

The Effects of Positive Behavior Support Parent-Training Programs on Parent-Child Relationships in Culturally and Linguistically Diverse Families

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ABSTRACT

A pre-postassessment, single-subject, pilot study was implemented, testing the hypothesis that positive behavior support (PBS) would improve family quality-of-life outcomes by reducing parental stress and challenging behaviors of preschool children who are culturally and linguistically diverse and reside in urban, disadvantaged communities. Six participants attended parent-training workshops designed to empower them to use PBS child behavior management strategies and enhance their own mental health outcomes via a functional parent-child relationship. Parental stress levels were measured and anecdotal reports of child outcomes obtained. Findings corroborate outcomes from preceding research supporting PBS as a socially valid, culturally responsive intervention effective at producing results acceptable to participants. Future research and suggestions are provided for closing the gap between research and practice.

An increasingly mutual goal of 21st-century clinicians, researchers, educators, and practitioners is to provide evidence-based, family-centered, and culturally responsive services to preschoolers (3–5 years) and their families. Their focus often is on families of preschool children who have challenging behavior (CB) and are at risk for social-emotional, social-behavioral, and/or mental disabilities across their life span. Moreover, their aim is to identify and disseminate research findings that determine and guide

legislation, practices, and policies for all families served.

Challenging behavior includes, but is not limited to, oppositional-defiant and conduct disorders (e.g., aggression, destructive behavior, violence), disruptive classroom behavior, and social-behavioral problems (e.g., poor social skills, poor or limited social interactions, off-task behaviors, and low rates of social competence). Urban boys, African Americans, older students, and children attending faith-based/for-profit early-

childhood development centers represent the highest proportions of preschoolers expelled (Anthony, Anthony, Morrel, & Acosta, 2005). In a national study of preschool programs in 40 states, Gilliam (2005) determined that students were being expelled at alarmingly high rates (6.67 students per 1,000 students enrolled in programming) from their classrooms and school systems because of CB displayed in class.

An influx of American families and their children with CB needing family-centered services persists (Park & Turnbull, 2001). According to Conroy, Dunlap, Clarke, and Alter (2005), a startling upward trend exists for young children with and without disabilities who have both challenging behavior and temperament dysfunctions in preschool settings. Similarly, Webster-Stratton (2000) reported that 7%–25% of children between the ages of 3 and 5 were diagnosed with oppositional-defiant disorder. In a comparable study, Kaiser, Cai, Hancock, and Foster (2002) found that the preschool children enrolled in Head Start programs were identified as having significant externalizing and internalizing behavior problems.

Demographic trends indicate increasing numbers of these families who are (a) culturally and linguistically diverse (CLD) (e.g., Native, Asian, Latino, European, and African Americans), (b) reside in underserved communities, and (c) have preschool children with and without disabilities or delays who have challenging behavior and/or temperament dysfunctions (Markey, Markey, Quant, Santelli, & Turnbull, 2002). Despite the current trends, a gap exists between family-centered, evidence-based, preschool intervention research and practice regarding CLD preschool students with CB and their families. These families face multiple obstacles to academic and social success and are at a disadvantage when interacting with and succeeding in educational and intervention service systems.

Numerous studies afford support for the effectiveness of positive behavior support (PBS) techniques on increasing the occurrence of appropriate actions of older elementary, middle, and high school students while subsequently reducing the occurrence of their challenging behaviors (Lassen, Steele, & Sailor, 2006; Utley

& Sailor, 2003). Utley, Kozleski, Smith, and Draper (2002), for instance, identified PBS as a culturally sensitive, assessment-based intervention effective at preventing or reducing the challenging behaviors of urban CLD school-aged children.

Fewer research studies, however, provide support for PBS interventions for preschool children with CB and their families who are CLD and reside in urban, underserved communities (Duda, Dunlap, Fox, Lentini, & Clarke, 2004). Evidence-based, parent-child intervention research that informs effective and culturally responsive positive behavior support practices that address the idiosyncratic referral, technological, resource, and support service needs of these families and their preschool children is critically important (Turnbull, Wilcox, Stowe, & Turnbull, 2001).

RISK AND RESILIENCY FACTORS

Early-childhood risk factors that prevent subsequent positive social-behavioral outcomes in preschool children include, but are not limited to, poverty, high parental stress levels, single or teen parenting, and violence in neighborhoods and home. Research is unequivocal regarding the need for interventions to be administered to preschoolers demonstrating high rates of challenging behaviors as early in life as possible (Fox, Dunlap, & Cushing, 2002). Some service barriers include the lack of professional cultural competence and the lack of involvement of family members in programming, which may prevent the provision of culturally sensitive and culturally competent early-intervention services (Lee, Zhang, & Schwartz, 2006). Children's resiliency levels combined with a strong functioning family unit serves as a protective function against future problem behavior in children.

It is essential that researchers and practitioners develop a keen sense of awareness of the factors influencing their identities (Utley et al., 2002). Moreover, it is essential that they are knowledgeable about CLD families and (a) the *risk factors* that promote dysfunctional parent-child interrelational systems, as well as the *resiliency factors* that encourage proper family functioning and

quality of life, (b) the effects of children's challenging behavior on the stress levels of their parents and vice versa, and (c) the current, efficacious, family-centered, and culturally responsive intervention studies known to improve parent-child relations. Therefore, the purpose of this article is to examine the effects of PBS training on CLD and disadvantaged preschool children with challenging behavior and their families.

EFFECTS OF PARENT AND CHILD FACTORS ON FAMILY SYSTEM

The development of a young child's challenging behavior is multifaceted and generally has parent-related correlates such as parenting behavior styles like the use of harsh forms of physical discipline (Coolhan, McWayne, Fantuzzo, & Grim, 2002) and lack of parental involvement (Fantuzzo, Tighe, McWayne, Davis, & Childs, 2002) as well as other variants (e.g., inadequate family interactions, maternal depression, poverty, inadequate child care and other forms of support, poor parent-child interactions, lack of parenting skills, and high levels of parental stress, parental work-family conflicts, and violence exposure) (Anthony, Anthony, Glanville, Nairman, Waanders, & Shaffer, 2005; Fantuzzo & McWayne, 2002; Kennedy & Bennett, 2006). Children who are raised by caregivers with high levels of parental stress are more likely to have low levels of social competence and higher levels of anxiety and aggression than those with families with less stress. Moreover, boys have been found to be more affected by parental stress than girls.

