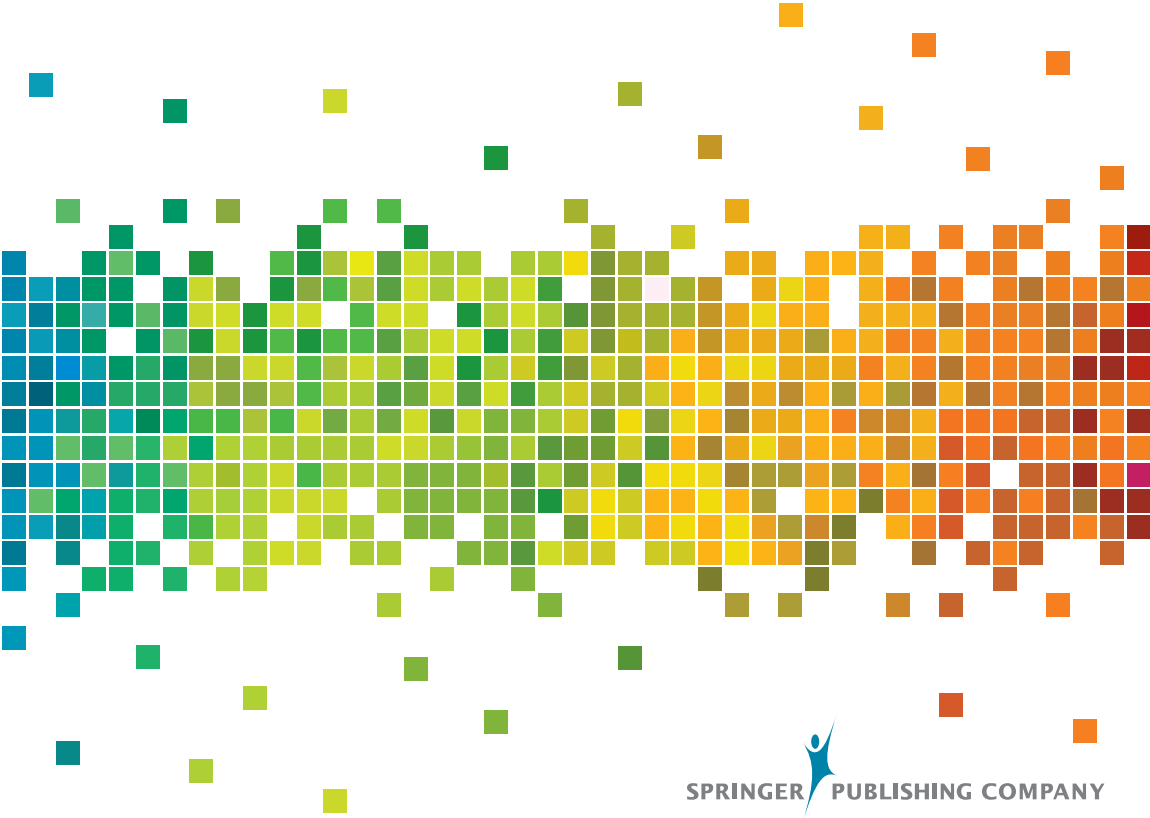
Arthur M. Nezu
Christine Maguth Nezu
Thomas J. D'Zurilla

# Problem-Solving Therapy

## A TREATMENT MANUAL



SPRINGER PUBLISHING COMPANY

# Problem-Solving Therapy

**Arthur M. Nezu, PhD, ABPP**, is distinguished university professor of psychology, professor of medicine, and professor of public health at Drexel University as well as honorary professor of community health sciences, the University of Nottingham in the United Kingdom. Dr. Nezu is currently editor of the *Journal of Consulting and Clinical Psychology*, associate editor of the *Archives of Scientific Psychology*, and consulting editor for numerous additional scientific and professional journals in psychology and behavioral medicine. He is also past president of the Association for Advancement of Behavior Therapy (now known as the Association of Behavioral and Cognitive Therapies) and the American Board of Cognitive and Behavioral Psychology. He is board certified by the American Board of Professional Psychology in three specialties (cognitive and behavioral psychology, clinical psychology, and clinical health psychology) and is a fellow of the American Psychological Association, the Association for Psychological Science, the Society of Behavioral Medicine, the Academy of Cognitive Therapy, the American Academy of Cognitive and Behavioral Psychology, and the American Academy of Clinical Psychology. Dr. Nezu has also been designated as a distinguished scholar/practitioner of psychology by the National Academies of Practice, is author or coauthor of over 200 scientific and professional publications, serves as a consultant to the Office of Mental Health Services of the Department of Veterans Affairs (DVA), is a member of the Special Medical Advisory Group, which advises the secretary and under secretary for health of the DVA, and is a member of the American Psychological Association's Treatment Guideline Development Panel for Depressive Disorders.

