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# The Role of Family and Cross-Setting Supports to Reduce Impairment and Promote Success

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## 2.1 Introduction

Families provide an invaluable resource in assessing and supporting the needs of individuals experiencing impairment. Impairment manifests itself in many ways within the family and has an impact on family functioning, routines, activities, and relationships between family members. However, all manifestations are contextually and developmentally relevant. An ecological perspective provides an alternative conceptualization of impairment to a biological, medical model. This framework extends the focus of assessment and intervention beyond the individual to other contexts within which the individual interacts. Families have a great deal of knowledge and expertise regarding an individual's level of behavioral, social, and academic functioning in multiple settings. In addition, development is an ongoing process and the role of families in assessing and reducing impairment must also consider the context of that individual across the life span. Life course theory provides a way to conceptualize impairments based upon an individual's developmental needs, resources, and supports available.

There are several benefits for partnering with families during the assessment process and the development and implementation of support plans. First, incorporating information from family members during the assessment process provides for greater conceptualization of impairment and how it may manifest during different family routines. It also allows professionals to gain an understanding of the family's

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strengths, needs, and available resources. Second, family members can greatly enhance the intervention development process. Understanding family roles, expectations, and routines allows for a contextual fit between interventions and the family environment. Third, family members can also play an essential role in the implementation of support plans. Developing a shared ownership for intervention implementation with the family can enhance treatment integrity and generalization of treatment effects across settings. Fourth, long-term support programs for individuals with impairment require extensive involvement of family members. Developing a professional–family partnership throughout the assessment and intervention process can promote empowerment within the family to become more self-sufficient in providing support and eliciting additional resources.

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## **2.2 Overview of Research**

The role of families in the process of assessment and intervention development has long been the interest of research endeavors in the area of impairment. This chapter provides a review of research that explores the relationship between impairment and family functioning, as well as the role of family involvement in comprehensive assessment and support development.

### **2.2.1 Impairment and Family Environments**

Families represent extremely complex systems; all families have strengths and needs, and all families, at times, function well and poorly. The presence of impairment provides new challenges to all members of the family and affects many different family aspects. Conoley and Sheridan (2005) identified five different forms of family stressors related to impairment that may be experienced by families: multiple treatment settings, financial stress, effect of impairment on siblings, managing support networks, and family dysfunction. Not all family stressors fall within these categories, but these five represent a solid framework of stressors to assess and manage. They are described in detail below.

#### **2.2.1.1 Multiple Treatment Settings**

One of the greatest stressors for families supporting an individual with impairment is the extensive number of settings within which assessment and treatment may take place. Many impairments require the assistance of a specialist to provide a comprehensive evaluation. Often these specialists are not located within immediate proximity of the family (Jackson & Haverkamp, 1991). In addition, the assessment process can be lengthy and can require multiple professionals and specialists in different disciplines and settings (Sloper & Turner, 1992). Thus the assessment and eventual treatment process requires a great deal of organization and coordination between services. This presents the family with the responsibility of rearranging their own schedules, paying traveling expenses, and expending their personal

resources of time and energy. Added to this is the consideration that supports to address impairment are often implemented across several environments and include a team of service providers (e.g., physicians, social/case workers, physical therapists, occupational therapists, psychologists, and counselors). Many impairments also involve a variety of treatment modalities, such as behavioral management, psychopharmacologic therapy, family therapy, and educational interventions (Gellerstedt & Mauksch, 1993).

### **2.2.1.2 Financial Stress**

Families requiring services resulting from impairment also tend to experience multiple situations that may increase financial stress (Mactavish, MacKay, Iwasaki, & Betteridge, 2007). The cost of providing services for families, especially those receiving services from multiple agencies, can place a strain on the family's economic viability. Traveling expenses, uncovered medical expenses, legal expenses, counseling expenses, rehabilitation expenses, and environmental modifications (e.g., alterations to the home) are all part of the picture for many families (Conoley & Sheridan, 2005). However, preliminary research indicates that a reduction of quality of life due to available financial resources may be experienced more by mothers than fathers of a child with impairment (Wang et al., 2004).

### **2.2.1.3 Effects on Siblings**

Another potential stressor for families is the impact of impairment upon siblings. Siblings respond to impairment in differing ways and at different times. The role of impairment upon a sibling's development and functioning remains unclear. Control studies have documented an increase in behavioral problems in siblings of children with different forms of impairment (Breslau, 1983; Gath & Gumley, 1987). Alternatively, studies have also demonstrated that siblings of children with impairment are not at risk for problem behavior (McHale, Sloan, & Simmeonsson, 1986).

Parent and family factors appear to play a significant role in the manner in which impairment affects siblings. To further explore this, Giallo and Gavida-Payne (2006) conducted research to evaluate factors that contributed to sibling adjustment to sibling impairment. They reported that the family degree of resilience and risk level were better predictors of sibling adjustment than the sibling's own coping ability and stress levels.

The manner in which siblings are cared for and disciplined by parents and caregivers is also a significant consideration. Parents have reported that they feel uncomfortable when providing differing degrees of discipline among their children with and without impairment (Fox, Vaughn, Wyatte, & Dunlap, 2002). In addition, parents have also reported concerns that their children without impairment may perceive parental favoritism towards siblings with impairment.

### **2.2.1.4 Managing Support Networks**

Families also have several support networks that they need to balance. These networks include formal supports, such as professionals and service providers, and informal supports, including friends and family. Families often receive information

and advice from both formal and informal supports. At times this information competes against each other, forcing family members to decide between the two. Potential criticism from relatives can also be a significant source of stress for the family (Miller, 1993).

Friends and relatives offer a great deal of support at the initial point of impairment (e.g., birth or trauma); however, over time these social networks taper their support to the family (Conoley & Sheridan, 2005). Over the long course of rehabilitation or treatment, individuals outside the immediate family begin to lessen their level of attention and availability.

Further, families may also find new support networks composed of parent support groups related to the nature of impairment. Typically, these groups are useful resources of information and advocacy related to the individual's social-emotional, behavioral, and academic functioning. However, sometimes the family does not identify with the experiences of members of the group, based on differences in the nature of impairment. This is particularly true of families with an individual who has multiple impairments. For example, an individual with both cognitive and physical impairments may not find a fit with support groups for cognitive impairments or physical impairments alone. This also can add stress to the family as they struggle to find social support groups that identify with their particular situation.

#### **2.2.1.5 Family Dysfunction**

Family functioning is heavily affected by a family's degree of resilience in the face of a crisis. The presence of impairment in a family tends to alter previous family roles, financial resources, family expectations, and family relationships. Impairment within a family can also increase stress, anxiety, depression, anger, blame, and hopelessness within family members (Heru & Ryan, 2002; Zarski, DePompei, & Zook, 1988). All of these changes can instigate difficulties in family functioning and potentially create dysfunction.

Although all families react to the presence of impairment in different ways, families with certain characteristics are more at risk for functional difficulties than others. Adverse effects upon family functioning are greater for (a) families that had poor family functioning before the advent of impairment and (b) families with parents who have existing psychological disorders (Wade, Drotar, Taylor, & Stancin, 1995). Families who are effective problem-solvers, have a sense of strong family coherence, develop effective coping strategies, and have an ability to adapt are more likely to maintaining strong family functioning in the presence of impairment (Ylven, Bjorck-Akesson, & Granlund, 2006).

#### **2.2.2 Positive Behavior Support and Families**

Positive behavior support is a "collaborative, assessment-based approach to developing effective, individualized interventions for people with problem behavior" (Lucyshyn, Horner, Dunlap, Albin, & Ben, 2002, p. 7) that builds upon the strengths and capabilities of families. Positive behavior support with families provide a

paradigm shift away from a deficit approach of impairment to one that promotes the positive contributions of an individual with a disability upon the family (Lucyshyn, Kayser, Irvin, & Blumberg, 2002). Within a positive behavior support framework, families are crucial and integral components of a comprehensive assessment. They are essential partners in (a) understanding contextual factors, setting identification/prioritization, of needs, and determining the functional purpose of behavior; (b) setting appropriate and relevant goals; and (c) developing and implementing support plans. Families are viewed as experts related to an individual's disability, familial impact, and important family cultural and ecological variables (Turnbull & Turnbull, 2001).

There is a practical emphasis on promoting positive behavior support within natural contexts, such as home or school environments (Fox et al., 2002). To accomplish this, collaboration between families, teachers, and professionals has become essential. It is only through effective communication and partnering with caregivers and educators that supports can be developed that fit the environment and context of these complex systems.

