

# Wyomissing Behavior Analysts, Ltd.

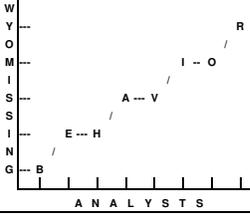
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## TOPICS IN BEHAVIOR SUPPORT

Gary Champlin, Ph.D.

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## THE LEAST RESTRICTIVE MODEL AND FUNCTIONAL ANALYSIS

Gary Champlin, Ph.D.

I consider the concept of “Functional Analysis” to be the major advance in the field of Behavior Management in the last decade. Functional Analysis is in many ways now replacing the “Least Restrictive Model” as a basis for deciding on appropriate treatment strategies.

For years, the hallmark of Behavioral Therapies was that they directly treated observable behaviors, not theoretical conceptualizations about what was going on in the mind or what Behaviorists liked to call “the Black Box”. Give me some M&M’s (and maybe a Time Out Room) and I could change any behavior. The origin or reason for the behavior was not considered important. Freudian Analysis may help us understand behavior, but it does not necessarily help us change behavior.

For years, our only guideline for deciding on a behavior strategy was the “Least Restrictive Model of Treatment” or as I like to paraphrase it “Don’t use a sledge hammer to hit a tack”. For the Behaviorist, it meant trying the M&M’s before the Time Out Room (or shock device); the more intrusive and traumatic techniques could be justified (and often times were), but only if all other less intrusive and traumatic (less restrictive) techniques had proven ineffective.

To apply the Least Restrictive Model, we developed “Hierarchies of Intervention”. Rewarding behavior using such things as tokens was placed low on the hierarchy, punishing behavior using a token fine was placed in the middle of the hierarchy and using time-out and various aversive (painful/unpleasant) techniques was placed high on the hierarchy. With increased concern about the extensive use of psychotropic medications (mind altering drugs such Haldol and Mellaril) and their potential side effects, they also were placed high on the hierarchy, i.e., considered to be highly restrictive and a last resort technique.

The use of the Least Restrictive Model has become less significant with the advent of “Functional Analysis”. Behaviorists are now beginning to return to a more Medical Model and seeing behaviors as symptoms with an underlying cause and/or serving some purpose. A more appropriate and effective treatment will be determined if we can figure out a behavior’s cause and/or purpose.

People do not engage in ‘maladaptive behavior’ (the old buzzword for behaviors we thought needed to be reduced). The behavior may seem maladaptive to others, but to the person it must be in some way adaptive (serve some purpose) or they wouldn’t do it.

If we figure out the ‘function’ (or purpose) a behavior serves, then we can figure out the best and most effective treatment for it. In many cases, but not always, it turns out this also will be the least restrictive.

Consider the following scenario:

John hits his ear repeatedly; it started a week ago and is getting worse; no behavioral interventions have yet been tried.

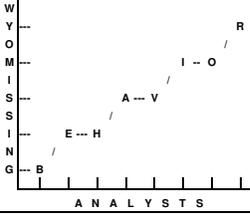
Which of the following is an appropriate first intervention according to the Least Restrictive Model?

- (a) reward John with an M&M for every 15 minutes with no ear hitting;
- (b) give a mild verbal reprimand each time John hits his ears;
- (c) administer a mild electric shock each time John hits his ear.

Hopefully, you selected (a). According to the Model, if (a) does not work, you may be justified in going to (b) and if it does work even trying (c).

BUT what if I now tell you a Doctor examined John and he says John has an ear infection. Does even choice (a) now make sense? An antibiotic, not M&M’s (or reprimands or shock) would appear the appropriate solution to John’s ear hitting. In this case, hitting his ear was probably caused by the infection. The purpose (or function) of the behavior was to make the pain go away. Functional Analysis in this case leads us to medication, not M&M’s!

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## FUNCTIONAL EQUIVALENCE

Gary Champlin, Ph.D.

One of the most effective ways to reduce/eliminate a problem (challenging) behavior is to teach a ‘functionally equivalent’ alternative (i.e., a substitute behavior that serves the same purpose - a replacement skill).

In a previous article we talked about “Functional Analysis” and the importance of assessing the purpose of a challenging behavior. Many times what a person is trying to get is itself okay, the real problem is how the person is going about getting it.

I still remember some of those team meetings from ten years ago. We would decide that a problem behavior was ‘attention seeking’ and then try to get rid of it by cutting off all the attention for it. What we were trying to do was make the problem behavior ‘ineffective’ and therefore useless to the person. If that did not work, we would try to get the person to just stop wanting attention altogether. Psychotropic medications in high doses were often helpful - they could get someone to stop wanting just about anything (and everything).

But what’s wrong with wanting attention anyway? Seems like a good sign to me - it means the person is socialized, enjoys and seeks human interaction, etc. The problem really is not that the person wants attention, it’s how the person is going about getting it. As such, the appropriate treatment would seem to be to teach alternative, more acceptable ways of getting attention and thereby making the old challenging behaviors ‘unnecessary’.

Functional Equivalence refers to this whole concept of teaching replacement skills (i.e., teaching new ways of getting the same things). If aggression is used to get attention, then teach the person how to say “Can we have a talk?”; if the problem is stealing coffee, maybe we should teach the person how to make his own cup of coffee.

Failure to teach these functionally equivalent skills is arguably the primary reason Behavior Management/Support Plans have limited effect. Either we fail to provide opportunity for the development or occurrence of any alternative/replacement skill or the skills we teach are just not quite as effective.

Often we try to use artificial reinforcers (M&M's, tokens, etc.) to reward 'not engaging in a problem behavior' without regard to the behavior's function or payoff. In this case, all we are doing is pitting the artificial reinforcer against the payoff (e.g., if you choose attention, you can't have an M&M, which is it going to be?). Instead of setting up a competition, how much better it would seem to work with the person to help them get what they really want.

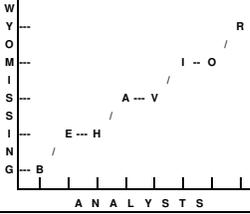
When we do try to teach a replacement skill do we make it just as effective as the problem behavior? Sure we try to pay more attention and reinforce appropriate behaviors, but boy do we ever jump when that problem behavior occurs. Somehow that replacement skill has to get the person as much, if not more, of what he wants.

Are the replacement skills just as available as the problem behavior? Often, the problem behaviors are the only source of control the person has; in a life that is structured and scheduled by others, the problem behaviors may be the only events that occur on the person's own schedule. The replacement skills need to be just as available.

There is a reason for the repeated occurrence of challenging behaviors. In many cases, it is for lack of an alternative. Teaching functionally equivalent replacement skills would seem a logical and effective way of decreasing challenging behaviors.

In many cases, challenging behaviors serve a communicative function. As such, the replacement skill should be an alternative way of communicating with others. "Functional Communication Training" is the subject of another article.

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## FUNCTIONAL COMMUNICATION TRAINING

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For many years, Behaviorists have noted an inverse relationship between problem behaviors and an individual's ability to communicate (be it with words or gestures). The less proficient the person's communication system, the greater the problem behavior. A number of studies have shown that the problem behavior could be decreased by teaching the person ways to communicate (and without resorting to any punishment techniques). A client who had temper tantrums to escape work was taught how to ask for a break. Another client who got aggressive when frustrated was taught how to ask for help.

What this all suggests is that the problem behavior was in fact the person's communication system. The problem behavior had a communicative function for the person.

Everyone wants to have some influence. If the person has no other way to communicate (or no one will listen to what the person is saying), then hitting people, breaking windows, etc. may be the only way to get a response. Teach the person an alternative way to communicate (and insure someone will listen) and the problem (oh yes - "challenging") behavior becomes unnecessary and might disappear.

Functional Communication Training is the ultimate in replacement skill or functional equivalence training. It is teaching the person how to communicate things the person needs or wants to say to us, not just things we want to hear.

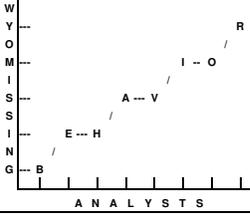
There are a variety of Systems and Training Programs to provide individuals with alternative ways to communicate. Sign Language has been around for a long time. I find Picture Communication Systems to be more useful with individuals with developmental disabilities.

There are a variety of Assistive Devices available. One such device is a Touch Talker which contains a tape recorder. The communicator simply selects and presses discriminable panels on the outside and a prerecorded message is played (e.g., "I want a drink", "I need to take a break", etc.).

In developing alternatives to challenging behaviors, I like to start with what I call an 'I want ...' Card. Whenever the person shows/gives the 'I want Card', the listener is to respond by trying to help the person get what they seem to want. If giving the Card is ever to replace the challenging behavior, it is important that the listener 'jump as high' (if not higher) in response to the Card as to the challenging behavior. Now, that is a challenge!

Functional Communication Training can be appropriate for someone who is verbal as well. We all have a need to improve our communication skills (e.g., to become more assertive). With the verbal individual, a comparable procedure to using the 'I want ...' Card is to use what I call a "Discussion Note". The idea of the Note is to teach the person that sitting down and talking through problems can be more effective than acting them out.

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## BEHAVIORAL PSYCHOPHARMACOLOGY

Gary Champlin, Ph.D.

“Behavioral Psychopharmacology” is a term coined by Robert Sovner, M.D., to refer to a set of methodologies for using drug therapy (behavior modifying medications) with the developmentally disabled. Behavioral Psychopharmacology is based on the following premises:

1. Psychiatry can play a significant role in the treatment of behavioral and emotional problems in developmentally disabled persons.
2. The developmentally disabled population develops the full range of psychiatric disorders.
3. In some cases, ‘challenging behavior’ may be the presenting complaint of such a disorder.
4. There are now available highly effective psychotropic drugs which do not impede the habilitation process or cause tardive dyskinesia.
5. The application of psychiatric diagnostic and treatment principles can enable some developmentally disabled persons to acquire new skills and function more independently in the community.
6. In selected individuals, psychotropic drug therapy must be viewed as a treatment of first choice (e.g., those persons suffering from an affective disorder).

There seem to be 3 reasons that Behavior Modifying Medications are used with the Developmentally Disabled:

1. to control behavior by sedating when behavioral techniques are ineffective;
2. as the treatment of choice for a diagnosed psychiatric condition;
3. as the treatment of choice for a medication sensitive behavioral disorder.

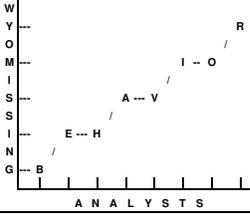
I would suggest that abuse can occur when we are 1) too quick to use medication for the first reason and/or 2) too slow to use medication for the second and third reasons.

With our current emphasis and focus on the use of Positive Approaches to Behavior Management, I have noticed a slackening in concern about medications (i.e., in an attempt to reduce the use of restrictive behavioral interventions, medications tend to be increased). As a treatment of choice, this is fine; as a more subtle method of control, it is not!!!

NOTES: Dr. Sovner is an internationally recognized expert on the diagnosis of psychiatric disorders and the use of psychotropic drug therapy for adults with developmental disabilities.

Dr. Sovner is Co-Editor of "The Habilitative Mental Healthcare Newsletter", a great source of up to date information on Behavioral Psychopharmacology. The Address for this Newsletter is The Editors, P.O. Box 57, Bear Creek, NC 27207.

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## POSITIVE APPROACHES & NONAVERSIVE STRATEGIES

Gary Champlin, Ph.D.

