

COGNITIVE BEHAVIOR THERAPY WITH OLDER ADULTS

Innovations Across Care Settings

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Integrated Depression Care for
Homebound Medically Ill Older Adults:
Using Evidence-Based
Problem-Solving Therapy

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The shift in demographics of American society has received a great deal of attention in recent years. Where once they reflected a small percentage of the census, older adults are now the fastest growing sector of the population in the United States. Older adults are likely to have relatively longer life spans given advances in medical treatments and public health efforts for healthier aging lifestyles. Consequently, the health and mental health care systems of care will be especially relied on by current and future older generations. This will place increased stress on such services. With the aging-boom effect, the overall number of older persons with mental disorders, particularly mood disorders, will also increase. With a dearth of geriatric professionals, a public health crisis looms. It is estimated that 60,000 to 70,000 geriatric social workers will be needed by 2020, yet less than 10% of that projected number is now available (Council on Social Work Education, 2001). Geriatric mental health problems will also demand more attention from service providers to minimize their effects on disability, health care utilization, and quality of life of older adults and their caregivers. As such, the need for accessible and quality mental health care for medically ill and disabled older persons is and will continue to be significant.

Policy initiatives for home and community-based services (HCBS) have expanded over the past decade because of the need for care coordination (American Association of Retired Persons [AARP], 2009). Such initiatives are established because older adults are challenged by the co-occurrence of health and mental health problems. The provision of effective HCBS has enabled many older people to remain in their

home rather than be admitted to institutions. In fact, most older adults age 50 and older wish to remain in their own homes and not transition to a care facility (AARP). Home-based services can contribute to improve quality of life by providing health and mental health services, and assistance with activities of daily living and other supportive services. There is evidence that HCBS can contain institutional costs, moderate the growth of Medicaid spending, and reduce nursing home facility admissions (Cheh, 2001; Federal Register, 2000; Government Accountability Office, 1994; Medicare Payment Advisory Commission, 2003; Mollica & Kassner, 2009). One such example of home-based services for older adults is the home health care (HHC) sector.

SIGNIFICANCE OF DEPRESSION IN MEDICALLY ILL OLDER ADULTS

The 2008 Institute of Medicine report, "Retooling for an Aging America," noted that for the older adult population, depression was identified as one of the priority conditions requiring substantial improvements in quality care based on its prevalence, expense, and policy relevance (Institute of Medicine, 2008). The 1999 Surgeon General's mental health report also noted that "depression in older adults not only causes distress and suffering but also leads to impairments in physical, mental, and social functioning" (U.S. Department of Health and Human Services, 1999, Chapter 5, p. 1).

Prevalence estimates of current major depression in elderly community range from 1% to 3% (Kessler et al., 2003). However, the prevalence is much higher in medical and treatment settings: 5% to 10% in primary care (Hybels & Blazer, 2003; Tai-Seale, et al., 2005), 14% in HHC (Bruce et al., 2002), and 24% in long-term care (Hyer, Carpenter, Bishmann, & Wu, 2005). Moreover, depression is twice as prevalent in the HHC setting as in primary care (Brown, Kaiser, & Gellis, 2008) and disproportionately higher than reported prevalence studies of community-dwelling older adults (Kessler et al.). Despite these high rates, evidence suggests that few depressed home care older adults receive adequate treatment, even though effective treatment options for depression exist (Brown, McAvay, Raue, Moses, & Bruce, 2003; Gellis, 2009).

Subthreshold depression (SD) is even more prevalent than major depression and ranges from 16% to 28% depending on the definition (SD) and the number of symptoms (Lyness, 2008). Our research group has estimated a prevalence rate of SD at 16% in a sample

($N = 289$) of older adults (age ≥ 65) receiving skilled nursing care from an acute HHC agency in New York state (Gellis, 2010). Among these medically ill older patients, depression was also characterized by symptoms (e.g., anhedonia and suicidal ideation) associated with negative outcomes. Given the expected growth of older adults coping with chronic illness and disability, the consequences of late-life depression and low rates of treatment (Wei, Sambamoorthi, Olfson, Walkup, & Crystal, 2005), improving the mental health care of homebound older adults is a priority.

A core service strategy in response to this challenge is the identification and implementation of effective interventions to enhance depression care and treatment for older adults (National Institute of Mental Health, 2006). The U.S. Preventive Services Task Force recommends screening for depression in adults if there is a mechanism in place for adequate assessment, treatment, and follow-up (Pignone et al., 2002). Home care is well positioned to provide such a system because of its mission of community-based health care to medically ill older patients.

BARRIERS TO DEPRESSION CARE FOR MEDICALLY ILL OLDER ADULTS

HHC serves some of the oldest and most isolated medically ill patients in the community. Studies have found that mobility limitations along with other disabilities are significant predictors of depressive symptoms (Beekman, Deeg, Braam, Smit, & van Tilburg, 1997; Raue et al., 2003). During medical appointments, primary care physicians (PCP) spend little time discussing or detecting mental health problems with their older patients and rarely refer them to a mental health specialist even if they exhibit symptoms of depression (Tai-Seale, McGuire, Colenda, Rosen, & Cook, 2007). HHC nurses who are responsible for the initial patient assessment may not have the formal training needed to accurately identify depression (Brown, Kaiser, & Gellis, 2008), and without recognizing depression, nurses will not be able to make appropriate referrals to home care social workers, PCPs, or external mental health services, thus depriving older patients of access to needed treatment services. Interviews with home care nurses and social workers and review of medical records indicate that depression is frequently undetected, placing the depressed medically ill home care older adult at high risk for negative mental and physical outcomes (Bruce et al., 2002; Gellis, McGinty, Horowitz, Bruce, & Misener, 2007).

FACTORS ASSOCIATED WITH POOR ACCESS TO GERIATRIC DEPRESSION TREATMENT

The problem of inadequate detection and treatment for depression in medically ill older adult is compounded by several sets of factors. First, patient factors include behaviors resulting from symptoms of depressive illness. Older home care patients often have intricate medical needs that may obscure depression detection. In addition, stigma, amotivation and pessimism, distrust, avolition, financial worries, and fear of losing independence may reduce an older person's willingness to seek mental health care when depression is detected. Finally, for homebound medically ill older persons, a lack of social support and transportation may also impede access to mental health care.

Second, provider factors are known to create barriers to effective mental health care and lead to underdetection and/or undertreatment of depressed medically ill older adult (Zeltzer & Kohn, 2006). HHC workers are constrained by time-consuming mandated assessment forms and may not be able or willing to devote additional time needed to gather appropriate history for older depressed patients. Knowledge and skill deficits in mental health care frequently discourage home care workers from assessing depression. Providers may also be uncomfortable in dealing with depressed patients because of preconceptions and biases about mental illness (Brown et al., 2003).

Finally, organizational factors may impede appropriate depression care. In HHC agencies, patient care is typically conducted without on-site supervision by PCPs. Likewise, home care nurses have little direct contact with patients' physicians. Sometimes, older adults do not receive appropriate depression care even when they are positively screened or do seek help (Gellis, 2010; Wei et al., 2005). PCPs often report feeling pressured for time to investigate all medical problems (Adelman, Greene, Friedmann, & Cook, 2008). In primary care, financial constraints of managed care are increasingly restricting the time spent with older patients, forcing psychiatric concerns to compete with comorbid medical conditions (Gallo et al., 2002).

COMMUNITY-BASED HOME CARE SERVICE DELIVERY OF INTEGRATED DEPRESSION CARE

HHC is a diverse and dynamic health service industry that annually serves approximately 7.6 million individuals by 83,000 providers, for acute illness, chronic medical conditions, and disability (U.S. Census

Bureau, 2004). Of these recipients, 86% are 65 years or older and approximately 64% are female (Center for Medicare & Medicaid Services, 2008). Medicare is the largest single payer of the annual \$57.6 billion in HHC services and is a key component of the Medicare wellness agenda because it significantly lowers overall health care costs by treating patients in the community rather than more expensive venues like hospitals, emergency departments, or nursing homes (Center for Medicare & Medicaid Services, 2008; Marmor, 2000).

