EFFECTIVENESS OF PROBLEM-SOLVING THERAPY

TO IMPROVE QUALITY OF LIFE AMONG UNIVERSITY STUDENTS

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A BSC RESEARCH REPORT SUBMITTED TO KINNAIRD COLLEGE FOR WOMEN IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

BSC (HONORS) IN APPLIED PSYCHOLOGY

BY

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RESEARCH COMPLETION CERTIFICATE

It is certified that Ms. Fiza Amjad of BSc (Hons) (session 2019 – 2023), Department of Applied Psychology has carried out research work entitled **"Effectiveness of Problem-Solving Therapy to Improve Quality of Life Among University Students"** under my supervision.

It is assured that research work is original and has not yet been published anywhere else.

Signature of Supervisor Dated 16 -05- 2023

Assistant Professor

Signature

Head of Department

ANTI-PLAGIARISM DECLARATION

I/we certify that this is my/our own research work. The work has not, in whole or in part, been presented elsewhere for assessment. Where material has been used from other sources, it has been properly acknowledged. The similarity index of the research report is 9% (nine percent). If this statement is untrue and I am found guilty of plagiarism, the punitive actions against me should be taken as per Kinnaird Anti Plagiarism Policy.

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Abstract

The present study investigated the effectiveness of problem-solving therapy in improving the quality of life among university students. From an undergraduate population, female participants (N = 30) were asked to complete the World Health Organization Quality of Life BREF (1995) and then were randomly placed in the control group or the experimental group which then received eight sessions of problem-solving therapy. Problem-Solving Therapy: A Treatment Manual published in 2012 by Nezu, Nezu, and D'Zurilla was used. Once therapy was completed following the seven steps as outlined by the author, participants from both the experimental and control groups completed the World Health Organization Quality of Life BREF scale once again. This was an experimental design with an independent group design and a repeated measures design. Results showed that quality of life increased among participants in the experimental condition after receiving PST while it reduced in the control group. Receiving group problemsolving therapy was an effective intervention in increasing coping tendencies among individuals. Problem-solving therapy is a cognitive-behavioral intervention designed to help individuals cope with stressful life circumstances. Further research of this nature should attempt to control for extraneous variables in the participant's environment. Campus counselors and educational social workers can benefit from applying the findings of this study. School psychologists can use Problem-solving therapy to increase the quality of life of students who may have various stressors in their lives.

Keywords: problem-solving therapy, World Health Organization Quality of Life BREF, scale, effect

TABLE OF CONTENTS

List of Tables

List of Abbreviations

Abbreviations	Full Form
PST	Problem-Solving Therapy
WHOQOL-BREF	World Health Organization Quality of Life BREF
SPSS	Statistical Package for the Social Sciences
QOL	Quality of Life

List of Appendices

Chapter 1

Introduction

Problem-Solving

Problem-solving is an essential skill in daily life. Knowing how to identify and confront problems, implement solutions, and learn from them is important for a functional and happy life. Daily stressors are present in everyone's life however, the student population is one that can be said to face more problems than nonstudents. Problem-solving therapy is designed to help individuals learn to cope with major and minor problems. Students may have family, financial, and social issues along with their demanding educational responsibilities. The more stressors in one's life, the lower the quality of life will be. Implementing problem-solving therapy in university students to increase their quality of life can make students better fulfill their responsibilities as students and as members of society in general. The World Health Organization defines the quality of life in a subjective manner based on how an individual perceives their personal position in life in their own culture and the value system of which they are a part. One's quality of life depends on their position in relation to personally set goals, standards, concerns, and expectations (World Health Organization, 2023).

A complication or difficulty is a circumstance that needs an acceptive and corrective response such as regaining emotional balance when an effective response is not immediately available. Multiple factors make a situation into a problem. The factors can be novelty such as moving to a new environment, ambiguity such as not knowing how a relationship is progressing, unpredictability such as feeling no control over a career path, conflicting goals such as different opinions regarding where to live or which house to buy, performance skills deficit such as being

unable to communicate with coworkers, and lack of resources such as inability to pay rent or tuition. Realizing a problem is made when either immediately or after multiple failed attempts. A problem can be a single-time occurrence such as missing the bus to work or dropping one's phone in a mud puddle. A problem can also be a series of related events, contrary parental restrictions, or deviant employee behavior. A problem may be chronic and ongoing such as continuous pain, medical illness, or feelings of loneliness. A problem is a person-environment relationship that can be an actual or understood discrepancy between one's reactions and ability to cope. The difficulty of a problem can change when the environment changes, the person changes, or when both change. Problems are ideographic so what may be a problem for one may be seen as a mere opportunity by another (Nezu, Nezu, and D'Zurilla, 2013).

The solution is the answer or pattern of acknowledging which is the result of the problem-solving process. A solution is efficacious when the goal of problem-solving is met. The constructive consequences are maximized while the adverse results are reduced (Nezu, Nezu, and D'Zurilla, 2013).

Based on the social problem-solving theory, there are two ways to manage stressful problems, generally and independently. One is the orientation one adopts while confronting problems and the other is how one goes about solving problems. Having a positive problem orientation allows people to assess problems as opportunities, are positive that trouble can be solved, and have a strong personal self-efficacy about solving the issue. Also, the individual should comprehend the fact that successful problem-solving requires energy and time. Negative emotions are an important aspect of the overall problem-solving process. A pessimistic problem orientation has the disposition to view problems as threats. Such people believe that can't be

solved and are skeptical about their ability to manage issues appropriately. Such people often become upset and frustrated when they find themselves amongst a problem faced with a problem or when pessimistic emotions take over. A person's disposition impacts the capability and motivation to solve problems in a focused manner. The style of one's problem-solving is the cognitive behavioral activities one does, to deal with stressful problems. There are three different styles include rational/ planful problem-solving, detached and avoidant problem-solving, and having a careless attitude toward solving problems (Nezu, Nezu, and D'Zurilla, 2013).

Using this therapy has five objectives which are making constructive problem-solving better, reducing a pessimistic problem orientation, and decreasing impulsivity when solving issues. Also, a planned way of solving issues is encouraged along with minimizing and avoiding solving problems (Nezu, Nezu, and D'Zurilla, 2013).

Problem-Solving Therapy

Problem-solving therapy (PST) is a cognitive behavioral intervention that attempts to aid individuals in coping with the life events that cause stress through rigorous and effective problem-solving. PST's underlying assumption of is that maladaptive coping leads to psychological issues such as depression. PST is often used to help the depressed because it teaches them to learn skills for better management of daily life problems. Unlike cognitivebehavioral therapy, the focus of PST is not just on changing thoughts and feelings but also on identifying and managing problems (Nezu, Nezu, and D'Zurilla, 2013).

Problem-solving therapy presents a way for the client to solve problems robustly. Cognitive and behavioral influences are used to assist people so that they become more capable of solving

problems to ensure their quality of life. Problems are unavoidable and inescapable but those who know how to effectively solve them are more adaptable and successful than those who are rigid and unable to adapt their behaviors and cognitions so that various problems are resolved. PST strives to increase resilience and prevent emotional setbacks in the clients.

Problem-solving therapy emerged from an in-depth review of the relevant research and theory regarding social problem-solving. The general problem disposition serves as a motivation function where one tries to handle and solve problems. Problem-solving skills are the cognitive behavioral activities that one engages in to develop or discover appropriate solutions to deal with real-life problems. There are four skills for solving problems which are defining the problem, generating alternatives, making decisions, implementing the solution, and verifying.

Psychological research is conducted to improve one's life quality. The purpose of psychological science is to reveal new and better ways of living and thriving in this rapidly changing complex world. Evidence-based strategies are developed, tested, and applied to identify and improve a particularly challenging situation. Being able to adapt and adjust as smoothly as possible is important for a healthy and satisfying life. The purpose of intervention strategies is to enhance positive and pleasant experiences and to minimize distress. There are numerous therapy approaches and intervention strategies tried and tested.

The two objectives of PST are adopting an adaptive worldview and effective implementation of specific problem-solving behaviors. Adopting a positive, optimistic, and accepting view of common everyday problems is important to live with minimal distress.

Problem-solving behaviors consist of emotional management and regulation and solving problems based on a set plan (Nezu, Nezu, and D'Zurilla, 2013).

The book manual used has conceptual and clinical revisions based on the clinical experience of the author and outcome literature. Advancements in psychopathology, decision theory, and neuroscience have also led to revisions. This is why PST is a "contemporary" psychosocial intervention that can enhance major and minor stressors. Minor stressors could be something like chronic daily problems and major stressors can include traumatic events (Nezu, Nezu, and D'Zurilla, 2013).

The manual focuses on strategies to help individuals better manage emotional imbalance. When emotions are abnormally regulated, effective problem-solving cannot take place. The SSTA model of coping with stress is described in the manual: stop, slow down, think, act. PST can be used as a psychotherapeutic approach and/ or as a brief skills-oriented training program. PST includes three major components which are problem-solving, problem, and solution. The process of solving problems is how one directs their managing efforts at altering a situation so it is not a problem any longer, maladaptive reactions to problems, and both the situation itself and the maladaptive emotional response to the problem (Nezu, Nezu, and D'Zurilla, 2013).

Quality of Life

PST has been used in many contexts and on different populations to increase life quality. Group problem-solving therapy was done on depressed patients and the effectiveness of this therapy was apparent to all the group members. PST has also been effective on individuals such as cancer patients and caregivers. PST can also be used as part of a larger treatment package with

multiple components: education, relaxation training, progressive muscle relaxation, etc. (Nezu, Nezu, and D'Zurilla, 2013).

