Problem Solving Treatment for Primary Care.

National Network of PST Clinicians, Trainers and Researchers

UCSF

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Chapter 1
Problem Solving Treatment for Primary Care Medicine.

Problem Solving Therapy for Primary Care Medicine (PST-PC) was originally developed in the U.K. by a research team headed by Professor Mynors-Wallis in 1998. It is important for anyone using this manual to read and refer to two excellent books on Social Problem-Solving Therapy: Social Problem Solving Therapy: Theory, Research and Practice (Nezu, Nezu and Perri, 1989) and Problem-Solving Therapy: A social competence approach to clinical intervention (D'Zurilla and Nezu, 1999).

Over the past few years, we have made a number of modifications to PST-PC to make it more user friendly to the typical patient in primary care medicine. These modifications were informed by our experience in using PST, as well as from feedback from our past patients and care managers/behavioralists in these settings.

PST-PC can be done individually or in a group setting. In order for PST-PC to be effective, one must make sure the patient (1) understands the rationale behind the model and (2) understands it’s application. Educating and socializing the patient to therapy is often important with primary care patients. Some have never been in therapy before, and therefore an explanation of how the treatment will work, how often you will meet, the importance of action planning and so forth will be very important to detail in the first session. A good care manager always asks patients what their expectations are of therapy, and tries to allay any concerns or misconceptions. Some people have had psychotherapy in the past, but most likely will not have been exposed to a structured therapy like PST-PC. It is important, in this case, that the patient understand the difference between PST-PC and traditional psychotherapy. Telling the patient that they will be learning a new set of skills rather than relying exclusively on discussion of problems is a key difference between PST-PC and traditional therapies.

PST-PC consists of seven stages that efficiently address psychosocial problems. These stages are (1) selecting and defining the problem, (2) establishing realistic and achievable goals (3) generating alternative solutions (4) implementing decision making guidelines, (5) evaluating and choosing solutions (6), implementing the
preferred solution and (7) evaluating the outcome. The unique feature of PST-PC over other psychotherapies is its fit with the case management process. Therapists can use these stages in creating a link between their patients and social programs, and in doing so, demonstrate the PST-PC process to their patients with the intent of patients using the process to solve non-case management problems. Thus, therapists and patients work together, using the same logic model to solve both social and psychological problems.

Chapter 2 of the manual describes the problem solving process. In chapter 3 we provide general information regarding of resources and organizations should help in developing action plans for patients with socio-economic need. In chapter 4, we discuss issues related to working with older adults, including the impact of ageism on motivation for change and how disability affects treatment. Also included are the PST form and the Problem List, described in Chapter 2.
Chapter 2

Problem Solving Treatment

This chapter describes the specific stages of PST-PC and how to use the PST-PC form to solve both case management and patient problems. This chapter will go through the step-by-step of how to use PST-PC with patients, from initial session to relapse prevention.

The Therapeutic Frame:

Time Frame: PST-PC is a brief treatment, it can be as brief as 4 sessions and as many as 12 sessions. How long you offer PST-PC will be determined by patient recovery, clinic mandate or design. In our research, we have found that the smallest effective dose of PST-PC is 4 sessions, offered over an 8-week period of time. The most ideal number is 6 sessions, this is when we tend to see the biggest difference in treatment outcomes when PST-PC is compared to other psychotherapies, but we believe that 9 sessions be the PST-PC sweet spot for most patients. Each session is 45 in usual mental health care and 30 minutes in primary care medicine.

Setting: PST-PC is effective in a variety of settings and presentations. There is evidence that PST-PC is an effective telephone therapy, primary care intervention, home-based treatment and finally as an internet intervention. We are in the process of determining PST-PC’s effect as a mobile health app.

Format: PST-PC is divided into three phases: Introduction/Education, Training, and Prevention phases. The first 1-2 PST-PC sessions is spent getting to know the patient, the problems they are experiencing, how their symptoms interfere with daily activities, and if they need remedial problem orientation work. Additionally, patients become familiar with the PST-PC process and socialized to the therapy. The middle sessions are spent encouraging the use of the PST-PC skills. The last session or two is spent helping patients develop a relapse prevention plan based on the PST-PC format.

Structure: To be effective, brief treatments need structure, but you don’t have to lose your therapeutic style or act like a robot when you do PST-PC. You can use your clinical judgment, just don’t go off the rails. The typical session structure looks like this:

1. Setting the Agenda
2. Review progress (PHQ-9, Action Plans, Pleasant Activities)
3. Selecting a problem and solving it

4. Reviewing the action plan and activities

5. Session wrap up.

**Introductory PST-PC Stages: Education, Activation and Problem Orientation.**

*Educate and activate your patient; OR How to establish a working alliance in a brief period of time.*

Like all therapies, for PST-PC to be effective, patients have to understand the treatment and buy into the therapeutic rationale. This is done through brief education of both the therapeutic frame (how you will work together) and the therapeutic rationale (why we use this model). You do not need to spend much time on this, just enough to explain to the patient how PST-PC works, and to answer any questions or concerns they may have about treatment. The basic things you want to cover in your education of PST-PC is:

**Introducing PST-PC Check List**

1. Explain treatment structure
   - □ Number of sessions
   - □ Length of visits
   - □ How often will meet
   - □ Structure of meeting
     - ○ Start with agenda
     - ○ Review PHQ-9
     - ○ 15 minutes problem solving
     - ○ End each session with an action plan
   - □ Importance of PHQ-9
   - □ Using a worksheet initially to solve problems
   - □ Work is collaborative

2. Explain PS theory of depression
   - □ Everyone has problems
We may become depressed when have too many problems or faced with problems we do not know how to handle.