HHC agencies use a structured and centralized organizational system to support the provision of Medicare-certified skilled nursing care and ancillary services in the patient's home, including social work, physical, occupational and speech therapies, nutrition, and home aides. Usually, patients are discharged from acute care hospital or referred by primary care to home health. The responsibility for care, however, is highly decentralized and remains with the patient's physician who often does not meet with the home care nurse or other providers and has never been to the agency (Figure 13.1). PCPs refer patients needing HHC to an agency that assigns a nurse who travels to the patient's home, completes a Medicare (Outcomes Assessment and Information Set) form, and develops a plan of care. Based on the intake assessment, the home care nurse can recommend internal home care social work services for depression treatment, patient or family/caregiver counseling, financial and housing issues, and services information and referral. Most patients (85%) are referred to home care for medical or

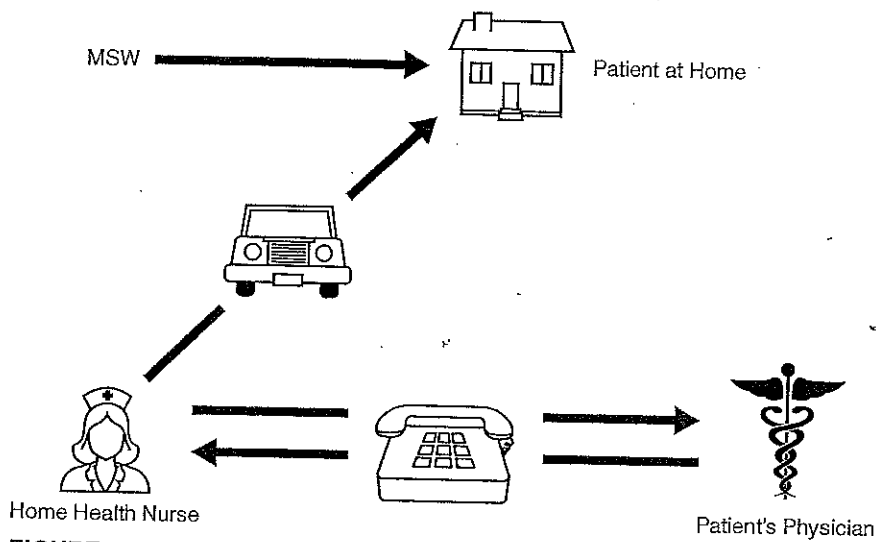


FIGURE 13.1 Home Care Service Structure

postsurgical needs for which they receive skilled nursing care. Mental health services are rarely provided to medically ill older adults identified with depression while receiving care (Brown et al., 2003, 2008). Home care nurses frequently do not refer depressed patients to primary care, but when they do, there is little to no further contact with the physician about the patient's clinical status or antidepressant treatment monitoring.

CLINICAL SOCIAL WORK ROLE FOR GERIATRIC DEPRESSION TREATMENT

Clinical social workers play a critical role in the HHC system by providing expertise in navigating complex systems of care—be those psychological, social, medical, or economic. Within home care settings, social workers provide brief psychotherapy, care coordination, family and caregiver counseling, information and referral for community social services, and financial and housing issues. Effective evidence-based social work practice that expedites the mental health care of home care patients and reduces negative outcomes is highly valued in the managed-care context. Our teams' problem-solving therapy (PST) research focus is targeted to integrating the depression care functions in home health and using the varied skills of the clinical social worker within the HHC organization to create a more synergistic and effective system of depression care that is sustainable. With additional training in PST as a depression treatment, home care social workers are uniquely positioned to provide depression care for medically ill older adults and thus bridge the divide between patient, home health, and primary care settings.

PSYCHOTHERAPY IS A VIABLE DEPRESSION TREATMENT FOR OLDER ADULTS

Psychosocial treatments, including problem-solving, cognitive behavioral, and interpersonal therapies, have demonstrated effectiveness among depressed older adults, particularly those who reject medication or who are not managing their daily living problems, not coping well with chronic medical conditions, or who are experiencing limited social support (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002; Gellis & Bruce, 2009; Gellis & Kenaley, 2008). PCPs, who are often the principal source of medical care for depressed older adults, tend to rely on

antidepressant medications as the main treatment for late-life depression and are significantly less likely to refer older patients to specialty mental health services (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003; Wei et al., 2005). However, older adults have reported a preference of psychotherapy over pharmacotherapy for their depression treatment (Gum et al., 2006; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001; Lundervold & Lewin, 1990). Our research group uses a home-based brief therapy—PST—as a key component of depression care for medically ill older adults because of the fast-paced nature of acute HHC service delivery. Based on our research, brief PST is feasible and acceptable to depressed older adults who are recipients of home care services (Gellis et al., 2007, 2008; Gellis & Bruce).

PROBLEM-SOLVING THERAPY MODEL FOR MEDICALLY ILL HOME HEALTH CARE OLDER ADULTS

PST is an evidenced-based, cognitive-behavioral clinical intervention, based on research demonstrating a strong link between social problem solving (SPS) and psychopathology (Nezu, 2004). The overarching treatment goal of PST is to foster adoption and implementation of adaptive problem-solving attitudes and behaviors as a means of decreasing emotional distress and improving overall quality of life (D'Zurilla & Nezu, 2007; Nezu, Nezu, & D'Zurilla, 2007). Originally developed by D'Zurilla and Goldfried (1971), Nezu and his colleagues (Nezu, 1987; Nezu, Nezu, & Perri, 1989) revised and adapted PST for the treatment of major depression. Early studies by Nezu and colleagues (e.g., Nezu, 1986; Nezu & Perri, 1989) established PST as an effective approach for the treatment of major depressive disorder (MDD). Subsequent research has found PST to be effective for the treatment of MDD in primary care settings (e.g., Mynors-Wallis, Gath, Davies, Gray, & Barbour, 1997), as well as for individuals with a medical illness, such as cancer (e.g., Nezu, Nezu, Felgoise, McClure, & Houts, 2003) or diabetes (e.g., Williams et al., 2004) that was concomitant with clinical depression. In fact, two recent meta-analyses provide significant quantitative support for the efficacy of this approach for reducing depression (Bell & D'Zurilla, 2009; Cuijpers, van Straten, & Warmerdam, 2007). With specific relevance to this chapter, PST has also been adapted to treat depression among older adults (e.g., Areán et al., 1993) and has consistently found to be effective for this population (e.g., Ciechanowski et al., 2004), including depressed older adult patients with executive functioning difficulties (Alexopoulos, Raue, & Areán, 2003).

PST helps to reduce depression by increasing an individual's optimism, self-efficacy, and skill levels in effectively coping with stressful problems. In addition, it focuses on a more realistic (as compared to catastrophic) appraisal and evaluation of specific daily living problems linked to depression, as well as developing and choosing the best possible solution alternatives and implementing such action plans to solve these problems. PST can also address anhedonia and psychomotor retardation through increased exposure to daily pleasurable activities (behavioral activation). Scheduling and implementation of daily pleasurable activities can be used as a pathway to problem-solving strategies and skills. PST that is integrated into routine home care practice and delivered by staff social workers is a practical option in the treatment of moderate-to-severe depression in older adults. Within our integrated depression care model, it is imperative to coordinate depression care management with PCPs to facilitate assessment of the older patient for antidepressant therapy because medication is known to be an effective treatment for depression.

Thus, we use PST depression treatment because of its conceptual relevance to medically ill older adults, its robust evidence base (Cuijpers, van Straten, & Smit, 2006; D'Zurilla & Nezu, 2001; Gellis & Kenaley, 2008) including our empirical work with community-dwelling and medically ill older adults, its brevity, and its acceptability to depressed patients and to HHC agencies.

PROBLEM-SOLVING CONCEPTUAL FRAMEWORK.

PST for depression is based on a model of depression that characterizes SPS as serving both mediating (e.g., Kant, D'Zurilla, & Maydeu-Olivares, 1997; Nezu & Ronan, 1985) and moderating (e.g., Nezu, Nezu, Saraydarian, Kalmar, & Ronan, 1986; Nezu & Ronan, 1988) roles regarding the relationship between stressful life events and depression. SPS is the multidimensional psychosocial variable that has been repeatedly identified as an important factor in the pathogenesis of both mental health and health problems resulting from poor adaptation to stress (Elliott, Grant, & Miller, 2004; Nezu, 2004). More specifically, SPS has been defined as the cognitive-behavioral process by which a person attempts to identify or discover effective or adaptive means of coping with stressful problems encountered during the course of everyday living (D'Zurilla & Nezu, 2007). In this context, it involves the process whereby individuals attempt to direct their coping efforts at altering the problematic nature of a stressful situation itself, their reactions to

such situations, or both. SPS refers more to the meta-process of understanding, appraising, and adapting to stressful life events, such as those related to the experience of a chronic illness, rather than representing a singular coping strategy or activity (Nezu & Nezu, 2010).

