

Overview of
Collaborative Problem SolvingSM
(CPS)

developed by

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"Treating Explosive Kids", &
"Lost at School"

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ABOUT THE SPEAKER

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- B.S. Computer Science, Paralegal Certification
- Advanced Training in Collaborative Problem Solving 2008
- Former Exec. Dir. of FSO Hunterdon/Somerset/Warren
- *NAMI NJ*:
 - *NAMI Basics*: National trainer, NJ Program Coordinator
 - *Educating the Educators (ETE)*: founder and presenter
- Awards:
 - 2007 MHANJ: *Golden Bell Excellence Award*
 - 2006 SPAN: *Parent-Professional Collaboration Award*
 - 2006 NAMI NJ: *Building Alliances Award*
 - Hunterdon Prevention Resources, board member
 - NAMI Hunterdon: board member, 2-time past president



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Keys to Preventing Reducing Challenging Behavior

1. Accentuate the POSITIVE.
2. Teach and model flexibility (through CPS).

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Explosive Outburst

An explosive outburst, like other forms of maladaptive behavior, occurs when the cognitive demands being placed upon a person outstrip that person's capacity to respond adaptively.

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**MOST OUTBURSTS
ARE
HIGHLY
PREDICTABLE!**

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Typical View of Challenging Children

- Guiding Philosophy: “Children do well if they *want* to.”
- Explanation: Children’s difficult behavior is attention-seeking or aimed at coercing adults into “giving in”.
- Goal of treatment: Induce children to comply with adult directives.
- Tools of Treatment: Reward, punishment as incentives.

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CPS Philosophy

- Guiding Philosophy: “Children do well if they *CAN*.”
- Explanation: Children’s difficult behavior is the byproduct of a learning disability in the domains of flexibility, adaptability, and frustration tolerance.
- Goal of treatment: Teach children who are lacking these cognitive and emotional skills.
- Tools of Treatment: Teach children and adults how to work toward mutually satisfactory solutions to problems underlying difficult behavior.

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CPS Principles

- Children will do well if they *CAN*
- Your explanation should guide your intervention
- Focus efforts on the front-end (pro-active)

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Lagging Skill Areas

1. Executive Function Skills
2. Language Skills
3. Emotional Regulation Skills
4. Cognitive Flexibility Skills
5. Social Skills

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Executive Skills

Plan, Organize, Strategize, Pay Attention, Remember Details, Hindsight, & Forethought

- Difficulty handling transitions, shifting from one mindset to another
- Difficulty doing things in a logical sequences
- Poor sense of time
- Difficulty reflecting on multiple thoughts or ideas simultaneously
- Difficulty maintaining focus on goal-directed problem solving
- Difficulty considering likely outcomes or consequences of actions
- Difficulty considering possible range of solutions to a problem

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Language Skills

Problem Solving is essentially a linguistic skill

- Difficulty expressing concerns, needs, or thoughts in words
- Difficulty understanding what is being said

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Emotion Regulation Skills

- Difficulty managing emotional response to frustration so as to think rationally (separation of affect) or react appropriately
- Chronic irritability, agitation, fatigue, and/or anxiety significantly impedes capacity for problem solving.

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Cognitive Flexibility Skills

- Difficulty seeing the “grays”. Concrete, literal, black/white thinking
- Difficulty deviating from routine or original plan
- Difficulty handling unpredictability, ambiguity, uncertainty, novelty
- Difficulty shifting from original idea or solution or adapting to changes in plan or new rules - possibly perseverative or obsessive
- Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
- Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., “Everyone’s out to get me,” “Nobody likes me,” “You always blame me,” “It’s not fair,” “I’m stupid,” “Things will never work out for me”)

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Social Skills

- Difficulty attending to and/or accurately interpreting social cues/poor perception of social nuances
- Difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills
- Difficulty seeking attention in appropriate ways
- Difficulty appreciating how his/her behavior is affecting other people; often surprised by others’ responses to his/her behavior
- Difficulty empathizing with others, appreciating another person’s perspective or point-of-view
- Difficulty appreciating how s/he is coming across or being perceived by others

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Executive Function Deficits => Challenging Behavior

- If you can’t sequence, then . . . You can’t plan.
- If you can’t plan, then . . . You can’t predict.
- If you can’t predict, then . . . You can’t identify cause/ effect.
- If you can’t identify cause/effect, then . . . You can’t identify consequences.
- If you can’t identify consequences, then . . . You can’t control impulsivity.
- If you can’t control impulsivity, then . . . You have an inclination toward inappropriate/challenging behavior.

