Problem-Solving Treatment for Complicated Depression in Late Life: A Case Study in Primary Care

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TOPIC. *Treatment of depression in primary care.*

PURPOSE. *To describe the application of problem-solving treatment for a person with complicated depression.*

SOURCES. *Specific treatment details from audiotaped therapy sessions; published literature.*

CONCLUSION. *This case demonstrates how an older person benefited from problem-solving treatment.*

Search terms: *Depression, geriatrics, primary care, problem solving, therapy*

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Many older adults with depression have a chronic and recurrent course beginning in their younger years and complicated in late life by medical co-morbidity, cognitive impairment, and diminishing psychosocial resources. A number of studies have found that older adults who experience chronic or recurrent depression respond best to a combined treatment approach (Areán & Cook, 2002).

While antidepressant treatment is a mainstay of therapy for chronic and recurrent depression in primary care, psychotherapeutic approaches enhance the therapeutic value of medication as well as the prevention of relapse in both younger (Fava, 1999) and older adults (Reynolds, Alexopoulos, Katz, & Lebowitz, 2001). Many older adults, however, seek help for depression in primary care where they have limited access to psychotherapy. In settings where psychological interventions are available, providers may be reluctant to administer brief and structured therapies for chronically depressed patients with complicated and long-standing psychosocial and interpersonal problems. In recent research with younger adults suffering from chronic and recurrent depression, those receiving antidepressant medication and a brief mood management program improved substantially and were less likely to suffer a relapse within a 2-year window (Fava).

In this article we discuss the complex case of an older patient who was treated for chronic depression in primary care medicine, using an integrated medication and psychotherapeutic approach (Unützer et al., 2001).

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Included are specific details regarding use of Problem Solving Treatment for Primary Care (PST-PC). We begin with a brief description of the model of care delivered—IMPACT.

The IMPACT Collaborative Care Approach

IMPACT (improving care for late life depression) is a research project that provided treatment to older adults in a primary care clinic (Katon et al., 2002). Patients are identified in primary care medicine either through primary care provider referral, clinic screening, or self-referral. Patients are then seen and followed by a care manager (either a nurse or a psychologist) in the primary care clinic who collaborates with the patient's primary care provider. Patients can be treated with antidepressant medication alone, psychotherapy alone, PST-PC psychotherapy alone, or a combination of the two treatments. The choice of treatment is arrived at jointly among the primary care provider, the patient, and the care manager, with consultation from a team psychiatrist. If antidepressant treatment is the treatment of choice, the team psychiatrist provides consultation to the care manager and the prescribing primary care provider concerning medication management. While most patients are started on and remain on either medication or psychotherapy, patients with chronic depression may be started on both treatments or started on an antidepressant and then given psychotherapy as an additional intervention if response to medication is minimal. A detailed description of this treatment model is provided elsewhere (Saur et al., 2002; Unützer et al., 2001).

The psychotherapy. Very few psychotherapies are designed specifically for primary care medicine. Problem Solving Treatment for Primary Care is one psychotherapy that has considerable empirical support for its efficacy (Catalan et al., 1991). PST-PC is an effective treatment for major depression (Mynors-Wallis, Gath, Day, & Baker, 2000; Mynors-Wallis, Gath, Lloyd-Thomas, & Tomlinson, 1995) and possibly dysthymia and minor depression in younger and older primary care patients (Barrett et al., 2001; Williams et al., 2000). Overviews of PST-PC, including its procedures and training program, have been published in detail elsewhere (Areán, Hegel, & Reynolds, 2001; Hegel, Barrett, & Oxman, 2000), and thus will not be described at length here. Briefly, PST-PC consists of seven consecutive stages (Table 1) that are applied to at least one problem per treatment session.