**Christine Maguth Nezu, PhD, ABPP,** is professor of psychology and professor of medicine at Drexel University and honorary professor of community health sciences, the University of Nottingham in the United Kingdom. She is past president of the American Board of Professional Psychology and designated as a distinguished scholar/practitioner of psychology by the National Academies of Practice. Dr. Maguth Nezu has contributed to scores of scientific publications, has presented extensively at professional conferences around the world, and is a member of multiple editorial boards of leading psychology journals in the United States and abroad. She is board certified in clinical psychology and cognitive and behavioral psychology by the American Board of Professional Psychology and the clinical director of Nezu Psychological Associates. She serves as a consultant and health sciences specialist to the Department of Veterans Affairs. Dr. Maguth Nezu has received awards for her contributions to the specialty of cognitive and behavioral psychology sponsored jointly by the American Board of Cognitive and Behavioral Psychology and the American Academy of Cognitive and Behavioral Psychology and is a fellow of the American Psychological Association.

**Thomas J. D'Zurilla, PhD,** is professor emeritus in the Department of Psychology at Stony Brook University. He has also been a practicing clinical psychologist, specializing in cognitive behavioral therapy, for more than 40 years. Dr. D'Zurilla was one of the pioneers in the cognitive-behavioral movement that developed within clinical psychology in the late 1960s and early 1970s. He participated in the development of the first behaviorally oriented clinical psychology training program. Collaborating with Marvin R. Goldfried, Dr. D'Zurilla developed the original model of problem-solving therapy, which was aimed at facilitating broader and more durable behavioral changes with cognitive and behavioral therapies. Their 1971 article titled "Problem Solving and Behavior Modification," published in the *Journal of Abnormal Psychology*, was recognized as a Citation Classic in Current Contents in 1984. Dr. D'Zurilla is an author on nearly 100 theoretical and research publications, most of them in the areas of social problem solving and problem-solving therapy. Together with Arthur M. Nezu and Albert Maydeu-Olivares, Dr. D'Zurilla developed the Social Problem-Solving Inventory-Revised (SPSI-R), which has become the most popular and useful measure in scientific studies on social problem solving and problem-solving therapy. Dr. D'Zurilla's work in these areas has been translated into several foreign languages, including Spanish, German, Japanese, Chinese, and French.

# Problem-Solving Therapy

## A Treatment Manual

Arthur M. Nezu, PhD, ABPP
Christine Maguth Nezu, PhD, ABPP
Thomas J. D'Zurilla, PhD

SPRINGER PUBLISHING COMPANY
NEW YORK

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

*Acquisitions Editor*: Sheri W. Sussman
*Composition*: Absolute Service, Inc.

ISBN: 978-0-8261-0940-8
e-book ISBN: 978-0-8261-0941-5
Online ancillary ISBN: 978-0-8261-9919-5

**Appendices are available from www.springerpub.com/nezu**

12 13 14 15/5 4 3 2 1



**Library of Congress Cataloging-in-Publication Data**

Nezu, Arthur M.
Problem-solving therapy : a treatment manual / Arthur M. Nezu, PhD, ABPP, Christine Maguth Nezu, PhD, ABPP, Thomas J. D'Zurilla, PhD.
pages cm
ISBN 978-0-8261-0940-8—ISBN 978-0-8261-0941-5 (e-book)—ISBN 978-0-8261-9919-5 (Patient handouts)
1. Problem-solving therapy. I. Nezu, Christine M. II. D'Zurilla, Thomas J. III. Title.
RC489.P68N49 2013
616.89'14—dc23
2012043303



Printed in the United States of America by Gasch Printing.

*This book is dedicated to U.S. veterans and service members*

# Contents

# Preface

Problem-solving therapy (PST) is a psychosocial intervention, generally considered to be under a cognitive-behavioral umbrella, that is geared to enhance one's ability to cope effectively with both minor (e.g., chronic daily problems) and major (e.g., traumatic events) stressors in order to attenuate extant mental health and physical health problems.

