A Critique of Sociocultural Values in PBIS

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Abstract Horner and Sugai provide lessons learned from their work with disseminating the Positive Behavioral Interventions and Support (PBIS) model. While PBIS represents an empirical school-wide approach for maladaptive student behaviors, the model appears to have limitations regarding sociocultural values and behavioral data collection practices. The current paper provides an overview of three identified areas for improvement and outlines how administrators using PBIS can incorporate acceptance and mindfulness-based intervention procedures to address the discussed limitations.

Keywords Positive behavioral interventions and supports · Behavior analysis · Acceptance · Mindfulness

According to Horner and Sugai (2015), Positive Behavioral Interventions and Supports (PBIS) is a framework for delivering sociocultural and behavioral supports to improve a broad range of outcomes for students. PBIS includes a hierarchical three-tiered system that differentiates students based on educational and behavioral support needs. Since its development in the 1980s and 1990s, there has been significant controversy regarding the similarities and theoretical differences between PBIS and the supported underlying foundation of applied behavior analysis (e.g., Johnston et al. 2006; Tincani 2007; Weiss et al. 2010). On the surface, PBIS appears to be an effective evidence-based practice for schools and is currently being used in 21,000 schools across the USA. While there is no question that PBIS

is a remarkable example of widespread dissemination, the extent to which the PBIS zeitgeist is successful at developing students' mental health repertoires across tier's remains open for discussion. Further, critical inquiry exploring the sociocultural values and interests within the PBIS model are needed (e.g., Johnston et al. 2006). Therefore, the purpose of the current paper is to analyze the sociocultural aspects regarding mental health disparities and distinctions within the PBIS model.

Upon examination of Horner and Sugai's "lessons learned," three broad concerns arise. First is the nature of a top-down systematic approach. Within PBIS, school administrators select and identify all cultural practices and behavioral expectations to be reinforced in school (e.g., be respectful, be responsible, be safe). Administrators also select behaviors to coincide with the broader culture of the school, which may or may not necessarily represent the culture of the student body. For instance, prevalence reports on race and ethnicity suggest that minority students attending public schools in the USA represent 34 % of the student body (15.4 % Hispanic American, 12 % African-American; Aud et al. 2010). However, minority public school teachers represent just 17 % of educators (8 % African-American, 6 % Hispanic American; Dee 2004).

Similarly, school administrators may be more likely to select behaviors associated with their own Eurocentric culture. Horner and Sugai argue that tier 1 focuses on school-wide proactive supports that are independent from documented student needs and are designed to support the majority of students by teaching behavioral expectations while correcting behavioral errors. Common school-wide social behaviors selected often support an assumption of healthy normality, wherein psychological health is a homeostatic state that is only disturbed during periods of psychological illness and distress (e.g., Hayes et al. 1999). As a result, students are taught that states of psychological health (i.e., feeling happy) are to be sought after and result in continual placement within

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tier 1. Concomitantly, students are taught that states of psychological illness or distress (i.e., any feeling other than happiness, or behaviors other than those considered respectful and responsible) are to be avoided. Students who engage in maladaptive behaviors as a way to deal with states of unhappiness are subsequently moved to tier 2 or 3. The tiered system, therefore, appears to categorize behavioral patterns based on administrative cultural sections of behavior and appears to focus on behavioral topography rather than underlying symptomology particularly within tier 1.

Second, the tier system as currently applied appears to leave students out of services until they engage in maladaptive behaviors. By design, students must engage in maladaptive behaviors to get access to additional mental health services. This is concerning given the mental health prevalence rates among school-aged children. For example, between 13 and 20 % of school age children in the USA experience a mental health disorder in a given year (Perou et al. 2013), while 14.2 % of adolescents between 13–18 years of age are treated with psychotropic medications (Merikangas et al. 2012). Further, 50 % of adolescents between 14 and 18 years of age with a mental health disorder drop out of high school (U.S. Department of Education 2011). Such prevalence rates and epidemiological studies highlight the increased number of school-age children suffering from a range of mental health issues. While preliminary researchers suggest the PBIS can be extended to at-risk and adjudicated youth (Scott et al. 2002), abused or neglected children (Buschbacher 2002), and urban children (Warren et al. 2003) (see also Johnston et al. 2006), it remains unclear the extent to which the hierarchical Tier system assists marginalized groups of children suffering from mental illness. Further, while Horner and Sugai argue that tier 1 can include wraparound mental health services, the quality and effectiveness of such mental health services remains unclear.

