Behavior Analysis in Practice
https://doi.org/10.1007/s40617-021-00579-3

RESEARCH ARTICLE

Cultural Responsiveness Curriculum for Behavior Analysts: A Meaningful Step Toward Social Justice

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Accepted: 21 March 2021

Abstract

Clients of applied behavior analysis (ABA), specifically Black, Indigenous, and people of color receiving treatment for autism spectrum disorder (ASD), regularly experience the effects of systemic racism via biases in the health care system. ABA as a science offers the necessary tools to support immediate, concrete actions to bring about social justice. This article offers a brief conceptual framework of critical race theory (CRT); cultural competence, responsiveness, and humility; and social justice concepts. Applications to health care are offered, addressing including systemic racism and implicit bias, along with points of personal reflection. These conceptual frameworks are synthesized in support of a cultural responsiveness curriculum, rooted in the tenets of CRT and cultural competence trainings in neighboring disciplines, that we offer as an immediate, actionable step that Board Certified Behavior Analysts can take today to broaden their perspective and proficiency. The prospective benefits of this work include effecting change in access to and outcomes of behavior-analytic services, particularly for the treatment of ASD in marginalized communities.

Keywords Critical race theory · applied behavior analysis · autism spectrum disorder · cultural responsiveness · cultural humility · cultural competence

Editor's Note
This manuscript is being published on an expedited basis, as part of a series of emergency publications designed to help practitioners of applied behavior analysis take immediate action to address police brutality and systemic racism. The journal would like to especially thank Associate Editor Dr. Jomella Watson-Thompson. Additionally, the journal extends thanks to Mawule Sevon and Dr. Natalie Parks for their insightful and expeditious reviews of this manuscript. The views and strategies suggested by the articles in this series do not represent the positions of the Association for Behavior Analysis International or Springer Nature.
—Denisha Gingles, Guest Editor

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Clients of applied behavior analysis (ABA), specifically those who are Black, Indigenous, and people of color (BIPOC) receiving treatment for autism spectrum disorder (ASD), regularly experience the effects of systemic racism via biases in the health care system. Policies and practices relating to delayed diagnosis, misdiagnosis, delayed intervention, reduced-intensity intervention, and restrictive placement represent evidence of systemic bias, all of which are deeply impactful on overall client outcomes. In order to promote social justice and equitable care outcomes, behavior analysts working within the health care system have a responsibility to take personal action.

This article will promote cultural responsiveness training as a vehicle to moving the field toward equitable outcomes for clients. Due to the number of cross-cultural interactions behavior analysts have with their clients, we need to understand how the principles of behavior analysis and delivery of these services are responsive to cultural and demographic differences (Miller et al., 2019). As clients of ABA come from different socioeconomic, cultural, and racial backgrounds, Board Certified Behavior Analysts (BCBAs) should be able to integrate cultural considerations into treatment plans and programs. This can be achieved by incorporating culture and

Published online: 22 June 2021

diversity education and ongoing collaboration throughout a BCBA's career development, as well as by recruiting and retaining BCBAs from a diverse range of backgrounds (Fong et al., 2017). Whereas other disciplines have offered curriculums to teach cultural competency, behavior-analytic literature documents insufficient cultural responsiveness training to alleviate these concerns (Fong et al., 2017).

This article addresses the gap in concrete theoretical and action-oriented frameworks relating to cultural responsiveness training for behavior analysts, particularly toward the responsible provision of behavior-analytic services to BIPOC clients with ASD. A brief conceptual review of critical race theory (CRT), with applications to ingrained inequities in health care services, is offered to orient the reader to systemic oppression within society. Concepts of cultural humility and cultural responsiveness will be referenced throughout as a means to understanding and remediating personal and societal bias. Components of the literature will be synthesized and translated into competencies, and presented as a competency checklist in the Appendix. This competency checklist is meant to be a starting point toward developing a comprehensive cultural responsiveness curriculum for behavior analysts, to be acquired during graduate training and supervised fieldwork and as ongoing development across organizational and community settings.