This study assessed the efficacy of problem-solving therapy on university students, specifically, to improve their quality of life. Individuals in their late teens and early twenties who transition to university life, find multiple aspects of life difficult and stressful. Although university life is supposed to be fun and exciting, exams and other demands invite distress. Common issues of university students consist of anxiety, family/ relationship problems, and lack of motivation. University students often feel exam anxiety, future anxiety, and social anxiety. Not knowing effective study techniques or time management can often lead to a feeling of incompetence and confusion as a student. Identifying and intervening with early intervention can lead to better improvement. Many students also face financial problems such as budgeting. The deadlines and due dates for assignments and projects can make studies feel too overwhelming and burdensome. However, with effective problem-solving and prioritizing, students may feel an increased quality of life (Porein, 2021).

Previous research shows that the quality of life of students can be enhanced if problemsolving training is given. Chinaveh (2010) conducted a study with a control group that did not get training and a training experimental group. The results showed that those in the PST training group had better life quality and psychological health and became better at problem-solving. How effectively one is able to solve problems, plays a role in social and psychological competence. When one is unable to effectively solve problems, psychological maladjustment and stressful outcomes are the results. University life presents social, interpersonal, and

academic demands. This time period is stressful and adjustment is based on how one copes, which impacts physical and psychological health.

Students should be trained and taught effective problem-solving techniques so that they can be socially competent and psychologically healthy. The better one's problem-solving skills, the higher one's adaptation and general competence. How everyday problems are dealt with is dependent on how one functions personally and socially. Studies have shown that social problem-solving also plays a positive influence on college freshman grade point average scores (D'Zurilla & Sheedy, 1992).

Theoretical framework

PST states that there are two types of orientations towards approaching a problem: a positive orientation, and a negative orientation. However, some people do not exclusively follow one orientation only. An example would be a person with a positive orientation when dealing with educational and career problems but a negative orientation when dealing with interpersonal problems. This is parallel to Mischel and Shoda's (1995) cognitive-affective system theory of personality according to which individual differences determine how one will behave across different circumstances. Clients who come to therapy may have different orientations toward different problems. Once the circumstances under which the client follows a negative orientation style are identified, then thoughts and behaviors for that particular domain and or circumstances of life have to be changed. The theory of personality pays importance to situational variables and the thoughts that an individual has which will determine what they think and how they will act.

In PST, it is essential for the therapist to recognize the client's behavior patterns across situations so that treatment can be successful. An initial step in PST therapy is changing the problematic orientation because this directly influences how effectively an individual can solve problems.

Personality traits differ for everyone and predispose every individual to how they will behave. Those having problematic cognitions and behaviors as a result of particular situations, need to learn how perception and beliefs can influence the felt consequences. PST was developed with the knowledge of how understated orientation styles were in talk therapies. When compared with studies in which orientation styles were excluded from therapy, the effectiveness of PST was much lower. Cognitive-affective theorists argue that behavior is a person's perception of themselves in certain circumstances and not a global personality trait (Nezu, Nezu, and D'Zurilla, 2013).

Literature review

Nguyen et al. (2018) conducted research to assess PST for primary care to make better complex decision-making amongst healthy senior citizens. It has been seen that many times older adults make poor decisions even when they are cognitively healthy. Older adults become more vulnerable possibly due to the irregular aging of the frontal lobes that leads to a lower ability of executive functioning. This study wanted to see whether psychosocial intervention in the form of PST would improve decision-making abilities in older adults. 20 participants older than 65 were selected who were emotionally and cognitively healthy. They were randomly placed either in the no-treatment control group or the PST condition. Those in the PST condition got four sessions 45 minutes in duration across two weeks. The Iowa Gambling Task (IGT) was given to measure the outcome of the control and treatment groups. A significant difference

between the two scores could be seen and those who got the intervention were notably better than subjects in the Control group. Those who got the intervention could make more advantageous decisions. Those who received therapy had better executive functioning and were better able to make complex decisions.

Nakku et al. (2021) conducted research to see the impact of PST when given by nonspecialist health workers on disability and symptom severity Perinatal depression is a mood disorder that affects new moms during pregnancy and after giving birth. This is an important health concern for people living in middle-income and low-income nations. Pregnant females were taken as participants who were in their second and third trimesters. The females were administered the 9-item Luganda version of the Patient Health Questionnaire for screening for depression. Participants whose scores were equal to or greater than five and whose depression was confirmed by their midwife were put in the treatment condition and were given PST. The PHQ-9 and WHODAS-2.0 were used at baseline as well as at three and six-month follow-ups after the intervention. From 2652 females, 153 were depressed of which 25% went through physical interpersonal violence and 25.5% went through sexual interpersonal violence as well. Around a third, of women with depression diagnosis (34.7%) received four or more group problem-solving therapy sessions. PHQ-9 scores were reduced and a significant decline in WHODAS scores was apparent as well. This study showed that PST given by trained and supervised midwives may reduce perinatal depression in women.

Zhang et al. (2018) conducted a meta-analysis and systematic review to see if PST could be used to reduce anxiety and depression among primary care patients. There is increasing demand for primary care patients to be treated for anxiety and depression. Searches were made

across six databases and manual searching was used as well. Initially, 153 studies were used and 11 studies comprising 2072 participants met the inclusion criteria of synthesis. Results showed that PST had a significant treatment effect on people in primary care with depression or anxiety. When a physician was involved in the PST, improvements could be seen among primary care patients with depression and/ or anxiety.

Hof et al. (2011) conducted a pilot study that assessed the viability, effectiveness, and acceptability of PST for common mental disorders in impoverished communities around Cape Town. Unfortunately, most people in Africa, are not diagnosed nor given any treatment even after being diagnosed with a disorder by the DSM-V. Even disorders that are very commonly treated in other countries are not treated so a move for simplifying the treatment for popular psychological disorders has taken place to make accessing treatment easier. Problem-solving therapy has the potential to fill the treatment gap for common mental disorders among underprivileged South African communities. Recruiting subjects for PST using the online medium was difficult so PST via booklets was selected instead. Volunteers experiencing psychological distress participated in group-delivered or individual self-help program which was 5 weeks in duration. Self-report questionnaires were used to evaluate the effectiveness. The study consisted of a total of 103 participants from which 73 subjects completed five weeks of brief PST in the workshop/ booklet format. Results showed that participants who completed worksheet booklets individually had a higher chance of dropping out than those who completed the booklet in groups. Brief problem-solving therapy was acceptable, feasible, and effective for treating short-term common mental disorders in deprived communities.

Malcarne et al. (2018) assessed the efficacy of PST for partners of males who had prostate cancer. Prostate cancer when diagnosed, adversely impacts not only the patients but their spouses as well. Distress increases while the quality of life lessens however, PST is seen to be effective in reducing distress and improving life quality. In the randomized control trial, amongst a total of 164 participants, 78 men were randomly assigned to PST and 86 were assigned to psychosocial care. Spouses of the patients completed destructive and dysfunctional problem-solving measures during preintervention and post-intervention as well as at follow-up 3 months later. Constructive problem-solving was much better from pre to post-intervention among the partners who received PST but did not increase among the spouses who got usual psychosocial therapy. This difference was also present at the 3-month follow-up. However, a decrease in dysfunctional problem-solving was not present. Those spouses who got PST had lower distress regarding cancer after the intervention and at follow-up. The dyadic adjustment was higher for partners who got problem-solving therapy instead of the usual psychosocial care after intervention but not at follow-up. In conclusion, PST effectively improved the constructive problem-solving and individual and dyadic outcomes of the spouses of men with prostate cancer spouses' constructive problem-solving.

Chinaveh (2010) conducted a study to assess the efficacy of PST on college students. PST training has been used to make the quality of life better for the recipients. A study included 79 college students who reported low quality of life and mental health. Some were randomly placed in 6 weekly training groups for problem-solving therapy or the control condition with no training. Quality of life and mental health was assessed on the first and last days of the program

along with the control group. Both qualities of life and mental health increased after the PST program but not in the control group.

Chinaveh (2013) conducted research on the effect of PST on adjustment and coping skills among college students. PST has also been examined in enhancing psychological adjustment and effective coping skills among Iranian college students. 80 students reporting low levels of coping responses were randomly placed in the PST training group or the no-treatment control group. The students receiving PST got 8 weeks of therapy. The coping skills of these students included avoidance and approach responses and psychological adjustment was evaluated on the initial day of the program and thirty days after the program with the control group. One's mental adjustment and coping response increased in the group receiving the training. An individual's appraisal of problem-solving is linked to how one perceives and copes with issues of everyday life.

Pugliese and White (2013) conducted PST on autistic students. Students with autism spectrum disorder may be academically capable but often suffer at the college level. PST which is an evidence-based intervention was used in a group-based format. Its purpose was to promote effective problem-solving and satisfaction and success at college. There were a total of five participants of which four completed at least eight of the nine sessions and the between-session assessment completion rate was 83%. Two participants showed improvement post-intervention in subjective distress and problem-solving ability but further research is needed.

Gellis et al. (2008) conducted a randomized control trial was done to see the effectiveness of PST on older adults with minor depression who were living in-home care. This study placed 30 older patients in the PST group and 32 were placed in the treatment-as-usual group which was the control condition. Results showed that those in the PST as compared to the

control group had significant improvement in depression symptoms and problem-solving abilities.

Rees et al. (2017) conducted a randomized control trial in which to assess the effect of PST on diabetic patients. The patient had diabetic retinopathy and diabetes distress. 40 placed were placed in the PST group or the control group and measures were taken at baseline, 3month, and 6-month follow-ups. Results showed that patients who received PST had improved depressive and self-care scores at the 6-month follow-up).

