Compassionate Care and Collaboration: Best Practices for Autism Intervention Teams

A webinar presented by Dr. Joanne Gerenser and Dr. Mary Jane Weiss on June 17, 2026.

Kristen Essex

And now, without further ado, I'm pleased to introduce today's speakers, Drs. Joanne Gerenser and Mary Jane Weiss. Thank you.

Dr. Joanne Gerenser is the Executive Director of the Eden 2 Programs in Staten Island, New York, and is the Vice Chair of the Scientific Council for the Organization for Autism Research.

In addition to authoring several chapters and articles on developmental disabilities, she is co-editor of the book ABA for SLPs: Interprofessional Collaboration for Autism Support Teams.

Dr. Mary Jane Weiss holds a BCBAD and is a professor at Endicott College, where she directs the master's program in ABA and autism. She also serves on the Scientific Council for the Organization for Autism Research. Without further ado, I'll turn it over to you, Joanne.

Joanne Gerenser

00:03:01

Great, thank you. Welcome, everybody. We have a lot to cover, so I'm gonna get started and try not to go at a crazy pace. So we're gonna be talking a lot about intercollaboration and weaving compassionate care throughout.

So, when I talk about interprofessional collaboration, I'm talking about the definition that really came out of the World Health Organization, and it's really where two or more disciplines learn from each other, work with each other, and ultimately, end up delivering, more efficient, more high-quality care.

So this is what the research tells us. When disciplines work together, our outcomes are better, right? We also know that autism is very complicated, and we know that, for the most part, it just can't be addressed with one discipline solely. It can increase efficiencies.

So, you know, obviously, if we're working together, we're not going to be working redundantly. And there's tremendous benefits from cross-training. My entire career, in terms of education, has been in the world of speech-language pathology, but all of my work has been with behavior analysts and people in the behavioral world, and so I've really been able to learn from both disciplines.

I was gonna get to this. So, here's the innovation that has come out of, when behavior analysts and speech pathologists actually work together. Obviously, in both these cases, they were married, but one is a behavior analyst and one is a speech pathologist. And out of that came something different, right? Something that couldn't probably have been done, solely with one or the other.

So what, you know, why is it that we're not just... you know, why are we talking about this, as opposed to just doing it? There are just a lot of issues with interprofessional collaboration across allied professionals.

So, and it... and really, we're talking about interdisciplinary collaboration with behavior analysts in particular, right? So who do behavior analysts need to work with? Teachers, OTs, psychologists, families, administrators, speech therapists, and so on, right? These... I put families in there because I get that they're not an allied professional, but they certainly are a partner in the work that we do.

So, what are the challenges, right? Well, what we do know is that there have been a tremendous number of publications lately that have talked about how allied professionals and even families experience inter-collaboration with behavioral analysts.

And I have to be honest, it's not overly positive. I do... I do believe that because of all of the work, a lot of it done by Mary Jane and her students and colleagues at Endicott, because of the publications and the work that's been being done on it, you're starting to see some real shifts, hence this... all the focus on collaborative, on compassionate care.

I think the other issue that's a challenge is just our clinical experiences. The, you know, as a speech pathologist, my theory of language is very different than a behavior analyst. And so, for some, that's the end of the road, right?

There's no movement forward. But for me, it's just a starting point, and then we move on from there.

The other thing that's really, that I think is important is that there is, and I'm not sure if everybody feels this, but there's a rising backlash against ABA, probably a lot of it due to potentially some bad actors, obviously, that a lot of it has been written about in the last couple of years, but even before that, you started to see SLPs speaking out against ABA, self-advocates speaking out against ABA.

And I think that's a real unfortunate situation, because I know from both clinical practice and from the research that nothing better has yet been developed than good ABA to help, provide people with autism the best chance at the highest quality of life.

So, I look at the barriers of inter-collaboration across different sort of categories. There are administrative barriers, cross-disciplinary barriers, and then there are barriers that are very specific to behavior analysts.

So, the administrative barriers occur across all of us, right? Time constraints. We just simply don't have... as an SLP, for example, I have to have, in my school, 100% effort, meaning my caseload is full.