CRT: A Framework for Identifying Racism Across Systems

To effectively take on the work of dismantling systemic racism, it is necessary to understand the relationship between race, racism, and power dynamics. CRT was developed by a collaboration between activists, legal scholars, and practitioners who questioned why racial inequality continued to persist despite legal changes brought about by the civil rights movement (Christian et al., 2019). CRT creates a framework intended to drive the reader toward action, in service to equitable health care services for BIPOC (Kolivoski et al., 2014). The field of behavior analysis can use the framework of CRT to understand the power structures that perpetuate racial inequities and hinder practitioners from delivering equitable services to all clients. Applying a CRT framework puts an emphasis on the role of race and power dynamics within health care systems and behavior-analytic practices. As behavior analysts become aware of the functional relationships within systems of oppression, they can move meaningfully toward social justice by taking conscious actions to improve equity in access to and quality of care.

The following are the major tenets of CRT (Calmore, 1992; Christian et al., 2019; DeCuir & Dixson, 2004; Kolivoski et al., 2014). For the purposes of this article, the applications and self-reflections provided pertain to racism within health care systems, and specifically to the provision of behavior-analytic treatment for clients with ASD.

Racism is normalized and ingrained within American society so deeply that it has become difficult to even recognize, let alone change. CRT strives to overtly recognize the systemic racism that has continued throughout history and how this racism has created a power dynamic within American social structures.Racism is an omnipresent part of American society and is often maintained through hierarchies of power that control the political, social, and economic structures of our society.

Application: An example of systemic racism within health care is bias, explicit and implicit. Implicit bias is defined in health care literature as the inconsistency between a provider's privately held feelings and beliefs and their conscious attitudes. In behavior-analytic terms, implicit bias is demonstrated when a person's private behaviors and beliefs (e.g., a diagnostician saying to themselves, "I diagnose all children equitably") are inconsistent with their overt behavior (e.g., diagnosing Black children with ASD at a later age, or after more follow-up visits, than white children, based on subconscious racial bias related to behavioral expectations). A meta-analysis of bias in health care reported that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patients' health outcomes (Hall et al., 2015). There are numerous ways in which the practicing BCBA regularly encounters the effects of explicit and implicit bias in health care; systemic inequities particular to the provision of ASD services have been documented in both access to timely diagnosis and in access to early intervention. Black and Latinx children are diagnosed later than white children, delaying access to critical treatment (Centers for Disease Control and Prevention, 2020; Mandell et al., 2002). Barriers to timely diagnosis and appropriate service delivery include differing cultural perspectives related to disability, physician training related to early diagnosis and service referral options, and a want of cultural competence in service providers (Blanchett et al., 2009). Another view, provided through interviewing Black families with children with ASD, highlighted that culturally significant differences in self-care skills were potentially a factor in misdiagnosis; specifically, young Black children with strong adaptive skills were misdiagnosed with behavioral disorders such as attention-deficit/hyperactivity disorder and obsessive-compulsive disorder rather than ASD (Burkett et al., 2015). Another example of implicit bias includes primary care providers holding stereotyped assumptions related to treatment adherence, and therefore making inconsistent recommendations across racial populations based on these unconscious biases.

Delayed and incorrect diagnosis is not in itself the limit to the problem. A delayed diagnosis not only delays the onset of treatment but also potentially affects the intensity of services accessed. For example, when a child begins ABA services after the age of 5, their availability is limited to hours outside of the school schedule. Additionally, certain government-

based funding sources are not available once a child becomes school aged (Zuckerman et al., 2017). Further, the nature of the program itself evolves as the delay to treatment grows. In a meta-analysis, Curtis et al. (2018) found a positive correlation between language disorders and challenging behavior, compared with typically developing same-age peers, with the difference becoming more pronounced with age. Therefore, it stands to reason that a delayed diagnosis, and consequently a delay in treatment addressing communication needs, may contribute to a longer learning history of harmful behaviors such as aggression and self-injury. These higher intensity challenging behaviors may then result in more intrusive behavior intervention plans and more restrictive educational settings.