Several family-related factors may contribute to parenting stress (e.g., the number of hours the father works, the mother's belief regarding the father's parental involvement). For instance, mothers who work outside of the home often experience less parental stress than those who do not. In addition, research shows that parenting stress is a predictor variable for children's internalizing and externalizing behaviors in preschool settings (Anthony, Anthony, Glanville et al., 2005). The social support systems available to families can have variable effects on outcomes

as a result of stressors opposing the family system: Those who have ample family support generally have less stress than those who have less support.

Research suggests that consistent parental stress may lead to harsh discipline of children, which in turn has also consistently been found to be related to increases in challenging behavior in children and parent's lack of alternatives for behavior management. Parental stress has been reported to be related to the use of severe physical discipline techniques, the lack of social competence in children, and high levels of challenging behavior displayed by preschool students within the classroom (Anthony, Anthony, Glanville et al., 2005). Positive behavior support has been found to be a culturally sensitive tool that is socially valid for reducing the challenging behavior of preschool children when there is a strong collaboration in research and practice between families and practitioners (Albin, Dunlap, & Lucyshyn, 2002). However, additional research (particularly experimental studies) is needed that examines the effects of PBS on family (i.e., parental stress levels) and child factors (i.e., challenging behavior) of CLD preschool students who reside in disadvantaged communities.

CURRENT STUDIES

Presently researchers have deemed the *family-centered/family quality-of-life/family-empowerment* models as superior to all other family service models (Turnbull & Turnbull, 2002). These researchers argue that the primary focus of these family support services is for professionals to identify and build upon family strengths while working in partnership with the family, children, and community members who, as reliable allies and stakeholders, assist in supporting and empowering the entire family unit. Hence, they argue that behavioral interventions are considered most effective when families are included as key players and are provided the education and assistance they need to develop their own skills to help themselves and their children.

Family quality-of-life (FQOL) constructs extend family-centered and individual quality-of-

life concepts and include the use of PBS. According to Smith-Bird and Turnbull (2005), "...the construct of family quality of life (a) addresses the needs of family members rather than focusing only on the child or mother-child dyad, (b) addresses the importance of families working in partnership with professionals to address their priority goals, and (c) emphasizes the family's strengths" (p. 174). Moreover, a good family quality of life is described as situations where (a) the needs of the entire family unit are met, (b) family members feel that their life together is pleasing to them, and (c) each family member is provided the opportunity to engage in activities that are worthwhile for him or her (Poston & Turnbull, 2004).

PBS is an effective values-based, and strengths-based, collaborative intervention (Carr et al., 2002; Duda et al., 2004) that can be implemented during a child's early years and throughout the life span (Fox, Dunlap, & Powell, 2002). PBS has also been found to be an effective, evidence-based approach for reducing challenging behavior and promoting significant improvements in quality-of-life outcome variables (Conroy et al., 2005; Duda et al., 2004), especially for preschoolers who have multiple risk factors (i.e., living in poverty or being victims of abuse and/or neglect) (Buschbacher, 2002). Furthermore, parent participation programs, like PBS, are key components to reducing and managing challenging behavior in children. However, limited research currently exists that examines the effects of PBS training for caregivers of preschool children on family outcomes (i.e., parental stress levels).

PURPOSE OF THE STUDY

The purpose of the current study was to implement a pre-postassessment, single-subject, pilot study to test two hypotheses. First, PBS training was hypothesized to decrease parental stress in specific domains of life for CLD family members who reside in urban, low-income, disadvantaged neighborhoods. Second, it was believed that PBS training would expand these families' expertise in managing their children's behavior, and thus increase their parental involve-

ment and partnering experiences with their children's preschool teachers and other stakeholders. Third, the use of PBS was hypothesized to be a socially valid (i.e., helpful and useful), culturally responsive intervention effective at increasing parents' ability to control their children's problematic behaviors (Albin et al., 2002).

The investigators sought to determine whether or not PBS was effective in promoting positive child and family outcomes by addressing the following research questions. First, what are the effects of training disadvantaged urban CLD families to use PBS strategies on positive family quality-of-life outcomes (i.e., lowered parental stress levels)? Second, is PBS training for these families a culturally responsive and socially valid intervention for preschool children with challenging behavior who are at risk for social and academic failure?

The current pilot study was conducted as a part of a larger, federally funded research project (Center for Evidence-Based Practice: Young Children with Challenging Behavior; Catalog of Federal Domestic Assistance [CFDA] No. 84.324Z), which was designed to identify effective preventative and intervention strategies for reducing children's challenging behavior, and thus improve their positive behaviors. The goals and intended outcomes of the present study were accepted by the institutional review board as a part of this study (University of Kansas, ACHE No. 15374).

METHOD

SETTING AND APPARATUS

The targeted early-childhood development center is located in an urban, generally poverty-level to low-income community in Kansas City, Kansas. The center's immediate neighborhood has an increasingly multicultural population. Moreover, local residents report often being faced with risk factors such as complex poverty-related issues and high rates of violence. The center serves infants, toddlers, and preschool children primarily from the local community. It is also used regularly by local early-childhood interventionists

and professionals as a place to meet with families and their children in need of special assistance.

All intervention and assessment sessions were conducted in the early-childhood development center. A laptop computer and Microsoft Powerpoint program were used to highlight salient program features. A Post-It Self-Stick Easel Pad (2.5 by 2.08 ft) was used to record individual responses to these features. In addition, the pad served as a guide to future discussions between trainers and participants about issues of central importance to the intervention program.

TARGET PARTICIPANTS

All family participants designated as primary caregivers of preschool children were recruited from the early-childhood development center. The early-childhood director and all four of the employed preschool teachers of the center were recruited to assist researchers with the implementation of the study. According to the center staff, most of the children enrolled in the program are considered to be on a positive trajectory for both social-behavioral problems and an underprivileged family quality of life. These early-childhood education professionals were excited about the proposed PBS program, and stated that it would definitely behoove all of their students and their families to learn more about the intended behavioral intervention.

