result is a poorly developed goal statement and a possible missed step. For example, a young female patient recognized that she could not adequately predict her expenses and income for the next month and set this as her problem definition. She focused in on her need to establish a budget and wanted to set this as her goal. Had the therapist allowed this to occur then the subsequent brainstorming process would have been nothing more than identifying the tasks she needed to accomplish to construct her budget (See Stage 6: Implementing the Solution). However, the therapist intervened and advised the patient that she was looking at a solution without fully understanding all facets of the problem. They then agreed that the real goal deriving from the problem definition was to “collect information to help predict her financial standing for the next month.” The solution of establishing a budget then became only one of several potential solutions, which included obtaining the services of an accountant, asking

her father for help, and getting some books on home finance management from the library. These options would have been cut off to her had she stayed with the original goal statement, thus leaving her with an inadequate solution to her larger problem.

If a solution is so obvious that it can be generated as the goal and lone solution alternative, then the problem probably does not require a full problem solving session. The patient can be directed to simply enact this solution, possibly with some brief attention to the creation of an action plan (e.g., Stage 6), and to go on to another problem for the session. Such scenarios are most likely to occur during later treatment sessions. These instances are often a good indication that the majority of difficult problems have already been addressed and/or that the patient has adequately learned the PST-PC strategy, thus suggesting that treatment is nearing completion.

Stage 3: Generating Multiple Solution Alternatives: Brainstorming

Once the goal has been set, the patient is asked to generate a range of potential solutions. Research has shown that depressed people often have a very difficult time generating solutions, partly because they are discounting the effectiveness of solutions before adequately defining them, and sometimes they are stuck on one solution as being the only way out of their problem (e.g. winning the lottery to solve financial problems). Teaching individuals to creatively think of a range of possible solutions is based on the premise that the availability of a number of alternative actions will increase the chances of eventually identifying particularly effective solutions. In other words, the "first idea" that comes to mind is not always the "best idea". Therefore, it should be emphasized to the patient that they should try to generate as many solutions as possible via "brainstorming" techniques. Potential solutions should not be discarded

or prejudged, even if initially they seem to be untenable or farfetched. Teaching patients to think of multiple solutions helps them to become more flexible in their perspective on problem resolution.

There are several important points to impress upon the patient. First, the quantity of solutions generated is important. The greater the numbers of potential solutions, the greater are the chances for successful resolution of the problem. Second, the patient should feel free to combine ideas when practical to do so, and to modify them as they develop their ideas. For example, the homemaker originally developed the idea to invite a particular friend to go out for dinner. Later in the brainstorming process she developed another idea of inviting a friend to take walks during the day. At this point she realized that the original friend was home during the day and lived right next door, thus making it more feasible to invite her for the walks rather than for dinner. She therefore modified the plan for dinner to include a different friend.

Third, the patient should never judge the ideas until the brainstorming process is completed, otherwise they may prematurely abandon a potentially successful and novel solution. Evaluation of the feasibility of each option is left for the subsequent stage (Stage 4: Implementing Decision-Making Guidelines: Pros and Cons). When patients begin to prematurely evaluate their solutions, or to dismiss them out of hand, the therapist must immediately interrupt them and dissuade them from prejudging any solutions until brainstorming is complete. Finally, if the patient is having great difficulty developing solutions, they should be encouraged to think of how other people might respond to the problem, or to deliberately invent a solution that is blatantly silly (although it should not be emphasized that generating silly ideas is the objective above generating multiple ideas). This depersonalizing tactic often helps the inhibited patient to reduce their self-consciousness about generating foolish ideas and being

socially embarrassed in the treatment session, and therefore promotes more creative thinking and effective brainstorming for the future.

In order to facilitate brainstorming it is helpful for the therapist to make statements such as “here comes the fun part; brainstorming”, “what else can you think of?”, “think freely”, “be playful with your ideas”, “don’t prejudge”, and “throw caution to the wind”. Therapists should steer away from statements such as “can you think of anything else?” and “can you think of any other ideas?” as these invite close-ended responses such as “No”, and can abruptly halt the brainstorming process. Patients who are particularly stuck and unable to generate ideas can benefit from another helpful tactic developed by Nezu and colleagues (e.g., Nezu, Nezu & Perri, 1989) known as the “Brick Technique”. To help the patient get the gist of brainstorming and the utility to listing any idea that comes to mind, the patient is asked to think of ideas for a neutral task – to generate as many uses as possible for a brick. Patients typically begin with stereotypical uses such as for a building or making a wall. The therapist then asks whether they could use it if locked out of the house, if they had a window that would not stay open, or what if they were attacked in an alley, etc. This exercise helps the patient to think “outside of the box”, and they quickly catch on that they should not limit themselves to conventional rules of thinking. In using this technique the therapist must be very clear about the rationale for the strategy, that it is to help them practice brainstorming while withholding judgement. Once, a therapist in training, having a particularly hard time getting a patient to brainstorm, stopped in mid-session, and asked the patient to begin thinking of all the uses she could for a brick without explaining the reason for the request. The patient looked at the therapist and said, “That has got to be the most ridiculous idea I have ever heard!” Needless to say, the therapist was in a tough spot and potentially lost some credibility with the patient.

Especially during early sessions, patients will often look to the therapist to develop solutions for them. Patients will frequently ask, “What do you think?” They may lack confidence in their own abilities or have become so negativistic about their situation that they believe they cannot possibly generate additional or novel solutions. These can be difficult and stressful experiences for the therapist when they know the patient should be learning to generate their own solutions but at the same time are motivated to be helpful to the patient. The immediate impulse is to offer ideas to the patient. However, this is never a good tactic. First, it teaches the patient to remain dependent upon the therapist for problem solving. Second, it deprives the patient of the personal fulfillment available to them from independent coping. Third, it does not teach them any new skills. Thus, no matter how hard the pull to offer suggestions, therapists should refrain from doing so.

Fortunately, several alternative tactics can be employed in such situations. The first and most obvious is to say to the patient that it is your job to teach them the problem solving technique but their job to come up with the problems, goals and solutions. This can be reinforced with a statement to the effect that the patient is the best judge of what is right for them and their situation, and that the therapist could come up with solutions but these would only be relevant for the therapist. This tactic alone will often suffice to get the patient on track with an independent brainstorming process. An additional approach is to make the above statements and then sit quietly waiting for the patient to generate the ideas. The prolonged silence that often follows can be quite uncomfortable for the new PST-PC therapist. However, biting one’s tongue often pays handsomely down the road. As the saying goes, “Actions speak louder than words”. When the patient realizes, as they sit quietly with the therapist, that the therapist will not do the work for them, they quickly learn the expectations of the treatment model. If all else fails,

another approach is to ask the patient if they or anyone else they knew encountered the problem before, and what solutions were tried, even failed ones. Listing failed solutions may seem to be an odd exercise, but remember, the patient will often have a skewed view of how successful an outcome was, and will not have usually gone through the task of actually evaluating the solution previously. Thus, there may be some aspect of a failed solution that is workable, and with some tweaking and discussion those solutions may prove to be quite valuable. Moreover, the exercise reinforces the act of brainstorming while withholding judgement.

Another alternative is to explain the underlying “teaching model” for PST-PC and provide an analogous teaching situation for discussion. The therapist can liken their role to that of a mathematics tutor in which the tutor will teach the student the steps to solving the mathematics problem but it is up to the student to actually solve the problem. Likewise, the PST-PC therapist’s role is to teach the patient the problem solving process but it is up to the patient to actually do the work. A final strategy is to turn the brainstorming problem into a topic for problem solving. Obviously, the patient must learn brainstorming as one of the skills for problem solving and therefore it is completely consistent with the PST-PC model to take the time to teach the skill. The therapist can then say, “Where would you go to find ideas about this?”, and “Who would you ask?”, and “How much do you know about everything there is to know about this...where would you get the information?”

Stage 4: Implementing Decision-Making Guidelines: Pros versus Cons

In Stage 4 the therapist prompts the patient to strategically evaluate the alternative solutions by implementing decision-making guidelines. Specifically, the patient is asked to consider consequences for each solution by drawing up a list of the “pros” and “cons” for each potential solution. The therapist asks the patient to think of the advantages and disadvantages,

the feasibility and obstacles, and any other benefits or challenges connected with each potential solution. It is generally helpful to think of pros and cons in four different areas: meeting long term goals, meeting short term goals, the impact the solution will have on the patient, the impact the solution will have on others/society. It is also important to help the patient think of the pros of a solution first. Most depressed patients will have an easy time listing the cons of a solution. If they do this first, they will be unlikely to think of any positives.

The underlying principles of decision analysis require some additional discussion. Few potential solutions, as is true for most situations in life, are comprised entirely of positive or negative elements. Likewise, employing categories of pro versus con, good versus bad, advantage versus disadvantage, etc. is actually an artificially constructed dichotomous framework that is not truly representative of the complexity of human decision-making processes. Therefore, although the dichotomizing method is a useful tactic for weighing the relative merits of each potential solution, it is actually more valid to think of pros and cons as existing along a dimension of facilitation versus obstruction. By doing so, each potential solution then only gains merit, or loses merit, relative to the other solutions. There are no absolute good or bad solutions. Thus, the only meaningful way to make choices between solutions is to be comparing and contrasting the overlapping themes and making estimates of greater or lesser magnitude of facilitation or obstruction on these themes.

For example, the overweight female may need to decide between decreasing her fat consumption and increasing her activity level. Each solution has its own set of advantages and disadvantages. Each has certain aspects to recommend it and each has certain aspects that pose challenges to it. Each may require a certain effort level, financial investment, and investment in time or assistance from others. Only by comparing between these elements for each of the

solutions can a meaningful decision be reached about the relative merit for each solution. This process replicates the natural decision-making process in everyday life and is the intent of the problem solving decision analysis process. In the end, the solution with the greatest absolute number of pros may not be chosen, and in the end, the solution with the greatest absolute number of cons may not be rejected, but the solution with the greatest relative merit will be selected.

Effective solutions are those that not only solve the problem, but also minimize negative outcomes for the self and others. As with facilitating brainstorming it is helpful to frame comments in an open-ended fashion, such as “What are the disadvantages of...?”, which implies that there is necessarily some component of advantage and disadvantage associated with each solution. Therapists should avoid comments such as “Can you think of any pros or cons of...?” which invites the patient to opt out of this process. The patient should be encouraged to consider whether each potential solution will: (a) make a significant impact on the problem; (b) have advantages or disadvantages in relation to the patient’s time, effort, finances, or need for cooperation from other people; and (c) have positive or negative effects on the patient’s friends and family. A useful strategy is to remind the patient of the most common themes to consider (i.e., time, money, effort, and cooperation from others) when introducing this stage as a means of priming them to consider the major factors for each solution.

As with all of the problem-solving stages it is ideal for the patient to derive their own pros and cons list. However, there are two occasions in which it is acceptable for the therapist to introduce information. The first is when the patient is overlooking a negative consequence, either for themselves or others, which is extreme. This would certainly include a consequence of significant physical or emotional harm to oneself or others, and may include episodes of interpersonal conflict, such as with a spouse or co-worker. The second instance is when the

patient mentioned an advantage or disadvantage earlier during the session, such as during the brainstorming phase, but appears to have forgotten this in the current stage. In this case the patient has already demonstrated that they are aware of the issue and the therapist is only reminding them to include it in the decision analysis process.

Stage 5: Evaluating and Choosing the Solution(s)

Even as the pros and cons are being laid out for each potential solution the therapist is already facilitating the process of comparing and contrasting the solutions as an aid toward making a choice of the final solution or solutions. The therapist does this by prompting the patient to compare the solutions along their pro versus con dimensions. Ideally, the solution selected should achieve the stated goals while carrying the least personal and interpersonal disadvantages connected with it. Some patients find this stage of problem-solving initially difficult to achieve alone, ruminating about possible solutions without being able to choose one, or overlooking important decision-making guidelines established in the previous stage. The therapist should begin this stage with a careful review of the relevant pros and cons for each solution.

The evaluation process should not be rushed. This stage represents the most important step toward developing critical thinking skills, i.e., the ability to carefully weigh the evidence and appropriately draw conclusions. Therapists should ask for one or more solutions by asking “which ones of these...” or “how many of these do you want to work on?” The patient may still choose only one solution, but they are at least given permission to pick more than one alternative. Therapists should use their own common sense about whether the chosen solution will have a significant impact on the goal. On the one hand the therapist does not want to overwhelm the patient with tasks they do not feel prepared to handle, but on the other hand they

do not want to trivialize or even potentially insult the patient's sense of competency by allowing a solution that is barely relevant or blatantly unsatisfactory for making progress on the problem.