Table 1. The Seven Stages of PST-PC

Stage 1: Problem Definition

Specific, feasible problem
- Described in objective terms
- Problem explored and clarified
- Complex problem broken down

Stage 2: Goal Definition

Goal is objective
- Described in behavioral terms
- Goal is achievable

Stage 3: Generating Alternative Solution(s)

Brainstorming is facilitated
- Solutions come from patient
- Withhold judgment

Stage 4: Decision-Making Stage

Consider pros and cons for each solution
- Solutions are compared to each other
- Psychosocial resources are addressed

Stage 5: Evaluating and Choosing the Solution(s)

Deliberate, systematic process
- Solutions satisfy the goals
- Negative impact is limited

Stage 6: Solution(s) Implementation

Specific tasks are identified
- Tasks are relevant to solution
- Tasks are within the patient's repertoire

Stage 7: Evaluating the Outcome

Review all homework assignments
- Exploration of failure
- Renew problem solving if necessary

These seven stages are presented to the patient during an initial visit, and a worksheet is used to guide each session. Each subsequent session (for a total of 4–8 sessions) is meant to reinforce problem-solving skills and practice using the problem-solving procedure on problems the patient is experiencing. Patients are encouraged to use these skills in between sessions whenever possible. Older patients with chronic depression will often present with multiple, interlinking problems that can seem overwhelming even to the therapist. The therapist may feel compelled to focus on more complex, emotionally laden problems. However, it is beneficial to focus on smaller, more attainable goals in the beginning.

The following case example illustrates how selecting straightforward problems to solve affords chronically depressed patients the opportunity to learn the skills without being distracted by intense affect and readily experience successes that will counteract feelings of helplessness. Encouraging reliance on the problem-solving worksheet for structure, having patients repeat the steps aloud while solving problems, and starting with small concrete problems makes for efficient learning.

Patients who successfully complete four to eight sessions of PST-PC are offered monthly follow-up sessions to ensure they continue to use the problem-solving skills learned. These sessions can be delivered individually or in a group setting. Monthly maintenance sessions are available to patients for up to 1 year after acute phase treatment starts.

The Case: PM

Assessment. PM was a 60-year-old married female who lived with her husband of many years. She suffered from a number of chronic medical conditions, including fibromyalgia, migraines, and gastrointestinal complaints. At the time of intake, PM was taking an antidepressant medication. She met diagnostic criteria for dysthymia and major depression, recurrent based on the structured clinical interview for *DSM-IV* (APA, 1994). She endorsed all nine *DSM-IV* depressive symptoms and all seven dysthymia symptoms at her initial interview (Table 2).

Table 2. PHQ-9 Scores and *DSM-IV* Symptoms Over Course of Treatment

	PHQ-9 Score (range 0–27)	*DSM-IV* Major Depression Symptoms (range 0–9)	*DSM-IV* Dysthymia Symptoms (range 0–7)
Initial visit (Week 1)	23	9	7
PST session 1 (Week 6)	13	5	6
PST session 2 (Week 7)	11	4	5
PST session 3 (Week 8)	7	4	5
PST session 4 (Week 9)	9	4	6
PST session 5 (Week 10)	6	2	4
PST session 6 (Week 12)	8	2	3
PST session 7 (Week 13)	13	5	5
PST session 8 (Week 15)	12	3	3
First maintenance session (Week 16)	5	2	2
Last session (Week 57)	3	1	0

At her initial assessment, PM reported feeling depressed all her life; she had one previous suicide attempt by taking an overdose of pills. In a psychiatric evaluation 2 years earlier, she had defined her problem this way: "I

cannot handle perceived rejection. It makes me feel worthless, sad, then angry, then depressed. I believe it stems from childhood." She noted this was progressively worsening in later life. She had a long history of psychotherapy and treatment with antidepressants, none of which she had found helpful.

Medication. During the prior 2 years, PM had been seen in psychiatric clinic for medication management with a variety of antidepressant medications, and she attended individual and group therapy. The groups were classes to teach cognitive skills to handle depression and anxiety. She found the information interesting but was unable to apply it to her life problems. She reported no sustained relief in depressive symptoms from therapy or medications. In addition to chronic depression, PM had limited skills to alter current life problems, thus contributing to her depression. Given the chronic course of her depression, the patient, provider, and therapist decided to initiate a course of fluoxetine since a previous trial on it was brief and at a lower dose. During the four weeks of medication only, PM met with the therapist, who provided supportive counseling. She had a partial response to the medication after 4 weeks but was still feeling depressed and hopeless. After a discussion about further treatment options, PM agreed to begin a course of PST-PC.

