Leading with Compassion: A Discussion and Steps Forward for Behavior Analysts

Britany Melton[a,*], Nancy Marchese[b], Mary Jane Weiss[c]

[a,*] **Corresponding Author:** Britany Melton, Endicott College, Journeys Autism Center, USA.
E-mail: bmelton@endicott.edu
ORCID: https://orcid.org/0000-0002-9513-0240

[b] Nancy Marchese, Endicott College, USA.
Breakthrough Autism, Canada.
E-mail: nancy@breakthroughautism.ca
ORCID: https://orcid.org/0000-0003-4265-4152

[c] Mary Jane Weiss, Endicott College, USA.
E-mail: mweiss@endicott.edu
ORCID: https://orcid.org/0000-0002-2836-3861

Abstract

The provision of applied behavior analytic (ABA) services is a highly efficacious intervention approach most often used to improve the lives of individuals with autism spectrum disorder (ASD)/Autistics. Given the advancement of the field, more nuanced skill sets of behavior analysts, such as compassionate care skills, are emerging as the focus of intervention as measurable, observable, and essential. As the field progresses, the identification, refinement, and assessment of more nuanced skills become crucial to the success of our interventions. Leading with a compassionate approach that balances habilitation with client happiness, assent, and engagement is of the utmost importance. This paper discusses the current trend in existing compassionate care literature and how those evaluations may potentially be extended to direct interventionists and Registered Behavior Technicians. In this paper, we argue that a behavioral framework should be used to conceptualize, train, and evaluate the demonstration of these skills in front line ABA practitioners.

Keywords:

Compassion, Autism, Happiness, RBT, Interventionist, ABA

Introduction

Applied behavior analysis (ABA) can be described as inherently compassionate (Baer et al., 1968). It is important to recognize that the science of behavior analysis is compassionate. However, the implementation of interventions informed by the science requires measures of social validity to verify social significance of the interventions. Measures of compassion in the provision of ABA-based services can aid in the evaluation of the social validity of interventions. Compassion has been defined as a direct action that is delivered to alleviate the suffering of another individual (Taylor et al., 2018). The provision of ABA-based intervention is a direct action (i.e., service) that may potentially alleviate perceived challenges of the individual or family and improve the lives of those we serve. While the idea of compassion in service delivery is not a new concept (e.g., Bannerman et al., 1990; Leaf & McEachin, 1999; Taylor et al., 2019; Wolf, 1978), there has been an increased focus and discussion on embedding it further into practice related to ABA-based interventions for individuals with autism spectrum disorder (ASD).

In an effort to better serve clients and families as well as improve collaborative relationships, compassionate care has taken a front seat in behavior analytic discussion, training, and research (Chadwell et al., 2018; LeBlanc et al., 2019; Taylor et al., 2018). Individuals most frequently responsible for the direct implementation of ABA-based interventions for individuals with ASD or intellectual disabilities (ID) are Registered Behavior Technicians (RBTs; Behavior Analyst Certification Board, n.d.). The RBT is an individual who has met the knowledge and competency requirements for certification from the Behavior Analyst Certification Board (BACB). These individuals are often the face of ABA-based intervention for autism (BACB, n.d.). It is imperative that these individuals are compassionate, caring, technical, and collaborative. In this paper, we will discuss broad issues of RBT certification and training that lead to future areas of improvement in the field of behavior analysis. We will also suggest potential remedies for contexts in which there is a deficit in compassionate care. We also propose that all behavior analysts must first lead with compassion to better serve our clients and families, as well as to improve the broad perception of the application of our science. At the same time, it is important to identify how practitioners, especially RBTs can balance compassionate care with habilitation and how effective instruction can co-exist with humane and compassionate intervention.

Perhaps one of the most recent examples of leading with compassionate care has been the work of Hanley and colleagues as it relates to the Practical Functional Assessment (Hanley et al., 2014), Skills Based Treatment (Ghaemmaghami et al., 2015; Iannaccone & Jessel, 2021), and the use of Universal Protocols (Ghaemmaghami et al., 2016; Rajaraman et al., 2022). These procedures are described as ways to implement behavior analytic principles while being guided by compassion and trauma-informed care. Happy, Relaxed, and Engaged (HRE) is a concept and practice used as a way to measure the child's enjoyment and assent with the program that is incorporated into skill-based treatment (Ghaemmaghami et al., 2021). HRE requires that the staff member operates in ways that produce reinforcement for the individual, thus engaging in direct actions to alleviate the suffering of that individual, which gets to the heart of compassion. There has also been an increased focus on how our interventions may impact individuals with ASD. For example, Rajaraman et al. (2022) outline ways in which behavior analysts may conceptualize and incorporate trauma-informed practices into the daily implementation of ABA. They discussed future recommendations for BCBAs to incorporate trauma-informed care into practice by 1) acknowledging that potential trauma exists, 2) creating environments rich in reinforcement that promote safety and trust, 3)