Center staff. The center staff worked in partnership with researchers to recruit families interested in participating in the study. This was accomplished by their sending an information sheet regarding the study goals and intended outcomes home with each child enrolled in the center's two preschool classrooms. Another form was also sent home that asked prospective participants to provide researchers with family contact information. The teachers collected the returned forms and provided them to the researchers. Teachers also followed up with families by reminding them to participate and return all requested forms. The preschool teachers who participated received monetary incentives to serve as a liaison between the target families and researchers.

The center staff was offered two, free, full-day PBS training workshops (held on Saturdays from 8:00 a.m. until 3:00 p.m.) in return for their assistance. A continental breakfast and lunch were provided to the staff and researchers, who ate together and had additional discussions. The workshops were designed to provide staff with an overview of the study goals, outcomes sought, and intervention strategies being implemented by target families with their children.

Target families. Fourteen families were recruited from the center to receive PBS training. Eight family members did not attend the intervention sessions and did not participate in the posttest assessment session despite frequent requests. Therefore, their data were not assessed or reviewed in this study. Only six families completed both assessment sessions and the majority of the intervention sessions (see Table 1 for a review of sessions attended by each participant).

Six family members of preschool children with challenging behaviors participated in the intervention study. These participants, including five maternal parents and one grandmother, represented a wide range of ethnic backgrounds. One father attended a session with the mother of his child but did not return thereafter. No other fathers agreed to participate despite several requests from the researchers. All family participants were provided fictitious names for the purpose of the study.

Marita is a Latino American mother who stated that she was in a "common-law relationship" with her significant other. She reported having difficulties in her parenting of one of her two daughters. More specifically, she stated that the problem with the daughter's behavior was mainly that she was overly independent, in that she wanted to make all decisions for herself and rarely did the actions requested by her mother. Case in point, the daughter generally did not want to go to her bed at night during her scheduled bedtime and would display problem behavior (i.e., loud and constant crying and getting out of her bed repeatedly throughout the night). The daughter also refused to eat when she did not want to do so (i.e., at dinner time). Marita stated that her daughter fought often over her shared

TABLE 1**THE TOTAL DAYS AND PERCENTAGES OF INTERVENTION SESSIONS ATTENDED BY FAMILIES**

| <i>Family Member</i> | <i>D1</i> | <i>D2</i> | <i>D3</i> | <i>D4</i> | <i>D5</i> | <i>D6</i> | <i>D7</i> | <i>D8</i> | <i>D9</i> | <i>D10</i> | <i>D11</i> | <i>D12</i> | <i>Total Sessions (N = 12)</i> |
|----------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|------------|------------|--------------------------------|
| Marita | * | * | * | | * | | * | | * | * | | | 7 (58%) |
| Martha | * | * | * | * | * | * | * | * | * | * | * | * | 12 (100%) |
| Tamika | * | | * | | | | * | | * | | * | | 5 (42%) |
| Tamara | * | * | * | * | * | | * | | | * | * | * | 9 (75%) |
| Ann | | | | | | | | | | | * | * | 2 (17%) |
| Sue | | | | | | | | | | | * | * | 2 (17%) |

space in the bedroom with her sister. She reported being stressed by the high level of refusals from her daughter in response to her requests both big and small as well as the constant problems between her daughters. Marita stated that her income level was between \$20,001 and \$30,000 for a total of four family members.

Martha is also a Latino American who reported that she was married during the time of the study. She expressed that she struggled to deal with the head-banging behavior of one of her two sons. According to Martha, when the target child was asked to do something by his teachers and family members, he would fall completely backwards, slamming his entire body onto the floor in the home as well as onto the concrete sidewalks outdoors. After the initial blow to the head from the fall, he would continue to lift his head and bang it down to the ground until an intervention occurred. Martha was not sure why this problem occurred so frequently. She stated that he would do it during times when he was asked to do something he liked. Other difficulties reported were that this child did not want to sleep through the night in his own room. Moreover, he was often seen playing with items that he knew that he should not have, such as the knives from the kitchen drawer. This mother stated that her income level was between \$10,001 and \$20,000 for a total of four family members.

Tamara is an African American who reported that she was single during the time of the study. Her income level was the lowest of all six participants (\$5,001–\$10,000). She described her daughter as recently showing an unusually high level of defiant and aggressive behavior, and felt that this was due to recent abuse and neglect by the child's father. Tamika reported that this child would often hit other children who did not play in the manner that she preferred. In addition, if she did not want to perform a particular task that her mother requested, she would not do so but would boldly engage in what she chose. For example, the daughter did not like to go to bed at her bedtime, which was 8:30 p.m. Rather, she preferred to stay up late and watch television. She would watch the television in her own room or with her mother in the living room instead of her bedroom, if she persisted with whining and crying. The child's father lived at a different residence and reported to researchers that their child did not exhibit these behaviors on the weekends at his home. The father reported that the reported difficulties with their child were due to the mother's drug and alcohol use and lack of patience. Tamika adamantly denied the father's claims.

Tamara is an African American mother who was married but separated from her Asian American husband. She stated that her son was a generally obedient child with a high level of social competence. However, the mother reported that the child did not like to do homework shortly

after his arrival home, and would often become extremely fussy despite consolation (i.e., crying about the situation for an extended period of time). The mother stated that he preferred to have play time directly after school. She stated that her income level was between \$10,001 and \$20,000 for a total of three family members.

Ann is a European American mother who was single at the time of the study. She stated that her daughter enjoyed staying up against her mother's wishes late into the night, and consequently, she was grumpy and unmanageable in the morning. As a result, both of them often experienced unpleasant feelings and interactions most of the day while at work and school. The mother indicated that the child's father was African American, had been incarcerated on a couple of occasions or more, and was not a part of their lives currently. She identified the child as an African American. Ann stated that her income level was between \$20,000 and \$30,000 for a total of four family members.

Sue is a European American grandmother who stated that she was single at the start of the study, although she reported that she and her boyfriend cohabitated. Due to absenteeism and personal problems in the lives of the parents, Sue obtained legal guardian rights to her two grandsons. Sue stated that both of her grandchildren were highly active children. However, the target grandson, who was in preschool, required more constant attention, reprimanding, supervision, and discipline from his caregivers than the other child. For example, she described a particular night that she was sleeping and woke to find that he had gone into her bathroom and spread feces on all of the surfaces (i.e., the toilet, walls, sink, floor, bathtub, and mirror). When asked why the child would not provide an answer. Moreover, this child enjoyed finding and lighting matches and nearly started a fire on several occasions. Sue stated that this was just a few examples of her grandson's challenging behavior, which ails her. She stated that her income level was between \$20,000 and \$30,000 for a total of four family members.