Similarly, the therapist should not emphasize the choice of a solution solely based upon whether it is the most "do-able". Although the feasibility of the solution is a definite factor the most important criteria for choosing the solution is whether it has a high likelihood of satisfying the goal. Therefore, the easiest solution to implement is not always the preferred solution and should not be necessarily chosen in isolation from other solutions. Issues of feasibility are best left for Stage 6: Implementing the Preferred Solution.

When the patient chooses a solution without appropriately reviewing the pros and cons, the therapist should point this out to the patient and bring this evidence to their attention. Likewise, if a potential solution is left on the drawing board which seems an obvious choice to the therapist based upon the decision analysis, the therapist should inquire about this to assure that a deliberate reasoning process was used in deciding not to include this as an option. Awareness of using the evidence to choose the solution should be verified by engaging the patient in a brief discussion and review of the important decision-making information after they have chosen a solution. In summary, the pros and cons should be reviewed at the start of this stage, followed by selection of a solution and a discussion of the rationale for the chosen solution.

Stage 6: Implementing the Preferred Solution(s)

Once chosen, the steps required to achieve the solution are identified and planned. We often refer to this stage as the "action plan." Details about the required behaviors and specific dates, times, and materials, as well as the need for assistance from others should be spelled out.

This stage helps to assure that “good intentions” are translated into definite action. The therapist should ask, “What is needed to be done or obtained?”; “Where is it to be done?”; “Whom does it involve?”; and “How will it be done?”

For example, the homemaker chose to ask a friend out for dinner. The following steps for implementation were outlined:

- (1) Call a friend (call as many as necessary to secure a date for the next week); start tonight.
- (2) Make reservations at a restaurant (call as many as necessary); start tonight.
- (3) Call babysitter; if not available, get babysitter list from friends.
- (4) Make appointment to have hair styled; call first thing tomorrow.

The patient must identify and choose tasks that they feel comfortable implementing but the therapist should assure that the tasks are sufficient to satisfy the requirements of the solution as well. Sometimes this means that the solution may need to be broken down into more simple sub-steps. In its extreme form this may mean going back to the original problem definition and beginning the process again. (Note: this again points out the necessity of establishing a clear problem definition and manageable goals at the start of the session.) More often it requires returning to the decision-making guidelines and re-evaluating the solutions. A new solution may be chosen if the original solution requires an action the patient feels unable to carry out. For example, the homemaker chose to use a babysitter rather than to ask her husband to stay home because she did not feel comfortable asking him to do so.

If the patient lacks confidence but wishes to proceed with a particular plan of action, then steps may become even more detailed so as to specify exactly what the patient is to say, where to sit, how to behave, etc. Thus, the patient and the therapist may rehearse an interview in an unemployment office, a discussion with a spouse, a telephone call about a bill complaint, etc. By

the end of this stage the patient should have a clear set of tasks that are assigned for completion between treatment sessions. These tasks are referred to as “homework” and are listed on the homework sheet.

This stage is sometimes rushed due to time constraints, as it is the last stage completed during the visit. Therapists should be aware that the action steps are the culmination of all the good work that has preceded it. Therefore, to rush through this stage is to lose the value obtained from having completed the previous stages. The successful outcome of the entire PST-PC process rests upon its proper completion. It is well worth the few extra minutes to do this stage well and assure a successful outcome for the patient

Stage 7: Evaluating the Outcome

The final stage is actually completed at the start of the subsequent session. The patient should have completed or attempted to complete the homework tasks set in the previous session, and should have recorded the outcome of these tasks on the homework sheet. The therapist begins the session by asking the patient about their success with the homework, and praising any progress. The therapist can then discuss problems and difficulties, bearing in mind that patients may selectively attend to failures. Therefore, it is important to praise all successes however small, without lapsing into a patronizing attitude. For successes, statements such as “Nice job”, “I knew you could do it”, etc., will suffice. It is also worthwhile to talk about the process, was there any additional information they learned about themselves and the situation, and if they would use this solution again in the future. It is important to think through success as well, as patients can often learn quite a bit about other problems by tackling and successfully solving one.

The review of homework should be followed by asking the patient about their sense of satisfaction with their effort and the impact of their success on their mood. Particularly during early treatment sessions, patients may state that the success had no impact on their mood. On these occasions the therapist should review the PST-PC model with the patient, and emphasize that they certainly are no worse off for having solved a problem and that mood alteration may lag in time a bit. It is important to encourage persistence. When mood improvement is reported the therapist should take advantage of this and again point out the link between effective problem solving and achieving a positive mood state. Often the patient will be on concurrent medications, such as antidepressants. When mood symptoms improve it is important to attribute and emphasize at least equal responsibility to the problem solving efforts as to medications. Attributions of success to medications alone are likely to interfere with continued progress after treatment. In other words, it is essential that the patient believe that their improvement has as much to do with their own problem solving efforts as with the medications they are taking.

In discussing failures, the therapist should always communicate that they see the patient's potential for effective coping, and thus facilitate a positive problem-solving orientation. This is also an opportunity to reinforce to the patient that the problem-solving process is useful in failed situations, too, that failures often result in more information about the problem that was not available earlier. Thus, solutions usually don't work out because we didn't have all the facts when solving the problem. And since no one ever truly has all the facts when initially solving a problem, failures are part of the process, part of life, and are really opportunities to improve our ability to cope with the problem. Thus, if difficulties have arisen, the reasons should be examined:

What did the patient learn about the situation that they did not know for sure before?

Exactly what happened when they tried to implement the solution?

Should the goal be defined more clearly?

Are the goals unrealistic?

Have new obstacles arisen?

Are the implementation steps difficult to achieve? If so, why?

Is the patient truly committed to working on the problem?

The answers to these questions will guide the way the new session is conducted. If the problem simply proves too difficult to tackle (usually due to the patient not having sufficient control over the source of the problem), then it is reasonable to go on to another problem or to modify the goal to focus on aspects of the problem over which the patient has more control. It is important to keep in mind, however, that the goal of PST-PC is not to solve all of the patient's problems in living, but to use the problems as a vehicle for teaching more effective problem-solving skills in general. Toward that end, the important point is that using the PST-PC approach will enable the patient to gain a sense of control over their life and thereby alter their perception of all their problems, whether resolved in session or not.

In a recent study (Hegel et al., 2002) we have found that compliance with homework during early treatment sessions is a strong predictor of improvement with PST-PC. Therefore, if the patient has not completed the homework tasks this issue must be taken up immediately and directly. It is possible that the patient may not have understood the central role of homework for PST-PC. It should be emphasized that progress occurring between treatment sessions is more important than progress achieved within a session. Acting on problems is the chief mechanism by which PST-PC exerts control over mood state. If the patient is not committed to following through on homework tasks the therapist should stress that the goals and solutions are chosen by

the patient, not by the therapist, and lead the patient in a discussion of their feasibility. If the patient has successfully completed the homework tasks then a new problem may be chosen and discussed.

By the start of Session 3 the therapist should also be following up on the patient's ongoing efforts regarding solutions and pleasant activities designed in earlier sessions. It is important for the patient to realize that their efforts should continue until the problem situation is completely resolved, if this is possible.

The final task to be accomplished in Stage 7 is to link the patient's efforts to the PST-PC model and reinforce their understanding of the rationale for the intervention. If the patient is to continue to be a motivated participant in treatment and is to continue to apply the problem solving strategy when treatment has ended, they must understand and endorse the value of the approach. When they have been successful with their homework and/or they report that they are satisfied with their efforts or their mood has improved as a result of their efforts, this is a perfect opportunity to make the case for the underlying rationale for PST-PC. Before moving on to choosing another problem for the current session the therapist must always make an effort assure that the patient understands the connection between problem solving efforts and a positive mood state. The therapist may make a statement such as the following:

“It is nice to see that you have made progress toward working on your problem, that you are feeling satisfied with your efforts, and most importantly, that your mood seems to have improved as a result of your problem solving efforts. This just goes to show the value of using a proactive problem solving approach in order to tackle your problems. As you make progress tackling your problems in a productive way you start to feel more in control of your life, and as you feel more in control of things your mood feels better.

This is exactly the way problem solving treatment is supposed to work. Congratulations on your progress!”

The Role of Activity Scheduling in PST-PC

Activity Scheduling is a strategy for helping patients incorporate pleasant and satisfying activities into their lives. The procedure is based on the research of psychologist Peter Lewinsohn (Lewinsohn et al., 1986) who showed that depressed individuals engage in significantly fewer pleasurable events than do non-depressed individuals. Lewinsohn’s theory of depression postulates that the lack of pleasant events causes the person to become depressed, and because the person is depressed they are less likely to seek out pleasant events. Thus, a downward spiral is established in which lack of pleasant events leads to depression, which in turn leads to fewer events, and therefore worsening depression, and so on.

The treatment implications are straightforward. In order to help a patient to reduce their depression the therapist must help them find and engage in pleasurable activities on a more frequent basis. The traditional treatment methods delivered in the mental health sector are fairly elaborate and time-consuming. However, the basic tenet of Activity Scheduling, that is, increasing the frequency of enjoyable activities, is one that lends itself to PST-PC, is easily incorporated into the primary care setting, and therefore is included in the treatment model.

A role can be found for Activity Scheduling for practically every patient. Just ask yourself the question, “What person would not benefit from more enjoyable events in their lives?”, especially if they are depressed. That being said, there are several circumstances in which Activity Scheduling should be used without exception. These are:

- (1) When the lack of pleasurable events is identified on the problem list;

- (2) When other problems are completely outside of the person's control;
- (3) When the solution to a problem is likely to result in noxious outcomes, at least for the short term; and
- (4) When the patient adamantly insists that they have no problems to work on.

Activity Scheduling proceeds just as any other PST-PC session, beginning with a problem definition such as, "Too few pleasant events each week." An Activity Scheduling Handout is included in Appendix 4.

The Seven Stages of PST-PC

Case Example: Alice

Alice was a 24-year old single woman employed as a social worker for the State's social services department. She was experiencing a depression of moderate severity, and was referred by her primary care physician for treatment. At the start of treatment the following initial problem list was created:

(1) Job dissatisfaction. Alice was very stressed by the needs of the abused and neglected children on her caseload. She felt that her superiors were not supportive of her efforts, and she struggled with her motivation to go into work each day.

(2) Isolation from family and friends. Alice's job required her to move away from her immediate family and longtime friends and made it difficult to visit. Due to her distance from home, as well as her financial limitations, she was restricted to visiting home only once per month.

(3) Loneliness. Alice had difficulty establishing a network of friends in her new area. Most importantly, she wished to begin dating.

(4) Weight Problem. Although Alice reported that she had always been overweight, she gained an additional 30 pounds since moving away from home. She admitted that she often ate to console herself, which frequently involved eating high calorie foods. She also complained that her busy work schedule and fatigue made it difficult to shop for and to prepare nutritious low calorie meals. Being overweight made her feel self-conscious and inhibited about pursuing a romantic relationship. Again, due to job demands and fatigue, Alice was not getting enough regular exercise to help with weight loss and self-image problems.

(5) Lack of enjoyable activities. Other than her monthly trips back home, Alice had a paucity of pleasurable events in her life. When not working she was typically at home by herself, watching TV and feeling bored.

Upon reviewing the problem areas, Alice could easily see that the resolution of her problems would require a mix between short-, mid-, and long-term solutions. The weight problem could lend itself to relatively short-term solutions, which could be started immediately. However, the problems of job dissatisfaction, and the lack of pleasurable activities and new friends would require more mid-range solutions that would need to be pursued over several weeks. Finally, the problem of lacking a dating relationship would need to be addressed over the long-term and probably after the completion of treatment as well.

Stage 1: Selecting and Defining the Problem.

Alice chose to address the weight problem. In order to clarify the problem the therapist asked why she had a weight problem. She answered that she was eating incorrectly and not exercising regularly mostly due to lack of time for shopping and lack of structure to her schedule for exercise. The therapist impressed upon her the desirability of choosing a very manageable problem for the first session in order to have an initially successful experience. Given that diet modification would require careful planning, shopping, and food preparation (as well as needing to dispose of less healthy foods already filling her cupboards), Alice chose to specify “lack of exercise” as her problem definition and initial focus for PST-PC.

Stage 2: Establishing Realistic Goals for Problem Resolution

Brimming with enthusiasm, Alice initially wanted to set a goal for exercising every day. The therapist cautioned her, however, that such an exercise schedule represented a drastic change in her daily routine, and asked whether this was truly a realistic expectation for herself during the first week. Alice then modified her goal to “exercise on five days during the next week.”