including potential opportunities for choice as much as possible, and 4) creating intervention programs that focus on the building of adaptive skills that will have a meaningful impact on the individual's life (Rajaraman et al., 2022). Not only are these strategies helpful in the potential reduction of trauma, but they also may help foster a compassionate relationship between the therapist and the individual.

Additionally, Ramey et al. (2022) sought to define "happiness" in individuals with ASD by replicating a previously established procedure by Parsons et al. (2012). Ramey et al. demonstrated that while it may often be a difficult concept for behavior analysts, happiness and unhappiness can be defined and agreed upon by observers. Ramey et al. defined indices of happiness and unhappiness for each participant based on questionnaires and validated those by creating happy and unhappy conditions. Percentages of idiosyncratic happiness and unhappiness were measured in each condition. The results highly correlated with the results on the questionnaires. This is a wonderful step in the right direction for the operational definition and measurement of emotional states for individuals with ASD. With these tools readily available in the literature, it is now time to add them to daily practice to ensure the social validity of our procedures.

The Circumstances View of Behavior as described by Friman (2021) is a description and/or explanation of how the field of behavior analysis is rooted in compassion. Friman explained that behavior, as viewed through the eyes of radical behaviorism, is a function of the circumstances of the individual. Often, other explanations of behavior would describe behavior as a part of the person and place blame on an individual when they engage in a behavior that is undesirable by society (e.g., commit a crime). However, behavior analysis would explain this behavior as a function the environment and the past reinforcement and punishment histories for that individual. Behavior analysis does not blame individuals, but rather, explains the behavior in the context of the individual's experience of the environment. Thus, behavior analysis by its very definition exemplifies compassion.

Behavior analysts place a high value on the use of evidence-based treatments and are committed to effective intervention. The commitment to effective intervention may have led to some challenges when working in interdisciplinary teams, and thus behavior analysts have faced criticism regarding collaboration (Leaf et al., this issue; Rohrer et al., 2021). Allied professions have expressed that behavior analysts can seem arrogant, dismissive of other perspectives, or rigid (e.g., Gaswieski et al., 2021; Gerenser & Koenig, 2019; Koenig & Gerenser, 2019; Schiebel & Walting, 2016; Welch & Polarajko, 2016). A primary related concern has

been the use of behavioral jargon; members of allied disciplines may not understand technical terms such as the terms such as tact and intraverbals (Critchfield, 2017). There are often dual uses of other terms, such as punishment. In either context, there may be a gap in understanding for nonbehavioral professionals. Additionally, behavior analysts must adhere to the Ethical Code for Behavior Analysts (BACB, 2020; Cox, 2019) which requires, amongst many other things, that behavior analysts support and only recommend evidence-based practices and procedures. This often leads to issues with non-behavioral colleagues, who may feel that their recommendations are dismissed because the procedures they are recommending are not yet evidence based. Behavior analysts may be attempting in these interactions to adhere to the ethical code; however, they may not possess the nuanced interpersonal skill set that would enable meaningful dialogue and effective compromises. Alternate certifications and allied professions also mandate adherence to ethics codes (e.g., American Psychological Association, American Speech/Language Hearing Association, American Occupational Therapy Association, Council for Exceptional Children). The complexities of autism require the expertise of multiple disciplines, and outcomes are enhanced through a multidisciplinary model (e.g., LaFrance et al., 2019; Slim & Rueter-Yuill, 2021). The importance of enhancing collaborative skills among behavior analytic practitioners has been strongly emphasized within the field, especially recently (Brodhead, 2015; Bowman et al., 2021). Such skills are important for all collaborative relationships, including those with families, allied professionals, and clients (Weiss et al., 2022). The discussion around compassionate care in ABA has mainly been focused on the master's level clinicians. Given that RBTs/practitioners likely encounter families and children frequently, we will outline how the provision of compassionate ABA can be extended to the RBT/practitioner level.