When we become depressed, we withdraw and don’t feel like doing anything.

This makes us feel hopeless and helpless.

The less we do, the worse we feel – it’s a cycle, but we can break it.

With PST-PC, we will be targeting one problem at a time, because the more we do, the better we feel.

3. Explained PST-PC process
   - PST-PC is seven steps
   - Starts with a brief problem list
   - Then we pick one problem
   - Define it, which means getting details about the problem
   - We set a goal
   - Come up with a list of ways to meet that goal
   - Talk about the list of options and evaluate them based on what is most feasible for you to do
   - We create a step-by-step plan
   - You do the plan and we talk about it at the next session
   - You will also solve other problems on your own between sessions
   - Don’t worry if a plan doesn’t work perfectly, that’s all part of learning more about the problem, and helps us come up with a better idea of what is going on.

4. Explanation Process
   - Check in with patient about understanding after each section
   - Ask patient if have any questions
   - Use easy to understand language
   - Be empathic
□ Stance is collaborative, not didactic

Setting the problem List:

The next step to prepare for PST-PC is to make a list of the problems patients feel are contributing to or suffering from their depression. In this phase, keep the list simple and structure the discussion around these common areas: Problems with friends, family, finances, work, school, chores, health, the law, and housing. Use the Problem List in the appendix to guide this discussion.

Problem Orientation (Optional):

For some patients, the very idea that their problems have solutions is beyond comprehension. When asked to think about their problems, some patients become emotionally overwhelmed and have difficulty focusing on the details of the problem, others are so hopeless and pessimistic that they simply do not believe their problems can be solved or they believe there are solutions but the outcome is "not good enough". Although emotion management, negativity and hopelessness are common features of depression, people experience these symptoms in varying degrees. We have found that most people suffering from depression can control their emotions and pessimism enough that they can start the seven-step PST-PC process right away and do not need extra help orienting their thinking to actively solve problems. Others however are disabled by their negative thinking and emotions, and will need a little extra help orienting their thoughts toward solving problems. For this reason, we have included, in the initial stages of PST-PC, a focus on managing emotions and negative thinking (called Problem Orientation in the Nezu PST-PC model) but have made it an optional step in the process for patients who are able to start solving problems and are more hopeful about the outcome.

The purposes of problem orientation are to make patients aware of their particular problems with daily living, to minimize the emotional content of the problems they face, and to increase their motivation in problem solving. The process of orientation consists of five distinct variables: problem perception, problem attribution, problem appraisal, personal control beliefs, and approach/avoidance style (Nezu, Nezu, Perri, 1989). In problem perception, the patient must identify a problem, and the context in which it is faced. Though the problem might bring up emotions for the patient, it is essential that they try to put the emotional baggage aside so they can attend to the problem in a strategic, methodical fashion. With problem attribution, the patient, with the aid of the therapist, must try to achieve a realistic perspective of the cause of the problem. They might have an overly negativistic perspective and consequently attribute an unrealistic percentage of the blame on internal factors. Conversely, patients might
have an attributional style that gives too much credence to external factors that might also be unrealistic. The patient must, then, attempt to find the realistic balance in order to disentangle the problem in a pragmatic fashion. In problem appraisal, the patient evaluates the problem in its significance and value to their personal well-being. The personal control variable is also important to address from the outset because patients must learn that they cannot change the behavior of others or many external circumstances. Instead, they have the opportunity to alter the way they react to the situations they cannot control, and to cope effectively with inevitable stressors. Additionally, the attitude with which the patient chooses to address the problem can make a difference. They must be proactive, rather than avoidant. They must not avoid issues that arise, but rather systematically address them. This issue might be particularly difficult for the patient with Executive Dysfunction to accomplish. The therapist must then make a concerted effort to encourage the patient to be motivated. Once these tasks have been accomplished, the patient and therapist will be ready to move on to the seven problem solving steps.

**Problem Orientation Strategies.**

*Emotion management:* Strategies for emotion management can be anything that helps calm emotions and redirect attention away from negative feelings to a relaxation state. Typical emotion management strategies are:

<table>
<thead>
<tr>
<th>Emotion management strategies</th>
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</thead>
<tbody>
<tr>
<td>Meditation</td>
</tr>
<tr>
<td>Relaxation Exercises</td>
</tr>
<tr>
<td>Deep Breathing</td>
</tr>
<tr>
<td>Prayer</td>
</tr>
<tr>
<td>Imagery</td>
</tr>
</tbody>
</table>

Selection of an appropriate strategy for a given patient should follow after weighing pros and cons in a problem solving format based on previously helpful experiences to the patient. The selected strategy is meant to be practiced by patients over time so that when they begin to feel overwhelmed by emotion, they can use these techniques easily. With all these strategies, patients will need a quiet place to practice for about 10 minutes a day. Patients record their mood before practice and after practice. They are also instructed to incorporate the strategies before each step of the action plan.

