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DIVERSITY AND INCLUSION FORUM

Inherent Tensions and Possibilities: Behavior Analysis and Cultural Responsiveness

Kristin L. Miller[1] · Alicia Re Cruz[2] · Shahla Ala'i-Rosales[2]

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Abstract

The demographics of the United States, and of the world, are rapidly changing; national and racial diversity is increasing and bifurcation of socioeconomic status continues. These societal patterns highlight the tensions and hopeful possibilities inherent in the science and practice of behavior analysis. In this paper, we review the general climate surrounding diverse populations and access to care, characterize the demographics of behavior analysis and leadership, and discuss the synergistic activities two related disciplines, public health and anthropology, may contribute toward social justice. We conclude with recommendations and goals for increasing cultural responsiveness in the study and practice of behavior analysis. Such responsiveness is likely to allow advances in our understanding of how behavior changes and what meaning those changes have for individuals and society.

Keywords Cultural responsiveness · Applied behavior analysis · Social justice · Diversity · Ethics

Increasingly, behavior analysts practice within culturally diverse settings. According to the Pew Center, by 2055, the United States may not have a dominant ethnic or racial majority (Cohn & Caumont, 2016). The number of culturally and linguistically diverse children in the United States is predicted to increase to 50% by 2020 (U.S. Census Bureau, 2015). In 2018, the National Center on Education reported that almost 20% of the estimated 50.4 million students in U.S. schools are living in poverty and the majority of students receiving special education are non-White (McFarland et al., 2018). Disparities and rapidly changing demographic compositions are not confined to the United States and

The original version of this article was revised: The captions for Figures 1 and 2 are correct, but the artwork currently above the Figure 2 caption belongs above the Figure 1 caption; and the artwork currently above the Figure 1 caption belongs above the Figure 2 caption.

✉ Kristin L. Miller
Kristin.Miller@juvobh.com

[1] Juvo Autism and Behavioral Health and Tri-Valley Anti-Poverty Collaborative, 1200 Concord Ave., Ste. 100, Concord, CA 94520, USA

[2] University of North Texas, Denton, TX, USA

are observed on a global level (World Bank Group, Global Monitoring Report, 2016). In many fields, there is ongoing discourse surrounding cross-cultural interactions (Danso, 2015) and social justice (Hempill, 2015; Rosales, Coe, Ortiz, Gamez, & Stroupe, 2012), and behavior analysts are increasingly part of the conversation (see, e.g., Fong, Catagnus, Brodhead, Quigley, & Field, 2016; Fong, Ficklin, & Lee, 2017; Fong & Tanaka, 2013; Sugai, O'Keeffe, & Fallon, 2012). Discussions about diversity and disparities call for a consideration of how the philosophical foundations and components of behavioral service delivery interact with the spectrum of culture and demographics in the United States.

The purpose of this paper is to examine the practice of applied behavior analysis (ABA) in an expanded disciplinary light, referencing the field's work in promoting social justice and similar work in other disciplines and movements in society as a whole, to be responsive to cultural and demographic differences. To this end, the synergistic contributions of other *applied* or *action* disciplines will be considered. *Applied* in any discipline means there is a commitment to testing and experimentation under natural conditions and to immediate betterment as guiding principles in pursuing both action and generalized knowledge (Baer, Wolf, & Risley, 1968; McKay & Marshall, 2001). The intent is to explore important concepts and intersections, sometimes using the language and frameworks of other disciplines as used by those disciplines, rather than to provide a behavioral reconceptualization of these terms and concepts. Our goal is to contribute to the promotion of a deeper level of responsiveness to cultural diversity, humility, and, ultimately, effective and sustainable behavioral practice across populations and for the betterment of humanity as a whole. We will end the paper with an overview of pathways to advance this goal.

Cultural Diversity and Social Justice

In this paper, *culture* is used to refer to a group that shares similar sets of histories, and we rely on a behavioral conceptualization presented by Sugai et al. (2012):

> the extent to which a group of individuals engage in overt and verbal behavior reflecting shared behavioral learning histories, serving to differentiate the group from other groups, and predicting how individuals within the group act in specific setting conditions. That is, "culture" reflects a collection of common verbal and overt behaviors that are learned and maintained by a set of similar social and environmental contingencies (i.e., learning history), and are occasioned (or not) by actions and objects (i.e., stimuli) that define a given setting or context. (p. 200)

When we speak of culture, we will use Sugai et al.'s description of shared learning histories, and when we speak of diversity, we are talking about groups that are different from other groups in how they may act, feel, and give meaning to events. The way in which education and medical professionals describe desired interactions between people of diverse cultural backgrounds varies and has changed over time to reflect a growing body of scholarship and understanding (see, e.g., Danso, 2015). We will examine three variations here: competence, responsiveness, and humility.

To different degrees, each of these three concepts addresses issues of social injustice and social justice. Social injustice involves denial or violation of human rights (health,

education, political, civil) of specific groups because they are thought to be inferior to the current hegemony or because they are vulnerable and not collectively protected by society; social justice usually means all people, regardless of their status, abilities, or identities are afforded basic human rights (United Nations Declaration of Human Rights, accessed 2019). According to Levy and Sidel (2006), "Many definitions of social injustice therefore hold that achieving social justice involves eradicating poverty and illiteracy, establishing sound environmental policy, and attaining equality of opportunity for healthy personal and social development" (p. 8). Although these larger societal issues are often matters of policy or population-based programs, behavioral practitioners either support or hinder social justice through the translation of their foundational philosophy and academic research, organizational policy and systems, and individual practices.