So there's very little time for intercollaboration. It's not a good model. It's not the most effective model, and yet that's the model that the New York State Ed is the only one they understand. Insurance mandates often don't cover

intercollaboration, right? And so, it's a... we've got to figure out a way around it, because in healthcare, they certainly have.

So hospitals. Clinics have figured out a way to ensure that nurses and doctors and clinicians can all collaborate. The other problem is that you might have different access, right? You may be the speech pathologist employed in the school, and the behavior analyst may be a consultant coming into the school, schedules may con... may be conflicting, they may purposely be separated, because in some cases, for example, I know families that don't tell the behavior analysts that they're getting private speech therapy.

So, these are just administrative conflicts to ensuring positive intercollaboration. Then there's perceived, and again, I say perceived because I don't, you know, this is what we think is happening. There are cross-disciplinary barriers. S

o, unique history, right? We each come from a different background, overlapping scopes of practice, differences in our definitions and misaligned terminology. So, obviously, the most famous sort of disciplinary split, started back in the Skinner-Chomsky debates, right? About where does language come from? Is language innate, or is language learned?

And we have very separate histories, whereas OTs may also have a... they look at behaviors from a much more of a sensory perspective than the functional perspective that comes from the behavioral world. I'm not saying that you have to agree, but I'm saying that you have to recognize and appreciate that people aren't coming in to be defiant or different.

This is the training that we received all throughout our academic, time, right?

Overlapping scopes of practice. I always say, we don't own language, and behavior analysts don't own behavior, right? They are just overlapping. And it's critical that we have incredibly strong interpersonal skills to not... to know how to not step on each other's toes, and yet continue to be able to do the work we need to do. I find, obviously, that SLPs who understand how to proactively avoid challenging behaviors using strong behavioral principles are more effective.

I also think that behavior analysts who recognize that speech therapists know a lot more about speech production, phonology, etc, are more effective as well. So, recognizing we do have overlapping scopes of practice, but that doesn't mean that we can't ultimately learn from each other across those areas.

Misaligned terminology just means things like, for example, there are professional homonyms, right? Meaning that the word function could have very different meanings in different disciplines. So, the function in behavior analysis is what's the purpose of the behavior, whereas in SLP world, it's got to do with communicative intent.

There are also professional synonyms, right? Requesting versus manding, communicative temptations versus establishing operations.

I understand that they're not exact, right? That manding doesn't correlate 100% to requesting, etc. But it's close enough when you're talking to each other to recognize that we might not understand each other's terminology.

Another issue, which I think is an important one, is this definition of evidence-based practice. And interestingly enough, it was only recently that I understood that behavior analysts actually DO use this definition for evidence-based practice. That it is a combination of these three pillars of professional experience, best available evidence, and client values.

Where the problem is, is that they tend to use empirically validated treatment to describe what their work is, and then basically criticize the work of SLPs, or OTs, or PTs as being not empirically validated, right?

But you can't really do that, right? They're not synonymous terms. There are very few treatments that are... that meet the standard of being empirically validated. Even in the world of ABA, for example.

If you are using verbal behavior as your primary theory behind the programs that you're doing, you are not using an empirically validated treatment, you're using evidence-based practice.
Because there have been no double-blind placebo studies, group outcome studies addressing solely verbal behavior. All of that work was done primarily through the EIBI model, right? So, we can't use these terms selectively.

And then, the last sort of pillar or group that I want to talk about are these behavior analyst-specific barriers, right? There's been a bunch of literature published, in the last 6, 7 years, a lot in the last few years, that looks at, how different allied professionals view their work with behavior analysts.

Because remember, SLPs and OTs don't seem to have problems. SLPs and PTs don't seem to have problems.
PTs and OTs don't seem to have problems. Now, I'm not blaming behavior analysts. I work with a ton of behavior analysts, but I am saying that the reality is, for whatever reason, behavior analysts don't seem to play in the sandbox in the same way that the other disciplines did.

So, the perceptions, the primary perceptions, the biggest one, clearly, and it's pretty factual, right, is that behavior analysts don't get the pre-professional training at the, in interprofessional collaboration while they're in college. And so many of them don't come to the table with the skills to be inter-collaborative. It takes a set of skills to do this. This is not innate.

