FOCUS on the Family Caregiver: A Problem-Solving Training Intervention

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Problem-solving interventions have documented effectiveness in treating distress among a variety of clientele. The authors discuss the application of training in social problem solving with family caregivers of persons who have incurred severe physical disabilities. Specifically, the authors outline training procedures (i.e., Project FOCUS) that enable counselors to assist family caregivers in developing effective problem-solving skills that may translate to increased wellness for each caregiver, and by extension, their care recipients.

"I've taken all the responsibility for the patient."
"I want to get over feeling responsible to keep him busy."
"I have feelings of guilt."
"It is a challenge to find new ways to do old things, and in dealing with new everyday solutions."

—Statements made by caregivers in a focus group convened to address caregiver issues (cf. Elliott & Shewchuk, 2000).

These statements provide a window to understanding the concerns of today's family caregiver. The new role of caregiver may be unexpected, particularly in the case of a sudden onset illness or injury (e.g., traumatic brain injury or stroke), and the concomitant duties may at times be overwhelming. Wellness of the caregiver, as well as the care recipient, is obviously affected. Research examining caregivers of older individuals, particularly those with Alzheimer's disease or other dementia illnesses, has shown that caregivers demonstrate higher levels of distress than noncaregivers on diverse measures of depression, anxiety, well-being, and physical health (Haley et al., 1995). Family caregivers may be particularly distressed when their care recipients endure chronic and uncontrollable bouts of pain and distress (Miaowski, Kragness, Dibble, & Wallhagen, 1997). Emotional distress and physical symptoms experienced by caregivers may be due in part to the subjective appraisal of caregiving as onerous and unrewarding (Chwalisz, 1996; Haley, Levine, Brown, & Bartolucci, 1987; Haley et al., 1996). In addition to emotional distress, caregivers often develop problems in cardiovascular, neuroendocrine, and immune functioning over time (Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991; King, Oka, & Young, 1994; Vitaliano, 1997). Finally, caregivers may receive little positive reinforcement for what they do, and they are often forced to neglect their own needs, leisure pursuits, and personal interests (Quittner, Opipari, Regoli, Jacobsen, & Eigen, 1992). Simply stated, the ability of the caregiver to provide support and assistance to their loved one may be reduced if the health and well-being of the caregiver erodes over time.

Caregivers of persons (adults and children) with acquired severe physical disabilities, such as spinal cord injury (SCI), face many unique circumstances that complicate the caregiving experience. When a family member acquires an SCI, for example, the normal pattern of life events in the family system may be disrupted. A young person with SCI may be forced to return to the parental home or may be unable to be "launched" from it (Whiting, Terry, & Strom-Hendriksen, 1984). Although most states have programs to promote personal independence after disability, cutbacks in public funds in many states have limited the availability of vocational rehabilitation and independent living programs for many persons with severe physical disabilities (Elliott & Shewchuk, 1998). Thus, they are compelled to reside with family members who then provide assistance and personal care. Furthermore, it is important to note that with most severe physical disabilities, there is no subtle, developmental course that may aide family members in planning for care. Instead, role changes and lifestyle changes occur abruptly and almost instantaneously with the onset of the disability. The role changes and lifestyle changes re-

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quired in these circumstances are necessarily related to long-term adaptation given that persons with such physical disabilities are likely to live for many years with a disability that is typically not terminal or life threatening.

The importance of the family caregiver role has been recognized by professionals interested in initiating interventions to assist the family caregiver (Myers, 1989). As practitioners of the wellness paradigm, counselors are uniquely qualified to provide interventions to family caregivers. For counselors offering assistance to newly appointed family caregivers, a focus on wellness provides an excellent backdrop for exploration of interventions focused toward maximizing physical, psychological, and spiritual health (Myers, 1991, 1992). According to counseling researchers in the area, wellness involves the integration of aspects of health (social, mental, emotional, spiritual, and physical components) and is maximally achieved when all components are in balance (Myers, 1991, 1992; Witmer & Sweeney, 1992). Wellness does not necessitate the absence of illness (as defined by health) but instead involves enhanced functioning in all areas of life and throughout the life span (Ginter, 1999; Greenberg, 1985; Myers, 1991). As such, wellness is a proactive lifestyle in which a person is responsible for choices of self-care, self-sufficiency, and empowerment. The goal of counseling, then, is to promote wellness among clients. Given the lifestyle change presented by an acute-onset severe physical disability, caregivers often experience an imbalance in at least one, if not several, of the aforementioned areas of health and would likely benefit from intervention.