Definitions of cultural *competence* vary across sectors but share common themes. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring service delivery to meet patients' social, cultural, and linguistic needs (Betancourt, Green, & Carrillo, 2002; Cross, Bazron, Dennin, & Isaacs, 1989). In 2003, the U.S. Department of Health and Human Services defined *cultural competence* as "the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services." Similar constructs of competence have been described and applied to the practice of behavior analysis by Fong and colleagues (Fong & Tanaka, 2013; Fong et al., 2016; Fong et al., 2017). The primary aim of cultural competence models is to make the interventions more accessible and consumable by people of diverse backgrounds. The rationales for attending to cultural differences and competence in behavior analysis, health care, human services, and education sometimes arise from the promotion of social welfare (to eliminate disparities and to improve outcomes) and sometimes reflect self-serving motivations (to meet legislative mandates, to gain a competitive edge, and to decrease malpractice claims; Goode & Dunne, 2003). To focus on promoting social welfare and to avoid self-serving motivations, Paasche-Orlow (2004) suggests an empowerment rationale that applies equally well to behavioral services: Culturally competent care reflects "an ethical commitment to patient autonomy and justice" (p. 3). Within this perspective, we would be mindful that the principles that apply to creating more sensitive and responsive environments for individuals from culturally diverse backgrounds equally apply to people who have been exposed to social and economic disparities. In fact, it is often the case that these two groups intersect.

The parallels between cultural considerations in medical, psychological, and behavioral practice are informative. In speaking on the ethics of cultural competence in medical practice, Paasche-Orlow (2004) discusses the importance of acknowledging culture, lived experience, and social and economic disparities as a vehicle for understanding individuals' orientation and to inform malleable aspects of service delivery. Although physicians (and behavior analysts) may demonstrate an appreciation of diversity, they often stop short of embracing true patient-centered care. Beginning in the current century, there has been a new understanding that patient-centered care is respectful and responsive to individuals' beliefs, values, and lived experiences (Institute of Medicine Committee on Quality of Healthcare in America, 2001).

Cultural *responsiveness*, a concept primarily used in education, is usually described as a collection of educational practices that respect and honor diversity. This includes

engaging all learners by incorporating cultural interests and preferences into the curriculum; creating a safe, inclusive, and respectful learning environment; implementing teaching practices derived from principles that cross disciplines and cultures; and promoting justice and equity in society (Wlodkowski & Ginsberg, 1995). Cultural responsiveness places a strong emphasis on viewing cultural variations and differences as strengths, rather than as needs that require accommodation. Cultural values and practices are to be woven into goals, curricula, and methods so as to contribute to the overall growth of both teachers and students as they learn from one another (Bassey, 2016). Cultural responsiveness has also been closely aligned with social justice, in that a primary aim of responsive practice is to decrease educational disparities and increase success for oppressed populations. In fact, cultural responsiveness is seen as part of the teacher's role in maintaining a democratic society (Bassey, 2016).

Cultural *humility* is a concept discussed across several disciplines (Abell, Manuel, & Schoeneman, 2015; Fischer-Bourne, Cain, & Martin, 2014; Murray-Garcia & Tervalon, 2014). Within this construct, there is an emphasis placed on the importance of self-reflection, including the recognition of one's own prejudices and implicit and explicit biases. It also includes responsible action following critical analysis about one's own behavior. The emphasis is not so much on developing competence with people of "other" cultures as it is with developing ongoing relationships while focusing on accountable change in one's self and one's institutions as a result of those relationships and the personal growth resulting from those relationships (Fischer-Borne et al., 2014). Perhaps the concept of cultural humility carries the strongest social justice emphasis. Cultural humility calls for practitioners to challenge societal oppression, recognize power differentials, and strive to balance power dynamics within their own behavior and within the systems in which they function (Fischer-Borne et al., 2015).

We cover these approaches to highlight several issues. First, there is a concerted effort across many disciplines, such as education, medicine, nursing, social work, and psychology, to grapple with cultural diversity and, to a lesser degree, social justice. The importance is generally recognized across every area of practice. Second, how we relate individually and systemically to the "other" is not an easy subject of study. There are complicated discussions and debates surrounding diversity and how we most effectively conceptualize the processes and adjust our behavior in relation to one another (Danso, 2015). Finally, ABA is part of the discussion; our discipline has roots that may both encourage and hamper efforts centered on culture and social justice.

Inherent Tensions and Possibilities

The discipline of ABA emerged during a time in U.S. history that held open discourse on inclusion and social justice (Wright, 1983). For example, President Johnson's speech on his Great Society initiatives at Athens University included strong sentiments related to eliminating disparities and creating a just society:

> With your courage and with your compassion and your desire, we will build the Great Society. It is a Society where no child will go unfed, and no youngster will go unschooled. Where no man who wants work will fail to find it. Where no citizen will be barred from any door because of his birthplace or his color or his

> church. Where peace and security is common among neighbors and possible among nations. (Johnson, 1964)

At its inception, ABA echoed the times and articulated a commitment to producing and understanding meaningful social changes (Baer et al., 1968; Wolf, 1978). A brief review of the early years of the *Journal of Applied Behavior Analysis* reveals a number of studies specifically aimed at empowering the disempowered. The genesis of ABA was a natural science approach aimed at social good: to "use our knowledge about human behavior to create a social environment in which we shall live productive and creative lives and do so without jeopardizing the chances that those who follow us will be able to do the same" (Skinner, 1953, p. xvi). The underlying premise of the ABA paradigm is that by addressing the behavior of individuals and their experiences, socially important problems can be understood and solved through scientific methods (Fawcett, 1991). Our foundations allow hope for goals of social justice and cultural competence, responsiveness, and humility.