Direct Implementation of ABA-based Interventions in Autism Treatment Settings

RBTs are most often the direct, client-facing, interventionists responsible for the implementation of ABA-based interventions with individuals diagnosed with ASD/Autistics (BACB, n.d.). These professionals are required to complete, at minimum, 40 hr of training, pass a competency assessment, as well as pass a standardized knowledge exam (BACB, n.d.). RBTs are also required to be supervised for at least 5% of working hours to ensure accurate and precise implementation of the treatment program and to maintain certification. Early in the development of the field of ABA, practitioners were few and the field was very small. Given the extensive growth of the field, there has been a drastic and almost exponential increase in credentialed professionals (BACB, n.d.). Today, the RBT credential requires a high school diploma and the previously listed criteria. It should be noted, however, that some have suggested that these minimal standards may result in insufficient competency and knowledge of our most forward-facing interventionists responsible for implementing behavior analytic procedures (Leaf et. al., 2021).

The role of the RBT is multi-faceted as they are crucial to the outcomes produced for learners. They must build rapport with the individual, implement various teaching protocols (e.g., functional communication training, discrete trial teaching, naturalistic teaching), collect various forms of data (e.g., antecedent-behavior-consequence, rate, interval), navigate mealtimes, toileting procedures, and more all while responding to all of the child's needs. When learning various protocols, it may be easiest for the staff member to implement clearly outlined procedures to increase procedural fidelity. Arguably, the best implementation of all above listed procedures involves clinical judgement on the part of the RBT (Leaf et al., 2016). For example, consider the application of differential reinforcement. This concept and practice require that one does not reinforce undesired behaviors or only reinforces desired behaviors (Vladescu & Kodak, 2010). Differential reinforcement, when implemented precisely, leads to great gains in skills and improvement in overall functioning (Vladescu & Kodak, 2010). Quality application of differential reinforcement requires that the staff member analyze the behavior of the individual and respond accordingly with varying amounts/levels of reinforcement contingent on various responses. However, without clear oversight, feedback, and a solid understanding of the implementation of differential reinforcement, the RBT may be prone to a variety of errors. For example, they might miss opportunities to reinforce better articulation or social bids that are especially clear to peers. In the context of challenging behaviors, they may exhibit "cold" reactions when the child engages in emotional behavior, which could disrupt rapport. As an illustration, when given the instruction, "do not reinforce that behavior," the RBT may rigidly interpret that as an instruction to ignore the child completely without regard for the behavioral function or emotional state of the individual. This could lead to a rigid interpretation of the behavior plan and result in less in-the-moment assessment and responding compassionately to the child across various situations. Rigid implementation of ABA can potentially lead to less compassionate responses (e.g., staff simply following plans rather than responding to the child and altering their own behavior). Implementation at a high degree of treatment fidelity does not need to be mutually exclusive to the application of compassionate care. The RBT is the

primary interventionist can respond compassionately and flexible to the child while applying the required underlying behavioral principles.

Compassionate Care as a Soft Skill

Board Certified Behavior Analysts (BCBAs) commonly receive little instruction on soft skills and how those may interact with the relationship between stakeholders (Rohrer et al., 2021). One potential reason for this may be that traditionally these skills have been viewed as challenging to operationalize and, thus, teach. No professional tools nor guidelines exist to support behavior analysts work in this area. Further, coursework and other formal education in behavior analysis historically has placed great emphasis on a technical understanding of the science. The field has begun to address these gaps and to look to remedy any lack of training or behavioral deficits (LeBlanc et al., 2019, Rohrer et al., 2021). Most of this work has focused on the interactions between professionals and/or professionals and caregivers. For example, Rohrer et al. (2021) suggested a checklist to evaluate the interaction between the BCBA and caregiver during interactions. The Compassionate Collaboration Tool utilized a 3-point Likert scale to assess the interactions that included both compassionate interactions married with collaborative behaviors. The need for advancement in this research and skill set is vast and essential. The field of behavior analysis will be greatly improved by the development of instructional approaches that target these skills. Alongside this effort, we must begin to develop measures of the direct interaction of therapists (RBTs or otherwise) with the recipient of the service. As the ultimate beneficiary of service and as the primary focus of intervention, the clients served must be consistently met with humane and compassionate care. At the present time, there is a paucity of published literature that focuses on interpersonal skills and other soft skills that may be important for RBTs to demonstrate. Further, there are very few resources on evaluating the extent to which compassion is integrated into their training.