*Negativity Bias:* Strategies for coping with negative focus help the patient evaluate their situation in a balanced way by teaching patients to recognize when they are over attending to negative environmental cues and how to draw attention to neutral or positive aspects of the situation. In PST-PC, we use modified Cognitive Behavioral Strategies (CB) to overcome this barrier. Rather than applying CB strategies for all situations, however, we ask patients to use the strategies specifically
when they encounter trouble implementing their action plans. If the patient decides to use the strategies for other situations, that terrific; but it is not necessary.

The negative focus strategies are:

**Negative focus strategies**
- Devil’s Advocate
- Weighing the evidence
- Practice seeing positivity bias

**Devil’s Advocate:** The devil’s advocate technique is one way to help patients counteract their negative thinking. All this involves is a few steps:

1. Write down the reasons why you would not do the action plan;
2. Take the opposite view from the negative reasons: what would you say to get someone else who is making the same argument you are making to do the action plan.
3. Organize the positive arguments and refer to them whenever you want to abandon the action plan.

**Weighing the Evidence:** This is a relatively easy exercise that can enhance motivation to engage in action plans and overcome negativity biases. Using the Weighing the Evidence worksheet in the appendix, all you ask the patient to do is:

1. Estimate the patient’s predicted probability that worst expectations will come true;
2. Ask the patient to think back to all the times they engaged in a similar action plan or activity and have them state how often the patient actually experienced the expected negative outcome, the estimate if that was less and about or more than half the time;
3. The patient’s assignment is to engage in the action plan and then document if the negative outcome actually occurred. Talk to the patient about the difference between their assumed, predicted and actually experience that the negative event happened.

**Practice using a positive focus:** Having a positive focus is the brain’s tendency to seek
out and pay particular attention to pleasurable and positive environmental cues. Like negative focus, this is a natural brain function. When people are depressed, a positive focus is muted, and patients will need to work hard to strengthen this cognitive process to overcome their depression. Patients who chose to control their negative focus by engaging a positive focus will need to practice using the strategies below until they feel comfortable (some patients claim it never feels natural, a majority claim they are helpful). Patients can chose to use one or all of the following tools to help them implement their action plans

- **Think outside yourself.** Ask yourself if you’d try to talk other people out of a similar action plan. If you wouldn’t, stop being so hard on yourself. Think about less negative statements that offer more realistic expectations about the action plan’s success.

- **Keep a “negative thought log”.** Whenever you experience a negative thought when implementing an action plan, jot down the thought in a notebook. Review your log when you’re in a good mood. Consider if the negativity was truly warranted. For a second opinion, you can also ask a friend or therapist to go over your log with you.

- **Changing perspectives.** Review your negative thought log. Then, for each negative thought, write down something positive or find an alternative explanation. For instance, “My boss hates me. He gave me this impossible task to do.” could be replaced with, “My boss must have a lot of faith in me to give me so much responsibility,”, “My boss has given me so much work because this is an important project with an impending deadline” or “Other people have been given similar assignments.”

- **Socialize with positive people.** Notice how people who always look on the bright side deal with challenges, even minor ones, like not being able to find a parking space. Then consider how you would react in the same situation. Even if you have to pretend, try to adopt their optimism and persistence when implementing your plan.

**REMEMBER: THESE STRATEGIES ARE OPTIONAL. IT’S BETWEEN YOU AND YOUR PATIENT TO DECIDE IF THIS WOULD BE HELPFUL.**
The Seven Stages of PST-PC Treatment

It is important to review the stages involved in PST-PC. They are

| 1. Selecting and defining the problem | 5. Evaluating and choosing solutions |
| 2. Establish realistic and achievable goals solution | 6. Implementing the preferred solution |
| 3. Generating alternative solutions | 7. Evaluating the outcome |
| 4. Implementing decision making guidelines | 8. Activity Scheduling |

Each stage of PST-PC is represented on the PST-PC form (appendix A). Below, we discuss each stage of PST-PC, and how to complete the form.

Stage 1: Selecting and Defining the Problem

The goal for this stage is to succinctly define the selected problem. We feel it is important to note that for case management problems the most pressing and urgent problems should be selected first, working down the list to the least pressing problems. Patients tend to be too distracted by urgent problems to learn PST-PC. By progressing through problem selection in this manner, patients will be ready to learn the PST-PC process.

Selection of patient problems, however, should progress in the opposite order. Selecting these less complex problems early on in PST-PC facilitates patient understanding of the model, and gives patients the opportunity to achieve success with the model in relatively short order. In our experience, focusing on a very sensitive problem can distract the patient from the learning process.

Most patients will describe their problems in vague and unclear terms. It is not uncommon to hear patients say that their problem is “procrastination”, “being poor” or “being sick”. While the essence of these terms may be true, the details are missing. What does it mean to procrastinate? Is the patient complaining about paying rent in a timely fashion or attending to a health plan the physician created?
How is “being poor” problem for the patient? Is the patient having trouble paying bills or can the patient pay bills but is unable to purchase gifts for friends? As can be seen, these general terms do not help in determining how to solve the problem.