Rather than representing an updated volume of the theoretical and empirical literature on PST or social problem solving, the purpose of this book is to serve as a detailed treatment manual and to delineate general intervention strategies of contemporary PST that are required to effectively conduct this intervention approach. This current version (why we refer to it as "contemporary PST") represents significant conceptual and clinical revisions of previous versions of this approach based in part on the authors' clinical and research experience, the extant treatment-outcome literature, and advances in related areas of research in psychology (e.g., decision theory, psychopathology) and neuroscience (e.g., neurobiology, stress, and emotions).

Because this volume is basically a treatment manual, in addition to describing the clinical guidelines, we provide multiple case examples and illustrations as well as worksheets, patient forms, and various handouts that serve as instructional aids.

This book is intended for a wide variety of professionals (e.g., psychologists, psychiatrists, social workers, primary care physicians, counselors, nurses, and teachers) who are interested in directive approaches to psychotherapy and skills training. Because PST has been adapted for a wide variety of populations and clinical problems, professionals should find this manual to be applicable for a multitude of their clients across multiple settings, including outpatient, inpatient, and primary care venues. We believe that clinical researchers interested in abnormal behavior, psychopathology, positive psychology, stress and coping, prevention, personal adjustment, creativity, decision making, and social problem solving will also find this book helpful. Last, this treatment manual, although very clinically oriented, can

also serve as a text for a variety of upper-level undergraduate classes as well as applied graduate courses.

**Note that the appendices, including the Patient Handouts contained in Appendices II and III, are also available for download on the publisher's website in order to provide them to clients as instructional and informational aids. To download, go to www.springerpub.com/nezu.**

We wish to thank our research and clinical colleagues who have knowingly and unknowingly enhanced our thinking over the years, our graduate student assistants who helped immensely with multiple research projects related to this book, and the multitude of patients and clients with whom we have had the honor to work using this approach. We also wish to thank Sheri W. Sussman at Springer Publishing Company, without whom this book would never have been realized.

# SECTION I

## Conceptual and Empirical Considerations

# ONE

# Introduction, Brief History, and Social Problem-Solving Constructs

Problem-solving therapy (PST) is a psychosocial intervention, generally considered to be under a cognitive-behavioral umbrella, that is geared to enhance one's ability to cope effectively with both minor (e.g., chronic daily problems) and major (e.g., traumatic events) stressors in order to attenuate extant mental health and physical health problems.

The major treatment goals of PST include:

1. The adoption of an adaptive worldview or orientation toward problems in living (e.g., optimism, positive self-efficacy, acceptance that problems are common occurrences in life)
2. The effective implementation of specific problem-solving behaviors (e.g., emotional regulation and management, planful problem solving)

Overall, PST has been effective in helping individuals suffering from a variety of health and mental health problems, including depression, anxiety, emotional distress, suicidal ideation, cancer, heart disease, diabetes, stroke, traumatic brain injury, back pain, hypertension, and posttraumatic stress disorder (see D'Zurilla & Nezu, 2007, for a detailed overview of the extant outcome literature). It has also been effectively used to treat individuals with schizophrenia and mental retardation as well as implemented as a means of preventing emotional difficulties from initially occurring or becoming worse in certain vulnerable populations, such as veterans returning from combat war zones. PST has further been evaluated empirically as an adjunctive strategy in order to enhance one's adherence to other forms of medical or psychological treatments, as a

means of improving the lives of caregivers as well as enhancing their ability to care for a loved one, and as a major treatment component of marital and couples therapy.

The purpose of this book is to serve as a basic treatment manual and to delineate general intervention strategies of contemporary PST that are required to effectively conduct this intervention approach. This current version (why we refer to it as contemporary PST) represents significant conceptual and clinical revisions of previous versions of this approach (e.g., D'Zurilla & Nezu, 2007; Nezu, Nezu, Friedman, Faddis, & Houts, 1998) based in part on the authors' clinical experience, the extant treatment-outcome literature, and advances in related areas of research in psychology (e.g., decision theory, psychopathology) and neuroscience (e.g., stress and emotions).

Whereas many fundamental aspects of contemporary PST remain the same as previous versions (e.g., the use of specific rational problem-solving steps to resolve or cope with stressful problems), this current manual especially emphasizes treatment strategies geared to help individuals better manage emotional dysregulation, a major barrier to effective problem solving. For example, rather than simply caution people to "STOP and THINK" when attempting to cope with a stressful problem as suggested in previous manuals, we have come to better understand the significant difficulties that individuals can have when attempting to do so if such problems are particularly stressful and associated with intense emotional arousal, including anger, depression, and anxiety. As such, we now advocate teaching people to use the "SSTA" method of coping with stress, where *S* = STOP; *S* = SLOW DOWN; *T* = THINK; and *A* = ACT (see Chapter 8 for a detailed explanation of this model).