There's a whole bunch of barriers... let me just go back to this for a second. Lack of information about our scopes of practice, right? You know, SLPs, I've... when I talk to SLPs that hate ABA, they constantly say that behavior analysts are practicing speech therapy without a license. But that's just not true. Behavior analysts have the right, and it's within their scope of practice, to work on language.

If you know what behavior analysts study... so there's this lack of understanding in some cases. Another perception that has been actually even supported in some literature is that they may have challenges, behavioral analysts might have challenges within some of the soft skills that are necessary for, sort of. Effective collaboration and communication.

And the fourth one, which I find interesting, is that they are less likely to implement recommendations made by allied professionals. And there are reasons for that. Again, for those of you that are behavior analysts listening to this, don't listen to this as criticism. Listen to this as what the literature currently is telling us, and what it means for you as a behavior analyst, or you as a speech pathologist.

Because there are clearly reasons why behavior analysts might not implement recommendations from an allied professional. I don't implement recommendations from some allied professionals, because they just don't fall within my definition of evidence-based practice. Doesn't mean I throw the baby out with the bathwater.

Parents have also reported barriers in their work with behavior analysts. I read an article, and I have to be honest, I was shocked that, in a study where they were basically interviewing families. There were some families who said they would trade a highly qualified behavior analyst in for a less qualified behavior analyst if that less qualified behavior analyst had better relationship skills with them as families.

Because that's how much they have to interact with these individuals, and how much stress and strain it can place on their lives, right? And so some of the things that they have said is that behavior analysts seem to prioritize the treatment agenda above forming a relationship. And again, this could be due to time constraints.

Or it could be due to... I don't really think that's important. There's some report of incongruence between the families and the behavioral analysts regarding recommended dosages.

There's some belief that behavior analysts don't seem to understand the complex family dynamic. You know, I remember years ago, years and years and years ago, when I first started working, and I was constantly giving all these, recommendations to families to do at home, and then I went on my first home visit, and I'm like, whoa.

There's no way they can do some of the things that I've recommended. They don't have one-to-one staffing. They don't have the ability to put anybody on a 20-second DRO, etc, etc. So, you really do... it takes, experience to understand the complex family dynamic.

And then, families have expressed concern that even though the BCBA task list emphasizes collaboration with other professionals, it doesn't seem to include families in that.

So, there are a whole bunch of recommendations for reducing barriers to enhance intercollaboration, and it's sort of set out across, different areas, right? Intercollaboration at the pre-service training level is really, really important.

I did a talk a while back with a very large provider, and somebody raised their hand and said, do you think that the training on interprofessional collaboration should occur at college, or should occur within the provider? And the answer is both, right?

Obviously, you're not going to have enough time, so clearly, continuing education credits and work is important, but it needs to start at the pre-professional training level.

You know, this is a hypothesis, there's no data to support this hypothesis, it's just something that I thought about, because I've seen the intercollaboration feedback, meaning the negative feedback from allied professionals, grow in the last few years, and I'm wondering if it's because up until about 8 years ago, 9 years ago, almost all of the BCBAs got, terminal degrees in something other than applied behavior analysis, because there weren't enough ABA master's programs out there, and so they were either teachers, or speech pathologists, or, you know, other types of

clinicians, social workers, and all of them did have IPC training at the pre-service level. But today, the bulk of people taking the test to be a BCBA have master's degrees in ABA, perhaps not benefiting from the type of IPC training.

The other thing, and Mary Jane will talk more… much more about these, is navigating treatment decisions when the person is not a behavior analyst, when they're recommending something to a behavior analyst that is not behavioral. And the last one that Mary Jane will talk a bit about is developing soft skills. A lot of this work, and the reason she's going to cover this, and can do a much better job, like I said, came out of the work that they've been doing at Endicott.

So, the only thing I want to talk about here is that, I want to get to this… is the IPEC, right? So, IPEC is actually a collaboration, it's an interprofessional collaboration. It started back in 2009 with associations of health professionals, primarily nursing, you know, radiology, right?

It started with healthcare. And what they developed was this interprofessional collaborative on training in order to ensure that people were competent and capable of interprofessional collaboration.