**FOSTERING CAREGIVER WELLNESS**

Interventions stemming from the wellness paradigm to date have included a focus on providing respite care and social support. Although some studies have shown benefits of caregiver support groups and social networks that offer assistance, respite care, and other buffering functions (e.g., Haley et al., 1996; Myers, 1989), evidence indicates that such support erodes over time (Quittner, Glueckauf, & Jackson, 1990). This suggests that informal efforts to intervene with family caregivers have not been highly successful or long lasting. In addition, it may be difficult to address individual caregiver needs within group situations or a respite network, and this may lead the caregiver to feel alone in his or her concerns. Therefore, individual interventions are necessary.

A cognitive-behavioral intervention approach that has been proven effective when used in other populations (i.e., adults with depression, caregivers of cancer patients) is training in social problem solving. The social problem-solving intervention can benefit family caregivers because the technique addresses each caregiver's unique needs and demands within an individual counseling context. Skills learned in training provided by counselors can augment caregiving, help decrease caregiver distress, and maximize wellness in the caregiver.

Particularly during their first year of caregiving, family caregivers contend with several competing demands, includ-

**PROJECT FOCUS**

Project FOCUS is a problem-solving training program we have developed specifically for family caregivers of persons with spinal cord injury. Family caregivers are encouraged to build on existing problem-solving tools and apply these tools to their new situation of providing care for a family member with a severe physical disability. This community-based program currently serves an approximately equal distribution of African American and Caucasian individuals. These individuals in our program come predominantly from lower to lower-middle socioeconomic status backgrounds. FOCUS is an acronym associated with the problem-solving process (Facts, Optimism, Creativity, Understanding, Solve), which assists the caregivers in recalling the problem-solving techniques. The concept within each step of the process is briefly covered in a handout (see Appendix) and is explained in greater detail later in this article. This handout is used as a guide for the caregivers to follow during training.

Before training in problem-solving skills is initiated, assessment of the caregiver's problem orientation and problem-solving skills is performed. Then, card-sorting tasks are used to determine what specific problems are of concern to each individual caregiver. After the assessment and card-sorting tasks are complete, the caregiver is introduced to the project and problem-solving training. A brief description of the theoretical background of problem solving follows, along with a detailed explanation of the assessment and training process.

**Theoretical Overview**

According to contemporary models of social problem solving (D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1990,
1999; Nezu & D’Zurilla, 1989), a person’s orientation to his or her problems determines the manner in which a person processes information about the self, the environment, and problematic situations encountered in everyday life. Problem orientation, or attitude toward problem solving, involves the ability to (a) ward off negative emotions (e.g., anxiety, depression, and anger) that hamper problem-solving efforts, (b) promote positive emotions and a sense of competency that facilitate problem solving, and (c) motivate an individual toward solving problems (D’Zurilla & Nezu, 1990; D’Zurilla & Sheedy, 1991; Nezu & D’Zurilla, 1989). Persons with a positive problem orientation often resolve everyday problems without much effort, preventing these problems from exacerbating. Consequently, a sense of competency and self-efficacy is reinforced as the individual recalls these successful experiences when more complex problems are encountered. In contrast, a negative problem orientation is associated with ineffectual coping, negative emotional experiences under general and stressful conditions, and more critical views of the self and personal abilities (Elliott, Herrick, MacNair, & Harkins, 1994; Elliott, Sherwin, Harkins, & Marmaro, 1995), which tend to reinforce a negative orientation and impair problem-solving efforts (Nezu, 1987; Nezu & D’Zurilla, 1989). A negative problem orientation is also associated with more health complaints (Elliott & Marmaro, 1994). Problem-solving skills encompass the specific, goal-directed strategies by which individuals define problems, gather facts about problems, generate alternatives, decide on solutions, and implement and monitor problem-solving strategies, according to the original model of D’Zurilla and Goldfried (1971).

