No Less Worthy: Recommendations for Behavior Analysts Treating Adults with Intellectual and Developmental Disabilities with Dignity

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Abstract

In this article, the authors offer recommendations for behavior analysts on how to treat adults with intellectual and developmental disabilities (IDD) with dignity. Initially, the importance of treating adults with disabilities with dignity is emphasized in terms of the impact on people with IDD, their family members, behavior analysts and other service providers, and the behavior analysis field in general. The recommendations are based primarily on the authors' professional and personal experiences along with similar experiences of others involved either personally or professionally in the disability field. The focus is on ways in which behavior analysts speak and behave that reflect dignity versus the lack thereof as perceived by others and, where relevant, consensus opinion within the professional field of IDD. Ways for behavior analysts to acquire and maintain awareness of manners of speaking and behaving that reflect dignity within the local settings in which they work are also provided.

Keywords Dignity · Intellectual and developmental disabilities · Adults

Most behavior analyst practitioners work with people with various types of intellectual and developmental disabilities (IDD). Surveys by the Association of Professional Behavior Analysts and the Behavior Analyst Certification Board (BACB) have indicated, for example, that the majority of behavior analyst practitioners work with people with developmental disabilities (Gillis and Carr 2014). An important consideration for these behavior analysts, as well as other practitioners, is performing their work in a manner that treats people with IDD with dignity.

The importance of treating people with IDD with dignity has been addressed from multiple perspectives. In particular, being treated and viewed with dignity is considered a critical aspect of quality of life (Rotholz 2009). The importance of dignity in this regard is acknowledged by leaders in human service agencies (Brady et al. 2009), parents (Turnbull and

Turnbull 2011), and individuals with IDD (Ford et al. 2013). Promoting dignity is likewise a defining feature of behavioral approaches involving positive behavior support (Kincaid et al. 2016) and is emphasized in curricula for training service providers in behavioral applications (Reid et al. 2015). Practicing in a manner that promotes the dignity of all clients is also a professional and ethical expectation of the BACB (2016).

In addition to affecting the lives of people with IDD, the degree to which behavior analysts promote the dignity of their clients with these disabilities has significant implications for behavior analysts as well as the field of behavior analysis. How behavior analysts interact with clients and other service providers affects the latter's perception of behavior analysts and behavior analysis (Foxy 1996). If behavior analysts speak and behave in ways perceived to be undignified toward people with IDD, that perception is likely to be quite negative (cf. Bailey 1991). In turn, negative perceptions and corresponding lack of acceptance of how behavior analysts speak and behave can detrimentally affect the adoption of behavioral methods by others who support people with IDD (Bailey 1991).

For behavior analysts to practice their profession in a manner that treats people with IDD with dignity, behavior analysts must be knowledgeable about what constitutes "dignity." However, precisely defining dignity (particularly in terms of what constitutes dignified behavior as perceived by others) can be difficult. In this regard, among the aforementioned

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references that emphasize the importance of viewing and treating people with IDD with dignity, no specific definition of dignity is provided. Additionally, as will be addressed later, what constitutes a dignified action at one point in time can later be perceived as undignified.

From a purely behavioral perspective, dignity can be considered using a Skinnerian approach (Skinner 1971). With this approach, dignity is viewed as a process by which a person is given credit or admiration for certain behavior (and blamed for other behavior), with more dignity traditionally attributed to behavior for which control of the behavior is inconspicuous. A central focus is the role of the environment in controlling such behavior—and particularly past and present contingencies—in contrast to control stemming from the notion of a person's inner causality. For our purposes here, however, it is likely that most service providers and the public at large are not well versed in Skinner's view of dignity. A more common approach to defining dignity would be based on a dictionary reference. Using this approach, dignity is formally defined as “the quality or state of being worthy, honored, or esteemed” (*Merriam-Webster's Collegiate Dictionary*, 1971) or “the idea that a being has an innate right to be valued, respected, and to receive ethical treatment” (“Dignity,” n.d.). Treating people with dignity can therefore be interpreted to mean treating them as worthy, honored, esteemed, valued, and respected, as well as treating them ethically. Although traditional, such an approach is still more subjective than what would likely be desired by most behavior analysts. That is, there does not appear to be a readily apparent, operational definition of behavior that represents treating people with dignity.