At the same time, several factors in both behavior-analytic scholarship and practice create barriers to fulfilling a social justice mission. The first relates to the demographics of behavior-analytic leadership and decision makers who have been largely representative of a colonial hegemony—Caucasian, male, and Western. The overrepresentation of the dominant male group has been addressed in various publications (see, e.g., Nosik, Luke, & Carr, 2018; Wesolowski, 2002). As in other professions, this group has exerted disproportionate influence on the questions and procedures of research in the behavioral sciences; as such, the cultural practices of the dominant group are reflected in the majority of disciplinary practices (Henrich, Heine, & Norenzayan, 2010). It should be noted that there is a reported increase in female researchers and editors for some behavior-analytic disciplinary journals (Li, Curiel, Pritchard, & Poling, 2018). At the same time, there is almost no information, aside from gender, about diversity, with the exception of Beaulieu, Addington, and Almeida (2018), who reported that 84% of recently surveyed BCBAs identify as "White." The fact that so little information has been collected and considered may be a form of "cultural blindness" (Cross et al., 1989), in which differences (histories, behaviors, reinforcers, etc.) between cultural groups are denied, assimilation to the dominant group is required, and few or no resources are allocated to understanding and being responsive to culture.

At least one call for avoiding colonial practices (authority, subjugation, and superiority) and for greater collaboration (participatory, shared control and input, respect, and equality) has been made in research in ABA (Fawcett, 1991) and many more in practice (e.g., Fong & Tanaka, 2013; Fong et al., 2016; Fong et al., 2017), especially in the areas of positive behavioral supports and interventions (e.g., Lucyshyn, Dunlap, & Albin, 2002; Sugai et al., 2012) and acceptance and commitment therapy (ACT; e.g., Fuchs, Lee, Roemer, & Orsillo, 2013). Therapies such as ACT have intentionally addressed cultural adaptation, and preliminary results are promising (LaRoche & Lustig, 2013; Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012). Still, there have been limited empirical evaluations of these efforts. The extent to which behavior analysts successfully serve diverse populations, have a diverse professional body, or successfully improve the well-being and the power dynamics for marginalized or oppressed populations is unclear.

The second issue relates to an articulated concern that practice agendas in ABA have paralleled the commodification of the capitalist rationale. A drift from the origins of

science for the social good to an enterprise for profit and privilege is noted by at least one group of behavior analysts (see Keenan, Dillenburger, Moderato, & Röttgers, 2010). Similarly, there is discussion about funding streams and organizational structures that present barriers to caring and compassionate practice in the field of medical practice (see, e.g., Rider et al., 2018), as well as in behavior analysis (Taylor, LeBlanc, & Nosik, 2018).

The third issue is related to the potentially conflicting realms of evidence-based practice and culturally responsive practice. This tension has been described by Harvard researcher Martin LaRoche and colleagues in the context of psychology, but it might also apply to behavior analysis (LaRoche & Christopher, 2008). Briefly, the issue is that a majority of research has been conducted without reference and attention to cultural issues, with "notorious" underreporting of race, ethnicity, and cultural information (Bernal, 2006; LaRoche & Christopher, 2008). Research is primarily developed with efforts aimed at increasing internal validity. This is often at odds with external validity, in that cultural issues are seen as "extraneous" and not amenable to experimental analysis or consideration. Furthermore, the resulting evidence-based interventions are viewed as commodities, with implicit strategies for stakeholder "buy-in" and "compliance" with treatment procedures (LaRoche & Christopher, 2008), especially in those cases where the dominant group is attempting make adherence and acceptance increase within communities of people of non-White, diverse backgrounds.

The fourth issue is that behavior analysis is a discipline that studies the process of behavior change, not necessarily "what" is changed. "What" is largely determined by the dominant cultural norms and the existing evidence base. It is generally considered the domain of the practitioner to ensure social importance for the individual (see, e.g., several widely used textbooks in ABA, such as Cooper, Heron, & Heward, 2007, and Mayer, Sulzer-Azaroff, & Wallace, 2014, which have short sections in this area, and the BACB Task List and the Professional and Ethical Compliance Code, 2014, which has two sections in this area). These sources direct practitioners to include the recipients of services in the planning and evaluation of behavior-change programs in a culturally responsive way; however, recent studies suggest that behavior analysts receive a paucity of training to effectively do so (Beaulieu et al., 2018; Fong et al., 2017). Many people may be practicing within the context of organizations that do not have sufficient organizational policy aimed toward promoting culturally appropriate intervention and equity in access to treatment.

These issues highlight both tensions and possibilities found in the discipline of behavior analysis. On one hand, we operate in a field developed in a Caucasian, male, and Western context and practice largely in a capitalist system besieged by medical funding contingencies that do not necessarily support time or effort for the behaviors required for cultural competence, responsiveness, or humility. On the other hand, ABA was founded on a commitment to meaningful social change and has from its inception sought to serve the greater good (Baer et al., 1968). Much of the research in ABA is dedicated to improving life for protected populations.

Common Missions

In consideration of the gap between the current state of practice and the more aspirational missions, one might begin by referencing the knowledge about social justice and cultural diversity developed in other disciplines to inform both individual

practice and systems-level change. Although several disciplines have focused on this work, we discuss two in depth (public health and applied anthropology) and list several other disciplines that would constitute appropriate referents for behavior analysts in practice and applied researchers.