Contemporary models of SPS indicate that it is comprised of two general, but partially independent, processes: problem orientation and problem-solving style (D'Zurilla, Nezu, & Maydeu-Olivares, 2004). *Problem orientation* involves the set of generalized appraisals and emotional reactions concerning problems in living, as well as one's ability to successfully resolve them. It can either be *positive* (e.g., viewing problems as opportunities to benefit in some way, perceiving oneself as able to solve problems effectively), which serves to enhance subsequent problem-solving efforts, or *negative* (e.g., viewing problems as a major threat to one's well-being, overreacting emotionally when problems occur), which functions to inhibit attempts to solve problems.

Problem-solving style refers to specific cognitive-behavioral activities aimed at coping with stressful problems. It can be either adaptive, leading to successful problem resolution, or dysfunctional, leading to negative consequences, such as emotional distress. *Rational problem solving* is the constructive style geared to identify an effective solution to the problem and involves the systematic application of various specific problem-solving tasks. It includes accurately identifying obstacles that need to be overcome to achieve reasonable goals, generating alternative solutions to cope with such difficult problems, making effective decisions regarding which coping strategies to engage in, and monitoring the consequences of one's coping attempts to determine the need to engage in additional problem solving. Dysfunctional problem-solving styles include (a) *impulsivity/carelessness* (i.e., the tendency to engage in impulsive, hurried, and/or incomplete attempts to solve a problem); and (b) *avoidance* (i.e., the tendency to avoid problems, procrastinate, and/or depend on others to solve one's problems).

This problem-solving conceptualization suggests that depression can result as a function of deficiencies, or decreased effectiveness, in these problem orientation and problem-solving style dimensions (Nezu, 1987, 2004; Nezu & Nezu, in press). For example, depressed individuals are often characterized by a strong negative orientation, having little faith in their ability to cope with stressful problems, often believing that problems are catastrophes, frequently blaming themselves for causing the problem, and becoming distressed when problems occur. Collectively, negative beliefs decrease one's desire or motivation to engage in any meaningful coping attempts. One's ability to effectively define and formulate problems and to set realistic goals is also decreased when

depressed, thus making it very difficult to identify effective solutions. Often, depressed individuals set unrealistically high goals—when not achieved, self-blame, frustration, and decreased motivation are likely to occur. Depressed individuals also tend to generate both fewer and less effective alternatives to problem situations. A negative problem orientation and lack of alternatives biases the depressed person to selectively attend to negative versus positive events and to immediate versus long-term consequences. The depressed individual may also have difficulty actually carrying out his or her plan because of specific behavioral and social skill deficits. Further, a negative problem orientation may impact on an individual's ability to be objective about the outcome of solution implementation. Thus, the depressed individual is unsatisfied with the coping attempt and may feel that the goals have not been achieved. In addition, poor problem solving has been found to be related to feelings of hopelessness and suicidal intent (D'Zurilla, Chang, Nottingham, & Faccini, 1998; Rudd, Rajab, & Dahm, 1994).

PST, then, is geared to teach older adults specific skills to (a) enhance their positive problem orientation, (b) decrease their negative orientation, (c) improve their rational problem-solving ability, (d) decrease their tendency to be avoidant, and (e) minimize their tendency to be impulsive and careless when attempting to cope with stressful problems in living. In addition, we believe that the PST model works for medically ill older adults because it specifically targets the skills of solving daily living problems and self-efficacy. Through modeling and reinforcement of cognitive and behavioral skills, PST can also increase older adults' sense of self-competence and self-efficacy in taking responsibility for day-to-day management of their illnesses and for reducing and minimizing the negative emotional and physical effects of their medical problems. Improved problem-solving and coping skills along with resulting self-efficacy are potential active components thus likely to buffer against the effect of risk factors on depression. Strengthening self-efficacy by allowing older individuals the experience of successfully dealing with and thus overcoming specific problems can be a primary strategy for preventing and reducing late-life depression.

PROBLEM-SOLVING THERAPY IN HOME CARE INTERVENTION COMPONENTS

PST in Home Care (PST-HC) is based on PST procedures for depression recently revised and updated (e.g., Nezu et al., 2007) and conducted by master of social work (MSW)-level clinical social workers (Gellis et al.,

2007, 2008). Standard PST (i.e., Attitude, Define, Alternatives, Predict, Try out [ADAPT] model of Nezu et al., 2007) was modified in several ways to increase its feasibility for homebound patients and to meet their needs living with one or more medical illnesses. First, treatment was provided in the patient's home. Second, PST was provided in six weekly 1-hour sessions conducted usually over an 8-week period. The clinical social work PST therapists were directed to ensure that the intervention protocol be made brief and relevant to the specific life circumstances of each homebound medically ill older adult patient. Educational brochures on the topics of "late-life depression" and "improving one's quality of life" were used in the PST sessions.

PST-HC involved teaching depressed older adults to (a) clearly define the nature of their daily living problem and develop a realistic goal to improve coping ability, (b) generate a wide range of alternative solutions, (c) systematically evaluate the potential consequences of each solution examining the advantages and disadvantages of each potential solution option, (d) select the optimal one to implement based on decision criteria (effort, realistic, cost, achievability), and (e) monitor and evaluate an actual solution outcome after its implementation. Table 13.1 provides an outline of the PST-HC therapy session skills sets and content for medically ill home care older adults.

An important component of PST is preparing the older adult for depression treatment. The PST therapist advocates with the older person for a positive optimistic outlook or attitude toward solving daily stressful problems (cf. Nezu & D'Zurilla, 1989). As PST is a brief treatment for depression, patients are also informed that they are being referred, when warranted, to their PCPs for antidepressant medication assessment. Psychoeducation on depression and the basics of solving daily problems are provided in the initial session but may also be reviewed over the duration of therapy as needed. Synthesized research data are provided by the therapist to inform the patient on what is known about the causes of depression, depressive symptom profiles, effective treatments, and its links to problem solving and behavioral activation.

Sessions 1 and 2 involve a general introduction, structure, and orientation to the PST therapy that includes developing a positive attitude toward solving one's problems, problem identification and establishing a realistic measurable goal, brainstorming and evaluating solution options, and trying out a solution. Sessions 3 and 4 involve continued psychoeducation and practice in the problem-solving skills. The last two sessions provide for an applied integration of the PST model, as well as for continued practice in the various problem-solving

TABLE 13.1 Problem-Solving Therapy in Home Care (PST-HC)

Session	Content
1 Adopt Positive Attitude <i>Skill Set:</i> Identify problems Develop goals	Orient and introduce problem-solving therapy for depression in home care (adopt positive attitude toward problem solving); explain connections between daily problems, stress, mood, and pleasurable events; review causes, symptoms, medications, and treatments for depression; identify and define nature of stressful problems in daily living; identify patient-coping responses; set realistic goal for relief of problem; orient to choose two pleasurable activities (daily scheduling); set homework activity; obtain permission to contact and update primary care physician; have a brief telephone contact with the patient during the week as a reminder to complete homework and pleasurable activities.
2 <i>Skill Set:</i> Brainstorm alternative solutions	Review homework; review log of pleasurable activities; review symptoms; review coping responses to problem; identify problem-solving style; review goals; generate many alternative solutions; identify/choose one or two solutions based on the following criteria: realistic, achievable, cost, effort (predict outcome effectiveness and consequences); instruct patient to try out chosen solutions with action plan and monitor outcome; troubleshoot any difficulties; set homework; choose/schedule two pleasurable activities each day; have a brief telephone contact during the week as a reminder to complete homework and pleasurable activities.
3 <i>Skill Set:</i> Review advantages (pros) and disadvantages (cons)	Review homework; review performance outcome for chosen solution; teach patient to reward self for efforts in attempted problem solving; review log of pleasurable activities; review symptoms; review goal and alternative solutions if solution was less than successful, or examine new problem and renew goals; brainstorm alternative solutions; choose one or two solutions (predict consequences: pros/cons); try solutions with action plan, monitor, and evaluate outcome; troubleshoot any difficulties; set homework; choose two pleasurable activities; have a brief telephone contact during the week for homework reminder; review patient progress with assigned home care provider.
4 <i>Skill Set:</i> Decide and choose solution(s)	Review homework; review performance outcome for chosen solution; patient rewards self for efforts in attempted problem solving; review log of pleasurable activities; review symptoms; review goal if solution was less than successful, or examine new problem and renew goals; generate alternative solutions; choose a solution (predict consequences) based on the following criteria: realistic, achievable, cost, effort; try solution with action plan; monitor and evaluate outcome; set homework; troubleshoot any difficulties; choose two pleasurable activities; have a brief telephone contact during the week as a reminder to complete homework and pleasurable activities.