These are two of the “hottest” buzzwords in the field today. If the word ‘positive’ or ‘nonaversive’ is not in the title of your presentation, article, etc., then you are probably not on ‘the cutting edge’ of the field. I must admit to giving in to this fashion and sticking these buzzwords in the title of a recent presentation.

“Positive Approaches” and “Nonaversive Strategies” both mean about the same thing, however, there is a subtle difference which I think reflects the whole issue. I think “Positive Approaches” is the preferable buzzword.

When we are talking about Positive Approaches to Behavior Management, we are talking about constructive and logical ways to improve the quality of life of the individual. Instead of just telling the person what they can’t do, we bother to offer the person some alternatives that might work out better (and for them, not just for us). When the person engages in a problem behavior (I mean ‘challenging behavior’), the focus is on helping the person by resolving the causes of the behavior (e.g., if self abuse occurs because of boredom, we teach/provide some new activities; if aggression occurs to escape difficult demands, we teach the person a way to ask for help; if a lifestyle of bizarre behaviors are to ward off social contact, we attempt to bond; etc.).

It is truly a challenge to the Caregiver to come up with real solutions to challenging behaviors. It was a lot easier when our focus was on beating them down with controlling and punishing procedures. When the person asks why s/he should do something, we give a reason that makes sense for the person, the reason is not: “Because I told you to, that’s why”.

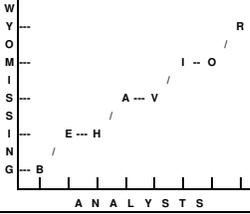
“Nonaversive Strategies” are positive approaches, but when we use this buzzword the emphasis is more on what we should not do rather than what we should do instead. This mis-emphasis is exactly what got us in trouble in the first place. We used punishment and other such controlling techniques to get the person to stop doing things we did not like, but we never bothered to teach the person what to do instead.

Aversive Strategies refer to an endless slew of punishing techniques that have been shown to in some way be effective at eliminating problem behaviors (e.g., solitary confinement, electric shock, water mist in the face, breaking ammonia capsules under the nose, corporal punishment, not “sparing the rod”, etc.).

I'd rather be known as someone who uses Positive Approaches than just someone who refuses to use Aversive Techniques. It is a quick fix for Regulators, Policy Makers, Provider Agencies etc. to make claim to using Positive Approaches by simply banning the use of Aversive Strategies and/or Restrictive Interventions. Unfortunately, this leaves the Caregivers with a list of Don'ts and no list of Do's.

If we develop a quality list of Do's, maybe the list of Don'ts won't be necessary. Now that's a Positive Approach! - the challenging behavior will decrease in frequency not because of fear of reprisal, but because it is just no longer necessary to use anymore.

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## GENTLE TEACHING

Gary Champlin, Ph.D.

Gentle Teaching is a positive approach to behavior management which focuses on the teaching of ‘bonding’ between persons with mental retardation and their care givers. Bonding refers to the development of a mutual tie of affection, a positive relationship between two people. In the Gentle Teaching Approach, this bonding is considered more important than the development of independent skills.

Many people use the term ‘Gentle Teaching’ to refer to the whole range of positive approaches (the same as we equate Kleenex and tissues). I prefer to limit the term ‘Gentle Teaching’ to the approach specifically espoused by its founder, John McGee, Ph.D.

John McGee has now written two books on the Gentle Teaching Approach:

[Gentle Teaching: A Non-Aversive Approach to Helping Persons with Mental Retardation](#)

[Being With Others: Toward a Psychology of Interdependence](#)

In both these books, John McGee asks us to critically evaluate our posture in interacting with persons with mental retardation. Our purpose should be to teach the person that there is ‘value and goodness inherent in human interactions, human presence and human participation’. This cannot occur if we rely on punishment to control and/or to obtain submission.

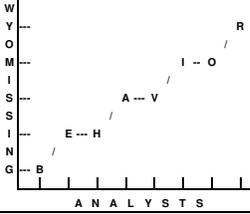
How is this bonding accomplished? The care giver needs to provide ‘noncontingent valuing’ (i.e., communicate to the person in as many ways as possible that s/he has worth regardless of momentary behavior, that this worth does not need to be earned).

As the title of John McGee’s second book suggests, the goal of treatment is not independence but ‘interdependence’; the goal is not to teach the person total self reliance, but to teach the person how to enjoy participating with others. I would argue that the most functional skill we can teach anyone is how to ask someone else for help.

When people first hear about Gentle Teaching, they usually think “I do that, I care, I value the mentally retarded”. As an approach to the behavior management of severe behaviors, however, Gentle Teaching is a lot more than just ‘caring’. It is a rather intensive and dramatic procedure in which the person is flooded with positive valuing statements and actions regardless of any negative behavior (even spitting in their face). In Gentle Teaching, the care giver is asked to ‘turn the other cheek’ (my metaphor, not McGee’s) and keep returning with more positives.

When I first heard about the Approach, I must admit to being rather resistive (What do you mean, they don’t need to earn anything?). I must also admit that the more I read and study John McGee’s works the more value and application I find for what he is saying. I am not a disciple of John McGee’s, but I am forever critically re-evaluating my posture in providing services to persons with mental retardation.

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## PROACTIVE & REACTIVE STRATEGIES

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Strategies for dealing with challenging behaviors (i.e., problem behaviors) can be classified as either PROACTIVE or REACTIVE.

Proactive Strategies are interventions which are used on an ongoing basis in an attempt to reduce the likelihood of occurrence of the challenging behavior. They are preventative and usually deal with the conditions that precede the behavior. The goal of Proactive Strategies is to reduce the future probability of the behavior.

Reactive Strategies are interventions which are used only once the behavior occurs. They are consequences (or reactions) to the behavior. The goal is to cut short the behavior, to minimize the damage.

A helpful analogy is fire management. Fire Departments use both Proactive and Reactive Strategies to protect people and property from the harmful effects of fire. Firemen teach fire safety courses to children and families (Proactive); they inspect buildings to insure compliance with codes (Proactive); they sponsor educational advertisements on television (Proactive). When there is a fire, they put out the fires and try to save lives and property (Reactive).

Positive Approaches to Behavior Management (and fire management) emphasize the use of Proactive as opposed to Reactive Strategies. If we do a good job with the Proactive Strategies, the Reactive Strategies will not be necessary (or at least will be necessary less often).

We can subdivide Proactive Strategies into 3 classes based on the focus of the intervention:

1. Environmental Adjustments
2. Positive Programming
3. Direct Treatments

Environmental Adjustments include any planned changes in the environment intended to make the challenging behavior less likely. Such adjustments attempt to fit the environment to the individual. A hyperactive child's behavior is less likely to be a problem in a funhouse than in an antique shop.

Positive Programming includes training in new skills to help the person deal with his/her environment and make the challenging behaviors unnecessary. Positive Programming attempts to fit the individual to the environment.

Direct Treatments attempt to establish rapid control until the slower, but more permanent, effects of Positive Programming can be achieved. Examples include various reward schedules, medication, dietary control, etc. The distinction from Environmental Adjustments is minimal. The point is that they are more direct preventative strategies.

We can subdivide Reactive Strategies into 2 classes:

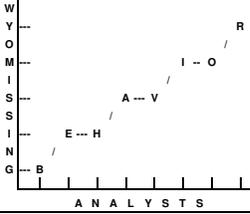
1. Direct Treatments
2. Crisis Intervention

Punishment is a Direct Treatment that is a Reactive Strategy. Nothing happens unless the behavior occurs.

Crisis Intervention Techniques are intended to insure the safety of the individual. They are used only as necessary. The goal is to stop the behavior, not necessarily reduce the probability of the behavior in the future.

If my daughter had a temper tantrum in the Mall, I might buy her an ice cream to make her happy. This would be a Reactive Strategy. I ended the temper tantrum, but probably increased the likelihood of tantrums in the future. I better figure out some Proactive Strategies to deal with the tantrums (or just let my wife take her to the Mall from now on!).

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## PERSONAL FUTURES PLANNING

Gary Champlin, Ph.D.

Of course, we all know what ‘Personal Future Planning’ is. It’s obvious from the name: it’s planning the future of the person; it’s the PFP, just another name for the IPP, IWP, IEP, IHP, .... Why are we changing the name again? So we can kill some more trees? To keep everyone off stride? Why?

Personal Futures Planning is a byproduct of our more positive and more ‘person-oriented’ approach to providing services for people with developmental disabilities. Innovators of this new approach prefer to say it is intended to complement (rather than replace) the more traditional IHP (or IEP, etc.). The IHP is often just a legal document to meet regulations, it is for the Team. Personal Futures Planning is for the person.

There are 3 steps in the Personal Futures Planning Process:

1. create a Personal Profile (capacity search)
2. development of a Plan
3. commitment of individuals to provide a Network of Support

Instead of a strength/needs list, there is a personal profile. The Plan is more focused on what the person wants rather than what we need to meet the regulations. Instead of a Team to work on the person, there is a Network of Support to work for the person.

Personal Futures Planning is a tool for fostering new ways of thinking about people with developmental disabilities. It is intended to help us focus on opportunities for people with disabilities: 1) to develop positive relationships, 2) to have positive roles in community life, 3) to have increased control of their own lives and 4) to develop the skills and abilities to achieve these goals.

Personal Futures Planning is an ongoing problem solving process. It helps those involved with the focus person to see the total person. The Plan is to be the person's vision of what he or she would like to be or do. It focuses on the positive attributes of the person rather than the deficits. Personal Futures Planning depends on the support and participation of a few individuals who care about the person and assist to insure things happen for the person.

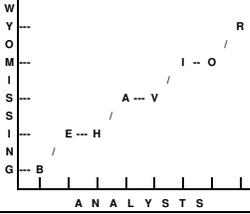
I believe that the common thread and the key to becoming more positive and person-oriented in our approach is to begin looking at things through the eyes of the person and seeing what they see (i.e., seeing things from their angle). Instead of standing in a confrontational posture face to face with the person and telling them what they can and cannot do, we need to stand beside them, walk with them and provide support and assistance. We might not always be able to do that, but the challenge is to try to be able do it more and more of the time.

If I've only confused you more or you want to learn more about Personal Futures Planning, an excellent starting place is the booklet:

“It's Never Too Early, It's Never Too Late:  
a Booklet about Personal Futures Planning”.

This booklet is available free (that's right - free!) by writing to Metropolitan Council, Mears Park Centre, 230 East 5th Street, St. Paul, Minnesota 55101.

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## REDIRECTION

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‘Redirection’ is a rather popular term in the developmental disabilities field. We are always wanting to redirect people. I once heard someone on a radio talk show recommend ‘redirection’ for a prostitute with a history of repeat arrests. It took me by some surprise to hear someone out of the field using the term.

How do you ‘redirect’ a prostitute? I presume that what she meant was we need to provide the person with an alternative way to earn money so she will not need to prostitute herself anymore. The challenge will be finding a vocation that is in fact functionally equivalent (remember that buzzword?). What skill could we teach the person that would allow her to make as much money, provides the same social stimulation, ..., and is also legal?

Redirection is the process of guiding a person toward an alternative way of obtaining Reward. The person is starting to go down a wrong path, so we do something to redirect him/her to the right path. We either redirect the person to an alternative way of getting the same Reward (e.g., talking rather than hitting to get attention) or an alternative way of getting some alternative Reward (e.g., work to earn money rather than hitting to get attention).

Redirection should be to some more preferable alternative and not just from the undesirable/challenging behavior. The guidance we provide should communicate “Do this instead”.