Public Health, Social Injustice, and Social Justice

Public health helps us understand where problems exist and the extent to which those problems promote injustice among groups of people. Public health emerged as a discipline at the turn of the last century as a result of an increased understanding of variables related to compromised health conditions and a societal commitment to health equity, prevention initiatives, and systems-level campaigns (Levy & Sidel, 2006). Behavioral practice informed by public health knowledge allows behavior analysts to better understand where inequities exist, the conditions under which they are formed, and how to systematically address these issues in their own communities of practice. For example, Winett, Moore, and Anderson (1991) offer methods to incorporate epidemiological data, verify the scope and importance of interventions, and identify underserved populations to decrease disparities and increase access to behaviorally based health care.

There are well-documented health disparities related to culturally and linguistically diverse individuals and individuals from backgrounds of low socioeconomic status (SES) that should be of concern to behavior analysts (see, e.g., Chen, Martin, & Matthews, 2006). Perhaps in part because poverty in America has shown increasing trends in recent years (U.S. Census Bureau, 2015), differential access to diagnostics and services for children with autism, for example, are increasing rather than decreasing (e.g., Durkin et al., 2010; Durkin et al., 2017; Mandell et al., 2009; Williams, Matson, Beighley, & Konst, 2015; Van Naarden-Braun et al., 2015). Conversely, children from culturally and linguistically diverse and low-SES backgrounds demonstrate overrepresentation in the prevalence of other developmental disabilities (Boyle et al., 2011; Spencer, Blackburn, & Read, 2015).

Public health programs use subpopulation data as evidence of utilization and engagement with services. For example, a 2014 internal audit at the Regional Center of the East Bay (2017) indicated disparities in the access and utilization of ABA services across the number of hours and the time in program for low-SES and culturally diverse families, prompting the incorporation of cultural competence training for vendored providers. The degree to which behavioral service providers and researchers have collected sufficient demographic data, including cultural background and SES data, as part of their intake procedures and protocols to ensure that the clients served and studied are demographically representative of the regional population is unclear. Certainly, the collection of these data is the first step to remediate disparities in access; public health practice informs us that the second step involves conducting outreach to underserved populations. Service utilization is probably more widely measured because it is the metric for billing for services. Again, the degree to which providers are identifying differences in utilization based on demographic variables is unclear. Behavior analysts have the opportunity to discover these differences if they do exist and investigate the reasons for these differences through key interviews, focus groups, and surveys so that responsive programs can be put in place, as opposed to determining that families are not "buying in" or able to abide by standard service guidelines (Angell, Frank, & Solomon, 2016).

To this end, public health professionals know that the simple accommodation of program elements, such as providing language interpretation, falls short of creating a responsive and respectful program. A Western, Caucasian, middle-class bias may be "baked" into the behavioral treatment cycle, beginning with assessment (see, e.g., discussions of cultural bias in screening tools by Harris, Barton, & Albert, 2014, and Perera, Jeewandara, Senevirante, & Geruge, 2017) and continuing through the selection of intervention targets and procedures, program participation requirements, and so on. Thus, it is important to learn from the populations served how they wish to be served and use behavioral principles to serve them in that way. The incorporation of other types of information-gathering procedures, discussed in the following section, may be of value.

If all of this seems daunting, it is important to remember that families operate from a strengths-based perspective. *Resilience*, a concept influential in the field of public health, refers to the elements (behaviors) that enable families to cope more effectively and emerge hardier from crises or persistent stresses (Hawley & DeHaan, 1996; Walsh, 1996; Wulff, Donato, & Lurie, 2015). Although resilient behaviors are often viewed as those the family either possesses or lacks, behavior analysts can support the development of resilience in a family by exhibiting compassion and empathy and by collaboratively developing goals and procedures that align with the family's perspectives regarding resiliency and the well-being of the family and community over time. In this way, families can practice being and feeling successful in ways that are in alignment with their cultural context, which may then lead to increased hopefulness, self-sufficiency, and coherence—at least in terms of their children's well-being—between their cultural context and that of the behavioral interventions. In the 2002 article "Deconstructing Paternalism: What Serves the Patient Best?" Tan explores the dichotomy between medical paternalism and patient autonomy. Tan states that the "principle of beneficence . . . [leads] to the physician's prerogative to act on his or her best judgment for the patient" (p. 148). Tan goes on to state that debates on medical paternalism should extend beyond who should make decisions to a greater understanding of the best interests of the patient from the patient's perspective. For behavior analysts, this translates into questions related to whether and how to intervene and how we know the answers to those two questions.

When the behavior analyst takes the time to explore and respect a family's orientation, and to provide rationales and details about procedures and the evidence base, it is more likely that the behavior analyst and the family will collaborate, that the family will become more resilient and better able to advocate for their preferences and needs, and that the behavior analyst will have an expanded view of how to change behavior across multiple cultural contexts and promote social justice.

Applied Anthropology, Specific Cultures, and Collaborative Methods

Understanding groups with shared cultural contexts and learning histories is the domain of anthropology. When that understanding is put to use, we step into the arena of an anthropology that applies methods, theories, and concepts to confront social and human problems. In other words, applied anthropology brings anthropology into action. This usually translates into political advocacy and ethical action (Partridge, 1985).