(Continued)

TABLE 13.1 Problem-Solving Therapy in Home Care (PST-HC) (Continued)

Session	Content
5 <i>Skill Set:</i> Try out chosen solution(s) action plan monitor	Review homework; review performance outcome for chosen solution; patient rewards self for efforts in attempted problem solving; review log of pleasurable activities; review symptoms; review goal if solution was less than successful, or examine new problem and renew goals; generate alternative solutions; choose a solution (predict consequences); try solution with action plan, monitor, and evaluate outcome; set homework; troubleshoot any difficulties; choose two pleasurable activities; prepare patient for clinical termination; review PST-HC steps; have a brief telephone contact during the week for homework reminder; review patient progress with home care provider
6 <i>Skill Set:</i> Evaluate review skills closure	Review homework; review performance outcome for chosen solution; patient rewards self for efforts; review log of pleasurable activities; review symptoms; review goal if solution was less than successful, or examine new problem and renew goals; generate alternative solutions; choose a solution (predict consequences); try solution with action plan; monitor and evaluate outcome; set homework; troubleshoot any difficulties; choose two pleasurable activities; clinical termination with patient; review PST-HC steps and wrap-up; review progress with patient and home care provider

skill components. The PST therapist uses a PST worksheet in each session as a guide to cover the problem-solving skills sets delineated in Table 13.1 with the older patient. The PST therapist completes the worksheet based on the patient's assessed needs for the week. Interviews with PST therapists in training indicate that the worksheet helped the trainee to maintain session structure and as a way for the older patient to learn the problem-solving steps needed to try out identified realistic solutions on a weekly basis.

CASE EXAMPLE 1: MRS. MARGOLIS

Mrs. Margolis, age 77, has lived alone in her own home for 4 years since her husband's death. She has diabetes and osteoarthritis. Recently, she was hospitalized for a fall. She has in-home nursing for diabetes disease management, and physical therapy for balance and walking exercise. She spends most of her time in her bedroom or in front of the TV, and most days, her only human contact is the home care service. She has a daughter in another city who calls her a couple of times a month. Mrs. M. says she is lonely, but does not initiate any contact with her family or neighbors. Mrs. M. is aware that she needs a homemaker service for house cleaning and meal preparation; she

talks with a home care nurse about her needs. However, Mrs. M. comes up with many reasons not to follow through. Her primary concern is money. She believes that her depressed mood and lack of interest is caused by her health problems, and she refuses to take medication. She is inclined, though, to try to talk with a social worker for her depression, but does not want to be in a group with older people and does not have means of transportation to get to therapy.

To identify stressful life problems, the PST therapist uses a *Problem List Form*, adapted for HHC older adult patients. For example, in Case 1, numerous problems are identified and the PST therapist uses the problem list form (see sample in Table 13.2) and prioritizes which problem to start with based on current expressed needs. This form delineates various older patient problem domains: (a) personal health, health care system/providers; (b) emotional or psychological; (c) finances; (d) living arrangements; (e) transportation; (f) relationships; (g) activities of daily living; (h) house management; and (i) socialization. Sufficient time is offered by the PST therapist to uncover the patient's problems and to develop a priority list (based on the older adult's needs) of problems to tackle and solve over six sessions. One important issue is that PST therapists are taught to distinguish between short- and long-term problems and concomitant solutions that may start to be used in therapy and continued posttherapy. One of the primary goals of the therapy is to teach the older person the necessary problem-solving skills to deal with daily life stresses in a rational and planned way to prevent depressive symptoms from reoccurring.

As mentioned, the PST therapist uses the *Problem List Form* to identify all current problems experienced by the older patient and the reason for referral. The therapist itemizes the type of problems reported by the older patient into identified life stress domains (described earlier). Many of the problems identified by older adults are related to their chronic medical conditions and symptoms of depression. The PST therapist uses a reflective nondirective style to engage the older patient and develop therapeutic alliance as well as a directive approach to engage in problem resolution. To ascertain the nature and extent of the problems identified, the therapist orients the older patient to the importance of developing a positive attitude toward solving his or her problems. The therapist gains insight into the problems identified by asking the five W questions (who, what, where, when, and why) for the older patient to gain awareness of why a certain problem persists. The PST therapist identifies the patient's problem-solving coping style using items from the Social Problem

TABLE 13.2 PENN-PST Problem List Form

Case Example: Mrs. Margolis <i>TIP: This worksheet is for the therapist to use during assessment.</i>
<i>Problems With Health Problems, Health Care, Obstacles:</i> Patient is concerned about falling, has numerous health problems, and refuses to take antidepressant medication.
<i>Problems With Emotional/Psychological, Loneliness, Isolation, etc.:</i> Patient has little contact with others; isolated.
<i>Problems With Money And Finances:</i> Patient stated that she is worried about her financial status.
<i>Problems With Living Arrangements:</i> She is living alone while her daughter lives in another city; they have some telephone contact.
<i>Problems With Transportation:</i> None, according to the patient.
<i>Problems With Relationships:</i> <input checked="" type="checkbox"/> Spouse or partner: <input checked="" type="checkbox"/> Family members: children, grandchildren, other family members <input checked="" type="checkbox"/> Friends, Other: Unknown
<i>Problems With Doing Activities Around The House:</i> The patient needs assistance with house cleaning.
<i>Problems With ADLs: Shopping, Cooking, Bathing, Taking Meds, Grooming, Dressing, Walking, etc.</i> The patient needs assistance with meal preparation.
<i>Problems In Coping With Stress</i>

Note. ADLs = activities of daily living.

Solving Inventory (SPSI; D'Zurilla, Nezu, & Maydeu-Olivares, 2002) to understand past coping attempts to resolve problems that may have been ineffective.

The PST therapist uses the *Session Worksheet* (Figure 13.2) for every session to document the steps that the patient is learning to use in solving problems. The PST therapist helps the older patient rate problems from highest to lowest priority. The patient is then asked to choose a priority problem that he or she would like to solve, and then a short-term goal is developed with the provision that it must be realistic and measurable. Once these tasks are completed, the older patient is oriented to the skill of freely "brainstorming" alternative solutions to solve the identified problem without judging each solution option during this phase. Once the older patient has completed this phase, the PST therapist directs the patient to examine each potential solution

Name:	Homework Review from Previous Session	
Date:	<u>Depression Score:</u>	<u>Pleasant Activity Level Score (PALS):</u>
Session #:	20–27 ...	Severe HOW PLEASANT, ENJOYABLE, OR REWARDING was the activity?
	15–19 ...	Moderately severe
	10–14 ...	Moderate 0 This was not pleasurable.
	5–9	Mild 1 This was somewhat pleasurable.
	1–4	Minimal 2 This was pleasurable.
	3	This was very pleasurable.

PENN-PST SESSION WORKSHEET	
S1. Socialize and orient to problem solving (positive attitude)	
S2. Problem identified in session:	
S2a. Specify goal (realistic, measurable):	
S3. Brainstorm solutions (to the identified problem below)	S4a. Evaluate each solution option (based on effort, time needed, achievable, etc.)