Lucyshyn, Albin, and Nixon (1997) assessed positive behavior support in relation to family environment and demonstrated the use of family input in establishing contextual fit. Working with the family of a 14-year-old with multiple disabilities, the researchers conducted a functional behavioral analysis, incorporating information provided by the family into functional hypothesis development and intervention implementation. Four specific family routines were targeted to identify six elements: (a) time and location; (b) people involved; (c) material resources; (d) structure and items to be completed; (e) family goals, values, and beliefs; and (f) typical interaction patterns. A comprehensive assessment was conducted, including an assessment of family ecology and a functional analysis. Behavioral support plans for each of the four routines were designed based on family strengths, resources, and goals. Direct behavioral observations and ratings of social validity indicated the support plans were effective in reducing problem behaviors and acceptable to the family. The contextual fit of the interventions also increased the family members' implementation of procedures with fidelity and consistency.

In an effort to better understand the experiences of families involved with family-centered positive behavior support, Fox et al. (2002) qualitatively evaluated the situations of 20 family members that participated in the process. The participants were involved with the "Family Network Project," a support program for families with children diagnosed with developmental disabilities and behavioral concerns. Families involved with the project were recruited from underserved communities and participated in positive behavior support interventions delivered through in-home services and group support. Through research interviews with participating families, three common themes emerged related to their experience with impairment. The first theme, "something is not right," was directly related to the assessment process and determining the nature of impairment. It was in these early stages that the family continued to seek answers for what was "wrong" with their child. Many families indicated some form of knowledge seeking to provide self-diagnosis or information gathering related to the impairment. The second theme, "a shoulder to cry on," described the families' experiences with formal and informal support.

Both support from professionals and social supports from friends and other families were reported to be helpful and commonly used. Family members described professionals, friends, and relatives who provided emotional support and encouragement as the most helpful. The final and most pervasive theme, “it’s a 24-hour, 7-day involvement,” depicted how impairment affects the entire family system and nature of family functioning. Families reported some discomfort when responding to problem behavior related to the impairment and difficulties providing consistent supports and consequences across all children in the family.

There has been a great deal of research demonstrating the effectiveness of family-centered, positive behavior support that extends far beyond the scope of this chapter. Positive results have been documented in the areas of: (a) reducing disruptive behavior in multiple settings (Fox, Vaughn, Dunlap, & Bucy, 1997); (b) producing greater generalization, maintenance, and treatment fidelity (Moes & Frea, 2000); and (c) high levels of family reported social validity and acceptability of the process (Koegel, Steibel, & Koegel, 1998).

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## 2.3 Guidelines for Assessment

Conducting a comprehensive assessment of impairment involves gaining a greater understanding of the contextual factors involved. An ecological-behavioral model for assessing impairment provides a perspective that includes immediate and surrounding contextual considerations within a developmentally appropriate framework. The goal is to understand the nature and degree of impairment within the current situation, based on what is occurring in the immediate setting (i.e., proximal variables) and factors from outside settings (i.e., distal variables) that may also contribute significantly to the impairment. Approaches to assessing impairment may be effective in determining proximal variables (e.g., antecedents, consequences) that have an impact on impairment; however, many assessment processes do not extend to understand distal variables (e.g., family environment, school environment, experiences in other settings) that also may have an effect on exhibited behavior. The consideration of both proximal and distal variables is essential for developing a comprehensive assessment of impairment.

An ecological-behavioral model follows the frameworks provided by ecological systems theory (Bronfenbrenner, 1979) and behavioral theory. The ecological-behavioral model is an alternative to previous deficit models of impairment, and conceptualizes problems as a mismatch between the individual and the environment, not solely within the individual. Thus, an individual’s learning and behavior are viewed as a function of continuing interactions between individuals and the multiple settings in which they interact (Pianta & Walsh, 1996; Sheridan & Gutkin, 2000).

Bronfenbrenner identified four systems involved in an individual’s development: (a) microsystem, (b) mesosystem, (c) exosystem, and (d) macrosystem. The ecological environment consists of these interdependent systems embedded within each other, like a set of Russian dolls. Therefore, the contextual environment relevant for an individual’s development does not simply consist of the immediate

**Table 2.1** Guidelines for incorporating family members and situational factors in the assessment process

- Develop a collaborative partnership
- Address issues related to diversity
- Assess family functioning
- Utilize a family-centered approach
- Assess previous courses of action
- Conduct a functional behavior assessment with family
- Link assessment to intervention

setting, as these four systems are interrelated. Taken together, these systems provide a multitude of influences upon impairment and are critical considerations in the assessment and support building processes.

The *microsystem* consists of the relationship between the child and the child’s immediate environment. Examples of this environment can include either the family or classroom setting. It is important to note that the microsystem is the interaction between the child and the environment, not just the child or environment on its own. The *mesosystem* reflects the interaction between two different environments with in which the child interacts. As such, a mesosystem can be comprised of the interaction between the home and school settings. The *exosystem* refers to an environment or context, in which the child is not involved, that has an impact on other members of a major ecosystem. In doing so, the exosystem has an impact on the child’s development in the immediate setting. This includes such factors or events at a family member’s place of work or a teacher’s home life. The fourth system, the *macrosystem*, consists of the larger overall context. This includes cultural and societal emphases and patterns, on which all other ecologies are based, such as (a) the overall societal attitudes, traditions, and beliefs and (b) the overarching political, legislative, and economic policies of society.

Behavioral theory, based on operant conditioning, contends that all behavior is governed by consequences and antecedents. *Antecedents* are events in the environment that cue an individual to exhibit a particular behavior. *Consequences* are the actions in the environment that occur after a behavior is exhibited. Although antecedents cue behavior, the occurrence of a behavior is controlled by the consequences of performing a behavior. If the consequence of a behavior is desired by the individual, then they are more likely to perform the behavior in the future. If the consequence is undesired, then it is less likely that the behavior will occur again. There are two categories of consequences within operant conditioning, reinforcement and punishment. Consequences are *reinforcing* if they increase the likelihood of a behavior’s occurrence in the future; alternatively, consequences are *punishing* when they reduce the probability of future occurrence. Problem behavior related to impairment can be effectively addressed by evaluating the nature and influence of consequences and antecedents.

The steps outlined in Table 2.1 indicate guidelines for conducting an assessment of impairment within an ecological-behavioral framework. This process utilizes a collaborative partnership with the family to assess contextual situations and how the

impairment is manifested. All of these steps emphasize different considerations during the assessment process and are critical for establishing a more comprehensive understanding of the context surrounding the impairment. These guidelines may be followed in many ways, but the core considerations are presented below.

### 2.3.1 Develop a Collaborative Partnership

The first step for including family members within a comprehensive assessment of impairment is to develop a collaborative partnership with the family. A *collaborative partnership* with families is defined as

“the establishment of a truly respectful, trusting, caring, and reciprocal relationship in which [professionals] and family members believe in each other’s ability to make important contributions to the support process; share their knowledge and expertise; and mutually influence the selection of goals, the design of behavior support plans, and the quality of family-practitioner interactions” (Lucyshyn, Horner et al., 2002, p. 12).

This is a critical philosophical shift for many professionals. To partner with families, one has to approach assessment with the fundamental belief that everyone has expertise to share. Family members have extensive expertise in the history of an individual’s impairment, how the impairment is exhibited in different settings, the functioning of the family, family need and resources, what has been attempted before to address or manage the impairment, and the goals for seeking services for the impairment. Professionals have expertise in approaches to assessment, professional judgment, information needed to be attained, and summarizing multiple sources of information (e.g., indirect and direct forms of assessment).

However, the emphasis for collaboration should be on developing a partnership with the family, not merely obtaining additional information. This provides an egalitarian approach to assessment and should continue through intervention development, implementation, and evaluation. A systemic way for family members to be involved through the assessment process should be developed. Often this includes established structured interviews of family members, but it should also incorporate a free-flowing conversational component to allow for open-ended questions that may be easier for families to respond to in a less-threatening questioning style (Turnbull & Turnbull, 1991). Further, family members should be allowed and encouraged to participate fully in the assessment process. This may require modifying language in the assessment process to reduce professional jargon and substitute common language for technical terms (Lucyshyn, Kayser, et al., 2002). A full collaboration with the family throughout this process ensures a complete contextual perspective of an individual’s impairment.



### 2.3.2 Address Issues Related to Diversity

The American society is one of the most diverse in the world. However, the American culture is based upon a Euro-American worldview. This worldview contains the following beliefs and values: individualism, competition, mastery and control over nature, a separation of science and religion, time as a unitary and static construct, and religion based on Christianity (Katz, 1985). Human service providers have been criticized for maintaining an individualized approach to assessing and addressing impairment (Quinn, 1995). This perspective is limiting and does not provide critical information regarding the influence of the family and community.