Over the last 15, 16 years, IPEC has now grown to represent 21 national health professionals. ASHA, right? Occupational therapy, physical therapy, psychology, social work, are now included in the 21 associations.

You know who's not included? Behavior analysts. ABA is not included.

It's interesting, because I don't know which association would join. Would it be ABAI? Would it be APBA? Would it be… right? So, the question always is, who's your national association if you are a behavior analyst? I'm not 100% sure I know the answer to that.

So, the core competencies in IPEC are values and ethics. None of them are rocket science, right? Values and ethics. Do we share ethical conduct and mutual respect? Roles and responsibilities? Communication, are we effective at communicating with each other, even if we disagree with each other?

My favorite quote, is this quote that I cannot remember who said it, but it's something to the effect of, a disagreement with truth… with trust, a disagreement with trust is the search for truth. Meaning, nobody needs to win, we just want to know what the right answer is. What's the right way to work with this child?

And then, if you don't trust each other, all you're doing is they have to fight, because somebody just wants to win. There's no real regard about what the right answer is.

And then the fourth core competency has to do with teamwork and interacting with a team of professionals that will be different disciplines.

The last thing I'm going to say, and then I'm going to turn it over to Mary Jane, unless there's a question or two that you want to throw in, but there was an article written by Lina Slim and Lilith Reuter-Yull that talks about the IPEC model and how to look at it from a behavioral analytic perspective. So, it's a great article.

The other interesting thing is that the practice board of ABAI has made a recommendation that they join IPEC. So, it's something that I really hope happens down the road, because I think it will address many of the issues that we're seeing in interprofessional collaboration and pre-professional training.

And now I turn it over to Mary Jane.

Kristen Essex

00:23:22

Thank you so much, Joanne. Sorry, Mary Jane, we do have time for, it looks like, for one question right now, and then we can save the rest for the last, Joanne, if that works for you.

Joanne Gerenser

00:23:30

Yep.

Kristen Essex

00:23:31

So, we do have, one attendee asks.

What do you believe are the primary concerns raised by critics of ABA, and how can the ABA community best address those concerns?

Joanne Gerenser

00:23:43

I'm sorry, repeat it again, what are the biggest concerns for the.

Kristen Essex

00:23:47

Sorry, hold on. What do you believe are the primary concerns raised by critics of ABA, and how can the ABA community best address those concerns?

Joanne Gerenser

00:23:59

Yeah, so I think that one of the biggest critics... criticisms is this, that behavior analysts are rigid, and that they are all compliance-driven, and it's not true, but it is true with bad actors.

So, part of the problem we have in the world of ABA right now is that we're very protocol-driven, and we're protocol-driven because RBTs are doing the bulk of the work, and RBTs have 40 hours of training. That's it. And so, we've got to come up with better training models for the RBTs.

We've got to try and figure out a way to move away from these rigid protocols, but you can't move away from rigid protocols with people that are not well trained.

So, catching up with the growth is part of what the real issue is. I think the other thing is, is that we have to talk more... we have to stop fighting with everybody, because the reason people criticize ABA is because they don't get to see the good stuff.

Because there's so limited interactions, and so, you know, I feel like we just have to stop poking the bear, right? We have to get better at interacting with other disciplines so they have a chance to see how effective ABA is. You know, for me, I love it. The minute I started working at Eden 2 and got trained in behavioral technology, it's so interesting. I just read a performance appraisal that was done on me in 1982. It was 2 months into my work at Eden 2, and it said that I used reinforcement very effectively, and learn the behavioral tools quickly.

You know why? Because it works. And it changed my life in working with children with autism. So, playing nicer in the sandbox, trying to figure out a way to provide better training, enhanced supervision to RBTs, those are the two big things.

Mary Jane Weiss

00:25:57

Amazing.

Thank you, Joanne, for really looking at all of these issues, from the perspective that we need to, really integrating some of these big picture challenges that we have for us in working across disciplines, and I just want to, give a shout out to Joanne and to all of the members of Allied Professions that have mentored me over time.

That have sensitized me to some of the issues that Joanne summarized today, and introduced me to some of the perspectives that we need to integrate into all of this. So, as Joanne mentioned, I'm going to talk a little bit now about some skill development.