PST has been conceptualized and implemented as both a system of psychotherapy (Nezu & Nezu, 2009) as well as a brief, skills-oriented training program (e.g., problem-solving skills training). This latter approach has tended to de-emphasize those PST treatment components geared to foster a positive problem orientation and enhance emotional regulation skills. Whereas programs representing this skills-only approach have been found to be effective, PST protocols encompassing the larger model (as advocated by Nezu, 2004) have fared significantly better regarding outcome (see Chapter 3; Malouff, Thorsteinsson, & Schutte, 2007; Nezu & Perri, 1989). However, given that both approaches have been effective, we present a case formulation approach of PST treatment in Chapter 4 that offers guidelines for PST treatment planning across various populations and circumstances.

## STRUCTURE OF MANUAL

Whereas the major purpose of this volume is to provide specific treatment guidelines for effectively conducting PST, we believe it is important to initially provide both the conceptual and empirical underpinnings of this approach for two reasons. First, such information can help the clinician to better understand the fundamental principles inherent in PST and thus be able to apply it more effectively with a variety of individuals and situations. We suggest that the research literature regarding PST, similar to *all* other psychotherapy approaches, has not been able to address *every* individual patient demographic and characteristic (and combination of these characteristics), such as age, ethnicity, sexual orientation, socioeconomic status, comorbidity, and so forth. As such, no manual can offer specific guidelines for every individual or contingency. This notion underscores our basic commitment that it is adherence to understanding and addressing these principles and treatment goals that are important to the success of PST, rather than the specific activities, exercises, scripts, or homework assignments that even we, ourselves, describe and offer in this manual.

Second, we firmly believe that the greater the degree to which our patients and therapy clients understand our approach, the more likely it is that treatment will be effective. In other words, in most cases, if clients understand (and hopefully share) our therapeutic worldview (e.g., why PST is important, how problem solving relates to distress, whether it has been previously documented to be effective for problems similar to those experienced by that client), it is more likely that they will "be on the same page," making treatment activities and objectives more understandable and transparent. As such, we provide the background material in hopes that the clinician has such information in his or her "back pocket" when providing the purposes of PST, the rationale for why it may be important to engage with a particular patient (i.e., why it is relevant to the person or persons requesting treatment), and the evidence showing that PST has been found to be effective in order to instill confidence both in this approach and in the therapist providing PST.

Given the above, we briefly present in this first section of the manual an overview of the theory underlying PST (Chapter 2) as well as the supportive research that documents its efficacy across various populations and clinical problems (Chapter 3). The next section offers an overview of problem-solving assessment and treatment planning (Chapter 4) as well as general clinical considerations (Chapter 5), whereas the third major section

provides for detailed clinical guidelines for conducting PST (Chapters 6 through 11). Where appropriate, we also provide examples of the various forms and worksheets that we have developed that can be helpful when conducting PST as well as sample scripts, clinical dialogues, and case examples to illustrate certain points and demonstrate how to conduct various strategies. Note that the Appendices, including the Patient Handouts contained in Appendices II and III, are also available for download on the publisher's website in order to provide them to clients as instructional and informational aids. For information, go to www.springerpub.com/nezu

## A BRIEF HISTORY OF PROBLEM-SOLVING THERAPY

In 1971, Thomas D'Zurilla and Marvin Goldfried published a comprehensive review of the relevant theory and research related to real-life problem solving (later termed *social problem solving* (SPS); D'Zurilla & Nezu, 1982; Nezu & D'Zurilla, 1989) that cut across a wide range of related academic and professional fields, including creativity, abnormal behavior, experimental psychology, education, and industry. Based on this review, these behaviorally oriented psychologists developed a prescriptive model of problem solving that consisted of two different, albeit related, components: (a) general orientation (later relabeled *problem orientation*) and (b) problem-solving skills. *General orientation* was defined as a metacognitive process that primarily served a motivational function (i.e., the more positive one's general orientation, the more likely he or she would attempt to solve or handle a difficult problem in living). This process was described as involving a set of relatively stable cognitive-emotional schemas that reflect a person's general awareness and appraisals of problems in living as well as his or her own problem-solving ability (e.g., challenge appraisals, self-efficacy beliefs, or positive outcome expectancies).

*Problem-solving skills* referred to the set of cognitive-behavioral activities by which a person attempts to discover or develop effective solutions or ways of coping with real-life problems. According to this early model, four problem-solving skills were identified: (a) problem definition and formulation, (b) generation of alternatives, (c) decision making, and (d) solution implementation and verification. In addition to describing the components of this model, D'Zurilla and Goldfried (1971) further presented preliminary guidelines and procedures for training individuals in these skills in order to help overcome deficits in their ability to cope effectively with stressful problems.