	Pros <input checked="" type="checkbox"/> (advantages)	Cons <input checked="" type="checkbox"/> (disadvantages)
1. Solution Option 1	1	1
2. Solution Option 2	2	2
3. Solution Option 3	3	3
4. Solution Option 4	4	4
5. Solution Option 5 etc.	5	5

S4b. Choose Solution (based on S4a evaluation)	S5. Steps To Achieve Solution (reduce barriers)	Try Out Solution/ Evaluate Outcome

<p>Homework/Activity Schedule for the Week:</p> <p>Pleasant activities:</p> <p>Solution(s) to try out:</p> <p>Use of coping cards, positive statements, stop-and-think rule, and so forth, as examples</p>

FIGURE 13.2 PENN-PST Session Worksheet

option for its advantages (Pros) and disadvantages (Cons) on the PST worksheet. This process assists the patient in shaping decisions about the solution options based on several decision-making criteria: (a) Is the solution option realistic? (b) Is the solution option achievable (i.e., Can I do it)? (c) How much effort do I have to expend? and (d) Is there an emotional or time cost? Based on the older patient's responses in the decision-making process, the patient can make an effective solution choice from the options list as an attempt to reach his or her goal and solve the identified problem.

During treatment sessions, emphasis is placed on psychoeducation about depression and scheduling pleasurable activities chosen from a list adapted for older adults based on the Pleasurable Events Schedule (MacPhillamy & Lewinsohn, 1982). Together, the PST therapist and the older patient develop a personal tailored list of pleasurable activities in each session as part of the weekly homework activity. The PST therapist encourages the older person to choose and complete one or two pleasurable activities each day until the next PST session. The pleasant activity scheduling builds on simple and graduated activities that target depressive symptoms.

The older patient is provided with a pleasant activities weekly scheduling form to keep track of type and frequency of activities. The older patient is asked to rate each completed activity using (developed for our studies) the PALS on a scale from 0 (*this was not pleasurable*) to 3 (*this was very pleasurable*) to reinforce behavioral activation. The PST therapist monitors and reviews the pleasant activity schedule in each session as part of the homework phase.

Finally, between-session homework assignments relevant to each problem-solving step are included as part of the therapeutic process. The older patient is encouraged to choose and try out a selected solution predicted to be realistic and achievable. A brief telephone call to the older patient in-between sessions is completed to support the therapeutic alliance and serves as a reminder to complete the homework—that is, trying out the chosen solution option and completing daily pleasurable activities itemized in the previous session.

PST therapists assess for late-life depressive symptoms at each session by administering the Patient Health Questionnaire-9 (PHQ-9) items (Spitzer, Kroenke, & Williams, 1999). The PST therapist completes this process because (a) it assists the therapist in tracking the treatment progress of the older patient; (b) it helps older patients monitor their own symptoms each week; (c) it provides a connection between how they feel and their level of pleasurable activity, thus counteracting anhedonia; (d) the PHQ-9 outcomes can be visually illustrated to the

client to interpret and explain progress; and (e) the process provides a way for older patients to take more control of their mood and engage in their recovery from depression.

PST therapists are asked to administer the interventions in a flexible manner, reviewing all skills for each patient but allocating different amounts of time, depending on the older person's needs. Flexibility is recommended in the use of terminology, mode of presentation, and homework format to fit individual difference in educational background, cognitive skills, and sensory capacity. PST therapists are encouraged to be flexible with the schedule of sessions to accommodate individual patient needs. Sessions are shortened or lengthened and scheduled around medical appointments based on patient needs and preferences.

COMMON PROBLEM-SOLVING THERAPY CHALLENGES

First Session: There are times when older patients pose challenges for the PST therapist, particularly in the first session. Older patients may deny the existence of depressive symptoms, suggest that the experienced symptoms are of a physical nature and caused by their illnesses, and they may not be able to see the interrelatedness of their physical and psychological symptoms. First, it is important to spend sufficient time in the first session to provide a rationale for PST and delineate the connections between the depressive symptoms, how one copes with daily stressors, and solving daily problems. It is important to spend sufficient time with the older patient listening to his or her issues and related daily problems while building therapeutic alliance. In addition, the therapist needs to expose the patient to the process of positive problem solving as part of developing a positive attitude toward problem resolution. This process is a component of the socialization of the patient to PST and attempts to instill hope in gaining control over one's quality of life. The therapist can also assess the patient's problem-solving coping skills using the revised SPSI. This will provide an understanding of the patient's problem-solving style and previous coping attempts of current and past daily problems.

Homework Compliance: Another problem that may arise is the completion of homework assignments. Tasks are provided to the patient at the end of the session as part of homework. PST therapists request that specific homework tasks be completed by the patient including (a) attempting a chosen solution to implement in real life, (b) evaluating the outcome, and (c) choosing and completing two pleasurable

activities daily until the next session. At times, patients will forget or lack the motivation to write down their evaluation of the outcome of their attempt at solving a problem, and instead, provide only oral feedback during a session on the outcome of the solution. Sometimes, assignments are unclear or are not sufficiently specific. There may also be unanticipated obstacles for the patient. At other times, the older patient may require assistance in reconfiguring the environment or arranging time to make it more favorable for homework completion. Telephone reminders between sessions are built into the therapy for maximum adherence. At other times, the therapist may be inconsistent in reviewing homework assignments. The review of previous homework should occur at the beginning of each session following the initial assessment session. In this way, the patient receives a message that adherence to homework completion is important to overall success in therapy and problem resolution. In such cases, it is recommended that the PST therapist spend sufficient time on the homework assignment and ask the patients to review and repeat their task prior to session termination. To increase homework adherence, the PST therapist or the patient can write down the tasks on a weekly homework form as a reminder. The forms should be in large print, identifying the steps to be taken for assessing the solution outcome, that is, (a) When and where will you try the solution? (b) How will you prepare yourself? (c) Will you need someone's help in completing the solution task? (d) Did the solution work in reaching the identified goal? (e) What do you think worked? (f) What didn't work? (g) What obstacles did you experience if any? (h) Was it difficult? (i) Did it require a lot of effort? In this way, the PST therapist helps the older patient to break down the components of the homework into manageable parts, and the patient has been empowered to help in the development and implementation of the homework task. The PST therapist can offer guidance in starting with small modest steps for success in reaching the stated goal. As the patient gains confidence in using the problem-solving steps, the PST therapist can adjust the pace to complement patient progress, thus reducing patient burden.

PROBLEM-SOLVING TREATMENT FIDELITY

Fidelity can assist to ascertain whether PST with depressed older adults can be provided as intended, and if increased treatment adherence to the procedures is related to a decrease in depressive symptoms. Our

PST training team collects information on treatment fidelity through various means, including audiotapes and live observations of sessions. We have developed a PST Therapist Fidelity Scale (PSTTFS) based on the work of Nezu et al. (2007) as seen in Figure 13.3. The fidelity scale covers all five components of the PST process and specific therapist tasks subsumed under each that would generally make for a high-quality session. Each component is observed and rated on a fidelity scale from 0 (*almost never*) to 4 (*almost always*), resulting in a global treatment fidelity score.

RESEARCH ON PROBLEM-SOLVING THERAPY FOR LATE-LIFE DEPRESSION IN MEDICALLY ILL OLDER PATIENTS

Several randomized controlled trials (RCTs) have tested PST on late-life depression outcomes among medically ill older adult recipients of HHC services. The first RCT in HHC compared the impact of PST-HC to usual care (UC) on outcomes of depression and secondary outcomes of problem-solving skills and quality of life (Gellis et al., 2007). Participants ($n = 40$) were older medically ill HHC patients receiving skilled nursing care in their homes because of various medical conditions (e.g., cardiovascular disease [CVD], diabetes, chronic obstructive pulmonary disease, cancer, hip replacement).

Our research team examined the feasibility, acceptability, and efficacy of PST-HC among isolated medically ill home care older adults. We trained home care nurses in depression screening, assessment, and referral of appropriate cases to an independent MSW-level social worker (i.e., PST therapist). The clinical social worker was trained and supervised in PST but not employed by the HHC agency. The PST therapist worked alongside a home care team comprised of nurses, social workers, physical therapists, and nurse supervisor. Communication with the PCP about the patient's depression level was provided by the assigned home care nurse.