A foundation to working effectively with diverse families is for professionals to develop their own cultural competence. This begins with awareness of one's own cultural background and framework. Through this process, an individual becomes aware of personal values, priorities, and expectations. For professionals assessing impairment, this includes evaluating their own goals for assessment and intervention, their role as the assessor/professional, their meaning of impairment for individuals and families, their perspective of how families should be structured, and what they consider to be effective styles of communication and parenting (Brassard & Boehm, 2007). Only through this self-evaluation can professionals be able to identify whether a difference in worldviews may exist between themselves and the people with whom they work.

In addition, professionals need to refrain from making assumptions about the priorities, goals, and resources of individuals and families from diverse linguistic and cultural backgrounds (Brassard & Boehm, 2007). Each family and community are different despite any linguistic or cultural similarities, and it is extremely detrimental to approach any situation based on perceived stereotypes. In the same manner that professionals self-assess their own beliefs, they should assist families to verbalize their own perspectives. The goal is to identify common and shared beliefs, goals, and expectations. Without determining shared goals, it is difficult to develop a collaborative partnership.

Communication with families from linguistically and culturally diverse backgrounds is also extremely important and can pose some challenges. Effective communication strategies allow for as much reciprocal dialogue as possible among individuals, families, and professionals. First, professionals often need to modify the terminology used in conducting assessments. Jargon and professional terminology can impede the understanding of the individual who is providing or receiving the information. Second, different families have different communication styles, both verbal and nonverbal. Not all families from diverse backgrounds are comfortable with probing and direct questioning from the person(s) conducting the assessment (Chen, Downing, & Peckham-Hardin, 2002). In these situations, more informal and casual questioning can be beneficial. Further, families from diverse backgrounds may favor informal contacts with individuals instead of formal meetings (Harry, 1992), indicating the importance for professionals to build relationships with the family (Chen et al., 2002). Third, it is sometimes essential to utilize

an interpreter to facilitate communication between professionals and family members. It is always recommended to use a qualified interpreter rather than a family member. When using an interpreter, it is preferred for all parties to look at each other as they are talking instead of the interpreter. It is also extremely important to consider how specific words may be transferred from one language to another. Many times, nuances are not able to transfer and unwanted connotations may be added, making it important for everyone to have effective communication with the interpreter to ensure the best possible communication.

Gaining an understanding of the family's values, beliefs, resources, and expectations allows the professional to truly assess the context surrounding the impairment. Developing an understanding of culture enables a person to view the world "through the eyes" of that person. Thus, being "multicultural" refers to being "multivisional" in perspective or extending one's ability to understand other people (Soriano, Soriano, & Jimenez, 1994). *Multiculturalism* refers to a "broad range of significant differences (race, gender, sexual orientation, ability, and disability, religion, class, etc.) that so often hinder communication and understanding among people" (Sue & Sue, 1999, p. 1064). This approach to a comprehensive assessment allows for intervention development to fit within the context of the individual and family.

### 2.3.3 Assess Family Functioning

Family functioning plays a critical role in the manner in which impairment is exhibited, maintained, or managed by the individual and its affect on other members of the family. It is widely accepted that family functioning is a multidimensional construct that is highly influenced by the relational processes within families. Common factors related to family functioning that should be assessed include family cohesion, family involvement, family adaptability, parenting styles, and a family belief system. In general, each of these aspects of functioning falls along a continuum with optimal functioning and family resilience existing within moderate degrees, outside of the extremes.

#### 2.3.3.1 Family Cohesion

The concept of *family cohesion* represents "family members' close emotional bonding with each other as well as the level of independence they feel within the family system" (Turnbull & Turnbull, 2001, p. 124). Levels of emotional connectedness between family members are influenced by the culture, age, and stage of life of the family member and vary significantly between and within families. Family cohesion exists on a continuum, ranging from enmeshed (very high), to very connected (moderate to high), to connected (moderate), to somewhat connected (moderate to low), to disengaged (very low) (Olson & Gorall, 2003). Interactions that are enmeshed are characterized by an overidentification with the family, resulting in extreme levels of consensus and limited individual autonomy and independence. Families that are disengaged are marked by high autonomy and low bonding,

depicting little attachment to the family system. Families that have a balance between enmeshment and disengagement tend to have healthier levels of functioning (Olson & Gorall, 2003).

### **2.3.3.2 Family Involvement**

The extent to which family members value and display interest in the activities of other family members defines the notion of affective involvement (Epstein, Ryan, Bishop, Miller, & Keitner, 2003). Affective involvement emphasizes the degree of interest as well as how family members demonstrate their interest and investment in each other, and exists on a continuum, ranging from lack of involvement to over-involvement. Considered to be the optimal level, *empathetic involvement* refers to a genuine interest; family members are invested for the sake of others in the family unit. Empathetic family involvement practices promote healthy functioning within families.

### **2.3.3.3 Family Adaptability/Flexibility**

The presence of impairment certainly highlights a family's ability to adapt to new situations. Family adaptability or flexibility represents a family's ability to modify its rules, roles, and leadership based on new situations or experiences. This restores a balance between (a) family members and the family unit and (b) the family unit and the community (Olson & Gorall, 2003; Patterson, 2002b). Families have differing degrees of adaptability that fall along a continuum from rigid/inflexible (extremely low) to somewhat flexible (low to moderate), to flexible (moderate), to very flexible (moderate to high), to chaotic/overly flexible (extremely high) (Olson & Gorall, 2003). Moderate degrees of adaptability (e.g., structured or flexible) may allow for healthier degrees of family functioning than those on the extremes (e.g., rigid or chaotic).

Families need to be both stable and able to adapt in order to function as a healthy system. Healthy, functional families are able to determine when it is appropriate to maintain stability or address change (Olson & Gorall, 2003). Successfully adaptive families (a) are proactive in the socialization and development of individual family members and (b) understand the importance of maintaining the family unit (Patterson, 2002a).

### **2.3.3.4 Parenting Styles and Problem-Solving Processes**

A family's ability to communicate and problem solve effectively is highly related to family functioning. This is particularly true of families who have an individual with impairment. Clear, direct, and honest communication, active listening, and positiveness are all communication styles associated with healthy family functioning. Family functioning also benefits from collaborative problem-solving that includes shared decision-making among family members, is goal-oriented, follows concrete steps, and builds on successes (Walsh, 2003).

A family's ability and overall style of communication and problem-solving is represented by the interactions between parents and children. Four types of parenting styles have been outlined by Baumrind (1991): authoritarian, indulgent,

uninvolved, and authoritative. Authoritarian parenting styles are marked by high levels of authority and control, with limited negotiation regarding standards of behavior. Indulgent parents, in contrast to authoritarian parents, allow children to regulate their own activities, standards, and rules, with few decisions imposed by caregivers. Uninvolved parents are not responsive to their children and do not provide behavioral demands. Authoritative parenting, is marked by a balance between freedom and responsibility. Authoritative parents engage family members in problem-solving processes to negotiate compromise and manage conflict.

### **2.3.3.5 Shared Beliefs and Values**

Another critical component of healthy family functioning is the presence of a shared belief system. Shared values and beliefs reinforce specific patterns regarding how a family reacts to new situations, life events, and crises and are necessary for strong family resilience. A family's response to impairment is often dependent upon the existence of shared family values and expectations. Having a common belief system helps families to make meaning of crises, situational events, and impairment and also facilitates hope and a positive outlook (Walsh, 2003).

Related to a shared belief system, a strong family schema represents a perspective that the family interacts with the world from a collective "we" versus "I" orientation (McCubbin, McCubbin, & Thompson, 1993). Strong family schemas help families perceive life in a realistic manner and not expect perfect solutions to difficulties that life presents (McCubbin et al., 1993).

### **2.3.3.6 Measuring Family Functioning**

When adopting an ecological-systems perspective, there is not one best way of assessing family functioning; rather, it is often necessary to evaluate multiple aspects of how the family operates (Bray, 1995). Methods of evaluating family functioning include family member self-report measures, observation of family interactions, and clinician rating scales.

Commonly used measures of family functioning include the McMaster Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983), Family Adaptability and Cohesion Scales (FACES IV; Olson, Gorall, & Tiesel, 2005), Family Environment Scale (FES; Moos & Moos, 2002), Parenting Stress Index—Fourth Edition (PSI; Abidin, 2012), Family Functioning Style Scale (Deal, Trivette, & Dunst, 1988), and the Family Functioning Scale (FFS; Bloom, 1985).

## **2.3.4 Identify Family Needs and Resources**

Families are best included in the assessment process through the use of a family-centered approach. A family-centered approach for assessment follows four guiding principles (Dunst, Trivette, & Deal, 1994): (a) determining family-identified needs and goals, (b) addressing family strengths and resources, (c) determining the family's social network, and (d) evaluating the family's degree of empowerment.