The purpose of this article is to provide recommendations for behavior analyst practitioners on how to treat adults with IDD with dignity. The primary basis for the recommendations is the authors' combined total of 100-plus years of experience working with people with IDD and their caregivers across numerous environments, including residential, center-based, community, vocational, educational, and family settings. That experience has provided numerous observations of ways people with IDD are treated that have been perceived as lacking dignity relative to contrasting ways perceived as demonstrating dignity. Additionally, where relevant, support for the recommendations is offered through similar reports of others involved professionally or personally in the IDD field. The recommendations are also based on one author's personal experience as a parent of an adult with a developmental disability and on interactions with other parents and family members.

In considering the recommendations to be presented, we hope that they are not interpreted as reflecting self-righteousness on our part. As will be illustrated later, over the years we have engaged in some of the practices that we are recommending be avoided. Due to both personal and professional reactions from others to those practices, our awareness has been increased regarding how we as behavior

analysts can sometimes be perceived as demonstrating a lack of dignity for people with disabilities in how we speak and behave. The intent is to increase awareness among other behavior analysts to possibly help avoid such practices and present our behavior-analytic field in a manner that is supportive of the dignity of people with IDD and is perceived as such.

The focus of the recommendations pertains to practitioner work with *adults* who have disabilities, although a number of the recommendations are also relevant for children. This focus is due to our experience suggesting that situations in which people are not treated with dignity are more common for adults than for children with IDD. Actions particularly within the adult service sector that impede the dignity of the service recipients have been reported frequently (Bigby and Beadle-Brown 2016; Reid 2015; Wehman et al. 2007). A focus on dignity within proclamations of legal rights, specifically for older individuals with disabilities, further suggests a particular need for attending to the dignity with which this population is treated (Malone and Kropf 1996).

The recommendations are presented in two major categories. The first category pertains to how we speak as behavior analysts. The second pertains to how we behave, or what we do. Although these two categories are not mutually exclusive, they nonetheless represent a means of organizing the recommendations for presentation purposes. They likewise may serve as general guidelines for concerned behavior analysts in terms of attending both to what one says and what one does in regard to treating adults with IDD with dignity. We offer *recommendations*, not mandates regarding how to speak and behave in regard to treating adults with IDD with dignity across all situations. There are undoubtedly appropriate exceptions to respective recommendations in certain situations, and examples of some of the most likely exceptions are noted where relevant.

Speaking in Ways to Reflect Dignity

Speaking in ways to reflect dignity pertains to how behavior analysts speak *about* people with IDD to service providers and the public. It also pertains to speaking *to* adults with IDD.

Speaking about Adults with IDD

A primary concern when behavior analysts speak about adults with IDD involves how people are referred to in regard to having a disability. Certain references to a disability can cast adults who have the disability in an undignified or otherwise negative light (Bigby and Beadle-Brown 2016). In turn, references that are perceived to be undignified can detrimentally affect how people with the disability perceive themselves when they hear the references (Friedman 2016), lead to stigmatization of people with the disability (Tasse 2013), reduce

the likelihood of other people wanting to interact with people who have the disability (Friedman 2016), and generally devalue people with the disability (Albert et al. 2016). In short, there is a strong consensus that certain names used when referring to disabilities can have multiple effects of a detrimental nature (Wehmeyer 2013).

In considering dignified ways of referring to the disability of an adult, the issue of *political correctness* warrants some attention. Political correctness in terms of the names used to refer to a disability generally pertains to bending the language for political or ideological ends (Turnbull et al. 2002). Political correctness is somewhat pervasive in the developmental disabilities field, and behavior analysts have not always been politically correct in their naming practices (Foxy 1996). Our concern is not with being politically correct, however, but with referring to people with IDD in ways they and their family members prefer. The concern is also with behavior analysts using naming practices in ways currently considered acceptable within the professional field of IDD at large, which consists primarily of professionals who are not trained or credentialed in behavior analysis.

Distinguishing between what may be politically correct versus what is truly important or acceptable to people with disabilities and to the general field can be difficult. The difficulty is due in part to changing customs with acceptable naming of disabilities over time. It is well established that how a disability is named at one time can go through a pejorative process to acquire a different, more negative connotation at a later time (Ford et al. 2013; Tasse 2013). A term used to describe the condition of a disability (e.g., feeble-mindedness, idiot, moron at various points in time) usually goes through several iterations, then a new term is agreed upon (e.g., mental retardation) followed by a period of use, and then that term acquires negative stigma and is abandoned in favor of a new term (e.g., intellectual disability). Behavior analysts are encouraged to stay abreast of changing customs for referring to disabilities such as IDD as desired by the consensus of people with this type of disability along with the general professional field (see Bailey 2000, for elaboration on the importance of awareness of such changes).

