

Positive Behavioral Support With Families

JOSEPH M. LUCYSHYN,
ROBERT H. HORNER, & KATHY R. BEN
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This article describes the features of a **positive behavioral support approach** with families of children with **severe disabilities** and **problem behaviors** such as aggression, self-injury, and property destruction. **The approach** has been informed and shaped by families, professionals, and researchers as we have **developed behavioral support for children** in home, school, and community settings (Kern Koegel, Koegel, & Dunlap, 1996). For families, the **goals** of the approach are to **improve** the child's behavior and life-style, to **build** the capacity of family members to **successfully** raise the child, and to **strengthen** the family as a whole (Lucyshyn & Albin, 1993).

Positive behavioral support builds on a long history of behavioral research, but is guided by human values and the real life problems confronting families and teachers. The approach marries values with a technology of behavior change. The approach is both child- and family-centered. It is concerned not only with problem behaviors but also with the strengths and life-style of the child. The family is regarded as the child's "most powerful, valuable, and durable resource" (Dunlap & Robbins, 1991, p 188). The approach also is compatible with the inclusion of children with disabilities in typical school settings. Positive behavioral support offers practical solutions to the challenge of raising a child with disabilities at home and educating the child in his or her neighborhood school. Nine features, summarized below, characterize positive behavioral support.

1. A focus on life-style changes.

A child with severe disabilities often develops problem behaviors in the context of a life-style with limited activities and friendships. For this reason, a central aim of the approach is to create a rich and valued life-style for the child that is acceptable and feasible to the family (Risley, 1996). Life-style goals may include, for example, ensuring that the child participates each week in a variety of preferred home and community routines (e.g., eating dinner with the family, going on a walk with dad), and helping the child develop friendships with a relative or a neighborhood peer.

2. Building effective environments.

In essence, positive behavioral support is about building effective environments. The focus is not on changing the child with problem behaviors but on changing the features of home, school, and community settings. A good support plan defines changes in the behavior of family members and educators (e.g., teacher, language specialist, behavior consultant), and it is these

changes in our behavior that result in change in the behavior of the child. Effective environments make problem behaviors irrelevant, inefficient, and ineffective.

3. Functional assessment: Understanding the purpose of problem behaviors.

A large body of research indicates that problem behaviors serve functions (Carr et al., 1994). For example, running away from a parent may provide a child with negative but interesting attention. Hitting a parent may terminate a demand to brush one's teeth. Functional assessment is a way to understand the meaning of problem behaviors from the child's point of view. An effective functional assessment includes interviews with family members and school personnel, and observations in the home or school to confirm emerging hypotheses about the purpose of problem behaviors (O'Neill, Horner, Albin, Storey, & Sprague, 1990). The outcomes of a functional assessment include: (a) a description of problem behaviors; (b) a list of conditions or events that predict the occurrence of problem behaviors; (c) clear hypotheses about the purposes of problem behaviors, and (d) direct observation data. The goal of the process is to use the assessment information to design an effective support plan.

4. Recognizing that problem behaviors are problems of learning.

Children with severe disabilities often develop problem behaviors for two common reasons. First, they may not possess the behaviors or skills that would take the place of problem behaviors as a means for achieving their wants or needs. For example, a child with autism may scream loudly while alone in the family room whenever she wants a new Disney video placed in the video machine. She screams to get an activity because she doesn't have the language skills to ask for help, or the performance skills necessary to change the video herself.

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Second, the social environment of the child may inadvertently teach the child to engage in problem behaviors. By our response to problem behaviors, the child may learn that the behaviors "work." For example, the parents of the child may respond to her screams by entering the family room and changing the video for her. The central message here is that problem behaviors can be reduced by teaching a child new behaviors and skills that make problem behaviors irrelevant to achieving his or her wants and needs.

5. Seeing communication as the foundation for positive behavior.

Many problem behaviors occur because the child does not know a more appropriate way to communicate a want or need. Understanding the purpose of problem behaviors is an essential first step for identifying the language (verbal, gestural, or augmentative) the child needs to communicate (Reichle & Wacker, 1993). For example, a child with a developmental disability may hit his head on the floor to get his mother's attention. He may be taught to communicate his desire for attention by saying or signing, "mom!" or "I need help." If the mother is his

primary source of attention, then it also would be necessary to increase the number and quality of social events with other family members and peers, and to teach the child to request attention from these individuals as well. Teaching language skills is at the heart of any effective behavioral support plan. An effective support plan ensures that using language is more effective and efficient at achieving one's wants and needs than engaging in problem behaviors.

6. Designing multicomponent behavior support plans.

An effective positive behavioral support plan typically includes multiple components (Horner & Carr, 1996). Five categories of intervention are commonly present: Ecological or life-style interventions, preventative strategies, teaching new behaviors and skills, effective consequences, and emergency procedures to prevent injury.

A good support plan creates a rich pattern of activities and relationships, but avoids the features of situations that "trigger" problem behaviors. Consider a boy with autism and deafness transitioning from a day-care center to home. When his father asks him to walk to the car, the boy tantrums. He does so to avoid the transition. From the child's point of view the transition is aversive. It interrupts preferred activities at day-care (e.g., snack time, playing with a peer). Also, he cannot predict what will happen after leaving with his father. For each feature of the problem, the family and consultant can define a support plan component. For the absence of predictability, they design a picture schedule of steps in the transition routine. In place of the aversive demand to leave, the parents offer a choice of preferred events (e.g., a healthy treat, seeing the ducks at the park), and a positive contingency statement ("Let's walk to the car and then go to the park!").