Acute phase problem-solving treatment (sessions 1–8). Prior to the first session of PST-PC, the therapist educated the patient about the cognitive-behavioral approach to treatment and the "here and now" focus of the intervention. PM came to the initial PST-PC session with a list of problems. These were vaguely defined and complex. For instance, the initial problems on the list were "procrastination," "rejection," "not getting out enough," "being overweight," and "watching too much TV." The therapist explained the seven problem-solving steps to the patient by first walking her through the problem-solving worksheet, and then taking one of PM's problems and helping her to use the seven steps to solve it. PM's initial choice was to work on procrastination, and the therapist helped PM break down the problem into definable and concrete terms. She decided to begin with papers in the dining room and office for the past year. The therapist then worked with PM to identify her goal and the obstacles to meeting her goal, which was thinking it all had to be done at once rather than working on it in parts. In generating solutions, she encountered difficulties, saying, "If I knew what to do, I would have done it already." This reaction to the brainstorming is not uncommon in chronically depressed patients, who typically feel helpless. When encouraged to think how other people would approach the problem, however, PM was able to begin generating a list of solutions.

Building on her success with problem definition and solution generation, PM had little trouble weighing the pros and cons of each solution. She encountered difficulty with identifying steps to implement the chosen solution. When the therapist asked her what steps she would take to implement her plan, PM initially said "to just do it." In order to develop a more specific plan, the therapist helped her specify times, days, and ways to implement her plan. PM indicated it was particularly helpful to think of the plan as small steps to the goal. By detailing the specifics of what she would need to do in order to implement her solution, PM felt more confident in her ability to solve her paperwork problem.

A tension many therapists experience with chronically depressed patients is the pull between teaching problem-solving skills and jumping in with complex problems. Because of the short-term nature of the treatment and the desire to start feeling better, PM, like many chronically depressed patients, wanted to focus on more complicated issues first. However, because patients like PM often have difficulties with emotional regulation, tackling complex problems, such as coping with rejection, often interferes with the skills-learning process. By encouraging PM to pick less complex problems initially, PM was able to learn the PST-PC approach and experience the immediate reinforcement of using the model, even during the initial session.

At the next session (#3), PM reported she had successfully implemented her plan, and wanted to begin focusing on more complex tasks—for example, her weight and house cleaning. PM had retained the skills she learned in

the first session and, during the next two sessions, required only modest prompting and assistance from the therapist. With each problem in these initial sessions, PM was able to implement her solutions. However, rather than focusing on her successes with PST-PC, PM would focus on past failed attempts at improvement and her expectation that at some point she eventually would sabotage her recovery from depression. Rather than explore the past failures or attempt to directly challenge her negative and hopeless thinking, the therapist would redirect PM to focus on her current accomplishments. By the fourth session, PM was able to implement the problem-solving process with greater ease and discuss decision making more effectively and with less assistance.

PM also was able to see how solving smaller problems had a positive effect on solving larger problems. For instance, consolidating her household chores with her TV time resulted in having more spare time with her husband, which in turn resulted in an improved relationship with him. PM also began to focus on her accomplishments, rather than worrying about what tasks she had not accomplished. She selected a motto for herself that she felt helped eliminate procrastination: "Do it now!" PM indicated that having a written plan from the sessions and repeated successes with the model motivated her to tackle her more complex problems, in contrast to the start of treatment, when she felt no hope for change.

By the fifth session, PM's Patient Health Questionnaire score (PHQ-9, a nine-item depression inventory) (Spitzer, Kroenke, & Williams, 1999) had decreased from the severely depressed to the mildly depressed range. She also reported her sleep was improving, her interest in activities was increasing, and her sense of hopelessness was dissipating. Because of PM's success in therapy, she and the therapist began to tackle emotionally complicated problems, namely PM's reaction to perceived rejection and her misattribution of the behavior of others. Prior to initiating PST-PC, PM had discussed these problems vaguely and felt little control over situations, which caused her to become emotional.