The collaboration and participation of those involved are embraced rather than avoided. This type of applied research aims at community-based change that integrates

advancing scientific knowledge with the intent to improve the welfare of people and communities. The transformation from observer to collaborator was not immediate. The original inspiration stemmed from *action anthropology*, a movement led by Sol Tax (1958, 1960). Tax's work emphasized providing communities with genuine control and choices, while avoiding the tendency of imposing researcher values on communities. Action anthropology was the precedent for *collaborative anthropology* that emerged in the 1970s (Schensul & Schensul, 1992). The premise was to maintain egalitarian power relationships within the research process and in relation to the broader social, economic, and political structures. This approach then fertilized the anthropological soil for *participatory* and *community-based* research (Greenwood & Levin, 1998). Community-based research works toward the well-being of oppressed populations while being critical of hegemonic structures that contribute to the status quo, inequality, and social injustice (e.g., Baer, Singer, & Susser, 2004; Castro & Singer, 2004; Johnston & Downing, 2004; Singer, 2006). Since the 1960s, applied anthropology has progressively become more and more engaged in the process of understanding how to responsively tailor methods and priorities. By some, it has been viewed as an effortful series of endeavors to find methods that are aligned with social justice and guided toward decolonizing practices (Allen & Jobson, 2016).

Anthropology can inform behavior analysis about cultural groups in many ways: about the patterns of behavior and values of specific groups, about historical and political variables affecting their well-being, about methods for self-reflection, and about methods for collaboration. In addition, the discipline of anthropology provides methodological dexterity for macro and micro levels of analysis, which become very productive in the understanding of the cultural dimensions of behavior. The ultimate goal of applied anthropology is intervention to provoke changes in the cultural and social dynamics of groups in ways that are conducive to social justice and equality. Powerful research strategies related to the practice of ethnography (the systematic study of cultures) can be incorporated from applied anthropology. This includes the use of qualitative methodologies, particularly those focused on people's narratives, or stories, and conversations as avenues for identifying key cultural symbols and meaning. Particularly in interventions, people's experiences are emotionally loaded; in these contexts, the use of narratives as a methodological core can be useful and productive. Furthermore, narratives can be helpful toward understanding the identity construction and meaning of social interactions involved within intervention programs (Bagatell, 2007). Ethnographies, one way of engaging in narrative conversations, can help behavior analysts understand different perspectives and lived experiences within and across cultures. The qualitative ethnographic methodologies of applied anthropology are oriented toward openly engaging in conversations with others to understand lived experiences and meaning. Ethnographies have standard methods for learning about others through observation and interviews (Westby, Burda, & Mehta, 2003). Although behavior analysts are often uncomfortable with verbal reports, listening to individual, family, and community narratives about their lives and experiences and the meaning they assign to events is the starting point. In sum, these methods serve as a way to understand their ascribed meaning to social realities, both within and outside of an intervention context.

Structured assessments and observations, such as the Verbal Behavior Milestones Assessment and Placement Program (Sundberg, 2008) or the Functional Assessment Screening Tool (LaRue, 2013), developed within one dominant culture (i.e., U.S.

Caucasian middle class) will be restricted to a limited number of responses and will reflect the history and perspectives of that culture and be rife with assumptions about the relative importance and values of intervention goals. Asking individuals about themselves, their families, and their cultures in ways that are more likely to invite unrestricted responding is the domain of anthropology. The results of ethnographic techniques will better help us understand and transform behavioral practice to be more inclusive and just. For example, variables such as the location of the interview, the types of questions asked, the types of responses to participants during conversations, and the methods of exploring topics in ways that glean additional information and meaning are a central part of the disciplinary knowledge of applied anthropology.

Intervention programs should be dynamic, responsive, and interactive social-validation procedures—such as ongoing, open-ended conversations with people we serve—which should be part of the dynamic (Finney, 1991). Anthropology has had a sustained effort to understand how the position of the ethnographer can influence the information gathered and how to ask questions in ways that invite interviewer self-reflection to reduce interviewer bias and influence (Bernard, 2018). Furthermore, the framing of these questions can reduce cultural blindness and facilitate meaningful engagement. Under these conditions, empathy and mutual understanding are more likely to occur.

Content Disciplines, Culture, and Social Justice

In addition to the benefits of process disciplines such as anthropology and public health, it is helpful to learn about the history and issues related to specific populations. There are content disciplines related to the shared experiences of specific groups of people. The importance of these disciplines is critical to advancing cultural responsiveness and is seen as a necessary development in the process of decolonization and the creation of socially just societies (Allen & Jobson, 2016). We will highlight just a few of these areas.

The program labels of these disciplines vary depending on the institution and the group compositions. For example, programs such as women's studies, gender studies, indigenous studies, African American studies, Latinx studies, Islamic studies, Jewish studies, and so on are dedicated to the specific concerns of the identified cultural groups. Often, these interdisciplinary programs are housed under one umbrella with specific missions focused on the advancement and well-being of the group. For example, this is a portion of the mission of the Department of African American Studies at the University of California, Berkeley (2018):

> The Department of African American Studies is an intellectual community committed to producing, refining and advancing knowledge of Black people in the United States, the Caribbean, Latin America, Europe and Africa. A key component of our mission is to interrogate the meanings and dimensions of slavery and colonialism, and their continuing political, social and cultural implications.

Understanding the historical and contemporary dimensions of the African American experience provides important context for transformative interventions. For example, learning about the importance and role of family and the collective community in providing support and guidance could facilitate increased cultural responsiveness and inclusion (Lynch & Hanson, 2011, pp. 140–183). Increased understanding of the factors

that have led to overdiagnosis of behavior disorders among African American children (McKenna, 2013) might lead to better approaches to advocacy for early diagnosis and starting behavior-change programs in a timely fashion. Understanding the historical atrocities and deceit of medical systems in relation to people of color (King, 2003) might increase the degree of transparency and collaborative planning within interventions. Learning such things will transform (i.e., change in structural and functional ways) the way we practice and conceptualize the mechanisms of our practice.