Redirection is usually assumed to be a rather positive intervention, but it does have some pitfalls:

1. Redirection is a reactive (as opposed to proactive) intervention. When a challenging behavior occurs, we redirect. ‘Direction’ would be the proactive version of Redirection. The more Direction we provide in the first place, the less Redirection should be necessary. If Reward is only made available through Redirection, then the challenging behavior will be maintained in order to gain the Redirection (and, in turn, the Reward).

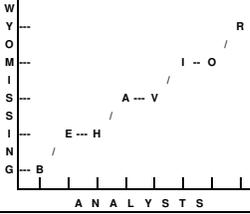
2. We often redirect without consideration of the reason for the challenging behavior (i.e., we fail to do a quick functional analysis). It becomes a way of ignoring the real problem. How would you like it if every time you got upset about something someone said to you: “Oh come on, let’s do this 500 piece puzzle”. I think I would be frustrated, insulted and more upset than ever. It would be a real insult!

Used appropriately and in the context of other proactive strategies, Redirection can be an effective alternative to Punishment. When a challenging behavior occurs our focus should be not just on communicating what not to do (Punishment), but what to do instead (Redirection). Whereas Punishment signals the end of Reward, Redirection signals a new opportunity for Reward. Redirection gets the person back on the ‘right track’.



“Don’t forget, if you do the puzzle 18 more times, you’ll make the Guinness Book of Records!”

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# Wyomissing Behavior Analysts, Ltd.

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## BEHAVIOR SUPPORT PLANS

Gary Champlin, Ph.D.

You may not have heard of this buzzword before. That's because I created it (I think!). It is my wishful thinking that "Behavior Support Plan" will become a buzzword in the not too distant future.

Until recently, I wrote "Behavior Management Plans". Such BMP's are getting a bad name though. It is a term associated with the old philosophy (pre-Positive Approaches). Using current perspectives, a BMP means controls, restrictive techniques and a focus only on reducing problem behaviors. "BMP's Can Work" just will not sell as a title for a Workshop.

The word 'manage' just has such a negative connotation. In one situation recently, I was rebuked for writing a BMP for someone who presumably did not have any problematic physical behaviors, but now was labeled as someone who needed a Plan, now had this in his permanent record, etc.! No matter that 90% of the Plan was positive and constructive, that the individual was on probation, etc.

Rather than fight, I decided to go with the trend and play the name game. I decided to re-title my BMP's as "Behavior Support Plans" (BSP's). It is "in" today to provide 'supports and services'. We are using this term more and more in the Human Services Field. The Manual for the Computer I just bought includes a section on the 'Supports and Services' available to me. Car Service Departments will soon be Support and Service Departments.

In writing my new BSP's, I usually make note of the change in name as an attempt to emphasize a more constructive and supportive approach. True, it is in part semantics, but it also keeps the pressure on to make sure that the Plan is constructive and supportive.

It remains true, however, that most of my BSP's are written because of some challenging behavior that needs to be reduced. It is nice to write behavioral goals in terms of increasing positive behaviors (e.g., will communicate using Picture Communication System) as opposed to reducing negative behaviors (e.g., will have no incidents of aggression), but the reality is that it is the negative behavior which is the real reason for the Plan.

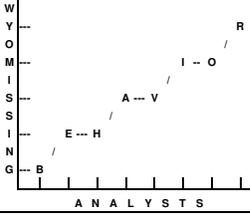
In my most comprehensive BSP, I include the following 5 components:

1. Standard Operating Procedures: some informal recommendations and guidelines for creating a more empathetic and supportive environment.
2. Replacement Skills Training: formal procedures for increasing positive behaviors that serve the same function as the negative behaviors and, hopefully, can replace and make the negative behaviors unnecessary for the individual.
3. Incentive System: formal procedures for motivating the individual to engage in the Replacement Skills as opposed to the negative behaviors.
4. Reactive Contingencies: formal procedures for responding/reacting in an effective and therapeutic fashion to the antecedents and escalation of negative behaviors when they do occur. (I use the framework: Upsetting Situations → Upset Behavior → Disruptive Behavior → Dangerous Behavior → Persisting Disruptive/Dangerous Behavior).
5. Crisis Intervention Considerations: guidelines for dealing with more extreme dangerous behavior when insuring immediate safety becomes the necessary focus.

Not everyone needs all these components in a BSP. My rule is that if a BSP needs #5 then it definitely needs #1-4; if it needs #4, it also needs #1-3 and so on. If the BSP only needs #1, then there really does not need to be a Plan at all.

Even with the name change, its still possible to write a rather restrictive and controlling Plan without much therapeutic value. Hopefully though, the name change keeps me focused on working with the person to change behavior, rather than working on the person as we so routinely did in the past.

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## RESTRICTIVE PROCEDURES

Gary Champlin, Ph.D.

The new regulations regarding Community Homes for Individuals with Mental Retardation were published in the Pennsylvania Bulletin, Volume 21, Number 32, 8/10/91. Provider Agencies are struggling to revise policies and procedures to meet these new regulations. An area of special concern is the regulation regarding 'Restrictive Procedures' (6400.191 - 6400.206).

The Regulations provide additional 'restrictions' on the use of Restrictive Procedures. They do not say they cannot be used, just that certain requirements must be met in terms of planning, documentation and monitoring of their use. The challenge is clearly there to use more positive approaches and avoid the use of such Restrictive Procedures.

While the Regulations appear to discourage the use of Restrictive Procedures, the definition of Restrictive Procedures itself is quite broad and, in fact, leads to an increased need to write what then are 'Restrictive Procedure Plans'.

In the new Regulations, a Restrictive Procedure is defined as:

... a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

That last phrase (engage in a behavior that the individual would not given freedom of choice) makes you think twice and has drawn a lot of attention. A first reaction is usually "Gee, I don't know if there is anything I do that is truly my choice". BUT then again, think about it - there are a lot of choices we could make, but opt not to for one reason or another. When we are forced to do something against our will our reaction is usually quite negative - and that's the point!!

Interpretation of the second phrase of the definition (interferes with the person's ability to acquire positive reinforcement) has also created a stir. In the Draft of the 'Inspection Instrument' for monitoring adherence to the Regulations, examples are given which include 1) rewards for appropriate behavior (e.g., if you eat your peas, you may go to the movies), 2) providing Positive Reinforcement at regular intervals only if an inappropriate behavior is not displayed (sometimes called Differential Reinforcement of Other Behavior or DRO).

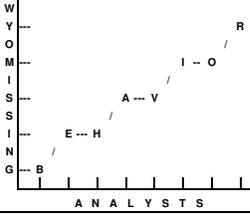
Unfortunately some of the immediate reaction to this second phrase has been that we are no longer allowed to use rewards to motivate behavior. Such an attitude misses the point. We need to be aware that our use of rewards also can be a source of control and manipulation of others. We need to realize that with every reward opportunity, there is also a punishment opportunity (i.e., the failure to obtain the reward). Did you ever get mad because you did not get something you wanted expected, that you thought you had a right to?

The positive outcome of these rather restrictive Regulations is to increase our awareness of what we are doing, to think twice and to reconsider some things we have taken for granted. Contingencies and Rewards and Punishments are present in every situation and cannot be legislated away. We need to arrange the individual's environment to allow as many natural contingencies as possible to operate. It is when we begin developing artificial contingencies that we get into trouble. Consider the following 2 contingencies:

1. "After we clean up the house, let's sit down and have some coffee".
2. "If you clean up your room, then I will give you a cup of coffee".

In both cases obtaining coffee is the reward and contingent on cleaning. But, which of these 2 contingencies seems more restrictive?; which is a more natural contingency?; which is a contrived contingency to control??

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## THE TOKEN ECONOMY

Gary Champlin, Ph.D.

The Token Economy was the mainstay of traditional Behavior Modification. Today, it is considered passé and its use even discouraged in some circles. The current Pennsylvania Community Home Regulations consider a Token Economy to be a 'Restrictive Intervention'. John McGee, the Father of Gentle Teaching, refers to the Token Economy as "the Psychologist's answer to Capitalism". Depending on your economic viewpoint, those are rather strong words.

In the traditional Token Economy, tokens are given as rewards for completing select desirable activities (If John makes his bed, he will get 2 tokens). The actual tokens can take a variety of forms: bingo chips, poker chips, washers, points recorded on a card, etc. The participant accumulates the tokens which later can be used to make purchases in a 'Token Store'. The Token Store can be a real place where various items are displayed or it can be just on paper like an Order Form. The Token Store can include items (toiletries, food items, etc.) or certificates for various activities (trip out for lunch, play Nintendo for 1/2 hour, etc.).

If giving tokens is a reward, then taking tokens can be used as punishment. The Token Economy can include 'token fines' for the occurrence of select undesirable behaviors (if John hits someone, he must pay 3 tokens). If such fines are to be used, they should not be added until the economy is well established. It is often difficult to get people to pay these fines. If the person values the tokens, it is tough to get them to give them up. Sometimes you end up with IOU's and future tokens earned are used to pay fines (like getting docked on a paycheck). Usually there needs to be a bankruptcy clause in the economy -- it is not good for someone to go too far in the hole -- it can be awfully demoralizing.

A variant of the Token Economy which I still make use of is Behavioral Contracting. A written Contract is developed specifying that if the person completes some number of defined positive activities, then some designated reward will be provided. In essence, each completion of one of the activities is worth one credit toward completing the Contract. In this case, the credit on the Contract is the token. Depending on the functional level of the person, the Contract might include circles to be colored in, blocks to be initialed, etc. as the way of concretely making clear to everyone the progress toward its fulfillment.

With Behavioral Contracting, it's real easy to add a punishment comparable to a 'token fine'. The Contract can simply identify that if some specified behavior occurs some set number of times (which can be just once), the Contract is voided and all is lost.

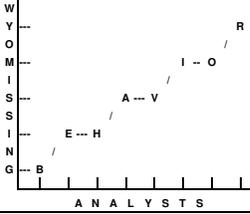
Like anything else, the Token Economy has its advantages and disadvantages. Token Economies have been used most frequently in institutions and in classroom settings. They are ideal for working with a group of people (patients, students, etc.). There is structure, but with some flexibility. The ways to earn tokens and to spend tokens can be the same for everyone or can be individualized. The participants get to make choices - how to earn tokens and then how to spend them. It can help insure everyone is treated fairly: the potential for consistency is enhanced, consequences are established up front and not after the fact, expectations and responsibilities are clear. It provides a medium for increasing constructive interactions between all parties.

Even without using token fines, realize that depending on how the Token Economy is set up and implemented it is not necessarily all positive. The token rewards can be used to control participants (if John does not earn the necessary tokens, he cannot get the item/activity he wants to buy). Beyond that, the items/activities that can be bought with the tokens might be things the person has a right to in the first place ( if John pays 5 tokens, he can use the telephone to call his Mother).

The need for a Token Economy tends to suggest there is something missing in the person's natural environment. A Token Economy is an artificial substitute for natural incentives (John brushes his teeth to earn 2 tokens, rather than to freshen his mouth because he is going out on a date). This is why the Token Economy has been so useful in the institutional setting. Realize in this case though, that it is not necessarily the Token Economy which is the problem, but the environment which necessitates its use in the first place!

Probably the most reasonable use of a Token Economy is as a person's preparation to one day getting a paying job (McGee was right → as training in Capitalism). Earning an allowance for completing chores at home can be seen as a kind of Token Economy. It leads to one day getting a job cutting grass, delivering papers, etc. and ultimately other competitive employment. If it includes the right tasks to earn tokens and the right items/activities to buy with the tokens, the Token Economy can be helpful to teach the person that certain things in life need to be earned (at least, in our capitalistic society!)

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## THE RIGHT TO RESPONSIBILITY

Gary Champlin, Ph.D.