Reflection: How does the restrictiveness, intrusiveness, and prognosis of a client's outcomes from the first day of treatment vary depending on whether they begin services at age 6, rather than age 2? How is service intensity (i.e., hours per week) potentially affected by a later diagnosis, and how are client outcomes impacted by treatment intensity?

Equality is not enough; CRT strives for equity, which is a step in the direction toward social justice. Whereas *equality* refers to providing the same opportunities and supports to all members of society, *equity* recognizes the need to support each person or group of people depending on their specific needs and abilities (Bronfenbrenner, 1973). For example, promoting "color-blindness" with in the health care system ignores the history of racism in America. It also ignores the unique experiences of BIPOC, which can result in making false assumptions about clients, thus perpetuating racism in the future. Furthermore, small changes are not enough; these are usually made to appease those in power rather than to create large systemic change. Small changes appease those in power because they are not overwhelming and do not threaten the power dynamic. However, focusing on implementing small changes perpetuates white supremacy because gains for BIPOC come at a slower pace.

Application: Timely diagnosis of BIPOC children cannot be accomplished by one-time marketing campaigns or local education initiatives alone. For example, although education about early signs and symptoms might be a useful and important initiative, a parent cannot obtain a diagnosis for their child without all components of the system working toward access: education about the efficacy and availability of early intervention for the pediatrician, advocacy tools for parents, insurance coverage that adheres to timelines for screening, and transportation to medical appointments. Of all of these measures, advocacy may be the most critical, as consequences for misdiagnosis are far reaching. Black children who ultimately receive an ASD diagnosis are often first misdiagnosed: These children are 5.1 times more likely than their white peers to be diagnosed with an adjustment disorder and 2.4 times more likely to be diagnosed with a behavioral conduct disorder (Mandell et al., 2007). This diagnosis may contribute to a higher likelihood of placement in educational settings designed for emotional disturbance and behavioral conduct disorders, rather than settings designed to support the core symptoms of ASD using behavior-analytic teaching principles. Students with disabilities, and particularly BIPOC students with disabilities, are more likely to encounter harsher punishment at school; they are also disproportionately likely to be referred to law enforcement (Merkwae, 2015).

Reflection: How does misdiagnosis affect the trajectory of a child's future? How greatly increased are a child's chances of encountering security personnel or law enforcement when they are placed in a classroom for behavioral conduct disorder, rather than ASD? How can behavior analysts improve timely access to diagnosis and appropriate care in their local communities?

Racism in America is formed through white supremacy, which continues to marginalize BIPOC. White privilege refers to social advantages one experiences based on being a member of the dominant race (Kolivoski et al., 2014). Historically, value in America is based on property rights, with the intersection of race and property creating a means to assess the reputation and status of an individual. CRT asserts that "whiteness" is the most powerful property value, leading to advantages among white people, including the perceived right to exclude people who are not white. CRT recognizes that BIPOC who conform to the "white way" of doing things are often rewarded by society, whereas those who choose not to conform are often ostracized, diminishing their opportunities and access to services. The "white way" of doing things refers to the social and cultural practices of people who are white. Furthermore, according to CRT, BIPOC can only make gains within civil rights movements if those gains do not substantially disrupt the hierarchy of power for white people (Kolivoski et al., 2014). This is important to recognize because in ABA services, programming and target behaviors often reflect the dominant culture of the BCBA, which may not be the desirable behavior depending on the cultural practice, which needs to be part of assessment or a consideration.