Ruby K Payne (2002), *Understanding Learning, the How, Why, What*

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**You will become a
surrogate
FRONTAL LOBE**

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CPS has 4 Goals

1. Allow adults to pursue expectations
2. Teach lacking thinking (cognitive) skills
3. Reduce meltdowns
4. Improve relationship between parent/child

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Plans Framework

Plan A: (A=Adult)

Imposing adult's will

Plan B: (B=Both)

CPS Plan

Plan C: (C=Child)

Eliminating or reducing the expectation

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Goals Achieved by each Plan

	Pursue Expectations	Reduce Meltdowns	Teach Skills	Improve Relationship
Plan A	Yes	No	No	No
Plan C	No	Yes	No	No
Plan B	Yes	Yes	Yes	Yes

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Implementing Plan B

1. Empathy (+ Reassurance)
2. Define the Problem (Identify Concerns)
3. Invitation

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Empathy

- Reflective Listening: "I hear you."
 - Lets child know you're listening
 - Keeps child calm
- Reassurance:
 - "I'm not saying 'No'."
 - "I'm not angry with you."
 - "You're not in trouble."
- Gets child's concern on the table

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Empathy (con't)

Getting *their* concern "on the table":

"What's up?"

"Drilling Down"

to get to the real reason WHY the child is having difficulty doing (or not doing) something.

OFTEN THE HARDEST PART OF CPS

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Define the Problem

Problem (in context of communication):

Two un-reconciled concerns

Getting *your* concern "on the table":

"I'm concerned that . . ."

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Invitation

“Let’s think about how we can work that out.”

Give them the first shot at it . . .

“Do you have any ideas?”

Then . . .
brainstorm possible solutions,
putting all on the table before evaluating any.

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Solutions considerations

- Solutions must be *mutually satisfactory* and *realistic*.
- For each proposed solution, ask 3 questions:
 1. Does this solution address your child’s concern?
 2. Does this solution address your concern?
 3. Is it do-able?
- If the answer is “yes” to all 3, give it a try.
- If no, state whose concern it *does* address and whose concern it *doesn’t* address or (if not do-able) that a similar thing was tried in the past and didn’t seem easy enough to do then. “Let’s think some more.”

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What if . . .

- The child doesn’t know what his/her concern is?
 - You take a shot at it. Ex: “Could it be that . . . You’re not tired at 10:30pm?” or “Is there anything that worries you about going to sleep?” etc.
- The child cannot appropriately articulate concern?
 - Again modeling appropriate words as examples above
- The child can’t come up with any solutions?
 - Give them a few moments, then you take a shot at it: Ex: “Perhaps we could try 10:45 for a few days and see how that works?”

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What if . . .

- You start trying a solution thinking it might work and it becomes obvious that it won’t?
 - “You know, it seems like this still isn’t working the way we’d hoped. Let’s see if we can come up with a different solution or perhaps we haven’t hit upon the concerns are yet. Let’s try again.”
 - Then go back to try to identify the real concerns or come up with a solution that’s workable for each of you.

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Proactive vs. Emergency Plan B

- Most meltdowns are predictable.
- Preemptively try Plan B when the child is calm or you know you are about to enter a potentially explosive situation.

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This is Hard!!!!

- Early on, CPS can feel like slogging through mud.
- Over time, a Plan B “rhythm” should develop.
- Very difficult problems may require more than one discussion.
- The first solution seldom solves the problem durably.
- Sometimes it’s necessary to take a break from the discussion and return to it later, after both parties have had more time to think.
- Initially, child is likely to propose solutions that are not realistic or mutually satisfactory.
- “Talking with” a child is not the same thing as doing Plan B.

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Common Difficulties Executing Plan B

- Plan B still resulted in meltdown.
 - Actually using Plan A.
 - Child is accustomed to Plan A approach and used to getting heated up whenever problems occur.
 - Adult discounts/rejects child's solution.
 - Giving choices is NOT Plan B – it's Plan A with choices!
- Identifying your child's real concern and identifying your real concern.
- Your Body Language and Tone of Voice give off a different vibe than the words you're using.

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Educators Wonder . . .

