E
t
effective skills in solving interpersonal and social problems en-
countered in everyday life are considered vital to personal ad-
justment and well-being (McFall, 1982). Theoretical models of
problem-solving ability posit that certain cognitive–behavioral
skills (Nezu & D'Zurilla, 1989) and optimistic appraisals of the self
and one's ability (Heppner & Krauskopf, 1987) are important char-
acteristics in the problem-solving process. Contemporary descriptive
research in problem solving has often used the Problem Solving In-
ventory (PSI; Heppner, 1988) as the preferred measure of self-
appraised problem-solving ability. In contrast, intervention research
is typically embedded in the social problem-solving model delineated
by D'Zurilla and colleagues (Nezu & D'Zurilla, 1989) as a theoretical
template to guide counseling strategies (e.g., Nezu & Perri, 1989).

Recently, Elliott, Sherwin, Harkins, and Marmarosh (1995) pro-
posed that these distinct strands of inquiry may be integrated with
meaningful results for counseling. This theoretical integration builds
on the legacy common to both models and construes the factors mea-
sured by the PSI in light of the functional components of the social
problem-solving model. In the initial D'Zurilla and Goldfried (1971)
formulation, problem solving was characterized by five general
stages: (a) problem orientation stage, (b) problem definition and for-
mulation, (c) generation of alternatives, (d) decision making, and (e)
verification. Contemporary thinking regarding the social problem-
solving model denotes two components that encompass the original
five stages. The problem orientation component functions to (a) ward
off negative emotions (e.g., depression and anxiety) that could hinder
problem solving, (b) elevate positive emotions and perceived com-
petence facilitative of effective problem solving, (c) inhibit tendencies
to respond impulsively to problems, and (d) motivate a person toward
The problem-solving skills component entails the cognitive–
behavioral strategies used to define problems, generate options, im-
plement solutions, and monitor outcomes. Subsequent work by Nezu
and Perri (1989) has demonstrated that the Personal Control (PC) and
Problem Solving Confidence (PSC) factors on the PSI operate in a
manner consistent with the problem orientation component, and the
Approach–Avoidance (AA) factor closely resembles the problem-
solving skills component as delineated in the social problem-solving
model (Nezu & D'Zurilla, 1989).

In a series of studies, Elliott and colleagues recently tested several
a priori hypotheses concerning the mood-regulatory function of the
problem orientation component. Consistent with their predictions,
PSC was predictive of positive mood states under routine and stress-
full conditions; PC was the single best predictor of negative mood
states at these times (Elliott et al., 1995). Similarly, another series
found PC to be the best predictor of trait negative affectivity and PSC
to the best predictor of trait positive affectivity (Elliott, Herrick,
MacNair, & Harkins, 1994). Furthermore, the AA scale demonstrated
weak associations with the measures of trait and state affectivity in
these studies, consistent with the theorized properties of the problem-
solving skills component. Collectively, these results support the con-
tention that a positive problem orientation promotes a positive
emotional tone and helps to ward off transient and prolonged expe-
riences of negative affect under general and specific conditions.

A positive problem orientation is vital in preventing the de-
velopment of depressive behavior (Nezu, 1987). Depression has been
characterized by elevated negative and decreased positive affect (Wat-
son, Clark, & Carey, 1988). Thus, persons with a negative problem
orientation may be more susceptible to ongoing experiences of neg-
ative affect and a dearth of positive moods. In contrast, a person who
has confidence in his or her ability to handle problems and who can
regulate behavioral and emotional reactions when solving problems
would be capable of warding off negative emotional experiences, of
handling minor problems with dispatch, and of maintaining an opti-
mal motivational state that enhances problem-solving efforts.

The mood-regulatory function of the problem orientation com-
ponent may be implicated in the development of depression that oc-
casionally accompanies pregnancy. Postpartum depression has been
associated with elements of social support (e.g., Collins, Dunkel-
Schetter, Lobel, & Scrimshaw, 1993; Cutchona, 1984) and social-
cognitive processes such as dispositional optimism (Carver & Gaines,
1987) and attributional styles (Cutchona, 1983; O'Hara, Rehm. &
Campbell, 1982). Despite these findings, depression during preg-
nancy (e.g., peripartum depression) consistently emerges as the best
overall predictor of postpartum depression (Gotlib, Whiffen, Mount,

Many counselors work with women who experience postpartum depression, and recommendations for assessment and intervention have recently appeared in the counseling literature (Albright, 1993; Pfost, Stevens, & Matejcek, 1990). Most contemporary conceptualizations of postpartum depression rely on biopsychosocial models to describe the many biochemical, environmental, and personal variables that can be potentially related to the development of depression in the postpartum period (Cutrona, 1982; Hopkins, Marcus, & Campbell, 1984; Whiffen, 1992). It would be helpful to study depression associated with pregnancy from theoretical models that offer clear directions for counseling.