MEASURES

Four measures were implemented. Three family demographic and background measures were

administered to ascertain salient identifying and family background information that may further serve to guide considerations for culturally responsive behavior support. Two of these assessments were administered to identify important demographics of the families: The Enrollment, Contact, and Monitoring Form (ENROLL) and the Child Measure: Family Profile—Wave 1 (WAVE). A background assessment of the quality of family support (Family Support Scale) (FSS) was implemented to monitor family background information regarding the availability and usefulness of family support systems currently available and sought after by participants. This measure was implemented during the pre- and postassessment sessions.

One stress-related outcome measure, the Parenting Stress Index (Abidin, 1983) (PSI), was implemented during the pre- and postassessment phases of the study to determine whether or not PBS is an efficacious, family-centered behavioral support intervention. More specifically, the measure was used to assess the effects of PBS training for families of preschoolers who are at risk and is multicultural on both child and family factors that are known to lead to high parental stress levels and a dysfunctional family unit. The PSI was designed to be used as an early screening tool to identify parent and child interrelational systems that are under stress, which can lead to the development of dysfunctional parenting behaviors as well as possible behavioral problems in the child.

ENROLL. The ENROLL form was used to identify the target child's ethnicity; to determine whether or not the mother was a teenager during the birth of the child, which may indicate higher levels of stress; and to identify and track enrollment information (i.e., address and telephone number). This measure was administered during the pre- and postassessment phases of the study.

WAVE. This 159-item measure was used by researchers prior to the intervention implementation to develop a family profile of the participants and their children. More specifically, the WAVE assessment was used to identify the demographic

information of the family (e.g., family's names, respondent's relationship to the child, early health care information of the parent and child, and the educational and work background of the caregivers). Also, the WAVE was used to examine two early-childhood family factors: First, whether or not the target child ever received a formal Individual Family Service Plan (IFSP) or Individual Education Plan (IEP); and second, if the child had received early-childhood intervention or special education services to improve his or her physical development, language, social adjustment, or behavior problems in any setting. This measure was only administered during the preassessment phase of the study.

PSI. The PSI is a screening tool based on a theory that the overall level of parental stress is considered a function of key parental and child characteristics as well as situational factors that are directly associated with the salient responsibilities attached to parenting. It consists of 120 items and includes an optional 19-item Life Stress section. Parents are asked to respond by marking the response that best captures how they feel: SA (*strongly agree*), A (*agree*), NS (*not sure*), D (*disagree*), and SD (*strongly disagree*). Some items have different answer formats. The Total Stress Score helps researchers and professional to make judgments as to whether additional professional interventions are warranted to improve the functioning of the family system. Parents who earn a Total Stress Score raw score at or above 260 are considered to be in critical need of a referral for professional consultation.

Normative data research provides support for sound PSI psychometric properties, particularly for those related to the characteristics of the selected target participants of this study (Anthony, Anthony, Glanville et al., 2005). For instance, Abidin (1983) stated that research has shown that the PSI is a reliable measure (i.e., test-retest reliability and internal consistency). Moreover, he provided validity research that supports its use with people (a) with behavioral problems, (b) who are culturally and linguistically diverse, (c) who are considered to belong to at-risk families, and (d) who have particular parental characteristics. Moreover, normativeness was established for

parents of children who are 1 month to 12 years of age and who have at least a fifth-grade education.

The PSI was completed by each family member to examine whether or not positive changes occurred for the family unit as a direct result of the PBS training. Analyses of three key components related to the parent-child functioning system (i.e., child and parental contributions to stress and an overall comprehensive index of stress) that promote parental stress were completed. This measure was administered during the pre- and postassessment phases of the study.

Child contributions to an inadequate family unit. Six subscales were measured to examine the contributions that the child makes toward a stressful parent-child relationship. They were distractibility/hyperactivity (DI), adaptability (AD), reinforces parent (RE), demandingness (DE), mood (MO), and acceptability (AC). High scores indicated that the child may have particular emotions and behaviors that serve to deter parents' abilities to properly function.

Parental contributions to an inadequate family unit. Seven subscales were measured to determine the contributions that the parents make toward a stressful parent-child relationship. These indices were competence (CO), isolation (IS), attachment (AT), health (HE), role restriction (RO), depression (DP), and spouse (SP). High scores indicated that the parent may possess qualities that obstruct the adequate functioning of the parent-child relationship.

Comprehensive levels of parental stress. Two indices were measured to identify the overall levels of stress in the parent-child relationship. The Total Stress score examines the combination of both the child and parent contributions to a stressful parent-child relationship. A score of 260 or more indicates urgent need for parents to seek professional help, as the parent-child relationship is considered to be at risk for the development of dysfunction. High Life Stress scores indicate that the parent may be experiencing high levels of situational circumstances (i.e., the loss of a job) that he or she has no control over. Moreover, high

Life Stress scores serve to intensify overall levels of stress.

PROCEDURE

A pre-postassessment across a 1-year, single-subject study was conducted. There were a total of 12 workshop sessions. Family interview sessions were generally conducted as a part of the first and last intervention session. Eleven intervention sessions were conducted for approximately 2 hours per session. One additional session lasted for 6 hours. The total number of intervention hours offered to families was about 28.

Participants generally met in the resource/lunchroom area of the center once a month, on Tuesdays (4:00 p.m. to 6:00 p.m.). Sessions were conducted in an intimate manner: The trainers and family members sat around a conference table facing one another, and each person was asked to share about their use and perceived effectiveness of PBS strategies since the last session. Dinner was provided to families, their children, and the teachers and staff who stayed after the center closed to support this study. Child-care provisions during intervention sessions were offered to all families participating in the study.

