
Problem-solving treatment in general psychiatric practice

Laurence Mynors-Wallis

The role of the general adult psychiatrist has changed significantly over the past decade. There is a focus (almost exclusively in some cases) on the management of patients with severe mental illness. Within the multi-disciplinary team, the key role of the psychiatrist is often perceived as the management of medication, making decisions about clinical risk and acting as gatekeeper to often restricted in-patient beds. Psychological and social interventions are commonly seen as the remit of other members of the team. Although psychiatric training should equip psychiatrists to have at least a reasonable understanding and practical knowledge of psychological treatments, many consultants in their day-to-day practice do not have sufficient time to utilise such treatments. These factors brought together result in a situation where the practice of many general adult psychiatrists is almost exclusively the treatment of patients with severe illness and within the treatment of such patients, psychiatric practice is much more about medication and risk management than the personal implementation of psychological interventions.

If busy general psychiatrists are to utilise psychological treatments in their day-to-day work, such treatments must be brief, focused and effective. The treatments must be feasible within a busy out-patient clinic. Behavioural treatments are a good model for such a treatment, and are often satisfying interventions with good outcomes.

Problem-solving treatment is a brief psychological intervention that has been shown to be effective in the treatment of major depression and for patients with a broad range of emotional disorders that have not resolved with simple measures. The treatment derives from cognitive-behavioural principles. The

rationale of problem-solving treatment is given in Box 1.

Problem-solving treatment can also have an educational role in general psychiatry: it can be taught to trainee psychiatrists as an introduction to brief psychological treatments.

What is problem-solving treatment?

Problem-solving treatment is a brief, structured psychological intervention. The treatment shares with other cognitive-behavioural treatments a focus on the here and now, rather than a dwelling on past experiences and regrets. The treatment involves an active collaboration between patient and therapist, with the patient taking an increasingly active role in the planning of treatment and the implementing of activities between treatment sessions. The treatment has been evaluated as an intervention lasting approximately four to six sessions.

Box 1 Rationale of problem-solving treatment

The patients' symptoms are caused by their everyday problems

If the problems can be resolved, the symptoms will improve

Problems can be resolved using the technique of problem-solving

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Box 2 Goals of problem-solving treatment

For patients to understand the link between their symptoms and their problems

To define the patient's current problems

To teach a problem-solving technique that attempts to resolve problems in a structured way

To provide patients with a positive experience of problem-solving

During treatment, the therapist and patient attempt to achieve four main goals (see Box 2). The first goal is to increase patients' understanding of the link between their current symptoms and their current everyday problems. Included in this goal is an understanding that problems are an expected part of everyday living, and that effective resolution of the problems will result in a reduction of symptoms.

The second goal of treatment is to increase the patients' ability to clearly define their current problems. The importance of setting concrete, specific and realistic goals for problem resolution is emphasised.

The third goal of problem-solving treatment is to teach the patient a specific problem-solving procedure in an attempt to solve his or her problems in a structured way. Specific problem-solving skills are introduced and practised using the real-life problems the patient is currently attempting to solve.

The final goal is to produce more positive experiences regarding the patients' ability to solve problems. Patients often feel beset and overwhelmed by the difficulties they face. Problem-solving treatment helps provide a sense of mastery and self-control.

Evidence supporting use of problem-solving

Depressive disorders

The most thorough evaluation of problem-solving treatment has been for depressive disorders. Depressive disorders are known to be linked with stressful life events, and patients with depression may be less likely to cope with these stresses in a clear problem-focused way. An early small study of group problem-solving therapy (eight 90-minute sessions) for students with depression, recruited by newspaper advertisement, indicated that problem-solving therapy was more effective than a waiting-list control (Nezu, 1986).

Two studies have evaluated the effectiveness of problem-solving treatment for major depression in primary care. In the first study (Mynors-Wallis *et al.*, 1995), 91 primary care patients with major depression were randomly allocated to either problem-solving treatment, amitriptyline or a placebo treatment involving both drug and psychological placebos. All treatments were given in six sessions over 12 weeks. At 6 and 12 weeks after treatment, problem-solving treatment was as effective in treating depression as amitriptyline, and significantly more effective than the placebo treatment. Problem-solving was associated with a low drop-out rate (only 7% of the sample compared with 19% for the amitriptyline sample) and was rated as helpful or very helpful by 100% of the patients receiving it (compared with 83% of the amitriptyline sample).