According to the integrative model of problem solving, a positive problem orientation—as measured by the PSC and PC factors on the PSI—should be related to higher levels of positive affectivity and lower levels of negative affectivity during pregnancy, which in turn would be associated with lower depression scores (Elliott et al., 1994; Elliott et al., 1995). In this manner, the problem orientation component exerts an influence on depression by promoting pleasant, motivational affects and regulating the experience of noxious, unpleasant moods.

We tested these predictions in this study. We anticipated that PSC scores would be predictive of depression, because this aspect of the problem orientation component has emerged in other research as a strong predictor of depression (Priester & Clum, 1993). Women with higher negative affect and lower positive affect would be vulnerable to depressive episodes (Watson et al., 1988), and these experiences are incompatible with a positive problem orientation (Elliott et al., 1994; Elliott et al., 1995). Therefore, we predicted that (a) ineffective PC scores would be associated with greater negative affectivity and (b) ineffective PSC scores would be associated with lower positive affectivity. These variables, in turn, would then be significantly predictive of higher peripartum and postpartum depression. Finally, we expected nonsignificant paths from the AA factor to the affectivity variables, because this factor should evince little, if any, relation with self-report measures of distress, consistent with prior research and theory (Elliott et al., 1994; Elliott et al., 1995).

**METHOD**

**Participants**

Participants were 100 women (mean age = 26.42 years, SD = 5.62; range = 15–40 years of age) recruited from Lamaze childbirth preparation classes in a metropolitan area (n = 66), from a university-affiliated obstetrical clinic (n = 28), and from an adolescent pregnancy support group (n = 6). Seventeen women were of African American heritage, and the remainder were White. Of these women, 77 were married, 1 was recently separated, 2 were divorced, and 20 reported their status as “single/not married.” Twenty-eight women had yearly household incomes of less than $10,000, 8 were in the $10,000–$20,000 bracket, 14 were in the $20,000–$30,000 bracket, 17 were in the $30,000–$40,000 bracket, 14 were in the $40,000–$50,000 bracket, and 19 had household incomes greater than $50,000. Eighty-two women had no children, 10 had one child, 6 had two children, 1 had three children, and 1 had four children. Three participants had not attended high school, 14 had some high school education, 15 had a high school diploma, 26 had some college course work, 5 had attended a technical or trade school, 36 had a bachelor’s degree, and 1 had pursued graduate work. All of the women were in their 8th month of pregnancy when they were first interviewed. They were contacted for the follow-up interview approximately 4 weeks postpartum.

**Measures**

**Problem Solving Inventory.** The Problem Solving Inventory (PSI; Heppner, 1988) was used to measure self-appraised problem-solving ability. The PSI contains 32 items that are rated on a 6-point Likert scale (1 = strongly agree to 6 = strongly disagree). The PSI contains three factors: Problem Solving Confidence (PSC), Approach–Avoidance (AA), and Personal Control (PC; Heppner, 1988). Adequate alpha coefficients have been reported, indicating that each factor has a reasonable degree of internal consistency (PSC = .85, PC = .72, and AA = .84; Heppner, 1988). The total score is relatively stable over a 2-week period (test-retest correlations from .83 to .89; Heppner, 1988). Validity estimates indicate that the PSI total score is significantly related in predicted directions with a variety of self-report and observational measures (Heppner, 1988). Higher scores indicate negative perceptions of one’s problem-solving ability. We used the PC, PSC, and AA scales as predictor variables.