Rationale

Problem-solving therapy has been shown to increase the quality of life among various populations across different cultures and countries. This therapeutic approach falls under cognitive-behavioral therapy with several treatment components which need to be followed through so one's ability to cope in stressful situations is enhanced. Once beneficial psychological and behavioral habits are learned, future difficulties will be better prevented. Although numerous studies have been done on the effectiveness of PST, a culture, population, and methodology gap exists. PST has been used on a vast array of populations, however, only a few studies have been done on improving the quality of life of university students. This therapy has not been used on a Pakistani population and this study will attempt to close the culture gap as well. The effectiveness of therapy developed by an American professor will be assessed in Pakistan. If this therapy is effective on Pakistani students, the result may be used on other Pakistani populations such as parents of mentally or physically challenged kids, newlywed couples, cancer patients, teenage mothers, and caretakers. Studies assessing the effectiveness of PST use various designs such as meta-analyses, systematic reviews, randomized controlled trials, etc in various countries.

However, an experimental design in Pakistan has not been used and this study will attempt to cover this methodology among the Pakistani population. School and university students undergoing high stake exams are under pressure and in stressful situations and in order to alleviate stress and increase the quality of life, campus counselors can use PST. Faculty members can teach PST components to students so that they can learn mental and physical techniques for better coping and confronting problems.

Objectives

The goals of the study are

1. To compare whether there is a significant difference in the QOL of university students in the experimental and control groups at the pre-intervention level.
2. To evaluate whether the treatment group of university students will have a higher QOL as compared to the control group at the post-intervention level.
3. To assess the impact of the intervention on the QOL among university students in the treatment group by comparing their pre- and post-intervention scores.
4. To determine if there is a significant change in the QOL of the control group from pre- to post-intervention levels among university students.

Hypotheses

1. There is likely to be a significant difference in pre and post-intervention scores in terms of QOL in the treatment group.
2. There would likely be no significant difference in the QOL of the control group at the pre-post level.

3. There is likely to be a significant difference in both groups (experimental and control) at the pre-intervention level in terms of QOL.
4. The treatment group is likely to have a significantly higher level of QOL as compared to the control group at the post-intervention level.

Chapter II

Method

Research Design

An experimental design aims to carry out research in an objective and controlled way to establish a cause-and-effect relationship between the independent variable and the dependent variable by relying on random assignment. This research is an experimental design with an independent group design and a repeated measures design. An independent group experimental design is one in which different people are placed in different experimental conditions. A repeated measures design is when multiple measurements are taken of the same variable from the same participants twice or more. These methods are mostly used in research involving the investigation of the effects of an intervention in two groups. (Creswell, 2013).

Through the World Health Organization Quality of Life BREF (WHOQOL-BREF) questionnaire, measurements were taken before and after the therapy intervention to see changes in scores. Initial screening was done on 50 individuals from which 15 were put in the experimental condition and 15 were put in the control group. A between-subjects design was used in which there were two groups of participants under different conditions. The two groups were the experimental group which got the psychological intervention of Problem-Solving Therapy and the control group. A within-subjects/ repeated measures design was employed pre and post-intervention to assess the experimental group.

Sample and Sampling Strategy

The sample size included N=30 participants between the ages of 17 to 21 years based on an initial screening of 50 participants. Domain scores for all of the students were calculated from which students with low quality of life were randomly selected and 15 students were placed in the experimental group and 15 students were placed in the control condition. Undergraduate female students fluent in English were part of the sample. Participants in this study were selected using convenient sampling from Kinnaird College for Women, Lahore. From the 30 participants who had low quality of life scores, each participant was assigned to one of two groups comprising 15 participants in each group by simple random assignment. Random assignment is a method through which study participants can be placed into different independent variable levels in an unbiased manner. The simple random assignment method ensures that every member will have an equal opportunity to be placed in either the control group or the treatment group(s) (Bhandari, 2021).

Inclusion criteria

Participants were selected for participation in this study only if they fulfilled a set of criteria. All participants were females between the ages of 18-23 who were single and fluent in English. All participants were willing to receive therapy and all were currently enrolled in the Applied Psychology undergraduate program at Kinnaird College.

Exclusion criteria

This study excluded students with any mental disorder or physical illness. Also, students unwilling to attend intervention and those with a high quality of life were excluded as well.

Table 2.1

Sociodemographic Characteristics of Participants

Sample Characteristics	Experimental Group		Control Group		Full Sample	
	n	%	n	%	n	%
Gender						
Female	15	50	15	50	30	100
Marital Status						
Single	15	50	15	50	30	100
Education						
Undergraduate	15	50	15	50	30	100
Employment Status						
Unemployed	12	80	13	86.66	25	83.33
Employed	1	6.66	1	6.66	2	6.66
Self-employed	2	13.33	1	6.66	3	10

Note. N = 30 (n = 15 for each condition). Participants were on average 18.87 years old (*SD* = 0.94), and participant age did not differ by condition.

Table 2.1 shows the demographic characteristics of participants. The study consisted of 30 participants whose ages ranged from 17 to 21 years with 18.87 years being the mean age.

Every participant was single was fluent in English (100%), and was an undergraduate student

majoring in psychology (100%). Most of the participants were unemployed (83.33%). However, a few girls were employed and working alongside their studies (6.66%). A few participants were self-employed (6.66%).

Data collection instruments

Problem-Solving Therapy Treatment Manual. The manual used is titled Problem Solving Therapy: A Treatment Manual (2012) written by Nezu, Nezu, and D'zurilla. This treatment manual is written in easy English. Using the book manual does not require any specific training nor is it mentioned in the manual itself. The manual is a laudable and distinctive resource that is open to use for a wide variety of individuals with mental and or physical problems. It has been tested for efficacy multiple times but has yet to be added to the student population. This therapy is a cognitive behavioral intervention designed to help individuals cope with stressful events. Maladaptive coping is what causes individuals to become distressed during stressful events and one can use the manual to help themselves feel better or the manual can be administered. Numerous studies had reported its effectiveness in comparison to control groups. This manual focuses on specifics through systematic observation and critical thinking so that appropriate solutions can be carved to reach desired goals. This therapy is considered to be under the umbrella of CBT. This therapy may be combined with other treatments such as medication.

World Health Organization Quality of Life- BREF (WHOQOL-BREF)

The World Health Organization Quality of Life-BREF Scale is a 26-item scale that measures one's quality of life. Each item is rated on a Likert-type scale ranging from 1 to 5. Each ordinal item is asked in regard to the past two weeks and the subject is asked to keep in mind their standards, hopes, pleasures, and concerns. Items 3,4 and 26 are reverse-coded. There are two

items measuring general health and four domains across which the 26 items are spread: physical health, psychological health, social relationships, and environment. Items in each domain are totaled to get domain total scores. The items in the physical health domain consist of daily activities, mobility, energy, sleep, functional capacity, and pain. The psychological domain consists of self-image, esteem, negative thoughts, positive attitudes, memory, religion, mental ability, and learning. The social relationships domain includes items on social support, intimate life, and personal relations. The environment domains consist of economic satisfaction, safety, social services, health, transportation, physical living, learning opportunities, and social services. Scale items 1 and 2 measure the overall life quality and general health which are analyzed separately (Vahedi, 2010).

Procedure

Pilot Study. A pilot study was done before the main study to check the feasibility, duration, and comprehension of the therapy intervention. After taking consent from (see appendix) a sample of 4 participants before administering the scale for screening, PST was implemented in a group setting. Relevant changes were made including printing all the worksheets for the sessions and increasing the session duration from 30 minutes to 50 minutes.

Main Study. Initially, consent was taken from the institute where research was conducted. Those participants who consented to complete the WHOQOL-BREF questionnaire were selected through convenience sampling.

The main study included 8 sessions for the treatment group and each session was 50 minutes in duration. First, an electronic survey of the WHOQOL-BREF was created so that participants could conveniently fill out the scale. Then 15 participants with a low quality of life

were randomly placed in the treatment group and 15 were put in the control group. The World Health Organization Quality of Life- BREF survey was administered pre and post-intervention which assessed the self-reported quality of life through the following four domains: physical health, psychological health, social relationships, and environment. Two initial items assessed general life quality and overall health. Participants were then invited for therapy and in the first therapy session, participants were debriefed and rapport was built. The next seven sessions were conducted weekly and fading was done in the last three sessions which were conducted biweekly.

Table 2.2

Table Showing 1st Session Plan for the Experimental Group

Content of Session 1 (duration 55 minutes)		
Assessment	**Domain**	**Rationale**
Review of the previous session	Overview (10 minutes)	All participants were warmly welcomed by the researcher and they were told their rights and rules.
	Introduction (10 minutes)	Awareness regarding the purpose of the study and efficacy of PST based on past

	Brief discussion and Problem-Solving Test worksheet (20 minutes) Differences between a positive and negative problem orientation were explained (10 minutes) Self-Statement Worksheet (5 minutes)	studies was told. The length and the duration of sessions was told. After a brief discussion of potential problems the participants were facing involving icebreaking comments, everyone was given a sheet to help them identify their problems. Participants were told the difference between orientation styles and impulsive, avoidant, and effective problem-solving. A printed list of positive self-statements was given to each participant to keep and refer to outside of sessions as well.