PST treatment was provided to the experimental condition participants for 6 weeks as an augmentation to UC services, and included approximately 1 hour per session per week in the patient's home, plus a midweek telephone call for homework reminder. Participants in the UC condition were told that they would receive standard acute HHC services based on their primary medical diagnoses and a referral for antidepressant medication assessment to their PCP. The UC group also received literature on facts about depression and its treatment and was encouraged to review the material with the home care social

PENN - Problem-Solving Therapy Training Institute

PST Therapist Fidelity Scale

PST Session # 1 2 3 4 5 6 Booster

PST Therapist trainee ID Code: _____ Agency Site: _____

Client ID Code: _____ Date of PST Session: ____/____/____ Date of Rating: ____/____/____

For each item, assess the PST therapist's fidelity level on a scale from 0 to 4

0	1	2	3	4
Never (almost never)	Rarely	Sometimes	Frequently	Always (almost always)

PST Components: A.D.A.P.T.

1. ATTITUDE (Adopt a positive optimistic attitude towards solving problems)

- _____ Socialize client/patient to PST: Problem Orientation
- _____ Provide introductory statements
- _____ Provide definition of problem solving, coping with life stresses
- _____ Provide rationale for PST & depression
- _____ Review depression symptoms (PHQ-9) [Form]
- _____ Review depression brochure and pleasurable activity rationale

2. DEFINE--the problem

- _____ Develop a "Problem List" [Form]
- _____ Get facts about problem, ask W5 questions (what when where who why & how) in clear concrete terms
- _____ Identify 1-2 problem(s) to work on from problem list
- _____ Ask about past coping attempts
- _____ Determine Problem Solving style:
rationale, impulsive/carelessness, avoidance
- Establish a Realistic Goal**
- _____ Specify realistic, rational goal-determined by client/patient
- _____ Describe in objective, behavioral, measurable terms
- _____ Goal is achievable
- _____ Goal follows directly from identified problem

Notes

FIGURE 13.3 Problem-Solving Therapist Fidelity Scale

Notes

3. ALTERNATIVES (generate alternative solution options)

- _____ Prepare client for brainstorming technique [Form]
- _____ Generate alternative options list for solving problem
- _____ Withhold judgment now

4. PREDICT (predict the +ve and -ve consequences)

- _____ Evaluate list of solution alternatives: [Form]
- _____ Consider Pros [+] (advantages) & Cons [-] (disadvantages) for self/others on following criteria:
- realistic? time effort emotional cost effects on family or friends
- _____ Choose solution option(s) that has the best chance of achieving the desired goal while minimizing the costs and maximizing benefits

5. TRY OUT (implement chosen solution)

- _____ instruct client to try out solution in real life
- _____ develop action plan to evaluate the outcome
- _____ review homework tasks (write down homework) [Form]
 - (a) Go over client's list of pleasant activities
 - (b) Plan pleasant activity schedule for the week
 - (c) Action plan to implement & evaluate solution

Homework Tasks

- _____ Identify pleasant activities [Form]
- _____ Schedule Daily Activity Planning
- _____ Identify and Review Homework tasks [Form]
- _____ Review last session homework; solution(s); activities

Therapy Process Tasks

- _____ Summarize process at end of session
- _____ Ask client about their homework tasks
- _____ Remind client about homework
- _____ Remind client about telephone call during week

Non-Therapeutic Factors

- _____ empathic, caring, confident, professional
- _____ clear & positive communication
- _____ builds therapeutic alliance
- _____ uses reflective/directive style

PST Session Fidelity Rating _____

NOTES / QUESTIONS / SUGGESTIONS FOR DISCUSSION

FIGURE 13.3 Problem-Solving Therapist Fidelity Scale (Continued)

worker during a standard planned home care visit. To ensure patient safety, each UC participant was contacted by telephone during the first 2 weeks to assess the need for crisis management or a referral outside the protocol. No direct counseling was provided during these telephone calls, only minimal information. All PCPs involved, by virtue of their connection to older patients, received a study letter informing them that their patient was receiving PST psychosocial treatment for depression and that they were being referred for antidepressant assessment. Our study team also provided each patient's physician with American Psychiatric Association treatment guidelines for geriatric depression. All patients who completed PST-HC did so in six sessions, with an average duration of 7.1 weeks (SD: 0.71). All follow-up interviews were completed in the patient's home. PST interventionists received 2 weeks of PST training and weekly PST supervision.

Data were obtained at baseline, posttreatment, and 3 and 6 months on all 40 participants. Of the 40 patients, most were Whites (80%), female (85%), living alone in an apartment or their own home (60%), and most had at least three diagnosed medical conditions (55%). At baseline, patients had moderate-to-severe levels of depression (BDI: 29.85 ± 6.3 ; GDS: 14.27 ± 5.9). There was also no difference at baseline between the groups in functioning as measured by the Quality of Life Index (QoLI: 8.30 ± 1.92) or in problem-solving abilities (SPSI-R: 8.86 ± 1.70). Participants in the PST-HC condition reported significantly lower levels of depressive symptoms compared with UC participants as measured by the Beck Depression Inventory (BDI) and the Geriatric Depression Scale (GDS), significantly higher quality of life scores, and significantly higher problem-solving ability scores as measured by the Social Problem Solving Inventory-Revised (SPSI-R) version. The PST-HC treatment group improved on the BDI scores with no advantage for the UC group, reflecting an effect size in the large range ($d = 2.7$).

Comparison of PST-HC and UC conditions on treatment satisfaction indicated that PST-HC scores were significantly greater than the UC group. Participants in UC and PST-HC conditions reported receiving similar types of home care services over the study period. There were no significant differences in the number of home visits, number of patients receiving mental health referrals, new psychotropic medications, or total number of primary care visits over the treatment period.

A second randomized trial tested the impact of PST in the HHC setting among 62 homebound medically ill older adults diagnosed with minor depression (Gellis et al., 2008). Although the level of depressive symptomatology is less than that for major depression, minor depression is serious, accompanied by significant functional decline,

increased health care use, and a risk factor for mortality from medical conditions as well as suicide (Horowitz, Reinhardt, & Kennedy, 2005).

To address the lack of evidence on psychosocial treatments for minor depression among acute home care patients, we conducted a 6-week RCT. Eligible older participants met *Diagnostic and Statistical Manual for Mental Disorders, Revised, 4th edition (DSM-IV)* criteria for minor depression and scored 11 or higher on the 17-item Hamilton Depression Rating Scale (HRSD; Hamilton, 1967). Criteria for minor depression were based on the *DSM-IV* research indicators, which included patient reports of two to four symptoms for at least 2 weeks. We compared treatment-as-usual (TAU) in acute home care, augmented with education on depression, to PST-HC added to TAU in home care. Sixty-two participants completed the protocol and provided baseline, posttreatment, and 3- and 6-month follow-up data. All patients who completed PST-HC did so in six sessions, with an average duration of 7.1 weeks. Patients in TAU were contacted weekly by phone over an average of 7.0 weeks to assess the need for crisis management or a referral outside the protocol. No direct counseling was provided during these phone calls, only minimal information.

The mean age for the study sample was 77.6 years and mean education level was 11 years. Of the 62 patients, most were Whites (85%), female (88%), living alone in an apartment or their own home (80%), and had at least three diagnosed chronic medical conditions (55%). Participants in the PST-HC condition were found to report significantly lower levels of depressive symptoms compared with TAU participants as measured by the HAM-D and GDS, and significantly higher problem-solving ability scores on the SPSI-R, but not significantly higher quality of life scores. Further, patients in the TAU condition did not experience any significant changes on any measure from baseline to posttreatment. Patients receiving PST-HC depression treatment reported significantly lower levels of depressive symptoms at 3- and 6-month follow-up points as assessed by the two indices: HAM-D and GDS depression measures. This suggests that the positive effects of the original PST-HC intervention were maintained 6 months following treatment.

In the previous RCTs, we discovered that a large percentage of home care patients (44%) had a primary diagnosis of CVD, a leading cause of death in older adults. Thus, we completed a small pilot trial comparing tailored home-based PST-HC and UC enhanced with depression education among depressed homebound older adults with CVD (Gellis & Bruce, 2009). Results indicated that the PST-HC depression intervention group reported more favorable treatment satisfaction

than controls and demonstrated significant improvement in depression scores. Most participants (63%) reported that they preferred talking to a depression therapist about their mental health symptoms rather than receive antidepressant medication.