**Depression.** The Inventory to Diagnose Depression (IDD; Zimmerman, Coryell, Corenthal, & Wilson, 1986) was used to assess peripartum and postpartum depression. The IDD is a 22-item instrument that requires a respondent to indicate the severity of each symptom of depression on a 5-point Likert-type scale. The sum of these responses provides a total severity score that serves as a single index of depressive behavior (Zimmerman, Coryell, Wilson, & Corenthal, 1986). Test-retest reliabilities have ranged from .91 to .93, and internal consistency coefficients of .92 have been reported (Zimmerman & Coryell, 1987; Zimmerman, Coryell, Corenthal, & Wilson, 1986). Comparisons with interview systems and other self-report measures of depression have revealed correlations ranging from .80 to .87 (Zimmerman & Coryell, 1987; Zimmerman, Coryell, Wilson, & Corenthal, 1986). The IDD is a sensitive measure of depression for college students, community-residing adults, and medical patients (Frank et al., 1992).

**Trait affectivity.** The Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) was used to measure trait positive and negative affectivity (TNA and TPA, respectively). The PANAS contains 10 positive and 10 negative affective adjectives. The instructional set provided by Watson et al. for assessment of trait affectivity was used: “Indicate to what extent you generally feel this way, that is, how you feel on the average” (Watson et al., 1988, p. 1070). Respondents then rated each adjective on a 1 (very slightly or not at all) to 5 (extremely) Likert-type scale to signify the degree to which they experienced that particular mood on the average. Internal consistency reliabilities for the TPA and TNA scales (.87 and .88, respectively) and test–retest reliabilities have been reported (.86 and .71 over 8 weeks, respectively; Watson et al., 1988). Validity coefficients for the scales indicate that they are appropriately correlated with similar measures of affect (Watson et al., 1988). Higher scores on each denote higher general levels of affectivity.

**Procedure and Analysis**

Childbirth trainers and physicians at the university clinic were told of the study, and permission was granted for recruiting expectant women into the study. Trained interviewers attended one of the La-maze sessions and informed the participants of the study. Interested
participants were given a packet that included informed consent and the measures. These were returned to the interviewer at the next session. Women were approached individually in the clinics and informed of the study. Interested participants either completed the measures with the interviewer or made arrangements with the interviewer to complete the measures at a later time. These recruitment procedures were designed to increase the diversity of the sample: Studies that recruit from a single clinic or hospital inadvertently work from a homogeneous sample with respect to key demographic characteristics (e.g., socioeconomic status, education, ethnicity, and so on), which in turn limits the generalizability of the results (O'Hara & Zekoski, 1988).

Participants were contacted approximately 4 weeks postpartum, based on the delivery due date reported in the first contact. The second measure of depression was administered at this time. Participants completed these instruments with the interviewer (n = 44), or the instruments were mailed to them and returned to the research team (n = 56).

To test the presumed relation of the problem orientation variables to depression, we used path analytic techniques following the LISREL framework (LISREL 8; Joreskog & Sorbom, 1993). It is possible, using an analysis of this type, to decompose the relations among the variables into direct and indirect effects. Standard errors are estimated for total, direct, and indirect effects, thus permitting each of these to be tested for statistical significance. These features would be necessary to test our hypotheses regarding the function of the problem orientation variables toward the prediction of postpartum depression.

To evaluate the hypothesized relations between the problem orientation variables and trait affectivity, and to demonstrate our presumed lack of relations between the problem-solving skills component (AA) and affectivity, we specified all possible paths from the problem-solving variables to the trait affectivity variables and peripartum depression. We also specified all possible paths from the affectivity variables to the depression variables.

RESULTS

Means, standard errors, and correlations used in subsequent analyses are displayed in Table 1. Mean scores on the PSI factors were comparable with scores observed among undergraduates (Chartrand, Rose, Elliott, Marmarosh, & Caldwell, 1993; Elliott & Marmarosh, 1994). The mean score on the TNA instrument was higher for our sample (21.74) than scores observed among community-residing adults (20.17 and 17.80 for school teachers and journalists, respectively; Elliott, Chartrand, & Harkins, 1994) and undergraduates (18.1; Watson et al., 1988). Similarly, the TPA mean score for our sample (21.20 and 17.06, respectively) was lower than scores observed among community-residing adults (20.17 and 17.80 for school teachers and journalists, respectively). These scores suggest that women in the eighth month of pregnancy may experience a greater negative emotionality and a lower positive emotionality than is typically observed in other samples. Average scores on the depression measure were higher for the sample in the eighth month of pregnancy than in the postpartum period (21.20 and 17.06, respectively).