Stage 3: Generating Multiple Solution Alternatives

During the brainstorming process Alice developed four potential solutions:

- (1) Join a health club.
- (2) Establish an exercise program at home.
- (3) Buy exercise equipment.
- (4) Take walks with friends and co-workers.

Stage 4: Implementing Decision-Making Guidelines

Alice identified many advantages and disadvantages (pros and cons) connected to her options for starting an exercise program. These included:

- (1) Join a health club. Pros: a. Exercise equipment readily available; b. Trainers on hand for guidance and motivation; c. The health club would be an option even during bad weather (Alice lived in a cold and often inclement climate). Cons: a. The membership fee would cause financial strain; b. She preferred to exercise with a partner (not trusting her own motivation based on past experience) and she didn't know anyone with a membership to the club; c. Travel to and from the club would tighten her already crowded schedule; d. Especially without an exercise partner, she would feel self-conscious exercising in front of other people.

(2) Establish an exercise program at home. Pros: a. Cheaper than a health club membership; b. More flexible for her schedule; c. She would not feel self-conscious about exercising in front of other people. Cons: a. Limited variety of exercises she could do at home; b. It would be boring to exercise by herself; c. She would still have to set aside time after her long work day, and she usually feels very tired and unmotivated by the time she returns home.

(3) Buy exercise equipment. Pros: a. One machine could provide enough exercises to give a workout for her entire body; b. She could exercise at home and not be self-conscious. Cons: a. Financial strain to purchase equipment; b. The time and motivation factors about exercising after work are still relevant; c. She would still find exercising alone to be boring.

(4) Take walks with friends and co-workers. Pros: a. More fun to exercise with others; b. The company of others would help to motivate her; c. If walking outdoors, the presence of other people would increase safety; d. No costs involved. Cons: a. She would have to find someone with whom to exercise; b. They would have to find a compatible time to exercise.

Stage 5: Evaluating and Choosing the Solution(s)

After considering all of the advantages and disadvantages Alice chose the solution of taking walks with friends. The factors playing the largest role in her decision were the lack of money for a health club membership and exercise equipment, and the low probability of her being able to motivate herself to exercise on her own, and especially after a long workday.

Stage 6: Implementing the Preferred Solution (s)

Alice committed herself to begin her exercise at the beginning of the next week to allow time for working out the logistical matters. She identified the following steps she must take:

- (1) Given that she had no friends other than her co-workers, she decided to speak with them about their interest in starting an exercise program. Some had already mentioned to her their interest in starting a walking program. She would speak to them the next day.
- (2) Once exercise partners were identified, they must find a common time convenient for exercising. She would recommend walking over the lunch hour.
- (3) If a common time were not convenient she must modify her work schedule.
- (4) Buy walking shoes this coming weekend.
- (5) Alice initially set a goal to exercise five days per week. However, while discussing the walking schedule she realized she spent two days each week out of the office. This necessitated a reconsideration of the original goal, and keeping in mind the premium placed upon success, the goal was changed to exercise three days per week.

Stage 7: Evaluating the Outcome

When Alice returned two weeks later for the next visit she reported that she had arranged to walk during her lunch hour with two co-workers. She walked on four days during the first week, but only on two days during the second week. She was complimented for her success in starting the exercise program, and then the failure to meet her goal for the second week was discussed. She had overlooked a bi-weekly meeting that took place during the noon hour on one of the days of the second week, and she had scheduled meetings with clients too close to lunchtime on two other days, thereby squeezing out her time for her walk. Nonetheless, with her initial accomplishments she was beginning to feel more optimistic about her situation.

The initial part of this session was devoted to problem solving for these obstacles. New solutions included planning to not schedule clients during the half-hour before lunch and to use

the time instead for paperwork or phone calls and not run the risk of running into her lunch hour. She had no control over the bi-weekly meeting and it was decided that she would simply miss the exercise walk on those days.

Chapter 4.
Conducting PST-PC Sessions Two Through Six

SESSION 2:

Time: 30 minutes.

The tasks for this session are to:

- (1) review the patient's progress and reinforce success and continued effort;
- (2) remind the patient of the problem solving treatment model;
- (3) guide and support the patient in acquiring and using problem-solving skills; and
- (4) facilitate a positive problem-solving attitude.

The session should begin with a review of progress on the homework tasks. This is actually Stage 7 of problem solving treatment, Evaluating the Outcome, and the reader is referred to Chapter 3 (The Seven Stages of PST-PC Treatment) for a full discussion of this stage. In early phases of treatment the patient's low mood may hamper their problem-solving ability. It is important therefore for the therapist to give the patient verbal support and reassurance in order to combat demoralization. Often the patient magnifies difficulties in implementing solutions and overstates lack of progress. Such attitudes must be disconfirmed by providing the patient with evidence of success based on what they have actually accomplished. Self-reward may be suggested as being useful to reinforce success. For example, going to the movies (an enjoyable activity) after success in achieving a goal that was difficult to attain.

The therapist should be careful not to spend so much time reviewing progress that time is limited for additional problem-solving. Typically, five minutes or less should be devoted to the

review, unless significant obstacles were encountered in completing the homework, or major new problems have arisen.

The remainder of the session should be spent in problem-solving and planning tasks to be accomplished before the next session. These tasks may be linked to the previous problem if it has not been resolved, or to a new problem. At times, the problem from the previous session may not have been completely resolved, but due to obstacles outside of the patient's control, or due to the protracted nature of the solution, further discussion during the current session is not warranted. In such a case, it is reasonable to address other problems after reminding the patient to continue their efforts on the previous problem. In fact, when conducting the review of homework, whether during Session 2 or subsequent sessions, the therapist should review all problems addressed previously to encourage continued effort throughout treatment. This does not need to be a lengthy discussion. The therapist should simply remind the patient of their previous tasks, and if the problem is unresolved, encourage continued effort toward achieving their solutions. Of course, if new or ongoing obstacles are encountered the previous problem may be used again for the current problem solving session.

Materials for Session 2:

Provide the patient with:

- (1) PST-PC Worksheet: Patient follows along with the therapist, using his or her own PST-PC Worksheet in session and is provided a copy of the completed worksheet from the therapist (photocopied).
- (2) Extra PST-PC Worksheet for independent problem solving between sessions.

SESSIONS 3 THROUGH 5:

Time: 30 minutes.

The aims of these sessions are to:

- (1) review the patient's progress and reinforce success and continued effort;
- (2) remind the patient of the problem solving treatment model;
- (3) consolidate the skills for the problem-solving strategy;
- (4) gradually increase the patient's independence in conducting problem-solving; and
- (5) facilitate a positive problem-solving attitude.

The patient and therapist should review the original problems, consider progress, and always be prepared to add new problems to the problem list. At this point, the patient may have worked through a series of short and mid-range goals to reach a long-term goal. For example, if the final goal was to secure a new job, the short-term and intermediate goals may have been:

- (1) to obtain information about the qualifications required;
- (2) to send application forms; and
- (3) to attend an interview.

For goals such as these, which are achieved in phases, the therapist should encourage continued effort over time and track progress as each phase progresses.

Materials for Sessions 3 through 5:

Provide the patient with:

Session 3:

- (1) PST-PC Worksheet (With therapist guidance, patient fills out in session using own copy)
- (2) Extra PST-PC Worksheet

Session 4:

(1) PST-PC Worksheet (Fill out with therapist if necessary, but the patient ideally takes the lead in filling out)

- (2) Extra PST-PC Worksheet

Session 5:

- (1) PST-PC Worksheet (Patient fills out in session; with assistance if necessary)
- (2) Extra PST-PC Worksheet

SESSION 6:

Time: 30 minutes.

The aims for this session are to:

- (1) review the patient's progress and reinforce success and continued effort;
- (2) remind the patient of the problem solving treatment model;
- (3) comment on the remaining problems from the problem list and encourage the patient to continue their problem solving efforts in the future;
- (4) begin to anticipate upcoming situations for potential or hypothetical problems in the future;
- (5) review and emphasize the problem-solving process, with emphasis on it being something the patient has learned and can now effectively apply independently of the therapist;

(6) agree on follow-up plans if necessary;

(7) facilitate a positive problem-solving attitude and optimism toward the future.

Materials for Session 6:

Provide the patient with:

- (1) PST-PC Worksheet (Patient fills out in session; with assistance if necessary)
- (2) Multiple copies of the PST-PC Worksheet

Termination Issues:

In Session 1 the therapist explains that the treatment will be limited to a specific number of sessions that will be provided over a specific number of weeks. Both the therapist and patient should keep this information in mind throughout treatment in anticipation of, and in planning for termination. As sessions progress the therapist should make a point of reminding the patient which session number they are undertaking and the number of treatment sessions remaining, such as “Okay Mrs. Smith, today is our third problem solving visit and we have three remaining.”

Throughout treatment the therapist should emphasize that problem solving can be used not only for current problems, but also for future problems. The therapist should reiterate that the goal of PST-PC is not necessarily to solve all of the patient’s problems but to teach them the problem solving approach so that they can apply it independently in their lives. In later sessions the therapist should gradually become less active in the problem solving process, turning over more responsibility to the patient for conducting the session, and this change should be made apparent and emphasized to the patient. For example, the therapist may say, “Okay Mrs. Smith, this is our third session and you are starting to catch on to the problem solving strategy. The

purpose of our visits is to teach you the problem solving strategy so I would like to have you take a little more of a leading role in guiding the session. So, could you please tell me, what is the first step you need to take in starting to solve this problem with your boss?" The therapist should always be ready to provide the patient with appropriate cues and prompts to assist them, but then again return control of the session back to the patient.

The therapist should lead off Session 6 with the reminder, "This is our final session." The therapist should review the problem list and identify any problems that should be considered in the final session. If additional problems have emerged there is not adequate time to fully address them in the session. The patient should be reminded of the steps they can go through to resolve them, and time may allow for problem definition and possibly goal setting, and the patient should then be encouraged and reassured by the therapist that they are now well suited to tackle this and future problems on their own.

If treatment has been successful the patient should feel convinced that they have contributed to their own recovery, with the use of commonsense problem solving techniques. Achievements during treatment should be summarized so that the patient leaves with a good feeling about the work they have done. If the message regarding the primacy of the patient's own effort has been delivered throughout the treatment, then problems with termination and dependency should be minor.

Chapter 5.

Facilitating an Appropriate Problem-Solving Orientation for PST-PC

According to Albert Bandura, people react to social situations based on their belief about how well they can manage the situation and the degree to which the situation is one that they can control. In social problem solving theory, this belief is called Problem Orientation and refers to how effective people believe they are at solving problems and how likely they can control the outcome of the problem. Some problem-solving theorists believe that regardless of how skilled someone is in problem solving, one's problem orientation is critical in determining whether or not a person will actively solve a problem or will avoid the problem. Being skilled to perform a behavior does not mean it will be engaged in. Action is determined by how much faith people have in their skills to affect change and the anticipated consequence of using those skills. Thus, a crucial part of helping people become more effective problem-solvers is helping them understand that problems are solvable, and that they have the skills to overcome most problems.

Facilitating an appropriate problem-solving orientation involves providing the patient with a positive and constructive orientation to problems in living and problem solving. The main goal here is to modify the patient's perceptions and beliefs that may interfere with attempts to engage in optimal problem-solving efforts. Proper application of PST-PC rests heavily upon the therapist's ability to promote a belief system in the patient that problems are an expected part of everyday life and that these are best approached as manageable challenges. The alternative belief system is that problems are unfair impositions or tragedies that are controlled only by external forces and are emotionally overwhelming. Obviously, the latter viewpoint is consistent

with a negativistic and depressogenic outlook on life, whereas the former is more optimistic and will promote more effective problem solving.

How the therapist helps patients develop more action focused problem orientation can vary by the type of problem solving model used. In social problem solving therapy, problem orientation is tackled directly through the use of cognitive therapy strategies. In the PST-PC model, problem-solving orientation is not specifically nor explicitly addressed, but comes about through the patient's experience with the problem-solving model and subsequent successes in using the model. The therapist facilitates the patient's shift in problem orientation by reviewing the patient's progress and pointing out successes in using the model. Thus, the therapist should always be thinking about facilitating the patients' belief in their ability to solve problems and should always be watching for instances in which the patient loses sight of this orientation. As such, facilitating this orientation should pervade all aspects of the problem-solving treatment and the therapist should always be on the lookout for "teaching moments" in which to introduce and reinforce its message.