Table 2.3

Table Showing 2nd Session Plan for the Experimental Group

Content of Session 2 (duration 55 minutes)		
Assessment	**Domain**	**Rationale**
Review of the previous session	Overview of the previous session (10 minutes)	Differences between orientation styles were explained along with tips on how to develop a positive orientation.

	Problem Worksheet (15 minutes) Group discussion (30 minutes)	Participants were given the Problem-Solving Test worksheet (see appendix) which was given in the last session. A group discussion was held so all participants could share and hear one another. Once every member shared their problem if they wanted to, other members gave potential suggestions and solutions.

Table 2.4

Table Showing 3rd Session Plan for the Experimental Group

Content of Session 3 (duration 55 minutes)		
Assessment	**Domain**	**Rationale**
Review of the previous session	Overview of the previous session (5 minutes) Selection and defining the problem clearly (15 minutes) Group discussion was done on how to apply positive and go about daily life with the	Quick summary of the previous session was given. Participants were asked to take out their worksheet from the last session and select one relevant and meaningful problem. Defining a problem worksheet was given to everyone to complete. All members discussed their problems and were able to develop objective definitions.

	problems present (20 minutes)	

Table 2.5

Table Showing 4th Session Plan for the Experimental Group

Content of Session 4 (duration 55 minutes)

Assessment	Domain	Rationale
Review of the previous session	Participants were summarized about the importance of objectively defining their problem (5 minutes)	Participants shared anything they wanted to about defining their chosen problem objectively. Participants were asked to mentally brainstorm possible solutions while a worksheet regarding brainstorming solutions was done as a group with the facilitator in which one participant shared their problem and the other members came up with possible solutions.
	Identify solution through collective brainstorming (15 minutes)	All participants were given a brainstorming worksheet (in appendix) but, many participants could not come up with various solutions for their problems so then group discussion began, and participants who wanted to share their problems

	Stress relief exercise (10 minutes) Homework (5 minutes)	shared, while other members came up with solutions. Everyone engaged in a stress relief exercise involving progressive muscle relaxation and positive imagery. Everyone was given a Problem-Solving Self Self-Monitoring Form worksheet (see appendix)

Table 2.6

Table Showing 5th Session Plan for the Experimental Group

Content of Session 5 (duration 55 minutes)

Assessment	Domain	Rationale
Review of the previous session	Homework sheet (5 minutes)	Everyone was asked to take out homework sheet and remind themselves of the brainstormed solutions
	Focus of session and Decision-Making worksheet (30 minutes)	Participants were guided to select and make a decision through analyzing the advantages and disadvantages of the selected solution by initially discarding inconvenient solutions and then grouping together similar solutions through the Decision Making worksheet (see appendix). 2-3 solutions were selected along with their pros and cons.

	Various slow-down strategies were explained and conducted (15 minutes)	Different strategies were told including deep breathing, fake smiling, fake yawning, exercise, mindful walking, gum chewing, and engaging in spiritual behavior.
	Homework	Everyone was given an ABC Thought Record worksheet (see appendix) to complete which would help identify the situation or event leading to particular thoughts, emotional reactions, and a subjective intensity rating.

Table 2.7

Table Showing 6th Session Plan for the Experimental Group

Content of Session 6 (duration 55 minutes)		
Assessment	**Domain**	**Rationale**
Review of the previous session	Homework sheet (10 minutes)	A discussion was done on the ABC Thought Record worksheet that each client completed in the past week.

	Mindful Meditation (10 minutes)	All participants were asked to engage in mindful meditation which began with focusing on one's breathing and ended with noticing and letting go of thoughts.
	SMART Action plan (10 minutes)	The importance of a SMART action plan was discussed. Everyone was explained that they needed to create, implement, and follow through with an action plan targeted to solve the particular problem.
	Action Plan Worksheet (10 minutes)	All participants were given an action plan worksheet (in appendix) to complete as descriptively as possible by helping one another.
	Discussion (10 minutes)	Then the session proceeded with participants being taught potential ways to overcome cognitive overload. Externalization, visualization, and simplification were taught and a Minding Your Mind (see appendix) printed sheet was given to be referred to so that participants could avoid the habit of using judgemental talk and disputing negative self-talk.

Table 2.8

Table Showing 7th Session Plan for the Experimental Group

Content of Session 1 (duration 55 minutes)		
Assessment	**Domain**	**Rationale**
Review of the previous session	Introductory discussion (10 minutes)	A discussion was done on the SMART action plan created and the progress regarding its implementation.
	Overview of the session (5 minutes)	The main purpose of this session was to see how each group member was carrying out and amending the action plan created before.
	Group discussion (20 minutes)	All participants were asked to engage in a discussion by listening to and giving suggestions to one another regarding how to be more successful in getting rid of the problem and how to be more positive.
	Listening to Feelings sheet and discussion about disputing negative self-talk (15 minutes)	Everyone was shown a Listening to Feelings sheet (see appendix) so that each participant could better understand what their emotions were telling them.

	Homework (5 minutes)	Participants were given an Action Plan worksheet for homework which allowed them to understand how effective the solution plan was in relation to the goals.

Table 2.8

Table Showing 8th Session Plan for the Experimental Group

Content of Session 8 (duration 55 minutes)

Assessment	Domain	Rationale
Review of the previous session	Homework sheet (10 minutes)	All participants were asked to share their responses to the homework worksheet.
	Group Discussion (30 minutes)	All participants shared their work on their plan and a positive desired change was felt. Group members offered solutions to one another.
	Facilitator's comments (10 minutes)	Encouraging and supportive statements were told to the participants along with a brief talk on becoming optimistic, seeing all problems as challenges to learn from, the importance and benefits of exercise, and engaging in self-time which has been shown to reduce stress and increase personal happiness and satisfaction.
	Conclusion (5 minutes)	All participants were thanked for their participation and were given a summary form to complete (see appendix). They were asked if they had any questions or comments to make which were addressed.

Session 1. In the first session, each participant was welcomed and told that they had the right to leave and that all they would say was to remain private. The study's purpose and the importance of their participation in each session were emphasized. Rapport was built by asking the participants their names along with their interests or anything that they wanted told to be shared. Icebreaking comments were made to allow everyone to feel comfortable and relaxed. The rationale of this therapy was explained with examples of existing literature review which shows the effectiveness of this therapy. The length and duration of sessions were explained. The participants were asked to share any problems that they were having and completed a worksheet to assess the nature of the problems in their lives. They were all psycho-educated by being explained how problems affect the body and the mind and how cognitive behavioral therapy has been generated to help reduce not only problems but personal perceptions of problems as well. In the first session, negative and positive orientation styles were explained as how one's thoughts and feelings in general and then in relation to one's person's ability to overcome a problem can form orientation style and how a client will respond to a problem. Differences between impulsive and avoidant problem-solving and rational and effective problem-solving were explained and participants were asked to discuss amongst one another the nature of their problems and their current problem-solving orientations. Participants were then explained the importance of a positive orientation instead of a negative orientation, how to take things lightly, and how to increase personal belief in their ability to solve problems. A printed list of positive self-statements was given to each participant to be referred to and used when feeling stressed or anxious outside of therapy.

Session 2. Participants were given a summary of session one and the differences between a positive and negative problem orientation along with how to begin taking everything in a

positive light. Participants were then explained how to recognize a problem so that a concrete path to solving the problem can be carved. Participants were given a problem-solving test worksheet along with a problem checklist from the manual on which they could write down any problems they were having such as interpersonal/ societal, family, educational, financial, physical, or mental. Group discussion was happening once clients write down their problems. They were asked to share if they wanted to. This way each group member could understand that they are not alone, that many others share the same problems as them, and that sharing will allow possible solutions to be generated from different people. This discussion allowed participants to recognize the situations and circumstances in their lives that were causing them stress and/ or anxiety.

Session 3. Participants were asked to use their problem-solving test worksheet to select one major meaningful and relevant problem that they wanted to work on currently. Participants were asked to think about and define the problem using a worksheet. Participants were asked to ponder and write down the available facts regarding a problem such as who is involved in the problem and when and where the problem occurs. After completing the worksheet, the second half of the session was spent in a group discussion regarding how to begin changing attitudes to become more positive.

Session 4. This session began with a small discussion regarding the problems that each participant chose in the last session and then the session was geared towards generating solutions. Now that each participant recognized the most significant problem in their lives, brainstorming solutions was the next step. Participants were guided to brainstorm as many relevant solutions as they could to their problem chosen. First, a group worksheet regarding brainstorming solutions was done as a group in which one member's problem was chosen and

the other members came up with possible solutions. After this, the same worksheet about brainstorming solutions was given to each member to complete individually. Many participants could not come up with various solutions for their problems so then group discussion began and participants who wanted to share their problems shared, while the rest of the group members came up with solutions in attempting to help. In this session, the feasibility or usefulness of solutions was not discussed instead only brainstorming was emphasized which allowed every group member to come up with creative potential solutions. In the last ten minutes of the session, each participant was asked to participate in a stress relief exercise involving progressive muscle relaxation and positive imagery. Participants were guided to use these activities outside of therapy as well when feeling anxious or angry. For homework, each participant was given a problem-solving self-monitoring to complete.