An illustration of the aforementioned process and the outcomes associated with lack of attention to the current desires of people with IDD is represented in the naming practices of the first author. When the term *intellectual disability* was first encountered as an alternative to *mental retardation*, the author's immediate response was that this was basically a case of political correctness. He continued to refer to individuals with mental retardation, to the subtle but apparent displeasure of a number of people with whom he interacted during his work activities. Due largely to information provided by the third author, he then became aware that there were very good reasons for the name change. Specifically, self-advocates with an intellectual disability had been striving for decades to do away with the

term *mental retardation* and *retarded* or the *R word* because of pejorative connotations (Lyle and Simplican 2015). He also became aware that leading professional organizations in the field were much more cognizant of the desires of people with IDD and their families in this regard relative to his knowledge. The organizations had studied the issue in depth, which led to name changes by, for example, the Association for Retarded Citizens to the Arc (Ford et al. 2013) and the American Association on Mental Retardation to the American Association on Intellectual and Developmental Disabilities (AAIDD; Tasse 2013). Had the first author attended more readily to the reported desires of self-advocates and their families and to the ongoing work of leading professional organizations, his naming practices likely would have changed and been perceived as more dignified at a much earlier time.

Related to how behavior analysts refer to a disability are their references to the recipients of their behavior-analytic services. Adult service recipients in the IDD field are referred to in different ways throughout the United States; they are called *consumers*, *clients*, *patients*, and so on. Certain references are well accepted by family members and service providers in some areas of the country but discouraged or prohibited in other areas (Courtney et al. *in press*). Behavior analysts should seek to identify the desired reference within the local area in which they work and attend to such when speaking about people they support.

For behavior analysts who travel across different communities with their work, special attention is warranted to initially identify acceptable references in respective locations. Such attention is important to reduce the risk of offending or insulting other service providers and recipients with how they speak or demonstrating what is perceived to be a lack of dignity with respect to their references. Using locally unacceptable references can also have the effect of these behavior analysts appearing to be unknowledgeable to other service providers, which can affect their credibility (LeBlanc et al. 2012).

One general guideline to help avoid speaking in a way that appears to be undignified when referring to the people with IDD with whom behavior analysts work is to adhere to *people-first* language (National Center on Birth Defects and Developmental Disabilities 2017). People-first language emphasizes working with people, not the disability. Such language involves talking about *people with a disability*, not *disabled people*, or *people with autism* in contrast to *autistic people*. Using people-first language is not an exercise in political correctness; it represents a consensus of what people with IDD and the professional disability fields prefer and is part of the professional conduct guidelines of the AAIDD (2012). Therefore, when behavior analysts are working in a new location and have not yet identified the locally accepted reference, it is usually acceptable to speak about service recipients as “people with an intellectual disability” or, simply, the “people they support.”

In addition to the aforementioned recommendations for speaking about a person's disability and references to service recipients in general, there are recommendations regarding how behavior analysts speak about adults with IDD that are more specific to certain situations (see Table 1 for a summary). Again, these are based on the authors' experiences along with support from others, as discussed in the following paragraphs.

Refrain from Speaking about People in Front of Them

A practice observed in some settings is behavior analysts and other practitioners speaking to others about a person they support in the immediate presence of the person. The conversation occurs without the involvement of the individual (e.g., as if he or she is not there). Such a practice is often viewed as not treating the person in a dignified or otherwise acceptable manner (Amado and McBride 2002). It is recommended that behavior analysts refrain from speaking about a person they support in front of him or her.

Sometimes it is reported that because the person with IDD does not understand what is being said, it does not matter what is said in front of him or her. However, it is still generally considered rude or disrespectful to talk about someone in that person's presence without involving the person in the conversation. It is recognized in some situations, however, that talking about a person with IDD in his or her immediate presence may be practically unavoidable. For example, if a behavior analyst is attempting to acquire information about an individual's challenging behavior as part of an assessment, the behavior analyst may have no opportunity to talk to a support staff member assigned to the individual without the individual being in close proximity (e.g., the staff member has to stay close to the individual for safety purposes). Nonetheless, our experience suggests that most people prefer not to have others talk about them in their presence as if they were not there and that (perceived) preference should be respected for people with IDD as much as reasonably possible, regardless of the severity of their disabilities.