Trainers and each participant were assigned a Pyramid Parent Training/Operation Positive Change (2001) curriculum handbook to be used during each intervention session. Markey et al. (2002) described how this curriculum model was developed by the Pyramid Parent Training Community Parent Resource Center in New Orleans, Louisiana and how it is to be implemented. They stated that this family-centered curriculum allows CLD families who are disadvantaged to use PBS (a) to empower them to participate skillfully in the behavior support planning process of their children, (b) to collect child behavior data, and (c) to conduct a functional assessment of their children's challenging behavior patterns. In addition to the curriculum handbook, participants were also provided pens, paper, and posters to carry out the tasks at hand during the sessions and at home. Participants were not asked to be responsible for

these items, but were simply encouraged to attend each session.

Trainers approached and interacted with participants in a manner aimed at enhancing family quality-of-life outcomes (Poston & Turnbull, 2004). For example, the primary focus of all intervention sessions was on the mother-child relationship to the child's challenging behavior instead of solely this behavior. Moreover, the family members were asked to identify and achieve personal and culturally appropriate goals for themselves, their children, and their entire family. In addition, all sessions focused on the strengths of the family members, their children, and other family members that may be utilized to establish a positive and gratifying family unit. Also, each family member was encouraged to search actively and independently for other forms of support that may help in their family's areas of need.

The curriculum handbook, which identified seven PBS strategies for promoting positive child behavior, was reviewed collaboratively among the families and trainers in a nonformal manner. Family members were asked to role-play during intervention session times to practice strategies, and also to use the strategies at home and in the community when their children displayed challenging behavior. Moreover, they were encouraged to try each of seven PBS strategies with their children and report on what worked and what did not work. The seven PBS intervention strategies taught to families are operationally defined in Table 2.

Participants were also taught to use a simplified functional behavioral assessment (FBA) to identify possible reasons why their children exhibited particular challenging behaviors repeatedly over time. Family members was asked to practice conducting FBAs at home with their children and share what they found about their children's behavior with the other research participants. In turn, all of the other participants were asked to provide feedback to the family member reporting (i.e., offering a suggestion to use a different strategy that may more effectively promote child positive social behavior than the one implemented). Trainers also participated by

TABLE 2**SEVEN POSITIVE BEHAVIOR SUPPORT STRATEGIES OPERATIONALLY DEFINED**

| <i>PBS Strategy</i> | <i>Operation Definition</i> |
|---------------------|--|
| Reinforce | Provide the child with positive reinforcement, or rewards, for their positive behavior displayed. |
| Ignore | Whenever possible, ignore child challenging behavior. |
| Redirect | Redirect the child's attention away from stimulus prompting the challenging behavior to occur. |
| Change environment | Alter the physical environment of the child. |
| Increase routines | Develop family schedule that will promote predictable activities and behaviors. |
| Offer choices | Allow the child to make decisions by allowing him or her to select between two or more choices determined by the parent. |
| Teach skills | Teach the child replacement skills that they can use instead of the negative ones previously used. |

sharing information regarding the challenging behavior of their children.

RESULTS

The ENROLL postassessment results indicated the demographic information of the family members did not remain the same as the preassessment findings (e.g., some families had discon-

nected home telephone numbers or a lack of minutes available to use on their mobile telephone numbers). The WAVE results are presented in Table 3. In addition, 66% (four of six) of the participants reported an increased presence of useful support services available to them and their families (see Figure 1).

Moreover, all of the participants provided anecdotal reports indicating that their children

TABLE 3**FAMILY PARTICIPANT DEMOGRAPHIC INFORMATION**

| <i>Participant's Name</i> | <i>Relationship to Child</i> | <i>Teen Mom</i> | <i>Age of Child</i> | <i>Early-Intervention Services</i> |
|---------------------------|------------------------------|-----------------|---------------------|------------------------------------|
| Marita | Mother | ✓ | 5 | |
| Martha | Mother | ✓ | 3 | ✓ |
| Tamika/John | Mother/father | | 4 | |
| Tamara | Mother | | 4 | ✓ |
| Ann | Mother | | 5 | ✓ |
| Sue | Grandmother | | 3 | |

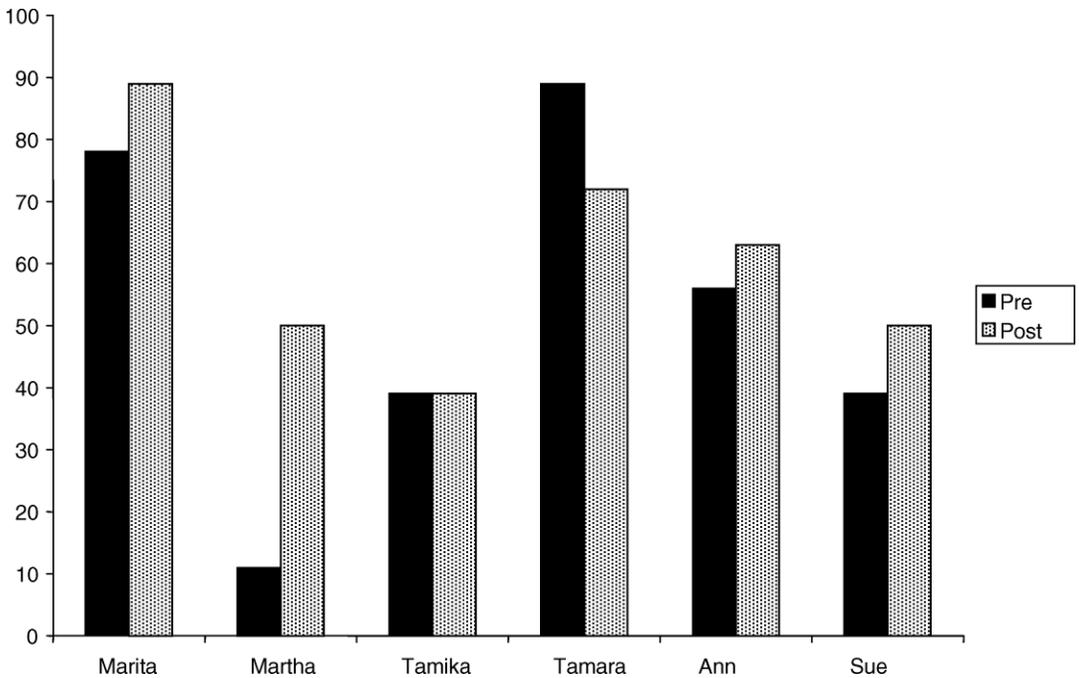


Figure 1
FAMILY SUPPORT SCALE FAMILY SCORES

exhibited less of the challenging behavior reported during the beginning of the study. They stated that after receiving the PBS training, they (a) felt more capable of using strategies to promote their child's positive behavior while more effectively controlling child challenging behavior, (b) experienced more enjoyable interactions with their children, and (c) believed that their child's problem behavior had lessened to a certain degree.