Families who also have substantial challenges due to immigration status, economic hardship, or racial and ethnic membership are more vulnerable than those of the dominant culture. The interconnection of different identity layers is what is known as *intersectionality*, and there are groups of scholars specifically devoted to understanding the nature of intersectionality and the variables involved. There is, in fact, an area of study, dis/ability critical race theory (DisCrit), surrounding the difficulties faced by people who are both disabled (such as children with autism) and also members of the nondominant social group for racial, ethnic, or economic reasons (Annamma, Conner, & Ferri, 2013). DisCrit posits that constructs such as racism and ableism deny rights to people who function outside of Western cultural norms, and as a result, those individuals are advertently or inadvertently harmed within many systems. Furthermore, ability is often viewed as a commodity to be purchased—one that may not accessible or conceptualized in a material framework. This has implications for service delivery in behavior analysis, in that individuals with disabilities from nondominant groups and their families will approach and be approached differently within the intervention process as a result of their intersectionality (Hanson, 2011).

Evolving Behavior-Analytic Practice

As behavior analysts, we probably strive for some combination of cultural competence, responsiveness, and humility. These concepts were tailored to specific areas of practice—primarily medicine, education, and social work. As these are likely to remain concepts in flux, we propose that behavior analysts evolve their practice at both the individual and organizational levels commensurate with the developments in other fields and society as a whole. This will require an ongoing conversation about both our impact on the direct consumers of services and the impact of behavior-analytic services on society. Presumably, we seek something beyond "buy-in" and "compliance" in our current behavior-change approaches. We suggest that the structures of our practice will look very different if the cultural preferences of different groups that behave and value differently than the dominant group are included. Our development will evolve in direct relationship to greater cultural diversity in our membership, in our research, in our practices, and in our leadership.

Figure 1 attempts to illustrate two contrasting approaches to behavior change. The first is a colonial approach in which a dominant group designs the goals and procedures and places individuals in their existing systems, with a consideration of culture from the behavior analysts' perspective in light of the behavior-change goals. The second illustrates an interactional approach wherein it is acknowledged that each participant has experiences and contingencies that will affect the change process by way of their individual perspectives, cultural identification, and other demographic variables. It will be at the intersections of these groups that the shared values, analysis, and learning will

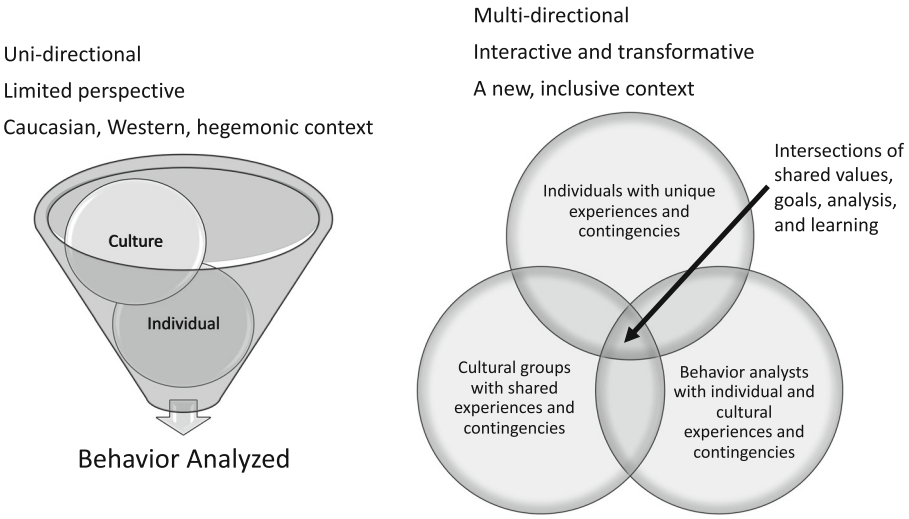

Fig. 1 Two possible, different ways of approaching relationships between behavior analysts, cultures, and individuals; the first is the current unidirectional approach and the second is an interactional/transformative aspiration

take place. This second construct is consistent with Wolf's seminal framework (1978), in which he called for better systems and measures to determine social importance because "it is clear that a number of the most important concepts of our culture are subjective, perhaps even the most important" (p. 210).

Fortunately, social validity and cultural responsiveness are not new notions in ABA. In 1978, Wolf proposed three levels of necessary assessment—the goals, the procedures, and the effects—in order to determine if "our clients are happy with our efforts and our effects" (p. 213). Wolf described several examples of measures and strategies to assess social importance, including asking people, providing support for a more anthropological lens. Additionally, Fawcett (1991) laid out guidelines for noncolonial approaches to community-based research in behavior analysis. They are equally applicable to behavioral practice. The first challenge for behavior analysts is to avoid entering into colonial relationships: where the behavior analyst holds power and control of the program and important consequences and the consumers do not. Fawcett contrasts this with collaborative approaches that utilize ethnographic, anthropological methods to understand and embrace "the importance of the knowledge and experience of participants" (p. 624). At the same time, he acknowledges the difficulties in ascertaining traditionally unempowered or disempowered people who have histories of marginalization, and he offers strategies to build goals and interventions together. These goals are expanded and supported by researchers and activists in the Community Toolbox, a free online research resource site for social change in communities, with a focus on cultural inclusion and community empowerment (Center for Community Health and Development, 2017).