Session 5. At the start of this session, each participant was asked to refer to their homework worksheet and then to focus on making a decision now. Participants in this session were guided to look in depth at possible solutions created in the last session. A systematic way was explained in order to come up with a solution so that any confusion in the minds of participants could be erased regarding the numerous potential solutions. The group was first guided to discard any solutions that were written down in the last session so that an effective solution could be identified. Then grouping of similar solutions was done by each participant on the decisionmaking worksheet given. Then participants were explained to select 2-3 solutions that they then evaluated in terms of advantages and disadvantages. In the last fifteen minutes of this session, participants were explained different slow-down strategies including deep breathing, fake smiling, fake yawning, exercise and mindful walking, gum chewing, and engaging in spiritual behavior. Participants were explained how to prevent overwhelming and negative

emotions through the S.S.T.A. method. They were then shown a figure of the method and how stress leads to adverse consequences. Clients were given an ABC Thought Record worksheet to complete until the next session which would help identify the situation or event leading to particular thoughts, emotional reactions, and a subjective intensity rating.

Session 6. At the start, a discussion was done on the ABC thought record worksheet that each client completed in the past week. Then all participants were asked to engage in mindful meditation which began with focusing on one's breathing and ended with noticing and letting go of thoughts. Once everyone was relaxed, the importance of a SMART action plan was discussed. Now group members were explained that they needed to create, implement, and follow through with an action plan targeting to solve a particular problem. After a brief discussion about the importance of goals and plans being SMART, each participant was given an action plan worksheet to complete as descriptively as possible. Group members feeling stuck on finalizing an action plan were guided to explain their problem and solution and help one another out. Participants were encouraged to carry out their action plans which would then be discussed in the following session. Then the session proceeded with being taught potential ways to overcome cognitive overload which was the problem that many participants were reporting. Externalization, visualization, and simplification were taught and a Minding Your Mind printed sheet was given to be referred to so that participants could avoid the habit of using judgemental talk and disputing negative self-talk.

Session 7. This session began with a discussion on the SMART action plan created and the progress regarding its implementation. The main purpose of this session was to see how each group member was carrying out and amending the action plan created before. The majority of the session time was spent in discussion in which group members listened to and gave

suggestions to one another regarding how to be more successful in getting rid of the problem and how to be more positive. Everyone was shown a Listening to Feelings sheet so that each participant could better understand what their emotions were telling them. A group discussion was done on feelings of hopelessness and strategies for disputing negative self-talk were discussed. Participants were told the importance of talking to significant others and how therapy thus far had hopefully helped them. Participants were given an action plan worksheet for homework which allowed them to understand how effective the solution plan was in relation to the goals. **Session 8.** This session began with a discussion reviewing the homework sheet. Through a group discussion, it was understood that all participants were working on their plan and a positive desired change was being felt among each group member when asked. Group members offered solutions to one another regarding how to implement techniques learned in the past sessions.

Encouraging and supportive statements were told to the participants along with a brief talk on becoming optimistic, seeing all problems as challenges to learn from, the importance and benefits of exercise, and engaging in self-time which has been shown to reduce stress and increase personal happiness and satisfaction. In the end, all participants were deeply thanked for their participation and were given a summary form to complete. They were asked if they had any questions or comments to make which were addressed.

Ethical Considerations

Initially, consent to collect data from participants was gotten from the institute department officials. The WHOQOL-BREF is ready for usage in numerous languages and is in the public domain available for usage. All willing participants gave verbal and written informed

consent to participate in sessions before beginning the research. Participants were informed about the rationale and purpose of the research and could withdraw at any point during the study. The confidentiality and anonymity of all participants were respected and maintained. Participants had the right to ask any questions and their questions and concerns were answered before, during, and after the study. Participants interested in the results were provided with the results along with further debriefing if required and those in the control group were ethically provided with a brochure (see appendix) containing PST steps in detail and intervention techniques at the end of this study. Data were statistically analyzed through SPSS and were presented with the utmost integrity.

Statistical analyses

Data were analyzed using the Statistical Package for the Social Sciences version 29. Inferential and descriptive statistics were used which include Descriptive Statistics: mean (M) and standard deviation (SD). Wilcoxon Signed-Rank test was used to check for the mean rank differences within groups at pre and post-intervention levels. To examine the effectiveness of PST, the differences between the experimental group receiving therapy and the control group were seen through the Mann-Whitney U test. This is the nonparametric test that was used to decide whether the pretest means scores are lower than the post-test mean scores of WHOQOL-BREF.

Chapter III

Results

In this study female university undergraduate students (N=15) were given PST to check for its effectiveness in increasing subjective life quality which was then assessed through the WHOQOL-BREF. A reliability analysis of the measures used in the study was done and their psychometric properties were calculated and presented in Table 3.1. To calculate the means and standard deviations of demographic data, descriptive statistics were used and are shown in Table 3.2. Analysis of the data in two domains was used to determine the effectiveness of the WHOQOL-BREF. First, to evaluate the impact of the intervention, the experimental group's pre and post-scores were compared using the Wilcoxon Signed Rank Test for within-group differences. The findings are shown in Tables 3.3 and 3.4. Secondly, pre and post-intervention scores on the WHOQOL-BREF were then compared between groups to evaluate group differences. Non-parametric tests were applied during analyses due to the small sample size (N = 30). The results of the treatment and control group were analyzed using the Mann-Whitney U Test, which is the non-parametric version of the Independent Sample T-Test. Table 3.5 shows the results prior to the intervention while Table 3.6 compares the post-intervention results between the experimental and control group.

Reliability Analysis

Table 3.1

Psychometric Properties of World Health Organization Quality of Life- BREF Scale

Measure	Post-test	Pre-test				
	Pre-test		Post-test		Pre-test	Post-test
	M		SD	Range	Cronbach's *a*	
WHOQOL-BREF	86.47	91.40	10.57	12.14	26-130	.79	.89

Note. M = Mean, SD = Standard Deviation, *a* = Cronbach's alpha.

A reliability analysis of the scale used in the current study was done to find the internal consistency of the scale. With a Cronbach's alpha of .79 at the pre-test level, the World Health Organization Quality of Life- BREF showed acceptable internal consistency. The postintervention Cronbach's alpha was .89 demonstrating good reliability.

Descriptive Statistics

Table 3.2

Means and Standard Deviations of Domain Scores

		Pre-test	Post-test	Pre-test	Post-test
		M		SD	
Domains	N				
Physical Health	30	3.18	3.44	.46	.55
Psychological Health	30	3.17	3.20	.54	.58
Social Relationships	30	3.44	3.67	.67	.54
Environment	30	3.46	3.65	.56	.63
Overall	30	3.54	3.88	.57	.63

Note. N = No. of participants. M = mean, SD = Standard Deviation

The table shows the domains of the WHOQOL-BREF. The results show that the physical health subjective rating increased from 3.18 to 3.44. The scores in the psychological health domain also increased slightly going from 3.17 to 3.20. The social relationships scores also increased going from 3.44 to 3.67. Scores in the environment domain also increased from 3.46 to 3.65. And lastly, scores from the two items measuring overall quality of life and satisfaction with health also increased going from 3.54 to 3.88.

Table
3.3

Wilcoxon Sign-Rank Test Showing PST Intervention Effect on Quality of Life at Pre (n = 15) and Post (n = 15) Levels of Intervention within Treatment Group

Variable	**MR**	**Z**	***p***
Quality of Life AI - BI		-2.47	.01**
	4.13		
	9.41		

Note. MR = Mean Rank, BI = before intervention, AI = after intervention, *p<.05, **p<.01, ***p<.001.

The Wilcoxon Signed-Rank test showed that there is a significant within-group mean rank difference in pre and post-intervention assessment on the quality of life scores. The students in the treatment group scored significantly higher in WHOQOL-BREF (Z = -2.47, p = .01) at post-intervention assessment as compared to pre-intervention assessment. Participants' quality of life increased after receiving group problem-solving therapy. These findings are consistent with the first null hypothesis since a significant difference is present between pre and post-intervention scores in the treatment group.

Table

3.4

Wilcoxon Sign-Rank Test Showing PST Intervention Effect on Quality of Life at Pre (n = 15) and Post (n = 15) Levels of Intervention within Control Group

Variable	**MR**	**Z**	***p***
Quality of Life AI - BI		-.70	.48
	6.00		
	6.86		

Note. MR = Mean Rank, BI = before intervention, AI = after intervention, **p*<.05, ***p*<.01, ****p*<.001.

The Wilcoxon Signed-Rank test demonstrated that the control group had insignificant within-group mean rank differences in pre and post-intervention assessment on the quality of life scores. The students in the control group did not elicit a significantly different score in WHOQOL-BREF (Z = -.70, *p* = .48) at the post-intervention assessment. Participants' quality of life did not improve when they had not received group problem-solving therapy. These findings are consistent with the second null hypothesis since there is no difference in the QOL of the control group at the pre-post level.

Table

3.5

Mann-Whitney U Test showing Pre-intervention Quality of Life scores between Treatment group (n = 15) and Control group (n = 15)

Variables	Group	MR	*U*	Z	*p*
WHOQOL-BREF	Treatment	12.23	63.50	-2.03	.04*
	Control	18.77			

Note. MR = Mean Rank, *p<.05, **p<.01, ***p<.001.

The Mann-Whitney U Test results showed that the treatment group receiving the intervention had a significantly lower quality of life (MR = 12.23, p = .04) as compared to the control group at pre-intervention. These findings are parallel to the third hypothesis since there is a significant difference in the experimental and control groups at the pre-intervention level in terms of QOL.

Table

3.6

Mann-Whitney U Test showing Post-intervention Quality of Life scores between Treatment group (n = 15) and Control group (n = 15)

Variables	Group	MR	*U*	Z	*p*
WHOQOL-BREF	Treatment	14.70	100.50	-.49	.61
	Control	16.30			

Note. MR = Mean Rank, *p<.05, **p<.01, ***p<.001.