Third, the collection of student behavior data is questionable. The behavior data as reported by Horner and Sugai appear to only reflect maladaptive problem behavior and discipline patterns. Office referrals and suspension records are not behavior per se, but rather a result of behavior. Furthermore, Horner and Sugai make no mention of positive behavior data collected such as psychological health or overall well-being. The PBIS system appears to react maladaptive behaviors rather than assess and analyze positive behaviors as suggested. Finally, it is unclear why teachers and other school staff are trained to collect data to determine the function of problem behaviors, particularly as the behaviors more likely to be collected result in office referrals. This is particularly concerning as office referrals usually lead to the same two functional outcomes: escape from the classroom and access to social attention (either from peers, educators, or both).

Taken together, it appears that PBIS is a reflection of current cultural norms and practices (e.g., healthy normality). However, current behavioral theoretical perspectives have undergone

a radical paradigm shift towards a more post-modern, culturally diverse practice. Given Horner and Sugai's stance on the systematic aspects of PBIS, rather than the intervention modality, it would appear that the same cultural shift could be made within a PBIS model. Behavioral psychology has shifted from healthy normality to a perspective valuing healthy abnormality; and as such, has systematically identified and empirically investigated acceptance and mindfulness-based theoretical practices and applications (e.g., Hayes et al. 1999, 2006; Hayes 2004; Baer 2003). Use of acceptance and mindfulness-based applications and practices have been demonstrated as effective within primary education settings (e.g., Barnes et al. 2004; Rosaen and Benn 2006; Wisner 2010). For example, acceptance and mindfulness interventions for children have resulted in positive effects on student self-esteem and self-acceptance (Broderick and Metz 2009), teacher reports of student externalizing behaviors (Schonert-Reichl and Lawlor 2010), and overall increases in student attending during class activities (Wilson and Dixon 2010). Such preliminary evidence suggests that acceptance-based interventions can assist students in fostering psychological flexibility (i.e., malleable and varying responses to aversive or painful experiences).

Given the systems nature of the PBIS model, it appears that school administrators can apply similar techniques into the model with three easy steps. The first step is to acknowledge the sociocultural differences between educators, administrators, and the student body. Recognition of cultural differences may assist educators with determining more culturally appropriate pro-social behaviors to identify as school-wide rules. For instance, general rules could be easily adapted to fit the cultural needs of an urban school, by selecting language and images that students identify with.

School administrators must also acknowledge the existence of human suffering across the lifespan, and the topographical differences of suffering across cultures. Suffering is a natural phenomenon within the human experience and school age children, regardless of cultural backgrounds, are not exempt. Rather than focusing on avoiding suffering, educators can teach students how to create repertoires to accept their suffering through healthy coping skills (rather than maladaptive behaviors to escape or avoid suffering). School-wide behavioral expectations can be adapted to correspond within an acceptance-based model (e.g., accept, choose, and take valued action).

Once school administrators select acceptance of healthy abnormality as a cultural value, the tier system could be altered and expanded to include mental health-related services within each tier. Classrooms can become a place where both educational and psychological learning take place. Teachers can incorporate acceptance and mindfulness-based techniques in their classrooms to address flexible ways for students to cope. Calendar time can include present moment focus, while noncompliance issues can lead to discussions around acceptance and commitment towards student values (e.g., receiving

a positive teacher report for mom and dad, or avoiding going to summer school for not passing the class). Current acceptance and mindfulness-based models have been applied school-wide (e.g., Dixon 2013), and there are emerging adolescent self-help workbooks (e.g., Ciarrochi et al. 2012) that can be easily translated for classroom activities. Changing behavioral data to collect would assist educators in determining the effectiveness of acceptance and mindfulness-based interventions. Data on psychological flexibility (e.g., Avoidance and Fusion Questionnaire for Youth; Greco et al. 2008), mindfulness (e.g., Child and Adolescent Mindfulness Measure; Greco et al. 2011), and overall health and well-being (e.g., Child Health Questionnaire; Landgraf et al. 1996) may give educators a deeper understanding of the education of the whole student rather than a glimpse into their maladaptive behavioral patterns.

Overall, PBIS represents a working model that can be adapted to fit the growing body of evidence supporting acceptance and mindfulness-based interventions for school-age children. However, additional research is needed to understand the effects of focusing on maladaptive behaviors with and without addressing general mental health issues. Future research should also investigate the extent to which acceptance and mindfulness-based interventions can be integrated into working PBIS models, and how such integration impacts overall student health and wellbeing. If as a culture we believe that our children are our future, then we need to be teaching them lifetime survival skills to include both educational and adaptive mental health and psychological skills. Combining acceptance and mindfulness-based interventions into a PBIS model may assist educators in reaching students in a new and radical way.