#### **2.3.4.1 Family-Identified Needs**

Individual and family interventions related to impairment have the greatest impact when they are developed to address the specific needs of the family (Dunst et al., 1994). As such, the most effective assessments provide information regarding self-determined needs of the family, not those identified by the professional. Professionals working with families in the assessment process assist family members to identify, define, and prioritize their specific needs. Needs are often identified within a hierarchy that determines the relative importance and immediacy for the family. A family's ability to address these needs is enhanced through the development of specific objectives. To help families achieve these objectives, professionals should also assist families in developing short- and long-term goals.

#### **2.3.4.2 Family Strengths and Resources**

All families have varied strengths and resources available to them that they can use to help address any issues related to impairment. It is important during the assessment process to not only identify these strengths and resources, but also determine the accessibility of the resources. Environmental or systemic conditions can sometimes provide families with barriers to attain resources. Thus, it is critical to determine how families may utilize their strengths to mobilize available resources.

#### **2.3.4.3 Social Networks**

In addressing individual and family needs and strengths related to impairment, connections between other systems and networks also need to be assessed. Collaborations with intra- and intersystemic partners are necessary for addressing the needs of the individual and family (Sheridan, Eagle, & Dowd, 2005). These linkages often exist within Bronfenbrenner's mesosystem and connect different environments within which an individual exists. During the assessment process, it is beneficial to determine the nature of any partnership between the family and human service, educational, health care, neighborhood, spiritual, or other community organizations. Importantly, not all networks need to be formal; informal and natural social networks are also quite helpful for families and provide extensive support.

#### **2.3.4.4 Family Empowerment**

A comprehensive assessment based on family-centered services also evaluates the family's degree of self-sufficiency. That is, what competencies does the family possess to achieve the identified goals? This is a picture of where the family is at the moment, or what skill or capacity development might enhance the family's ability to address issues related to impairment. This level of assessment allows for interventions to be developed that build capacities within the family as opposed to simply correct a problem.

#### **2.3.5 Assess Previous Courses of Action**

Families can provide extensive information on previous efforts to address concerns related to impairment. Primarily, they can assist in understanding (a) what supports have been implemented previously and (b) whether they were effective. These two

questions provide an opportunity to gain vital information related to the social validity of previous support plans and the fidelity with which plans were implemented. Assessing previous efforts is a critical component to establishing current support plans that are contextually appropriate and have the best chance to be implemented appropriately and consistently. Building from previous efforts can expedite the process and prevent one from “reinventing the wheel.”

### **2.3.5.1 Social Validity**

A key aspect of assessing past strategies is to ascertain the family’s perspective of the effectiveness and acceptability of the intervention. This is referred to as the social importance of an intervention, or social validity. Whether or not a family perceived a previous support plan to be effective or acceptable for their unique context provides fundamental information for the development of a new plan. The key is to incorporate or modify aspects that the family deemed effective or acceptable into current strategies. Even the best plans will not be implemented if they are considered to be unacceptable for a given situation or context.

### **2.3.5.2 Treatment Fidelity**

Not surprisingly, a support plan is only effective if it is implemented appropriately. Support plans that are not implemented as intended or consistently are likely to fail to produce beneficial results. There are many reasons that an intervention may not be implemented effectively, including (a) a lack of knowledge or expertise, (b) limited resources to provide the opportunity, or (c) a lack of contextual fit between the plan and the surrounding environment. Family members can provide information regarding their ability and resources available to carry out a support plan consistently. This assists professionals in determining if training, modeling, repeated practice, additional resources, or other modifications are necessary to ensure that the support plan developed is implemented with fidelity.

## **2.3.6 Conduct a Functional Behavior Assessment**

One of the key purposes of conducting an assessment is to gain information that will assist in developing interventions that have a contextual fit. In many cases this contextual fit may involve home or schools settings, and often both. A prominent and evidence-based method to assess how to support an individual with an impairment is through functional behavior assessment. A functional behavior assessment is a systematic process designed to evaluate how impairment is associated with behavioral, academic, or social difficulties within specific situations, environments, or contexts. Functional behavior assessment also provides an opportunity to partner with families to evaluate the effect of situational problems upon impairment, and should be conducted with input from the family to ensure that they are contextually appropriate.

There are two forms of functional behavior assessment used when assessing the nature and degree of impairment: (a) contextual, those that evaluate conditions within a single setting (e.g., home or school) and (b) cross-setting, those that look

**Table 2.2** Guidelines for conducting a functional behavior assessment

- Identify and operationally define a prioritized concern
- Identify antecedents, consequences, and setting events
- Develop hypotheses regarding the function of the problem
- Build behavioral support plans derived from hypotheses

at similarities and differences within conditions across settings (e.g., both at home and school). Although contextual functional behavior assessment may gather information regarding proximal variables from the immediate setting, cross-setting assessment also provide information of distal variables from outside, additional settings.

Information attained in a functional behavior assessment comes from multiple informants (e.g., the individual, family members, caregivers, educators, service providers) and multiple sources. Typically, a functional behavioral assessment includes information from record reviews, structured interviews, and direct behavioral observations. Record reviews provide background information from previous assessment reports, educational achievement, social service case history, and documented progress towards behavioral or educational planning goals. Structured interviews allow for a professional to discuss more detailed information in person with the individual and family. However, not all information provided by the family needs to be received through structured interviews as informal conversations can also provide useful, detailed information. Through behavioral observations, direct information regarding how the impairment is manifested in different contexts can be ascertained. Direct observations are used to collect data on the frequency, duration, or intensity of specified difficulties. In addition, direct behavioral observations provide assessment information that includes what happens before and after problem behaviors occur.

Functional behavior assessment consist of four major components that are outlined in Table 2.2. In general, a functional behavior assessment serves to answer two basic questions: (a) under what conditions a behavior occurs more/less frequently (e.g., setting, surrounding individuals, time of day), and (b) what might be the possible reasons for a behavior to occur.

First, professionals and family members (and/or teachers) work together to collaboratively define, in operational terms, how the impairment manifests itself into identified difficulties or needs. Through this process family members (and/or teachers) identify their concerns related to the impairment and prioritize the most important area, difficulty, or need to support. Generalized difficulties are redefined and prioritized into one or two specific, primary difficulties for immediate intervention.

Second, through a series of interview questions the family identifies the before and after events related to the identified concern. This process identifies the antecedents, consequences, and setting events that may maintain or govern the specific difficulty or problem behavior. Additional information can also be obtained through behavioral observations of the individual in the home or school setting.



To comprehensively assess the context surrounding the impairment, it is advised that professionals also assess family routines and the family environment (Lucyshyn, Kayser, et al., 2002). This can also be conducted through interviews with family members, open-ended conversations, rating scales, and observations.

Third, using this information, family members (and/or teachers) and professionals collaboratively develop potential hypotheses regarding the function, or purpose, of how the impairment may be exhibited through problem behavior or identified difficulties/needs. These hypotheses should be testable, meaning that through observations a generated hypothesis can be verified or rejected. Other than determining that a problem behavior related to impairment represents a skill deficit, there are two main functions of behavior (Crone & Horner, 2003). First, a behavior may occur in order to get something, either a tangible object or attention. Second, the motivation for performing a behavior may result from avoiding or escaping something undesired.

Fourth, information and data collected during the assessment process are connected to intervention development. Behavioral support plans are developed that are linked explicitly to the hypothesized function. Specifically, alternate, more appropriate behaviors are reinforced that serve the same function as the problem behavior. A major principle in developing behavioral support plans through functional behavior assessment is for the individual to experience the same function for performing the appropriate behavior as the inappropriate behavior.

Family members should be involved throughout the functional behavior assessment process within the guidelines of the collaborative partnership. Information provided by the family is typically ascertained through the use of structured interview forms, such as the Functional Assessment Interview (FAI) form (O'Neill et al., 1997) and the Functional Behavioral Assessment Interview (Crone & Horner, 2003). There are also several valid observation forms that are used with a functional behavioral assessment, including the functional observation interview (FOI) form (O'Neill et al., 1997) and behavioral observation scatterplot forms.

### **2.3.7 Link Assessment to Intervention**

The final component of a quality, comprehensive assessment is to link the findings from the assessment to supports or interventions for the individual or family. It is important to utilize the information ascertained in the assessment process to enhance the effectiveness of supports provided. This link between assessment and intervention ensures that the services delivered are contextually appropriate. Otherwise, interventions that are developed will not be implemented with fidelity.