A second study evaluating problem-solving treatment for major depression in primary care (Mynors-Wallis *et al.*, 2000) sought to answer two further questions. First, is the combination of problem-solving treatment and antidepressant medication more effective than either treatment alone? Second, can the problem-solving treatment be delivered as effectively by suitably trained practice nurses as by general practitioners (GPs)? One-hundred-and-fifty-one patients were randomly allocated to receive problem-solving treatment from a GP, problem-solving treatment from a practice nurse, antidepressant medication alone from a GP, or the combination of problem-solving treatment and antidepressant medication. The antidepressant medication used was a selective serotonin reuptake inhibitor (SSRI). The results from this study at 6, 12 and 52 weeks indicated that there were no significant differences between any of the four treatment groups, providing further support for problem-solving treatment as an effective treatment for depressive disorders in primary care.

In common with other psychological and drug treatments for depressive disorders, predictors as to which patients might benefit from drug treatment and which might benefit from problem-solving treatment remain elusive (Mynors-Wallis & Gath, 1997). Clinical experience suggests that patients who readily accept the link between their problems and symptoms and those who wish to work within the collaborative framework of problem-solving treatment do well. Patients who wish to take a more passive role and be 'made better' by the doctor or nurse are harder to motivate to take part in the treatment.

There is some evidence that problem-solving treatment may be effective for older adults (aged over 55 years) with a depressive disorder (Arean *et al.*, 1993). A four-centre study in the USA compared paroxetine, problem-solving treatment and placebo for the

treatment of minor depression and dysthymia (Barrett *et al*, 1999). A five-centre European study evaluated problem-solving treatment and a group educational programme for depressive disorders identified by community sampling (Dowrick *et al*, 1998).

Emotional disorders

In primary care, psychological disorders do not necessarily fit into simple ICD-10 categories (World Health Organization, 1992). Many patients present with a range of depressive and anxious symptoms – emotional disorders. Although many of these disorders resolve quickly, a significant proportion of patients develop chronic conditions with significant clinical and social morbidity. Two studies have evaluated problem-solving treatment for such patients. The first selected patients identified at high risk of poor outcome. These patients were randomly allocated to receive either four sessions of problem-solving from a research psychiatrist or treatment as usual from their GP. At the end of treatment and at 6-month follow-up, patients treated with problem-solving showed significantly greater improvement on all standardised measures; they also reported greater satisfaction with treatment (Catalan *et al*, 1991).

A second study evaluating problem-solving treatment for emotional disorders in primary care sought to evaluate the treatment as given by community nurses (Mynors-Wallis *et al*, 1997). Community nurses were first trained in the techniques of problem-solving, and were then used as therapists in a trial treating patients with emotional disorders. Patients with emotional disorders of at least 1 month's duration were referred by their GP. These patients were randomly allocated to either problem-solving treatment given by a trained nurse therapist or to treatment as usual from their GP. Although there was no difference in symptom scores between the two groups at 8 or 26 weeks, patients who had received problem-solving treatment took significantly less disability days and days off work. One of the problems faced in this naturalistic study was the wide variability in the illness severity and chronicity of patients referred. A lesson from the study was that guidance is needed as to the type of patients who might benefit from problem-solving treatment, as opposed to watchful waiting alone or more intensive and specialist interventions.

Deliberate self-harm

Acts of deliberate self-harm are often committed in the context of psychosocial problems. Intuitively,

therefore, problem-solving treatment would seem to be an appropriate and valid treatment. Two studies have evaluated problem-solving treatment for patients following an episode of deliberate self-harm. Hawton *et al* (1987) evaluated problem-solving treatment as a part of a counselling intervention, by comparison with treatment as usual by the GP, for patients following an episode of deliberate self-harm. There were no major differences in outcome between the two groups. Two subgroups, however, did show some benefit from problem-solving – women and individuals with problems in their relationship with their partner.

In a second study (Salkovskis *et al*, 1990), problem-solving treatment given by a community psychiatric nurse was effective in reducing the distress experienced by overdose patients, selected as having a high risk of repetition. Short-term effectiveness was also demonstrated in preventing further overdose attempts. As with the treatment of emotional disorders, the key to the effectiveness of problem-solving treatment following deliberate self-harm is to target the appropriate patients. Further research is needed to fully answer this particular question.

Schizophrenia

Falloon *et al* (1984) have described the use of problem-solving techniques within the context of family therapy for patients with schizophrenia. Problem-solving is used to clarify the particular problems each family faces and to enhance the family's coping skills.

How to provide problem-solving treatment

Problem-solving can be given over 4–6 sessions. The first session will need to last about an hour. Subsequent sessions can be of about 30 minutes.