Nezu and colleagues have spearheaded the efforts to identify the variables responsible for an adaptive problem-solving orientation (e.g., Nezu, Nezu & Perri, 1989), and much of what follows is adapted from their work. There are four specific attitudes related to problem-solving orientation that can either facilitate or hinder effective problem-solving efforts. These attitudes, along with methods to explicate and address them in treatment, are described in detail below.

1. Acceptance of Problems as a Normal, Predictable Part of Living.

This involves helping to patient to reject beliefs that problems in life are evidence for personal deficiencies. The therapist helps the patient identify external aspects of problematic

situations rather than assume internal and negative attributions toward the self. This attitude also helps to minimize emotional reactivity when confronted with a problem.

Treatment Strategies.

The therapist should look for statements from the patient that communicate a belief that problems, and specifically “my problems”, are somehow not the norm for life or that they are “unfair” in some fashion. For example, “These problems are proof that I am defective”, “No one has problems like mine”, “It is awful (terrible, intolerable) when things don’t go right”, “I am the cause of ALL of my problems”, “If I am a good person I should not have any problems...life should be fair!”

When a patient has a particularly difficult time with the negativistic thinking described above, a very helpful procedure to promote a more adaptive attitude toward problems is to reverse roles with the patient. This strategy is called The Devil’s Advocate. During the role-play, the therapist asks the patient to provide a counter-argument to the therapist’s proclamation of any of the above statements or any statements that the patient has raised about their problem. In this manner the patient is invited to wear a different hat vis-à-vis these beliefs, that is, one of an objective listener or friend, rather than the depressed individual biased by their negative emotional state. It is important that the patient be thoughtful in convincing the therapist in the role-play why these thoughts may not be entirely accurate. By encouraging the patient to think of a rationale for the counter argument, the process of correcting negative problem orientation becomes more meaningful. The process of identifying a more realistic set of beliefs and their rationale is a helpful exercise to dissuade the patient from adhering so tenaciously to this set of beliefs.

Another helpful strategy is to review the problem list form with an eye toward finding areas in living in which the patient does not have problems. This is called Weighing The Evidence. Most patients have at least a few areas in their lives that are non-problematic. For instance, although the patient may have significant job and financial difficulties they may have a very satisfying set of relationships within their family. This is particularly effective for challenging beliefs about being “defective” in all aspects of their life. The therapist can then emphasize that having problems in some areas of one’s life is to be expected and that this is more a normal part of living than a general weakness or character flaw of the individual. The therapist may go on to ask the patient to identify family members, friends or acquaintances that are experiencing problems in areas in which they are not. In this way the patient can see that they are not being “singled out” for problems in living and that other people (perhaps perceived by the patient as “having it all together”) themselves have problems, and often in areas in which the patient is actually quite proficient. All of these approaches help the patient to view problems as being natural, equally distributed amongst most people, and not necessarily due to a weak disposition or personal failing of some kind.

2. Belief in One’s Ability to Solve Life’s Problems Effectively.

This involves facilitating perceptions of competency and self-efficacy despite the experience of transient emotional distress. Although a perfect solution cannot be found for many problems, there can be numerous effective alternatives that can be implemented to have at least a partial and significant impact on the problem area.

Treatment Strategies

The therapist should look for statements from the patient indicating a belief that problems are out of their control, or that there is only one and conclusive solution to problems. Statements indicating such an attitude are: “All my problems are caused by others and this unfair world!”, “The first solution that comes to mind is usually the best”, “Acting on instincts is the best way to approach problems”, “There is a right solution to every problem”, or as one of our patients said “Ninety-nine percent correct is 100 percent wrong!”

As above, adopting the “Devil’s Advocate” strategy can effectively force the patient into the position of discounting many of these assumptions. In some cases, often due to refractory or treatment resistant medical conditions or the necessity of changing another person’s behavior, complete solutions are not available. In such cases the therapist can help the patient identify the areas which are realistically out of their control (e.g., taking away the paralysis left by a stroke, or forcing a loved one to stop drinking alcohol) and to focus on those areas they may realistically have an impact upon (e.g., finding alternative means for getting some desired activities completed for the stroke patient, and finding a support system for relatives of alcoholics, respectively). Refocusing the orientation to changeable aspects of the problem can be done by asking patients how the unsolvable problem has created other problems in their lives, in what way is the problem a deterrent in reaching other goals. Refocusing the aim or goal of the problem can often help engage patients with refractory problems into the problem solving model. If they are able to see that permanent paralysis, say, is indeed a permanent condition, but that the consequences of having paralysis can be solved, then they will be more likely to understand how problem solving applies to their lives.

3. Labeling of Discomfort, Distress, and Physiological Symptoms as Cues to Identify the Existence of a Problem.

Affective (e.g., sadness, anxiety), cognitive (e.g., pessimism, worry) and physiological (e.g., low energy, upset stomach) symptoms can be used as cues to indicate that a problem exists and to begin a problem-solving process. In this way, rather than being perceived as a distressing experience that one suffers from, the symptom may be perceived as an indicator for effective action. The symptom now becomes a useful tool for the problem-solving process rather than a feared experience that triggers further avoidance and withdrawal from action.

Treatment Strategies

A useful intervention to help the patient view their emotions or other symptoms as cues for problem-solving is to draw an analogy from another aspect of their life, such as from work or home. For example, the therapist could ask the patient to tell how they know a problem exists at work. They often respond that they get a signal from a co-worker, a boss, or simply notice that things are not working properly. Likewise, at home for example, we know the toaster has a problem when it repeatedly burns our toast. These signals are cues to start a problem-solving process to correct the situation. Our personal lives don't always come with such convenient cues, or we often do not pay close attention to the cues that do exist. Therefore, we must rely upon our emotional and physical states to "cue" us that a problem exists that needs mending. The therapist can emphasize to the patient that these internal states of being are our natural signals to begin the problem-solving process. Nezu and colleagues also use the analogy of physical pain to demonstrate how emotional pain is really just a signal that something is wrong and must be fixed. When someone consistently feels pain in his knee when he walks, the pain

signals the person that not only is something wrong, but they must stop what they are doing and change their behavior so the knee will not ache. The person has a variety of options – he can sit and never walk again, which does not solve the problem, but alleviates the pain temporarily, or he can see a doctor and have his knee fixed, which solves the problem. Like knee pain, depression functions the same way. When there is a problem in the environment, the person experiences depression. Depression signals the person to do something to stop the pain, and he has several options. One is to avoid the problem, not think about it, which temporarily stops the pain but does not fix the problem, or he can do something active to change the situation, which solves the problem and permanently stops the pain.

4. Utilization of the “Stop and Think” Technique in Problem Situations.

Once negative symptoms are identified as cues that a problem exists the effective problem-solver then launches into a problem-focused course of action. The therapist helps the patient learn to “Stop and Think” about what events preceded the change in affective state as a first step to identify a problem to be resolved. This inhibits intensification of emotionality and helps orient the patient toward using the problem solving skills. This also helps the patient objectify their feelings, reinforcing the use of feelings as red flags.

Treatment Strategies

To facilitate the “Stop and Think” technique the therapist can ask the patient to visualize a red traffic light when they notice a negative feeling, thought, or physical cue. The red light signals the patient to “Stop” and to minimize the effects of acting impulsively out of emotionality, or of actually escalating the affective response. The cue to “Think” reminds the

patient to initiate the problem-solving process. At this point, the patient can then begin the problem definition phase of treatment. As they stop, relax and then think about what is making them feel badly, they can then begin to take a detailed record of what is happening right now with an aim toward identifying the goal and defining the problem.

Summary

Although Problem Orientation is not an official stage of PST-PC, it is, none-the-less, an important concept to keep in mind when working with depressed patients. A consequence of depression and the unsuccessful management of prior problems is the belief that the world is a harsh and complicated place that the patient is ineffectual in. Helping patients overcome this belief facilitates their faith in the problem solving process, and ultimately in the likelihood that they will use PST-PC once therapy ends.

Chapter 6.

PST-PC Group for Maintenance of Therapeutic Response

Overview

The Problem-Solving Group (PSG) is a maintenance-phase intervention for patients who have successfully completed 4-8 weeks of individual, acute-care PST-PC. This monthly meeting, led by the depression clinical specialist, has three primary goals: (1) to reinforce the skills patients learned during the acute phase of treatment; (2) to help patients maintain the treatment benefits they experienced from being treated with PST-PC; and (3) to prevent relapse. This is not meant to be a treatment in and of itself but a means to bolster the improvements made by patients during acute treatment with PST-PC. During the maintenance phase of treatment, patients will meet monthly to review the seven problem-solving steps, discuss any difficulties they have encountered using PST-PC, and to continue using the problem-solving strategy. While monthly attendance is not mandatory, it is strongly encouraged.

Rationale

When people learn new skills, they often need guided practice until the skill becomes part of their usual functioning. Some people will do just fine with the acute phase of PST-PC training and will use the strategy to solve their problems without needing additional maintenance sessions. Others, however, will need some subtle hand-holding during the first few months they use the seven steps alone. Maintenance sessions are a good way to provide this hand-holding without merely becoming an extended therapy.

There are a number of advantages to providing patients with a maintenance phase treatment for PST-PC. First, patients will have an opportunity to fine-tune their newly acquired problem-solving skills. The monthly meetings will ensure that patients will actually use the new

skills to solve future problems. Second, periodic check-in with patients after response to an acute phase treatment can offset potential relapse. By identifying patients who are struggling with their problems and having a resurgence of depression, you can prevent a full relapse by providing the patient with early intervention. Third, the meetings serve as booster-shots of PST-PC. This booster shot involves review of the seven steps, discussion of old and new problems, thus encouraging the patient to continue using PST-PC.

Why a group?

You may have heard that most people do not like to attend groups because of their fear of sharing personal information with other people they do not know. It is true that most people are reluctant to join a group at first, but many people who do attend find the process to be uniquely therapeutic. Certain populations, like older adults, tend to benefit from group for the following reasons: (1) the group serves as a form of social support and a safe place for patients to help each other solve problems; (2) groups allow people to see that there are others out there who are struggling with similar problems and feelings; (3) group provides a forum for people to see how their behavior affects others; (4) in PST-PC groups, patients can experience mastery by helping other members of the group with their problems.

Who should be in the group?

The primary purpose of the group is to help patients who have made treatment gains to maintain those gains. Therefore, this group is for patients who received acute phase treatment with PST-PC, have responded to treatment and are no longer feeling depressed. Patients who are not recovered are still considered active cases and therefore should be receiving acute care treatment. Once those patients have responded to treatment, they can then participate in the maintenance class.

You may have some patients who have recovered from their depression but who may not have grasped the PST-PC skills entirely. Those patients can also be members of the PST-PC class, and may actually benefit from participation, since they will have an additional opportunity to fine tune their problem-solving skills.

The PST-PC Maintenance Group

Getting Started

In this section, we discuss what you need in order to get your PST-PC group started. Before you start a group, you will need the following (1) a conference room with a chalk board, marker board, or a large pad of paper with an easel; (2) between 4-12 people who can meet at the same time; (3) a regular time that the group meets; (4) extra copies of the PST-PC worksheet; (5) pencils; and (6) a list of all the potential attendees.

The conference room. This room should be big enough to hold a maximum of 12 people. Ideally, you will usually want to have a surface like a chalk board to write on so that as you work through a group member's problem, you can write it on the board for everyone to see the process. If that is not possible, you can have the members use the PST-PC worksheet as they work through a member's problem. In addition, you will ideally want a room you can reserve on a monthly basis. Having the same room, at the same time each month will help people remember where to go, without you having to call or mail them instructions to the room each month. However, having the same room is not always feasible. In the event that you cannot reserve the same room each month, you will need to develop a system to either call or mail to the patients directions to the meeting place, or have an agreed upon meeting place where you can escort patients to the conference room. Finally, you will ideally want the conference room in the primary care clinic. This minimizes the stigma of having to go to a group in a mental health

setting. If you cannot find a conference room in medicine, try to find one that IS NOT in psychiatry and is easily located.

The number of attendees. In order for a group to be a group, you will need a minimum of four people and a maximum of eight. The usual rule of thumb is that when you expect eight people, only 6 will show up. Sometimes everyone does show and the one therapist managing eight people is a considerable amount of work, although it is still manageable. Any more participants than that becomes chaotic. Anything less than four people is no longer considered a group because of the limited interaction between patients. This is not to say that if you expected 6 people and only 3 came, that you should cancel the group. You should go ahead with the plan. Our point is that you do not want to start with such a small number that you eventually have no attendees.