In providing services to people with mental retardation, we are often torn between three postures or approaches: Protection, Control and Support. Our feeling of responsibility for the immediate welfare of the individual leads us to the first two postures (protection and control). When we begin to recognize the need to transfer some of that responsibility to the individual, we are led to the third posture (support).

When we assume people cannot make their own choices and/or cannot fend for themselves, we seek to protect them from harm. We don't let them near the hot stove for fear they will burn their finger. They never get to experience the hot stove.

If they try to go near the stove, we try to control them by redirecting them (positive approach) or, if necessary, inventing some other consequence (punishment) to discourage them from going near the stove again. We put the "heat on", but never let them feel the hot stove.

When we protect and control people too much, we smother them. A vicious cycle is created. There is an increasing need to protect and control to the point our contrived/artificial interventions become worse than the natural consequences from which we are protecting them.

The resolution is to recognize the need for people to begin assuming more responsibility for their own behavior. As such we assume a more supportive posture in which assistance is provided while allowing more natural consequences to apply. Our role becomes to provide guidance and not specific direction. We let people know the stove is hot and what can happen, but we do not stop them from touching it and finding out for themselves.

Should we let everyone touch the stove? Definitely not! The decision for each individual needs to be a function of that person's capacity to understand about stoves and getting burned.

The same 3 criteria that are relevant to anyone in giving informed consent apply: 1) the person needs to have information, 2) the person needs to be able to process that information (weigh risks and benefits), 3) the person's decision must be voluntary (not coerced).

If no one ever told the person before, we should educate. If the person is unable to understand, we have a responsibility to protect and maybe even control. If the person stumbles and accidentally falls, by all means, we should react to protect.

Our current Positive Approaches advocates giving people more choices. When we do this, however, we must also be willing to give them the “Right to Responsibility”. If we are not willing to allow people the responsibility for the consequences of their choice, then we probably should not have provided the choice in the first place!

Herbert Lovett (1985) said: “It makes more sense if consequences are a natural result of the person’s choice (as opposed to arbitrarily inflicted punishments). This gives the individual the dignity of risk and the opportunity to live with the consequences of their own behavior.”

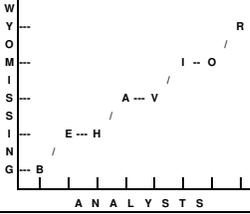
When we start thinking this way, the naturalness of consequences becomes more significant than the restrictiveness. The “Least Restrictive Model” is replaced by the “Most Natural Model.”

How do we switch to this more supportive approach? We need to take care to transition people gradually. Years of protection and control leave people with few skills for dealing with new responsibilities.

In a systematic fashion we need to set up situations for people to have increasing opportunities to experience the consequences of their own behavior. We need to have people be more responsible for fixing or getting their own snacks before we make them responsible for their entire dinner.

The Supportive Approach means assisting people to do things for themselves and not doing everything for them. As their skills improve, the supports are reduced. Increasingly, people are then provided the “Right to Responsibility” and “The Dignity of Risk”. The stove is used to cook dinner and not to burn fingers!

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## FACILITATED COMMUNICATION

Gary Champlin, Ph.D.

Facilitated Communication is a method for assisting people to communicate by pointing to letters in order to spell words and to make sentences (e.g., typing on a keyboard). The assistance has involved physical support (i.e., backward pressure, not guidance) as well as verbal and emotional support (e.g., “I believe in you and know you can do it”).

The ‘backward pressure’ means that the person’s hand is held up (as opposed to being guided down) to the key or letter board. In order to point at or select a particular letter, the person must apply pressure against the support (not just give in to it). Now that sounds interesting! In helping people to do things, we have usually been more oriented to guiding people by applying pressure in the same direction we want them to go and then fading the guidance as they seem to catch on. How could it be that someone is now saying that pressure in the opposite direction works better?

Well, there are some even more astounding things about this Facilitated Communication. It has even been featured on the television shows “Prime Time” and “Larry King Live”. It seems that this method has allowed some people with Cerebral Palsy and Autism (who previously seemed to be capable of very little and to have extremely low IQ’s) to communicate some rather profound thoughts. People with autism have typed out sentences like “I do not like being autistic”, “My body does not always do what I tell it to do”. As titled in one article, the method has allowed us to truly discover “The Lost Person Within”.

Imagine the shocked and skeptical reaction of others to hear of all this, especially if we were the ones to have given the IQ Tests, worked with these people for years, and prided ourselves for the great job we felt we were doing with the only technology we had.

I must admit to being one of the skeptics. I’d argue that its good to be a skeptic, or should I say, “one who critically evaluates”. The method has been criticized as being a hoax and that it is really the people giving the support (the Facilitators) who are doing the typing. That could be in some cases. If it is done correctly, however, the idea of backward pressure would seem to suggest against it. There are now an overwhelming and ever growing number of examples in which people have typed things their Facilitator never knew. People are noted to use a style unique to themselves and regardless of who happened to be doing the facilitating.

Give someone a new voice and you are liable to hear some things you don't like. Some controversy has been aroused by people typing out statements about things that happened to them in the past (e.g., someone hit them, someone sexually abused them, etc. ). Oh boy! Now what do we do with that?

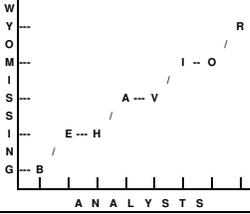
Thus far, the Courts have not been inclined to accept testimony provided through Facilitated Communication - after all, that other person is supporting their hand or arm. The person is not saying it totally independently. I suspect the Court Rulings will start to sway in the other direction (as has my own skepticism) with the avalanche of reports of successful use of this Facilitated Communication. Part of the method is also to fade the support - from the hand to the arm to the shoulder to maybe no physical support at all. This is not likely to be possible with everyone. For those that do, it will be difficult to deny they are not typing their own thoughts. But which is not to say that there might not be cases in which the Facilitator is the one directing the pointing or that people cannot lie using a typewriter just as they might with their voice!

Why does this Facilitated Communication seem to work? The theory seems to be that the problem for some people is not that they are not intelligent, but rather that there is a problem with the brain's ability to control muscle responses → there is a neuro-motor disability. It is more obvious in people with cerebral palsy who engage in a lot of involuntary movement and seem not to be able to control their limbs and/or mouth movements. In a similar (but different) way, people with autism may also be unable to control their behaviors and movements (e.g., the repetitive and seemingly illogical abusive behaviors).

Speech is complicated and requires a great deal of motor control (which most of us take for granted). With Facilitated Communication, the requested motor response is pointing or pecking at a key. It is about as simple a motor response as you can get. The physical support appears to be important for getting the person to focus and/or connect → it helps to overcome that neuro-motor disability.

Facilitated Communication is a method not a goal. It is a method for helping people to access information they have already learned. It is not teaching people how to read or write. Have you ever noticed or heard of a person with autism who was always looking at books, memorizing phone books, watching Jeopardy? Did you see the movie "Rain Man"? Maybe some people really are smarter than they act!!! All we have to do is help them to find a better way to let us know. Facilitated Communication appears to be one answer for some people.

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## TOWARD A “WHOLE BRAIN” APPROACH

Gary Champlin, Ph.D.

Over the last decade we have witnessed an evolution in the field of Developmental Disabilities from an emphasis on technology to humanism. During the era of technology, the buzzwords were things like behavior modification, reward and punishment, data based, programs, goals and objectives, goal plans, etc. With the current trend toward humanism, the buzzwords changed to things like person centered, positive approach, faith, visions, futures planning, inclusion, etc..

The Technicians among us who were the heroes of the field a decade ago now balk and resist this humanistic movement. No one denies the importance of caring and the importance of the individual, but what about all that technology that served us in the past ? Do we just throw it out ? Sure it was abused, but many people benefited from it too. There is a continued debate between the advocates of Positive Approaches (the Humanists) and the advocates of “The Right to Effective Treatment” (the Technicians).

The Technicians tend to be the Scientists and Professional types with Bachelor of Science Degrees (and then some). They have made a living teaching and doing research. They have done careful experiments and published their results. Success meant the independent variable (the intervention) produced a statistically significant change in the dependent variable (the behavior).

The Humanists never really understood (or wanted to understand) all that technical stuff. After all, they had Bachelor of Arts Degrees and/or just had a lot of personal experience. They were more motivated by ideals than statistical outcomes. They just wanted to help people.

Where do you think you fit in this evolution? Myself, I have a Bachelor of Science Degree. I have a Ph.D. in Experimental Psychology. I recently got a Masters in Business Administration. There is no denying it - I am one of those Technicians. I made my bones working on a “Behavior Modification Ward” at a State Hospital. Over the years, my approach has evolved as I learned of new technology and experienced my own successes and failures. If you asked if I cared about the people with whom I worked (my clients), I would have been offended at the suggestion and most definitely answered yes. But to be honest, my focus was on the technology.

If I have to identify a single event that introduced me to the humanist evolution, it was hearing about Gentle Teaching while working at a State MR Center. It was a threat to my technology. I read the book (John McGee, et. al.). It was tough reading for me. It seemed more like poetry than science. There was a lot I agreed with, but it seemed to lack substance and validation.

The humanist movement has evolved a great deal since Gentle Teaching. I was just at a 3-Day Convention entitled "Everyday Lives" in Hershey, PA and no one even mentioned Gentle Teaching. I enjoyed the Conference. The Humanists struck me as more realistic (down to earth) and less visionary (in the clouds) than they used to be. I was disappointed, however, that everyone was still talking about ideals and feelings with very little about the nuts and bolts of getting things done (the technology with which I feel more comfortable).

Is there a way to understand what's going on here and make some sense of all this? I believe there is and it has to do with the fact that we have two hemispheres in our brain - a left and the right. (Just like a Technician to give a biological explanation!).

There is research (mixed with some folklore) to suggest that these hemispheres are not equal, but rather that each has some unique functions. The left hemisphere is responsible for speech, logic, math, reading, analysis, perception of order, etc.. The right hemisphere is responsible for spatial, music, synthesis, emotion, intuition, creativity. Just as we are right handed or left handed, there is evidence to suggest that for each of us one hemisphere is dominant. Those of us who are left brain dominant tend to be more academic, analytic, precise and logical. Those of us who are more right brain dominant tend to be more artistic, creative, intuitive and emotional.

The suggestion here is that the Technicians among us are left brain dominant and the Humanists are right brain dominant. The current evolution toward a more person centered and positive approach is a right brain movement. Right brained people are ecstatic and jump to their feet. Left brained people shudder and squirm in their seats.

There is a Personality Inventory called the Myers-Briggs Personality Type Indicator (MBTI). It is more popular in the business/organizational world than in human services. It is based on a theory of psychological types described by C. G. Jung. It is based on the theory that seemingly random and disorderly behavior can be explained by differences in the way individuals prefer to use their perceptions and judgments. Preference is distinguished on 4 dimensions: extroversion - introversion (E or I), sensing - intuition (S or N), thinking - feeling (T or F), judgment - perception (J or P). An individuals type is then indicated by 4 letters.