Box 3 Aims of first session

- To list the patient's symptoms and problems, and to establish a link between them**
- To explain the rationale and principles of problem-solving treatment**
- To illustrate the stages of problem-solving by using a specific problem as an example**

Box 4 Stages of problem-solving treatment**Stage 1 – explanation of treatment and its rationale, formulation of problem list****Stage 2 – clarification and definition of problem****Stage 3 – setting achievable goals****Stage 4 – generating solutions****Stage 5 – choice of preferred solution****Stage 6 – implementation of the preferred solution****Stage 7 – evaluation**

In the first session, the most important task is to motivate the patient to comply with treatment (see Box 3). This motivation can be achieved if the patient recognises that the therapist has listened to and understood the patient's difficulties, and has used this understanding to explain the principles of problem-solving clearly and simply. Problem-solving treatment can be considered as a series of stages (see Box 4).

Stage 1 – explanation of treatment and its rationale

There are three steps:

(a) Recognition of emotional symptoms

Obtain a full account of the patient's symptoms; emotional, cognitive and physical. A full knowledge of the patients' symptoms helps the patient to feel understood but is also needed to link problems with symptoms.

(b) Recognition of problems

List the patient's problems. This list can be compiled by enquiring about potential problem areas such as relationships, work, money, housing, health and leisure activities.

(c) Making the link between emotional symptoms and problems

A link should be made between the patient's symptoms and problems. The patient should understand that his or her symptoms are an emotional response to his or her problems. The therapist then explains that the patient can tackle his or her problems during treatment, and that if successful, resolution of the problems will lead to resolution of the symptoms. Although unrealistic

expectations should not be fostered, some optimism should be encouraged in order to motivate the patient. At this point, it is important to emphasise that the patient will play an active part in the treatment.

Stage 2 – clarification and definition of problems

A list of problems should already have been drawn up. The next step is to choose one particular problem that is important to the patient, and which the therapist considers feasible for problem-solving. This problem should be defined as clearly as possible. In specifying the problem, it may help if the patient considers four questions:

- (a) What is the problem?
- (b) When does the problem occur?
- (c) Where does the problem occur?
- (d) Who is involved in the problem?

Large problems should be broken down into smaller and more manageable parts. Usually, the patient presents several related problems. The therapist and patient should review these problems carefully, and then select one or two problems to tackle initially. The choice of a particular problem should be guided by (a) what is seen as relevant to the patient and (b) problems for which achievable goals can be set.

See Box 5 for a patient-based problem list.

Stage 3 – setting achievable goals

Once the problems have been clarified and defined, the next stage is to set one or more achievable goals. In making this choice, it is important to take into account the balance between the patient's resources and obstacles. The patient's resources may include:

- (a) personal strengths and assets;
- (b) education, leisure activities and social and financial resources;
- (c) support from other people, such as spouse or other relative, friend, or professional person such as a social worker or clergyman; and
- (d) self-help groups: direct advice about the availability of self-help groups may be appropriate.

Achievable goals should be SMART goals; Specific, Measurable, Achievable, Relevant and Timed.

It is important that the patient develops a sense of achievement early in treatment; for this purpose, goals should be identified that can be achieved

Box 5 A problem list

Mrs W was a 43-year-old office administrator for a light engineering company. She had been married for 16 years and her husband had severe arthritis, which resulted in him being wheelchair-bound and unable to work. They had no children. Mrs W was referred into the study following a 9-month history of worsening depression. Her main complaint was of poor memory and concentration

Mrs W was still not completely convinced that her symptoms were due to a depressive disorder, and some time was spent at the beginning of this session explaining the nature of depressive illness, and the physiological and cognitive effects that might occur. A problem list was then drawn up:

**Problems at work – overworked, hours of 8a.m.– 7p.m.
an unsupportive boss
difficult and possibly dishonest subordinates
previous attempts to resolve difficulties had failed**

Husband – although Mr and Mrs W were spending a lot of time together, Mrs W felt that her main role was as a nurse and that they were doing few ‘normal’ things that they could both enjoy

Housework – Mrs W felt that the house was becoming increasingly untidy and dirty, and was in need of a spring clean, but she did not have the energy to do this

Mrs W decided she wanted to work on problems 1 and 2 first – both seemed problems that could be further defined and for which achievable goals could be set

quickly, for example, before the next session. Medium-term goals can be attained in stages over the course of treatment. Goals are often more achievable if they can be achieved by the patient alone rather than relying on someone else (see Box 6).

Stage 4 – generating solutions

Once an achievable goal has been set, the patient is asked to brainstorm as many solutions as he or she can generate. Potential solutions should not be discarded or pre-judged, even if initially they seem to be silly or unworkable.