These studies demonstrated the following: (a) PST significantly reduced depression scores relative to controls; (b) depression assessment and treatment is feasible in home care; (c) treatment is acceptable to older adults; and (d) integrating depression care in home health is acceptable to home care nurses and social workers. Through extensive qualitative interviews with home care workers and managers, we learned that the following required components were needed for "real world" integrated depression service delivery: (a) home care nurses need comprehensive training in depression screening, assessment, and referral; (b) home care social workers need training in evidence-based PST depression treatment; (c) training in appropriate communication about depression within home care and with primary care; and (d) a structured internal referral and follow-up mechanism within the agency for depression care. Home care nurses reported that they could improve their skills in screening and referral of appropriate depressed patients, but they stated that the home care social worker was the most appropriate staff within the home care organization to provide brief depression treatment in the patient's home (Gellis et al., 2007, 2008).

SUMMARY

In summary, the observation that PST-HC intervention is effective in reducing depressive symptoms in later life is encouraging for several reasons. First, from the patient perspective, these findings suggest that despite the complexity and magnitude of chronic medical and of physical disability in the average older adult receiving home care services, clinically significant depressive symptoms can be alleviated and quality of life improved with a brief and manualized psychotherapy. Psychosocial interventions such as PST, which are based on cognitive and behavioral theory principles, have also been found effective in the treatment of older primary care patients with major and minor depression. The mechanism by which the intervention reduces depressive symptoms involves, to some extent, improvement in the participant's ability to solve problems by generating new options, evaluating the solution options, and making realistic decisions about solving life stressors.

Second, from a community-based service delivery perspective, our empirical work suggests the feasibility of providing home-based psychotherapy in the context of routine HHC services. The effective use of clinical social workers is especially relevant because the cost of independent social work home visits for Medicare patients is a reimbursable service. The data also suggest that modifications made to traditional PST to increase its feasibility in HHC (e.g., six session, problem-solving skill development, flexible scheduling, and home visits) do not undermine its potential effectiveness.

Third, the brevity of PST-HC is also advantageous relative to the typical 12 to 16 sessions used for cognitive or interpersonal therapy. This line of research demonstrates home and community-based "real world" rigorous research applications of a potentially feasible and replicable depression intervention for homebound medically ill acute home care patients. The PST depression intervention is theoretically driven, empirically supported, manualized, brief, and can be provided by integrated home care clinical social workers in the patient's home.

REFERENCES

- American Association of Retired Persons. (2009). American Association of Retired Persons Public Policy Report. Fact Sheet. Providing more long-term support and services at home: Why it's critical for health reform. Washington, DC: AARP Public Policy Institute.
- Adelman, R., Greene, M., Friedmann, E., & Cook, M. (2008). Discussion of depression in follow-up medical visits with older patients. *Journal of the American Geriatrics Society, 56*, 16–22.
- Alexopoulos, G. S., Raue, P., & Areán, P. A. (2003). Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. *American Journal of Geriatric Psychiatry, 11*, 46–52.
- Areán, P. A., Alvidrez, J., Barrera, A., Robinson, G. S., & Hicks, S. (2002). Would older medical patients use psychological services? *The Gerontologist, 42*, 392–398.
- Areán, P. A., Perri, M. G., Nezu, A. M., Schein, R. L., Christopher, F., & Joseph, T. X. (1993). Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults. *Journal of Consulting and Clinical Psychology, 61*, 1003–1010.
- Beekman, A., Deeg, D., Braam, A., Smit, J., & van Tilburg, W. (1997). Consequences of major and minor depression in later life: A study of disability, well-being and service utilization. *Psychological Medicine, 27*, 1397–1409.
- Bell, A. C., & D'Zurilla, T. J. (2009). Problem-solving therapy for depression: A meta-analysis. *Clinical Psychology Review, 29*, 348–353.

- Brown, E., Kaiser, R., & Gellis, Z. D. (2008). Screening and assessment of late-life depression in home health care: Issues and challenges. *Annals of Long Term Care, 15*(1), 27–32.
- Brown, E. L., McAvay, G. J., Raue, P. J., Moses, S., & Bruce, M. L. (2003). Recognition of depression in the elderly receiving homecare services. *Psychiatric Services, 54*(2), 208–213.
- Bruce, M. L., McAvay, G. J., Raue, P. J., Brown, E. L., Meyers, B. S., Keohane, D. J., et al. (2002). Major depression in elderly home health care patients. *American Journal of Psychiatry, 159*, 1367–1374.
- Centers for Medicare & Medicaid Services. (2008). *National health expenditures projections, 2007–2017*. Retrieved June 14, 2010, from www.cms.hhs.gov
- Cheh, V. (2001). *The final evaluation report on the National Home Health Perspective Payment Demonstration: Agencies reduce visits while preserving quality*. Princeton, NJ: Mathematica Policy Research, Inc.
- Ciechanowski, P., Wagner, E., Schmaling, K., Schwartz, S., Williams, B., Diehr, P., et al. (2004). Community-integrated home-based depression treatment in older adults: A randomized controlled trial. *Journal of the American Medical Association, 291*, 1569–1577.
- Council on Social Work Education. (2001). *Executive summary: Strengthening the impact of social work to improve the quality of life for older adults and their families: A blueprint for the new millennium*. Washington, DC: Sage-SW.
- Crystal, S., Sambamoorthi, U., Walkup, J., & Akincigil, A. (2003). Diagnosis and treatment of depression in the elderly Medicare population: Predictors, disparities, and trends. *Journal of the American Geriatrics Society, 51*, 1718–1728.
- Cuijpers, P., van Straten, A., & Smit, F. (2006). Psychological treatment of late-life depression: A meta-analysis of randomized controlled trial. *International Journal of Geriatric Psychiatry, 21*, 1139–1149.
- Cuijpers, P., van Straten, A., & Warmerdam, L. (2007). Problem solving therapies for depression: A meta-analysis. *European Psychiatry, 22*, 9–15.
- D’Zurilla, T. J., Chang, E. C., Nottingham, E. J., IV, & Faccini, L. (1998). Social problem-solving deficits and hopelessness, depression, and suicidal risk in college students and psychiatric inpatients. *Journal of Clinical Psychology, 54*, 1–17.
- D’Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78*, 107–126.
- D’Zurilla, T. J., & Nezu, A. M. (2001). Problem-solving therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (2nd ed.). New York, NY: Guilford Press.
- D’Zurilla, T. J., & Nezu, A. M. (2007). *Problem-solving therapy: A positive approach to clinical intervention* (3rd ed.). New York, NY: Springer Publishing Company.
- D’Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, C. (2002). *Social problem-solving inventory revised (SPSI-R): Manual*. North Tonawanda, NY: Multi-Health Systems.
- D’Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, A. (2004). Social problem solving: Theory and assessment. In E. C. Chang, T. J. D’Zurilla, & L. J. Sanna (Eds.), *Social problem solving: Theory, research, and training* (pp. 11–27). Washington, DC: American Psychological Association.
- Elliott, T. R., Grant, J. S., & Miller, D. M. (2004). Social problem-solving abilities and behavioral health. In E. C. Chang, T. J. D’Zurilla, & L. J. Sanna (Eds.), *Social*

