Chapter 1
What Is Collaborative Problem Solving and Why Use the Approach?

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Noncompliant, defiant, aggressive behavior is a leading cause of referral for youth mental health services [8]. Furthermore, not only are behavioral difficulties the primary concern of parents during early childhood but also a leading cause of teacher stress in schools [2]. Children who evidence such behaviors are typically assigned any of a variety of psychiatric and related disorders, including attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), attachment disorders, depression, bipolar disorder, anxiety disorders, autism spectrum disorder (ASD), nonverbal learning disorder, language processing disorders, and sensory integration disorder. Regardless of the label, parents, educators, mental health clinicians, pediatricians, and the juvenile justice system all struggle with how to manage these difficult and seemingly intractable behaviors.

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Our society's current treatment of children with challenging behavior flows directly from "conventional wisdom" that understands challenging behavior as being coercive, attention seeking, manipulative, and/or the by-product of poor motivation. This viewpoint leads to interventions relying on operant procedures such as rewards and punishments. Giving or revoking privileges in a home, sticker charts and detention and suspension in school, or more complex point and level systems in therapeutic facilities are all examples of such interventions. These interventions typically fail to solve the chronic problems caused by challenging behavior. As long as we continue to view children with social, emotional, and behavioral challenges through the lens of this conventional wisdom, it is likely that failure rates and costs will remain disturbingly high and true success stories of at-risk kids will remain disturbingly low.

The Paradigm Shift

Fifty years of research in the neurosciences has shown us why our current interventions demonstrably do not work. Conventional wisdom is wrong. Challenging kids do not lack the will to behave well. They lack the *skills*. In the same way that youth with learning disorders struggle with thinking skills in areas like reading, writing, or math, research in the neurosciences has shown that most youth who exhibit chronic challenging behaviors lack the skills needed to behave well. Specifically, youth with behavioral challenges are delayed in the development of critical *thinking skills* related to flexibility, frustration tolerance, and problem-solving [1]. In some cases, these lagging skills are the direct result of chronic, toxic stress, or trauma experienced during early childhood that has been shown to be a neurotoxin to the brain – literally delaying brain development [10]. However, there are myriad causes of such delays in development. The analogy of a learning disorder is quite apt. Not long ago, kids who had trouble reading were thought of as lazy or dumb and treated as such –

despite the sad irony that the child struggling to read was usually trying harder than anyone else in the class to do so. Thankfully, today, people recognize that these children and adolescents have a disability that simply requires a different method of teaching.

In the Think:Kids program at Massachusetts General Hospital, we aim to accomplish a similar shift in perspective and practice with youth with challenging behavior who are still completely misunderstood and their challenges completely mistreated. Rather than try to motivate these kids to behave better, we recognize that these children are ironically trying harder than anyone to behave themselves but lack the skills to do so. Our approach teaches the skills of frustration tolerance, flexibility, and problem-solving through a structured and replicable process of helping adults and kids learn how to resolve problems collaboratively.

The Collaborative Problem Solving Approach

The Collaborative Problem Solving (CPS) approach represents a novel, practical, compassionate, and highly effective model for helping challenging children and those who work and live with them. The CPS approach was first articulated in the widely read book, *The Explosive Child* [3], and subsequently in the treatment manual for the approach entitled, *Treating Explosive Kids: The Collaborative Problem Solving Approach* [4].

First and foremost, CPS provides an overarching philosophy and way of thinking, which helps serve as an anchor for adults working with these youth, especially amidst challenging circumstances. This overarching philosophy, epitomized by the phrase, “Kids do well if they can,” suggests that all children are inherently motivated to try to be as successful and behave as adaptively as possible. Implicit in this philosophy is also the understanding that if a child is not behaving adaptively, something (other than a lack of motivation or desire to do well) must be standing in his or her way (Video

1.1). It is then the job of the adults to figure out what specifically is interfering and to determine how best to help.

Once adults have been acquainted to the overarching mind-set, or philosophy behind the approach, CPS provides a specific assessment, planning, and intervention process all of which flow from this basic premise.