The results of the Mann-Whitney U test show that the experimental group does not have a significant mean rank difference in the quality of life as compared to the control group at the post-intervention level. These findings provide evidence against the fourth null hypothesis since the hypothesis was inclined towards a significantly higher level of QOL in the treatment group as compared to the control group at the post-intervention level but, this was not apparent.

Table
Summary of the Findings

1. There were significant mean rank differences in the experimental group and control group at the pre-intervention level.
2. There were no significant mean rank differences in the experimental group and the control group post-intervention level.

3. The experimental group reported a higher quality of life after invention than before, and the control group reported a higher quality of life at the pre-test and a lower quality of life at the post-test.

Chapter IV

Discussion

The outcomes of this research provide insight into the effectiveness of PST which is a cognitive behavioral intervention to help reduce the overwhelming stressors of life among undergraduate university students. The purpose of this study was to see whether a difference in the quality of life scores would emerge between the experimental group and the control group. The WHOQOL-BREF was administered pre and post-intervention to assess for differences in the scores. Scores in the experimental condition improved while scores in the control condition decreased most likely due to environmental factors. While the homogeneity of this sample is useful for assessing the experimental effects of PST on quality of life, it reduces the external validity of the findings

The results of this study support three of the four hypotheses since there was a significant difference in pre and post-intervention scores of QOL in the treatment group. Also, there was no significant difference in the QOL of the control group at the pre-post level. There was a significant difference in the QOL between the experimental and control group at preintervention. Evidence against the fourth hypothesis was found.

Keeping in mind the first hypothesis, the Wilcoxon Signed-Rank test showed that there is a significant within-group mean rank difference in pre and post-intervention within the treatment group based on the assessment of the quality of life scores. The students in the treatment group had higher quality of life scores at post-intervention assessment as compared to pre-intervention

assessment. The results of this study are consistent with previously conducted randomized control trials assessing the efficacy of PST.

The Wilcoxon signed-Rank test showed that the control group had insignificant withingroup mean rank differences in pre and post-intervention assessment on the quality of life scores. Since the control group was not given any therapy, their quality of life was expected to not change.

The third hypothesis predicted a difference in QOL scores in the experimental and control group before intervention. The present findings can be seen from the statistical analysis of the Mann-Whitney U Test measuring pre-intervention scores. The participants in the experimental group had lower baseline scores with a mean rank of 12.23 than the participants in the control group which had higher baseline scores with a mean rank of 18.77. After conducting the Mann-Whitney U test for the post-intervention scores, the mean rank of the experimental group was 14.70 while for the control group, it was 16.30. As can be seen, the scores for the experimental condition increased while the control group scores' mean dropped.

Evidence was apparent against the fourth null hypothesis which predicted a significant increase in the QOL scores post-intervention as compared to the control group. Results of the Mann-Whitney U test show that the experimental group does not have a significant mean rank difference in the quality of life as compared to the control group at the post-intervention level. There may have been multiple reasons for the change in the scores of the control condition which has led to the insignificant mean rank differences between the two groups. Since this was an experimental research, threats to internal validity are present. However, it should be noted that threats to internal validity are inevitable when using this type of experimental design. Whereas past

researchers have found differences between the experimental and control group (Gellis et al., 2008; (Rees et al., 2017), the present study has shown that the experimental group does not have a significant mean rank difference in the quality of life as compared to the control group at the post-intervention level.

Multiple alternate explanations for the cause of changes in the scores of the control group can be understood and explained. Since the scores of the control can be seen to have decreased over time without any intervention, the quality of life scores of the control group participants was impacted by external environmental causes. There may be multiple reasons for this including selection bias, selection-maturation interaction, history, maturation, testing, and social interaction as described by Donald T. Campbell (Flannelly et al., 2018).

Selection bias is a potential bias in the participants who were placed in the experimental and control groups. Participants in both conditions could have differed in some important ways leading to the present results. Since the participants in the control and experimental condition were undergraduate psychology major students, they could have interacted with one another leading to selection-maturation interaction (Flannelly et al., 2018).

History is a relevant potential threat because this study lasted several weeks. History consists of what the participants might have experienced during the course of the experiment other than the therapy intervention itself. In the present study, the ending sessions were done with participants in the experimental group close to the semester midterm exams. After the last sessions, the WHOQOL-BREF was administered in both groups. This was a time of high stress involving multiple assignment submissions, tests, and exams. This may have been a reason why the control group's scores of quality of life were reduced (Flannelly et al., 2018).

Another reason could be the maturation effect leading to participants changing their responses while completing the WHOQOL-BREF. Factors that could lead to maturation can include differences in the mood of the participants, subjective fatigue and tiredness, or inattention during pre and post-intervention. It could be that the participants studied the questionnaire after initially completing it. When they refilled the questionnaire, they may have changed their responses (Flannelly et al., 2018).

Testing could be a potential threat because the same questionnaire was used twice on all participants. The initial completion of the questionnaires could have made participants more receptive and aware of their environment and current quality of life. So when the participants initially completed the form, they may have reconsidered their subjective feelings about their quality of life which could lead to changes in responses at the re-test stage (Flannelly et al., 2018).

Strengths

This study had several strengths since this research design was a replication of numerous research already conducted and therefore this study can be replicated as well. This study consisted of therapy sessions conducted practically which can be implemented for others outside the study as well. Practical applications of cognitive behavioral therapy have had high success rates and the present experimental group results are consistent with previous research.

Limitations

There are some limitations to this study that are obstacles to the generalization of the results to other settings. The sample size is smaller when compared to the samples used by other studies assessing PST effectiveness. Using a larger sample could give more accurate results. The

researcher approached the participants who were students with busy schedules and extracurricular activities already scheduled. The initial sample to be part of the study was 60 participants of which 30 would be placed in the experimental group and 30 in the control group. Due to participant attrition, low and incomplete attendance at therapy sessions led to the sample size being reduced. The sample size was reconsidered and reduced to 15 including only those who participated in all or almost all therapy sessions. Also since the sample size consisted of undergraduate students only, generalizing to postgraduate students should be done with caution. In the present study, extraneous variables could have been better controlled for. Since the type of data collected was self-reported, it can only be assumed that participants were honest with their responses.

Clinical Implications

The implications of this study are of particular interest to educational social workers and campus counselors since poor problem-solving coping and negative problem orientation can reduce the effectiveness of educational institutes in imparting knowledge to students. This study suggests that implementing PST among undergraduate students will lead to effective problemsolving abilities. Despite the limitations mentioned, these results suggest several theoretical and practical implications.

Suggestions

Further research should attempt to implement better sample recruitment strategies so that the sample is greater in size and with more variability. Further research should attempt to control confounding variables in the environments of the participants so that threats to internal validity can be reduced.

Conclusion

The study results show that participants' quality of life increased after receiving group problem-solving therapy. PST is an effective talk therapy intervention to use among groups of students to increase. Students were thankful to have received group therapy through which they learned that by sharing and listening to the problems of others, one can feel better. Students showed a better quality of life after therapy meaning that the psychological and behavioral skills taught throughout the session were beneficial in increasing psychological, physical, social, environmental, and overall satisfaction with life. Undergraduate students were helped and were taught simple techniques of acceptance, coping, and facing further problems with guidance and sharing through a supportive weekly therapy session. Despite some limitations, the present study has enhanced our understanding of the relationship between quality of life and PST. The findings of this study add to the expeditious research about talk therapies improving the quality of life of various populations. We hope that the current research will stimulate further investigation of this important area.

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APPENDIX A

INFORMED CONSENT FOR PARTICIPATION

I am Fiza, a student of the Psychology Department at Kinnaird College for Women currently studying in semester 8th. These therapy sessions are the requirement of a final year research report supervised by Ms. Sonia Adil. The objective of these sessions is entirely for learning purposes.

Your participation in the therapy sessions is entirely voluntary and you may refuse to discontinue participation at any time without penalty. Your decision about whether or not to participate will be respected and will not affect your relationship with the researcher. If you do participate you can have your data withdrawn at any time. You will not be given any incentives for participation. You will be asked to share experiences related to your personal life and childhood. It is recommended to report to the researcher during session time as soon as you sense any discomfort. The requirement of each session will be about 55 minutes long and will not be video audio recorded. And there will be 8 interview sessions in total. Your privacy will be highly maintained and whatever is said throughout the sessions will remain confidential and private.

Signature of the Participant: _____ Signature of the Researcher: _____

APPENDIX B **WHOQOL-BREF**

The World Health Organization Quality of Life (WHOQOL) – BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.**

Name **Date Administered**

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

		Very poor	Poor	Neither poor nor good	Good	Very good
2.	How satisfied are you with your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The following questions ask about how much you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	Extremely
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4.	How much do you need any medical treatment to function in your daily life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5.	How much do you enjoy life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6.	To what extent do you feel your life to be meaningful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7.	How well are you able to concentrate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8.	How safe do you feel in your daily life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9.	How healthy is your physical environment?	☐1	☐2	☐3	☐4	☐5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	☐1	☐2	☐3	☐4	☐5
11.	Are you able to accept your bodily appearance?	☐1	☐2	☐3	☐4	☐5
12.	Have you enough money to meet your needs?	☐1	☐2	☐3	☐4	☐5
13.	How available to you is the information that you need in your day-to-day life?	☐1	☐2	☐3	☐4	☐5
14.	To what extent do you have the opportunity for leisure activities?	☐1	☐2	☐3	☐4	☐5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	☐1	☐2	☐3	☐4	☐5

		Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with you sleep?	☐1	☐2	☐3	☐4	☐5
17.	How satisfied are you with your ability to perform your daily living activities?	☐1	☐2	☐3	☐4	☐5
18.	How satisfied are you with your capacity for work?	☐1	☐2	☐3	☐4	☐5
19.	How satisfied are you with yourself?	☐1	☐2	☐3	☐4	☐5
20.	How satisfied are you with your personal relationships?	☐1	☐2	☐3	☐4	☐5
21.	How satisfied are you with your intimate life?	☐1	☐2	☐3	☐4	☐5

22.	How satisfied are you with the support you get from your friends?	☐1	☐2	☐3	☐4	☐5
23.	How satisfied are you with the conditions of your living place?	☐1	☐2	☐3	☐4	☐5
24.	How satisfied are you with your access to health services?	☐1	☐2	☐3	☐4	☐5
25	How satisfied are you with your transport?	☐1	☐2	☐3	☐4	☐5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	☐1	☐2	☐3	☐4	☐5

Do you have any comments about the assessment? SCORING:

		Equations for computing domain scores	Raw Score	Transformed Score (0-100)
Domain 1	Physical Health	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18		
Domain 2	Psychological	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)		
Domain 3	Social Relationships	Q20 + Q21 + Q22		
Domain 4	Environment	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25		

APPENDIX C

Experimental or Control group = .