And some tools that might help us get closer to enacting these values, to making progress in some of these really important goals.

And, I'm gonna talk about a couple that I think are really helpful that have come out of the behavioral analytic literature in the last 10 years or so.

Newhouse Oystein et al. in 2017, published a tool that helps us make a decision on medical or biological interventions, and it's just a 2x2 matrix. It's kind of beautifully simple in a way, focusing on the extent to which something is evidence-based, and the extent to which it's compatible.

Broadhead really got us started about our recent interest in interprofessional collaboration and how to work with non-evidence-based interventions in that regard in 2015, with his article about how we make decisions about that. And it begins with asking questions about the safety and the efficacy of interventions.

And those... those decision trees, I think, help kind of focus us on what we really need to be thinking about. Not the philosophical assumptions, but focusing in on issues of efficacy, on issues of safety, on issues of compatibility of perspectives and approaches within the team, etc. Because if we have something that's evidence-based and compatible, great!

No problem, right? If we have something that's evidence-based but incompatible, we need to do some real problem solving about how we're going to integrate that.

And there are 4 different scenarios that can be, encountered in that way. Not evidence-based but compatible might lead us to actually look at this on a single case basis.

How can we collect data on this? How can we understand the extent to which this intervention may or may not make a difference for this learner? We may not yet have accrued data that raise this to the level of evidence-based, but if it's compatible with everything else going on for this learner, we could explore that.

We could then be in a position to make database decisions with the rest of the team about it.

Not evidence-based, and not compatible. Also, not really that confusing, but might mean we have a little bit of an implementation challenge, right? We might need to talk about the reasons why we think the team should not pursue this particular intervention.

So, I think that this kind of matrix for making these decisions is really helpful in terms of helping us attend to some of those most important dimensions.

This is the broadhead model that really kind of highlighted this whole issue for all of us 11 years ago. It starts us with, is client safety at risk? It moves us into a question about our level of familiarity with the treatment. In the absence of that familiarity, our task is to become familiar with it and to reassess client safety, and then to examine whether or not it might be compatible with the other approaches we're using with that learner.

Hold that thought, because we'll get back to that later.

An example of a dilemma that might be used in this regard, you know, there are many, but something like, you know, someone mentions they want to do rapid prompting method.

Or someone mentions they want to do a gluten-free diet. There are resources that can assist us as members of interprofessional teams to kind of work through that. Has it been categorized along the continuum of evidence-based practice in a way that's instructive and that's illuminating for us as a team moving forward? What's the status of its classification? And then, are there position statements, especially across disciplines.

I have found several organizations are particularly helpful in that regard. The American Academy of Pediatrics has quite a few recommendations and position statements about interventions for autism.

ASHA definitely wins the prize for having the most clear and specific position statements to guide practice toward or against certain interventions being incorporated, as well as the American Occupational Therapy Association. And one of the things I love about that is, by definition, just watching the evolution of those resources within other disciplines and across disciplines help us... helps us have a more broad view.

An interdisciplinary approach to what other learned bodies are saying about the evaluation of these particular techniques that I have found to be really instructive, and it keeps me from being too myopic, where I'm talking only from the perspective of my own discipline, but I'm actually incorporating the contributions of other disciplines as well.

Those treatment categorization resources include one I really like from Autism New Jersey. It was developed for parents to help guide treatment decisions.

And, it's about the categorization of treatments into red-yellow, red light, yellow light, and green light procedures. Green light procedures meaning go, these have been shown to be helpful and effective and pose no risks, yellow light meaning, well, we're still awaiting more data on the extent to which these contribute to effective treatment, and red light procedures being those that are cautioned against the incorporation of.

And the red light list, which is listed here, is a short list, right? Because it's restricted to only those things that are known to be harmful or ineffective.

And that is a short list. Many things are really yellow light procedures, but a few things actually fall into a red light procedure where it is not recommended based on issues with ineffectiveness and safety.

I also really like checking position statements. So ASHA, for example, has a position statement on rapid prompting method, and look at the language when I mentioned just how clear and directive ASHA is in their position statements. It says it's the position of ASHA, that the use of rapid prompting method is not recommended.