Waiting until you have at least 4 people who can attend the group may mean a delay for your first few individual patients. While you are waiting to increase your group membership, make sure to check in with these patients by phone at first, so that they don't have their maintenance treatment delayed.

A regular meeting time. It can be a challenge to find a group time that everyone can attend. The best rule of thumb is to go ahead and pick a time that people are most likely to attend and set that as the firm time. For younger patients an after-work time (e.g., at 5 pm, or an early evening meeting) is usually best. For older or ill patients, day time groups tend to be the best. Many older or ill people do not feel comfortable being out at night because of safety and vision problems. If you pick a time that no one can attend, change the time. However, this is a monthly group and most people should be able to make the time to come.

Copies of the PST-PC worksheet. Since you will be doing problem solving in the group, you will need extra sheets. Bring enough so that everyone you expect to come will have 3 sheets. They will use one to two sheets in the group and the third is for them to take home afterwards.

Pencils. You should be prepared in case members forget to bring a pen or pencil.

List of Participants. It is a good idea to know how many people you expect to come and their names. This will remind you about who attends so that you can write up your encounter notes later. This list will also prepare you for how many are expected to show.

Length and Frequency

The PSMG meets monthly for 90 minutes. The group should start no later than 10 minutes after the start time. Sometimes people get lost or arrive late, but on average most people do not arrive later than 10 minutes. Do not go more than 10 minutes after the end time. Any time longer than 100 minutes is exhausting to most people.

Your role

Your official title is “group facilitator”. As the title implies, you will merely facilitate the group process. You have the following jobs to do:

1. Provide structure to the 90 minutes. You will be responsible for keeping track of the time, setting the agenda, and introducing the next step.
2. Make sure everyone gets air time. If you see that one patient is monopolizing the discussion, it is your role to redirect the patient. If you see that one patient is particularly quiet, it is your role to draw that person out.
3. Enforcing the group rules. It is your responsibility to make sure that no one talks while one of the patients is talking, and that no one be judgmental.

4. Help the patients problem-solve. Patients are expected to solve their own problems in the group. However, the group, at certain points, may be asked to help a patient out. Your job is to facilitate that process by asking the group questions that will direct them to solve problems. On some occasions, you will have the group do a joint problem-solving session on a special topic. You are only to help direct the problem solving process if the patient cannot do that for him/herself and the group has trouble helping the patient.

Format

The environment. Always arrive about 5-10 minutes before the group starts. This will allow you time to make sure the room is set-up for the group. If a table is not available, then make sure they have clipboards or some other hard surface to make notes on. Ideally, the chairs in the room should be arranged in a circle, around a table so that the patients have a surface to write on. Having patients sit in a circle facilitates group interaction. If chairs are set up to look like a classroom, then your group will look and feel more like a lecture than a group. It is important to have the patients interact on the problem-solving process, so that they can feel supported by the other members, and can participate in the problem-solving process. If you cannot arrange the room in this way, be aware that you will have to do more work to make sure that you do not end up lecturing and that the patients interact with each other.

The group "feeling". The PSMG is technically considered to be psychoeducational. This means that you will be providing a mix of didactics, support, and some counseling. The group should feel somewhat like a seminar or workgroup. There will be structure to the time, and you are meeting to complete a particular task (problem-solving), but the group must work together to solve problems. When a patient raises a problem to be solved, you must get the

group to work on the problem with the identified patient. You will know that your group is successful when you see patients helping each other out and you are doing very little work.

The group structure. The group time is divided into the following increments:

Introductions/check-in:	10 minutes.
Setting the agenda:	10 minutes (less time for small groups)
Review of PST-PC:	10 minutes
Questions about PST-PC:	10 minutes
Break:	10 minutes
Problem Solving:	35 minutes
Wrap up:	5 minutes

These times are approximate and in some cases you will need to spend more time on one section and less on another. Make sure, however, you at a minimum review the seven steps to problem solving and that the group solves one problem.

Introductions. Some months you will have new members entering the group. It is always a good idea to have members introduce themselves. Have each member give the following information about themselves:

- 1 . N a m e
- 2 . Number of meetings they have left
- 3 . One positive thing about themselves.

With patients who are feeling down, there is a tendency to want to tell the group their problems. If this happens, gently redirect the patient and inform them that the group will discuss problems, but not just yet. This will minimize the amount of time spent in introductions. To help guide the process, particularly for new members, you should introduce yourself first, providing the same information that each member must provide. Also, time limits for each person can help minimize the amount of time spent in this process.

Setting the agenda & checking in. Once everyone has been introduced, make sure you review the group rules briefly. Everyone will have a copy of the rules, but you will want to make sure that the rules are understood. Next, go around the room and ask how people have been doing. If members have attended a previous group, have them update everyone on the problem they picked to solve and how the plan went. If the plan failed, this could be added to the list of potential problems to solve in that session. Ask members if they have a problem for which they want consultation from the group. **DON'T GET DETAILS YET - A SIMPLE "YES" OR "NO" SHOULD SUFFICE.** Keep a list of all the potential problems and questions that come up so that the group can decide on the agenda.

If you have a chalk board (or equivalent) list the agenda for the evening, including the PST-PC review, PST-PC questions, and then prioritize the problems that need to be solved. You will not get to everyone's problem, and you should remind the group of that. Help them to pick the problems that should get attention for that evening. A typical agenda will look something like the following:

-
1. Introductions
 2. Updates: Homework from last month.
 3. Review of PST-PC
 4. Problems to solve: How to handle the holidays.
 5. Review of plans for next month
 6. Announcements

*adapted from Group Cognitive Therapy, Yost et al. (1985)

Make sure that you do not focus on the same people every group. Give everyone a chance to have a problem solved!

Review of PST-PC. Spend the next 10 minutes reviewing the rationale behind PST-PC, the seven steps, and the importance of using the worksheet. Hand out the worksheets to everyone (3 per member). During this time, ask if anyone needs clarification on the seven steps. If there is a question, DO NOT ANSWER IT YET! Ask the group for the answer first. This facilitates learning on their part, and increases the probability that they will work as a team. If the group can't answer the question, then go ahead and answer it.

Problem-Solving with a group. Using PST-PC with a group is slightly different than PST-PC one-on-one. The key thing to remember is that you are now teaching THE GROUP to problem-solve and you will need to have the members involved in the process. However, you do not want the group to take over the problem solving process for the individual patient. If the group, or you as the leader, solve problems for a patient, then the patient does not get a chance to practice the seven steps. Instead of solving the problem for the patient, the group's role is to assist the patient, as you did when working individually with your patients. When a patient volunteers to solve a problem in group, the other members are asked to keep their comment to themselves unless specifically requested to do so by you or the patient. At the end of the problem solving, the group as a whole is then asked to comment on the process, if they have any questions about doing the seven steps, and to discuss how working on this problem has helped them or might apply to their situation.

You should spend no more than 15-20 minutes on one person. If the patient has not finished with the problem solving, ask him/her if s/he feels comfortable completing the problem-

solving alone. If so, move on to the next person. If not, spend a little more time but no more than 5 more minutes.

When going through a problem, it is useful to write the process on the chalkboard. This way, the other members can follow along. It is also useful for the members to fill out a worksheet with the patient. This procedure helps keep the group focused on the task. We discuss below how to teach each step in the group setting.

Defining and breaking the problem down. In this step, you will ask the patient first what s/he needs to think about in order to define the problem (i.e.: who, what, where, when, how). Then, ask the patient to define their particular problem along these lines. If the patient can do this successfully, ask the group to comment on the definition and if they have any additional questions for the patient to help them understand the problem being solved. If the patient is struggling, ask the group to help first before you help the patient. Ask the patient first if s/he would like help from the group, and then ask the group. “What kind of information does s/he need to help define the problem?”

Establishing realistic goals for problem resolution. Once a problem is defined, most patients will be able to define the goal. As in the above step, ask the group to help only if the patient is struggling.

Generating multiple solution alternatives. This step is usually a good exercise for the group to participate in. Again, the patient should attempt to come up with solutions first, but afterward, you can ask the group to think of some more solutions the patient has not thought of.

Implementing the decision making process. After the patient has review the pros and cons of the solutions, you may not need to have the group provide input. However, you can ask the group if they have any questions.

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Evaluating and choosing the solution. Because the patient is in the best position to choose their plan, you may expect very little input here from the group. However, you may still ask the group to give the patient feedback about the choice and to ask questions.

Implementing the preferred solution. This step is likely to be just for the patient to do. Unless they would like the group to help them come up with a plan, you do not need to ask the group's input.

Evaluating the outcome. This step is generally done during the review earlier in the group time. At the next meeting, have the patient update everyone on the problem they were to solve and trouble shoot any solutions that did not work.

Special Problems

What if no one has a problem they want to solve? In the event that everyone is doing very well, you should have a list of content areas that the group can work on together. Potential areas are:

1. Finances
2. Planning a special trip
3. The holidays
4. Getting a new hobby
5. Preparing for late-late life
6. Meeting new people
7. Care giving
8. Relapse Prevention
9. Improving health.
10. Household

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11. Family
12. Social
13. Work

Present the list to the group and have them pick a content area they would like to work on. Have them generate potential problems in that area, and then select a problem to work on.

During certain times of year, you may want to assign to the group a particular area to review. For instance, an October group is an ideal group to cover problems that commonly arise around the holidays. Some older patients may have initially been depressed because of losing a spouse. Problem-solving around these anniversaries can also be a helpful exercise.

What if everyone has a problem they want to solve? Sometimes you'll have too many problems to solve in one session. One way to address a problem glut is to pair people up into twos or threes and have them work on each other's problems. Each person should have 15-20 minutes to work on their problem, giving each group about 30-40 minutes to work on each persons' problem. While they are paired up and working in this way, you should circle the room and ask if anyone needs help from you. At the end of 40 minutes, have each person present the problem they had and briefly review the problem and the plan they came up with.

What happens if someone is in crisis? First determine if the problem is one that can be solved in group. If the patient is too upset to work on it in the group, then ask if the patient can wait until after the group to talk about the crisis. If not, employ the pairing up strategy discussed above and work with that patient individually for about 20-40 minutes. If the patient is truly in an emergency, employ the emergency procedures your organization uses.

Preparing Yourself for PST-PC Maintenance Group

Leading a group is not as easy as it looks. Running a group is more than doing PST-PC with 4-8 people, it is doing PST-PC with 4-8 people, all who will be interacting with you and with each other. There are several good books on how to lead groups, in particular The Handbook of Behavioral Group Therapy, Upper & Ross (Eds), 1985, Plenum Press, NY, NY, The Theory and Practice of Group Psychotherapy, Yalom (1975), Basic Books, NY, and Group Cognitive Therapy: A Treatment Approach for Depressed Older Adults, Yost, Beutler, Corbishley and Allender, (1986), Pergamon Press, NY. These sources can give you some idea about the challenges of running groups and how to overcome these challenges. We discuss the more common problems later, however, if you feel this is insufficient, please feel free to read these other sources.

There are a number of things you will need to do to prepare yourself for group. First, make sure you are familiar with all the people who will be attending. For the most part, you will know everyone in your group, because you trained them in problem-solving prior to the maintenance group. However, as your caseload increases, details will slip your mind and you will need to refresh those details by reviewing the notes you made for each patient. Second, make sure you are mentally prepared for group. Try to schedule 30 minutes before the group to clear your mind of other work and to review the notes from the previous month. Also schedule about 30 minutes after the group to review the group, to determine if you will need to follow up with anyone, and to make your notes. Third, make sure you have all your materials ready for the group and the room you reserved is truly open during the time you reserved. Sometimes, impromptu meetings arise and the space you reserved is now occupied because it looked empty.

It is better to handle these problems BEFORE the group arrives. Finally, make sure you know how many people will be attending. A reminder call to your patients before hand will help you

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Preparing the Patient for PST-PC Maintenance Group

Group therapy carries quite a stigma because of its history. When most people think of group therapy, they envision scenes from the Bob Newhart Show, and Encounter Groups. In addition, most people are worried about sharing their problems in front of strangers. They may be afraid that the other members will ridicule them, or think poorly of them. Rarely do people think about psychoeducational classes, or seminars when they hear the word “group.” There are a number of ways that you can prepare your patients for the group and make the idea of participating in the group acceptable.