Subsequently, by virtue of being a graduate student in clinical psychology under the mentorship of D'Zurilla, Art Nezu became especially interested in the clinical applications of this approach. His initial efforts involved confirming several of the theoretical tenets of the PST model, including the positive benefits of training individuals to better define social problems (Nezu & D'Zurilla, 1981a, 1981b), generate alternatives (D'Zurilla & Nezu, 1980), and make effective decisions regarding such problems (Nezu & D'Zurilla, 1979). Based on research regarding the stress-buffering properties of effective problem-solving coping (e.g., Nezu & Ronan, 1985, 1988), D'Zurilla and Nezu later developed the relational/problem-solving model of stress referred to in Chapter 2 (Nezu & D'Zurilla, 1989), which provided for a conceptual framework supporting the broad-based applicability of PST across a wide range of problems and populations.

In the 1980s, Nezu and colleagues focused their research activities on the relationship between problem solving and clinical depression, an effort resulting in the development of both a conceptual model of depression (Nezu, 1987) and an adapted version of PST for depression (Nezu, Nezu, & Perri, 1989). Since Nezu's earlier outcome studies evaluating the efficacy of PST for major depressive disorder (e.g., Nezu, 1986a, Nezu & Perri, 1989), PST has come to be viewed as an efficacious, evidence-based psychosocial treatment alternative for depression, as supported, for example, by recent meta-analyses of this literature (e.g., Bell & D'Zurilla, 2009b; Cuijpers, van Straten, & Warmerdam, 2007).

Since that time, we, as well as many other researchers and clinicians, have adapted this earlier model to treat a wide range of psychological problems and patient populations. Significant examples include geriatric depression (e.g., Areán et al., 1993; Areán et al., 2010); primary care patients (e.g., Barrett et al., 2001; Mynors-Wallis, Gath, Day, & Baker, 2000); caregivers of adults with various medical illnesses (e.g., Rivera, Elliott, Berry, & Grant, 2008; Wade et al., 2011 [traumatic brain injury]; Bucher et al., 2001 [cancer]); adults suffering from a variety of chronic diseases, including cancer (e.g., Allen et al., 2002; Nezu, Nezu, Felgoise, McClure, & Houts, 2003) and diabetes (e.g., Hill-Briggs & Gemmell, 2007; Toobert, Strycker, Glasgow, Barrera, & Bagdade, 2002); depressed, low-income minority adults (e.g., Ell et al., 2010; Ell et al., 2008); persons with mental retardation (e.g., Nezu, Nezu, & Areán, 1991); adults with personality disorders (e.g., Huband, McMurran, Evans, & Duggan, 2007; McMurran, Nezu, & Nezu, 2008); generalized anxiety disorder (e.g., Dugas et al., 2003; Provencher, Dugas, & Ladouceur, 2004); and sexual offenders (e.g., Nezu, D'Zurilla, & Nezu, 2005; Wakeling, 2007). The primary basis for such adaptations involved the hypothesis that the targeted problem is significantly related to ineffective

real-life problem solving (Nezu & Nezu, 2010a; Nezu, Wilkins, & Nezu, 2004). In other words, ineffective SPS can serve as a vulnerability and/or maintaining factor regarding a wide range of psychological disorders and problems. This diathesis-stress model is explained in detail in Chapter 2.

## DEFINITIONS OF CONSTRUCTS

The following are definitions of three major concepts integral to PST: problem solving, problem, and solution.

### Problem Solving

We define *real-life problem solving* (frequently referred to in the literature as social problem solving in order to differentiate it from the type of problem solving typically not occurring within an interpersonal or social context) as the self-directed process by which individuals attempt to identify, discover, and/or develop adaptive coping solutions for problems, both acute and chronic, that they encounter in everyday living. More specifically, it reflects the process whereby people direct their coping efforts at altering

**a.** The nature of the situation such that it no longer represents a problem (referred to as problem-focused goals; for example, overcome a barrier to their goals, reduce the conflict between two sets of goals)
**b.** Their maladaptive reactions to such problems (referred to as emotion-focused goals; e.g., reduce negative emotional reactions, enhance ability to accept that problems are a normal part of life)
**c.** Both the situation itself and their maladaptive emotional responses to the problem