References

- Aud, S., Fox, M., & Kewal Ramani, A. (2010). *Status and trends in the education of racial and ethnic groups (NCES 2010-015)*. U.S. Department of Education, National Center for Education Statistics. Washington, DC: U.S. Government Printing Office.
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10(2), 125–143.
- Barnes, V. A., Davis, H. C., Murzynowski, J. B., & Treiber, F. A. (2004). Impact of meditation on resting and ambulatory blood pressure and heart rate in youth. *Psychosomatic Medicine*, 66, 909–914.
- Broderick, P. C., & Metz, S. (2009). Learning to BREATHE: a pilot trial of a mindfulness curriculum for adolescents. *Advances in School Mental Health Promotion*, 2, 35–46.
- Buschbacher, P.W. (2002). Positive behavior support for a young child who has experienced neglect and abuse: Testimoials of a finily member and professionals. *Jorurnal of Positive Behavior Interventions*, 4, 242–248.
- Ciarrochi, J., Hayes, L., & Bailey, A. (2012). *Get out of your mind and into your life for teens: A guide to living an extraordinary life*. Oakland: New Harbinger.
- Dee, T. S. (2004). The race connection: are teachers more effective with students who share their ethnicity? *Education Next*, 4(2), 52–59.
- Dixon, M. R. (2013). Don't stop believing: journeys school. *Behavior Analysis in Practice*, 6(1), 78.
- Greco, L. A., Lambert, W., & Baer, R. A. (2008). Psychological inflexibility in childhood and adolescence: development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment*, 20(2), 93–102.
- Greco, L. A., Baer, R. A., & Smith, G. T. (2011). Assessing mindfulness in children and adolescents: development and validation of the Child and Adolescent Mindfulness Measure (CAMM). *Psychological Assessment*, 23(3), 606.
- Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, 35(4), 639–665.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: an experiential approach to behavior change*. New York: Guilford Press.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1–25.
- Horner, R., & Sugai, G. (2015). School-wide PBIS: An example of applied behavior analysis implemented at a scale of social importance. *Behavior Analysis in Practice* (in this issue).
- Johnston, J. M., Foxx, R. M., Jacobson, J. W., Green, G., & Mulick, J. A. (2006). Positive behavior support and applied behavior analysis. *The Behavior Analyst*, 29(1), 51–74.
- Landgraf, J. M., Abetz, L., & Ware, J. E. (1996). *Child Health Questionnaire (CHQ): a user's manual*. Boston: The Health institute Press.
- Merikangas, K. R., He, J., Rapoport, J., Vitiello, B., & Olfson, M. (2012). Medication use in US youth with mental disorders. *Archives of Pediatrics & Adolescent Medicine*. doi:10.1001/jamapediatrics.2013.431.
- Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., et al. (2013). Mental health surveillance among children—United States, 2005–2011. *Morbidity and Mortality Weekly Report*, 62(02), 1–35.
- Rosaen, C., & Benn, R. (2006). The experience of transcendental meditation in middle school students: A qualitative report. *Explore: The Journal of Science and Healing*, 2(5), 422–425.
- Schonert-Reichl, K., & Lawlor, M. S. (2010). The effects of a mindfulness-based education program on pre- and early adolescents' well-being and social and emotional competence. *Mindfulness*, 1, 137–151.
- Scott, T. M., Nelson, C. M., Liaupsin, C. J., Jolivet, K., & Christle, C. A., et al. (2002). Addressing the needs of at-risk and adjudicated youth through positive behavior support: Effective prevention practices. *Education & Treatment of Children*, 25, 532–551.
- Tincani, M. (2007). Moving forward: positive behavior support and applied behavior analysis. *The Behavior Analyst Today*, 8(4), 492.
- U.S. Department of Education. (2011). *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act*, Washington, D.C.
- Warren, J.S., Edmonson, H. M., Griggs, P., Lassen, S. R., McCart, A., & Turnbull, A., et al. (2003). Urban applications of school-wide positive behavior support: Critical issues and lessons learned. *Journal of Positive Behavior Interventions*, 5, 80–91.
- Weiss, M. J., DelPizzo-Cheng, E., LaRue, R. H., & Sloman, K. (2010). ABA and PBS: the dangers in creating artificial dichotomies in behavioral intervention. *The Behavior Analyst Today*, 10(3-4), 428.
- Wilson, A. N., & Dixon, M. R. (2010). A mindfulness approach to improving classroom attention. *Journal of Behavioral Health and Medicine*, 1(2), 134–139.
- Wisner, B. L., Jones, B., & Gwin, D. (2010). School-based meditation practices for adolescents: A resource for strengthening self-regulation, emotional coping, and self-esteem. *Children & Schools*, 32(3), 150–159.