Information attained from both family-centered service and functional behavior assessment approaches allow for a systematic way for the assessment process to be connected with intervention development. Both assessments and interventions provided within a family-centered framework follow the same four principles: (a) family-identified needs and goals, (b) family strengths and resources, (c) family's social network, and (d) family's degree of empowerment. This makes it easier to connect



the information received from families to the provision of supports. Similarly, functional behavior assessment systematically generates hypotheses of behavioral function that lead directly to intervention development. The creation of a competing pathways model (Crone & Horner, 2003) during functional behavior assessment and positive behavior support development ensures a direct link between assessment and intervention.

However, in all instances, it is the development of a collaborative partnership between families and professionals that truly influences the quality of assessment information and adherence to treatment recommendations. Through open communication, supports can be developed that address needs related to impairment and fit within the ecology of the family. But, a true partnership establishes a shared ownership of the (a) problem or area of need, (b) implementation of supports, and (c) evaluation of support plan effectiveness.

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## 2.4 Life Course Theory

The life course theory proposes that development is an ongoing and interactive process that occurs across an individual's life span. Further, the theory posits that early experiences and the broader ecological context strongly influence development, particularly during critical or sensitive periods (Fine & Kotelchuck, 2010). Given this perspective, it is helpful to consider the family's role in assessment and intervention practices at different life stages including early childhood, school-aged, and the transition into adulthood. Families represent the one constant and stable presence across the course of a child's life and thus are uniquely positioned to provide a longitudinal perspective regarding their child's development.

### 2.4.1 Early Childhood Assessment

Early childhood experiences provide the foundation for later development, and assessment conducted during these formative years can support optimal delivery of early intervention and prevention services. Early childhood assessment consists of a "flexible, collaborative decision making process in which teams of parents and professionals repeatedly revise their judgments and reach consensus about the changing developmental, educational, medical and mental health service needs of young children and their families" (Bagnato & Neisworth, 1991, p. xi). Best practice guidelines in early childhood assessment highlight the importance of authentic assessment procedures that are family centered, developmentally appropriate, and purposeful (Neismworth & Bagnato, 2007). These guidelines are supported by professional organizations including the National Association for the Education of Young Children (NAEYC), the National Association of Early Child Specialists in State Departments of Education (NAECS/SDE), and the Division of Early Childhood (DEC).

### **2.4.2 Authentic Assessment Practices**

Authentic assessment practices gather information about a child's social, developmental, and behavioral functioning from knowledgeable caregivers within naturally occurring contexts (Dennis, Rueter, & Simpson, 2013). This approach emphasizes assessment techniques such as interviews and observations in lieu of individually administered standardized assessments. In contrast to traditional methods, children are assessed while participating in age-appropriate activities that incorporate familiar materials, events, and situations so that the results reflect the child's actual performance. The use of multisource and multi-informant assessment measures can provide a comprehensive picture of a child's strengths and areas of need across settings. Further, results can be used to inform instruction, intervention, and program planning (Macy & Bagnato, 2010).

### **2.4.3 Purposes of Early Childhood Assessment**

Assessment must serve a specific purpose, and results must be used towards the intended objective. One purpose of assessment is to inform instruction. In this case, assessment results are used to support teaching decisions and improve learning by providing instructionally relevant strategies that early childhood educators can implement in their classrooms. A second purpose of assessment is to identify individual or groups of students that may benefit from targeted intervention. These data are used to select evidence-based interventions that can support a child's functioning and enhance their developmental trajectory. A third purpose is to evaluate the effectiveness of early childhood programs. When assessing programs, data are used to improve practices and measure progress toward outcomes. Finally, as children transition from early childhood programming to school-based contexts, assessment data are often used to determine eligibility for services.

### **2.4.4 Transition from Early Childhood to School-Based Services**

The transition from early childhood to school can be an exciting time; however, it often represents a significant adjustment for children with disabilities and their families. The success of this transition can play a critical role in influencing future educational outcomes and life opportunities (Dockett & Perry, 2007; Fabian & Dunlop, 2006), so careful consideration must be paid to the selection and administration of assessment instruments. Although best practice guidelines recommend the use of a family-centered approach (Neismworth & Bagnato, 2007), many caregivers find the assessment process challenging. Specifically, families may encounter difficulties such as limited understanding of the assessment processes, duplication of assessments, waiting lists, discontinuity of services, limited communication, and disregard for family experiences (Tudball, Fisher, Sands, & Dowse, 2002). To promote a successful transition, it is important to consider the degree to which

assessment practices engage parents as partners by (1) promoting bidirectional communication to demystify the process, (2) valuing caregivers' expertise and experiences, (3) encouraging joint development of educational goals, and (4) coordinating supports to minimize gaps in service delivery.

### **2.4.5 Assessment of School-Aged Children**

The current educational landscape promotes preventative frameworks for supporting the academic, social–emotional, and behavioral development of school-aged children. Rising out of this framework is an integrated model for assessing and supporting student and family needs: Multi-Tiered System of Supports (MTSS). MTSS is a framework that integrates current educational models based upon a three-tiered system of prevention, namely School-Wide Positive Behavioral Interventions and Supports (PBIS) for behavioral/social concerns and Response to Intervention (RtI) for academic needs. These preventive models provide opportunities for assessment and intervention at three levels of support: universal, targeted, and individualized. Degrees of intensity of assessment procedures and intervention are increased as students are provided supports at higher level of the framework. Universal supports are provided to all students in a school. Targeted supports are provided to groups of students who need more additional support. And, individualized supports provide the most intensive and complex assessment and interventions, often being multifaceted and multi-setting.

This multi-tiered model should not be viewed as existing within the structure of the school alone; it also extends to the delivery of services based upon collaborative school, community, and family partnerships. Each level of support (e.g., universal, targeted, individualized) provides opportunities for schools to partner with families. As such, families have a great role in the assessment procedures used within all three tiers; however, varying in degrees of intensity.

#### **2.4.5.1 Family Involvement in Assessment at the Universal Level**

As part of a MTSS scoped and sequenced school-wide initiative, families can be actively involved in universal (school-wide) procedures. The ecological approach to family intervention and treatment (EcoFIT; Dishion & Stormshak, 2007; Fosco, Dishion, & Stormshak, 2012; Stormshak & Dishion, 2009) is a school-wide approach to providing family-centered services and facilitating healthy family–school connections. At the universal level, several strategies are employed, including developing a family resource center, engaging school personnel in proactive collaborative contacts with families, and a screening system to identify students who may benefit from additional support (Fosco et al., 2012).

The screening system is particularly relevant for family involvement in assessment. At the beginning of the school year, schools using EcoFIT may distribute a parent student readiness screener (Moore et al., 2016) that asks parents to rate areas of concern for their child (e.g., avoiding difficult or challenging tasks). In addition to rating whether children may have concerns in specific areas, parents can also

indicate whether they believe their child would benefit from additional support. The use of a proactive parent screener allows all parents in a school community to report about their children's needs. It also serves as an important entry point for school personnel to partner with families to address child needs (Fosco et al., 2012). In fact, parent report of concerns about their child on a parent screener in the fall have been found to be statistically significantly correlated with parent-report of school initiations of contact the following spring (Moore et al., 2016). Thus, it may be that proactively engaging families who report concerns or request support in the fall may prevent future school-initiated contacts later in the school year when child behaviors may have increased in severity and/or frequency.

#### **2.4.5.2 Family Involvement in Assessment at the Targeted Level**

Within the MTSS framework, many schools notify families of academic, social-emotional, or behavioral concerns when determining the appropriateness of targeted interventions at the second tier. The determination for providing more intensive supports to a student not responding to core universal instruction requires more intensive assessment, and often requires family consent. This assessment is twofold, (a) whether the child requires more intensive supports and (b) what are the appropriate supports to provide.

Families are able to provide critical assessment information when considering providing targeted supports. Targeted supports can be provided in areas of behavior, social-emotional, and academic functioning. Each of these areas has unique ways for families to be involved in the assessment and intervention process. Without this family input, schools may have significant difficulty providing the type of support that best matches the need.

Within the behavioral and social-emotional realms, families are often asked to complete rating scales related to the areas of functional difficulty. Parent rating scales provide information regarding home and community settings and are often compared to teacher ratings for the same set of behaviors/degree of functioning. There are many widely used rating scales in schools. The Behavioral Assessment Scale for Children-3 Parent Rating Scale (BASC-3 PRS; Reynolds & Kamphaus, 2015) provides parent input regarding problem behaviors, and can be helpful for making determination for classifications based on the Individuals with Disabilities Education Act (IDEA 2004) and the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013). The Social Skills Improvement Rating Scales-Parent (SSIS-Parent; Gresham & Elliott, 2008) provides information related to social functioning. And, the Multidimensional Anxiety Scale for Children-2 Parent form (MASC; March, 2012) assesses difficulties related to anxiety.