Table 1 Speaking About Adults With Disabilities in Ways That Reflect Dignity in Specific Situations

Recommendations

Refrain from speaking about a person with a disability in the immediate presence of the individual without involving the person in the communication; attempt to speak about the person to another individual in a separate location or at least in a manner that is not likely to be apparent to the person who is the focus of the conversation.

Refer to the person, not a behavioral characteristic.

Avoid the potentially pejorative term *low functioning*; consider people-first language, such as someone with "more significant" or "more severe" disabilities.

Respect the adult status of the person.

Refer to People as People, Not as their Behavioral Characteristics

Another practice that results in perceptions of speaking in a manner that does not treat adults with IDD with dignity is referring to a person based on behavioral characteristics rather than the individual himself or herself (Bigby et al. 2012). An example of this practice is calling someone who has a history of grabbing items or people a "grabber" (Bigby and Beadle-Brown 2016). Within the behavioral field, examples we have observed include referring to a woman who hoards items as a "hoarder" and referring to a man who engages in self-injury as a "head hitter" or "sibber." These types of slang references are certainly not restricted to behavior analysts (Albert et al. 2016), as they are often observed among the public at large (Werner 2015). Nonetheless, they place the recipient of the reference in an undignified light (Hewitt 2014). Use of the references also reflects badly on the speaker to many listeners, especially when the references relate to a problem behavior (as if the speaker views the problematic behavior as the dominant essence of the person).

Potential Pejorative Nature of "Low Functioning"

Related to referring to people based on a behavioral characteristic is the use of the term *low functioning* when talking about people with more severe IDD. We have observed use of this reference by some behavior analysts. Sometimes the reference is used in a version of people-first language (e.g., "I work with individuals who are low functioning") in contrast to referring to only one predominant behavioral characteristic, as discussed previously. It is nevertheless recommended that the term *low functioning* be avoided when talking about people with IDD.

This is another recommendation based on our experiences and opinion and should be considered in light of that basis (although we have also experienced occasions when family members and service providers have reacted unfavorably to us and other behavior analysts referring to someone they know as low functioning). Having experienced the pejorative process with certain terms over the decades, such as with *retarded*, as described previously, we believe that *low functioning* is likely to follow a similar process. We recommend using alternative references, such as people with "more significant challenges" or "more severe disabilities."

Speaking about People in Accordance with their Age

Much has been written about the detrimental effects of treating adults with IDD as if they were children, or *age-inappropriate* treatment (Reid and Parsons 2017; Thompson et al. 2004). The concern here is with one particular aspect of age-inappropriate treatment: behavior analysts talking about

people in a manner that is not respectful of their adult status (see also Bigby et al. 2012). For example, in many settings it is common for behavior analysts and other practitioners to refer to adults with whom they work on a first-name basis. This is a generally accepted custom in most parts of the United States *if* the practitioners have established a relationship with the respective adults and are very familiar with them and vice versa. In contrast, if such a relationship has not been established and/or there is not good familiarity, the accepted custom is usually to use an adult's last name accompanied by *Ms.*, *Mr.*, or *Mrs.*, especially if the adult is clearly older than the practitioner.

Using titles in this manner is also due mainly to our experiences, such as having been introduced to an older adult in a support setting by a staff person referring to the adult as *Mr.* or *Ms.* That introduction appeared to reflect respect for the individual's adult status more than when we have been introduced to an adult by the staff person using the individual's first name, particularly when we were referred to in the introduction as *Mr.* or *Ms.* We have also been in situations in which service providers are referred to with adult titles, yet the people they support are referred to by their first names. Such a dichotomy in how adults with disabilities are referred to can evoke the perception that the latter people are less worthy than the former.

A general guideline for determining how to speak about or to an adult with IDD in regard to titles is one of social reciprocity. It is recommended that whatever titles are used (or not used) be extended to conversations about or with adults with IDD in a given setting in interactions among support personnel in this setting. If, for example, a behavior analyst is typically referred to by his or her first name, then it would be socially appropriate for the behavior analyst to also refer to adults with IDD by their first names. The primary concern is to avoid a lack of reciprocity in terms of referring to adults without disabilities one way and referring to those who have IDD another way.