Application: There are multiple applications to ABA aligned with this tenet. First, this concept may extend to the programming and delivery of reinforcement in behavior-analytic programs for ASD. If a behavior analyst is unaware of their implicit biases and does not reflect on their own cultural norms and how these differ from a client's, they may design treatment programs that reward a client for engaging in culturally inappropriate or uncomfortable behavior. Programs targeting an increase in direct eye contact or a decrease in cosleeping behaviors are examples. The particular concern this tenet of CRT highlights is that, effectively, the client is only able to succeed or access reinforcement for

engaging in Western-centric behavior. Further, a family may agree to goals that are culturally inappropriate out of fear of upsetting or losing their clinical team.

The second application of this tenet relates to the intersection between challenging behavior, restrictive procedures, and property value. In a 2010 report from the U.S. Department of Education outlining state-specific policies for use of restraint in the school setting, multiple states explicitly allowed for use of restraint in the event of a student engaging in property damage. Disproportionate use of restraint against Black and Hispanic students, compared to their white peers, has also been well documented (Katsiyannis et al., 2020). This leads to the conclusion that BIPOC students in particular are at risk of encountering restrictive and potentially harmful procedures when a true emergency (e.g., threat of imminent significant injury) is not present. Effectively, one could argue that in this way, school property is valued equally with or above the safety and well-being of students, and particularly BIPOC students.

Reflection: How does the inherent power dynamic between the clinician and client/family potentially lead to coerced cooperation with an inappropriate treatment plan? How do state policies regarding the use of physical restraint contribute to a society that values property over personal well-being, and how can behavior analysts impact such policies in service to a more just society?

Empathy is not enough to dismantle racism. Empathy refers to the feelings one experiences in response to someone else's feelings, and it is a way to understand someone's perspective when they have had life experiences different from one's own. Although empathy is an important first step for clinicians to respect their clients and their clients' experiences, it is not enough to combat the deeply rooted aspects of racism. Experiential knowledge from BIPOC is paramount in truly understanding the depths of racism. For example, narrative storytelling helps tell the story of racial oppression within oppressed and marginalized populations. CRT encourages learning directly from the experiences of minorities in order to truly understand the persistent and oppressive nature of racism in our society (Calmore, 1992; Christian et al., 2019; DeCuir & Dixson, 2004; Kolivoski et al., 2014).

Application: Insufficient self-reflection and understanding of how a behavior analyst's own cultural beliefs may impact service delivery can impact the quality of treatment that a consumer receives. Behavior analysts should endeavor to develop this cultural self-awareness. Furthermore, just as empathy is not enough to dismantle racism, acknowledgment of cultural differences is not sufficient to serve a client when programming behavioral support services. A behavior analyst must learn about the client's culture-specific needs and integrate those needs meaningfully into the treatment plan. For example, Black parents may share that they feel it is necessary to educate their child on appropriate behaviors related to interacting with persons of authority, including police officers. It is not the place of the behavior analyst to attempt to persuade a family to accept their own constructs of social roles, such as the belief that authority figures are meant to help the child; rather, the culturally responsive behavior analyst should respond to the family's cultural context by researching skills related to the family's desired repertoire, and by identifying treatment goals that include teaching appropriate interactions in the community.

Reflection: How can behavior analysts develop an increased awareness of personal and systemic biases and take action to remediate their effects with clients? What guidelines for publication should be adopted by peer-reviewed journals in the field to ensure improved reporting of racial demographic information, in order to clearly demonstrate the effects of these interventions across BIPOC clients?

Cultural Responsiveness: A Pathway to Social Justice

Whereas other disciplines offer curriculums to teach cultural competency, there is insufficient formal cultural responsiveness training for behavior analysts, although there are helpful publications to direct the field toward next steps. Terminology varies, so beginning by establishing a shared vocabulary is useful. Concepts of cultural competence, cultural responsiveness, and cultural humility have been defined by complementary disciplines. According to Thorpe and Williams-York (2012), *cultural competence* entails being able to function within the context of the cultural beliefs, behaviors, and needs of clients and their communities. *Cultural responsiveness* emphasizes listening to the populations that behavior analysts are serving, understanding their experiences, and using behavioral principles to serve clients in the ways that they would like to be served (Miller et al., 2019). *Cultural humility* refers to the process of self-reflection and understanding one's own implicit and explicit biases and how these biases may influence treatment planning and implementation; furthermore, cultural humility focuses on the personal growth and changes one can make in order to provide more equitable health care to people of all backgrounds (Miller et al., 2019).