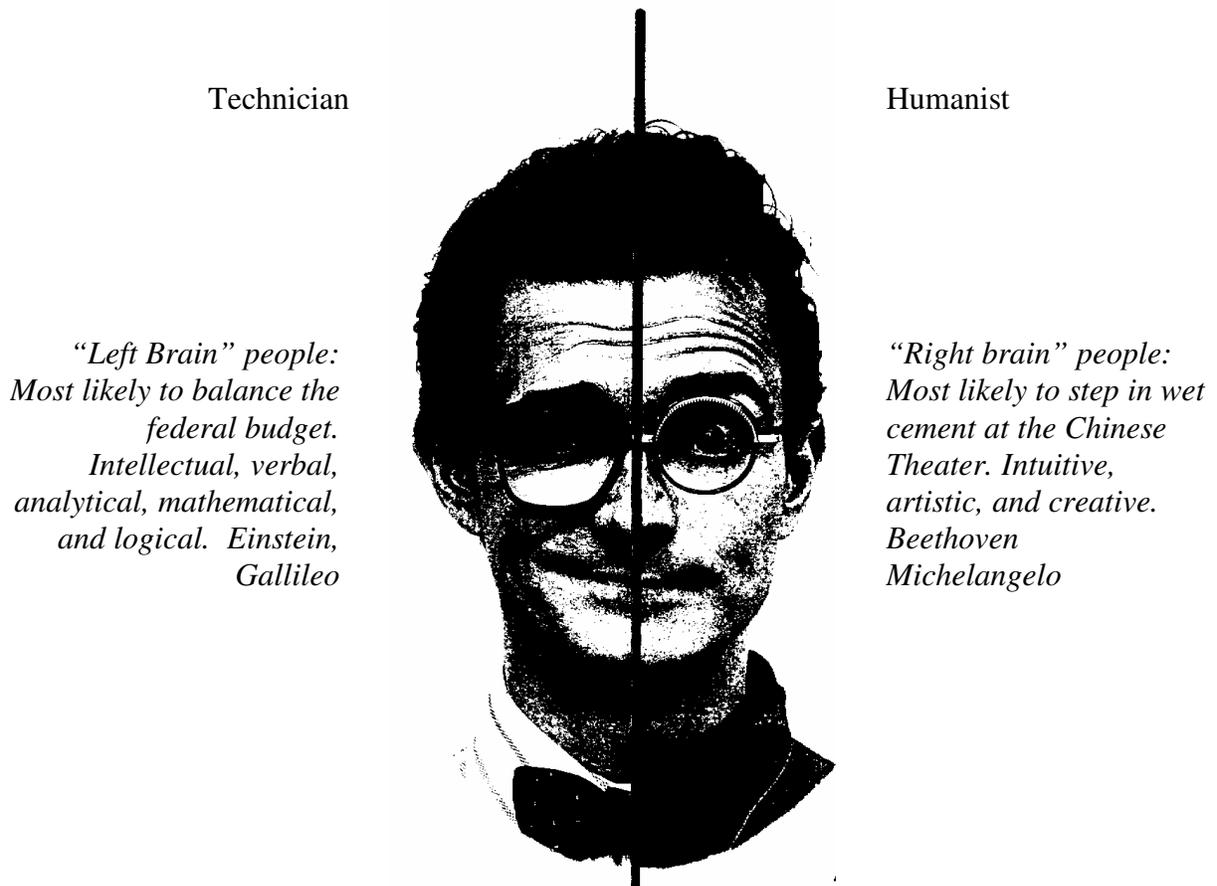
Critical to Jung's Theory and the MBTI is the idea that these are preferences, that there is no right or wrong, that each type has merits and drawbacks. The truly integrated person is able to balance the less preferred with the more preferred (e.g., prefers to be an Introvert, but can be an Extrovert when needs be.)

It turns out that I am a ISTJ (the typical Technician). A colleague of mine is a ENFP - the exact opposite on each dimension (and the typical Humanist). As long as we don't kill each other, we gain a lot from each other's complementary strengths. It has helped each of us become more balanced and integrated in our approach.

I would hypothesize that if this MBTI was given to various people in the Developmental Disabilities Field we would find a correlation between Personality Type, the Technician/Humanist dimension and Brain Dominance. If testing of this hypothesis revealed no statistical difference, I would blame it on the growing number of integrated people in the field - those that can combine the strengths of the Technician with those of the Humanist (or vice versa.)

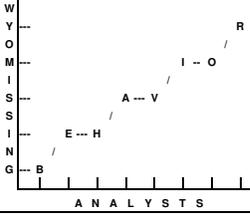
It explains a lot for me - why the written regulations (left brain) do not seem to fit the advocated approach (right brain), why the funding streams (very left brain), do not seem to fit the vision (right brain), why I squirm when the charismatic speaker suggests we all just have to have faith in the vision.

As an individual, I know my challenge is to find that balance between the right and the left - to become truly integrated in my approach. And so also for the Field, the challenge would seem to be to develop a "Whole Brain" Approach in which the technology is refined to support the vision.



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## SEXUALITY in persons with

Gary Champlin, Ph.D.

In persons with what ?? The fact of the matter is that each of us possesses a “SEXUALITY”.

We often prefer to ignore the sexuality of people (with ... MR) when providing supports and services. After all, SEX is a real “bag of worms” and we are uncomfortable even talking about it. We have enough trouble figuring out SEX for ourselves, no less trying to figure it out for someone else. SEXUALITY is an issue that is easier ignored or denied. If push comes to shove, we can always fall back on the “it’s a private issue” to rationalize not dealing with it.

I trust you will agree that the word “SEXUALITY” sounds a lot better than the word “SEX”. It is important to understand that SEXUALITY involves a lot more than just the physical act of sexual expression.

SEXUALITY can be defined as the integration of the physical, emotional, intellectual and social aspects of an individual’s personality which express maleness or femaleness. SEXUALITY is an expression of one’s personality and is evident in everyday actions. Sexual Intercourse is our most intimate way of expressing and receiving affection.

In Schuylkill County I have had the pleasure of participating in the development of a Policy on SEXUALITY - we call it a “Socio-Sexuality Policy”. The word “Socio” is there to emphasize this idea that we are talking about a lot more than just sex.

Many of the issues related to SEXUALITY are the same ones we deal with regarding other behaviors - it’s just a much more charged and sensitive area. On one hand we are concerned about respecting the autonomy and rights of persons, on the other hand we acknowledge our responsibility to protect them from harm. The issue of Capacity to Consent becomes real important here.

I have found some help for myself in dealing with these issues by thinking of a triangle with the perspective of 3 different people at each corner - a PRIEST, a STATE TROOPER and a CIVIL LIBERTARIAN. In deliberating a particular situation, I like to consider the issues from each of these points of view.

- The Priest represents the perspective of religion, morals and ethics.
- The State Trooper represents the perspective of the legal system (and there are Laws in Pennsylvania about various sexual activities, marriage and people “so ... deficient that such person is incapable of consent”).
- The Civil Libertarian represents the perspective of individual rights, that the person should be allowed to do what s/he wants and we have no business interfering.

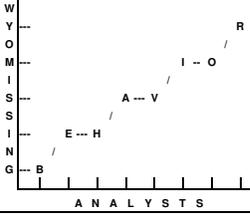
I have always had to remind myself that our “positive approaches” movement needs to be tempered with considerations of our legal responsibilities. We talk about giving people more choices and being least restrictive. But we also need to be careful not to leave people on their own who are ill equipped to deal with the challenges they face. What seems like a wonderful concept at a person-centered team meeting may look pretty foolish and indefensible in a courtroom.

Somehow we need to find a balance between the various perspectives. Some Agencies focus on the legal issues - we are state funded, the law says it is illegal, therefore it is not allowed here. Others take the rights approach - it’s the person’s right, it’s private and we are not getting involved. There are few Agencies with Policies - after all, it’s probably better to ignore and deny the issue, no matter how you write the Policy someone is going to be mad - the Priest, the State Trooper or the Civil Libertarian. You can’t win so why even try.

In helping develop the Policy in Schuylkill County, I have become aware that there are no “one right answers”. We have decided that it is not for us to define the sexuality of people, but to assist them to define it for themselves. Our Policy does not give the answers, but it does set up some reasonable procedures for trying to help make decisions that make sense. If I ever make it to Court over a SEXUALITY issue, it will be that decision making procedure and not the ultimate decisions which will be my best defense.

What’s your Policy on SEXUALITY?

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# Wyomissing Behavior Analysts, Ltd.

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## THE “MOST NATURAL” MODEL OF TREATMENT

Gary Champlin, Ph.D.

For many years, the “Least Restrictive” Model of Treatment has provided the primary basis of evaluating of behavioral interventions for people with mental retardation. In keeping with our current thinking on Inclusion and the right and need of people to be part of their community, I believe it is time to start thinking in terms of a new Model which by analogy I would name “The Most Natural Model of Treatment”.

The Least Restrictive Model calls for the least restrictive or intrusive treatment to always be chosen, all other things equal. The current Positive Approaches Movement has emphasized the use of nonrestrictive interventions and the absolute prohibition of many of the more restrictive interventions (i.e., use of aversive stimuli). In Pennsylvania, Regulations for MR Community Homes and Day Service Facilities include an extremely broad definition of what is considered restrictive and set rather stringent guidelines on their use (thereby discouraging their use except as a very last resort). The result has been a mind set that nonrestrictive is always better and that restrictiveness (regardless of source) is the sole basis for evaluating all intervention.

In the last decade, there has been an increased emphasis on the concept of Behavioral Diagnostics (or Functional Analysis). It is the basis for my corporation’s name “Wyomissing Behavior Analysts”. Behavioral Diagnostics provides an alternative to the Least Restrictive Model in selecting treatments. It calls for the use of interventions that fit the determined cause of behavior (as opposed to just the least restrictive). For example, if a person is determined to be hitting himself in the ear because he has an earache, medication rather than rewarding M&M’s would be the appropriate intervention.

An extension of Behavior Diagnostics is the belief that many of the aberrant behaviors we observe in people with mental retardation are not characteristics of mental retardation, but are the result of the rather protective and artificial environments we have tended to create for them. The natural contingencies that operated for other people were not allowed to operate for them.

Arguably, the restrictive behavioral technologies that have been developed by Behavioral Psychologists over the years have only been attempts to compensate for this lack of natural contingencies. The error was thinking that two artificials make a natural!!!

What is needed now is a new way of thinking in which we emphasize this use of natural opportunities and contingencies to help people develop to their fullest potential. This is very much a basis of our current trend toward Inclusion: allowing people to be part of their communities; providing opportunities for people to belong, to do and be like everyone else -- for better or for worse!!!.

Inclusion means opportunity for choice of lifestyle and not restriction to a particular prescription. It means living with the same opportunities and restrictions that other people experience. Choice means also experiencing the consequences of one's choice. In 1985 Herbert Lovett said: "It makes more sense if consequences are a natural result of the person's choice (as opposed to arbitrarily inflicted punishments). This gives the individual the dignity of risk and the opportunity to live with the consequences of their own behavior."

When we start thinking this way, the naturalness of consequences becomes more significant than the restrictiveness. The "Least Restrictive Model" is replaced, or at least supplemented, by the "Most Natural Model." The reality of the situation is that natural consequences can be quite restrictive (e.g., if no money - then can buy no ice cream, if rip up all shirts - then need to buy new clothes and less money for ice cream, etc.). These are not interventions imparted by someone, they are natural consequences.

Using this thinking, "Restrictive Interventions" might better be re-defined as "the extent to which an intervention interferes with the operation of more natural contingencies". Contingencies are natural to the extent Staff/Supporters do not need to intervene to provide consequences.

How do we switch to this Most Natural Model? We need to take care to transition people gradually. Years of protection and control leave people with few skills for dealing with new responsibilities. In a systematic fashion we need to set up situations for people to have increasing opportunities to experience the consequences of their own behavior. This will require varying levels of support and intervention to contrive situations (less natural and more restrictive), but is necessitated by the unnatural and/or protective environments people have and/or still live in (e.g., Institutions, Community Homes, and even many Family situations).