Assessment

The Collaborative Problem Solving Assessment and Planning Tool (CPS-APT) is used by adults to structure the assessment process. This process begins by allowing the adults around the youth the opportunity to describe the specific types of *challenging behavior* that the youth exhibits. This gives an opportunity for the adults to describe how challenging the behavior is and to potentially receive some empathy for what is required to contend with these daily challenges. Listing the challenging behaviors also allows the adults to gauge the level of acuity and risk involved in those behaviors. For example, refusal carries less immediate risk than assaultive behavior. Once the adults have described the nature of the youth's challenging behavior, the discussion is oriented around identifying the predictable circumstances in which those behaviors occur. The situations in which the challenging behaviors occur are referred to as the list of *problems to be solved*. These problems to be solved encompass the precipitants, antecedents, or triggers to the challenging behavior and the specific expectations that the youth is not meeting. Adults are instructed to try to achieve as much specificity as possible in identifying the situations in which the challenging behavior occurs. That specificity will prove helpful when it comes time for the problem-solving process. In addition, identifying specific precipitants in turn enables adults to hypothesize about the lagging skills underlying those problems. Once adults have identified these specific precipitants, they then use the reference sheet on the second page of the CPS-APT to identify the primary skills deficits giving rise to the challenging

behavior. Adults are instructed that these initial hypotheses will be tested during the intervention phase. For now, these hypotheses serve to foster a compassionate and understanding mind-set with regard to the youth's challenging behavior. Once adults have identified a number of specific precipitants and have guesses as to the underlying skills deficits causing those situations to be problematic, they are ready to begin the planning process.

Planning

The planning process in CPS involves reviewing the goals that adults have with regard to the youth. The range of goals typically discussed include reducing challenging behaviors, pursuing adult expectations, solving chronic problems durably, building skills, and forming a helping relationship with the youth. Once goals have been discussed, the planning process involves illustrating how adults have three options for responding to any of the problems on their list of problems to be solved. Those options include imposing their will, which we refer to as "Plan A," dropping an expectation temporarily, which we call "Plan C," and attempting to solve the problem collaboratively in a mutually satisfactory way, which we refer to as "Plan B." Adults are then encouraged to reflect on which of their goals each of the three Plans pursues. In doing so, adults come to see that Plan A is an attempt to get their expectations met, but likely does not reduce challenging behavior and often times actually triggers it. Adults also come to realize how Plan A does not solve problems in a durable way, build neurocognitive skills, or contribute meaningfully to the forming of a helping alliance. It is important to clarify to adults that Plan C does not represent "giving in" or capitulating. Rather, Plan C is a strategic decision on the part of the adults to prioritize other goals. By temporarily dropping an expectation, adults come to see that challenging behavior is reduced, even though the expectation is temporarily set aside and no skills are trained. The heart of CPS, however, involves

the process of Plan B, where adults pick specific problems and use a standardized process to try to resolve them collaboratively with the youth. Adults are taught to understand how the ingredients of this process of working toward a mutually satisfactory solution to a problem build a helping relationship and engage both interaction partners in the practice of training crucial neurocognitive skills. The empathic nature of the Plan B process is also less likely to trigger the youth and, as such, reduces challenging behavior while still pursuing adult expectations (Fig. 1.1).

Adults are instructed that while Plan A may be required for immediate safety issues, those circumstances will recur if the problem is not solved durably and skills are not built. While Plan B has significant advantages to the other two options, it is not feasible to collaborate on solving all problems simultaneously. As such, the planning process of CPS involves prioritizing which problems to focus on first. Adults are instructed to focus on problems that the youth is more invested in or that may simply be easier to solve as a starting point. Once adults have selected the problems they want to begin working on first, they must decide how the other problems will be handled in the interim. Plan A is selected if pursuing adult expectations is more important than reducing challenging behavior. Plan C is selected if keeping the youth

GOALS	PLAN A	PLAN C	PLAN B
Try to get your expectation met	✔	✖	✔
Reduce challenging behavior	✖	✔	✔
Build skills, confidence	✖	✖	✔
Solve problems	✖	✖	✔
Build relationship	✖	?	✔

Figure 1.1 Goals purused by using each of the three plans taught in CPS

calm and reducing challenging behavior are a higher priority than pursuing the expectations of adults in that specific circumstance.