Determining appropriate academic supports at the second tier of MTSS requires specific information from families regarding the child's present level of academic performance. This information includes family input regarding the primary language spoken at home, opportunities for practice at home, family culture and value system, and acculturation and socialization considerations.

### **2.4.5.3 Family Involvement in Assessment at the Individualized Level**

Coordinated family involvement in assessment and intervention at the universal and targeted levels is essential to address impairment and promote child and youth success. However, there are some children and youth who will need specialized individual supports. The Family Check-up (Dishion & Stormshak, 2007) and Conjoint Behavioral Consultation (Sheridan & Kratochwill, 2008) are two structured models with extensive empirical support (Garbacz, Swanger-Gagné, & Sheridan, 2015) that actively engage families through comprehensive assessment, intervention development, intervention implementation, and progress monitoring.

The Family Check-up (FCU; Dishion & Stormshak, 2007) is the primary service available for families who receive EcoFIT (Stormshak & Dishion, 2009). As previously mentioned, EcoFIT is a multilevel model for engaging and intervening with families (Stormshak & Dishion, 2009). At the universal level, a family resource room is established at the school (Fosco, Frank, Stormshak, & Dishion, 2013). The family resource room includes information and resources for families about available services. A parent consultant can work with families to provide relevant information about their child's needs, briefly consult (e.g., about homework), and attend school meetings with families. In addition, parent seminars about topics relevant to family needs can be provided. For families that may benefit from additional support, the FCU can be initiated.

The FCU is derived from the Drinker's Check-up (Miller & Rollnick, 2002) and uses similar motivational features. The FCU includes assessment and feedback for families in a three-session format (Dishion & Stormshak, 2007). The first session builds on prior initial contacts (e.g., telephone) and focuses on discussing goals and histories, supporting parents, expressing optimism, and assessing motivation (Dishion & Stormshak, 2007). In the second session, parents may complete an assessment packet. The assessment focuses on ecological characteristics of the systems affecting the child (Dishion & Stormshak, 2007). As an augment to the self-report assessments, families may also be videotaped completing a structured task (Stormshak & Dishion, 2009). In the third meeting, the feedback about assessment findings is discussed with families in terms of their motivation and appropriate resources based on assessment findings and linked to a menu of intervention options (Stormshak & Dishion, 2009). The menu of intervention options is collaboratively examined with families to identify reasonable next steps. Interventions may include (a) support and problem-solving and (b) skill-building interventions. Following the FCU check-ins may be conducted by the parent consultant.

Reviews of research on the FCU have consistently found strong empirical support for its use (Garbacz et al., 2015; Stormshak & Dishion, 2009). Specifically, the FCU is associated with improvements for young children and adolescents. The FCU is linked with improved problem behavior for young children (Dishion et al., 2008). For adolescents, family engagement in the FCU is associated with better school

attendance (Stormshak, Connell, & Dishion, 2009), lower substance use (Dishion, Nelson, & Kavanagh, 2003; Stormshak et al., 2011), increased self-regulation (Fosco et al., 2013; Stormshak, Fosco, & Dishion, 2010), and lower rates of antisocial behavior (Stormshak et al., 2011).

Conjoint Behavioral Consultation (CBC; Sheridan & Kratochwill, 2008) is a structured model for addressing impairment through comprehensive assessment, intervention development, and intervention implementation. CBC brings together family members, educators, and other service providers within a partnership framework. Within this model, members of the consultation team work collaboratively to address the developmental, academic, social, and behavioral needs of an individual with impairment and the needs of the family.

CBC follows a structured but flexible, evidence-based, problem-solving model and is based on both (a) an ecological-systems perspective (Bronfenbrenner, 1979) and (b) the principles of positive behavior support including behavioral problem-solving (Kratochwill & Bergan, 1990). Through the process of CBC, parents, educators, and other service providers share in the identification of the strengths and needs of families and the development, implementation, and evaluation of interventions to address those needs in home and school environments. The problem-solving model of CBC follows four stages (i.e., needs/problem identification, needs/problem analysis, plan/treatment implementation, plan/treatment evaluation) and allows for each phase to be recycled as needed.

Research examining CBC has consistently found that CBC is efficacious for children with academic and social behavior concerns (Sheridan, Clarke, & Ransom, 2014). CBC can improve behavior outcomes for elementary-age students at school (Sheridan et al., 2012), reduce behavior problems at home (Sheridan, Ryoo, Garbacz, Kunz, & Chumney, 2013), and strengthen the parent–teacher relationship (Sheridan et al., 2012). CBC and interventions that include CBC are associated with positive effects on children’s homework performance, family involvement in education, and the family–school relationship (Power et al., 2012; Weiner, Sheridan, & Jenson, 1998). Furthermore, CBC has been applied to pediatric settings and effectively addressed presenting concerns (e.g., blood glucose levels; Lasecki, Olympia, Clark, Jenson, & Heathfield, 2008; Sheridan et al., 2009).

## 2.4.6 Transition to Adulthood

As youth begin transitioning from educational settings and close adult supervision to postsecondary schooling, employment, and independent living, there are many activities families can engage in with their children to reduce impairment and support life success. Many of the aforementioned topics (e.g., use of positive behavior support) continue to be relevant during this stage. In fact, promoting child and youth life success includes building upon the firm foundations created throughout a child’s life.

Children identified with an educational disability have an Individualized Education Program (IEP). Prior to ninth grade, the IEP focuses on services the school provides to address the child’s educational needs (PACER Center, 2013).

By age 16, or before, the IEP begins including specific ways to plan for the youth's life after high school. Federal law mandates that schools solicit parent engagement in IEP meetings (34 C.F.R. § 300.322); however, evidence suggests many families do not attend some IEP meetings (Landmark, Zhang, & Montoya, 2007). Reviews and meta-analyses of parent involvement in secondary schooling suggest that parent involvement is associated with improved youth academic performance and achievement (Catsambis, 1998; Jeynes, 2008). Empirical evidence for parent involvement at the secondary level underscores the legal mandates, and indicates the importance of continued family involvement as youth transition to adulthood.

In addition to empirical evidence and legal mandates, it is conceptually meaningful for parents to be engaged in their youth's transition services. By the time a youth begins making the transition to adulthood, parents will have been the constant throughout many IEP meetings comprised of different individuals across several schools. Families have also provided proximal support to their child and contributed meaningful information to educational stakeholders and community advocates. Thus, parents are the backbone and *sine qua non* in their youth's life (Timmons, Butterworth, Whitney-Thomas, Allen, & McIntyre, 2004).

There are many ways families can support their youth during transition planning activities. For example, parents can advocate for their youth when key decisions are made about their educational or vocational plans (Timmons et al., 2004). In addition, parents can attend and actively participate in IEP meetings and other school meetings, and communicate regularly with their child's educators (Landmark et al., 2007). It may be more difficult for some families to navigate the transition planning process than it is for other families; it may be particularly difficult for families from culturally and linguistically diverse backgrounds (Kim & Morningstar, 2005). Thus, it is important for educators to support families as they advocate, share information, and collaboratively plan for their youth's transition to adulthood. Educators can share information, encourage family involvement, facilitate supportive connections across families, and increase social supports for families (Kim & Morningstar, 2005).

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## 2.5 Conclusion

Families provide an invaluable, and often underutilized, resource in the contextual assessment of impairment and the development and implementation of support plans for individuals with impairment. A framework based on ecological-behavioral theory and life course theory provides the backdrop for partnering with families to assess and address strengths and needs. Conducting contextually and developmentally appropriate, comprehensive assessments includes establishing a collaborative partnership with family members. Through this partnership, issues related to diversity can be addressed and appropriate, collaborative goals can be developed. Information provided by family members helps assess the level of family functioning, current family needs and resources available, and previous efforts to address those needs. Family members should also be included in the development of cross-setting functional behavioral assessments and the process of using assessment



information to drive the development and implementation of contextually appropriate support plans. Undoubtedly, families provide a wealth of knowledge, expertise, and resources that are extremely beneficial in understanding context, reducing impairment, and promoting success.