Support means assisting people to do things for themselves and not doing everything for them. As skills improve, the supports can be reduced and more natural contingencies allowed to operate. Increasingly, people are then provided the opportunity to exercise their Human Rights, are provided the "Right to Responsibility" and are free to experience "The Dignity of Risk".

One key area in which we have typically failed to allow people to experience natural consequences is in the area of money management and budgeting. Money is a natural source of opportunity and restriction on people's choices. It opens up many doors and opportunities for choice. But it does not grow on trees (or in MAC Machines). Even the most Positive Approacher sometimes has to say "No" because there is no money.

Because of their presumed limited capacity, we have often not involved people in the management of their own money (e.g., monthly SSI check, leisure budget, etc.) and/or the money budgeted for their Program (Community Home, Day Services). When we do not involve them, we fail to allow the person to experience opportunities for choice as well as natural consequences; we are forced to artificially protect and/or restrict.

Consider the following examples of application of this “Most Natural” Model:

1. A Resident of a Community Home makes excessive use of the telephone, but who has never seen a telephone bill. Staff look for ways to control his telephone use. In a positive vein, they might appeal to him with counseling about the responsibility that goes with the right. But what is the responsibility? For most of us it is to pay the bill which then creates some natural choices for us -- pay a big telephone bill every month or get a new car or whatever.
2. A Resident has a temper tantrum and breaks the Community Home’s television. Who should pay for it? If they were involved in the budgeting of Program funds then it really would not matter who pays for it -- there still would be a cost to the Resident: money allocated for some planned trip might need to be re-allocated to buy a new television. The loss of the trip would be a punishment for breaking the television -- in this case a consequence which is the natural result of the behavior and not an intervention inflicted by Staff. There lies the critical difference between a restrictive intervention and a most natural consequence!!

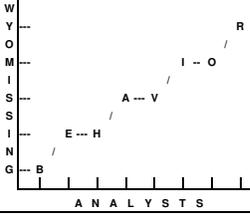
The “Most Natural” Model does not apply just to money. Consider the following additional examples:

3. The Residents of a Community Home were having difficulty evacuating for Fire Drills. (Did you ever hide when the alarm went off in your Office?). Thinking along the lines that it would be quite natural in a real disaster for the neighbors (or Red Cross) to be outside with coffee and donuts, it was arranged that donuts be served at the assigned evacuation site. If a Resident evacuates, he gets some of the donuts. If he fails to evacuate, he misses out. This is what I would call a “contrived natural consequence”. The situation was contrived, but the consequence was natural in that it followed without any additional intervention by Staff. Now if Staff served the donuts back in the house after the drill, that would be different → denying a donut to the Resident who did not evacuate would then be unnatural, and I would agree, more restrictive.
4. Behavioral Contracting is a traditional behavior intervention which I have always found useful. It involves negotiation and choice making while helping establish incentives for both parties to complete necessary but less preferred activities. According to the current Community Home Regulations, however, Contracting is considered a Restrictive Intervention and requires review and approval by a Restrictive Procedure Committee. One Committee that reviewed a Plan I wrote insisted that each new Contract was a new Restrictive Procedure and needed to be individually reviewed by the Committee. The necessity of such review was going to be more restrictive than the Contract in the first place.

Thinking in terms of the “Most Natural” Model, I am now switching to a more natural arrangement using what I call a “Things to Do About \_\_\_\_” List. The person decides what they want. Instead of telling them what they need to do to earn it (Contracting), we list what they need to do in order to get it for themselves (with help and support as necessary). Instead of needing to earn 20 tokens to go to the movies on Saturday, the person needs to save some money, call the theater to find out the show times, find someone who wants to go with them, make arrangements to meet them, etc.

It turns out there are far more opportunities for growth and experience of consequences using this “Things to Do About \_\_\_\_” List than with any Contract. Is it restrictive?? I guess it depends on your definition. I’m satisfied that it is a lot more natural!!!

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## AUTONOMY vs. PATERNALISM

Gary Champlin, Ph.D.

In our society we place a rather high value on our freedom, independence and self-determination (Autonomy). At the same time we also pride ourselves on being a concerned and caring people always ready to help others in need -- sometimes to the point of thinking “we know best” (Paternalism). Autonomy and Paternalism are best viewed as at opposite ends of a continuum.

Paternalism <-----> Autonomy

When we seek to assist another person, we are challenged to strike a balance between protecting the right of the individual to be independent and self-determining (Autonomy) and our own sense of obligation to do what we think is best for the individual (Paternalism). This is the challenge for parents raising children, adult children caring for their now aged parents, health care professionals intervening with clients and even friends helping each other out.

Incapacity is perhaps the greatest threat to Autonomy. To the extent a person is incapacitated in some way, the person is then dependent on someone else. With this dependence comes an inequality, a loss of some Autonomy and a loss of power. The person may seek to neutralize this power differential in some other way. For a person with limited capacities, the only alternative may be the development of what are called “challenging behaviors”. Rather than combat these challenging behaviors with even more intrusive interventions (Paternalism), the more effective approach may be to provide the person with alternative opportunities for independence and increased influence and control (Autonomy).

For parents raising children, there is a need to transition from a posture of protection to control and then to support. Paternalism is gradually transitioned to Autonomy. When the transition does not proceed smoothly there are two potential and contrasting outcomes → an overly dependent adult child (stuck on Paternalism) or an estranged adult child (rebellious in pursuit of Autonomy).

Roles can be reversed when the adult child’s parents develop some serious medical problems and/or dementia syndrome. The adult child is then faced with the challenge of intervening with the parent → assisting the parent to remain as independent as possible (Autonomy) while also providing care to insure safety and welfare (Paternalism).

The incapacitated person is not the only one who necessarily has their Autonomy threatened. If a parent is in need of care, but pushes to remain independent, the Autonomy of the adult child is compromised by the necessity to provide that care on the parent's terms. Unresolved, a power struggle can ensue which can be a lose-lose situation for everyone.

The client seeking assistance from a health care professional maintains some level of Autonomy with the right to select the professional of choice and the right to refuse any recommended treatment. Informed Consent is required for any treatment.

Informed Consent includes 3 components - 1) relevant information must be provided, 2) the person must have the capacity to evaluate and appreciate the consequences of any alternative actions 3) the person's choice must be voluntary. The health care professional has some responsibility for all 3 components -- to provide understandable information to the client, to assess the ability of the client to use that information, to allow the client to make his/her own choice. If a client is suspected or determined to lack the capacity to use the information, then the right to self-determination (Autonomy) may need to be subjugated and an alternative source of consent sought (Paternalism).

The client is not the only person with Autonomy. The health care professional also has a source of independence and self-determination (Autonomy). If the client is uncooperative and/or in any way compromises the professional's ethics, he can choose to refuse to provide treatment. The private practice professional will usually have more such Autonomy (and therefore power) than the professional working for a government agency. The latter will need to seek other ways to neutralize this power differential -- perhaps the source of our stereotypes about governmental workers!!

These same issues regarding Autonomy and Paternalism also exist in the more casual case of one friend assisting another in some activity. Consider the case of 2 neighbors and friends -- one a carpenter and the other an accountant. The accountant asks the carpenter for help in building a deck on his house. With regard to building the deck, the accountant is dependent on the carpenter. The carpenter can take advantage of this dependency (and consequent power) to take over the project (Paternalistic) or he can just be willing to help as asked and thereby leave control with the accountant (Autonomy). Both the carpenter and the accountant maintain some ultimate Autonomy, i.e., the carpenter can decide he has no time, the accountant can decide to hire a contractor and give up on doing it himself.

We have been talking about two kinds of capacity here - the ability/skill to complete some task (e.g., build a deck) and "Decisional Capacity" (e.g., deciding to have a particular medical treatment). Typically, we use Decisional Capacity to compensate for skill incapacity. It is one of the 3 necessary components and a prerequisite to giving Informed Consent and allowing someone else to do something to or for us.

We have a special challenge when a person has the ability/skill to complete a task, but not the necessary related Decisional Capacity. There is the elderly person who can still write a check but might lack the ability to decide for what (or what not) to write it. There is the adolescent or person with mental retardation who has the physical ability/skill to engage in sexual activity, but might lack the capacity to make decisions about engaging (or not engaging) in it.

Decisional Capacity requires 3 abilities: 1) to understand and appreciate the consequences of one's potential choices, 2) to evaluate and make a choice 3) to communicate and/or execute that choice (whether you do it yourself or get someone else). All 3 components are critical. The person who lacks the ability to initiate and follow through on a decision (i.e., to communicate a decision by word or action) may be no less incapacitated than the person who lacks insight into the consequences of behavior due to some intellectual impairment.

It should be clear that capacity is not an all or none thing. We each have our own profile of abilities/skills. The accountant might need help with building a deck, but would be able to help the carpenter with doing his taxes. Decisional Capacity is also subject to variation depending on the nature and complexity of the decision to be made. Just about anyone can decide which cereal to have for breakfast. Appreciating the consequences and deciding between various approaches to treating cancer (e.g., medication, radiation, surgery), however, may be beyond some people's ability to comprehend. With some issues (e.g., sexuality), there are differences of opinion regarding just what consequences are critical and need to be appreciated in order to make a decision (health?, moral?, social? financial?, etc.)

Perhaps the most important and overriding capacity is the ability to assess one's own incapacity -- to be aware and recognize one's own need for help in certain other areas. Awareness of incapacity is what allows us to compensate, i.e., to ask someone else for help (e.g., to get an accountant to do our taxes). Lack of awareness exacerbates the potential consequence and danger of any of our incapacities (e.g., IRS auditing). Claiming incapacity and ignorance will be no excuse because of the assumption of the capacity to assess one's own incapacity (i.e., if you could not do it yourself, you should have gotten someone to do it for you!).

Everyone faces the potential of some increased incapacity (head trauma, health problem, dementia syndrome such as Alzheimer's Disease, etc.). While we still have capacity (and Autonomy), we are encouraged to plan for the possibility of such incapacity (and thereby minimize any Paternalism). President and Mrs. Clinton recently publicized the fact they were drafting "Living Wills". Forms for creating "Durable Powers of Attorney" are now readily available even in some supermarkets.

Setting up both a Living Will and/or a Durable Power of Attorney require that the person have capacity at the time they are developed. They are both acts of Autonomy. The person must be able to understand and appreciate the consequences of the action. A person with severe mental retardation or who already is in a later stage of Alzheimer's Disease undoubtedly would not meet the criterion of capacity to set up a Living Will or Durable Power of Attorney.

A Living Will maximizes Autonomy at the expense of Informed Consent. A Living Will requires the anticipation of some rather unforeseeable circumstances. The idea is to decide now (Autonomy) what you would want later when you might not be able to decide (and also not be able to change your mind!!).

A Durable Power of Attorney maximizes Informed Consent at the expense of Autonomy. A Durable Power of Attorney involves designating someone to execute decisions you make as long as you are still capable and allows the designee to start actually making the decisions for you in the event you become incapacitated.

Presumably the designated Power of Attorney is someone with whom you have shared your thoughts and values and is committed to making decisions as s/he believe you would if you could. At the cost of having this substitute decision maker (giving up Autonomy), the decisions can be made based on an understanding of the immediate and actual circumstances (Informed Consent). A complete Durable Power of Attorney should include specification of designee(s) and exactly what activities each is responsible for (e.g., financial, medical, placement).

The comparable option in the case of an already incapacitated individual would be the appointment of a Legal Guardian. This is an act of Paternalism. The Guardian is designated by the Court to serve on behalf of the person to oversee all or some designated part of his/her affairs and make decisions for the person when necessary.