Social justice is defined by the Universal Declaration of Human Rights (United Nations, 1948) as a state in which all humans are afforded basic human rights regardless of status, abilities, or identities. By learning about the cultural histories of clients, and the specific challenges they have experienced within the health care system (e.g., overdiagnosis of intellectual disabilities and conduct disorders among BIPOC), behavior analysts can develop culturally responsive behavior plans that can lead to transformative interventions, bringing the field a step closer to social justice (Miller et al., 2019). Cultural

humility promotes social justice by focusing on the behavior analysts' role in challenging societal oppression, recognizing power differentials, and eliminating power dynamics (Fisher-Borne et al., 2015). It is therefore our position that promoting a curriculum for cultural responsiveness and cultural humility in ABA is a meaningful step toward promoting social justice and dismantling systemic racism.

Behavior analysts need to ensure that the delivery of their services is responsive to cultural and demographic differences because clients of ABA come from different socioeconomic, cultural, and racial backgrounds (Fong et al., 2017). Furthermore, individuals who are racially and ethnically diverse should be recruited to become BCBAs in order to expand the field of behavior analysis. Beaulieu et al. (2019) conducted a survey of behavior analysts, receiving responses from 707 behavior analysts. The majority of respondents were U.S. citizens (86%), white (84%), and female (83%); racial minorities made up just 16% of respondents, with no single minority reaching above 6%. According to the U.S. Census Bureau, by 2044, the United States will become a majority-minority nation. With the makeup of the nation increasing in diversity, and the majority of surveyed BCBAs identifying as white, it stands to reason that the field will need to take explicit care to ensure practitioners are sufficiently self-reflective and equipped to program for cultural needs outside of their own (Beaulieu et al., 2019; Miller et al., 2019).

Challenges to Developing Cultural Responsiveness

Inconsistencies in training continue to present a barrier to acquiring cultural competence. According to a survey published by Beaulieu et al. (2019), 88% of behavior analysts agreed that training on cultural competence was very or extremely important; however, 82% of certificants reported having little to no training on cultural competence in their behavior-analytic coursework. Baer et al. (1968) included in their dimensions of ABA that the science is required to address behaviors of social significance; however, formal training for behavior analysts does not consistently include how to identify behaviors of particular cultural significance. Further, although the *Professional and Ethical Compliance Code for Behavior Analysts* calls practitioners to practice within their scope of confidence, seeking mentorship as needed for any populations served (Behavior Analyst Certification Board, 2014), the current and upcoming Task Lists do not explicitly set forth cultural competencies. Additional challenges to providing academic training in cultural competencies include difficulty in recruiting culturally and ethnically diverse BCBAs, a lack of mentoring opportunities, negative perceptions about cultures different from one's own, language barriers, and tokenism (Fong et al., 2017).

Finally, a review of the recommendations from the literature may pose a challenge to two behavior-analytic pillars: observation and measurement. Taking the time to mindfully understand one's own cultural beliefs and biases will allow behavior analysts to mitigate these biases (Fong et al., 2017), but how does one measure critical professional development skills such as self-awareness, reflection, and appreciation for diversity? There is much work being accomplished on this front through acceptance and commitment training (ACT), particularly in the work to develop a repertoire of "noticing" the relationship between private events and one's corresponding overt behavior. Exploring how ACT can be used to identify shared values and critical interventions for change is an article unto itself, and outside the scope of this article, but exciting and important work that can help behavior analysts learn to lean in to the less tangible skills required within a cultural responsiveness curriculum.