Stage 5 – choice of preferred solution

The therapist encourages the patient to draw up a list of the pros and cons for each potential solution. It may be useful to ask the patient to prepare this list as a homework task. The patient should select a preferred solution, that is a solution that best achieves the stated goals with the least personal and social disadvantages. Some patients find this stage of problem-solving the most difficult to achieve alone; such patients may ruminate about possible

solutions without being able to choose one (see Box 7).

Stage 6 – implementation of the preferred solution

It is important not to rush this stage because the patient may lack the confidence to implement the preferred solution. The steps needed to achieve the solution may have to be broken down into simple sub-steps. There should be clear specifications of the sub-steps and when they should be carried out.

The patient should have a clear set of tasks that need to be completed between therapy sessions (see Box 8). These tasks are referred to as homework.

Box 6 Achievable goals

First, Mrs W decided that she needed a break from work in order to assess the difficulties that she was facing. She decided that she needed 2 weeks off work. The second goal was to go out with her husband on at least two occasions in the week

Box 7 Generation and choice of solutions

In the clinical example of Mrs W, the solutions considered for obtaining 2 weeks off from work included taking annual leave, taking sick leave and resigning from the job. She chose taking sick leave and thought she should consult her GP to ask for a sick certificate. The possible solutions for going out with her husband included a cinema trip, a meal in a pub, a visit to a local beauty spot, a trip to Bournemouth and a visit to friends. Mrs W decided not to choose the solution immediately but to discuss it with her husband.

Box 9 Aims of session two and subsequent sessions

Review the patient's progress and reinforce success and continued effort
 If problem resolution not successful, explore changes to strategy and develop new implementation plans
 Address problems from the problem list and new problems as they emerge
 Gradually increase the patient's independence in conducting problem-solving and facilitate a positive problem-solving attitude

Stage 7 – evaluation

It is important that in second and subsequent problem-solving sessions a detailed evaluation of progress made since the previous session is undertaken (see Boxes 9, 10, 11, 12 and 13). Failure to complete tasks successfully may be because of a poor understanding of the treatment process and in particular the homework. Unforeseen obstacles may arise or patients may simply lack the motivation to fulfil tasks outside the treatment sessions. Achievable goals need to be redrawn in the light of experience.

The patient and therapist should review the original problems, consider progress and always

be prepared to add new problems to the problem list. The patient may work through a series of short- and mid-term goals to reach a long-term goal. For example, if the final goal is to secure a new job, the short-term and intermediate goals might be to:

Box 10 Mrs W – session two

Mrs W was given 2 weeks' sick leave by her GP. She had telephoned her immediate boss at work to explain why. She had made it clear that the stresses and difficulties at work were the cause of her illness. She had been very successful in planning sessions out with her husband, had been to the cinema and to visit a local beauty spot. She was also planning a weekend trip to Bournemouth for 2 weeks' time.

After this review of progress, the rest of the session was spent looking in detail at the work difficulties that Mrs W faced. She had been overworked for some time and had tried to solve this herself by beginning to work part-time, that is, on 4 instead of 5 days. Although the company had readily agreed to this, the reduction in her working hours had not been accompanied by any reduction in workload. She was still working 6 days a week and many evenings. One particularly troublesome problem was that colleagues telephoned her at home throughout the evening. Two achievable goals were set:

- (a) to receive no telephone calls from work after 7.00p.m.
- (b) to make an appointment to see one of the company directors in order to sort out her workload.

Box 8 Implementation plan**Solution**

Sick note from GP

Steps

Ring work to tell them she is not coming in
 Ring for appointment with GP
 Explain to GP that she is not coping at work and needs time off from work for treatment to be a success

Solution

Discuss with husband plans for time together

Steps

Ring cinema for a timetable – ask about disabled seating
 Explain to husband about treatment plan after supper
 Plan two trips out before next week

Box 11 Mrs W – session three

Mrs W had decided that her husband would answer all her evening telephone calls. He was very pleased to do this as it gave him a useful role. She and her husband continued to go out, in fact, three or four times a week because she had been off work. Both felt that this was very beneficial. Mrs W was going to see the director the day she returned to work.

The remainder of this third session was spent discussing in detail what Mrs W would say to the company director. She believed that he would be sympathetic to her difficulties, but would like her to come up with potential solutions. Mrs W decided that she would ask for a further reduction in her hours so that she would be working only 3 days, which would allow a colleague at work who wanted to work full-time to take over some of her jobs. Mrs W earmarked two areas of her work that she felt could be supervised by this colleague.

Mrs W also resolved to talk to her immediate boss, in order to explain to him in more detail how intolerable the work situation had become, and also to air her concerns about one of her subordinate's possible dishonesty.