It is likewise recommended that referring to people with disabilities with respect for their adult status be reflected in the writing of practitioners, such as with evaluation reports and behavior support plans. Not only would such written references (i.e., referring to *Mr.* or *Ms.* in contrast to the individual's first name) likely reflect more dignity for the adult to whom the document pertains, it could also prompt others who read the documents to respect his or her adult status in their communications. Written references to adults with IDD in the behavior-analytic literature (i.e., participants in research presented in journal articles) in the way we are recommending is by no means commonplace. Consequently, there is not total agreement in the behavior-analytic profession with our recommendation, or the issue simply has not received the attention of authors. We believe that more attention should be paid to this issue for the potential betterment of how our behavior-analytic profession is perceived (cf. Bailey 1991).

Behaving in Ways to Reflect Dignity

Behaving in ways to reflect dignity pertains to how behavior analysts interact with adults with IDD. The recommendations in this category are presented in regard to escorting or traveling activities, interacting with a group of individuals in public, and supporting a dignified appearance (see Table 2 for a summary).

Escorting and Traveling with Adults with IDD

Many behavior analysts experience situations in which they are escorting or otherwise walking with an adult with IDD. Common examples include escorting someone between locations in a support center, accompanying a person to community college classes for support purposes, and going shopping. When a behavior analyst is walking with a person he or she supports, it is recommended that the behavior analyst walk side by side with the individual rather than walk in front of the individual.

When walking with another adult, most people walk side by side rather than one person walking in front of the other person. When a service provider walks in front of an individual he or she supports, it can create the impression that the former person is of more importance than the latter. In public settings such as a grocery store, for example, it can appear to others that the individual with a disability is dutifully following the support person, which does not present the latter individual in a very dignified light (Parsons et al. 2009).

Table 2 Behaving in Ways That Reflect Dignity

Recommendations
When escorting or traveling with an adult with a disability
Walk side by side with the person, not in front of the person.
Whenever possible, push a wheelchair from the side instead of from behind.
If it is necessary to physically prompt movement, do so from the side by guiding the elbow or with a hand lightly on the lower back in contrast to pulling or tugging the person.
If you are traveling with a group of adults with disabilities in a van or similar vehicle, sit with the people with disabilities in contrast to segregating them in the back of the vehicle from support persons who sit in the front.
Sit with a group of individuals in public places (e.g., restaurants) in contrast to support persons sitting at one location and the people with disabilities being segregated at another sitting location.
Refrain from eating or drinking in the presence of individuals with disabilities when they do not have opportunities to eat or drink; either restrict eating and drinking to situations in which the people with disabilities are not present or ensure that everyone present has immediate opportunities to eat or drink.
Support a dignified appearance: When an individual's grooming or attire may place the individual in an undignified or otherwise negative light, take immediate action to remedy his or her appearance.

The same recommendation pertains to walking or escorting an adult in a wheelchair who cannot use the wheelchair independently. Whenever physically possible, it is recommended to push the wheelchair from a side position rather than from behind (see McLaughlin 2005, for a personal explanation of this recommendation). Again, people do not usually walk together with one person in front of the other or, in this case, with one person behind the other. It is also perceived as unnatural for a person to interact with another adult who is behind the former individual (McLaughlin 2005).

A related concern pertains to how a behavior analyst prompts or otherwise encourages an individual to walk with him or her, such as during a transition from one room to another in a residence or day support center. A practice observed in some situations is a service provider pulling on the clothing of the person being supported during the transition (with the provider walking in front of the individual). Pulling on someone's clothing is quite undignified and potentially abusive. If physical prompts are necessary to accomplish the transition, the prompts can often be provided effectively in a more dignified manner by walking next to the person and guiding the person by the elbow or with a hand lightly touching the lower back of the person.

Behavior analysts also frequently escort or travel with groups of adults with IDD. A common situation is a group of people riding in a van to go to and from work, a day support program, or various community locations. A practice that is sometimes observed in this type of situation is for support personnel to sit in the front of the van and the people with disabilities to sit in the back.