Building a Curriculum for Cultural Responsiveness

Health care is intertwined with cultural, linguistic, religious, sexual, and racial factors that make up a client's identity; ultimately, the goal of including cultural responsiveness training is to increase the quality of client services and outcomes (Echeverri & Chen, 2016). Developing cultural responsiveness is an ongoing discipline, and one that should be a focus of graduate coursework, supervised field experience, and ongoing continuing education (Fong et al., 2017). Components of the frameworks described in the next section are blended to create a basic curriculum for cultural responsiveness in the Appendix. Although content is suggested for different critical points of the career path, the practicing behavior analyst can select any target from the suggested list and begin growing their skill set at any time (Brodhead et al., 2018; Calmore, 1992; Christian et al., 2019; DeCuir & Dixson, 2004; Kolivoski et al., 2014; Miller et al., 2019; Thorpe & Williams-York, 2012; Tormala et al., 2018).

Guiding Principles of the Curriculum

Several authors have contributed to the growing, cross-disciplinary body of literature offering frameworks for cultural competence and cultural responsiveness. We leaned on guiding principles put forth by Miller et al. (2019) to serve as the domains for the proposed curriculum. According to Miller et al., cultural responsiveness (a) encourages practices that respect and honor diversity; (b) incorporates cultural interests into curriculums in order to engage learners from all backgrounds; (c) encourages safe, inclusive, and respectful learning environments; (d) uses cross-disciplinary and cross-cultural philosophies within curriculums; (e) promotes equity and justice within society; (f) decreases educational disparities; and (g) increases success for oppressed populations. In the Appendix, the guiding principles (Miller et al., 2019) are interpreted as competency domains for behavior analysts, including actionable targets, outcome areas, and

generalization criteria (Brodhead et al., 2018; Calmore, 1992; Christian et al., 2019; DeCuir & Dixson, 2004; Kolivoski et al., 2014; Miller et al., 2019; Thorpe & Williams-York, 2012; Tormala et al., 2018).

Training Targets and Outcomes Areas

The literature offers areas of focus toward becoming culturally responsive, including allocating time and environments dedicated to responsive practices to learn about, and directly from, people of different cultural backgrounds; creating conditions for both personal and professional development, as multiple cultural experiences will lead to a deeper understanding of the culture; engaging in meaningful conversations and seeking new experiences; nurturing a community of intentional practice dedicated to inclusion and social justice; and reflecting on progress in comparison to personal, organizational, and disciplinary baselines. Self-reflection and self-awareness are common themes in the literature. This reiterates a critical component of CRT, which is that the patient or client is the expert on their life and condition, and BCBAs must strive to understand their perspective as a part of their treatment plan.

In order to help behavior analysts apply these broad outcomes, these themes are translated into multiple target behaviors (or competencies) per domain, incorporating specific recommendations from the referenced articles and tie-ins to CRT, such as learning from lived experiences. The target behaviors focus foremost on interactions with clients and their families; to build generalization across exemplars, targets related to colleagues, community, and policy are offered as well. The targets are applicable at the individual, organizational, community-wide, and industry-wide levels. Examples include reevaluating individual treatment plans to prevent the use of restrictive procedures, collaborating with colleagues to bring increased awareness of cultural bias and improved skill sets for addressing those in programming and client relationships, engaging in pediatrician outreach to improve equitable access to early diagnosis in the community, and pursuing revisions to public policy in order to secure access to timely, safe, and ethical treatment for all clients.

Learning Contexts

In order to achieve cultural proficiency, it is recommended that students learn the foundational aspects within educational settings (i.e., graduate programs, trainings, conferences), as well as in applied, supervised settings (i.e., practicum sites, supervised fieldwork), in order to practice the desired behaviors with their clients. A good place to start is to create a cultural framework that reflects the needs and values of ABA-related theory, practice, and services and then develop these training and educational materials to guide ABA students and practitioners (Fong et al., 2017). In the Appendix, target behaviors recommended for study as part of graduate coursework are indicated with "ABA coursework" in the Learning Context column. Additionally, supervisors should plan to model the appropriate repertoires during supervised field experience, and behavior analysts should continue to expand their skills in these areas through continuing education units after certification. We also encourage certification boards to undertake formal adoption of cultural responsiveness curriculums to ensure that the topics are consistently included in approved coursework and that up-to-date, fully inclusive content can continuously evolve.