From Identification to Practice

It has been noted that some practitioners in the field of behavior analysis are lacking in compassionate care behaviors or skills (LeBlanc et al., 2019, Rohrer et al., 2021; Rohrer & Weiss, 2022; Taylor et al., 2018), especially in the context of the parent-professional relationships. It is important that this work is also extended to client-instructor interactions. Practitioners must continue to lean on previous research (e.g., Baker, 2013; Harris & Weiss, 1997) and continue to develop behavioral measures of these interactions as well as develop behavioral measures of authentic or genuine interactions. Measures of authenticity will allow professionals to make better decisions regarding efficacious training techniques as well as improve our intervention quality.

Given that behavior analysts should evaluate compassionate interactions using a behavioral framework, they should also train RBTs to use a behavioral framework when working with individuals with ASD (Leaf et al., 2021). This will better inform the RBT on how, when, why, and under what circumstances to flexibly respond to the individual during times of high stress or concern. Compassionate behaviors are just that, behaviors. These behaviors are measurable, observable, and trainable; similarly, interventions can be evaluated to increase or decrease those behaviors. While measuring aspects of behaviors such as the extent to which a behavior is genuine or authentic may prove to be quite challenging, it is imperative that we do so to achieve best outcomes and high consumer satisfaction.

Rapport building between clinicians and caregivers of people with ASD may be facilitated through training in compassionate care (LeBlanc et al., 2019; Taylor et al., 2018). For example, Marchese (2021), in an unpublished dissertation, developed and evaluated seven instructional modules to support training graduate students in compassionate care skills. A modified behavioral skills training package was implemented across each module that included a pre-test, online PowerPoint presentation (i.e., sample of the literature, modeling on how to display various compassionate care skills), active rehearsal of target skills via homework assignment, feedback on the assignment, and a post-test. The modules were delivered via a class wide training format. Results were compared to a second control group of students who did not access the training module nor the homework assignment. The control group only completed the pre- and post-tests. Overall, students in the experimental group demonstrated statistically significant increases in knowledge (i.e., post-test scores across modules) and performed well on the behavior component of the instructional modules. This study provides a preliminary demonstration that compassionate care training can be integrated within a class wide training format.

Assessment tools may also be used to support the application of compassionate care skills within clinical environment. Marchese (2021) undertook a multi-step approach to develop the Parent Partnership Questionnaire (PPQ), a tool to support collaboration between parents of children with autism and their clinician. The development included a content creation phase that involved conducting semi-structured interviews with parent of children with autism, an online survey for parents to give feedback on the clarity and understanding of questions within

the draft tool, and finally procedural integrity checks and reliability testing were conducted on the final version of the tool. The PPQ outlines various open-ended questions for clinicians to ask parents to gain an understanding of their priorities, values, and potential logistical considerations that may ultimately facilitate parent engagement. It is hypothesized that the administration of this tool allows clinicians to gather information from parents while developing rapport between both parties. The PPQ may offer clinicians a structure to support the application of compassionate care skills in clinical setting. The development of tools like the PPQ will offer the field more ways to better operationalize, measure, evaluate and teach skills relating to therapeutic relationships and compassionate care.

We are hopeful that the BACB will expand consideration for soft skills on the next task list for RBTs. The current task list outlines that the RBT adheres to all elements of the Ethics Code which includes behaviors like compassion and elements of soft skills. One potential consideration for expansion is to include fluency or demonstration of soft skills in the current 5th edition task list (BACB, 2021). This may facilitate the advancement of our field, the general perception of our practice and most importantly client and family outcomes. There have already been steps toward this in the research as evidenced by Rohrer and Weiss' (2022) preliminary investigation. Specifically, Rohrer and Weiss first identified empathetic and compassionate skills, then subsequently divided them into three categories that could be measured, observed, and evaluated. The skills identified were interviewing skills, interest in the family, and joining the family. Using behavior skills training, the researchers taught four master's students in behavior analysis these skills via telehealth. The results were promising in that all participants improved in engagement, social validity measures, and other standardized forms of measurement from other fields (e.g., the Jefferson Scale of Physician Empathy). All participants in this study had bachelor's degrees and were earning master's degrees in behavior analysis (Rohrer & Weiss, 2022). An important extension of this research would be to expand this research to the RBT level. Specifically, such training could target areas of interaction between the RBT and the family and/or child. It is essential as the field that this concept be extended to interactions between the client and the instructor/RBT.