The originally specified model that included all possible paths from problem solving to the affectivity variables and peripartum depression was estimated. This statistically resulted in a good fit to the data, \( \chi^2(3, N = 100) = 3.73, p = .29 \). However, all paths emanating from AA were not statistically significant, consistent with our theoretical notions about this variable and the problem-solving skills component. In addition, the direct paths from the problem orientation variables to both depression variables and from the affectivity variables to postpartum depression were not statistically significant. Only PSC and PC had statistically significant influences on positive and negative affectivity (ps < .05). PSC was significantly associated with positive affect, and PC was associated with negative affect, as expected. Moreover, the relative value of the chi square to the degrees of freedom likely represents an overfitting of the model to the data.

Consequently, the model was respecified with each of the nonsignificant direct paths deleted to achieve a more parsimonious explanation of the structures underlying the data. It should be noted that this model also included an estimate of the common unspecifiable sources of variance that would be expected to exist over time between the two administrations of depression. Figure 1 displays the significant direct effects of the hypothesized problem orientation and affectivity variables on depression during pregnancy and in the postpartum period (all ps < .05). The direct effect of PSC to TPA was significant, as predicted. PC was also directly related to TNA, as expected. TNA had a significantly positive effect on peripartum depression, and TPA had a significant negative effect on peripartum depression. Peripartum depression, in turn, was significantly related to postpartum depression.

Several significant indirect effects were observed. The effect of PSC through TPA was statistically significant in the prediction of peripartum and postpartum depression (.11 and .10, respectively; ps < .05). Furthermore, the indirect effects of PC on initial depression (.15) and postpartum depression (.14; ps < .05) were significant. The significant indirect effects represent the total effects of the problem orientation variables on peripartum and postpartum depression. In other words, it is necessary to consider the intervening affectivity variables to detect the effects of the problem orientation variables on depression during pregnancy and in the postpartum period (Bollen, 1989).

Finally, both TNA and TPA exerted significant indirect effects to postpartum depression (.37 and .22, respectively; ps < .05). Although the total effects of the affectivity variables on postpartum depression were statistically significant, the indirect effects and not the direct effects were significant. Thus, the relation of the affectivity variables to postpartum depression must be considered concomitantly with peripartum depression.

TABLE 1

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSC</td>
<td>.50</td>
<td>.62</td>
<td>.28</td>
<td>-.45</td>
<td>.10</td>
<td>.15</td>
<td>.25</td>
<td>.34</td>
<td>.73</td>
</tr>
<tr>
<td>2. PC</td>
<td>.67</td>
<td>.39</td>
<td>-.40</td>
<td>.24</td>
<td>.27</td>
<td>17.45</td>
<td>5.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. AA</td>
<td>-.32</td>
<td>-.39</td>
<td>.16</td>
<td>.19</td>
<td>46.08</td>
<td>12.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. TNA</td>
<td>-.33</td>
<td>.48</td>
<td>.43</td>
<td>21.74</td>
<td>7.49</td>
<td></td>
<td></td>
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<tr>
<td>5. TPA</td>
<td>-.36</td>
<td>-.36</td>
<td>34.19</td>
<td>7.22</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. T IDD</td>
<td>-.67</td>
<td>21.20</td>
<td>10.06</td>
<td></td>
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<tr>
<td>7. T IDD</td>
<td>17.06</td>
<td>10.13</td>
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</table>

Note. N = 100. PSC = Problem Solving Confidence; PC = Personal Control; AA = Approach-Avoidance; TNA = Trait Negative Affectivity; TPA = Trait Positive Affectivity; T IDD = Inventory to Diagnose Depression: total score during eighth month of pregnancy; T IDD = Inventory to Diagnose Depression: total scores 4 weeks postpartum.
The overall fit of the model to the data was adequate, $\chi^2(8, N = 100) = 12.94, p = .11$. The ratio of the chi-square to the degrees of freedom (1.61) and the goodness-of-fit and adjusted goodness-of-fit indexes (.96 and .90, respectively) indicate that the model represented a relatively good fit to the data. Deleting the nonsignificant paths in the second model permitted a more parsimonious explanation without a statistically significant decrement in fit. It must be acknowledged that this model is but one of several that could possibly provide a satisfactory fit to the data. Yet the final model provides a reasonable test of the relations we hypothesized among these variables. The effects observed in the final model accounted for approximately 36% of the variance in postpartum depression, 24% of the variance in peripartum depression, 15% of the variance in TNA, and 20% of the variance in TPA.