A very common misconception during the planning process of CPS is to confuse simply setting expectations with imposing one's will when those expectations are not being met. Adults are reassured that they should continue to set appropriate, realistic, and predictable expectations for youth, and that doing so is critical for all youth. The three Plans are used when those expectations which have been set are not being met by the youth. The simplicity of these three options allows adults to create a plan that facilitates consistency among the adults around the youth. While not every situation can be made predictable, through this planning process, adults also realize the dangers of Plan A in any emergent situation as well as a temporary benefit of Plan C. Perhaps most importantly, adults realize that Plan B is the only one of the three options that effectively pursues each of the five goals listed above.

Intervention

As mentioned above, the heart of the intervention of CPS is the process of Plan B. However, it is important for people to recognize that Plan B is only one component of the CPS approach. The philosophical shift in mind-set and the above described assessment and planning process all contribute meaningfully to the outcomes of CPS. While adults are often eager to being practicing the process of Plan B with youth, it is always important not to neglect fidelity to the other aspects of the model.

Having established the specific circumstances in which challenging behavior predictably occurs, adults are taught that the far preferable form of Plan B is what is referred to as Proactive Plan B as opposed to what is called Emergency Plan B, the latter of which takes place in the heat of the moment, and as such, is much less likely to durably solve

problems. Emergency Plan B is a form of crisis management or de-escalation, where Proactive Plan B takes place well before a predictable problem occurs and during a time when the youth is well regulated and accessible and the adult has had time to think and plan. Whether conducted emergently or proactively, Plan B has three basic ingredients to it. Those ingredients are intended to always be done in the same order:

1. Empathy: clarify youth concern
2. Share the adult concern
3. Brainstorm, assess, and choose a solution

The Empathy ingredient is often the most challenging for adults. It involves beginning the conversation with a neutral observation about the problem to be solved (as opposed to the challenging behavior). Adults are taught specific tools to facilitate the process of gathering information from the youth about the youth's concerns or perspective about the problem to be solved. These tools include clarifying questions, educated guesses, reflective listening, and the targeted use of reassurance. Adults are instructed that their goal in this first ingredient is to gather as much information as possible regarding the youth's concerns. The role of adults in the first ingredient is often described as that of a detective on an information-gathering mission. Only once adults have identified a youth's concerns or perspective about a specific problem to be solved do they move to the second ingredient of Plan B where they describe their own concerns or perspective about the same problem succinctly to the youth. The third and final ingredient of Plan B involves inviting the youth to brainstorm potential solutions to the problem and assessing together when they address both parties' concerns and are realistic and doable. The youth is given the first opportunity to generate solutions and is encouraged to reflect upon whether they are indeed mutually satisfactory, realistic, and doable, before selecting a solution and making a plan to enact it. Adults are taught to expect Plan B to not go smoothly in the beginning. In fact, they are trained to notice where Plan B conversations get stuck, as those places illustrate whether the

hypothesized skills deficits are indeed where the youth struggles. Adults come to realize that there is no more effective way to figure out with which problem-solving skills a youth struggles than by paying attention to where the youth gets stuck when problem-solving. Similarly, adults come to understand that the best way to help youth develop better problem-solving skills is by engaging in repeated practice at solving problems with them. It is the repetition of the three ingredients of Plan B where the skills training occurs. The fact that this skills training occurs in a naturalistic and relational context is crucial to the generalizability of the skills training (the neurobiological principles underlying this form of skills training through the practice of Plan B will be covered in depth in Chap. 2. Once adults come to realize that the power of Plan B is as much in the process as the outcome, they tend to persevere when Plan B gets stuck and/or when initial solutions do not prove effective. Ultimately, the repetition of the Plan B process solves problems while meeting adult expectations and reduces challenging behavior while building skills and relationship.

From the Living Room to the Staff Room

CPS was first used as a parenting approach before being formally tested in outpatient therapy for families with children who met criteria for oppositional defiant disorder and exhibited some mood dysregulation. A randomized controlled trial found that CPS produced significant improvements across multiple domains of functioning at posttreatment and at 4-month follow-up. These improvements were in all instances equivalent, and in many instances superior, to the improvements that resulted from parent training [5].