Box 12 Mrs W – session four

Mrs W was now back at work and said that her colleagues had been very sympathetic. She was, however, finding it difficult to free up enough of her time in order to achieve the goal of only working 3 days. She set herself the goal of having 1 day per week of not doing any work-related activity. Ways of achieving this were discussed and Mrs W decided to draw up a timetable for herself. Her husband had begun answering the telephone in the evening and had been successful in delaying calls until the next morning. However, Mrs W was finding it difficult to cope with the anxiety of not knowing what the calls had been about.

- (a) obtain information about the qualifications required;
- (b) send for application forms;
- (c) apply for a job; and
- (d) attend for an interview if asked.

Combining problem-solving treatment with antidepressant medication

The rationale for using problem-solving treatment for patients with major depression has been described above. Although the evidence suggests that problem-solving treatment and antidepressant medication in combination are no more effective than either treatment alone, problem-solving treatment can be used as an adjunct to the prescription of medication. There are two reasons for this. First, there is evidence that poor compliance with medication reflects, at least in part, the view of patients that

Box 13 Mrs W – session five

Mrs W had managed to restructure her work so that she was working only 4 days. She saw this as a great achievement, and did not feel that it was realistic, or even desirable, to reduce her workload to 3 days, although in fact that was all she was being paid for. She was able to not work each Wednesday. It was agreed that she would not be telephoned on this day. She and her husband planned to use Wednesdays as an opportunity to go out together. Evening telephone calls had almost ceased, and Mrs W had started taking them herself, but agreed that if they became more frequent, she would ask her husband to answer them again.

Mrs W picked up another problem from her problem list, which was housework. She still believed that the house needed a spring clean. She looked at different options as to how this might be done. She decided that she would contact 'Maids', a local cleaning service, to find out how much it would cost her for them to come and spring clean the house.

At the end of this session she did not believe that she needed any more help.

their symptoms are caused by problems within their environment and that these are not likely to be helped by medication alone. Second, problem-solving provides a structured way of assisting patients with their social difficulties, and the antidepressant medication can be seen as part of this process in that physical symptoms are resolved, enabling patients to implement problem-solving interventions.

Patients with anxiety disorders referred into general psychiatric practice are by definition of poor prognosis and hence may be a group for whom problem-solving treatment may be of benefit. Generalised anxiety disorder in particular is a chronic relapsing and remitting condition with few well-evaluated therapies. For such patients, the use of problem-solving helps to provide an understandable explanation for their symptoms and also a practical approach to dealing with the everyday stresses. Problem-solving strategies can be implemented alongside other anxiety management techniques. Problem-solving treatment is not appropriate for agoraphobia or specific phobias.

Personality disorders

General psychiatry remains beset by how to manage patients with a personality disorder. Problem-solving techniques may be a helpful treatment for some of these patients. The emphasis is on the patient identifying and then resolving his or her problems. Patients have to set goals for treatment and the therapist assists with this. The offer of such a treatment may not be welcomed by patients who want their problems to be solved for them. However, the offer of a course of problem-solving treatment not only avoids getting caught up in the rather sterile discussion that there is nothing that can be done, but also provides a very clear, time-limited, here and now treatment focusing on what the patient identifies as his or her goals. Responsibility for goal-setting and implementation remains firmly with the patient.

Conclusions

Problem-solving treatment is a brief effective intervention for a range of non-psychotic anxious and depressive disorders. The structure of the treatment fits well into the standard out-patient clinic. Problem-solving treatment provides a model for a psychological intervention that is easily

understood by patients (for treatment) and by colleagues (for training).

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Multiple choice questions

- The stages of problem-solving include:
 - setting a problem list
 - reviewing past successes and failures
 - examining the patient/therapist relationship
 - setting achievable goals
 - defining problems precisely.

2. Achievable goals in problem-solving should be:
- chosen by the therapist
 - achieved before the next treatment session
 - achieved within a defined time span
 - related to problems chosen
 - linked to relationship difficulties.
3. Problem-solving treatment is a proven treatment for:
- depressive disorders
 - simple phobias
 - mania
 - adolescent depression
 - anxiety disorders in primary care.
4. Problem-solving treatment is most effective when:
- combined with antidepressant medication
 - when delivered by community nurses
 - when delivered over ten sessions
 - patients have many psychosocial problems
 - patients have a chronic illness.
5. SMART goals are:
- simple
 - modest
 - achievable
 - resisted
 - timed.

MCQ answers

1	2	3	4	5
a T	a F	a T	a F	a F
b F	b F	b F	b F	b F
c F	c T	c F	c F	c T
d T	d T	d F	d F	d F
e T	e F	e T	e F	e T

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