- How will teachers have time to use CPS in a classroom with so many other students to consider?
 - CPS takes less time than explosions.
 - It only takes more time initially. School in New England found that teachers actually save 30 minutes/week using CPS.
 - Other students will benefit from "overhearing" use of CPS.
 - Sure beats *years* of using ineffective techniques.

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YOU might be wondering . . .

- My child has a normal/high IQ, so he doesn't have learning disabilities, so he CAN do this if he really puts his mind to it.
 - IQ and learning disabilities are NOT the same thing.
 - Skill deficits . . . Deficits in the frontal lobe AT THAT MOMENT, UNDER THOSE CIRCUMSTANCES.
 - We ALL have times when even the most brilliant among us reacts less-than- appropriately to frustrating situations.

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Or wondering . . .

- What about the "real" world? What if my child has a Plan A boss?
 - Plan A is a problem to be solved
 - How does your child learn problem-solving skills? Plan B.
 - Which skill is more important in the real world: blind adherence to authority taught with Plan A OR learning how to work things out with people with Plan B?

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Or wondering . . .

- We were all brought up on Plan A and we turned out OK.
 - Did we really all turn out OK?
 - Divorce rates 50%
 - 50% – 85% of Americans are unhappy with their jobs
 - Look at the state of the world today

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And, Finally . . .

- This is so new and different, how do I hang in there until we get to a workable solution?
 - Solutions are only a bonus.
 - You will be getting much more valuable *dividends* along the way.
 - You will be *communicating* with your child instead of *arguing* with your child and, hence, fostering a mutually respectful relationship with your child.
 - AND you'll be modeling effective problem solving skills.

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REMEMBER:
Children do well if they CAN!

Instead of thinking . . .

- “What is it going to take to motivate this child to behave differently?”

Try thinking . . .

- “Why is this so hard for this child?”
- “What’s getting in the way?”
- “How can I help?”

You CAN Do This!
Every Child is Worth It!
 and . . .
It really DOES work!!!

CPS
RESEARCH STUDIES

Study #1: Outpatient ODD
 (Greene, Ablon, et al, 2004)

- 50 clinically referred boys and girls
- Age range: 4-13 years
- All met criteria for ODD
- None met full criteria for CD
- All met at least sub-threshold criteria for severe major depression or bipolar disorder
- Random assignment to PMT (n=19) or CPS (n=28)

Figure 1. Maternal Ratings on ODD Rating Scale

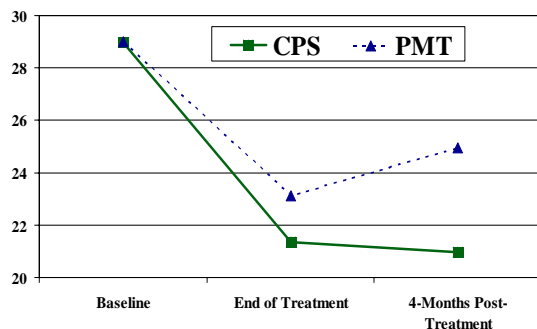
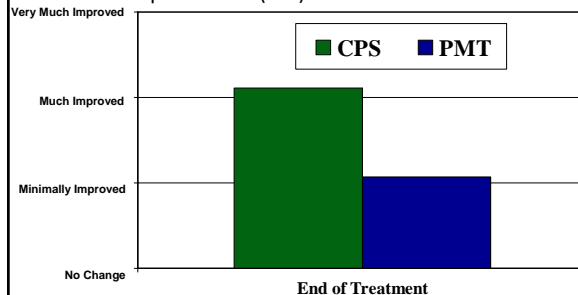
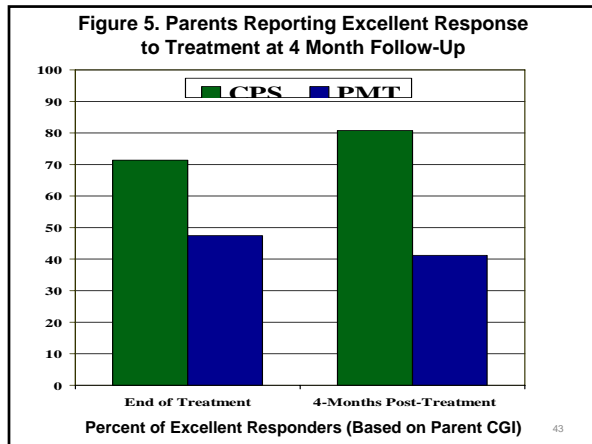