Rather than representing a singular type of coping behavior or activity, SPS is conceived of in our model as the multidimensional meta-process of ideographically identifying and selecting a set of coping responses to carry out in order to effectively address the particular (and potentially unique) features of a given stressful situation. Note that PST is geared to enhance the efficacy of the process of one's problem-solving activities in order to increase the likelihood that such efforts are ultimately successful. As such, it is important to remember that an effective solution for one individual may not be an effective solution for another person experiencing the same or similar problem. Further, a solution that previously worked for a given

person at one point in time may not necessarily work again in a similar situation for the same person at a later date, as that person and/or circumstances may have changed. Therefore, one important feature of effective problem solving is the ability to match adaptive responses with the demands of a given problem while taking into account a variety of external and internal factors present at a given time.

Note that we particularly distinguish between the concepts of problem solving and solution implementation. These two processes are conceptually different and tend to require different sets of skills. Problem solving refers to the process of finding or developing solutions to specific problems, whereas solution implementation refers to the process of carrying out those solutions in the actual situation. Problem-solving skills are conceptualized as being general, whereas solution-implementation skills are expected to be specific to a given situation depending on the type of problem and type of solution. The range of possible solution-implementation skills includes all the cognitive and behavioral performance skills that might be required for effective functioning given a particular person's environment. Because they are different, problem-solving skills and solution-implementation skills are not always correlated. Hence, some individuals might possess poor problem-solving skills but good solution-implementation skills, or vice versa. Because both sets of skills are required for effective functioning, it may be necessary at times to combine PST with training in other social or behavioral skills (e.g., assertiveness skills, communication skills) in order to maximize positive outcomes.

## Problem

We define a problem as a life situation, present or anticipated, that

**a.** Requires an adaptive response in order to prevent immediate or long-term negative consequences (e.g., difficulty regaining practical and/or emotional homeostasis)
**b.** Wherein an effective response is *not* immediately apparent or available to the person experiencing the situation due to the existence of various obstacles or barriers

Note that the demands engendered by the problem can originate in a person's own social or physical environment (e.g., breakup of a relationship; natural disaster) as well as internally or intrapersonally (e.g., desire to make more money, confusion about life goals, sadness due to a lack of social support).

The barriers that make the situation a problem for a given individual or set of individuals can involve a variety of factors. These can include:

**a.** Novelty (e.g., moving to a new environment)
**b.** Ambiguity (e.g., confusion about how a relationship is progressing)
**c.** Unpredictability (e.g., lack of control over one's career path)
**d.** Conflicting goals (e.g., differences of opinions about which house to buy)
**e.** Performance skills deficits (e.g., difficulties in communicating with one's coworkers)
**f.** Lack of resources (e.g., limited finances to pay a mortgage)

A person might be able to recognize that a problem exists immediately or only after repeated attempts to respond effectively have failed. A problem can be a single time-limited event (e.g., missing a train to work, dropping one's car keys down an elevator shaft); a series of similar or related events (e.g., repeated unreasonable demands from one's boss, repeated violations of a curfew by one's teenage daughter); or a chronic, ongoing situation (e.g., continuous pain, strong ongoing feelings of loneliness, or a significant medical illness).

As we define it, a problem is not a characteristic of either the environment or the person alone. Rather, it is best characterized as a person-environment relationship represented by a real or perceived imbalance or discrepancy between the demands of the situation and one's coping ability and reactions. Therefore, a problem can be expected to change in difficulty or significance over time, depending on changes in the environment, the person, or both. This relational view of a problem has major implications for problem-solving assessment, as it suggests that problems are very ideographic; in other words, what is a problem for one person may not be a problem for another person. Moreover, what a problem is for a given person at one point in time may not be a problem for this same person at a subsequent time.

## Solution

A solution is a situation-specific coping response or response pattern that is the product or outcome of the problem-solving process when it is applied to a specific problem situation. An effective solution is one that achieves the problem-solving goal or set of goals (i.e., changes the situation for the better and/or reduces the distress that it produces), while at the same time maximizing other positive consequences and minimizing negative

consequences. Important outcomes include the effects on others as well as oneself, long-term effects, and short-term consequences. Within this context, it should be noted that the quality or effectiveness of any particular solution can vary for different individuals or different environments, depending on the norms, values, and goals of the problem solver or significant others who are responsible for evaluating the individual's solutions or coping responses.