PARENTING STRESS INDEX RESULTS

The PSI pre-postassessment results indicated that the PBS intervention was effective at lowering 67% (four of six) of the target family members' levels of child and parental stress-related factors, which previously had served to diminish their efficient family functioning. The subscale categories results indicated improvements for at least 67% (four of six participants). Results are described under three categories, including both child and parental contributions to parental stress and an overall assessment of stress.

Child domain. Results indicated the PBS intervention was effective at improving 67% (four of six) of the PSI subcategories under the child domain: AD, RE, DE, and MO. The intervention was effective at reducing all (six of six) of the AD scores, 67% (four of six) of the RE and MO scores, and 83% (five of six) of the DE scores. No differences were found for the DI and AC subcategory scores.

Parent domain. Results indicated the PBS intervention was effective at improving 83% (four of seven) of the PSI subcategories under the parent domain: CO, IS, AT, and RO. The intervention was effective at reducing 83% (five of six) of the AT scores and 67% (four of six) of the CO, IS, and RO scores. No differences were found for the HE subcategory. Only 17% (one of six) of the DP scores and 33% (two of six) of the SP scores indicated a positive difference.

Comprehensive stress. Sixty-seven percent (four of six) participants had the same or improved postassessment total stress scores. Thirty-three

TABLE 4**FAMILY REPOSSES REGARDING THE EFFECTIVENESS OF POSITIVE BEHAVIORAL SUPPORT STRATEGIES TO REDUCE THEIR CHILD'S CHALLENGING BEHAVIOR**

| <i>Strategy</i> | <i>PBS Strategies for Families</i> | <i>Family Code 1</i> | <i>Family Code 2</i> | <i>Family Code 3</i> | <i>Total for All Families (N = 3)</i> |
|-----------------|--|----------------------|----------------------|----------------------|---------------------------------------|
| 1 | Positive reinforcement | Yes | Yes | Yes | 3 |
| 2 | Ignore problem behaviors | Yes | No | Yes | 2 |
| 3 | Redirect child's attention | Yes | No | No | 1 |
| 4 | Change environment | Yes | Yes | Yes | 3 |
| 5 | Increase predictability and scheduling | Yes | Yes | Yes | 3 |
| 6 | Offer choices | Yes | Yes | Yes | 3 |
| 7 | Teach new skills | Yes | Yes | Yes | 3 |
| Totals | | 7 | 5 | 6 | 18 |

percent (two of six) family members had a significant increase in their total stress levels. Eighty-three percent (five of six) of the participants had the same or improved life stress scores with one participant having a postscore of 0. Only one participant had a substantial increase in their life stress.

SOCIAL VALIDITY ASSESSMENT RESULTS

Although no direct or standardized measure of family quality of life or challenging child behavior was implemented, anecdotal parental reports were obtained. Fifty percent (three of six) of intervention families who attended PBS training sessions completed a questionnaire about their perceptions regarding the intervention effectiveness (see Table 4), their current and future implementation of the PBS strategies (see Table 5), and their satisfaction with the training and intervention results as well as their desires to suggest PBS training to other families of children with challenging behavior (see Table 6). Specifically, families were asked about the use of seven PBS strategies (see Pyramid Parent Training/Operation Positive Change, 2001, pp. 9–10). One parent was unavailable for questioning due to complication regarding a custody battle for her

child, which precluded her participation on this day. The other two parents did not report on the reasons why they were absent the day of assessments or unavailable thereafter.

Results illustrated in Table 4 indicated that all of the families assessed agreed that four of the seven PBS strategies were effective at reducing their children's challenging behavior while facilitating their good behaviors. Although 66% (two of three) of the families reported that "ignoring the problem behaviors" was helpful, one parent disagreed and added that this strategy promoted more frequent occurrences of her child's challenging behavior. Only 33% (one of three) of the participants reported the strategy of "redirecting the child's attention" as a viable intervention, whereas the other two parents considered it to be a negative way of deceiving their children.

Additional PSI results demonstrated that all (100%) of these families stated that they implemented PBS strategies at home daily to promote positive social behaviors in their children and that they would continue to do so. They also reported that they used these strategies to deal with their children's challenging behaviors across various settings like the home, school, and community. See Table 5.

TABLE 5**FAMILY RESPONSES REGARDING THEIR CURRENT AND FUTURE USE OF POSITIVE BEHAVIOR SUPPORT WITH THEIR CHILDREN WITH CHALLENGING BEHAVIOR**

| <i>Strategy</i> | <i>PBS Strategies for Families</i> | <i>Family Code 1</i> | <i>Family Code 2</i> | <i>Family Code 3</i> | <i>Total for All Families</i> |
|-----------------|--|----------------------|----------------------|----------------------|-------------------------------|
| 1 | Positive reinforcement | Yes | Yes | Yes | 3 |
| 2 | Ignore problem behaviors | Yes | Yes | Yes | 3 |
| 3 | Redirect child's attention | Yes | Yes | Yes | 3 |
| 4 | Change environment | Yes | Yes | Yes | 3 |
| 5 | Increase predictability and scheduling | Yes | Yes | Yes | 3 |
| 6 | Offer choices | Yes | Yes | Yes | 3 |
| 7 | Teach new skills | Yes | Yes | Yes | 3 |
| Totals | | 7 | 7 | 7 | 21 |

Results also showed that all of the family participants (100%) acknowledged that they were satisfied with the PBS training. Moreover, they all agreed that they would recommend the use of PBS strategies to another family or friend, including those who are CLD, currently dealing with the stressors of raising a child with challenging behavior. See Table 6.

FIDELITY OF TREATMENT ADMINISTRATION

Two PBS administrators (first and second authors) provided training in positive behavior support to families together. The second author trained with a larger research project to become reliable in the implementation of this program.