The first implementation of CPS in a system was on a child psychiatric inpatient unit at the Cambridge City Hospital outside of Boston Massachusetts. By training inpatient staff to use CPS, the hospital was able to completely eliminate the use of restraint and seclusion [6]. As the results from that

study were shared publicly, multiple inpatient units across North America became interested in using CPS as a means to decrease restraint and seclusion. Subsequent studies replicated the dramatic reduction of restraint and seclusion in child and adolescent inpatient units [9].

The next systemic implementation of CPS occurred in juvenile detention facilities in the state of Maine, where recidivism rates were dramatically reduced in addition to restrictive interventions [11]. Interest in CPS became more widespread throughout a variety of therapeutic programs including residential treatment centers, day treatment centers, and therapeutic schools, and large multiservice systems began training staff in CPS across multiple settings and campuses [12].

Ultimately, school systems also became interested in using CPS to transform disciplinary policies and procedures as a means to decrease challenging behavior and resulting teacher stress as well as rates of detention, suspension, and expulsion [13, 14]. Since that time, various other types of systems and programs have found that implementing CPS addresses their concerns and goals, including mentoring programs, foster care programs, and police forces. Because CPS provides a common, unifying philosophy, language, and process that is applicable across systems from individuals' homes to schools, to therapeutic, and to correctional facilities, we have found that it has been an appealing approach for a vast array of systems. CPS has been increasingly implemented across entire communities, large national and international organizations, and systems of care [7].

Lessons Learned from Implementation

As CPS has been exported to many different types of settings, and more and more entire systems, it has become increasingly clear what the primary obstacles are to effective implementation and how best to address them. Reflecting on what has been learned through the field of implementation science, our lived experience mirrors many of those conclusions [2].

This book represents our latest thinking on how best to implement CPS, flowing both from lessons learned from implementation science as well as from our experiences. It includes much of the information we have been gathering for the last two decades on how to maximize the chance of success implementing the CPS approach across different types of settings.

Chapter 2 focuses on the effect of chronic, toxic stress and trauma on brain development and helps readers to understand how CPS promotes the types of interactions necessary for healthy biologic development. The concepts described in this chapter are relevant in any setting where CPS is implemented but especially in settings that serve youth who have been exposed to chronic stress and trauma. Chapter 3 provides an overview of the field of Implementation Science and its implications for the implementation of CPS specifically. As stated above, taking these factors into account when designing an implementation plan is crucial to maximizing successful outcomes. Chapter 4 focuses on implementation of CPS in milieu and community-based settings. The chapter will highlight common issues related to implementation across therapeutic settings and also covers implications for specific settings. Chapter 5 details the nuances of implementing CPS specifically in educational settings. Special attention is devoted to the integration of CPS within existing school structures. CPS also lends itself well to implementation across entire systems; Chap. 6 describes the critical factors to consider when planning large-scale, system-wide implementation. The next two chapters provide important information about evaluation: Chap. 7 focuses on mechanisms to assess CPS integrity with a particular eye toward helping systems use such data to maintain the integrity of implementation over time, while Chap. 8 assists the reader in developing a plan for systematically evaluating the outcomes associated with implementing CPS across all types of settings. Implementation of CPS often reveals challenges among staff that can be successfully addressed using the CPS process itself; finally, Chap. 9 focuses on the relevance of CPS for management, supervision, and mentorship.

Conclusion

Social, emotional, and behavioral challenges manifest themselves in youth of all ages and all backgrounds, and we encounter these children in many different settings. Youth educational, mental health, and correctional services, though well intended, have been limited in their ability to address challenging behaviors in youth. Adults know that reward and punishment techniques don't work for many of the youth they serve; but *they don't know what else to do*. CPS is an evidence-based approach that has proven effective across all these settings by teaching adults that instead of punishing challenging behaviors, they can help children to develop skills in the areas of problem-solving, flexibility, and frustration tolerance – skills that, once developed, will naturally result in improved behavior. The remainder of this book provides detailed information about ways you can increase the odds of successful implementation of CPS in your setting.

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