Effective problem solving has been related to greater use of instrumental problem-focused coping in times of stress (MacNair & Elliott, 1992) and an assertive interpersonal style (Elliott, Godshall, Herrick, Witty, & Spruell, 1991). Effective problem-solvers might experience fewer health problems because they may have a more proactive, conscientious style of coping. Furthermore, care recipients who are with caregivers who possess many impulsive and careless problem-solving tendencies have more difficulty accepting their condition and are at risk for developing preventable health complications over time (Elliott, Shewchuk, & Richards, 1999). In addition, when caregivers of persons with recent-onset SCI have a negative orientation toward problem solving, they have more problems with depression, anxiety, and ill health throughout the first year of caregiving, regardless of the actual demands of caregiving or level of physical impairment of the care recipient (Elliott, Shewchuk, & Richards, in press).

The effectiveness of problem-solving training has been documented in treatment of clinical depression among adults (Nezu & Perri, 1989) and elderly individuals (Aarens et al., 1993), suicidal ideation (Lerner & Clum, 1990), distress among persons with chronic illness (Roberts et al., 1995), and in improving self-management skills of undergraduates (Richards & Perri, 1978). This model has also been successful in alleviating distress among family caregivers of individuals with cancer (Houts, Nezu, Nezu, & Bucher, 1996).

Measuring Social Problem Solving

Before beginning the intervention, we first determine each caregiver’s problem orientation and specific problem-solving skills using the Social Problem Solving Inventory—Revised (SPSI-R; D’Zurilla, Nezu, & Maydeu-Olivares, 1995). A caregiver rates the extent to which each of 52 statements is true of him or her on a 5-point Likert scale (0 = not at all true of me, to 4 = extremely true of me). The measure has five scales: (a) Positive Problem Orientation (e.g., “Whenever I have a problem, I believe that it can be solved”); (b) Negative Problem Orientation (e.g., “When my first efforts to solve a problem fail, I get discouraged and depressed”); (c) Rational Problem-Solving Skills (e.g., “Before I try to solve a problem, I set a specific goal so that I know exactly what I want to accomplish”); (d) Impulsivity/Carelessness (e.g., “When I have a decision to make, I do not take the time to consider the pros and cons of each option”); and (e) Avoidance (e.g., “I wait to see if a problem will resolve itself first before trying to solve it myself”) (D’Zurilla & Chang, 1995). Scores on all five scales are then examined as a profile by which the clinician can understand the caregiver’s attitude toward problem solving and tendencies when problem solving.

Card Sort Procedures

After measuring each caregiver’s problem-solving orientation and skills, two unique card-sorting tasks are used to determine which areas may be problems for the caregiver and his or her loved one. The card-sorting (or Q-sort) task used in our intervention is based on 24 problems identified by a focus group of 7 caregivers (4 Caucasian women, 2 African American women, and 1 African American man; specific information and procedures concerning development of these cards may be obtained from the second author or the following publications: Elliott & Shewchuk, 1999, 2000). A single problem is listed on a card for a total of 24 cards. Each caregiver in our project is asked to examine the deck of 24 cards and place all 24 cards into different piles based on their perceived similarities. The caregiver is instructed to separate them into as many or as few piles as desired and to move cards into different piles as necessary until satisfied with how the cards are arranged. The caregiver is then asked to give each group a name so that the counselor can understand the unique theme of each group and what separates each group from the others. This technique encourages the caregiver to think about how problems might overlap or share similar characteristics. Understanding the similarities between problems may be helpful for generating possible solutions that may have been used successfully in other similar situations.

A second method of card sorting is also used in which each caregiver is asked to rank order on a continuum from 1 (most problematic) to 7 (least problematic) the 24 cards as they apply to the caregiver’s unique situation. All 24 cards
are used, and the caregiver is instructed to place a certain number of cards at each level of the continuum (2 cards under #1 and #7, 3 cards under #2 and #6, 4 cards under #3 and #5, and the remaining 6 cards under #4). This forced-choice format is used to determine which item(s) is (are) the most problematic and may need to be explored further during the problem-solving training. This method of card sorting has many advantages. It requires a new caregiver to consider problems that may be outside immediate awareness or may help the caregiver to label a particular experience as a problem. This technique also allows the caregiver to talk with the counselor about problems that he or she may have been previously unwilling or unprepared to discuss (Brown, 1986; Elliott & Shewchuk, 2000). The counselor may use this approach to help the caregiver prioritize problems that need immediate attention from those that are less urgent. This technique also allows the caregiver to consider problems that may arise in the future and plan how they wish to prevent these problems from occurring or lessen the problems' potential impact. The caregiver can then plan for potential consequences of and obstacles to his or her goals.