At this point in therapy, PM could now discuss her rejection concerns in the here and now, rather than focusing on past rejections. She also was more adept at breaking down and defining her problems with rejection. PM broke this problem into two domains: her behavioral/emotional reactions to being rejected, and her tendency to interpret other people's behavior as rejecting. PM decided to approach her reaction to feeling rejected first. In the course of defining this problem, PM revealed that when she felt someone was rejecting her, she would engage in self-injurious behavior (e.g., hitting herself). This was a long-standing problem that had not responded to treatment in the past. In attempting to solve this problem, PM specified her goal was to stop harming herself when she felt rejected. PM again experienced difficulty generating solutions, initially indicating she should forgive the person for rejecting her. However, as she began to brainstorm solutions, she was able to move from potentially unfeasible solutions to using more concrete strategies, such as behavioral distraction (i.e., engaging in a competing activity, such as cleaning the house or exercising). Encouraged by her previous successes, PM was able to implement these solutions and reported she was no longer hitting herself.

In sessions 6 and 7, PM was able to begin addressing her interpretation of others' actions as rejection. In discussing the antecedents of her self-injurious behavior, she was able to recognize that her pattern of hurting herself never led to resolution of the problem but only increased her negative feelings about herself and others. She recognized that ignoring her feelings of rejection would be only marginally successful, in that while she was no longer hitting herself, she still felt quite hurt by perceived rejections. This led to angry interactions with her husband for not recognizing her pain even when she had not told him what upset her. Her expectation was that her husband of many years should know what she wants and what bothers her, and thus felt that if she was upset with him, he must have hurt her intentionally. Her goal was to change how she interpreted and reacted to these situations. She discussed a number of solutions, such as not commenting or telling herself "it isn't important," as well as considering the other person's feelings and resolving the problem with the person.

In the end, PM chose to actively resolve problem situations through assertive communication and by getting more information about the other person's point of view. This change in her interpersonal behavior resulted in an improved relationship with her husband and less negative feelings about herself. At subsequent sessions she stated, "I think now before I speak to my husband and consider if this will make things better or worse." This is an excellent use of decision-making guidelines (stage 4) in the immediate moment.

Influencing the patient to implement a here-and-now focus for her problems, including her feelings of rejection that had evolved from her past, may have been the key aspect to promoting a lasting change in the patient. Once she learned she could change her reactions today to perceived rejections from the past, she became increasingly more open to using PST-PC.

In spite of this progress, PM experienced an increase in depression symptoms after six sessions (Table 3). Her explanation for the exacerbation of symptoms was that she had visitors from abroad and was the only person at home who spoke their language. She found this stressful, but believed she was coping better than she would have before PST-PC. She problem solved to take two days off during the visit and allow others to entertain the guests.

By the last session of acute phase PST-PC (session 8), PM was having fewer arguments with her husband and getting more positive attention from him. She continued to work on her rejection sensitivity issues as they affected her in the here and now. She stated that when she watched a program about child abuse or other painful childhood experiences, she would revert to experiencing her own pain and wanted her husband to comfort her. Her first thought was to turn off the program, but as she analyzed this she realized she needed a way to turn off her reaction as well. Her solution was to start a journal to write down the good things in her current life, including the fact that she is a lovable person and could have love and attention from her husband as a woman rather than as a hurting child.

Table 3 gives an indication of the process of skill acquisition that PM experienced during her acute course of PST-PC. According to the problem-solving skill checklist,

Table 3. PST-PC Strategies Used

	First PST Session (Week 6)	Fourth PST Session (Week 9)	Eighth PST Session (Week 15)	Last Session (Week 57)
When my first efforts to solve a problem fail, I know if I persist and do not give up, I will eventually find a good solution.	2[a]	2	3	4
When I am trying to solve a problem, I get so upset that I cannot think clearly.	4	3	1	0
When I have a decision to make, I weigh the consequences of each option and compare them against each other.	0	3	3	3
When I am attempting to solve a problem, I go with the first good idea that comes to mind.	4	0	0	0
When a problem occurs in my life, I put off trying to solve it for as long as possible.	4	3	3	0

[a]*Key:* 0 = not at all true of me; 1 = slightly true of me; 2 = moderately true; of me; 3 = very true of me; 4 = extremely true of me

her initial learning occurred in the areas of weighing the pros and cons of various options rather than going with the first idea that came to her mind. This was apparent in her ability to generate more solutions with greater ease. She also analyzed solutions more openly and showed a greater awareness of positive and negative consequences.