Don't call PSMG “group”. In many ways, PSMG is not really a psychotherapy group, it is psychoeducational. The group has a classroom or seminar type of atmosphere and the patients will be focusing on a specific skill they are learning or fine-tuning. It is therefore appropriate to refer to PSMG as a class, seminar, workshop, workgroup, meeting, gathering, or team. In a study by Areán & Robinson (1997), changing the name of a psychoeducational group from “Coping with Depression Group” to “Coping with Depression Class” resulted in a 50% increase in acceptance of the group. Bear in mind that for some people, even the word “class” has a certain stigma, particularly if they did poorly in school or simply didn't like school. That's why other terms like “meeting”, “team” or “workshop” may be better terms. It is up to you to decide which term you prefer to use - just don't refer to it as “group”.

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Education. Like any other treatment you offer a patient, explaining to them what they can expect will help motivate their attendance. Explain the structure of the meeting, that they do not have to talk about very personal problems, and that you will be there to help them, if they feel uncomfortable. Answer any questions they have and reassure them specifically that :

1. No one will challenge them or confront them.
2. They do not have to share personal information.
3. The purpose is to help them continue using PST-PC and prevent relapse.
4. This is a good way to prevent a recurrence of depression.
5. You know everyone there and that they are all good people who have been struggling with the same problems.
6. Listening to other people's problems will not make them depressed again. The meeting will focus on solving problems, not dwelling on them.

Capitalize on your relationship. It is an advantage that you are the one running the group. Your patients will be more likely to attend because they know you and have been working with you to help them with their depression.

Case Management. Troubleshoot any obstacles the patient feels would get in the way of attending. Remind them that the meeting is once a month, and if they need transportation or any other help, you can help them set that up.

The Process of Group/Class

We have already discussed, in previous sections, about the process of PSMG. In this section, we will talk about general group processes, so that you can be prepared for what tends to happen when people work together in a group. Not only will you be helping patients to problem-solve, but you will have to be mindful of how the group members are interacting. You want to

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make sure the environment is safe for people to discuss their problems. You can do this quite easily by (1) establishing group rules, (2) facilitating communication, (3) facilitating cohesion, and (4) being aware of the “problem” members.

Class Rules/Guidelines

It is a good idea to review guidelines with the group members. Always have on hand a copy of the guidelines, like the one in Appendix 7, and review it with the group at each meeting.

These are basic guidelines you will want to enforce:

1. Coming on time. Remind the members that they only have so much time to problem solve and therefore arriving on time is important.
2. Participation. Remind them that they do not have to share their deepest, darkest secrets, but if they participate even with simple problems, they will get more out of the group.
3. Giving others a chance to speak. Remind them that there are other people in the class and that everyone needs a chance to speak.
4. Reserve judgment or criticism. Let them know that this is not a place to confront others or to point out major flaws in another’s personality. The meeting is to help each other solve problems, not to criticize.
5. Confidentiality. This is very important. Inform patients that they are not to discuss outside anything that goes on in the meeting. If they wish to share what they have learned with friends or family, that is fine. But they should not talk about any person or specific problem discussed in group.

Generating Discussion.

It can be hard to get a group to participate at times. As the group facilitator, you do not

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want to do all the talking in the group. The best way to generate discussion is to ask the group or particular member of the group questions. These questions may be followed by a period of silence, but stick it through - eventually someone will answer the question. If no one does, ask someone directly.

Facilitating Cohesion

One of the key elements of group therapy that keeps members working together and coming back to the treatment is cohesion, or a positive relationship between group members. There are many ways to facilitate cohesion, the best way being to have members work together on a task. While reviewing the PST-PC steps, for instance, having group members review the steps together is one exercise that increases their relationship. Pointing out parallels between patients' problems is another way to increase cohesion. When one patient is solving a problem, have the group work along with the patient on their own worksheet and give the patient feedback about the process. Finally, occasionally having the group pair up and work on a generic problem together also creates a bond between the group members.

Problem Members

Occasionally you will have members in your group that will need special attention or who may be disruptive to the group process. It is important to address these problem members, rather than ignore them, because your members may drop out. Below we describe the most problematic patients and how to best handle them.

The Scapegoat. This is usually a member of the group whom nobody else likes. There may be legitimate reasons not to like this person, but it is important that this person feel comfortable in the group and not feel ostracized. Be very careful that you or any member not ignore this person or be overly critical. If this person makes a suggestion that the group members come down hard on, make sure that you support the scapegoat's attempt at helping and

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remind the group to reserve judgment and criticism.

The Story-Teller. This is the person who tends to go into great depth about the problem they are having. This type of person also monopolizes the time and usually will want to say something at every meeting. Make sure that you redirect this person as much as possible. Also remind the person the time is limited and that the group has a lot to cover. Just as in your individual sessions, do not be afraid to redirect the story-teller and keep in mind that the goal of the meeting is to reinforce problem solving therapy, not to be a place to vent frustrations.

The Co-Therapist. This is the person who tends to have advice for everyone but does very little of their own problem solving. This person will likely get little out of the group because so little time is actually spent on their problems. Make sure you have them work on a problem of their own on occasion - don't let them sit back and solve everyone else's problems.

The Quiet One. Like the Co-Therapist, this person gets very little out of the group because s/he does not really participate. You can facilitate this person's participation by asking him/her DIRECTLY to help with or contribute a problem. You can also talk to this person after the meeting to find out if they are feeling anxious about participating and help problem solve around the anxiety.

The Pals. This is a situation where two or more people have grown fond of each other and tend to chat up a storm during the meeting. You must stop that as soon as it starts, as it is very disruptive to the meeting to have people talking while someone else has the floor. While it is great to see patients become friends, and can be quite helpful to their recovery, they still need to be reminded that when someone has the floor, they should be listening.

The Chatter Box. Like the Pals, this is someone who talks while someone else has the floor, but instead of talking with friends, s/he tries to engage other members in conversation whether they

want to talk or not. As with the Pals, remind the Chatter Box that when someone has the floor, they should be listening.

Can members socialize outside of the meeting?

Group therapy experts used to believe that it was important for group members not to socialize outside of the group. The rationale for this thinking was that if some patients were excluded, those who were excluded may not want to continue with therapy. Additionally, some patients who do not want to socialize with their group members may feel pressured to do so. Finally, establishing relationships beyond the group context may make sharing feelings and opinions more difficult, once fellow members become friends. These are all valid concerns. However, it has been our experience that it is difficult to enforce a “no socializing” rule. It is best to explain to the group the pitfalls of socializing outside of group. If they still socialize outside of the group try not to dissuade them, as there are a number of benefits to socializing, such as decreased loneliness and an opportunity for support. Just be mindful of the potential problems that can arise from socialization.

Chapter 7.
Special Populations

The PST-PC studies conducted to date in the U.S. have included minorities and older adults in the samples. Through our experience we have learned that a few strategies can help to make PST-PC more user friendly for these populations. The purpose of this chapter is to go over the modifications and strategies we have made to PST-PC to make them useable for older adults and minorities.

PST-PC with Older Adults

Several studies have found that older adults who suffer from depression can benefit from psychotherapy (Areán and Cook, 2002). PST-PC in particular has been found to alleviate depression, more so than other forms of psychotherapy (Areán et al., 1993; Alexopoulos, Raue and Areán, 2003). Even with these promising findings, certain modifications are necessary for older adults to benefit from therapy. The content of PST-PC in and of itself does not need to be modified, rather, it is the way in which material is presented to older patients that is different with older adults. These modifications we are about to discuss have their roots in research on age differences in information processing and cognitive aging. For a more detailed discussion of the theoretical rationale for psychotherapy modification for older adults, we refer the reader to an excellent article by Knight and Satre (1999).

Geriatric Specific Modifications

Rationale for modifications: Conducting therapy with older adults is in many ways similar to therapy with younger patients. Like their younger counterparts, older patients' depression can often be traced back to specific, problematic life problems, they are capable of learning new skills, and they have been found to benefit from psychotherapy treatment. However, there are

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subtle differences between younger and older adults that make therapy with older adults more of a challenge. Older people, particularly depressed older people, tend to need extra time, attention and repetition to learn new skills. Older people also have longer histories in general and specific to depression, and will often need more time to tell their stories. Further, older people process information differently than younger people. Finally, several studies show that older adults tend to develop more passive coping styles as they age, making the implementation of active interventions more difficult in this population.

Despite these limitations, behavioral interventions are very useful in the treatment of geriatric depression. The therapist must make certain adjustments to the way in which s/he typically provides care, but overall, these are skills and techniques the therapist can become proficient in with very little practice.

There are several aspects of the PST-PC model that can be amended to make the intervention geriatric friendly. The geriatric-specific modifications include:

- Increasing the number of available sessions from 6 to 8.
- socializing older people to the process of therapy.
- the use of maintenance groups (discussed in Chapter 6).
- reliance on repetition of the skills learned.
- accounting for disabilities common in late-life
- use of specific refocusing techniques.

1. ***Increasing the number of available sessions from 6 to 8.*** While not all older people will want to make use of this many sessions, our experience shows that in order to adequately learn the skill being taught, older people need extra time to practice the skill while seeing the therapist. This is due in part to the cognitive changes that take place as one ages and in part to the number of psychosocial stressors older people face. Often older people take longer to respond to

Problem-Solving Treatment for Primary Care therapies created for younger people. Even adding as little as two sessions can make a big difference in how well older patients learn problem-solving skills.

2. *Educating the patient about the process of therapy.* Most older people are not socialized to the process of psychotherapy. Often, an older person will view therapy, particularly therapy with a member of their primary care team, the same way they do a visit to the doctor: looking for the therapist to give them a cure or quick fix. They will often not expect to be doing homework or learning a skill. This expectation, coupled with the tendency for older people to take on a passive style of coping, makes training them in problem-solving skills difficult. The therapist is responsible for educating the patient about PST-PC process and must reinforce through out the 6- 8 weeks the patient's responsibility to take an active role in their care. This can be accomplished by educating the patient about the structure of PST-PC, explaining that the primary purpose of the therapy is to teach the patient to learn to solve their own problems, and by actively involving the patient in the problem-solving process.

3. *Repeating skills and information – cue and review.* As mentioned above, older people take longer to learn new information. Although a number of cognitive changes take place as people age, the most relevant changes to learning based therapies like PST-PC are those associated with cognitive slowing, decreased fluid intelligence, and declines in working memory. As we age, the rate at which we can react to new information and process it slows considerably. Slowing does not imply that older people are incapable of abstract reasoning. In fact abstract thought is a particular strength of information processing in late life. Further, reasoning ability in older adults remains intact because of their vast store of previous experience, or crystalized intelligence. Rather, the effect that cognitive slowing has on older patient's ability to process PST-PC information is on the speed to which the new information can and should be presented. Changes in working memory also impact the rate to which older people can process information.

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Because of decreased efficiencies in working memory, new information must be presented more slowly, in a variety of modalities, and repeated a number of times for the new information to be adequately processed.

All of the data on information processing in late life indicates that the best way to teach older people new information is to tell them the new information a couple of times and in different ways. For instance, when educating a patient about PST-PC, break down the information into small sections (i.e.: the rationale, problem definition, establishing a goal, generating alternatives, decision making, choosing the solution, implementing the solution, and evaluating the outcome.). After discussing one section, it is helpful to summarize what they were told, and ask them questions about the information you just taught them. Also have the patient write down the new information, either on the training materials or in a notebook. This procedure helps them focus on the content of what they are being told, increasing the likelihood that they will remember the information.

Always leave time at the end to review the session. This is another form of repetition that is quite fruitful and can help the patient understand what just happened in the session. Point out to the patient how the problem was chosen, how the problem went from being a vague problem to something concrete that led to creating a goal, and so forth. This way, the patient has a moment to think about the problem-solving process and how it applies to their specific problem.

4. **Refocusing.** Some older people can be tangential in session, or feel that therapy is a place to unload all their problems by talking about the problem in minute detail. If education about the process of PST-PC is not enough to stop them from engaging you in a long discussion about their problem, you may need to stop the patient and get them to focus on the task at hand. Unless you interrupt the patient, you will spend all your time listening to the problem and very little time solving it.

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One of the hardest things to do is to interrupt an older person in the middle of their story.

It is very common to feel like you are their only source of support and that it is disrespectful to interrupt an older person. In truth, you do your older patient a greater disservice by not refocusing them. Although they may receive temporary relief from their depression in the form of supportive listening from you, they learn nothing about how to manage their problems. Specific refocusing techniques include informed interruption (let the patient know at the beginning of the session that you may need to interrupt them because of the limited time you have together), reminding patients of the time limits you have, and setting a timed agenda early in the meeting.