**Problem-Solving Training**

Problem-solving training for the caregiver includes five major components (adapted from the original problem-solving model proposed by D'Zurilla & Goldfried, 1971): (a) facts/problem definition, (b) optimism/orientation, (c) creativity/generation of alternatives, (d) understanding/decision making, and (e) solve/implementation and verification. This training protocol also parallels the protocol for problem-solving training for depression outlined in Nezu, Nezu, and Perri (1989). It is important to note that the five components should be viewed as a continuous and interlinking process rather than five stages to be followed in serial order. For example, the counselor may decide to begin with the optimism component of the model when working with a caregiver who is less motivated (as determined through the SPSI-R assessment device) and continuously address the optimism component throughout the training process.

**THE FIVE COMPONENTS OF FOCUS**

**Facts/Problem Definition**

This component involves description of a problem that was identified as such in the card-sorting procedures. The caregiver is asked to articulate the specific problem and then break it down into manageable parts. The caregiver is instructed to seek all available facts about the problem in an effort to answer who, what, when, where, why, and how of the situation. The caregiver is also instructed to ask experts for information regarding the problem situation if necessary. For example, if the problem situation concerns a constellation of physical symptoms, the caregiver would be encouraged to contact the physician's office. When describing the problem, the caregiver is encouraged to give the facts in unambiguous, concrete terms, separate facts from assumptions, and differentiate relevant from irrelevant information.

Within this phase of training, the caregiver is assisted in articulating a specific, attainable goal in an effort to overcome the identified problem. The counselor encourages realistic goals and discourages "perfect" goals. The caregiver is assisted in determining potential obstacles to meeting the established goal—solutions to these obstacles will also be generated in the creativity phase. If the problem situation is complex (i.e., involves several problem areas that are subsumed under one large problem situation, such as several smaller interpersonal conflicts that have an effect on one's relationship with another person), the caregiver is encouraged by the counselor to focus on one aspect of the situation at a time because smaller, more discrete goals are typically easier to solve.

**Optimism/Orientation**

The primary goal in this segment in the problem-solving training paradigm is to assist the caregiver in developing a sense of optimism regarding his or her abilities to problem solve. This includes instilling a belief that one is sufficiently skilled to solve the problem and instilling a sense of motivation to engage in the problem-solving process while simultaneously regulating emotional experiences to maintain a sense of confidence. Often, when the counselor recognizes the importance and breadth of the caregiver's role, the caregiver begins to feel a sense of pride in accomplishments to date, which motivates continuation in this training process. The caregiver is asked to provide an example of recent personal successes in problem solving and to consider the motivational characteristics of a personal role model who is an effective problem solver. Furthermore, the caregiver can feel more optimistic regarding problem solving with the recognition that (a) problems are a common ("normal") part of everyone's life, (b) many other caregivers have similar problems, (c) problems can be predicted and prevented, and (d) there have been personal problem-solving successes in his or her past. The idea that optimism must be accompanied with realism is stressed. In other words, the caregiver should have realistic expectations about the time and effort that will be necessary to identify and use chosen strategies, and the caregiver should not expect to "move mountains."

In addition to the aforementioned, the individual is assisted in recognizing a problem when it occurs and thereby recognizing when problem solving is applicable. One manner in which this can be accomplished is through recognition of emotional cues (e.g., anger, sadness, frustration, irritability) that a problem exists. We call these cues "red flags" or signs that the person should be problem solving. The caregiver is encouraged not to be impulsive when solving problems and not to avoid solving problems because both of these processes usually complicate the initial problem. Specifically, we discuss that impulsive attempts often result in careless mistakes. The caregiver is encouraged to take the time necessary to analyze situations, to tolerate discomfort when solutions are
not immediate, and to withhold judgment until the problem-solving process is complete.

After discussing the aspects of a positive problem orientation at length with the caregiver, the counselor leads the caregiver in an exercise designed to increase motivation for solving problems. One exercise we use is a reversed role-play scenario. Specifically, the counselor adopts a maladaptive problem orientation, and the caregiver is asked to successfully counter-argue the attitudes presented by the counselor (e.g., “I don’t have any problems at all,” “Only someone who is experiencing the exact same problem can be helpful to me; no one else can understand,” “I should avoid making decisions no matter what the consequences”). By counter-arguing the attitudes, the caregiver can develop skills to use to counter-argue personal attitudes that may decrease motivation and impede problem solving at a later time.