Descriptive Statistics[a]

	N	Percentiles 25th	50th (Median)	75th
predomainscore	0	.	.	.
postdomainscore	0	.	.	.

a. Experimental or Control group = .

Experimental or Control group = Control group

Descriptive Statistics[a]

	N	Percentiles 25th	50th (Median)	75th
predomainscore	15	3.0769	3.4615	3.8462
postdomainscore	15	3.1154	3.7308	3.9231

a. Experimental or Control group = Control group

Experimental or Control group = Control group

Descriptive Statistics[a]

	N	Percentiles 25th	50th (Median)	75th
predomainscore	15	3.0769	3.4615	3.8462
postdomainscore	15	3.1154	3.7308	3.9231

a. Experimental or Control group = Control group

Wilcoxon Signed Ranks Test

Ranks[a]

		N	Mean Rank	Sum of Ranks
postdomainscore - predomainscore	Negative Ranks	5[b]	6.00	30.00
	Positive Ranks	7[c]	6.86	48.00
	Ties	3[d]		
	Total	15		

a. Experimental or Control group = Control group

b. postdomainscore < predomainscore

c. postdomainscore > predomainscore

d. postdomainscore = predomainscore

Wilcoxon Signed Ranks Test

Ranks[a]

		N	Mean Rank	Sum of Ranks
postdomainscore - predomainscore	Negative Ranks	4[b]	4.13	16.50
	Positive Ranks	11[c]	9.41	103.50
	Ties	0[d]		
	Total	15		

a. Experimental or Control group = Experimental group

b. postdomainscore < predomainscore

c. postdomainscore > predomainscore

d. postdomainscore = predomainscore

Test Statistics[a,b]

	postdomainscore - predomainscore
Z	-2.472[c]
Asymp. Sig. (2-tailed)	.013

a. Experimental or Control group = Experimental group

b. Wilcoxon Signed Ranks Test

c. Based on negative ranks.

NPar Tests

Mann-Whitney Test

Ranks

	Experimental group or Control group	N	Mean Rank	Sum of Ranks
predomainscore	Control group	15	18.77	281.50
	Experimental group	15	12.23	183.50
	Total	30		

Test Statistics[a]

	predomainscore
Mann-Whitney U	63.500
Wilcoxon W	183.500
Z	-2.036
Asymp. Sig. (2-tailed)	.042
Exact Sig. [2*(1-tailed Sig.)]	.041[b]

a. Grouping Variable: Experimental group or Control group

b. Not corrected for ties.

NPar Tests

Mann-Whitney Test

Ranks

	Experimental group or Control group	N	Mean Rank	Sum of Ranks
predomainscore	Control group	15	18.77	281.50
	Experimental group	15	12.23	183.50
	Total	30		

Test Statistics[a]

	predomainscore
Mann-Whitney U	63.500
Wilcoxon W	183.500
Z	-2.036
Asymp. Sig. (2-tailed)	.042
Exact Sig. [2*(1-tailed Sig.)]	.041[b]

a. Grouping Variable: Experimental group or Control group

b. Not corrected for ties.

NPar Tests

Mann-Whitney Test

Ranks

	Experimental group or Control group	N	Mean Rank	Sum of Ranks
postdomainscore	Control group	15	16.30	244.50
	Experimental group	15	14.70	220.50
	Total	30		

Test Statistics[a]

	postdomainscore
Mann-Whitney U	100.500
Wilcoxon W	220.500
Z	-.498
Asymp. Sig. (2-tailed)	.619
Exact Sig. [2*(1-tailed Sig.)]	.624[b]

a. Grouping Variable: Experimental group or Control group

b. Not corrected for ties.

Test Statistics[a,b]

	postdomainscore - predomainscore
Z	-.706[c]
Asymp. Sig. (2-tailed)	.480

a. Experimental or Control group = Control group

b. Wilcoxon Signed Ranks Test

c. Based on negative ranks.

Experimental or Control group = Experimental group

Descriptive Statistics[a]

	N	Percentiles 25th	50th (Median)	75th
predomainscore	15	2.9615	3.1538	3.3462
postdomainscore	15	3.1923	3.6154	3.7692

a. Experimental or Control group = Experimental group

Wilcoxon Signed Ranks Test

Ranks[a]

		N	Mean Rank	Sum of Ranks
postdomainscore - predomainscore	Negative Ranks	4[b]	4.13	16.50
	Positive Ranks	11[c]	9.41	103.50
	Ties	0[d]		
	Total	15		

a. Experimental or Control group = Experimental group

APPENDIX D

Decision Making

Problem:

Potential Solution:

Advantages	Disadvantages	Neutral

Questions to think about when evaluating advantages and disadvantages:

- How will this solution affect my own wellbeing? (physical, emotional, psychological)
- How much time and effort will it require? • Are there any financial costs or benefits?
- How does it fit in with my other goals and commitments?
- How will it affect the wellbeing of the people who are close to me?
- Is the solution feasible?

Selecting and Defining a Problem Defining a Problem Clearly

Problem area I want to work on:

Gathering the available facts:

- What is the problem?
- When does the problem occur?
- Where does the problem occur?
- Who is involved in the problem?
- How often does the problem occur?
- What have you done to solve the problem in the past?
- Do you have control over this problem?

If you get stuck:

Why is this problem a problem?

Clearly define problem statement:

A Better Approach to Life

Want to learn how to better cope with stress in everyday life?

Problem-Solving Therapy

The solution to your pain.

Overview of PST

PST is a brief psychosocial treatment for patients experiencing depression and distress related to inefficient problem-solving skills. The PST model instructs patients on problem identification, efficient problem-solving, and managing associated depressive symptoms.

Why for Students?

PST sessions encourage students to cope better with day-to-day problems and traumatic events and reduce their impact on mental and physical well-being.

No pain, complete gain.

The solution is the answer or pattern of acknowledging which is the result of the problem-solving process. A solution is efficacious when the goal of problem-solving is met. The constructive consequences are maximized while the adverse results are reduced. Find solutions through the following 8 steps.

Heal your body and heal your mind via these steps!

(1) selecting and defining the problem, (2) establishing realistic and achievable goals for problem resolution, (3) generating alternative solutions, (4) implementing decision-making guidelines, (5) evaluating and choosing solutions, and (6) implementing the preferred solution.

Problem-solving is an essential skill in daily life. Knowing how to identify and confront problems, implement solutions, and learn from them is important for a functional and happy life. Daily stressors are present in everyone's life however, the student population is one that can be said to face more problems than nonstudents. Problem-solving therapy is designed to help individuals learn to cope with major and minor problems. Students may have family, financial, and social issues along with their demanding educational responsibilities. The more stressors in one's life, the lower the quality of life will be. Implementing PST in university students to increase their quality of life can make students better fulfill their responsibilities as students and as members of society in general. Using this therapy has five objectives which are making constructive problem-solving better, reducing a pessimistic problem orientation, and decreasing impulsivity when solving issues.

Based on the social problem-solving theory, there are two ways to manage stressful problems, generally and independently. One is the orientation one adopts while confronting problems and the other is how one goes about solving problems. Having a positive problem orientation allows people to assess problems as opportunities, are positive that trouble can be solved, and have a strong personal self-efficacy about solving the issue. Negative emotions are an important aspect of the overall problem-solving process. A pessimistic problem orientation has the disposition to view problems as threats. Such people believe that can't be solved and are skeptical about their ability to manage issues appropriately. Such people often become upset and frustrated when they find themselves amongst a problem faced with a problem or when pessimistic emotions take over. A person's disposition impacts the capability and motivation to solve problems in a focused manner.