## REVISED MODEL OF SOCIAL PROBLEM SOLVING

Based on decades of continuous research and program development, we have significantly revised the original D'Zurilla and Goldfried (1971) model of problem solving over the years. According to contemporary social problem-solving theory, attempts at coping with stressful problems are largely determined by two general but partially independent dimensions: (a) problem orientation and (b) problem-solving style (D'Zurilla, Nezu, & Maydeu-Olivares, 2004). Note that this basic model has been repeatedly validated across numerous populations, cultures, and age groups (D'Zurilla & Nezu, 2007).

### Problem Orientation

Problem orientation is the set of relatively stable cognitive-affective schemas that represent a person's generalized beliefs, attitudes, and emotional reactions about problems in living and one's ability to successfully cope with such problems. Rather than being two ends of the same continuum, as the original D'Zurilla and Goldfried (1971) model suggested, subsequent research has continuously identified two types of problem orientations, positive and negative, that function orthogonally (Nezu, 2004).

A positive problem orientation involves the tendency for individuals to

**a.** Appraise problems as challenges
**b.** Be optimistic in believing that problems are solvable
**c.** Have a strong sense of self-efficacy regarding their ability to cope with problems
**d.** Understand that successful problem solving involves time and effort
**e.** View negative emotions as an integral part of the overall problem-solving process that can ultimately be helpful in coping with stressful problems

A negative problem orientation is one that involves the tendency to

**a.** View problems as threats
**b.** Expect problems to be unsolvable
**c.** Have doubts about one's ability to cope with problems successfully
**d.** Become particularly frustrated and upset when faced with problems or confronted with negative emotions

Because an individual's orientation can have a strong impact on his or her motivation and ability to actually engage in focused attempts to solve problems, the importance of assessing and addressing this dimension in treatment has always been significantly underscored (Nezu, 2004; Nezu & Perri, 1989). In support of this emphasis, two recent meta-analytic reviews of the extant literature of randomized controlled trials of PST found that exclusion of a specific focus on this orientation dimension led to significantly less efficacious outcomes across various populations (Bell & D'Zurilla, 2009b; Malouff et al., 2007).

Note that we are not suggesting that individuals can be characterized exclusively by either type of orientation across all life problems. Rather, each represents a general tendency to view a certain type or set of problems from a particular perspective. For example, it is very possible (and common in our clinical experience) for an individual to be characterized as holding a positive orientation when addressing achievement relevant problems (e.g., work, career), while additionally having a negative orientation when dealing with affiliation or interpersonal problems (e.g., dating, parenting issues). This is in keeping with Mischel and Shoda's (1995) cognitive-affective system theory of personality that accounts for individual differences in predictable patterns of behavioral variability across situations. For example, it is possible for stable situation–behavior relationships to exist, such that if a given person is confronted with situation A (e.g., representing relationship problems), then he or she is likely to approach it with a negative problem orientation. But if the same person experiences a situation representing a different class of problems (e.g., work- or career-related difficulties), then it is plausible that he or she can approach it with a positive problem orientation. As such, we believe assessing for these situation-behavior patterns is crucial to successful treatment (i.e., accurately identifying both strengths and weaknesses by type of situation).

## Problem-Solving Styles

The second major SPS dimension, problem-solving style, refers to the set of cognitive-behavioral activities that people engage in when

attempting to solve or cope with stressful problems. Our research has identified three differing styles: (a) rational problem solving (now referred to as planful problem solving, (b) avoidant problem solving, and (c) impulsive-careless problem solving (D'Zurilla, Nezu, & Maydeu-Olivares, 2002; D'Zurilla et al., 2004). Rational or planful problem solving is the constructive approach to coping with stressful problems that involves the systematic and thoughtful application of the following set of specific skills:

1. Problem definition (i.e., clarifying the nature of a problem, delineating a realistic problem-solving goal or set of goals, and identifying those obstacles that prevent one from reaching such goals)
2. Generation of alternatives (i.e., thinking of a range of possible solution strategies geared toward overcoming the identified obstacles)
3. Decision making (i.e., predicting the likely consequences of these various alternatives, conducting a cost-benefit analysis based on these identified outcomes, and developing a solution plan that is geared toward achieving the problem-solving goal)
4. Solution implementation and verification (i.e., carrying out the solution plan, monitoring and evaluating the consequences of the plan, and determining whether one's problem-solving efforts have been successful or need to continue)

We note here again that researchers at times have incorrectly equated rational problem solving with social problem solving, and tended to disregard the important clinical implications inherent in the more complex model that includes orientation variables presented in this chapter (Nezu, 2004).

In addition to planful problem solving, two styles have been further identified, both of which, in contrast, are dysfunctional or maladaptive in nature. In general, both styles are associated with ineffective problem solving. Moreover, people engaging in these styles tend to worsen existing problems and even create new ones.