Because of prompt dependency and the lack of scientific validity, furthermore, information obtained should not be assumed to be the communication of the person with the disability.

They go on to say that ASHA recognizes the human right of communication, as expressed in a number of other, documents from the United Nations, etc. And they raise the issue that facilitator-dependent techniques really are not consistent with the communication rights of autonomy and freedom of expression, and may prevent access to the person's human right of communication.

And so if I were, in Broadhead's model, trying to ascertain, what do we know about this? I'm not familiar with rapid prompting method, and I want to know more, I would be helped tremendously by encountering this particular position statement, which would really raise some of these very significant concerns about the pursuit of it.

So if we were to revisit rapid prompting, I would find that it lacks an empirical basis, that there are not supporting data, that it's classified as a red light procedure in those Autism New Jersey guidelines, that there are position statements against them. For example, the one I showed you from ASHA. And I think, like, wow, we really need to talk as a team about this.

This is something that we need to talk about in terms of its similarity to facilitated communication, being a facilitator-dependent technique. It seems to have an anti-science or pseudoscience quality, where belief is a variable, and where it's really not a teachable technology. And that would lead me to the decision that this isn't really, one that's appropriate to pursue at the individual level.

Bottom line, many procedures should not be investigated because they're red light procedures where there's evidence of harm, documentation of its clarity of having no effect, position statements exist against them, but many others are just not yet empirically validated and could be explored with data.

When operational definitions are put in place, are agreed upon, a data collection system guides the subsequent decisions of the team, and the team's agreed to that ultimate decision of continuance or discontinuance based on evidence of its impact for that learner.

And I think we can serve a useful function sometimes as behavior analysts within those teams where we can help, with the data collection when it's appropriate to engage in data collection, and we can also share resources with the team about those classifications and resources that might be available that could serve us in guiding those decisions.

How do we land? Obviously, we want to rely on science, we want to make data-based evaluations, if we do intervene with a method, and we want our decisions about continuation of an approach to be guided by the data for that individual.

Obviously, within the wheelhouse of behavior analysis, is really looking systematically at the assessment of this, doing an individualized approach, looking at whether we have data that it makes a significant positive impact for this individual.

And we can argue for an empirical test of that practice and really look to gather data on the individually relevant aspects of that intervention for the learner in our care.

Let's talk a little bit about skills.

I think one of the skills that Joanne actually highlighted in talking about how much this is actually considered part of the professional training of allied disciplines, and not so much yet in behavior analysis, is the importance of understanding the knowledge and skills and abilities and expertises of allied disciplines.

Recognizing what an SLP on the team knows that I will never know, recognizing what an OT has been trained in that I've not been trained in is really important for functioning within an interdisciplinary team.

You know, if we're going to pursue those yellow light, interventions, we want to design a way to examine that intervention for this learner, and then we want to listen to those data. We want to actually make our decision about continuance or not continuance of that based on those data.

Some of the skills are, you know, we want to teach the scope and expertise that's associated with each discipline, so that people develop an appreciation for and a respect for those disciplines.

We want them to engage in activities that could build that understanding, maybe shadow an SLP, maybe shadow an OT, attend sessions, understand what's being worked on and how, and demonstrate the understanding of the other disciplines approach.

This, article that I mentioned was developed by the team of individuals at Melmark, where interdisciplinary modeling is embedded, and this is a pre-service training that's available to trainees in behavior analysis in order to develop those requisite skills that Joanne was referencing, and that maybe aren't yet present in the pre-service training of behavior analysts.

Another skill, remember Broadhead's model, that highlight on translation? Can this be translated into behavioral principles?

Kristin Bowman is a graduate of our doctoral program in behavior analysis who noticed that issue of translation. She was teaching our collaboration courses, for our students who are in our autism concentration.

And she said, you know, they're automatically rejecting a lot of procedures as not translatable.

And I think maybe they don't understand what it means to be translatable. And she identified that as a potential skill set deficit, and she sought to teach that skill.

This is the article that came out of that work. I'm very happy to share any of the references that I talk about today with, any and all of you, if it builds your library of kind of some of the work that's being done in the skills and tools. And she found that translation skills could be taught and acquired, and that also, importantly, instruction resulted in more procedures being seen as potentially able to be translated.