By session 8, PM also had increased confidence in her ability to solve problems. This was evident by her discussion of long-standing problems and emotional reactions that had affected her all her life. She reported being less upset when a problem arose and she could think more clearly. Her work on difficult lifelong behavior patterns and seeing change in them helped improve her sense of self-efficacy. Around this same time she completed a consumer satisfaction card in her primary care clinic that included the following comment about her PST-PC therapist: "She kept me in the present with problem solving and made me see myself by constantly encouraging me to stay in the present."

Maintenance PST-PC Sessions

PM's progress was followed over the next 40 weeks through monthly maintenance sessions. During this time, PM continued to use her problem-solving skills independently. She had eight monthly follow-up sessions to maintain and build on her new skills and continued to follow up on problems that had been discussed earlier, such as her rejection sensitivity and interpersonal skills. She also occasionally presented a problem-solving worksheet to discuss how she independently solved a new problem. During this maintenance period, her PHQ-9 scores remained low, indicating only mild depressive symptoms. Her only residual depressive symptoms were overeating and fatigue. PM's husband verified her improvement.

By the end of the year of treatment, PM demonstrated that her new skills were well established and she was no longer putting off problems. Her statements included, "I know it works," and "Finding solutions became a part of me." When she had an exacerbation of fibromyalgia, she stated, "I know it will get better." She also found that the structure of the PST-PC sessions helped her stay on task so there would be resolution of problems, stating, "You made me work it."

PM also reported an improved relationship with her husband following her treatment. Through problem solving, PM learned that to get the support she wanted from her husband, she needed to tell him her expectations. Her husband corroborated that she no longer expected him automatically to know her needs, was less angry, and dealt with frustration better than before treatment. He said she "handles everything that comes her way without flying off the handle."

Nursing Implications

The IMPACT model uses a nurse in a primary care clinic to coordinate care and provide PST-PC. A psychiatric nurse clinical specialist or psychiatric nurse practitioner is well prepared for this collaborative care role. Nurses have a solid background in medication management and often provide education regarding medications and their side effects. The nurse's background education is especially important in understanding this older population that has many co-morbid medical illnesses. The PST-PC model for therapy has similarities to the problem-solving aspects of the nursing process; nurses could apply this knowledge to using PST-PC in therapy with patients.

Nurses also could choose to use PST-PC in private practice, a psychiatric clinic, or hospital. PST-PC is being use with positive results with patients ages 18 and up in a managed care primary care clinic. Nezu, Nezu, and Perri (1990) developed a 10-session problem-solving therapy model called social problem solving to be used in outpatient mental health clinics. PST-PC provides here-and-now help and skill building for patients, which will help them cope with new problems as they arise. This model helps augment the time spent in therapy sessions and amplifies the primary care physician's care of the patient. This would be a selling point to all payers—HMOs, other health insurances, and private pay patients. There may be reimbursement issues for implementing this model depending on the medical care system and state or federal requirements.

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Although the information presented here is not the final word on the effectiveness of combined treatment of depression in primary care, it does illustrate the feasibility and potential effectiveness of this approach to treating chronic recurrent depression in older primary care patients.

Conclusion

This case study illustrates the utility and feasibility of the combination of antidepressant medication and PST-PC, a brief structured psychotherapy, in the management of chronic depression in older primary care patients. Until now, older adults like PM who have complicated courses of depression were generally excluded from treatment trials for depression, often because of co-morbid medical illness or because of apparent Axis II pathology (Barrett et al., 2001; Williams et al., 2000). This case illustrates how treatment of complicated cases need not be automatically referred to specialty mental health care, but can be managed in primary care settings if appropriate treatment resources are available. Despite her long-standing and complex interpersonal problems, PM experienced significant improvement with a combination of antidepressant medication and eight sessions of PST-PC. Most notably, her treatment gains persisted after one year.

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