## References

- Abidin, R. R. (2012). *The Parenting Stress Index professional manual*. Odessa, FL: Psychological Assessment Resources.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Bagnato, S. J., & Neisworth, J. T. (1991). *Assessment for early intervention: Best practices for professionals*. New York: Guilford Press.
- Baumrind, D. (1968). Authoritarian vs. authoritative parental control. *Adolescence*, 3, 255–272.
- Bloom, B. L. (1985). A factor analysis of self-report measures of family functioning. *Family Process*, 24, 225–239.
- Brassard, M. R., & Boehm, A. E. (2007). *Preschool assessment: Principles and practices*. New York, NY: Guilford.
- Bray, J. H. (1995). Family assessment: Current issues in evaluating families. *Family Relations*, 44, 469–477.
- Breslau, N. (1983). The psychological study of chronically ill and disabled children: Are healthy siblings appropriate controls? *Journal of Abnormal Child Psychology*, 11, 379–391.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Catsambis, S. (1998). *Expanding knowledge of parental involvement in secondary education* (Rep. No. 27). Washington, DC: Center for Research on the Education of Students Placed At Risk.
- Chen, D., Downing, J. E., & Peckham-Hardin, K. D. (2002). Working with families of diverse cultural and linguistic backgrounds. In L. K. Koegel, R. L. Koegel, & G. Dunlap (Eds.), *Positive behavior support: Including people with difficult behavior in the community* (pp. 133–154). Baltimore: Paul H. Brookes.
- Conoley, J. C., & Sheridan, S. M. (2005). Understanding and implementing school-family interventions after neuropsychological impairment. In R. C. D'Amato, E. F. Fletcher-Janzen, & C. R. Reynolds (Eds.), *Handbook of school neuropsychology* (pp. 721–737). New York: Wiley.
- Crone, D. A., & Horner, R. H. (2003). *Building positive behavior support systems in schools: Functional behavior assessment*. New York: Guilford.
- Deal, A. G., Trivette, C. M., & Dunst, C. J. (1988). In C. J. Dunst, C. M. Trivette, & A. G. Deal (Eds.), *Enabling and empowering families: Principles and guidelines for practice* (pp. 175–184). Cambridge, MA: Brookline Books.
- Dennis, L. R., Rueter, J. A., & Simpson, C. G. (2013). Authentic assessment: Establishing a clear foundation for instructional practices. *Preventing School Failure*, 57(4), 189–195.
- Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The family check-up with high-risk young adolescents: Preventing early-onset substance use by parent monitoring. *Behavior Therapy*, 34, 553–571.
- Dishion, T. J., Shaw, D., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The family check-up with high-risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. *Child Development*, 79, 1395–1414.
- Dishion, T. J., & Stormshak, E. (2007). *Intervening in children's lives: An ecological, family-centered approach to mental health care*. Washington, DC: APA.
- Dockett, S., & Perry, B. (2007). *Transitions to school: Perceptions, expectations, experiences*. Sydney, Australia: University of New South Wales Press.



- Dunst, C. J., Trivette, C. M., & Deal, A. G. (1994). Enabling and empowering families. In C. J. Dunst, C. M. Trivette, & A. G. Deal (Eds.), *Supporting and strengthening families: Methods, strategies, and practices* (pp. 175–184). Cambridge, MA: Brookline Books.
- Epstein, N. B., Baldwin, L., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, 9, 171–180.
- Epstein, N., Ryan, C., Bishop, D., Miller, I., & Keitner, G. (2003). The McMaster model: A view of healthy functioning. In F. Walsh (Ed.), *Normal family processes* (3rd ed., pp. 581–607). New York: Guilford Press.
- Fabian, H., & Dunlop, A.-W. A. (2006). *Outcomes of good practice in transition processes for children entering primary school*. Paper commissioned by the van Lee foundation as evidence for their response to the EFA Global Monitoring Report 2007.
- Fine, A., & Kotelchuck, M. (2010). *Rethinking MCH: The life Course Model as an Organizing Framework Concept Paper*. U.S. Department of Health and Human Services and Services Administration Maternal and Child Bureau. Retrieved from <http://www.hrsa.gov/ourstories/mchb75th/images/rethinkingmch.pdf>
- Fosco, G. M., Dishion, T. J., & Stormshak, E. A. (2012). A public health approach to family-centered prevention of alcohol and drug addiction: A middle school strategy. In H. J. Shaffer (Ed.), *APA addiction syndrome handbook: Vol. 2. Recovery, prevention, and other issues*. Washington, DC: American Psychological Association.
- Fosco, G. M., Frank, J. L., Stormshak, E. A., & Dishion, T. J. (2013). Opening the “black box”: Family check-up intervention effects on self-regulation that prevents growth in problem behavior and substance use. *Journal of School Psychology*, 51, 455–468.
- Fox, L., Vaughn, B. J., Dunlap, G., & Bucy, M. (1997). Parent-professional partnership in behavioral support: A qualitative analysis of one family’s experience. *Journal of the Association for Persons with Severe Handicaps*, 22, 198–207.
- Fox, L., Vaughn, B. J., Wyatte, M. L., & Dunlap, G. (2002). What we expect other people to understand: Family perspectives on problem behavior. *Exceptional Children*, 68, 437–450.
- Garbacz, S. A., Swanger-Gagné, M. S., & Sheridan, S. M. (2015). The role of school-family partnership programs for promoting student social and emotional learning. In J. Durlak, T. Gullotta, C. Domitrovich, P. Goren, & R. Weissberg (Eds.), *The handbook of social and emotional learning: Research to practice* (pp. 244–259). New York, NY: The Guildford Press.
- Gath, A., & Gumley, D. (1987). Retarded children and their siblings. *Journal of Child Psychology and Psychiatry*, 28, 715–730.
- Gellerstedt, M. E., & Mauksch, L. (1993). Chronic neurologic impairment: A family problem. *Family Systems Medicine*, 11, 425–431.
- Giallo, R., & Gavidia-Payne, S. (2006). Child, parent, and family factors as predictors of adjustment for siblings of children with a disability. *Journal of Intellectual Disability Research*, 50, 937–948.
- Gresham, F. M., & Elliott, S. N. (2008). *Social skills improvement system rating scales*. Minneapolis, MN: NCS Pearson.
- Harry, B. (1992). Developing cultural self-awareness: The first step in values clarification for early interventionists. *Topics in Early Childhood Special Education*, 12, 222–250.
- Heru, A., & Ryan, C. (2002). Depressive symptoms and family functioning in the caregivers of recently hospitalized patients with chronic/recurrent mood disorders. *International Journal of Psychosocial Rehabilitation*, 7, 53–60.
- Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2004).
- Jackson, A., & Haverkamp, D. E. (1991). Family response to traumatic brain injury. *Counseling Psychology Quarterly*, 4, 355–356.
- Jeynes, W. H. (2008). Effects of parental involvement and family structure on the academic achievement of adolescents. *Marriage & Family Review*, 37, 99–116.
- Katz, J. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, 13, 615–624.
- Kim, K.-H., & Morningstar, M. E. (2005). Transition planning involving culturally and linguistically diverse families. *Career Development for Exceptional Individuals*, 28, 92–103.

- Koegel, L. K., Steibel, D., & Koegel, R. L. (1998). Reducing aggression in children with autism toward infant or toddler siblings. *Journal of the Association for Persons with Severe Handicaps*, 23, 111–118.
- Kratochwill, T. R., & Bergan, J. R. (1990). *Behavioral consultation in applied settings: An individual guide*. New York, NY: Plenum Press.
- Landmark, L. J., Zhang, D. D., & Montoya, L. (2007). Culturally diverse parents' experiences in their children's transition: Knowledge and involvement. *Career Development for Exceptional Individuals*, 30, 68–79.
- Lasecki, K., Olympia, D., Clark, E., Jenson, W., & Heathfield, L. T. (2008). Using behavioral interventions to assist children with Type 1 diabetes manage blood glucose levels. *School Psychology Quarterly*, 23, 389–406.
- Lucyshyn, J. M., Albin, R. W., & Nixon, C. D. (1997). Embedding comprehensive behavioral support in family ecology: An experimental, single-case analysis. *Journal of Consulting and Clinical Psychology*, 65, 241–251.
- Lucyshyn, J. M., Horner, R. H., Dunlap, G., Albin, R. W., & Ben, K. R. (2002). Positive behavior support with families. In J. M. Lucyshyn, G. Dunlap, & R. W. Albin (Eds.), *Families and positive behavior support: Addressing problem behavior in family contexts* (pp. 3–43). Baltimore: Paul H. Brookes.
- Lucyshyn, J. M., Kayser, A. T., Irvin, L. K., & Blumberg, E. R. (2002). Functional assessment and positive behavior support at home and families: Designing effective and contextually appropriate behavior support plans. In J. M. Lucyshyn, G. Dunlap, & R. W. Albin (Eds.), *Families and positive behavior support: Addressing problem behavior in family contexts* (pp. 3–43). Baltimore: Paul H. Brookes.
- Mactavish, J. B., MacKay, K. J., Iwasaki, Y., & Betteridge, D. (2007). Family caregivers of individuals with intellectual disability: Perspectives on life quality and the role of vacations. *Journal of Leisure Research*, 39, 127–155.
- Macy, M., & Bagnato, S. J. (2010). Keeping it “R-E-A-L” with authentic assessment. *NHSA Dialog*, 13(1), 1–20.
- McCubbin, H. I., McCubbin, M. A., & Thompson, A. I. (1993). Resiliency in families: The role of family schema and appraisal in family adaptation to crises. In T. H. Brubaker (Ed.), *Family relations: Challenges for the future* (pp. 153–177). Newbury Park, CA: Sage.
- McHale, S., Sloan, J., & Simmeonsson, R. (1986). Relationships of children with autistic, mentally retarded and non-handicapped brothers and sisters. *Journal of Autism and Developmental Disorders*, 16, 399–415.
- Miller, L. (1993). Family therapy of brain injury: Syndromes, strategies, and solutions. *American Journal of Family Therapy*, 21, 111–121.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: The Guilford Press.
- Moes, D. R., & Frea, W. D. (2000). Using family context to inform intervention planning for the treatment of a child with autism. *Journal of Positive Behavioral Interventions*, 2, 40–46.
- Moore, K. J., Garbacz, S. A., Dishion, T. J., Gau, J. M., Brown, K. L., Stormshak, E. A., et al. (2016). Proactive parent engagement in public schools: Using a brief strengths and needs assessment in a multiple-gating risk management strategy. *Journal of Positive Behavior Interventions*, 4, 230–240.
- Moos, R. H., & Moos, B. S. (2002). *Family environment scale manual: Development, applications, research*. Palo Alto, CA: Mind Garden, Inc.
- Neismworth, J. T., & Bagnato, S. J. (2007). What are the professional standards for assessment of preschool children? In S. J. Bagnato (Ed.), *Authentic assessment for early childhood intervention: Best practices*. New York: Guilford Press.
- O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). *Functional assessment and program development for problem behavior: A practical handbook*. Pacific Grove, CA: Brooks/Cole.
- Olson, D. H., & Gorall, D. M. (2003). Circumplex model of marital and family systems. In F. Walsh (Ed.), *Normal family processes* (3rd ed., pp. 514–547). New York: Guilford Press.

