ADAPT-C PROBLEM-SOLVING TREATMENT PROTOCOL – Components to cover in each session:

Session 1: Introduction and rationale

1. Establish a positive relationship (i.e., communicate warmth, trust, caring, and respect)
2. Present an overview and rationale of the program
- Why the focus will be on problem solving
- What the patient will get out of it
- How PST will uniquely be adapted to a given patient's experience
- What will actually occur during the training
3. Encourage optimism (i.e., have the patient leave the session with the expectation that this training will be of help)
4. Communicate that the therapist sees the person's potential for effective coping

Session 2: Problem Orientation

1. Facilitate a positive and constructive problem-solving orientation that is focused on improved physical and psychological functioning,
2. Emphasize the idea that problem solving is a viable means of coping with problems,
3. Reduce cognitive distortions or faulty belief patterns that might interfere with effective problem solving and,
4. Facilitate acceptance of emotional reactions and use of emotions as an important problem-solving tool.

Session 3 and 4: Problem Definition

Help patients to:

1. Seek out all available facts (eg, cancer tx)
2. Describe the facts in clear and objective language
3. Be objective – separate facts from assumptions
4. Identify what makes the situation a problem
5. Set realistic goals

Session 5: Generation of Alternatives

Help patients learn brainstorming principles:

1. Quantity breeds quality.
2. Defer judgment.
3. Learn to differentiate between strategies and tactics
4. Teach additional techniques.

Session 6: Decision Making

1. Teach the patient to identify the wide range of consequences (personal, social, short term, and long term) of each alternative idea.
2. Help the patient to make estimates of the value and likelihood of these various consequences
3. Use easier problems initially as practice examples
4. Teach the patient to develop an overall solution plan that addresses multiple factors associated with a problem
5. Emphasize the notion that solution path should contain backup plans
6. Practice decision making tasks with personally relevant problems

Session 7: Solution Implementation and Verification

1. Facilitate the patient's motivation to carry out a solution plan using worksheets
2. If necessary, recycle back to various problem orientation exercises to help encourage patient to implement solution
3. Have the patient rehearse/ role-play carrying out the solution to increase likelihood that he or she will optimally implement it in the future
4. Help the patient develop appropriate monitoring systems relevant to a particular problem and solution plan.
5. Teach the patient to self-reinforce if the problem is solved, and to troubleshoot if the outcome is unsatisfactory.

Session 8: Practice

1. Begin and end sessions in a similar manner as the previous skills-training sessions.
2. Ask patients to review how they applied the problem-solving skills to assigned or new problems since the past session.
3. Discuss areas that have been difficult for them
4. Review completed sets of problem-solving worksheets and assist patients to self-evaluate strengths and difficulties in solving a given problem.
5. Return to certain ideas or training exercises previously introduced to enhance patients' understanding of a given issue or skill acquisition regarding a particular strategy.
6. Continue evaluating and monitoring patients' motivation to practice the problem solving skills.
7. Encourage patients to ask questions regarding the structure or content of these sessions.
8. As a means of enhancing maintenance and generalization, discuss potential problems that may occur in the future.

Session 9: Practice and Termination (You may conduct additional sessions if clinically indicated.)

1. Continue with Practice functions
2. Continue to process the closure of therapy and the therapeutic relationship
3. Review the initial goals of PST, as discussed in the first session
4. Ask patients for examples of how these goals have been met
5. Give your feedback regarding treatment progress
6. Address areas of strengths and weaknesses
7. Give recommendations on how to maintain gains (i.e, practice or monitor self-improvement)
8. Reinforce the patient to encourage continued use of skills gained
9. Encourage patient to use problem solving skills to process feelings, thoughts about termination

ADAPt-C Stepped Care Treatment Algorithm

Step 1[1] (8 weeks)

Based on patient preference, start first line antidepressant (AD) or Problem Solving Treatment (PST)[3]

Antidepressant (AD) OR **PST**

(usually an SSRI - titrated to therapeutic dose)[4] (if patient prefers psychotherapy)

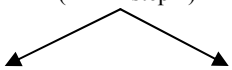
Evaluate response to step 1 treatment.[5]

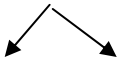
Patients with full response go to maintenance treatment. Others go to step 2

(AD in step 1) (PST in step 1)

Step 2

(4-8 weeks)





Partial response to step 1[5]	No response [5]	Partial response[5]	No response[5]
Different AD type[6]	PST	Add 1st line AD	1st line AD
or	or		
Augment AD[7]	Different AD type[6]		

Evaluate response to step 2 treatment.