Problem-Solving Test

1. I feel afraid when I have an important problem to solve.
2. When making decisions, I think carefully about my many options.
3. I get nervous and unsure of myself when I have to make an important decision.
4. When my first efforts to solve a problem fail, I give up quickly, because finding a solution is too difficult.
5. Sometimes, even difficult problems can have a way of moving my life forward in positive ways.
6. If I avoid problems, they will generally take care of themselves.
7. When I am unsuccessful at solving a problem, I get very frustrated.
8. If I work at it, I can learn to solve difficult problems effectively.
9. When faced with a problem, before deciding what to do, I carefully try to understand why it is a problem by sorting it out, breaking it down, and defining it.
10. I try to do anything I can in order to avoid problems in my life.
11. Difficult problems make me very emotional.
12. When I have a decision to make, I take the time to try and predict the positive and negative consequences of each possible option before I act.
13. When I am trying to solve a problem, I often rely on instinct with the first good idea that comes to mind.
14. When I am upset, I just want to run away and be left alone.
15. I can make important decisions on my own.
16. I frequently react before I have all the facts about a problem.
17. After coming up with an idea of how to solve a problem, I work out a plan to carry it out successfully.
18. I am very creative about coming up with ideas when solving problems.
19. I spend more time worrying about problems than actually solving them.
20. My goal for solving problems is to stop negative feelings as quickly as I can.
21. I try to avoid any trouble with others in order to keep problems to a minimum.
22. As soon as someone upsets me or hurts my feelings, I always react thesame way.
23. When I am trying to figure out a problem, it helps me to stick to the facts of the situation.
24. In my opinion, being systematic and planful with personal problems seems too cold or "business-like."
25. I understand that emotions, even bad ones, can actually be helpful to my efforts at problem solving.

TABLE 8.1 Listening to Feelings: What Your Emotions Might Be "Telling You"

EMOTION: FEAR/ANXIETY

Ways People Describe This Emotion: *Nervous, jittery, "on edge," scared, anxious, restless, uncomfortable, worried, panicked.*

Information to Look For: *Any sense of impending hurt, pain, threat, or danger. Anxious or nervous thoughts; sweating, dry mouth, upset stomach, dizziness, shallow breathing; urge to run away and hide, avoid situations.*

Examples of What the Information May Reveal:

- You fear physical or emotional injury for yourself or others.
- You fear that you are inferior to others and your sense of self-esteem is threatened (examples include fears about your intelligence, talents, physical skill, or outward appearance).

Why This Information Is Important:

- You can now work on better managing your fears, rather than trying to avoid them.
- You can examine the fears you have and see if they are realistic.
- You can face your fears and work on ways to reduce them. Similar to facing a schoolyard bully, facing your fears often leads to greater self-confi dence, even if you sustain a bruise or two.

FEELING TYPE: ANGER

Ways People Describe This Emotion: *Frustrated, irritated, enraged, mad, "pissed off," angry, states a desire to break something or hurt someone.*

Information to Look For: *Being blocked from getting what you want—the block can be due to circumstances or specifi c people.*

Examples of What the Information May Reveal:

- You want success, achievement, or to be the best, but you see someone or something in the way.
- You want a relationship, but it seems like hard work, or you see the other person as creating problems.
- You want to be loved or admired, but others do not appreciate you.
- You want to be able to control circumstances or the reactions of others, but it is impossible to have that much control over situations or people.

Why the Information Is Important:

- You may discover that your anger is less about the other person and more about yourself, your pride, or what you want. Rather than focusing on your anger, you can direct your energies toward making your own life better.
- You may have unrealistic expectations regarding others or yourself. It may be time for you to "get real"—give yourself and others a break from such harsh standards.

FEELING TYPE: SADNESS

Ways People Describe This Emotion: *"Let down," disappointed, devastated, hurt, unhappy, depressed, drained, miserable, downcast, heartbroken.*

Information to Look For: *Losing something or holding the belief that you have lost something or someone important to you.*

Date:

Problem-Solving Self-Monitoring Form

What was the problem? (Describe the situation; be sure to indicate who was involved, why it was a problem for you, and your goal or objectives in the situation)

What was your emotional reaction to the problem? (Be sure to note your initial feelings, as well as your emotions throughout—did they change?)

What did you do to handle the problem? (Describe what you tried to do to solve or cope with the problem; try to be as specifi c as p ossible, describing your thoughts and actions)

What was the outcome? (Describe what happened after you tried to handle the problem; be sure to indicate your emotional reactions to this outcome, how satisfi ed you were with this outcome, and whether you believe the problem was solved)

ABC THOUGHT RECORD

Situaon or Event (A)	Thoughts (B)	Emoonal Reacons (C)	Intensity Rang (1-10)

"MINDING YOUR MIND"

Identifying Negative Self-Talk & Converting to Positive Self-Talk

SIGNS THAT YOU ARE USING NEGATIVE SELFTALK

- Using "judgmental" words such as "must" and "should"
- Using *catastrophizing* words for circumstances NOT related to life and death matters
- Overgeneralizing

STRATEGIES FOR "DISPUTING" NEGATIVE SELFTALK

- Argue against negative self-talk with logic
- Argue against "should" or "ought" with "why should I?"
- Question catastrophic words and assess real damage potential of situation
- Challenge overgeneralizations
- Use challenging POSITIVE self-statements

PROBLEM-SOLVING WORKSHEET

Briefl y describe the problem (Can it be changed?):

State your problem-solving goal (BE REALISTIC):

Describe the major obstacles to achieving your goal at this time: a.
b.
c.

Think of alternative ways to achieve your goal. Be creative. List at *least* 3 solution ideas:
1.
2.
3. 4.
5.

What are the major "pros" or positive consequences of these differing alternatives?

What are some of the "cons" or negative consequences?

Decide which alternatives are the best by choosing the ones with the best *positive* consequences and fewest *negative* consequences. Write down your action plan.

Carry out the plan & observe the consequences: Are you satisfi ed that your plan worked?

Generating Solutions (1 of 2)

Use the following worksheet to write down your problem and the potential solutions if you prefer a list format. Don't feel that you have to stop at 12 solutions. Turn over and use the back of the page if you come up with more.

Problem:

Potential Solutions:

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

Creating and Implementing A SMART Action Plan

My Action Plan

Problem:

Solution:

Plan:

Specific	
Measurable	
Achievable	
Relevant	
Timebound	

Problem Solving Therapy

ard Font Paragraph

Summary

Step 1: Problem Orientation

- Take a moment to stop and check your attitude.
- Mentally rehearse the characteristics of positive problem orientation, if necessary, to place yourself in the right direction for effective problem solving.

Step 2: Recognising and Identifying Problems

- Choose a problem from your problem list to use on this summary sheet.
- If you want to work with a new problem, use the steps in your workbook to help you identify it.

Step 3: Selecting and Defining a Problem

- Remember to define your problem as clearly as possible. This makes it easier to generate relevant solutions.
- Use the questions in your workbook to guide you.

My problem is:

Step 4: Generating Solutions

- Use this space to brainstorm as many ideas as you can that could contribute to solving your problem.

Possible solutions are:

Step 5: Decision Making

- Look at your brainstorm of ideas. Are there any ideas you can immediately cross off as part of an initial selection?
- Can you group any other ideas together?
- Choose 2 ideas with potential to solve your problem and list the advantages and disadvantages, and then rate them.

Solution 1

Advantages	Disadvantages	Neutral

Solution 2

Advantages	Disadvantages	Neutral

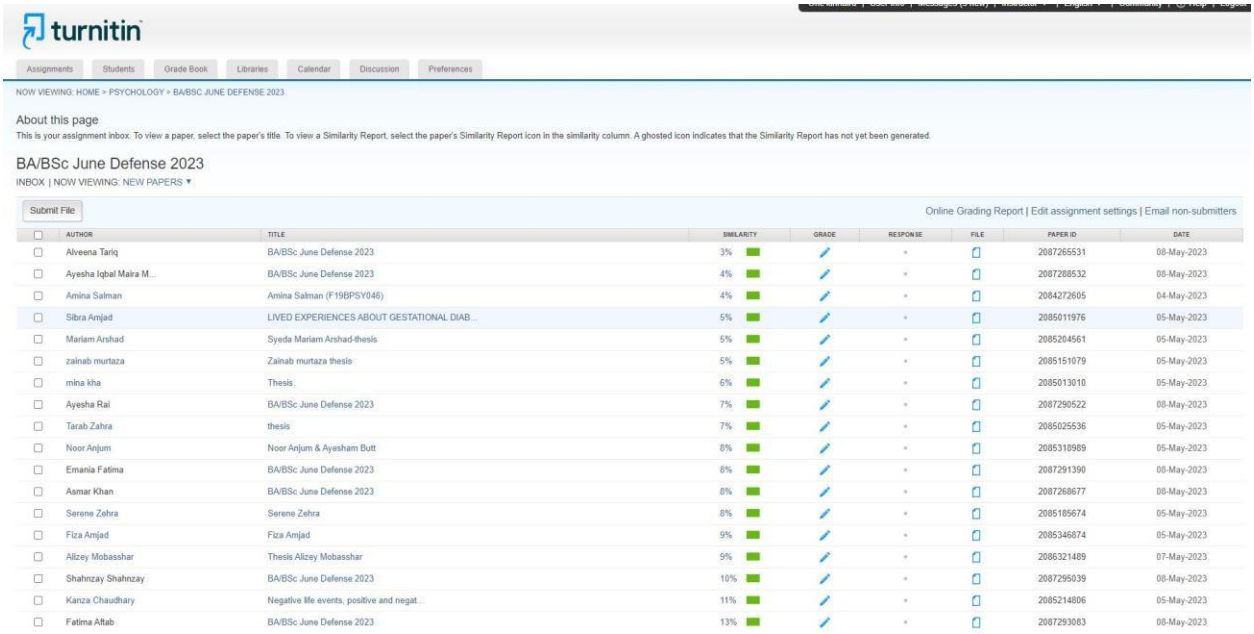
Step 6: Creating and Implementing an Action Plan

- Use the space below to create an action plan to implement your chosen solution.
- Don't forget to check your plan fits the SMART criteria.

Step 7: Reviewing Progress

Did you get underway? If not, identify the obstacles and update your action plan. If yes, is the problem solved? Start working with a new problem if ready!

APPENDIX E



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