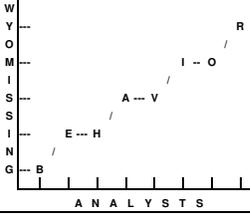
Guardianship is still not a rationalization for extreme Paternalism. The Guardian should be expected to still allow the maximal Autonomy to the person. When a decision must be made by the Guardian, it should be made based on what the person would do if they had capacity, not what the Guardian would prefer or personally want to do.

Guardianships should be considered a last resort. They are only necessary in the most extreme case or when there is some unresolved conflict. Although they may meet the incapacity requirement for appointment of a Guardian, many people with mental retardation already have a sufficient level of support to make such an appointment unnecessary. The role of service providers is to maximize their capacities (Autonomy) and provide care and support to compensate for areas of incapacity (Paternalism).

Saying "the person was never adjudicated incompetent" is not an acceptable rationalization for not intervening when a person engages in a pattern of unsafe and irrational behavior. Parents, adult children, health care professionals and even friends/acquaintances bear responsibility for making ongoing evaluations of capacity. The parent evaluates and decides when to increase the child's responsibility. The adult child evaluates and decides when it is time to begin to reverse roles with the parent. The health care professional evaluates and decides what level of supports the client requires. The friend/acquaintance seeking a relationship must be concerned that the prospective partner is truly consenting.

The issues regarding Autonomy vs. Paternalism are clearly complex. Arguably, we all have rather limited decisional capacity in this area. Hopefully this article has shed some new light and perspective on the issues. And oh yes -- my area of expertise and capacity is Psychology, not Law. Consult an Attorney for additional information regarding Living Wills, Durable Power of Attorneys and Guardianships; and also Living Trusts !!! (added 11/04/94, GDC).

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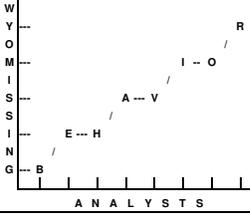
## TEACHING RESPONSIBILITY

Gary Champlin, Ph.D.

1. The best way to teach **Responsibility** is to give it.
2. **Teaching Responsibility** involves teaching that behavior has **Consequences**.
3. **Support** means assisting a person to take **Responsibility** for his/her own behavior.
4. Giving **Responsibility** not only means allowing **Choice**, but also allowing the consequences of that **Choice**.
5. **Responsibility** for small **Choices** today is preparation for big **Choices** tomorrow.
6. Giving **Responsibility** means a “**Belief in Competence**”.
7. To make people more **Responsible**, we need to look for ways to “toss the ball in their court”.
8. **Rights** are opportunities to be exercised (e.g., exercising the right to vote means being allowed to stand on line and wait at the local polling place).
9. This was intended to be “**The Land of Opportunity**”, not “The Land of Free Giveaways”.
10. In general, material items and money are things which should be **Earned** while love and affection are feelings which should be **Unconditional**.
11. The purpose of **Behavior Analysis** is to determine the most logical ways to help change behavior, not to excuse it.
12. **Behavior** that is easily excused is behavior that is easily repeated.
13. **Natural Consequences:** the consequences which would occur without any additional interference by a caregiver.

14. **Logical Consequences:** consequences which are appropriate and somehow relevant to the behavior.
15. **Punishment:** the antithesis of **Reward** → without Reward there is no Punishment; without Punishment there is no Reward.
16. To be effective, **Discipline** should be both **Consistent** and **Persistent**.
17. **Rewards** and **Punishments** are consequences for behavior, not for people.
18. **Self Esteem:** a sense of self-value which develops both from receiving the unconditional regard of others and also from achieving one's own successes.
19. **Frustration Effect:** when a goal is blocked, the person is energized to try harder.
20. **Errorless Learning:** when an environment is arranged to insure only success, the person never learns to deal with frustration or failure.
21. **Learned Helplessness:** when repeated efforts only lead to repeated failures, then the person develops feelings of despair, hopelessness and helplessness.
22. **Psychological Welfarism:** when outcomes are provided regardless of behavior and/or behavior provides no differential consequences, the person comes to believe that someone other than himself is **Responsible**.
23. **Rescuing:** repeatedly protecting a person from experiencing the consequences of his/her own behavior leads to **Psychological Welfarism**.
24. **Nagging:** giving repeated verbal prompts because you really do not believe the person is **Responsible** for his/her own behavior.
25. It is easier to take **Responsibility** for one's own **Dreams and Desires** than someone else's.
26. There is a special challenge when the **Capacity** to make decisions about a behavior lags the **Ability** to engage in the behavior (e.g., sexual activity).
27. Carrying some of the previous 26 thoughts to the extreme can be dangerous. **Balance** is the key!!!

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## POSITIVE STEREOTYPING

Gary Champlin, Ph.D.

Advocacy has definitely become the “in-thing” in the field of Mental Retardation. It is no longer limited to special groups such as The Arc. The theme of this advocacy has been uplifting the perceived quality and worth of people with mental retardation to the point some have now come to refer to it as “positive stereotyping” (Jacobson and Mulick, 1994).

We usually think of “stereotyping” as a rather negative way of thinking. It involves attributing a set of characteristics to a whole group without looking at the individual. It leads to the development of bias, prejudice and bigotry.

We can easily dismiss and overlook these negative connotations when we stereotype in positive ways (e.g., Ethnic Pride, Self Advocacy Groups, etc.). For people with mental retardation, there are a number of examples of this positive stereotyping in recent years: AAMR’s new definition of MR which instead of labeling the person labels the level of support, the Facilitated Communication craze which was/is based on a “Belief in Competence”, the entire Inclusion movement which is based on the belief that “Everyone Belongs”.

But let’s go back and not forget the negative aspects of such stereotyping. The perception of an “ingroup” automatically suggests there are “outgroups”. Ethnic Pride can be a mask for prejudice. A “Belief in Competence” and that “Everyone Belongs” can blind us to the significance of individual differences, strengths and limitations, and the necessity of truly “Person Centered Planning”.

A current buzzword, and one which I have adopted, is the word SUPPORT. I don’t write Behavior Management Plans anymore. I write Behavior Support Plans. The implication is helping the person do for themselves. It is not intervening against the person, but with the person. Sounds great! But maybe it’s just another case of this Positive Stereotyping. It suggests that everyone can do just about anything if only given just a little bit of help and the right situation.

Nonsense!! Everyone can’t do everything. Everyone is not competent. There are a lot of “person centered” reasons to have to do things against someone’s will. For one reason or another, some people just can’t “belong”.

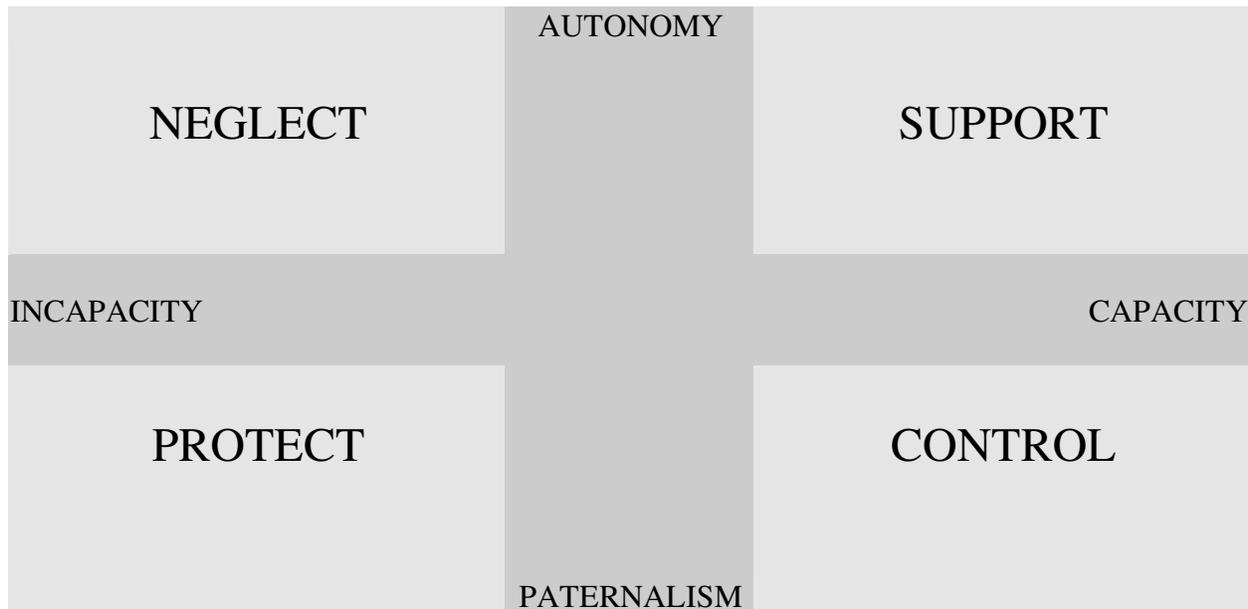
It's nice to say we are only going to focus on people's strengths and capacities, but not to the point it blinds us to their needs and limitations. It's nice to advocate for people's right to Autonomy (independence, freedom of choice, etc.), but sometimes there is a need take a more Paternalistic Approach (We know what's best for you) -- whether that turns out to be to "allow" a choice or to act contrary to it.

I would suggest reserving the word SUPPORT for the case of assisting a person to become truly autonomous in utilizing determined capacities (i.e., to meet his/her fullest potential). Using the Schemata presented below, it is only one of four possibilities.

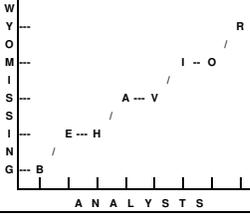
It would be nice to always be operating in the SUPPORT quadrant, but it just isn't reality. Such support easily can become NEGLECT when we fail to recognize incapacity. When a person is incapacitated, PROTECTION may sometimes be the more responsible approach. When the person is presumed to have capacity, but behaves in a socially unacceptable way, CONTROL may still be the only option.

The real test of our commitment to advocacy probably is not so much in the Support quadrant (autonomy for the person with capacity), but in the Protection quadrant (paternalism for the person without capacity). It is in this quadrant that we accept ultimate responsibility, but still might recognize the importance of respecting people's preferences (We know what's best for you and that is to help you with exactly what you're asking to do!).

Such Advocacy does not have its foundation in "Positive Stereotyping". It does not require a "Belief in Competence", but rather, it requires an "Acceptance Regardless".



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## SOME POTENTIALLY DEMEANING ACTS

Gary Champlin, Ph.D.

We have made tremendous strides in the last few years in recognizing people with mental retardation as real people with wants and needs, talents and abilities, and deserving to be treated with dignity and respect just like anyone else. We have been sensitized to see that our well meaning attempts to help have sometimes been overprotecting and overcontrolling. We now try to focus on peoples' capabilities rather than weaknesses. We attempt to promote people's autonomy and opportunity to have influence and control of their own lives. We now talk about support, inclusion and person-centered approaches.

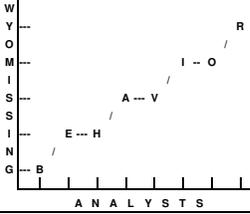
But even under the shroud of these more positive and less restrictive approaches, is there still a potential for being demeaning and disrespectful to people? Have we just created a nicer way of protecting and controlling? Have we now just become more benevolent dictators?