Defining problems involves the following:

- Discussing the specifics of the problem
- Breaking large problems down into small steps
- Using concrete and observable terms to describe the problem

**Discussing specifics of the problem.** It is practically impossible to solve any problem without a thorough understanding of the problem to be addressed. 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 patients, this means having them describe in detail the factors that make their situation problematic. Getting information about the unmet needs, why they have not been addressed and all the barriers and obstacles encountered by patients is important before therapists and patients embark on developing an action plan.

**Breaking down large problems into smaller and more manageable parts.** Problems are often comprised of a number of smaller, yet distinct, interrelated parts. Failure to differentiate these components leads to an overly vague problem definition that in turn leads to an inefficient action plan. Being poor is a large problem, with many potential issues. One patient had complained that being poor affected her ability to do several things, such as pay her rent on time, purchase medication, buy new clothing, and purchase gifts for her grandchildren. Each of these areas is a problem in its own right, deserving of its own, separate action plan. Further, as can be seen in this example, some problems are case management problems and others are patient problems. Therapists can enact a plan to pay for medication, but only patients can enact a plan to buy gifts for family.

**State the problem in a clear and objective form.** Once the problem has been broken down into smaller parts, and all aspects of the need or problem have been discussed, patients and therapists can now define the problem or need succinctly. It is important to describe the problem or need into observable terms, such that patients and therapists will know definitively when the problem or need has been met. Examples of defined problems versus undefined problems are:
Sometimes patients will identify neurovegetative symptoms of their depression, such as problems with energy, sleep, or motivation, as problems. 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 doing self care activities.” As patients become more effective in resolving these functional problems their depression will begin to lift and the symptoms of low energy and motivation will improve.

Once the problem has been succinctly defined, write it down on line one of the PST-PC form.

**Stage 2: Establishing Realistic and Achievable Goals for Problem Resolution**

Once the need or problem is defined, the next step is determining what patients would like to see changed. This goal should be as clearly and succinctly defined as the problem or need is. The goal should also be achievable with a reasonable amount of effort and time. Therefore, it is important to take into account the balance between the available resources and the time frame for its achievement. Patients and therapists will have long-term goals that they intend to reach by the end of the 12 weeks. These long-term goals can usually be broken down into steps that can be accomplished from meeting to meeting. For instance, one patient had a long-term goal of paying off his debts. This goal was further divided into setting a
budget, paying off his utility bills first (before winter), then his credit card bills and finally his medical bills. These were further divided into smaller, achievable steps, such as finding out which financial programs he was eligible for. By breaking the goals into smaller goals that could be reached each week, the patient felt a sense of success, more so than if his only goal was to relive his debts.

Setting clear behavioral goals is important during Stage 7 when the success of the solution implementation is evaluated. When the set goal stipulates a specific outcome (e.g. getting transportation, calling one’s family) and those outcomes occur, then it is clear that the problem-solving plan worked. Once the goal has been defined, this is recorded on line 2 of the PST-PC form.

Stage 3: Generating Multiple Solution Alternatives: Brainstorming

Once the goal has been set, you are now ready 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. 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. Successful brainstorming involves:

- Listing at least five solutions
- Solutions must address the goal
- Patients and therapists must withhold judgment
- For patient problems, the solutions must come from the patient, not therapist

List at least five solutions. 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 or need. Having a large number of solutions also allows patients and therapists to combine ideas when practical to do so.

Therapists using this approach may find it difficult to generate more than one or two obvious solutions for a particular need. For instance, if a patient needs to get to
medical appointments and is not linked to Para transit, the obvious solution for the therapist is to link the patient to that service. However, for the benefit of the patient, it is worth while to consider other options so that the patient can observe that there is usually more than one way to solve a problem, and the patient can observe the therapist employ the decision making strategies described later.

*Solutions must address the goal.* At times, patients tend to list whatever idea comes to their mind without considering the relevance to the problem. This is a relatively rare occurrence, but does happen. If, when generating solutions, patients begin to list what appear to be irrelevant solutions, therapists should ask how the solution is related to the goal, **even before the brainstorming process ends.** Sometimes patients list seemingly irrelevant solutions because there is another aspect to the problem that was not discussed. In this case, problems should be redefined and goals newly specified.

*Withhold judgment until the next stage.* Do not judge the ideas until the brainstorming process is completed, otherwise a potentially successful and novel solution may be prematurely abandon. Evaluation of the feasibility of each option is left for the subsequent stage (Stage 4: Implementing Decision-Making Guidelines: Pros and Cons).

The solutions should be listed in the grid on item 3 of the PST-PC form.

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

The purpose of stage 4 is to strategically evaluate the alternative solutions by implementing decision-making guidelines. Therapists and patients create a list of the “pros” and “cons” for each potential solution. This involves asking the following questions:

- Does the solution meet long term and short goals
- What is the impact the solution will have on the patient, other people and/or society.
- Is the solution feasible

*Does the solution meet long term and short term goals?* The main point of this
question is to determine the feasibility of therapists and patients being able to implement the solution between meetings. Some solutions may be excellent at addressing a need in the long run, but if selected, should probably be combined with another solution that can meet a short-term goal so that patients experience some success from week to week.

*What is the impact the solution has on the patient, other people, and/or society?* The main point in asking this question is to determine if the solution will create some other, unforeseen problem. For instance, relying on family for transportation may meet a goal of going to weekly physical therapy appointments, but may result in overburdening the family. It is not enough to meet the goal, a good solution also minimizes any negative impact on others.