- problem solving: Theory, research, and training* (pp. 117–133). Washington, DC: American Psychological Association.
- Federal Register (2000). Medicare program; prospective payment system for home health agencies. Health Care Financing Administration (HCFA), HHS. Final rule. *Federal Register*, 65(128), 41128–41214.
- Gallo, J. J., Meredith, L., Gonzales, J., Cooper, L., Nutting, P., Ford, D., et al. (2002). Do family physicians and internists differ in knowledge, attitudes, and self-reported approaches for depression? *International Journal of Psychiatry in Medicine*, 32, 1–20.
- Gellis, Z. D. (2009). Evidence based practice in older adults with mental health disorders. In Roberts, A. R. (Ed.), *Social Workers' Desk Reference*. London: Oxford University Press.
- Gellis, Z. D. (2010). Depression screening in medically ill home healthcare elderly. *Best Practices in Mental Health: An International Journal*, 6(1), 1–16.
- Gellis, Z.D., & Bruce, M.L. (2009). Problem solving therapy for depression among home health care patients with cardiovascular disease. *American Journal of Geriatric Psychiatry* (published ahead of print). DOI: 10.1097/JGP.0b013e3181b21442.
- Gellis, Z. D., & Kenaley, B. (2008). Problem solving therapy for depression in adults: A systematic review. *Research on Social Work Practice*, 18, 117–131.
- Gellis, Z. D., McGinty, J., Horowitz, A., Bruce, M., & Misener, E. (2007). Problem-solving therapy for late-life depression in home care: A randomized field trial. *American Journal of Geriatric Psychiatry*, 15(11), 968–978.
- Gellis, Z. D., McGinty, J., Tierney, L., Burton, J., Jordan, C., & Misener, E. (2008). Randomized controlled trial of problem-solving therapy for minor depression in home care. *Research on Social Work Practice*, 18(6), 596–606.
- Government Accountability Office. (1994). *Successful state efforts to expand home services while limiting costs* (GAO-HEHS-94-167). Washington, DC: Author.
- Gum, A. M., Areán, P. A., Hunkeler, E., Tang, L., Katon, W., Hitchcock, P., et al. (2006). Depression treatment preferences in older primary care patients. *The Gerontologist*, 46(1), 14–22.
- Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, 6(4), 278–296.
- Horowitz, A., Reinhardt, J., & Kennedy, G. (2005). Major and subthreshold depression among older adults seeking vision rehabilitation services. *American Journal of Geriatric Psychiatry*, 13, 180–187.
- Hybels, C., & Blazer, D. (2003). Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine*, 19, 663–696.
- Hyer, L., Carpenter, B., Bishmann, D., & Wu, H. S. (2005). Depression in long-term care. *Clinical Psychology: Science and Practice*, 12(3), 280–299.
- Institute of Medicine. (2008). *Retooling for an aging America: Building the health care workforce*. National Academy of Sciences, Washington, DC: The National Academies Press.
- Kant, G. L., D'Zurilla, T. J., & Maydeu-Olivares, A. (1997). Social problem solving as a mediator of stress-related depression and anxiety in middle-aged and elderly community residents. *Cognitive Therapy and Research*, 21, 73–96.
- Kessler, R., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K., et al. (2003). The epidemiology of major depressive disorder. Results from the national

- comorbidity survey replication. *Journal of the American Medical Association*, 289(23), 3095–3105.
- Landreville, P., Landry, J., Baillargeon, L., Guerette, A., & Matteau, E. (2001). Older adults' acceptance of psychological and pharmacological treatments for depression. *Journal of Gerontology*, 56B, P285–P291.
- Lundervold, D., & Lewin, L. M. (1990). Older adults' acceptability of pharmacotherapy and behavior therapy for depression: Initial results. *Journal of Applied Gerontology*, 9, 211–215.
- Lyness, J. M. (2008). Naturalistic outcomes of minor and subsyndromal depression in older primary care patients. *International Journal of Geriatric Psychiatry*, 23, 773–781.
- MacPhillamy, D., & Lewinsohn, P. (1982). The pleasant events schedule: Studies on reliability, validity, and scale intercorrelation. *Journal of Consulting and Clinical Psychology*, 50, 363–380.
- Marmor, T. (2000). *The politics of Medicare* (2nd ed.). Hawthorne, NY: Aldine de Gruyter.
- Medicare Payment Advisory Commission (2003, June). *Report to the Congress: Variation and innovation in Medicare*. Retrieved June 14, 2010, from http://www.medpac.gov/documents/June03_Entire_Report.pdf
- Mollica, R. L., & Kassner, E. (2009). Taking the long view: Investing in Medicaid home and community-based services is cost-effective. AARP Public Policy Institute. *Insight on the Issues*, 26, 1–8.
- Mynors-Wallis, L. M., Gath, D., Davies, I., Gray, A., & Barbour, F. (1997). Randomized controlled trial and cost analysis of problem-solving treatment given by community nurses for emotional disorders in primary care. *British Journal of Psychiatry*, 170, 113–119.
- National Institute of Mental Health. (2006). *Special meeting on current research in psychosocial interventions for late-life mental disorders*. Arlington, VA: Geriatrics Research Branch, Division of Adult Translational Research and Treatment Development.
- Nezu, A. M. (1986). Efficacy of a social problem-solving therapy approach for unipolar depression. *Journal of Consulting and Clinical Psychology*, 54, 196–202.
- Nezu, A. M. (1987). A problem-solving formulation of depression: A literature review and proposal of a pluralistic model. *Clinical Psychology Review*, 7, 122–144.
- Nezu, A. M. (2004). Problem solving and behavior therapy revisited. *Behavior Therapy*, 35, 1–33.
- Nezu, A. M., & Nezu, C. M. (2010). Problem-solving therapy for relapse prevention in depression. In S. Richards & M. G. Perri (Eds.), *Relapse prevention for depression*. Washington, DC: American Psychological Association.
- Nezu, A. M., Nezu, C. M., & D'Zurilla, T. J. (2007). *Solving life's problems: A 5-step guide to enhanced well-being*. New York, NY: Springer Publishing Company.
- Nezu, A. M., Nezu, C. M., Felgoise, S. H., McClure, K. S., & Houts, P. S. (2003). Project Genesis: Assessing the efficacy of problem-solving therapy for distressed adult cancer patients. *Journal of Consulting and Clinical Psychology*, 71, 1036–1048.
- Nezu, A. M., Nezu, C. M., & Perri, M. G. (1989). *Problem-solving therapy for depression: Therapy, research, and clinical guidelines*. New York, NY: John Wiley & Sons, Inc.

- Nezu, A. M., Nezu, C. M., Saraydarian, L., Kalmar, K., & Ronan, G. F. (1986). Social problem solving as a moderator variable between negative life stress and depressive symptoms. *Cognitive Therapy and Research, 10*, 489-498.
- Nezu, A. M., & Perri, M. G. (1989). Social problem solving therapy for unipolar depression: An initial dismantling investigation. *Journal of Consulting and Clinical Psychology, 57*, 408-413.
- Nezu, A. M., & Ronan, G. F. (1985). Life stress, current problems, problem solving, and depressive symptomatology: An integrative model. *Journal of Consulting and Clinical Psychology, 53*, 693-697.
- Nezu, A. M., & Ronan, G. F. (1988). Stressful life events, problem solving, and depressive symptoms among university students: A prospective analysis. *Journal of Counseling Psychology, 35*, 134-138.
- Pignone, M. P., Gaynes, B. N., Rushton, J. L., Burchell, C. M., Orleans, C. T., Mulrow, C. D., et al. (2002). Screening for depression in adults: A summary of the evidence for the U.S. Preventative Services Task Force. *Annals of Internal Medicine, 136*(10), 765-776.
- Raue, P., Meyers, B., McAvay, G., Brown, E., Keohane, D., & Bruce, M. (2003). One-month stability of depression among elderly home-care patients. *American Journal of Geriatric Psychiatry, 11*, 543-550.
- Rudd, M. D., Rajab, M. H., & Dahm, P. F. (1994). Problem-solving appraisal in suicide ideators and attempters. *American Journal of Orthopsychiatry, 64*, 136-149.
- Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary care evaluation of mental disorders. Patient Health Questionnaire. *Journal of the American Medical Association, 282*, 1737-1744.
- Tai-Seale, M., Bramson, R., Drukker, D., Hurwics, M. L., Ory, M., Tai-Seale, T., et al. (2005). Understanding primary care physicians' propensity to assess elderly patients for depression using interaction and survey data. *Medical Care, 43*(12), 1217-1224.
- Tai-Seale, M., McGuire, T., Colenda, C., Rosen, D., & Cook, M. (2007). Two-minute mental health care for elderly patients: Inside primary care visits. *Journal of the American Geriatrics Society, 55*, 1903-1911.
- U.S. Census Bureau. (2004). *Economic census*. Retrieved October 2002, from <http://www.census.gov>
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General. [Chapter 5]*. Washington, DC: U.S. Government Printing Office.
- Wei, W., Sambamoorthi, U., Olsson, M., Walkup, J., & Crystal, S. (2005). Use of psychotherapy for depression in older adults. *American Journal of Psychiatry, 162*, 711-717.
- Williams, J. W., Katon, W., Lin, E. H. B., Nöel, P. H., Worchel, J., Cornell, J., et al. (2004). The effectiveness of depression care management on diabetes-related outcomes in older patients. *Annals of Internal Medicine, 140*, 1015-1024.
- Zeltzer, B., & Kohn, R. (2006). Mental health services for homebound elders from home health nursing agencies and home care agencies. *Psychiatric Services, 57*(4), 567-569.