When working with individuals who impulsively solve problems (as assessed with the SPSI-R), a different technique is used. The caregiver is instructed to recognize the occurrence of a problem situation and label the situation as a problem. This can help deter the tendency to react automatically. First, the caregiver is asked to generate a list of areas in life in which problems may occur (caregiving, relationships, job, children and education, etc.). Then the caregiver creates a second list that includes specific current problems as well as predicted areas of vulnerability unique to the caregiver.

For those individuals who are typically unassertive when problems arise, we use a method to help the caregiver to recognize “red flags” as cues to the existence of problems. In this exercise, the caregiver and counselor generate a list of feelings and explore how the feelings serve as cues for the presence of a problem. The caregiver is encouraged to stop and think when these emotions are detected and to avoid reacting automatically.

Once the caregiver is familiar with the problem-solving process, the person is asked to provide a brief written description of the aforementioned recent problem situation that was articulated in the Facts/Problem Definition segment. This exercise emphasizes how the first two segments of the model intersect. Then the caregiver is instructed to indicate how he or she initially reacted to the situation (both emotionally and behaviorally) and describe how those reactions compare with a positive problem orientation. This illustrates to the caregiver how negative emotions can be used as a cue that a problem exists. It also provides an opportunity for the caregiver to understand what aspects of a positive problem orientation will be most useful in maintaining a positive outlook through the problem-solving process, given the available facts of the problem situation.

Creativity/Generation of Alternatives

This portion of the problem-solving training involves actively brainstorming multiple solutions to the identified problem. Because a caregiver may believe that there is only one correct answer or may tend to solve the problem with the first idea that comes to mind, training in this area is critical. First, the caregiver is instructed to think of as many solutions to the problem as possible and write each one down on a worksheet. When the caregiver reaches an impasse, the counselor suggests solutions. It is crucial that judgments are withheld at this point in the process, which means that “silly” or “impossible” solutions count equally as potential solutions. The caregiver is reinforced for deferring judgment and for giving as many alternative strategies as possible. The caregiver is encouraged to be as specific and concrete as possible in generating strategies.

The following techniques are offered to increase the number of items generated: (a) combining different solutions together to make another solution, (b) changing a solution slightly to create more solutions (adding or subtracting from it), (c) imagining oneself and his or her role model(s) in the actual situation(s) and considering what each would do and say in the situation, and (d) recalling potential solutions to other similar problems that were evaluated during the card-sorting procedure. Although there is no required number of solutions, the caregiver is instructed that having more options will increase optimism about his or her ability to solve problems.

Understanding/Decision Making

After having generated several options, it is now time for the caregiver to integrate all the information gathered to this point and consider which solutions to implement. Before deciding on a solution, the caregiver is encouraged to consider the potential outcomes of the chosen solutions and weigh the costs and benefits of each. This is done by rating each alternative as it relates to feasibility, achieving goals, perceived fit between the option and the problem at hand, and coping with obstacles. This step is the essence of the “stop and think” paradigm, in which the problem solver weighs the pros and cons of each solution alternative before proceeding with implementation. Finally, the caregiver rates the likelihood that he or she will implement each solution alternative (0 = not at all likely, 1 = somewhat likely, 2 = very likely). Recall of the facts identified earlier in the process may be beneficial in processing information during this segment. Of course, maintaining a positive problem orientation is also crucial during this phase because the caregiver will be most likely to implement those solutions about which he or she feels most optimistic.

Solve/Implementation and Verification

The final phase in the problem-solving training process is the act of solving the problem and then systematically reviewing the outcome to determine how the solution worked and the degree to which the actual outcome approximates the expected one. Because the counselor is not typically present during this stage, the caregiver is requested to provide feedback at the next meeting with the counselor. The caregiver is asked to evaluate how effective his or her solution was in solving the problem and to identify the actual effects on each individual involved in the problem situation and solution. This self-monitoring component is crucial to promote understanding about what made the chosen solution effective.
or ineffective and how to implement similar or alternative solutions in future problem situations. This component builds self-esteem, self-efficacy, and self-empowerment.