**DISCUSSION**

Our findings provide a theoretical glimpse into the dynamics that possibly culminate in heightened levels of depression among expectant and postpartum women. A lower sense of confidence in problem-solving ability was directly related to a lower experience of positive affect and then indirectly to greater depression among expectant women. Self-appraised skills in regulating emotional and behavioral reactions in problem-solving situations were related to lower negative affectivity scores and indirectly with peripartum depression. Both PSC and PC had indirect effects on postpartum depression. The effects observed in the final model accounted for approximately 36% of the variance in postpartum depression, 24% of the variance in peripartum depression, 15% of the variance in TNA, and 20% of the variance in TPA.

A positive problem orientation can be related to depressive behavior by affecting prevailing mood states in the manner explicated by Nezu and D'Zurilla (1989). According to the social problem-solving model, a person with a negative problem orientation is likely to face a myriad of ongoing problems and unpleasant affects as a result of recurring negative consequences from unresolved issues, ineffective coping efforts, and from the ensuing pessimistic beliefs about the self and the environment (Nezu & D'Zurilla, 1989). Expectant women face many changes as pregnancy advances, and those who have a negative problem orientation may experience fewer positive and more negative emotions over time, rendering them susceptible to mood disturbance, negative cognitions, and somatic complaints that characterize depressive behavior. Expectant women who have a greater sense of confidence and more skills in regulating emotions and behavior may experience a more positive emotional tone that brightens their outlook, staves off unpleasant affects, and buffers them from the rigors of advanced pregnancy. In this process, they may be more likely to experience a rewarding sense of competency before and after delivery.

A priori predictions concerning the differential relations of the PSI variables to trait affectivity were upheld. These findings support several basic assumptions outlined in the integrative model of problem-solving. The PSI factor, for example, seems to have a particular association with self-report variables sensitive to subjective distress levels. Ineffective PSI scores have been significantly associated with worrying (Dugas, Lefranc, Rheume, Freeston, & Ladouceur, 1995), the use of emotion-focused coping strategies over time (MacNair & Elliott, 1992), more menstrual-related pain complaints among under-graduate women (Elliott, 1992), and greater psychosocial distress among persons with severe physical disability (Elliott, Godshall, Herrick, Witty, & Spruell, 1991). In a recent 3-month prospective study, the PSI factor emerged as a better predictor than other social-
Problem Solving and Depression During Pregnancy and in the Postpartum Period

cognitive variables of health-related complaints of undergraduates during the week of final examinations (Elliott & Marmarosh, 1994). The inability to regulate negative moods may render persons coping with long-term health conditions more susceptible to prolonged experiences of noxious, unpleasant affects, which in turn develop into symptoms of depression and anxiety.

As a second dimension of the problem orientation component, the PSC factor seems to exert a primary influence in a motivational fashion. PSC may reflect a positive expectancy set that facilitates a sense of competency and optimism, consistent with the social problem-solving model. This extends prior work that has linked PSC to measures of positive affectivity and extraversion (Elliott et al., 1994). Under times of stress, the relation of PSC to positive mood may be pronounced, in that persons might actually feel a "boost" in positive mood as they respond to a challenge (see Elliott et al., 1995, Study 2). The indirect effects of PSC on depression through affectivity suggest that the primary contribution of the problem orientation component to depression associated with pregnancy and childbirth may be in its mood-regulatory properties.

Our findings also support a priori predictions concerning the relation of AA to trait affectivity. Although AA was significantly correlated with both affectivity variables, subsequent path analysis found that AA was not significantly predictive of either trait affectivity or depression, as expected. Although this factor was originally construed to be a part of the general orientation component (Heppner & Peterson, 1982), post hoc evidence implies its primary contribution may be in the prediction of instrumental, proactive activities (e.g., problem-focused coping; MacNair & Elliott, 1992). The AA factor may prove to be a better predictor of instrumental activities and outcomes that have a clear behavioral pathway. Variables of this nature may be determined more by proactive efforts than by appraisals of one's general orientation about problem solving. Consistent with this interpretation, effective AA scores have been significantly associated with less sedentary activity among undergraduates (Godshall & Elliott, 1995) and a lower incidence of pressure sores and urinary tract infections among persons with severe physical disabilities (Herrick, Elliott, & Crow, 1994). These secondary complications might have been prevented in part by adherence to long-term self-care regimens. Further research is needed to test the relation of the AA factor to other instrumental and outcome variables.