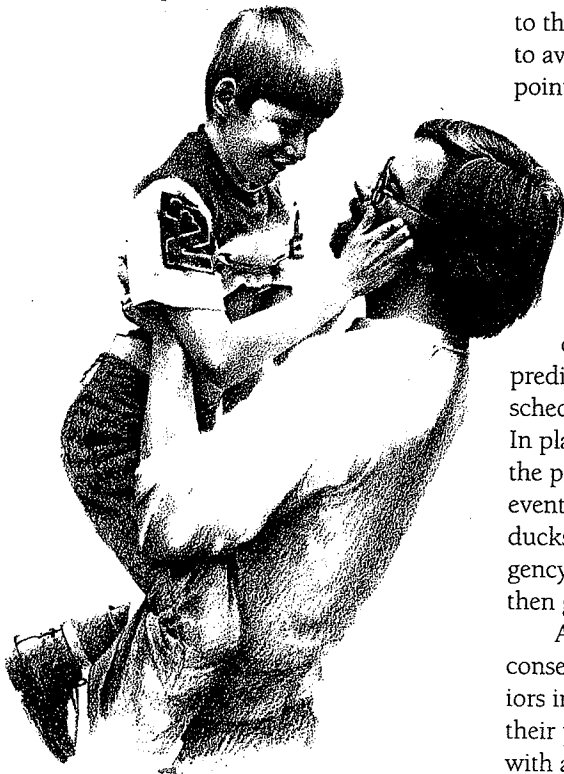
An effective plan also includes consequences that make problem behaviors ineffective and inefficient at achieving their purpose. For example, a young girl with autism screams to avoid parental

demands to perform tasks independently (e.g., using utensils to eat at the dinner table). The family introduces the following consequence. When the child screams, a parent immediately states a safety signal, "two more and then we rest," briskly puts the child through the task, and then gives the child a short break. Although screaming is not rendered entirely ineffective at escaping the task demand, it becomes very inefficient at achieving this purpose. After a few days, the child stops screaming and begins calmly (and later happily) using her utensils to eat. Effective consequences also may involve mild forms of punishment such as brief reprimands or a temporary loss of privileges, but never include procedures that cause physical pain, loss of dignity, or humiliation.

7. Designing contextually-appropriate support plans.

Another feature of positive behavioral support is the design of plans that are not only technically accurate but also a good "fit" with the characteristics and ecology of the child's family and home life, or the child's teacher and school (Albin, Lucyshyn, Horner, & Flannery, 1996). Designing a plan that possesses a good "contextual-fit" requires that we listen to and learn from family members and teachers about themselves and the settings in which they support the child. For families and home-based support, a good support plan should reflect family goals and values, build on family strengths, incorporate available resources and social supports, and diminish stressors.

Because of the complexities of family life, and the many demands on parent time and energy, we also have found it useful to implement behavior support plans in one valued family routine at a time (e.g., getting ready for school in the morning, going grocery shopping with a parent), and to embed support procedures into the ecology of routines (e.g., time, place, people, resources, tasks, goals). By doing so, plan implementation becomes focused and simplified. Family success in one routine builds confidence and momentum toward success in other



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routines. The central message here is that designing contextually-appropriate support plans may make the plan easier to implement and promote durable changes in behavior and life-style.

8. Developing collaborative partnerships.

Within a process of positive behavioral support, we strive to develop positive, reciprocal, collaborative partnerships with family members, educators, and other key stakeholders (Turnbull & Turnbull, 1991). We view family members as experts in their own right; experts about their child, about their family's culture and ecology, and about their goals and visions for the future. We recognize that for the holistic goals of positive behavioral support to be fulfilled, each of us must listen, learn, and change together. During assessment and plan design, for example, parents and other team members strongly influence the selection of interventions. During implementation support, parents and the child's teacher actively participate in evaluating progress and improving interventions.

9. Supporting with humility.

We believe that the complexities and subtleties of effective support to children with disabilities and their families require an abiding sense of humility. In our work with families, we do not find that we have all of the answers to the issues and problems confronting the child, his or her parents, or the teacher at school. During assessment activities, for example, family members and educators share their knowledge about effectively supporting the child, and these insights are incorporated into a proposed plan. Throughout implementation support, the consultant remains alert to errors in plan design, and responsive to critical comments from family members or educators about the acceptability or feasibility of plan procedures.

In summary, positive behavioral support is an approach to understanding why problem behaviors occur. The

approach involves engineering effective environments in which problem behaviors are no longer functional (useful) from the child's point of view. Multicomponent support plans are designed to be effective and contextually-appropriate. During the support process, collaborative partnerships are forged with the family and other stakeholders. Through this unity of thought, action, and spirit (Singh, 1995), families are empowered to achieve their vision of family life in the home and community with their child with disability.

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Families interested in receiving more information about positive behavioral support are encouraged to contact the Family Connection, a national referral service, at (800) 854-4938.



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