**FINAL POINTS OF CONSIDERATION**

This five-phase problem-solving training process requires approximately 2 to 3 hours to complete during an initial meeting with a caregiver. Manuals are available that describe the use of this intervention with other groups (e.g., terminal cancer patients and their family members) and provide informative examples (D’Zurilla & Nezu, 1999; Nezu, Nezu, Friedman, Faddis, & Houts, 1998; Nezu, Nezu, & Perri, 1989). In the Project FOCUS model, our training with caregivers also includes (a) regular telephone contacts with the caregivers emphasizing and reinforcing effective problem solving each month during the year; (b) regular mailings of informative and instructive materials over the year to the caregiver; and (c) follow-up evaluations and “booster sessions” at 6 months and 12 months to reassert problem-solving orientation and skills, and level of distress (i.e., depressed mood, anxiety), and to retrain and reinitiate the caregiver as necessary. These components reinforce use of effective problem-solving principles throughout the year. The caregiving career seems to follow a dynamic course over the first year after an injury to a family member (Shewchuk, Richards, & Elliott, 1998). Therefore, we distribute problem-solving training over the duration of a year rather than over the course of several weeks, as suggested by other social problem-solving researchers (Nezu & Perri, 1989). In addition, our approach considers the immediate and specific problems reported by each individual caregiver and matches the intervention with the problems unique to each caregiver (Elliott & Shewchuk, 2000). This can promote self-empowerment among caregivers and foster a sense of pride and accomplishment.

We believe that family caregivers of persons who receive training in problem solving will have greater well-being, will be more likely to use rational problem-solving skills, and will report less distress. By extension, persons with severe physical disabilities whose caregivers are trained in problem solving may have fewer secondary complications in the first year following the injury and thus require less medical attention. We intend to promote health, well-being, and independence among caregivers and their family members.

**CONCLUSION**

Counselors are uniquely qualified to assist caregivers in maximizing their health and well-being through individualized cognitive-behavioral intervention provided by the Project FOCUS model. The model illustrates that caregivers can benefit from problem-solving training that enhances their ability to regulate emotional experiences when encountering problems and provides them with the cognitive-behavioral skills for effective problem solving. In using this model, counselors consider the immediate and specific problems of a caregiver. The caregiver is empowered with self-care skills and the ability to handle situations that arise in an effective fashion; the person seeks more information when needed and takes a proactive role in all aspects of the caregiver experience. These skills may promote independence from formal health care systems and empower caregivers and their family members to achieve a greater level of wellness and self-sufficiency.

**REFERENCES**


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APPENDIX

Project FOCUS

Facts: Get the facts! First, define the problem. When you have determined what the specific problem is, your goal becomes solving that problem. In order to determine the necessary steps leading to your goal (i.e., solving the problem), you will need to decide what information (facts) you already have to assist you in solving the problem, and decide what else you need to solve the problem. You may need to ask an expert (e.g., nurse, physical therapist, mental health practitioner, physician) in order to get the necessary information (facts). Utilize the experts. We are here to assist you. No question is a dumb question.

Optimism: Be optimistic, but realistic. You will feel better about yourself and your ability to problem-solve when you are hopeful and positive. Think of a role model who handles problems effectively (either someone you know personally—a friend or relative—or know about—president, hero). How would they feel in this situation? Think: "I CAN do this!"

Creativity: Be creative in your ideas! What other ways can you solve the problem that you have not thought of before? Brainstorm! Think of as many ways as possible that you can solve the problem (both old and new ways). You will be determining later which ideas may work best, but for now, think of as many as you can.

Understanding: Do you understand what the problem is? Understanding the problem, the facts about the problem, and the possible solutions to the problem will assist you in solving the problem. It is also important to know and understand the possible consequences (both positive and negative) for each of the ideas of how to solve the problem that you thought of previously. Finally, it will also be important to have an understanding of the difficulties, or potential obstacles, involved in reaching your goal.

Solve: Solving the problem is the final step. Given the preceding information (facts, ideas of how to solve the problem, and understanding), you can develop a plan of action (e.g., steps), which will lead to your goal, as you outlined above. Then solve the problem and see the outcome. Does the outcome match your expectations, your goals? If not, go back to your list of ideas and try another idea. Try not to be impulsive. Stop and Think.