An impulsive/careless style is the problem-solving approach whereby an individual engages in impulsive or careless attempts at problem resolution. Such attempts are narrow, hurried, and incomplete. A person characterized as frequently engaging in this type of response pattern typically considers only a few solution alternatives, often impulsively going with the first idea that comes to mind. In addition, he or she scans alternative solutions and consequences quickly, carelessly, and unsystematically and monitors solution outcomes carelessly and inadequately.

Avoidant style is another dysfunctional problem-solving pattern, this one characterized by procrastination, passivity, inaction, and dependency on others. This type of problem solver prefers to avoid problems rather than confronting them head on, puts off problem solving for as long as possible, waits for problems to resolve themselves, and attempts to shift the responsibility for solving his or her problems to other people.

## PROBLEM-SOLVING THERAPY: TREATMENT OBJECTIVES

In order to achieve the treatment goals stated at the beginning of this chapter, the specific treatment objectives for PST can be thought of as

1. Enhancing positive problem orientation
2. Decreasing negative problem orientation
3. Fostering planful problem solving
4. Minimizing avoidant problem solving
5. Minimizing impulsive/careless problem solving

## PROBLEM-SOLVING THERAPY: TREATMENT COMPONENTS

Conceptually, several major obstacles can exist for a given individual when attempting to reach these treatment goals. These include the existence of any or all of the following:

a. Cognitive overload, especially when under stress
b. Limited or deficient ability to engage in effective emotional regulation
c. Biased cognitive processing of various emotion-related information (e.g., negative automatic thoughts, poor self-efficacy beliefs, difficulties in disengaging from negative mood-congruent autobiographical memories)
d. Limited motivation due to feelings of hopelessness
e. An ineffective or maladaptive problem-solving style

In order to achieve these treatment goals and objectives, PST focuses on training clients in four major problem-solving toolkits. Students of PST will recognize several revisions and updates in this current description of contemporary PST, as compared to previous treatment manuals (e.g., D'Zurilla & Nezu, 2007; Nezu et al., 1998; Nezu et al., 1989).

The four toolkits include

1. Problem-Solving Multitasking
2. The Stop, Slow Down, Think, and Act (*SSTA*) method of approaching problems
3. Healthy Thinking and Imagery
4. Planful Problem Solving

Section III of this manual will describe these toolkits and provide for detailed clinical guidelines in order to effectively conduct PST.

## SUMMARY

PST is a psychosocial intervention primarily geared toward enhancing one's ability to cope effectively with life stressors as a means of decreasing existing health and mental health difficulties as well as preventing future difficulties from occurring. Since the original model of D'Zurilla and Goldfried (1971) was published, multiple adaptations have occurred, addressing a wide range of clinical populations and problems. Moreover, this original model has been revised in accordance with research both directly addressing PST as well as from other related areas of psychology and neuroscience. Definitions of important concepts were provided in this chapter, including problem solving (i.e., the self-directed process of directing one's coping efforts at changing the nature of a situation such that it no longer represents a problem, one's maladaptive reactions to such a situation, or both), problem (i.e., a life situation that requires an adaptive response but for which no effective action is immediately apparent), and solution (i.e., a coping response that is the outcome of the problem-solving process when applied to a specific situation).

The revised model of SPS includes two major dimensions—problem orientation (i.e., a person's generalized beliefs, attitudes, and emotional reactions to problems in living and his or her ability to effectively cope with them) and problem-solving style (i.e., the cognitive and behavioral activities that are applied to solve or cope with problems in living). Research continuously identifies two orthogonal types of orientations—positive and negative—as well as three types of problem-solving styles (i.e., rational or planful problem solving, avoidant problem solving, and impulsive/careless problem solving).

Overarching PST treatment objectives include the following: (a) enhancing one's positive problem orientation as well as his or her planful problem

solving and (b) minimizing one's negative problem orientation, avoidant problem solving, and impulsive/careless reactions. Major obstacles to achieving such objectives include the presence of (a) cognitive overload, (b) poor emotional regulation skills, (c) biased cognitive processing, (d) feelings of hopelessness, and/or (e) ineffective planful problem-solving skills. Given this context, PST trains individuals in a myriad of skills that fit into four toolkits, labeled: *Problem-Solving Multitasking*, *The SSTA Method*, *Healthy Thinking and Positive Imagery*, and *Planful Problem Solving*. Section III of this manual provides for detailed guidelines in teaching these skills.

The next chapter describes the underlying conceptual model upon which PST is based.