Patients with full response go to maintenance treatment. Others are considered for step 3.

Step 3[8] Consider

- Trial of a 2nd or 3rd type of antidepressant
- Combination of antidepressant and PST (if not already tried in step 2)
- Other augmentation of antidepressants (if patient has had a partial response to an antidepressant in step 2)[7]
- Referral to specialty mental health care
- Treatment of comorbid psychiatric disorders (for example OCD, Panic disorder, PTSD)

Continuation and Maintenance Treatment: In general, patients treated with antidepressants should continue the medication for 6-9 months after remission is achieved. For patients experiencing their first episode of depression, medication can be tapered following this course of treatment. Patients who are at high risk for relapse (history of dysthymia, more than 2 prior depressive episodes, or persistent depressive symptoms) are encouraged to continue maintenance treatments for at least 2 years. Decisions about maintenance therapy for patients with 2 uncomplicated episodes of depression can be based on clinical judgment and patient preference. Provide monthly telephone supportive calls and symptom monitoring. Invite to support group.

Additional Treatments to be considered during the course of the intervention[9].

[1]Step one:

Step one treatment will be the initial treatment step for the vast majority of intervention patients. Only the occasional patient who has just completed and failed what appears to be an adequate trial of step one treatment should be considered to start at step two in consultation with the consulting psychiatrist (see below).

[2]Depression secondary to general medical condition or medication. Potential causes of depression in cancer patients include: brain metastases, whole brain irradiation, corticosteriod treatment, hypercalcemia, denurtrition, electrolyte imbalances, and paraneoplastic syndromes (Berney et al 2000). Reversible causes of depression should be sought and addressed if possible. If depression symptoms persist, depression should be treated. Consultation between the oncologist and consulting psychiatrist will be key in this step.

[3]Initial Treatment Choice.

In most cases, patients will be started on PST or an antidepressant medication, **usually a SSRI**. Patients who have previously failed or not tolerated an adequate trial of an SSRI will be considered for an alternative antidepressant (see below). Patients who have previously responded to an antidepressant from a different class should be restarted on the previous antidepressant whenever possible. SSRIs are preferred over TCAs in general at this step because of their lower rates of side effects, particularly in older adults. Patients' report of pain, nausea, and fatigue will also be used to guide first line choice of antidepressant. For example, mirtazapine may be the first line agent in patients with prominent nausea, anorexia, or insomnia. If there are no other medical contraindications, a tricyclic antidepressant may be recommended for a patient with pain. SSRIs alone or in combination with a psychostimulant may be appropriate for patients with severe fatigue. Physicians should pay close attention to potential drug-drug interactions between antidepressants and patients' other medications.

[4]Titration of initial treatment.

Antidepressants should be started at low doses and titrated to a therapeutic dose over a period of 4-6 weeks. See Manual for recommended titration schedules. If patients cannot tolerate a particular treatment (i.e., intolerable side effects even with careful titration and clinical management), consider a switch to an alternative antidepressant or PST after 2-4 weeks and 'restart' step 1. Strategies for managing common side effects of antidepressants are outlined in Manual.

[5]Treatment response:

An adequate trial of step 1 treatment means that patients have completed an 8-week antidepressant trial at a sufficient dose (see manual for dosing guidelines) or a trial of 6-8 sessions of PST. Patients who have had a full response to step 1 treatment (see below) should proceed to relapse prevention planning (see below) and maintenance treatment. Patients who do not have a full response to step 1 treatment should be discussed in the weekly team meeting with the psychiatrist. For patients on PST, a consultation with the psychiatrist will be arranged. Manual provides an outline for such consultations.

The following is a general guideline to defining treatment response:

(1) Full response / remission:
(a) Major depression: Fewer than 3 / 9 DSM IV depressive symptoms **AND** at least a 50 % reduction in the PHQ-9 score.
(b) Dysthymia: Fewer than 2/7 DSM IV depressive symptoms **AND** at least a 50 % reduction in the PHQ-9 score.
(2) Partial response: At least a 30 % reduction in DSM IV depressive symptoms **and** the PHQ-9.
(3) No response:
(a) Major depression: 5 or more DSM IV depression symptoms OR greater than 15 on the PHQ-9.
(b) Dysthymia: 3 or more DSM IV dysthymia symptoms OR greater than 10 on the PHQ-9.