5. *Accounting for disabilities common in late life.* Disabilities common in frail elderly can also impede the progress of PST-PC. For example, visual impairment affects patients' ability to see printed in-session material. Therefore, other methods of delivery, such as audiotaping sessions for at-home review, are often used to expand upon or reinforce session information. Treatment forms for PST-PC have been modified with larger print for those who can see but have trouble reading small print and provide larger writing spaces to accommodate changes in fine motor skill that are a result of arthritis or stroke. In addition, therapists will need to learn how to speak to people with age-related hearing impairment; such as by speaking with a deeper tone and highly distinct speech.

6. *The use of maintenance groups.* Preliminary research shows that older people are less likely to relapse if they are involved in maintenance treatments, particularly those done in a group format. These maintenance interventions are meant to serve as "booster" sessions, where the patients can take a refresher course in PST-PC or trouble-shoot around a particularly difficult problem they are trying to solve. Making these groups available also provides the patient a forum to learn from other people their age and to reinforce what they learned in the training

phase of PST-PC.

7. *Availability of clinical case management.* Older adults often have many medical and psychosocial problems that they cannot manage themselves, no matter how good they are at solving problems. Clinical case management serves as a good adjunctive treatment to help put out the fires in the older person's life. Preliminary data indicates that case management can potentiate behavioral interventions. However, it is important to keep case management separate from PST-PC. As the difference in therapeutic stance may be confusing to the older patient, in sessions where you anticipate doing both PST-PC and case management, make sure you specifically state when you are teaching the patient PST-PC and when you are no longer in that role.

PST-PC with minority populations.

As in PST-PC with older adults, PST-PC with minorities does not really differ in the content that is presented. Further, the process by which information is presented does not differ either. However, PST-PC therapists will need to be aware of the socioeconomic and cultural constraints in doing therapy with minority populations.

When working with any patient, one must always be mindful of that person's cultural background. Being familiar with a patient's cultural beliefs about medicine and mental illness will help you to communicate with your patient and will increase the probability your patients will adhere to treatment. While it is impossible to know all the nuances of each culture, there are

still overarching themes you can keep in mind when working with minorities. These are respect, family support, stigma, spirituality, access barriers, and acculturation.

Respect

The concept of respect can be a deterrent to treatment. Sometimes, minorities will try to be respectful of their doctor and will not complain to you about medication side effects or lack of effectiveness of treatment. They may see any complaints about their physicians' recommendations as being disrespectful. It is therefore important to align yourself with the primary care provider and explain that you are asking questions about side effects and response to help the doctor treat the patient's depression. It is also important to say the doctor wants to know about any problems because s/he knows that these treatments sometimes need to be adjusted or changed. This information will help the patient feel less anxious about being disrespectful.

Family support. In many cultures, when the identified patient cannot take care of themselves or the family suspects the patient needs help with their medical care, another family member will assume responsibility for making the patient's appointments, will want to sit-in on the visits, and will be responsible for making sure the patient adheres to treatment recommendations. They will also function as the patient's gatekeeper, screening all treatment related issues. When this is the case, this person must be involved in all aspects of the patient's care. This person will most likely be the family member who accompanies the patient to the first visit, but you should always make sure by asking the patient "Is this the person who handles all your appointments and medicines?" Because of the reasons discussed in the respect section above, you should always explain to the family member that you like to spend a few moments alone with your patients to

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get to know them. This allows the patient some private time to talk about any problems s/he does not want the family to know about.

Stigma. In working with minority patients, it is important to discuss with them their beliefs and attitudes about depression and any fears they may have about people in their community finding out they are in treatment for depression. Much of the cultural stigma around depression can be addressed through the use of psychoeducational materials. However, do not simply hand the patient or the family member the materials and expect them to read it. Go over all the information in the office and discuss any questions. For those patients who are fearful of stigma, offer to hold the materials for them so that they can read them over at each visit. Also, if provided with an educational videotape, offer to have them look at the video in the clinic. Even though they may have a VCR, they may never play the tape for fear that someone will catch them watching it. Also, the use of overly processed or glossy materials can make the patient feel the treatment is impersonal. You can personalize the materials for them by writing on the pamphlets and highlighting the points in the materials the patient feels was important to learn.

Spirituality. Religion and spirituality in minorities are often very important components of the culture. A good way to assess for improvement or worsening of depression is to assess patients' level of activity in their church community. In African Americans and Latinos, the use of prayer is often a very important coping mechanism and should be encouraged when the patient indicates they are no longer employing this practice. In traditional Latino communities, spirituality may also involve the use of healing herbs and "remedios", and visits to a "curandero" are not uncommon. When asking about medicines the patient is taking, it is also important to ask about the use of "botanicos" and other herbal remedies. It is also important to respect their use of these herbs.

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Access barriers. Many minority patients have trouble making regular appointments because of the many demands on their time. In addition to their own doctor visits, minority patients, women in particular, take care of grandchildren, spouses and will often put the needs of their family before their own needs. Time then is important, and as a provider you must remain flexible, but also encourage the patient to look after themselves. A helpful technique in getting minority women to attend to their own needs is to educate them about how spending time on themselves makes them stronger and more able to manage their family demands.

Other access barriers include transportation and finances. In considering the frequency of treatment visits, you should also assess for how long it takes patients to get to the clinic and how difficult it would be to arrange transportation. Cost of care is also important to consider since minorities are often on fixed incomes.

Acculturation. There are no hard and fast rules to working with minorities. How you work with minority patients will depend in large part on how acculturated they are and to what degree they feel connected to their ethnic community. Before assuming that any of the issues discussed above is true for your Hispanic, Asian or Black patient, get to know the person first, and treat them with the same respect and consideration you would any patient. If they never were religious, recommending prayer will only offend the patient. Make sure you spend some time talking to the patient about the issues discussed above, so that you can deliver culturally appropriate care.

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APPENDIX 1

PROBLEM-SOLVING TREATMENT FOR DEPRESSION

Therapist Narrative Session One Introduction

Introduction and Explanation of PST-PC Structure

Hello Mrs. [name]. It's nice to meet you. My name is [name].

I'm a colleague of your doctor Dr. [name]. I know you've talked with him/her about your depression and have agreed to participate in our Problem-Solving treatment. Problem-Solving Treatment is an effective treatment for depression. Do you have any questions before we get started?

You and I are going to meet for a total of six visits. We will meet for an hour today and the rest of the visits will be half an hour. We will meet weekly for the first four weeks and then we will meet every other week for the last two visits.

Today I'm going to teach you Problem-Solving skills and how to apply them to treat your depression. I'll help you select an actual problem you're currently struggling with and help you identify actions to take to solve the problem. Then, during the time until we meet again next week, you'll actually do the tasks you choose to work on, sort of like homework. When we meet again next week, we'll review how it went and start the process again, so that you can expect to apply the full problem-solving technique for at least one problem each visit. Do you have any questions at this point?

Symptoms Are Caused by Depression

Your Primary Care Provider, [name], referred you to our depression Study, and the Study doctor, too, interviewed you and diagnosed you with depression. Do you have any questions about this, or the diagnosis, or what it means?

What kind of symptoms do you have? [Develop short list of 3 or so symptoms. Translate patient "code" words into corresponding clinical symptoms, e.g. feeling "crummy" may mean having low energy, being "weepy" is evidence of feeling sad, "not sleeping well" may mean mid-cycle awakening and difficulty falling back asleep.] **We're going to be keeping track of these symptoms to see how you improve. I'll be asking you about them each visit, essentially as a way of tracking how well the treatment is working for you.**

[If by this point patient has not yet accepted the diagnosis of depression, explain a "mind/body" model; such as] **I understand that your symptoms feel to you like a physical illness.**

Stomach aches and headaches can often be an indication of a physical problem. But you should know that there is really no such thing as a purely physical illness, just as there is really no such thing as a purely emotional illness. For example, when we feel excited, our body gets excited too: our heart beats faster and we have trouble sitting still. And when our body is sick, like when we have the flu, it's natural for our feelings to be a little low as well. Have you ever had these feelings? Everything is controlled by the brain, both our feelings and our physical functions, so when one is affected, the other is affected too. So depression can often feel very physical to some people, because the depression is actually affecting you physically. But your doctor has examined you and is confident that you don't have a physical illness, so we need to remember that the main cause of your physical problems is depression, and that's what we need to treat. I've just said a lot and want to make sure I'm being clear. I'd like to hear what your understanding is of what I've just said. Could you give me a basic summary of what you've heard?

Link Between Problems, Depression, and the Role of PST-PC

Lets talk a little bit more about problems and depression. Unresolved problems can make depression worse and can actually even cause depression. In addition, low motivation and low energy caused by depression makes it even more difficult to work on the problems which then makes us feel even worse, and so on. It's a vicious cycle, a downward spiral. The purpose of PST-PC is to take the "problem" piece out of the cycle. When we feel more in control of our problems, we feel better overall. Our mood is better. We feel more encouraged and hopeful. And, as our depression goes down, our activity level goes up still further. This is an upward spiral. PST-PC improves our ability to solve our problems and ultimately improves our mood. But the improvement follows action; the actions you'll be taking between our visits to work on your problems. The most important part of PST-PC is not what takes place in our visits together, but what you do between our visits. Putting into action the new solutions you discover through PST-PC. How does this sound? Does it seem to make sense to you?

Problem-Solving Orientation

Depression is often caused by problems of living and feeling depressed can often be a cue that there are problems in one's life. We all encounter problems in our lives, big and small, everyday. It's a normal part of living. Having problems isn't unfair, really; it's just a part of the way life is. If we let problems pile up unresolved, however, it can become overwhelming and lead us to feeling depressed. Using problem-solving skills, people can learn to cope better with their problems and feel better as a result. In Problem-Solving Treatment, which I'll just call "PST-PC" from now on, I'll explain the details of the treatment and provide encouragement and support, but the ideas, plans, and actions come from you. PST-PC will not only be useful now, but can also help you when future problems arise.

We can almost always exert some degree of control over our problems. And, if we're able to tackle problems as they arise, it will decrease the likelihood that we become, or stay, depressed. The best way to do this is to use your feelings as a signal that there is a problem

to be solved. Think of depression as another type of pain you might have. If you have a stomach ache, you know that you should do something to ease the pain, perhaps drink some antacid, or next time not eat something that upsets your stomach. A depressed mood is like any other type of pain – it's a signal that there are problems in one's life that need attending to and we can use this as a cue to take action. To stop and think, "What problem might be troubling me?" We can then put our problem-solving skills to work and begin to feel better.

Unfortunately, when you or any one else is depressed, the tendency is to feel like there is no hope to solving a problem. You're not exactly ignoring your pain, but most people tend to avoid facing the problem, rather than trying to solve it. You may feel like things are hopeless, you don't have the ability to cope with the problem, or that there is no solution available to you. Does any of this sound familiar to you? (ASK PATIENT TO DESCRIBE THIS AND THE THOUGHTS THEY HAVE). With this new approach to coping with depression and your daily problems, I'll be asking you to put those thoughts aside, and to focus instead on the evidence we have regarding the hopelessness of your situation and on what other methods we can try to solve the problem. This will be our attempt to test together whether your situation really is so hopeless or if there is a solution or set of solutions that can change your situation. So, I'm asking you to suspend your disbeliefs for a bit while we work together and see if we can solve your problems. Does this all make sense to you? What questions do you have for me at this point?

The 7 Steps of PST-PC

Okay, so let me explain how PST-PC works. PST-PC has seven steps: One, define the problem; two, decide the goal you want to achieve; three, brainstorm a lot of different possible solutions; four, look at the pros and cons of each possible solution; five, pick the solution that seems the best; six, put the solution into action; and seven, review how it worked out. By the end of today's first session, we will have worked through all of these steps together and you will have identified a real problem and solution for yourself to work on in the coming week.

The first step is to define the problem. Here you want to pick a problem that's feasible to solve, meaning a problem that's manageable, a problem that you, yourself, can exert some control over. You'll need to explore the different aspects of the problem, to understand the details, to separate the facts from the assumptions, and to clarify where the sticking point really is. You should break down big or complex problems into smaller, more manageable pieces. And you'll want to define the problem in a way that's easy to measure your progress toward solving. For example, "I feel crummy" could mean a lot of things, but "I'm not doing enough fun things in my life" is clear and measurable. The more clearly and precisely you can state the problem, the better your chance of solving it successfully.

The second step is to set a goal. The goal should be the way you would like to see the problem change. It should also be realistic and achievable; something you can really do or make progress on between now and our next visit. And, you'll want to state the goal in such a way that you can easily measure the progress you make toward it, so that you'll

know when you've achieved it, or how your doing. It's much easier if the goal can be stated in terms of something you did or didn't do, or something that happened or didn't happen. For example, if you state your goal as: "I want to have more fun;" that's kind of vague. How will you know when you've done what you had in mind? On the other hand, if you sate that same goal as "I will do two fun things this week," you can actually *measure* how you did, you'll know easily if you did it or not. Does this seem clear? Does it make sense?