Whereas Fawcett focused on community research and action in behavior analysis, Sugai et al. (2012) called for a contextual consideration of culture when implementing positive behavioral supports in school settings. They first highlighted the disparities in outcomes and opportunities and the disproportionate numbers of children in special education from the nondominant culture, suggesting several variables that should be considered to create a culturally relevant, system-wide support for schools. Their

emphasis is on the organization and responsiveness of the system to cultural differences to validate cultural relevance. At the systems level, they make several recommendations, including encouraging leadership representation by culturally and linguistically diverse people and providing opportunities for faculty to learn about the families of the children they serve.

More recently, Fong et al. (2016) have offered a set of suggestions for behavior analysts to develop cultural awareness. The recommendations center on understanding one's own cultural identity, as well as specific strategies, such as culturally responsive assessments tools and the development of communicative competence. At the organizational level, Fong et al. (2016) call for the identification of an individual who would guide the cultural progress of the organization and incorporate cultural awareness training into supervision and training practices. They close their discussion by emphasizing the need for continued openness to learn and develop systematic guidelines for working with culturally diverse clients.

Here, we build on the recommendations made by Fawcett (1991), the Community Toolbox (Center for Community Health and Development, 2018), Sugai et al. (2012), and Fong et al. (2016) in three levels: leadership in the field, organizations and companies, and individual practitioners. In these recommendations, we reference our knowledge of public health and applied anthropology and our own personal, professional, and cultural experiences to develop and guide culturally responsive practice and promote social justice in ABA.

Leaders in the field of behavior analysis should increasingly work to bring the discipline in line with current social movements and conditions, as well as developments in related disciplines. Activities may include advocating for populations who are unserved or underserved, advocating for the expansion of behavioral services to other populations who would benefit (rather than, e.g., continuing to focus primarily on children with autism), championing programs of research that study and support the delivery of behavior-analytic services in culturally diverse populations, and training behavior analysts to work effectively with diverse populations. Behavior analysts should form special interest groups and partner with professionals in public health and public policy to guide their work and learn from those who have been effective in this sphere for decades.

Many behavior analysts lead companies and organizations. Organizational leaders play a vital role in the translation of behavior-analytic services through their protocols and practices. First, organizations can be responsive in addressing disparities by tracking the demographic data of their clients and referencing regional demographics to ensure equal representation in and access to their services. When disparities are discovered, they should be remediated through systematic outreach. Second, organizations must also measure service utilization rates and determine if disparities exist for subpopulations served. If so, the reasons must be discovered and remediated at the program level. For example, organizations might find that their policies are unfriendly to particular cultures or that criteria are impossible to meet for families who have unstable economic conditions. Perhaps there are simple accommodations (e.g., language translation, matching staff and families from the same culture) that can be made. But often the changes need to be more substantial and have barriers to implementation (e.g., insurance companies allowing only a certain amount of time for an assessment, calling for the use of particular assessments, restricting the treatment goals and participants). We can consider meeting the needs of the greater community through more fluid models of service, which for some families may involve different layers of service providers, different configurations of

service times, options of on-site and in-home services, and health navigators. Although these are difficult issues, it is the responsibility of the field to drive its own best practices instead of deferring to third-party payers to develop our practice guidelines.

Individual practitioners are responsible for implementing best practices, keeping their education current, and referencing cultural movements and developments in related fields.

Figure 2 lists pathways for professionals to increase their skills. Pathways, metaphorically, are routes that have not been well developed, like superhighways, but allow flexible travel and fluidity. Each pathway is meant to help explore, develop, and, perhaps, dissipate some of the tensions that have been intrinsic to a field created and maintained in a primarily Caucasian, Western, and cis-male context. More importantly, they are intended to work toward more inclusive practices that will invite, include, and respond to the voices of all people, including those who are non-Caucasian, non-Western, and non-cis male. It is clear that efforts to increase cultural responsiveness and humility must be made at all levels (Cross et al., 1989).

Allocate Resources, Time, and Behavior

Creating a change from the dominant paradigm to an inclusive paradigm will take the allocation of dedicated resources, time, and behavior from academics and practitioners at all levels. This literally means scheduling agenda items and hours in the workday to talk about culture, to seek new experiences with people of different cultures, to create missions and learning activities dedicated to responsiveness, and to evaluate the effects of increased efforts. It means spending time and attention on strategic efforts to make progress from baseline. It also means figuring out how to do this within systems that rely on fixed numbers of billable hours in a workday for practitioners.

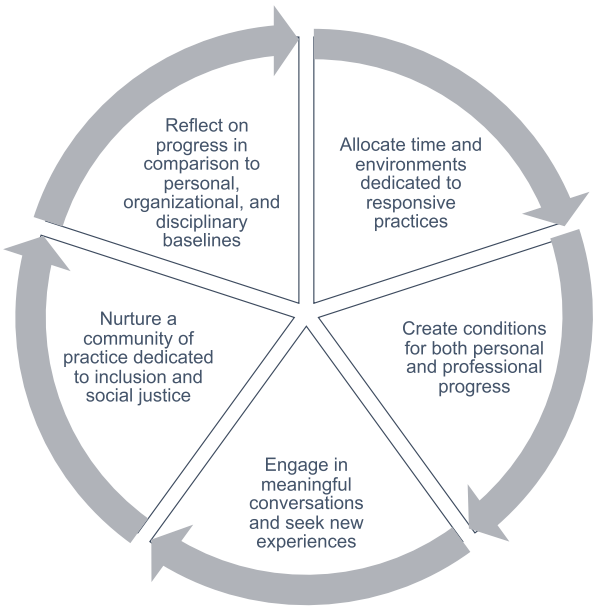

Fig. 2 Interrelated goals and five pathways likely to lead to more inclusive practices and social justice

Seek New Experiences

Learning about culture requires direct exposure and feedback. It is not enough to change the topography of responding and focus on a checklist of "culturally correct" ways of interacting with people who are different from ourselves. Without the right stimulus and reinforcer control, our behavior will be, and feel to others, disingenuous. The stimulus and reinforcer control will not be aligned with responsiveness to culture, but rather aligned to creating the conditions for "buy-in." Buy-in is unidirectional and tacts a colonial relationship, albeit one formed on positive reinforcement rather than coercion, but still colonial. The first step is learning to understand and explore one's own cultural experience. Developing intercultural communication skills will be part of the process of personal and professional growth (Fong et al., 2017; Sugai et al., 2012).