Figure 2. Therapist Ratings of Clinical Global Improvement (CGI) at End of Treatment





Study #1 Outcome

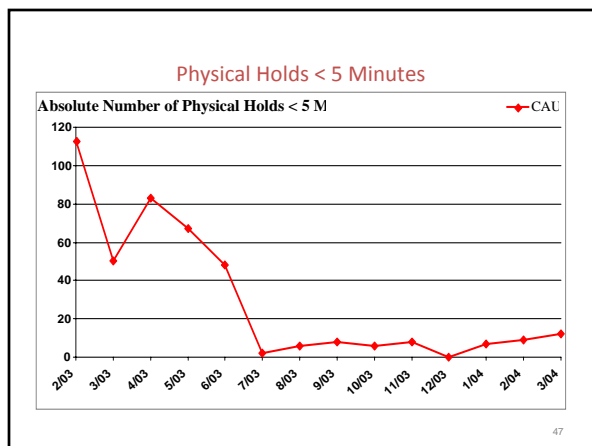
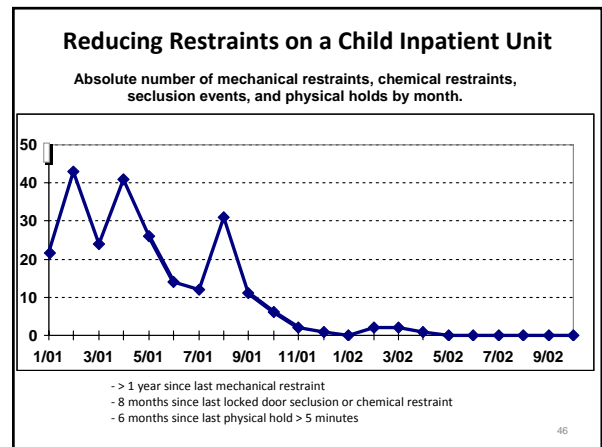
(Greene, Ablon, et al, 2004)

- Parents in the CPS condition reported significant reduction in parenting stress, including significant improvement in feelings of competence
- Parents in the CPS condition reported significant improvements in parent-child interactions, including parental feelings of competence in limit-setting and parental ratings of child's autonomy

Study #2: Psychiatric Inpatient

(Greene, Ablon, et al, 2005)

- Implementation of CPS on an inpatient psychiatry unit (Child Assessment Unit, Cambridge City Hospital)
- Age range of patients = 3-13 years
- Training of staff included weekly supervision (twice a week, two hours each session) for a duration of approximately six months
- Prior to implementation, unit characterized by very high levels of physical, chemical, and mechanical restraint, locked-door seclusion, and staff injuries



Study #2 Outcome

(Greene, Ablon, et al, 2005)

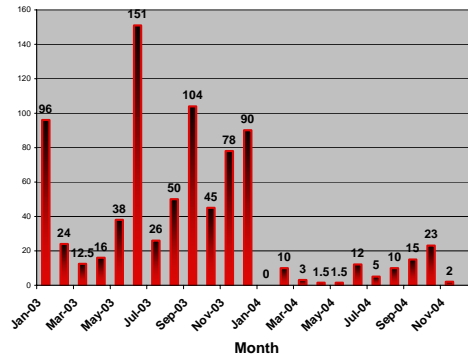
- Implementation of CPS was associated with elimination of chemical, physical, and mechanical restraint and locked-door seclusion
- Staff and patient injuries were significantly reduced
- Acuity of unit was constant over time

Study #3: Juvenile Justice

- Implementation of CPS in the high custody unit of Mountain View Youth Development Center, a juvenile justice facility in the State of Maine
- Training of staff included weekly supervision

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Average Length of Time Spent in SMU



Study #3: Outcome

- Implementation of CPS was associated with significant reduction in number of assaults, use of force, and placements in seclusion (by at least 50%)
- Implementation also associated with drastic reduction in average time spent in seclusion: from 731 to 83 hours/year (or 61 to 8 hours/month)

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"I felt so alone,
so afraid,
so desperate,
so blamed...
I was so worried
about my child...
nothing was
working...
then I found
Think:Kids."



www.ccps.info

(Center for Collaborative Problem Solving)

www.thinkkids.org

(CPS Institute)

www.lostatschool.org

(Resource for educators)

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