The third step is brainstorming. Have you heard that term before? What does "brainstorming" mean to you? We're gonna' use brainstorming here to mean coming up with as many different possible solutions that you can think of or imagine, being just as creative as possible, considering every conceivable possibility. The more ideas you come up with here, the better. It's really important at this step not to prejudge anything, not to rule anything out. The reason, of course, is that the more potential solutions you have to pick from, the better the chance you'll have of finding a successful solution to the problem. And I want to remind you that these need to be your ideas, your solutions, they need to come from you, because you know your situation best. After all, it is going to be your problem that you'll be working on and you're going to be the one doing it.

The fourth step is to consider all the pros and cons. And we'll do this for each possible solution you came up with. We'll go through each solution, one by one, and I'll ask you to think of all the advantages and disadvantages for each, and to write them down for each, so we can then go back and compare. What I mean by advantages and disadvantages is identifying what are the aspects of each solution that would make it easy to do, and what would make it hard to do. What are the facilitating factors for each solution, and what are the obstacles and barriers? Usually these kinds of things involve time, money, effort, and cooperation needed from others. In other words: How much time will it take? Do I have enough time for it? How much will it cost? Do I have the extra funds? How much effort will it take? Can I do it? And, finally, will I need to get others involved, or can I do this on my own? What impact will my solution have on others? As we make a list of all the pros and cons for each solution we'll compare them to the others so we can pick the one that's the best and that has the least negative impact on you and others. This can sound kind of complicated but the most important thing here is to suspend your judgment of the solution until you've had a chance to consider all the pros and cons. What is your idea of what I just described to you?

Step five is to choose the solutions that appeal to you the most from reviewing the pros and cons; the ones that seem to offer the best chance for success-all things considered; the ones that limit the negative impact on you and others; and something you feel that you would really be able to do.

Then you'll need to develop a Plan of Action. That will be the sixth step. Here you need to plan out all the individual steps that you'll need to take in order to achieve the solution. The who, what, where, when, and how. You know, who will I need to get involved? What, specifically, am I going to do? When will I do it? Where will I do it? And, how, exactly, will I go about it? Are there any impediments that might get in the way? The more the specific your plan is, including all the necessary details you can think of, the better the

likelihood of your following through with it and being successful. [Part of this step will be to make sure the patient does not develop a Plan of Action that has potentially insurmountable obstacles or pitfalls. Here the therapist can be more involved to make sure the plan is viable].
When this step is finished, you'll be ready to go and to put your plan into action.

The last step, step seven, is evaluating how it went. That step will actually come next time we meet. Your task for between visits will be to put your plan into action. At our next visit we'll start by seeing how it worked out but you can review your progress on your own as well if you like. We'll start by asking how did it go? Were you successful in your plan of action, or did something come up to interfere with it? If something got in the way we will try to figure out what that was. We'll look at how you feel about having made the effort and how making the effort affected your mood. Making the effort is the key. Even if it turns out not working out the way you want, you can always make some adjustments based on the experience you've gained and try again.

There, now we've reviewed all the seven steps for problem solving. I know it sounds like a lot of work and maybe a little confusing, but believe me, it really works quite well and easily once you get a little used to it. But first I'd like to answer any questions about all this that you might have in mind.

Activity Scheduling

So far we've focused a lot on problems, but it's also important to have a little fun in your life, to have some pleasurable activities you like to do. When people get depressed they tend to stop doing things they enjoy, either because they lose interest or energy or both. Unfortunately, when you stop doing enjoyable things you get even more depressed. The more depressed you get the less you do, and so on in a vicious cycle that takes you even further down into a depression. Does this make sense to you? Have you stopped doing things you once enjoyed?

So, one of the things we will be emphasizing is finding ways for you to get involved in potentially enjoyable or pleasant activities on a regular basis, just about every day. It doesn't have to be something really big or expensive or that requires a lot of time. It can be something as simple as enjoying a cup of tea, or watching a favorite movie, or going for a walk. The important thing is to get these things into your life on a regular basis so you can interrupt the downward spiral and start to reverse the depression cycle. So, what kind of things do you enjoy doing or have you stopped doing? For example, Is there any hobby that you have been interested in beginning or trying?

Problem List Generation

Okay, now that we have talked all about problem solving lets start talking about how we are going to apply it for your situation. So, what kinds of problems are you currently experiencing? [Allow the patient to spontaneously list their problems, briefly, then use the problem list worksheet to cue them for possible additional problems]

APPENDIX 2

Introducing PST-PC to the Patient in Session 1 Checklist

1. Structure of PST-PC Treatment

- 6 Visits
- Today' Visit: 1-hour; Visits 2-8: 30-minutes
- Weekly and Bi-weekly Visits
- Teach problem solving skills
- Work through at least one problem per week
- Work on homework between visits

2. Establish that Symptoms are Due to Depression

- Assure understanding that depression is causing symptoms
- Collect brief list of key depressive symptoms
- As necessary, use “mind/body” explanation
- State that will track symptoms during treatment

3. Link Between Problems, Depression and PST-PC

- Depression is often caused, or made worse, by the problems of living
- Worsening depression interferes with problem solving: Vicious cycle / Downward spiral
- PST-PC strengthens problem-solving skills
- Improved problem-solving lifts mood
- Improvement follows action

4. Problem-Solving Orientation

- Problems are a normal, predictable part of living
- Problems are not unfair, and should be expected
- Negative mood is a cue that problems exist
- Some degree of control can almost always be achieved
- Taking action alone will cause mood to improve

5. The Seven Stages (Steps) of PST-PC

1. Clarifying and defining the problem
2. Establishing objective achievable goal
3. Solution alternatives: Brainstorming
4. Decision guidelines: Pros and Cons
5. Choosing the preferred solution(s)
6. Implementing the solution(s)
7. Evaluating the outcome

6. Activity Scheduling

- Depression stops people from doing enjoyable things
- Fewer enjoyable things causes and worsens depression
- Vicious cycle / Downward spiral
- We will focus on increasing enjoyable activities each day

7. Problem List Generation

- Focus on current problems
- Allow patient to first spontaneously report current problems
- Systematically review categories from problem worksheet

APPENDIX 3

PROBLEM SOLVING TREATMENT FOR DEPRESSION

PATIENT HANDOUT

PST-PC Treatment:

- Brief: 6 sessions – 1 hour today, then 30 minutes.
- Practically focused on current, real-life problems.
- Collaborative between patient and therapist.

How It Works:

- Depression is often caused by problems in life.
- PST-PC helps patients begin to exert control over the problems in their life.
- Regaining control over problems improves mood and helps patients feel better.

Depression is very common. It's often caused by problems of living. We all encounter problems in our lives, big and small, everyday. It's a normal part of living. Having problems isn't unfair, really; it's just a part of the way life is. If we let problems pile up unresolved, however, it can become overwhelming and lead us to feeling depressed. People who are depressed can learn ways of dealing with these problems. Using problem-solving skills, people can learn to cope better with their problems and feel better as a result.

We can almost always exert some degree of control over our problems. And, if we're able to tackle problems as they arise, it will decrease the likelihood that we become, or stay, depressed. A depressed mood is a signal that there are problems in one's life that need attending to and we can use this as a cue to take action. To stop and think: what problem might be troubling me? We can then put our problem-solving skills to work and begin to feel better.

Problem-solving is a systematic, commonsense way of sorting out problems and difficulties. If you can learn how to problem-solve easily, you can lessen your depressive symptoms and feel better without having to take pills. In problem solving treatment, the therapist explains the details of the treatment and provides encouragement and support, but the ideas, plans, and action come from you. Problem solving skills will not only be useful now, but can also help you when future problems arise.

PST-PC has 7 important stages:

1. Write down a clear description of one problem to work on. What is the problem about? When does the problem occur? Where? Who is involved? Try to break up complicated problems into several smaller ones and consider each one separately.
2. Set a realistic goal. What would you like to happen? Choose a clear and achievable goal.

Problem-Solving Treatment for Primary Care

3. Brainstorm. List as many solutions as you can think of. Don't rule anything out.
4. Consider the advantages and disadvantages (pros and cons) for each potential solution. What are the benefits of each solution? What are the difficulties or obstacles?
5. Choose the solution that seems the best. Which solution seems the most feasible and has the least impact on your time, effort, money, other people's effort, etc.?
6. Develop an Action Plan. Write down exactly *what* you will do and *when*.
7. Review and evaluate your progress. Make needed changes. How has this helped your mood?

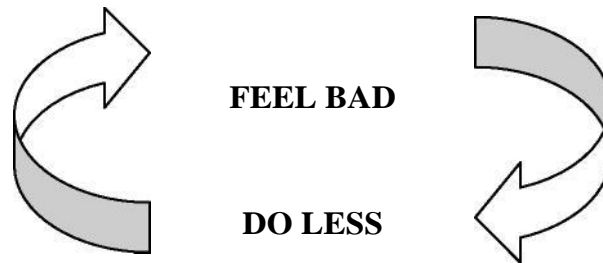
Problem-solving may not solve all of your difficulties, but it can teach you a better way to deal with them. As you begin to feel more in control of your problems, your mood will feel better too.

APPENDIX 4

PATIENT HANDOUT

Why is it Important to Do More Pleasurable Activities?

When people get depressed they don't feel up to doing the kinds of things they typically enjoy. By doing fewer enjoyable things they begin to feel even worse. As they feel worse, they do even less, and get caught up in a vicious cycle of doing less and less and feeling worse and worse.



As part of problem solving treatment we will help you set a goal of doing at least one pleasurable activity each day. In other words, arranging to provide yourself with a “treat” each day. Sometimes working on the problem of too few pleasant activities can be a simple and effective way to start to learn problem solving skills.

The positive benefits are:

- (a) You can use problem-solving steps to help with pleasurable activities;
- (b) You will start to assert control over your life in a positive and beneficial way; and
- (c) Your success with doing pleasurable things will give you motivation to tackle some of the more difficult problems in your life.

Appendix 5

**PROBLEM SOLVING TREATMENT FOR DEPRESSION
PROBLEM LIST**

1. Problems with relationships: Spouse or partner Family members: children, grandchildren, other family members Friends Other:	8. Problems with having a daily pleasant activity:
2. Problems with work or volunteer activities:	9. Problems with sexual activity:
3. Problems with money and finances:	10. Problems with religion or moral values:
4. Problems with living arrangements:	11. Problems with self-image:
5. Problems with transportation:	12. Problems with aging:
6. Problems with health:	13. Problems with loneliness:

**Appendix 6
PROBLEM-SOLVING WORKSHEET**

Name: _____ Date: _____ Visit #: _____

Review of progress during previous week:

Rate how satisfied you feel with your effort (0 – 10) (0 = Not at all; 10 = Extremely): ____

Mood (0-10): ____

1.

2. Goal:

3. Solutions:

4. Pros vs. Cons (Effort, Time, Money, Emotional Impact, Involving Others)

Problem:

a)	a) Pros (+)	a) Cons (-)
b)	b) Pros (+)	b) Cons (-)
c)	c) Pros (+)	c) Cons (-)
d)	d) Pros (+)	d) Cons (-)

e)	e) Pros (+)	e) Cons (-)
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5. Choice of solution:

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6. Action Plan (Steps to achieve solution):	Write down the tasks you completed.
a)	
b)	
c)	
d)	
Pleasant Daily Activities. Date Activity	Rate how Satisfied it made you feel (0 – 10) (0 = Not at all; 10 = Extremely)

Version 9/24/02

Next appointment:

Appendix 7

PST-PC Maintenance Class Guidelines

Because we meet only once a month, and the time we have together is short, it's important to come to every class and to be on time. Give it your best shot even if you don't feel at your best.

If you know you will be late or can't make it, please call me at XXX-XXXX.

No one is forced to participate in class but your participation is important. You can learn by just listening but you will learn more by sharing and doing.

Remember everyone needs a chance to talk. The team that works together works the best.

Give others a chance to speak.

Please reserve judgment or negative criticisms.

Please speak your mind but be respectful.

Everything discussed is confidential! Please do not discuss what we talk about in here outside. If you must discuss, don't use other people's names.

If you are unhappy with the class or just think it's not for you, please let me know. You have the power to change and improve the classes.

Important phone numbers:

you have a question or you can't make a class:
XXX-XXXX.

you have an emergency and you can't reach me, call XXX-XXXX;