Table 1 provides a suggested process for the evaluation and analysis of compassionate interactions when incorporated into in-the-moment decision making by BCBAs and RBTs. When using this approach to every interaction, the BCBA or RBT may be better equipped to analyze and alter their behavior given various situations. This is not a new concept, as this closely resembles the antecedent-behavior-consequence evaluation procedures (Cooper et al., 2019). This is a hallmark of ABA intervention and is easily applied to situations that would improve compassionate behaviors on the part of the RBT. This simple framework could aid the RBT in evaluating their own behaviors relating to the nature of the interaction between child and therapist and in identifying how their behavior is impacting the emotional state of the child. The therapist could then more thoroughly respond to the child in a way that is intentional and leading with a compassionate approach. When using this approach, the RBT can learn how to best answer questions in times of calm interactions (e.g., the child is engaged, assenting to learning opportunities, seems content with interactions from the therapist) and when to alter responses in times of crisis (e.g., severe problematic behaviors, refusal to complete tasks, minor problematic behaviors).

Table 2 provides an expansion of Table 1 that outlines some potential examples of situations the RBT may encounter. In the example of the calm situation, specific behaviors are listed that lead the therapist to believe the child is in a calm state. The response is outlined, as well as an analysis of how the therapist response did or did not change the behavior of the child. In the crisis, clear behavioral descriptors are present, the response is clearly described, and the analysis of the response allows the therapist to observe that the behavior was improved. Often, RBTs are provided only with consequence procedures and not with the analysis of how that response impacted the child's behavior. In addition, RBTs may not be trained in analyzing antecedent conditions at this level. Indeed, the skill set should include understanding indices of unhappiness (Ramey et al., 2022), and identifying when the client is no longer happy, relaxed, and engaged. This is not to suggest that practitioners should abandon consideration the function of the challenging behavior nor function based treatments. That is, careful consideration of the potential contraindicative intervention strategies must be included in application of compassionate care skills. Effective intervention can include both the application of compassionate care and what is needed to facilitate meaningful skill building. One is not mutually exclusive of the other. This framework includes evaluation of both the response to the client within the framework of compassionate care and what is therapeutically appropriate to build skills while reducing challenging behavior. For example, the RBT can learn how to embed learning opportunities, progressively shift schedules of reinforcement, and differentially respond to the client while ensuring the client well cared for both emotionally and physically.

Table 1

A process for evaluation and analysis of compassionate interactions.

Situation	Behaviors	Response	Analysis
Identify the situation that is potentially causing stress or enjoyment to the individual	What behaviors are you seeing that lead you to believe this?	What are some potential acceptable responses to this behavior provided the behavior plan and training?	How does my behavior improve or worsen the condition of the individual?

Table 2

A process for evaluation and analysis of compassionate interactions - Examples

Situation	Behaviors	Response	Analysis
Identify the situation that is potentially causing stress or enjoyment to the individual	What behaviors are you seeing that lead you to believe this?	What are some potential acceptable responses to this behavior provided the behavior plan and training?	How does my behavior improve or worsen the condition of the individual?
Examples			
Calm: playing with the RBT	Steady eye contact; approaching therapist; occasional smiling	Continue with activity; increase learning opportunities;	My response led to the continuation of calm behaviors; reassess if any behavior changes
Crisis: provided task demand, removed play materials	Crying; avoidant of task materials; flat affect	Preference assessment; label potential emotional state; provide additional choices	My response improved the state of the child; child began approaching me calmly

Summary

To date, the literature addressing the improvement and refinement of compassionate care skills in behavior analysis has largely been limited to that of parent/caregiver and professional (e.g., BCBA) interactions. We strongly believe this focus must also include addressing the soft skills of direct care interventionists at the RBT level. There has been significant growth in the identification of behaviors that may comprise a definition of compassionate skills (LeBlanc et al., 2020; Marchese, 2021; Melton et al., in press; Rohrer & Weiss, 2022; Taylor et al., 2018). Further research should refine and extend these investigations to direct interventionists. The field of behavior analysis at its very core is compassionate, and there has been a resurgence of interest in how this core value can be enacted consistently in practice (e.g., Baer et al., 1968; Bannerman et. al., 1990; Friman, 2021; Foxx, 1996; Rohrer et al., 2021; Taylor et al., 2019; Wolf, 1978). As the field progresses, the identification, refinement, and assessment of more nuanced skills is crucial to the success of our interventions. Leading with a compassionate approach that balances habilitation with client happiness, assent, and engagement is of the upmost importance. A compassion-based approach will advance the partnership between professionals and clients and will ensure that we are held accountable in making socially significant differences that are validated by those we serve.

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