*Is the solution feasible?* The main point in asking this question is to determine whether or not patients and therapists actually have the resources to enact the solution. A therapist may be able to help patients with transportation by driving them to appointments, but that is unlikely to be a feasible 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. The pros and cons of each solution should be listed in the grid next to each solution under item 3 of the PST-PC form.

**Stage 5: Evaluating and Choosing the Solution(s)**

The next stage in problem solving is to prompting the patient to compare the solutions along their pro versus con dimensions. This involves:
A thorough examination of all solutions
- Comparing solutions

Determining which solution has the least cons and the

_A thorough examination of all solutions._ Therapists should begin this stage with a careful review of the relevant pros and cons for each solution. This within-solution evaluation involves determining if a solution has more against it than for it. This process helps to begin weeding out less effective solutions, and opens up discussion for how a weak solution may be strengthened.

_Comparing solutions._ After the merits of each solution have been detailed, therapists and patients can then compare the solutions to one another. The solution that should be selected is the one with the least number of negative consequences and the largest number of positive outcomes associated 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. When patients choose a solution without appropriately reviewing the pros and cons, therapists should point it out and bring the 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.

The chosen solution should be written out on item 4 of the PST-PC form.

**Stage 6: Implementing the Preferred Solution(s)**

Once chosen, the steps required to achieve the solution are identified and planned. This is the action plan. To create a clear action plan, patients and therapists must:

- List out the steps in implementing the solution
List the steps in implementing the solution. Therapists and patients consider all the steps it would involve in implementing a solution. As an example, the steps involved in linking patients to Para transit involve calling Para transit and reviewing eligibility, determining if there is a waiting list, collecting the appropriate forms and dropping the off to the patient, mailing in the forms, calling to follow-up on the status of the application. Specifying when each task is to take place is also important. Using the same example, therapists may indicate that the first call to Para transit will happen as soon as they return to the office. For patients, determining the timing of steps is very important in supporting adherence to the plan. Patients are more likely to actually implement an action plan if they start the first step as soon as the therapist leaves the home.

Consider all potential obstacles. Patients must identify and choose tasks that they feel comfortable implementing. Therapists 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. 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.

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.

The action plan is fill-out on item 5 of the PST-PC form.

Stage 7: Evaluating the Outcome

The final stage is actually completed at the start of the subsequent meeting. Patients and therapists should have completed or attempted to complete the action
plans set in the previous session, and should have recorded the outcome of these tasks on item 6 of the PST-PC form. In addition to determining if a solution met a goal, proper evaluation of outcomes includes answering the following questions:

- Were you satisfied with the outcome?
- Did you learn anything new about the problem?
- Is there anything you would have done differently?

**Were you satisfied with the outcome?** The review of homework should be followed by asking patients 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 therapists should review the PST-PC model, and emphasize that they certainly are no worse off for having solved a problem. It is important to encourage persistence. When mood improvement is reported, therapists should point out the link between effective problem solving and achieving a positive mood state.

**Did you learn anything new about the problem?** This question is particularly pertinent to reviewing solutions that do not succeed in meeting needs or goals. In discussing patient failures, therapists should always communicate that they see patients’ potential for effective coping, and thus facilitate a positive problem-solving orientation. This is also an opportunity to reinforce 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.

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 patients 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 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 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 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.

It is important to note that PST-PC is not always as easy a skill to learn as it looks. It is important for therapists to watch closely for signs that a patient is having trouble with a particular stage of the model. In those situations where the patient is struggling with a particular step in the process, it may be necessary for the therapist to spend time reviewing exactly what to do at that particular stage. For this reason, we have developed…and provide…supplemental reading materials and exercises for the therapist to use in these situations. These supplemental materials are not required to be used in while doing PST-PC, but can be used when a patient is having a difficult time understanding the process.
Termination

Termination or completion of BA-PC ends when the patient mood improves or they are independently engaging in valued activities without much consultation from the behaviorist. When this happens, it is important to create a relapse prevention plan. In this session, you will do the following with the patient:

1. **Review the course of treatment.** Show the patient the progress they have made by showing the changes in PHQ-9 and activities engaged in.

2. **Discuss with the patient their person warning signs of depression.** Have the patient brainstorm with you signs and symptoms they need to be tracking to ensure they don’t become depressed or anxious again.

3. **Discuss with the patient activities they could do to keep their mood up.**

4. **Create a daily prevention plan.** Have the patient come up with activities that are known to improve mood and create a plan to engage in those activities on a regular basis.

5. **Create a plan for when they may be relapsing and cannot change the course.** This can include scheduling another appointment with you or the primary care physician. Here is an example of a relapse prevention plan.
RELAPSE PREVENTION PLAN

My early warning signs are:

1. Sleeping too much
2. Getting grouchy
3. Not doing my housework

Activities that I know help my mood:

1. Walking every morning
2. Going to church and volunteering
3. Eating healthy food

Everyday I will:

1. Walking every morning for at least 10 minutes
2. Eat well
3. ________________________________

Warning signs that I need to call the doctor:

1. When I can’t get out of bed and stop doing things.
2. ________________________________
3. ________________________________
Chapter 3
Special considerations when working with older people

Ageism and boundaries

In the American society, aging is seen as a time of despair, disability, and pain. One need only look to the cosmetics industry to see the plethora of products aimed at reducing the appearance or suggestion of age – hair dies, Rogaine, Botox, wrinkle creams – all products suggesting that the natural course of aging is something to avoid. Ageism is a negativistic belief about older people that is present in people of all age groups. Because most of us grew up with some ideas about older adults, and because our society is rife with stereotypes about aging, our attitudes toward age and aging need to be considered when working with older adults in the context of psychotherapeutic and case management interventions.