- Olson, D. H., Gorall, D. M., & Tiesel, J. W. (2005). *Faces IV package*. Minneapolis, MN: Life Innovations.
- PACER Center. (2013). *A guide to preparing your child with a disability for life beyond high school*. Minneapolis, MN: PACER Center.
- Patterson, J. M. (2002a). Integrating family resilience and family stress theory. *Journal of Marriage and Family*, 64, 349–360.
- Patterson, J. M. (2002b). Understanding family resilience. *Journal of Clinical Psychology*, 58, 233–246.
- Pianta, R. C., & Walsh, D. J. (1996). *High risk children in schools: Constructing sustaining relationships*. New York: Routledge.
- Power, T. J., Mautone, J. A., Soffer, S. L., Clarke, A. T., Marshall, S. A., Sharman, J., et al. (2012). A family–school intervention for children with ADHD: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 80, 611–623.
- Quinn, W. H. (1995). Professional understanding of the community: At a loss for words? In P. Adams & K. Nelson (Eds.), *Reinventing human services: Community- and family-centered practice* (pp. 245–259). New York, NY: Adeline de Gruyter.
- Reynolds, C. R., & Kamphaus, R. W. (2015). *Behavior assessment system for children – Third Edition (BASC-3)*. Bloomington, MN: Pearson.
- Sheridan, S. M., Bovaird, J. A., Glover, T. A., Garbacz, S. A., Witte, A., & Kwon, K. (2012). A randomized trial examining the effects of conjoint behavioral consultation and the mediating role of the parent–teacher relationship. *School Psychology Review*, 41, 23–46.
- Sheridan, S. M., Clarke, B. L., & Ransom, K. A. (2014). The past, present, and future of conjoint behavioral consultation research. In W. Erchul & S. Sheridan (Eds.), *Handbook of research in school consultation* (2nd ed.). New York, NY: Routledge.
- Sheridan, S. M., Eagle, J. W., & Dowd, S. E. (2005). Families as contexts for children’s adaptation. In S. Goldstein & R. Brooks (Eds.), *Handbook of resiliency in children*. New York: Kluwer Academic/Plenum.
- Sheridan, S. M., & Gutkin, T. B. (2000). The ecology of school psychology: Examining and changing our paradigm for the 21<sup>st</sup> century. *School Psychology Review*, 29, 485–502.
- Sheridan, S. M., & Kratochwill, T. R. (2008). *Conjoint behavioral consultation: Promoting family–school connections and intervention* (2nd ed.). New York: Springer.
- Sheridan, S. M., Ryoo, J. H., Garbacz, S. A., Kunz, G. M., & Chumney, F. L. (2013). The efficacy of conjoint behavioral consultation on parents and children in the home setting: Results of a randomized controlled trial. *Journal of School Psychology*, 51, 717–733.
- Sheridan, S. M., Warnes, E. D., Woods, K. E., Blevins, C. A., Magee, K. L., & Ellis, C. (2009). An exploratory evaluation of conjoint behavioral consultation to promote collaboration among family, school, and pediatric systems: A role for pediatric school psychologists. *Journal of Educational and Psychological Consultation*, 19, 106–129.
- Sloper, P., & Turner, S. (1992). Service needs of families of children with severe physical disability. *Child: Care, Health and Development*, 18, 259–282.
- Soriano, M., Soriano, F. I., & Jimenez, E. (1994). School violence among culturally diverse populations: Sociocultural and institutional considerations. *School Psychology Review*, 23, 216–235.
- Stormshak, E. A., Connell, A. M., Véronneau, M.-H., Myers, M. W., Dishion, T. J., Kavanagh, K., et al. (2011). An ecological approach to promoting early adolescent mental health and social adaptation: Family-centered intervention in public middle schools. *Child Development*, 82, 209–225.
- Stormshak, E. A., Connell, A., & Dishion, T. J. (2009). An adaptive approach to family-centered intervention in schools: Linking intervention engagement to academic outcomes in middle and high school. *Prevention Science*, 10, 221–235.
- Stormshak, E. A., & Dishion, T. J. (2009). A school-based, family-centered intervention to prevent substance use: The family check-up. *The American Journal of Drug and Alcohol Abuse*, 35, 227–232.

- Stormshak, E. A., Fosco, G. M., & Dishion, T. J. (2010). Implementing interventions with families in schools to increase youth school engagement. The Family Check-Up Model. *School Mental Health, 2*, 82–92.
- Sue, D. W., & Sue, D. (1999). *Counseling the culturally different*. New York, NY: Wiley.
- Timmons, J. C., Butterworth, J., Whitney-Thomas, J., Allen, D., & McIntyre, J. P., Jr. (2004). Managing service delivery systems and the role of parents during their children's transitions. *Journal of Rehabilitation, 70*, 19–26.
- Tudball, J., Fisher, K. R., Sands, T., & Dowse, L. (2002). *Supporting families who have a child with a disability, for Families First Inner West*, SPRC Reports 1/03. Sydney: Social Policy Research Centre, UNSW.
- Turnbull, A. P., & Turnbull, H. R. (1991). Family assessment and family empowerment: An ethical analysis. In L. H. Meyer, C. A. Peck, & L. Brown (Eds.), *Critical issues in the lives of people with severe disabilities* (pp. 485–488). Baltimore: Paul H. Brookes.
- Turnbull, A. P., & Turnbull, H. R. (2001). *Families, professionals, and exceptionality: Collaborating for empowerment* (4th ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.
- Wade, S., Drotar, D., Taylor, H. G., & Stancin, T. (1995). Assessing the effects of traumatic brain injury on family functioning: Conceptual and methodological issues. *Journal of Pediatric Psychology, 20*, 737–752.
- Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42*, 1–18.
- Wang, M., Turnbull, A. P., Summers, J. A., Little, T., Poston, D., Mannan, H., et al. (2004). Severity of disability and income as predictors of parents' satisfaction with their quality of life during early childhood years. *Research and Practice for Persons with Disabilities. Special Issue: Family and Disability, 29*, 82–94.
- Weiner, R. K., Sheridan, S. M., & Jenson, W. R. (1998). The effects of conjoint behavioral consultation and a structured homework program on math completion and accuracy in junior high students. *School Psychology Quarterly, 13*, 281–309.
- Ylven, R., Bjorck-Akesson, E., & Granlund, M. (2006). Literature review of positive functioning in families with children with a disability. *Journal of Policy and Practice in Intellectual Disabilities, 34*, 253–270.
- Zarski, J. J., DePompei, R., & Zook, A. (1988). Traumatic head injury: Dimensions of family responsiveness. *Journal of Head Trauma Rehabilitation, 3*, 31–41.

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