TABLE 6**FAMILY RESPONSES REGARDING THEIR SATISFACTION AND DESIRE TO RECOMMEND POSITIVE BEHAVIOR SUPPORT TRAINING TO OTHER FAMILIES OF CHILDREN WITH CHALLENGING BEHAVIOR**

| <i>Strategy</i> | <i>PBS Strategies for Families</i> | <i>Family Code 1</i> | <i>Family Code 2</i> | <i>Family Code 3</i> | <i>Total for All Families</i> |
|-----------------|--|----------------------|----------------------|----------------------|-------------------------------|
| 1 | Positive reinforcement | Yes | Yes | Yes | 3 |
| 2 | Ignore problem behaviors | Yes | Yes | Yes | 3 |
| 3 | Redirect child's attention | Yes | Yes | Yes | 3 |
| 4 | Change environment | Yes | Yes | Yes | 3 |
| 5 | Increase predictability and scheduling | Yes | Yes | Yes | 3 |
| 6 | Offer choices | Yes | Yes | Yes | 3 |
| 7 | Teach new skills | Yes | Yes | Yes | 3 |
| Totals | | 7 | 7 | 7 | 21 |

TABLE 7**FAMILY RATINGS OF TRAINER NO. 1 REGARDING THE USEFULNESS OF POSITIVE BEHAVIOR SUPPORT TRAINING WITH THOSE WHO ARE CULTURALLY AND LINGUISTICALLY DIVERSE**

| <i>Evaluation Question</i> | <i>Family Code 1</i> | <i>Family Code 2</i> | <i>Family Code 3</i> | <i>Family Code 4</i> | <i>Percentage for Families (N = 4)</i> |
|--|----------------------|----------------------|----------------------|----------------------|--|
| 1. Trainer provided useful information | Yes = 1 | Yes = 1 | Yes = 1 | Yes = 1 | (4/4) = 100% |
| 2. Trainer's style made information understandable | Yes = 1 | Yes = 1 | Yes = 1 | Yes = 1 | (4/4) = 100% |
| 3. PBS training appropriate for families with a child with challenging behavior | No = 0 | No response | Yes = 1 | Yes = 1 | (2/4) = 50% |
| Family's overall rating of the trainer (1 = poor; 2 = okay; 3 = good; 4 = excellent) | Excellent = 4 |

She then trained the first author. All participants were asked to attend all training sessions to ensure treatment fidelity. After the training session ended the participants were asked to discuss how well they identified with the trainers and the importance of the materials and results of the intervention. Results for Trainer 1 are presented in Table 7 and those for Trainer 2 are presented in Table 8.

DISCUSSION

Preschool programs unequivocally benefit children who are culturally and linguistically diverse and live in low-income or poor communities. These programs often serve as shields against those risk factors that may thwart their typical development (e.g., Spanish-speaking children are able to learn English and families are able to receive the help that they need in raising their children). However, preschool programs are not independently sufficient for ensuring positive

child development; rather, family members' involvement in this programming is mandatory to achieve this goal (McWayne & Owsianik, 2004). Parents who have high levels of stress generally do not participate in preschool programming (e.g., parental training sessions) offered to them and their children. Consequently, early-childhood, family-centered researchers and practitioners are faced with challenges to identify and implement evidence-based research and practices that builds upon these students' and families' strengths (Park & Turnbull, 2001).

Years of scholarly research suggests that the challenging behaviors of every preschool student need to be systematically assessed and properly addressed at the onset of problems to prevent subsequent and more severe dysfunctions (e.g., criminality, social rejection, substance/tobacco/alcohol abuse, unemployment, mental disorder, delinquency, and school failure) (McMahon, Washburn, Felix, Yakin, & Childrey, 2000; Webster-Stratton, Reid, & Hammond, 2001). Moreover, research, legisla-

TABLE 8**FAMILY RATINGS OF TRAINER NO. 2 REGARDING THE USEFULNESS OF POSITIVE BEHAVIOR SUPPORT TRAINING WITH THOSE WHO ARE CULTURALLY AND LINGUISTICALLY DIVERSE**

| <i>Evaluation Question</i> | <i>Family Code 1</i> | <i>Family Code 2</i> | <i>Family Code 3</i> | <i>Family Code 4</i> | <i>Average for All Families</i> |
|--|----------------------|----------------------|----------------------|----------------------|---------------------------------|
| 1. Trainer provided useful information | Yes = 1 |
| 2. Trainer's style made information understandable | Yes = 1 |
| 3. PBS training appropriate for families with a child with challenging behavior | No response | No response | Yes = 1 | No response | Yes = 1 |
| Family's overall rating of the trainer (1 = poor; 2 = okay; 3 = good; 4 = excellent) | Excellent = 4 | Good = 3 | Good = 3 | Excellent = 4 | Very good = 3.5 |

tion, and practice underscore the vital importance of empowering families, particularly those who are CLD, to manage their children's behaviors successfully.

Current findings of this study provide evidence of the efficacy of PBS with CLD families and their young children. The results contributed to a more lucid understanding of family outcomes of PBS training and the social validation of this procedure with mothers of at-risk preschool children who are CLD and reside in low-income urban areas. This was accomplished by examining the effects of PBS on the parental stress levels, anecdotal parental reports of child behavior, and social validity ratings. In summary, the findings provide additional support for PBS as an efficacious, culturally sensitive, socially valid, new-paradigm intervention for all families and their preschool children. Moreover, they show that families continue to be willing collaborators in research and practice of PBS despite their stress levels (Albin et al., 2002; Lucyshyn, Dunlap, & Albin, 2002).