Here's my up-to-date list of 12 ways we are potentially demeaning and disrespectful to people with mental retardation:

1. **Redirecting:** We talk about redirection as a less restrictive way of intervening to help people calm down and avert crisis escalation. But there are two ways to redirect: 1) to a totally different subject, 2) to a better way. The first way is the one that can be demeaning. It's like saying "Who cares what's bothering you. Do this now." The second type of redirection is more difficult, but definitely, more respectful.
2. **Ignoring:** This is another one of those "less restrictive" options. The rule is to ignore the behavior, not the person. But again, it's like saying who cares. Instead of saying your behavior has power and influence (for better or worse), it's saying it does not matter.
3. **Least Restricting:** We are so worried nowadays about not requiring anyone to do anything they would not otherwise do of their own choice. I'm not sure I could deal with so much freedom in my life! I'd wonder if anyone cares anymore. If we really have a "Belief in Competence", then we should also believe people can deal with having a few requirements in their lives too!

4. **Rescuing:** We are all for allowing people to have choices, but then if they get in any trouble we rush to help them out of it. All of a sudden we start thinking they aren't responsible for themselves after all. Part of making a choice is experiencing the consequence of the choice. Allowing behavior to have consequences, is what really allows behavior to have power!!!
5. **Not Telling:** When we think people can't handle something (good or bad), we tend to avoid telling them about it until the very last minute. What about the right to know? When you go to the doctor you expect him to tell it to you straight → the good and the bad! When we shelter people from information, they are denied a chance to learn, to cope, to develop competencies.
6. **Reviewing Committees:** We have Committees to protect the rights of people with mental retardation. In protecting their rights, however, these Committees can also violate them. It's Big Brother watching over them. They are not free to negotiate their own deals. They need this Committee to oversee their decisions. The choices are not theirs after all.
7. **Gifting:** People can be smothered with kindness. Gifts can be so obligating. When someone gives you something as a gift, you lose the opportunity to choose it for yourself. It's a kind of psychological restraint. It's not always so easy to take it back and get what you really wanted!
8. **Doing For:** When we do things for people we take away their opportunity to do and choose for themselves. The message is that you don't think they can do it without you. Maybe they'd rather do it themselves!
9. **Rewarding:** Rewards can be like bribes. They are seemingly nice ways of controlling people. There are two parts to any reward contingency: 1) if you do such and such, you'll get the reward, and also 2) but if you don't do such and such, you'll get nothing!!
10. **Punishing:** If we allow people responsibility for their own behavior, then why should we feel the need to inflict additional consequences on them? It's when we are always rescuing people (#4) that we usually feel the need to inflict other punishments. Two artificials do not make a natural!!
11. **Speaking For:** Advocates need to be careful that they are truly advocating for the person. In many cases we talk about being "person-centered" when we really are "cause centered". We hear what we want to hear. Of course they want what we think is best for them!
12. **Stereotyping:** Whether it is a positive or negative stereotype, we are still lumping everybody together. We still need to look at the person, not the group. A person should also have the right to not be included, to not be part of a class action suit, etc.

Truly person-centered planning means providing supports to help people obtain their own dreams and desires. It allows for success and failure. It provides opportunities and not outcomes. It focuses on abilities, but also needs to recognize limitations. It balances the dignity of risk with the need to also provide responsible care. Reprinted from The Arc of Berks County Newsletter (January 1995). For subscription information call 610-603-0227 or e-mail [berksarc@ptd.net](mailto:berksarc@ptd.net).



# Wyomissing Behavior Analysts, Ltd.

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## PERSON-CENTERED BEHAVIOR SUPPORT

Gary Champlin, Ph.D.

In the past 10+ years we have made tremendous strides in moving to a more person-centered approach to supporting people to make changes in their own lives. We have recognized that we do not always know better (Paternalism) and that some level of self determination (Autonomy) is critical -- even for people with limitations in capacity for independent decision making.

This movement has been most evident in the development of behavior change programs which in some venues have gone from being called "Behavior Modification" to "Behavior Management" to "Behavior Supports".

The hallmark of a truly person-centered approach is the ability to put yourself in the person's shoes and see the world from their point of view -- to empathize, not necessarily sympathize. The key is to use your insight and judgment, while seeing things through their eyes with their personality and lifestyle preferences.

People can speak for themselves to varying degrees. When they can, they should. When they cannot, it falls on someone else to speak for them. It is a real challenge and responsibility to speak for someone else. It is tough to keep your own biases and preferences out of the equation. It is real easy to slip away from Autonomy and back to Paternalism. "Person-Centered" can easily become "Cause Centered" as we force our own vision and ideals into the equation.

In drafting more "Person-Centered Behavior Support Plans", I have found it helpful to take this advocacy approach -- to get inside the person, see things from their point of view, and write down as best I can what they would say about how they would want to be treated and what they would want others to do (or not do) to help them.

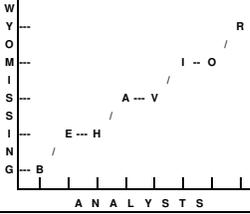
At the least, this approach has helped me to tone down my language and get away from some of the fancy jargon. For sure, it increases my sensitivity to seeing things from the person's perspective. It is analogous to a "Living Will" -- while they have capacity to do so (in this case with me as the agent for this capacity), they are identifying how they would like to be treated.

What follows is an extract from such a more "Person-Centered Behavior Support Plan". What were programmatic guidelines for staff now becomes the person's "Requests for Respect and Support". Note how in this case the particular person is not choosing to do whatever s/he wanted all the time. I don't think any of us really want that much freedom. Or am I bringing my preferences and values into this again? It's not easy. The challenge remains!!!

## \_\_\_\_\_’s Requests for Respect and Support:

1. Please **treat me with dignity and respect** regardless of my momentary behavior (sometimes I can get an attitude). I do best when I am given some assurance and feel like I belong.
2. Like most people, I don’t like to do a whole bunch of things in a row that I don’t like. Help me to **spread things out**. Mix in some things I like.
3. If I agree to and do one thing, **don’t heap on** additional requests or requirements. I won’t believe you next time when you ask me to do “just one thing.” It is important that I can trust you.
4. Never make promises you can’t keep. **Be honest** with me.
5. I have trouble saying good things about myself. Assist and encourage me to make **positive statements about my own behavior**. If I seem to need it, give me a hint.
6. If you need to point out something I’m not doing quite right, be sure to **aim your comments at my behavior** and **not me** as a person. I would like to think I am a good guy who just makes a mistake now and again.
7. Give me choices whenever possible. Giving me **two choices** is a way you can tell me my limits, but still leave me with some feeling of control.
8. I usually have trouble dealing with change and new situations. Sometimes I just need time and space to work things out on my own. **BUT** don’t go too far! **Let me know you are available**, but then let me make the next move. Whatever you do, don’t nag me!!!
9. Every once in a while I can get so upset and carried away that I do something that endangers myself or someone else. Try to **give me time and space** to get control of myself on my own.
10. When I get upset, I have trouble controlling my feelings and behavior. Especially when I’m not in control, I need to know that you are in control!! **Be assertive with me and set clear and reasonable limits**.
11. If I start verbally threatening to do something, **acknowledge that I’m upset** so I know you care, and remind me of my limits.
12. If I get really dangerous and you think its an emergency and you have no other choice but to take a hold of me to keep me from hurting myself or someone else → then do it! **Just be careful!** Hopefully and if you do it right, I will find some comfort in being held and realize you are trying to help me.
13. If I don’t seem to be calming down, it may be helpful to suggest I **sit on the floor**. That is a safer place for me to be and will make it less likely you will need to hold on to me.
14. I would appreciate some **input into any Reports** that are written about things that happen with me. I may not be in good shape to do it right away, but maybe later after I calm down.

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## INCLUSION or SECLUSION ??

Gary Champlin, Ph.D.

I recently was asked to consult regarding the case of a 21-year-old man (boy?) with Pervasive Developmental Disorder and Severe Mental Retardation. He was in a residential/institutional placement subsidized by his home school. His parents were very pleased with this placement. They would argue that he made significant progress there.

But he turned 21 and had to graduate. The funding stream changed from the School District to the County MH/MR. The parents were convinced by the County that it would be good for him to move into the community. He was placed in a 8-bed Community ICF-MR. He was scheduled to attend a nearby Adult Training Facility with a pre-vocational emphasis.

His adjustment was not dramatic. He seemed to be doing okay. But then it became apparent that the frequency of his head banging was increasing. His parents saw some holes in the drywall at the ICF. They became very concerned. They started looking closer at what was (or was not) going on. They lost faith in the Provider Agency. They wanted their son back at the residential institution where they believe he was happier and got better care.

This is not an unusual story. There are many stories of people who blossom when they move into a more inclusive setting. But there are also many stories like this one. Why the difference?

The individual in this story moved to an ICF-MR in a rural setting. Arguably, he was not included at all. A van took him from the ICF to the ATF and back. He needed an escort to leave the house. There were 3 staff, but 8 people needing their attention. They had a van, but it needed to be shared by the 8 people. Going out was a big event.

His parents suggested that he moved from the city to suburbia. That's okay if you have some wheels, but not if you need to rely on others for transportation. At the institution everything was within walking distance. At the ICF, he was trapped.

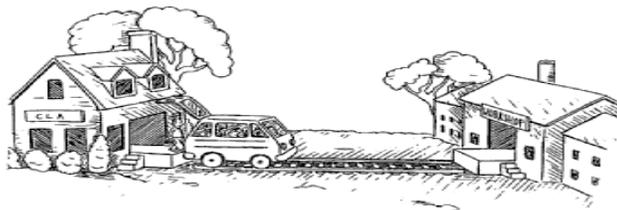
The Staff at the ICF seemed nice enough, but they were always new, seemed to be just passing through, upwardly mobile, in transition themselves. At the institution, there seemed to be more stability. Staff were accumulating years toward retirement. They knew the clients for years. Relationships were established.

The one place this individual did get to go was to the Adult Training Facility. He spent time there doing his favorite puzzles. The same ones he liked to do at the ICF. He did some pre-voc work. His co-workers were the same guys from the ICF. There were 3 program areas so he would not get too bored being in one place. He looked forward to the ride home. Once back at the ICF, he got upset waiting for someone to cook dinner. At least at the institution he did not have to smell the food cooking. He was free to do his puzzles some more. He seemed to like them. After all, he did them all the time! It was his choice!?

What's the message(s) here? Deinstitutionalization does not necessarily lead to Community Inclusion. A Community Home is not necessarily less restrictive. Quality of Life is not automatically improved by a community placement. Not everyone is cut out for suburbia. There is a difference between necessity and choice. Institutions are not all evil. Little ICFs are sometimes nothing more than big ICFs but without many of the amenities.

All this said, should the individual discussed here go back to the institution like the parents are insisting? If his head banging is bad enough, I'm hard pressed to argue. Maybe his quality of life was better there. Maybe he was happier. If we are really Person-Centered, I think we really need to consider it. It's only when we become Cause-Centered that we know better and insist the community is the only choice.

But there is more than one community. There are a lot of places where each of us would not be happy living either. Some people like green pastures. Others like the bustle of the city. The community is sometimes what we make of it. The challenge in this case may just be to find more things for this fellow to do in his new community. Moving is an adjustment for anyone. It takes some work. He needs to meet some people. He needs to check out what is around for him to do. Maybe he can even get a part-time job and meet some people. On the way home he could stop and do some shopping for something to cook for supper. Or he could splurge and eat out with some co-workers. Afterwards, he could rent a video to watch at home. Or maybe there's a game scheduled and he volunteers as an assistant coach for the local tee-ball team. Now we're starting to talk about inclusion! Maybe he'll even forget about that head banging. No time. Too many other things to do.



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