Past research and thinking concerning postpartum depression has often explored the role of social-cognitive variables (e.g., causal attributions, mastery, and optimism). At times, these findings have been contradictory and inconsistent, with no clear implications for counseling interventions. It should be emphasized that our model took into account the presumed relations of a problem orientation to ongoing affects and peripartum depression in the prediction of postpartum depression. Consistent with earlier research, our findings reveal peripartum depression to be a strong predictor of postpartum depression. Our results indicate that any comprehensive model of postpartum depression must first explain the mechanisms by which depression develops and is maintained during pregnancy. Dysphoric mood may be a primary mechanism in the development of depression during pregnancy and in the postpartum period.

The degree to which our findings are specific to the subset of women who volunteered for our study is unknown. Although deliberate attempts were made to obtain a representative sample in the community, results may not generalize to women in general. Nevertheless, the veracity of our findings concerning the theoretically consistent relationship among problem orientation, affectivity, and depression is strengthened by results from prior programmatic re-

search. This finding could be further tested in research that uses a more prospective, longitudinal design, measuring problem-solving abilities earlier in pregnancy and following closely the emotional experiences of participants over time. The observed pattern of results in this study should be replicated and cross-validated with another sample.

**IMPLICATIONS FOR COUNSELING PRACTICE**

This study indicates that women at risk for depression during pregnancy and in the postpartum periods may evidence (a) heightened and prolonged negative moods and (b) a dearth of positive affective experiences during pregnancy. These affects may reflect a negative problem orientation, in that the individual may lack skills in staving off negative moods and in promoting positive moods in routine and in stressful circumstances. Negative expectancies, a sense of decreased control over events and emotions, and pessimistic attitudes may also be apparent. Counselors should assess the presence and intensity of these risk factors when working with expectant women.

Problem-solving training can be implemented as a prevention measure (see Heppner, Neal, & Larson, 1984), and the principles of problem solving can be easily integrated into childbirth preparation programs. Research has demonstrated that group psychoeducational interventions that incorporate training in problem solving are effective means of alleviating depression, hopelessness, and despair (Arean et al., 1993; Lerner & Clum, 1990; Nezu & Perri, 1989) and in improving self-management skills (e.g., Richards & Perri, 1978).

It may be particularly helpful for counselors to use strategies that enhance women's problem orientation (see Nezu & Perri, 1989). For example, counselors can facilitate a positive, rational, and constructive set of beliefs and expectancies by normalizing the experiences reported by expectant women, thereby promoting a realistic acceptance of problems as a natural, recurring aspect of life in general, and during pregnancy in particular. Counselors can help participants to discriminate between aspects of a problem that may be outside the realm of personal volition and their emotional reactions to the problem. It is important that participants learn to label, identify, and explore negative emotional reactions as cues to the existence of a problem. Depressed moods may signal a sense of loss, helplessness, irrevocable change, or a lack of pleasurable, rewarding personal experiences. Anxiety may belie a sense of trepidation about the birth, parenting, or a significant relationship; irritability or anger may indicate that the pursuit of personal goals may be somehow thwarted or frustrated. Articulating these moods and the possible beliefs or assumptions that accompany them can help participants to gain some sense of control over emotional reactions that can inhibit or impair effective problem solving. Training in the problem orientation component can also incorporate emotion-focused techniques (e.g., distraction, imagery, or breathing techniques) that are beneficial in brief, short-term stressful episodes in which a person has little actual control (Auerbach, 1989). Collectively, training in these skills can reinforce favorable opinions about the self and promote a cognitive set conducive to more complex tasks, such as generating viable goals and solutions crucial in effective problem solving.

Training in the problem-solving skills component can also be accomplished in a group format, and this would involve instruction in (a) generating and evaluating possible solutions to a problem, (b) selecting and implementing a solution, and (c) monitoring subsequent progress of the solution. Including a significant other in training experiences such as role plays, brainstorming, and trouble-shooting problems often encountered in pregnancy, childbirth, and infant care.
may enhance the generalizability of problem-solving training. Women who have reliable, supportive others in the social network who lend assistance have been found to have more confidence in their own ability to parent, and this confidence in turn is an effective deterrent to postpartum depression (Cutrona & Troutman, 1986).

REFERENCES


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