An older patient’s attitudes toward a therapist can take many forms. Indeed, some have noted that because elders have more years of experience, he or she can have feelings about the working relationship that stem from experiences in any life stage, including the family of origin, nuclear and extended family, and other relationships. A therapist must be aware of this range of possibilities, and of the fact that a patient can see the therapist as a parent, a spouse, a child or grandchild, or an expert.

For a therapist, ageism will likely arise in work with older adult patients. For many therapists, a lack of professional training with older adults leaves them especially vulnerable to their own fears about aging. Often, these feelings stem from his or her positive or negative stereotypes about older people, and his or her own fears regarding infirmity and aging. For example, one younger therapist observed that she had difficulty interrupting or confronting her elderly patients while conducting PST-PC. She connected this to being taught as a child to be extremely respectful to her grandparents and other elderly people. Once she had identified the source of her behavior, she could more accurately assess the situations that required her to be more assertive with her patients.

Relevant to ageism are the decisions made by therapists regarding
boundaries in the working relationship. For good reasons, many mental health professionals were trained to maintain an emotional distance and not accept gifts or physical contact from patients. However, it is true that among the current cohort of older adults, it may be relatively common to offer a small gift or a hug to the therapist, and to become insulted if this is not handled appropriately. This may be especially true for older adults from certain cultures. For example, one therapist provided in-home therapy to an elderly Filipino couple, who insisted on serving tea and a snack during each session. The therapist did her research and learned that this behavior was typical of this culture and cohort; despite her initial discomfort with the ritual, she assessed the impact on the working relationship to be minimal and decided to allow the tea to continue. The main lesson here is to perform a truly comprehensive assessment when conceptualizing the elderly patient and making decisions about boundaries, taking into account personal, cohort-based, and cultural factors.

The following questions may be useful in evaluating ageist attitudes and boundaries within the working relationship with an elderly patient. Several of these were inspired by the “contextual, cohort-based, maturity, specific-challenge” (CCMSC) model of case conceptualization developed by Knight for use with older adults.

<table>
<thead>
<tr>
<th>Questions to consider about the patient:</th>
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<tbody>
<tr>
<td>What cohort does this patient come from? How might that affect her interactions with me? How does it affect her coping strategies?</td>
</tr>
<tr>
<td>What is this person’s cultural background?</td>
</tr>
<tr>
<td>What is this patient’s specific family history, independent of age or cohort?</td>
</tr>
<tr>
<td>What does aging mean to this person?</td>
</tr>
<tr>
<td>What is this person’s current social world, and how does it fit with his current needs?</td>
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</tbody>
</table>
Questions therapists can ask themselves:

What does “aging” and “old age” mean to me?
What are my stereotypes about older people?
How comfortable am I with my own aging and loss of function, and that of my loved ones?
What is my cohort and how does that affect my behavior and my perspective?
What did I learn as a child about older people, and about how to interact with them?
How do I do want to be seen by this older person?

Adapting PST-PC for Older Adults

Despite the overall similarities between working with older and younger adults, experienced geriatric providers agree that some adaptations may be needed to make the treatment maximally effective. These adaptations include taking time to socialize older adults to the process of PST-PC, adjusting the pace of PST-PC to account for age-related changes in information processing, and allowing flexibility in the delivery of PST-PC to overcome medical and physical barriers to care. At the same time, older adults bring unique strengths to therapy that therapists can capitalize on such as past experience and wisdom.

Accounting for Changes in Information Processing

Although research shows that older people maintain a significant degree of mental flexibility and can learn new tasks, older adults do learn somewhat differently than younger persons. There are a number of cognitive changes associated with aging that should be attended to when providing psychotherapy to an older patient. The most relevant changes to psychotherapy are those associated with cognitive slowing, decreased fluid intelligence, and working memory. Taken together, these changes indicate that psychotherapy – which relies on the ability to draw inferences, process new material, and recall information – often must be delivered at a slower pace, over multiple meetings, and in a multifaceted way.

Cognitive slowing. The speed to which we react to stimuli, and hence process information, slows considerably as we age. Although slowed reaction time does not necessarily interfere with the ability to process new and/or abstract material, new
information should be presented more slowly and over a longer period of time to counteract the effects of cognitive slowing.

Psychotherapies adapted for older populations tend to be structured so that new material raised in treatment is reviewed a number of times and presented through a number of modalities. In PST-PC, this process involves first giving older patients a rationale for a new skill and elucidating the relevance to their problems. Next, the therapist demonstrates the new skill with a generic example, and finally engages the patient in the skill using a patient example. In following this process, the therapist can check to make sure that the older patient understands the application of the new skill and can successfully practice the skill between sessions.