Ongoing Competency Assessment

Once a cultural responsiveness curriculum is in place, as with any intervention, ongoing assessment of proficiency, maintenance, and generalization is important. Thorpe and Williams-York (2012) and Tormala et al. (2018) included recommendations for assessing skill sets and demonstrating generalization. In the Appendix, suggested outcomes and evidence of generalization are included in their respective columns. Outcomes help to orient the learner to the larger picture of what may be accomplished by mastering target behaviors. Evidence of generalization supports a mentor in assessing whether the behavior analyst is able to implement the learned skills meaningfully with their clients, in their communities, and within provider organizations.

The Appendix also includes a method for measuring the need for ongoing support. A behavior analyst who is newly demonstrating a target behavior may require ongoing coaching in order to reach mastery of the skill. Once a behavior analyst is able to implement the domain skills in novel contexts, they may be described as independent. A third scoring column is offered in order to indicate behavior analysts who so excel in a given area that they could effectively mentor others in those skills. This should be the column that behavior analysts aspire to, so that there is a continual stream of mentorship available to newly minted BCBAs. Finally, those who serve as mentors should seek continual development in these areas in order to prevent drift and to keep current with evolving cultural needs.

Discussion

The curriculum suggested here is not exhaustive but is offered as an initial step, informed by cultural responsiveness frameworks in various fields (Brodhead et al., 2018; Calmore, 1992; Christian et al., 2019; DeCuir & Dixson, 2004; Kolivoski et al., 2014; Miller et al., 2019; Thorpe & Williams-York, 2012; Tormala et al., 2018). To move this work forward, leadership is called upon at systemic (e.g., credentialing and governance) and organizational levels to promote social justice within the field of ABA. This can be encouraged by creating cultural awareness training in supervision and training practices, systemic guidelines for working with

culturally diverse clientele, behavioral practices that are sensitive to current social movements and conditions, partnerships with public health and policy professionals to ensure that those who have been underserved now have advocacy for behavior analysis support, and special interest groups to focus on learning cultural diversity from different populations (Miller et al., 2019). Critical next steps include formal, widely embraced adoption of a shared cultural responsiveness curriculum to incorporate into behavior-analytic coursework requirements, ongoing training, mentorship opportunities, and recertification work. Moving into the future, the field of ABA must strongly advocate for person-centered care, including encouraging the integration of the lived experiences, values, and beliefs of all individuals receiving care. This is a necessary focus in order to achieve a world where all individuals can access the quality services they need and deserve.

