Does it Pass "The Acid Test?"

Leslie E. Packer, PhD

Many problematic "behaviors" may actually be symptoms of a student's neurological condition. This does not mean that you shouldn't or can't address them, but it does add another layer of complexity because symptoms may not be modifiable via simple rewards and consequences that teachers often use in the classroom. So before you decide to try to modify that "behavior" via behavior modification techniques, consider the following questions:

1. **Whose problem is it?**

   If the symptom or behavior does not significantly interfere with the child's functioning and doesn't really interfere with the other students' ability to learn, leave well enough alone.

2. **Are the potential consequences of the behavior so se rious, even if the behavior is infrequent, as to warrant intervention?**

   If the symptom or misbehavior endangers the child or others and/or if it jeopardizes the child's placement or program, then intervention must be considered even if the behavior is infrequent -- and the more interventions, the better. But behavior modification should probably not be your first intervention. Your first interventions involve changing the environment and what you do before the problem occurs, assessing the child to see if there are unaddressed learning disabilities, and consulting with the child's parents and treating professionals to get their understanding of the behavior and their ideas.

3. **Is the student or child capable of modifying the behavior if we (simply) boost their motivation by applying consequences?**

   If your answer is "No, they probably won't be able to do it if we just boost the motivation by applying consequences," then you should *not* implement plan that merely applies consequences.

4. **If the student is capable of exhibiting the desired behavior, is s/he capable of exhibiting it *consistently*?**

   If the student is not capable of exhibiting the desired behavior consistently even with boosted motivation, then any rigid behavior modification plan is may produce distress, agitation, and *worsening* behavior or symptom severity.

5. **Can those responsible for administering the plan adhere to the plan consistently?**

   If you can't, don't even start.

© Leslie E. Packer, Ph.D., 2001 (revised 2004). "Mad Scientist" cartoon copyright Dennis Cox. This handout may be reproduced for personal, noncommercial use. For all other purposes, request permission from reprintrequest@schoolbehavior.com

6. **Have you assessed the student thoroughly and are you confident the problem is not language-based or indicative of a skills deficit that requires remediation or accommodations?**

If the child is having a lot of behavioral problems, have you obtained a neuropsychological evaluation and language-based evaluation? If there are any suggestions of sensory intolerance, have you obtained an evaluation on sensory integration? If not, you should obtain additional needed evaluations *before* developing any intervention plan.

7. **Are accommodations, other therapies and interventions already in place (e.g., speech therapy)?**

If they're not, and if the behavior doesn't jeopardize health, safety, placement or program, they need to be in place for a while so that you can see what, if any, behavioral problems are left.

8. **Would medication be likely or unlikely to help the behavior or symptom?**

Sometimes what may be needed is pharmacological management. As much as the author does not like jumping to a pharmacological intervention, it may be necessary and appropriate in a particular case. By communicating with the student's parents and treating professionals, you can share your concerns and observations and hopefully have a frank discussion of all options to help the student with behavior. Note that if the behavior is fairly chronic and a symptom of executive dysfunction, medication is not likely to help, but environmental supports and training can.

9. **Do the parents and school agree on the cause of the behavior/symptom?**

If the school and parents don't agree as to what's causing the problem, they will each have different ideas about how to address it. If this situation occurs, and if the parents and treating professionals are saying one thing and the school is saying another, my recommendation is that you listen to the parents and treating professionals unless the school has someone on staff who really has genuine expertise on the child's diagnosed conditions. If you need another opinion or assessment, consider an Independent Evaluation or psychiatric consultation with an outside consultant to guide the team.

A Cautionary Note:

Under the Individuals with Disabilities Education Act (IDEA) in the U.S., if a behavior interferes with the student's ability to benefit from their educational program or if interferes with the ability of peers to learn or the ability of the teacher to teach, then it should be addressed, and IDEA mandates that a Functional Behavior Assessment (FBA) be used for students in special education with such needs. An FBA is based on the assumption that behavior serves a function, and the assessment is to determine what function the behavior serves so that an appropriate plan can be developed. In actual practice, however, the author has seen numerous examples of where school personnel decide that a behavior is "attention seeking" because they respond to the behavior and the behavior stops. A teacher's attention or peers' attention might, in some cases, constitute "secondary gain" for a student, but with most symptoms or behavioral features, the function of the behavior is generally not "attention-seeking" and is more related to internal events.

© Leslie E. Packer, Ph.D., 2001 (revised 2004). "Mad Scientist" cartoon copyright Dennis Cox. This handout may be reproduced for personal, noncommercial use. For all other purposes, request permission from reprintrequest@schoolbehavior.com