*Decreased fluid intelligence.* While the overall reasoning ability of older adults is not impaired because of their vast store of previous learning (“crystallized intelligence”), the rate at which they can process new information and make inferences (“fluid intelligence”) is slowed. Although the details of memory functioning among older adults are quite complex, there is consensus that working memory, an aspect of memory functioning that is responsible for processing information prior to long-term memory formation, becomes less efficient with age. Again, providing repeated exposure to new information is important, to help ensure adequate learning. Another useful technique, which makes use of intact crystallized intelligence to improve information processing in psychotherapy, is to rely on patients’ vast stores of previous experiences. *Life review,* a technique commonly found in reminiscence therapies, is an excellent tool for linking new material to older patients’ past experiences. This technique is best illustrated in a case example (see Case Example).

Although this example describes using life review in a relatively unstructured manner, therapists may conduct more targeted life review around specific issues. For example, it can be helpful to talk about previous times when the patient faced similar issues and how they managed to resolve or cope with those issues earlier in their life. Ideally, such a review can remind patients of coping skills they already have. Even if patients did not cope effectively with those issues in the past, however, life review discussions can still serve as a valuable learning tool in the therapy.

*Contextual Adaptation.* As stated previously, for some older adults a number of practical and health-related barriers may exist, requiring certain contextual modifications to the therapy. The most common therapy adaptations to address contextual issues include: a) relaxing the therapeutic frame to accommodate fatigue, illness, and psychosocial demands; and b) adapting psychotherapy elements to address common physical disabilities and coordinate with other care providers.

*The therapeutic frame*
The traditional therapeutic frame can be a barrier to the delivery of psychotherapy in older populations. The typical expectations that patients come in weekly for appointments, that treatment be delivered during a 50-minute time span, and that it occur in specialty mental health settings may be hard for many older patients to meet. The therapeutic frame must remain flexible with regard to treatment location, session length, and access. Because many older adults are coping with care giving crises, temporary disability due to short-term illnesses or the exacerbation of chronic illnesses, or ongoing medical illnesses that require a number of appointments, being able to participate in regular psychotherapy can be a complicated goal to attain. To account for these factors, therapeutic approaches that allow for flexibility in treatment have been developed for late-life psychotherapy. These include modifying psychotherapy for non-mental health settings, briefer sessions, and using the telephone and/or written materials.

*Accounting for physical disabilities*

Disabilities common in frail elderly (e.g., impairments in vision, hearing, or mobility) also can impede the progress of therapy, when no adaptations are undertaken. Ideally, the therapist assesses disabilities and attempts to facilitate patients’ receipt of needed medical and social services (e.g., medical treatment, getting new glasses or dentures). The therapeutic process also may benefit from close, ongoing collaboration with other health care professionals, particularly in working with frail elderly with multiple medical problems and medications.

For patients with reading impairments (due to vision loss or illiteracy), audio-taping sessions for at-home review can be used to reinforce session information (30-32). For some patients, treatment forms should be modified with larger print and with larger writing spaces to accommodate changes in fine motor skill (e.g., due to arthritis or stroke).

For patients with hearing loss, hearing problems cannot always be corrected via hearing aids, or patients may refuse to use such devices. When working with these patients, the therapist must be keenly aware of the degree of impairment. In some cases, sitting closer to older patients and near the ear that is less affected by hearing loss can greatly help with communication. Speaking slowly, and in low tones (particularly important for female therapists) also can help the older patient hear the material. If these methods prove ineffective, microphones connected to headphones the patient wears can be used to amplify therapists’ voices. Relying on written communication is another option that has been used successfully in some cases.

Finally, chronic or acute physical impairments may interfere with patients’ ability to attend and sit through sessions. Therapy sessions may need to be briefer
due to fatigue or pain. Therapists also need to assess for and attempt to correct any environmental barriers for these patients, such as lack of transportation, lack of wheelchair accessibility, loose rugs, or poor lighting.

In summary, psychotherapy for older adults typically means more sessions to process information. It also mean that new information, whether it is in the form of learning skills or exploration of experience, may need to be reviewed with the older adult to ensure comprehension and assimilation of information. Because of illness and other competing demands on time and energy, the therapeutic frame must be flexible, but not to the detriment of the patient. Finally, adaptations to address physical impairments may be important to consider.

**Strengths of older adults**

In spite of the challenges that may arise in psychotherapy with older adults, older adulthood also can be a time of growth, and older adults often retain strengths that therapists can use to maximize therapeutic benefit of the work together. For example, although some cognitive functions may be less efficient, research suggests that, compared to younger adults, older adults “have a larger repertoire of experience from which to operate, use more effective strategies, and better integrate emotional information”. These findings suggest that it can be beneficial for therapists to explore, together with their older patients, the strengths they have developed over their lifetime and ways to use those strengths to approach current issues. Even “mistakes” or regrets can be used to determine different courses of action for the future. Elders in distress are likely to overlook or minimize their assets and past accomplishments, and the therapist may need to be very proactive in assessing and identifying patient strengths during the session. For example, one elderly woman described herself as not accomplishing much in life, then went on to talk about raising three children on her own after her husband’s early death. She minimized her role in raising her children, although further discussion revealed that she had worked very hard and frequently expressed love and support to her children. Such discussions can serve to build elders’ sense of self-worth and encourage them in dealing with current issues.