Initial response to antidepressant medications usually occurs within 2-6 weeks. If there is NO response (see above) to antidepressant treatment after 4-6 weeks of an antidepressant at a therapeutic dose, an alternative plan should be initiated. If there is a partial response by weeks 4-6, a full trial (8-10 weeks) of the antidepressant at a full therapeutic dose is recommended.

[6]Antidepressant selection at step 2

See Manual for general information about antidepressant medications. Patients who have failed an adequate trial of a first-line antidepressant at step 1 (usually an SSRI) should be considered for a trial of an antidepressant from a different class. The choice of the second agent may vary depending on the clinical circumstances. If the first trial was with an SSRI or if the patient has a severe depression with prominent neurovegetative symptoms, a combined seratonergic and noradrenergic agent such as **Venlafaxine XR** may be appropriate. At this stage, patients may also be considered for a trial of a nonSSRI/nonSNRI antidepressant, such as **Bupropion SR** or **Mirtazapine,** at a therapeutic dose (see Manual).

[7]Augmentation Strategies:

In general, augmentation strategies are not preferable as first or second step treatments in general medical settings because they require closer clinical monitoring, more complex drug regimens, and often greater expense to the patient. There are, however, times when a patient has had a partial response to an initial antidepressant agent and augmentation with either psychotherapy (PST) or another medication is clinically indicated. An exception to this general rule is the addition of low dose Trazodone (i.e., 25- 50 mg po qhs) for insomnia in patients who are on an SSRI. See also appendix for management of common side effects.

Recommended augmentation strategies include:
(1) Combination of an antidepressant and PST
(2) Combination of an SSRI and a dopaminergic antidepressant such as bupropion
(3) Combination of an antidepressant with lithium, if there are no medical contraindications
(4) Combination of an antidepressant with a stimulant such as methylphenidate
(5) Combination of an antidepressant with thyroid hormone

[8]Step 3:

Patients who have not had a full response at step 2 should be **discussed in the weekly team meeting and strongly considered for an extended psychiatric evaluation and referral to specialty mental health care**. The choice of treatment at this step depends on the clinical situation, the resources available, and the patient's treatment preferences.

Recommended treatment strategies for step 3 include:
- A trial of a 2nd or 3rd type of antidepressant,
- Combination of antidepressant and PST (if this has not already been tried at step 2),
- Other augmentation strategies (see no. 7 above). This is particularly helpful if the patient has had a partial response to treatment at step 2,
- A referral for additional treatments in a specialty mental health setting,
- Specialized treatments for comorbid psychiatric disorders such as OCD, panic disorder, or PTSD,

[9]Additional treatments may be considered by the CDCS at any stage in the treatment course include referrals to specialty m/h or support groups.

Antidepressant Medications:

Generic	Brand	Starting Dosage	Dosage Range
Fluoxetine	PROZAC	20mg qd	20-60mg qd
Paroxetine	PAXIL	20mg qd	20-50mg qd
Sertraline	ZOLOFT	50mg qd	50-200mg qd
Buproprion	WELLBUTRIN	100-150mg qd	100-400mg qd
Venlafaxine	EFFEXOR	37.5-75mg qd	75-225mg qd
Citalopram	CELEXA	20mg qd	20-60mg qd
Escitalopram	LEXAPRO	10mg qd	10-20mg qd
Mirtazapine	REMERON	15mg qhs	15-45mg qhs

Common Potential Side Effects: SSRIs (e.g. Fluoxetine): GI distress (Nausea/Vomiting/Diarrhea), sexual dysfunction (decreased libido, anorgasmia, delayed ejaculation), insomnia, restlessness, agitation, increased anxiety initially, headache, dizziness, sedation, tremor, and watch for potential drug-drug interactions when prescribing with other medications. Buproprion: Activation, insomnia, restlessness, tremors, increased anxiety, headache, dose dependent risk for seizures (therefore, avoid in patients with seizures, bulimia, or risk of electrolyte imbalances). SNRIs (e.g. Venlafaxine); GI distress, activation, diaphoresis, headache, dose dependent hypertension, sexual dysfunction. Mirtazapine: sedation and weight gain.

ALLEVIATING DEPRESSION AMONG PATIENTS WITH CANCER (ADAPt-C)

This ADAPT-C manual was developed by Kathleen Ell, D.S.W., Principal Investigator and Megan Dwight-Johnson, MD., co-Principal Investigator of the ADAPT-C Pilot Study. Sections of this manual were adapted from earlier study materials developed for the Impact study (Jürgen Unützer, MD., Principal Investigator) and Partners in Care (Kenneth Wells, MD., Principal Investigator).

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