Appendix

Cultural Responsiveness Curriculum: Competency Assessment Checklist

Domain	Target Behaviors	Learning Context	Outcomes	Evidence of Generalization	*Requires Coaching*	*Independent*	*Can Mentor Others*
A. Respects and honors diversity	i. Self-reflective: identifies personal values and personal cultural context and how these values may influence interactions with clients ii. Writes treatment goals that are culturally appropriate, as confirmed by client/family iii. Promotes practices and policies that recognize diversity as a strength (i.e., policies that indicate actionable path to diversifying participants in positions of influence and leadership)	-ABA coursework -Supervised field experience	Program efficacy improves, as caregivers are more likely to implement outside of session times.	-Able to demonstrate with a novel client, without explicit coaching -Contributes meaningfully to organizational policies			
B. Incorporates cultural interests into curriculum	iv. Asks clients questions about working with a person of a different race in the past and in the present, in order to learn about relevant history (i.e., prior BCBA not responsive to cultural needs) v. Actively listens to and learns from lived experiences of client and family; clarifies needs and translates into programs vi. Identifies client/family values at intake; incorporates values into program goals and naturally occurring schedules of reinforcement	-ABA coursework -Supervised field experience	Encourages a person-centered approach to ABA services, which increases BCBA - caregiver alignment, as clients and their families are included in the process and their needs are valued	Able to engage clients without mentor support			
C. Encourages safe, inclusive, and respectful learning environments	vii. Listens to clients (i.e., includes them in intake assessments and treatment planning and individualizes treatment plans based on clients' lived experiences) viii. Participates in community and cultural events and seeks guidance from local ambassadors to learn community needs and values ix. Supports team members' rights to work in a safe, comfortable work environment free from harassment and discrimination; supports colleagues by elevating their concerns to leadership in provider organizations until resolved	-Supervised field experience -Each CEU cycle	-Creates a person-centered and community-focused approach to services -Client families feel safe to advocate for changes to programs.	Able to respond to client feedback related to cultural needs and preferences; demonstrates responsive treatment planning with novel clients			
D. Utilizes cross-disciplinary and cross-cultural philosophies within curriculum	x. Learns about wraparound support services, as part of a medical model, by studying outcomes literature/attending trainings xi. Forms referring relationships with providers of interdisciplinary services (e.g., marriage and family therapists, speech and language pathologists, psychologists) xii. Incorporates scope of competence self-assessment to identify when additional training is needed and when referring out is appropriate	-CEUs	Patient-centered, whole-client, whole-family programming	Coordinates care across interdisciplinary service providers, based on client's unique needs			

E. Promotes equity and justice within society	xiii. Engages in policy and public outreach (e.g. SIGs, association membership) xiv. Seeks out mentors in the field to learn from the experiences of other BCBAs, learns from colleagues re: cultural and ethical considerations that may not arise during graduate classes xv. Actively engages with communities of color to learn which behaviors are socially significant (e.g., modifying curriculums for teaching skills related to community safety and interactions with law enforcement for Black youth and other oppressed populations) xvi. Works to abolish unsafe, restrictive behavior management practices through changes to individual treatment plans and advocacy for changes to local, state, and federal policy	-Supervised field experience -CEUs	Recognizing the impact that racism has on the efficacy and acceptability of behavioral support services	Takes action to participate in social justice initiatives at the personal, organizational, and community levels			
F. Decreases educational disparities	xvii. Supports clients and families in acquiring advocacy skills xviii. Engages in pediatrician outreach to promote awareness of local resources and services xix. Contributes to community education by providing materials and trainings to caregivers and other stakeholders xx. Ensures demographics of accepted referrals are reflective of ethnic makeup of the community served	-Supervised field experience	Builds strong community and advocacy networks, with the ultimate goal of improving access to diagnosis and care	Engages in advocacy, outreach, and community education beyond the supervised experience			
G. Increases success for oppressed populations	xxi. Develops self-awareness (i.e., provides behavioral services to vulnerable populations, including individuals with autism, creates a power dynamic between behavior analyst and client); recognizes how practitioner's race, client's race, and interracial interactions further perpetuate the power dynamic between provider and client/family xxii. Engages in courageous conversations with supervisors and colleagues about how race may influence interactions with clients xxiii. Demonstrates support for marginalized colleagues by engaging in meaningful allyship, amplifying the voices of the oppressed, and advocating for just educational opportunities, recruiting and promoting systems, and pay practices xxiv. Reviews demographics of clients served; reports out as Equitable Outcomes Scorecard	-Supervised field experience -CEUs	-Client outcomes are equitable across socio-economic, racial, and other demographic factors. -BIPOC colleagues are afforded equitable opportunities to access quality education and career advancement.	Engages independently in advocacy for clients and colleagues			

Note. ABA Applied behavior analysis, *BCBA* Board Certified Behavior Analyst, *SIG* Special interest group, *CEU* Continuing education unit.

Compliance with Ethical Standards

Conflicts of interest The authors declare they have no conflicts of interest.

Ethical approval This article was written in compliance with international regulations regarding research.

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