LIMITATIONS

This study had several limitations. First, it had a small sample size of only six participants. Second, despite several requests and reminders from the researchers, no family members other than mothers agreed to participate in the study, except for one father, who attended one session with his girlfriend. Third, attendance for all of the selected participants, except one participant who attended all sessions, was sporadic, which may have affected treatment fidelity variables. This is not surprising, as it has been reported that families with high levels of parental stress, low levels of family income, and a high level of socioeconomic disadvantage are more likely to miss an intervention session than those who are not (Andra & Thomas, 1998). Lucyshyn, Blumberg, and Kayser (2000) has suggested three strategies for overcoming intervention barriers by improving the quality of support services offered to families who have children with problem behaviors (e.g., culturally competent professionals offering family-centered PBS services within

the home setting during a time that works best for the family). Fourth, stress levels of the children of these mothers were not measured to determine whether or not the PBS training of their parents actually lowered their stress levels as well. Fifth, a direct and standardized measure of family quality-of-life outcomes (The Beach Center on Disability, 2003) was not implemented. Sixth, all barriers were not overcome, as language and cultural communication problems persisted due to different dialects of Spanish of the school professional, research assistants, and families. Seventh, participants were not formally assessed as to reasons for their lack of attendance during treatment sessions, despite their agreement to participate during the review of the study's consent form.

Increases in parental stress paired with a low socioeconomic status (SES) have been found to be primary reasons for poor therapy attendance (Andra & Thomas, 1998). On the contrary, logistical problems (i.e., inconvenient session times, an overwhelming family schedule) are key barriers to parental involvement of African Americans in therapy sessions, rather than family dysfunction, parental stress, depression, and low SES. Families who believed that their children were in direct need of the proposed services were more likely to attend intervention sessions than those who did not feel that the services would be useful.

FUTURE RESEARCH

Many of the successes/challenges to service provisions facing 21st-century early-childhood family-systems researchers and professionals may have as a nucleus their decisions regarding the new paradigm as outlined by Turnbull and Turnbull (2002): Those who utilize this model may be more capable of providing socially valid services to urban, culturally and linguistically diverse families and their young children with and without disabilities that facilitate the attainments of their idiosyncratic goals than those implementing services based on the old paradigm. New-paradigm researchers are called to continue to address family-centered and family quality-of-life/family-empowerment issues (i.e., methods to

lower parenting stress to improve family functioning).

High levels of parental stress have been shown to be related to poor social-behavioral outcomes in early childhood that, if not corrected, continue to progress. For example, Anthony, Anthony, Glanville et al. (2005) provide support for previous findings that parental stress is related to teachers' ratings of child social competence, and their internalizing and externalizing behavior displayed in school. Consequently, there is a need for researchers and professionals to continue to use PBS training to modify child outcomes. It is equally important for researchers and professionals to identify and intervene with other family-outcome variables.

Although this study provided some support for positive behavior support training as effective for lowering variables related to the stress of parenting, replication studies that examine the causal effects of PBS training on members of the entire family unit (i.e., fathers, grandparents, siblings), and not simply mothers and their children, continue to be warranted. Additional early-childhood, family-systems research that addresses family outcomes of individuals (i.e., fathers) other than the children's mothers is needed. Moreover, future research needs to examine factors that may assist with promoting parental participation in intervention sessions aimed at improving family quality of life for people who are culturally and linguistically diverse.

Successful social, educational, and learning models for young children must continue to include culturally sensitive approaches combined with evidence-based PBS techniques to instigate healthy and positive emotional and social behaviors of both children and their CLD families (Utley et al., 2002). Additional research is needed on the effects of positive behavior support on preschool child and family outcomes. Family-specific outcomes that provide empirical support for an enhanced quality of life for the entire family unit are also important. Further studies need to examine the effects of PBS on family members other than mothers, such as fathers, siblings, other family members, and close friends to the family. Moreover, this query should extend

to other community settings the families are found to frequent (e.g., churches) (Poston & Turnbull, 2004) to help identify individual family support that may be instrumental to the facilitation of child positive social behaviors, substantially lower levels of parental stress, and other factors that promote a high quality of life (i.e., resiliency factors).

CONCLUSIONS

Data reports from this study show that positive family and child outcomes were evident. Parental stress was lowered for most of the intervention participants after the implementation of the positive behavior support training sessions. All of these CLD families reported that the challenging behavior problems (i.e., head banging) presented prior to the study had either completely stopped or were substantially lower and more manageable after the training. Moreover, these parents commonly reported that their overall family quality of life had improved. They strongly expressed a reduction in their child's constant rates of particular problem behavior and a perceived enhanced skills in promoting their children's good behaviors and preventing their bad behaviors. In addition, the parents reported that they were now capable of handling problem behavior without necessarily using more harsh forms of discipline (i.e., spanking them).

Identifying and providing evidence-based, early-childhood education, care, prevention and intervention services for CLD families and their children, services that are family centered, family empowering, and culturally responsive and promote a rewarding family quality of life, is a primary issue facing researchers, professionals, and legislators of the early 21st century (Lucyshyn et al., 2002; Turnbull & Turnbull, 2001). It has been shown that the development of comprehensive and effective family, school, and community systems, and thus partnerships, is best for producing superior family systems as well as positive academic and social outcomes for children with and without disabilities (Summers, Gavin, Hall, & Nelson, 2003). A key component to this three-tiered collaborative approach, which cannot be disregarded if the approach is to be

successful, ensures that all of the various family members served be afforded with essential and requested information, training, resources, and support that will ensure their viability and involvement as stakeholders and parents.

This comprehensive new-paradigm, family-centered, and culturally sensitive approach may facilitate the synergy among well-equipped families; combined with high-quality early-childhood education, prevention, intervention, and care services and programming; plus the availability and usefulness of local community agencies, resources, and support systems (i.e., faith-based institutions). Moreover, this synergism across students' life spans may serve (a) to support the subsequent positive physical, emotional, and mental health and social-behavioral development of all preschool children with varying abilities and their families; (b) to reduce ethnic, racial, and socioeconomic gaps between CLD children and others in the areas of school readiness and in subsequent school success and completion, testing, placement, and programming (Magnuson & Waldfogel, 2005); (c) to close the gap that stands between an understanding of federal educational mandates (i.e., the NCLB and IDEA) and the implementation of related national educational policies in schools, which have been found to promote more positive and culturally sensitive disciplinary techniques for child management (i.e., schoolwide positive behavior support) (Fox & Little, 2001; Jones, Caravac, Cizek, Horner, & Vincent, 2006; Sailor, Zuna, Choi, Thomas, & McCart, 2006) and reduce or eliminate negative forms of school discipline (i.e., zero tolerance, frequent office referrals, school expulsion) (Wald, 2001); and (d) to improve the social conditions of citizens across communities nationwide.

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AUTHORS' NOTES

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