Another potential strength of older adults is the presence of more complex emotionality (i.e., multiple emotions in response to an event or issue) to explore and integrate in therapy. This ability can be beneficial in psychotherapy and perhaps especially in working on the complex and multi-faceted issues common to old age.
Case Example: life review in PST-PC

Mr. J. was a disabled, 80 year old man referred to problem-solving therapy for major depression. During the course of therapy, Mr. J. learned the steps involved in PST-PC through the “say-it, show-it, do-it” method described previously, but he was still struggling with understanding the process of PST-PC and was not applying the model between sessions. More out of frustration than therapeutic gain, the therapist decided to spend a session letting Mr. J talk about his problems in a free-form fashion. As Mr. J. spoke about his depression, he began discussing the job he had before he became disabled and how good it made him feel to be the “go-to” person for the roadblocks faced by his company when rolling out a new product. As the therapist listened to Mr. J. talk about how he managed to solve problems in one particularly complex situation, the therapist noticed similarities between Mr. J.’s problem solving process at work and the PST-PC model. She then asked, “Is that how you usually solved problems at work? Did you typically follow those steps?” Mr. J. discussed a few more examples of how he solved problems at work, and as he spoke, the therapist tracked the terms he used for his problem-solving steps and used the PST-PC worksheet to record the process Mr. J. took to solve these problems. After a few instances of life review, the therapist then showed Mr. J. what she had done and drew a parallel between his work style and PST-PC. Mr. J. thought for a moment, began nodding his head, and then, as if a light bulb had gone off, he said, “Has this been what you’ve been trying to get me to do? Well, why didn’t you say so?!” By using the patient’s life review material, the therapist was able to successfully teach PST-PC skills to Mr. J. and subsequently help him overcome his depression.
Appendix A
Problem List
Case management list

Patient Name:___________________Date: __/__/____

Urgent needs (Emergency)

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

Priority needs

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

4. ____________________________________________

5. ____________________________________________

6. ____________________________________________

Needs that can wait

1. ____________________________________________

2. ____________________________________________
<table>
<thead>
<tr>
<th>PST problem list</th>
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<tbody>
<tr>
<td><strong>Family</strong></td>
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<tr>
<td>1. ______________</td>
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<td>2. ______________</td>
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<tr>
<td>3. ______________</td>
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<tr>
<td><strong>Financial</strong></td>
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<tr>
<td>1. ______________</td>
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<td>2. ______________</td>
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<tr>
<td>3. ______________</td>
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<tr>
<td><strong>Social</strong></td>
</tr>
<tr>
<td>1. ______________</td>
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<td>2. ______________</td>
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<tr>
<td>3. ______________</td>
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<tr>
<td><strong>Health</strong></td>
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<td>1. ______________</td>
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Appendix B

Problem Solving Form
Problem Solving Worksheet

Date:_______________  Name:________________  Visit:______

Review of Progress:_________________________________________

1. Problem Definition:_______________________________________

2. Goals:_________________________________________________

3. Solutions:

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<th>4. Pros</th>
<th>Cons</th>
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</table>

4. Pros

5. Choice:_________________________________________________

6. Steps:

   a) 

   b) 

   c) 

   d) 

7. Satisfaction?  ☹ ☹ ☹ ☹ ☩ ☩ ☩ ☩ ☩ ☩

   0  1  2  3  4  5  6  7  8  9  10

8. Activities for week:_______________________________________
Argument Worksheet

Playing the Devil’s Advocate
Write your reasons for not doing your action plan here:

___________________________________________________________________
___________________________________________________________________

Write down why your reasons are not good reasons here:

___________________________________________________________________
___________________________________________________________________

Getting Your Arguments in Order
List three good arguments you can use to help you do your action plan:
(1) 
(2) 
(3) 

Look at these arguments whenever you start to consider not doing your action plan.
1. **How can I view the situation from a different perspective?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Predicted likelihood of bad outcome</th>
<th>Past experience</th>
<th>Actual experience</th>
</tr>
</thead>
<tbody>
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2. **How other family members, friends may have thought or reacted to a similar situation?**

3. **Think of someone optimistic whose opinion you highly value. How would they perceive the situation?**
Cheat Sheet for Emotion Management

1. Set aside 10 minutes everyday.
2. Find a quite spot where you will not be bothered.
3. Record what your tension level is.
4. Close your eyes and take five slow and deep breathes.
5. Start your practice.
6. End your practice.
7. Record your tension level.
My practice plan is:

- Relaxation
- Imagine
- Meditation
- Prayer

<table>
<thead>
<tr>
<th>Tension</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>Before</td>
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<td>After</td>
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</table>
RELAXATION TRAINING

1. Close your eyes and think of a beautiful picture that makes you relax.
2. Take a deep breath through your nose, like filling your stomach with air.
3. Hold your breath and count to 5.
4. Exhale slowly until all air is out (sometimes as you exhale, it may be helpful to whisper a word slowly, for example, “relax”).
5. Wait for 15 seconds.
6. Repeat.

Please practice these exercises according to the clinician’s recommendations before you apply them in an anxiety provoking situation.

Write down your thoughts and feelings and rate the effectiveness of the exercises on a scale of 1-10 (1=not effective; 10=most effective) after each training session.

Please be aware that they may be an increase in anxiety in the beginning of the training sessions before the exercises are effective.