When service providers separate themselves in a van from the people they support, it represents a type of local segregation—the people with disabilities are physically segregated from the people who do not have disabilities. The segregation in the van can be perceived as treating the adults with disabilities in a disrespectful or otherwise negative light (Bigby et al. 2012), similar in ways to the historically negative effects of more large-scale segregation (Wehman et al. 2007). It is recommended that when behavior analysts ride in a van as passengers, they sit with the adults with disabilities with whom they are riding in contrast to all of the latter riding exclusively in the back of the van.

There are also some likely exceptions to the recommendations regarding traveling and escorting practices, depending in large part on the reason a behavior analyst is present in these situations. For example, a behavior analyst may ride in a van with a group of adults with IDD to assess an individual's challenging behavior that tends to occur in the van. In this situation, it may be necessary for the behavior analyst to separate himself or herself from the individual to observe the ongoing situation without interfering with the usually occurring activities.

Being with a Group of Adults with IDD in Public

Similar types of local segregation exist in public situations involving groups of adults with IDD. One of the most common involves public dining. Adults with disabilities are sometimes observed in restaurants to be congregated at one table while support staff are seated at another table. Related types of public segregation include when adults with disabilities sit in a group at a movie theater while the staff congregates together in separate seating or when adults with disabilities sit at a bench or picnic table in a park while the staff sits somewhere else. These types of seating arrangements can be perceived as stigmatizing for adults with IDD because of their segregation. It is recommended that behavior analysts avoid segregating the people they support in such situations (with the likely exceptions due to the purpose of the behavior analyst's presence).

Another potentially stigmatizing effect of behavior analysts separating themselves from a group of adults with IDD in a public setting pertains to the communication practices that are observed. People are generally more likely to interact with others who are in close physical proximity compared with those who are physically separated from them. Correspondingly, in the aforementioned situations, it is common to observe support personnel interacting more frequently with each other than with the people they support (Gabel et al. 2013). This distinctive seating and interaction pattern is especially a concern for adults with more severe disabilities who require active support to interact, such as modeling, prompting, and reinforcing interactive behavior. A number of the latter individuals are likely to engage in behavior that is particularly stigmatizing in public, such as stereotyping, when not actively supported to engage in behavior that is more socially common for the situation (Reid et al. 2010).

There is another concern with dignified treatment associated with dining, although it is not restricted to public situations. This concern pertains to a behavior analyst or other support person eating or drinking in front of an individual with a disability when the individual does not have access to something to eat or drink. Our experience suggests that this practice is not currently as common as in years past, and a number of agencies have policies prohibiting the practice. However, not all behavior analysts are aware of such policies, and the practice is still observed.

Concerns with a support person eating or drinking in front of an individual who does not have the immediate opportunity to eat or drink are twofold. First, it can be an unpleasant situation for a person to be in the presence of someone who is eating or drinking and yet not be able to eat or drink himself or herself. Second, this act on the part of the staff person can be perceived as discourteous or rude by others in the immediate vicinity if the staff member does not offer the individual something to eat or drink. It is recommended that behavior analysts

avoid this practice and discourage it among others whenever possible.

Supporting a Dignified Appearance

The importance of the physical appearance of people with IDD has been recognized for some time both in the behavior analysis field and the professional disabilities field (McClannahan et al. 1990; Nutter and Reid 1978). Physical appearance can influence acceptance of people with IDD in both positive and negative ways, with the latter including the promotion of prejudice and discrimination (McClannahan et al. 1990). The reference to physical appearance here pertains not to bodily characteristics but to how individuals are groomed and attired.

It is recommended that behavior analysts attend to how people they support appear in regard to their grooming and attire. More specifically, when working with an adult with IDD, it is recommended that behavior analysts act in a reasonable way to help remedy any aspect of appearance that is likely to reflect poorly on the individual. Observed examples of grooming or attire that can reflect poorly on an individual include the individual wearing a blouse with noticeable food stains, wearing pants that are too large (such that private body parts are observable with certain movements), and wearing shoes on the wrong feet (see McClannahan et al. 1990, for further discussion).

When behavior analysts notice an aspect of appearance being out of place with someone with whom they are working, failing to help the individual improve the aspect not only promotes a continued undignified appearance but can also reflect poorly on behavior analysts. The impact on the perception of behavior analysts is reflected in observations of family members, friends, or other service providers intervening in such situations to help remedy the situation (when the behavior analyst has not taken remedial action). These include, for example, when someone indicates to a behavior analyst that he or she needs to help the individual with whom the analyst is working to wipe her nose, zip his pants, or button her blouse. The implication is that the other person was sufficiently concerned about the dignity of the individual to notice the problem with appearance and acted accordingly, yet the behavior analyst was not so concerned.