The second step is the application of "multiple exemplar training" (Stokes & Baer, 1977) to culture and social justice. It stands to reason that in order to learn, multiple cultural opportunities are likely to lead to increased cultural understandings. From applied anthropology, we learn how to have conversations that help us understand the lived experiences of others and, just as importantly, to understand what those experiences mean to them. Our conversations and ongoing methods of communication should also allow for grace and humility (Hook, Davis, Owen, Worthington, & Utsey, 2013)—that is, learning behaviors that indicate genuine interest and openness to differences in others, minimize assumptions and superiority, kindly acknowledge mistakes and misunderstandings, and provide opportunities for restoration when conflicts and tensions have occurred.

Forming genuine personal and professional relationships with people of diverse backgrounds, people different from ourselves, is likely to lead to increased personal growth and cultural understanding, especially when done in a community of practice (the next pathway). Within a personal sphere, it means facing some degree of discomfort going into conditions that are unfamiliar (e.g., going to a mosque if you are not Muslim, joining Juneteenth celebrations if you are not Black, or attending a quinceañera if you are not Latino). Reflect on what you learn and allow these experiences to influence your actions and discussions within your community of practice.

What we need to learn is not about the habits and preferences of culture X but rather how to learn about learning about the cultures of others and to be open to constantly changing conditions that may very often be different from our own experiences—knowing that we are shaped by our experiences and that we can be shaped by the experiences of others. This learning necessitates us learning the particulars but not being fixed on them and allowing one another to influence and change each other—and our practice—for the betterment of all. Our goal is to improve from baseline, as individuals, as practitioners in treatment contexts, and as a discipline. How our considerations of culture interact with our ethical guidelines and our ethical conceptualizations will also have to be in constant negotiation (Rosenberg & Schwartz, 2018).

Nurture a Community of Practice

An intentional community of practice is designed to foster learning around a shared mission (Wenger, McDermott, & Snyder, 2002). The intention in this case is to create

an environment that sets the occasion, arranges opportunities, and provides reinforcement—that creates a behavior trap for culturally responsive patterns of behavior (Wolf, 1978). A community dedicated to inclusion and cultural responsiveness will reflect that goal in its mission statement and will direct behavior toward that mission (Center for Community Health and Development, 2017).

Toward this aim, our mission would include a commitment to increasing cultural competence, responsiveness, and humility, and our actions would involve directed study of the increasingly large number of resources available about ways to develop. As previously stated, we can learn from the work of other disciplines. What we learn as individuals we bring back to our community of practice and consider how this knowledge can forward the mission of social justice.

Reflect and Evaluate

Data occur in context. Data systems for cultural and social justice goals need to be collected and considered. The data systems with respect to culture and social justice, to the best of our knowledge, are not yet built. As they are being built, we can have ongoing, data-based reflection within our communities about what we are learning. Each person in our intentional communities will learn through both our successful and unsuccessful experiences, both in developing measures and in effecting change. In doing so, we will add to the collective knowledge and skill base of the organization as a whole (Cross et al., 1989).

Conclusions

The demographics of the U.S. population are rapidly shifting. In many areas of the country, large populations of ethnically and racially diverse families from different SES backgrounds, and with dissimilar health beliefs and practices, are accessing behavioral services. This is especially true in areas of the country in which services are more accessible due to insurance mandates. Traditionally, behavioral interventions have been developed by and oriented toward Caucasian, middle-class Americans who share commonalities in regard to the understanding of disease and disability through an aggressive, medical-model treatment lens. However, behavior analysis has also called for noncolonial approaches to behavior change in its research and practice (Fawcett, 1991) and a commitment to social value determined by those whose behavior is changing (Wolf, 1978).

Through the recognition of and conflict created by the diminishing of the American Caucasian dominance and voice, our basic approaches to behavior change and leadership will also be put into question and transformation will occur. Unlike physical well-being, behavioral well-being may be less fixed in terms of an all-knowing knowledge base. The laws of behavior that have been studied are robust. Reinforcement and punishment are two basic mechanisms that apply across a range of organisms, behaviors, and settings. However, beyond the basic mechanisms and functions of these two pillars of behavior change, topographies and configurations vary widely. One person's reinforcer can be another's punisher. That is where there is room for growth, hope, and the possibility of the discipline developing its own kind of resilience. Providing

culturally responsive, inclusive services and meaningful change does not necessitate compromising the underlying foundational philosophy and tenets of effective behavior intervention, but cultural competence requires a respectful understanding of the values and beliefs of the people receiving services. With the assistance of tools and knowledge developed across disciplines, behavior analysts can continue to evolve their practice toward promoting a greater degree of social justice in their work and within society as a whole.

Compliance with Ethical Standards

Conflict of Interest No authors have known conflicts or dual interests related to this manuscript.

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