How a behavior analyst helps remedy noticeably poor grooming or attire will require thoughtful consideration on his or her part and knowledge of the individual's skills. The help provided may involve teaching the individual naturalistically how to recognize and remedy the situation (Parsons et al. 2009), seeking assistance from a caregiver who has a closer relationship with the individual, or simply making the correction himself or herself. The primary point of concern is that the behavior analyst should do *something* to remedy the appearance problem.

Another consideration regarding perceived problems with grooming or attire pertains to the issue of individual rights and preferences. For example, a woman with IDD may explicitly prefer to wear her clothing or hair in a manner that appears to be unkempt or otherwise unsatisfactory to a behavior analyst or other support person. Adhering to the aforementioned recommendation could go against the individual's preference or even her right in such a situation. Behavior analysts must give careful thought to individual rights and preferences when determining how—or whether—to intervene in this and other related situations (for a discussion of balancing rights and preferences with treatment and support activities, see Bannerman et al. 1990).

Obtaining and Maintaining Awareness of Ways of Speaking and Behaving to Promote Dignity

As noted previously, treating adults with IDD with dignity can be difficult due to changes in acceptable practices over time and in different locations. Consequently, as also stressed earlier, it is recommended that behavior analysts actively strive to obtain awareness of what is currently acceptable in the particular settings and communities in which they work. Such awareness is necessary to promote speaking and behaving in ways that reflect dignity for adults with disabilities as perceived by them, their families, and other service providers. Awareness of acceptable practices likewise is important to avoid speaking and behaving in ways that are likely to come across as disrespecting the dignity of the very people behavior analysts desire to support.

There are several recommendations for behavior analysts to obtain awareness of currently acceptable practices in the settings and communities in which they work. Many of these are similar to those applicable when behavior analysts work with people whose cultural backgrounds are different than practitioners' own backgrounds (Fong et al. 2016). The recommendations are also similar to those offered for behavior analysts beginning to work with a different population than with whom they were trained to work or beginning to work in settings that are new to them, such as when moving from a service agency for young children to that for senior citizens (LeBlanc et al. 2012).

The first recommendation pertains to attending to acceptable practices within the professional discipline of IDD (cf. LeBlanc et al. 2012). Knowledge about currently expected ways of speaking and behaving with dignity toward people with IDD in accordance with the standards of the professional field can be obtained by interacting with, and listening to, other professionals in the field whose specialty is not necessarily behavior analysis. Relevant information can also be acquired by attending professional conferences in the field,

such as the Annual Conference of the AAIDD on a national level as well as state AAIDD conferences. Periodically reviewing key journals in the professional field can likewise be useful (e.g., *Intellectual and Developmental Disabilities*).

On a more immediate basis, it is recommended that behavior analysts regularly attend to how adults in general typically treat each other in the local community in which they work. Generally accepted interaction patterns among the local populace can be a useful guide for how and how not to interact with adults who have IDD. For example, in some places in the Deep South, it is customary to hear adults referred to with a title and their first name (e.g., “Ms. Shonetta,” “Mr. Danny”). Therefore, referring to an adult with an intellectual disability in the same manner would likely be acceptable. In communities in other parts of the United States, these types of references are essentially never heard, such that it would not be recommended to refer to a person with IDD in this manner in the latter locations.

Finally, we agree with others that the “Golden Rule” is a useful guideline (Scott 2007). In short, treat others as you desire to be treated. This principle of human reciprocity is well accepted across numerous cultures (“Golden Rule,” n.d.). Relatedly, when considering how to speak or behave in regard to an adult with IDD, behavior analysts can decide if they would want their son or daughter, mom or dad, grandmother or grandfather, or any other loved one treated in a certain way. If not, then behavior analysts should generally refrain from treating people with IDD in that manner.

Compliance with Ethical Standards This article does not contain any studies with human participants or animals performed by any of the authors. Because there are no experimental participants associated with this article, informed consent was not applicable.

Conflict of Interest The authors declare that they have no conflicts of interest.

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