These are the data that show, the baseline performance, how they did with the worksheet, how they did it when the worksheet was faded, but I want you to focus instead on this graph, which was not in the article, because the editors, didn't think that these data were very compelling.

But it's my favorite part of her study, which is, this shows two groups of students in two different sections of a collaboration class.

One of those classes was taught the translation skill set, and the other was not, although everything else about their courses were identical.

And you can see, in baseline, they're roughly equivalent between 15 and 20% of procedures are being seen as translatable to behavioral principles.

But look at the difference with those who received training in translation skills. They go up to 75-80% of suggested interventions as being potentially translatable, whereas the group that didn't receive that training actually got a bit worse, right?

So, we were able to show that when people are actually actively trained, what it means to translate, how would you translate someone's idea into behavioral principles, how would you design a test of it.

That it made these practitioners of behavior analysis much more open to the suggestions that were coming from allied disciplines, which I think is really exciting.

And there are lots of other strategies that we could talk about. Becoming familiar with resources from other disciplines. What do their ethics codes say, right? What are their position statements about? Becoming adept at translating interventions we just spoke about, acknowledging the contributions of other disciplines, like in that pre-service training.

And minimizing jargon, so that we're not putting up barriers, or introducing other ways that might interfere with our ability to have really productive conversations with professionals from other perspectives, other disciplines, and other ways of describing the same phenomenon we might be observing.

And then there's the whole realm that Joanne pointed out of interpersonal skills. So important, sometimes called soft skills, often kind of broadly now talked about the interpersonal skills that are essential for professional practice.

One tool that was developed by Jess Rohrer and colleagues several years ago looked at some of the compassion and collaboration component skills that are important for behavior analysts. This was with a focus toward working with families.

Incorporating family and individual client input, but some of them are broader, discussing the rationale for selected targets, ensuring that that rationale is aligned with input, soliciting input from the other stakeholders and individuals that are being collaborated with, and using precise, everyday language.

Again, staying away from jargon, engaging in active and attentive listening, refraining from interrupting, soliciting questions. In other words, these are skills that are part and parcel of professional practice, but may need to be emphasized more significantly in our pre-professional and professional training of behavior analysts than has been the case up until now.

And I think that it's really interesting to look at some of those things, like, are we matching our vocal and non-vocal behavior to that other individual's preferences and style?

Are we engaging in the kinds of behaviors that let people know we are really listening to them, we are taking in what they're saying, we are, able to engage in a reciprocal conversation that may lead to compromise, or a joint perspective that really helps move forward the interprofessional team dynamic.

Jess Rohrer actually taught some of these compassion skills to students of behavior analysis, again, with a focus on working with families, but again, also relevant to some of the work done in interprofessional collaboration contexts with members of allied professions, looking at things like basic interviewing skills, showing interest in the individual, joining with them, making statements of partnership, and, ensuring that there's alignment with that other individual's goals, concerns, preferences, etc.

And in that, she used BST to teach those component skills to individuals, and she looked at their acquisition of those things, but she also looked at an ancillary measure that's used in a lot of medical research, the Jefferson Scale of Physician Empathy, and some social validity measures that are interesting.

And she was able to show that, yes, these skills, which were low to moderate in all cases across her participants, were acquired, maintained, and generalized in a way that you can see here in these graphs.

Lauren Savioli, a student at Simmons College, who I was an outside member for her dissertation, recently replicated this work in supervision, which I think is really cool.

Again, taught using BST, focused on newly certified early career BCBAs, and within the context of supervision, demonstrated that these skills could be taught, acquired, generalized to real-life supervision contexts.

Given some of the issues we have with burnout and quality assurance within the profession, this is also really encouraging.

Social validity ratings in all of those contexts have also been shown to be really high.

And generally speaking, what we have is an emerging body of research on interpersonal skills in ABA. We now have a number of different labs of individuals, several studies within my own lab, and some other groups across the country, all working on moving kind of the call to action that came out of Taylor et al.'s work in 2018, which showed some deficits in that interpersonal skill repertoire of behavior analysts, and really moving into attempts to empirically build those skills, to operationally define, to measure them, to teach, and to train them.

And I think it's really exciting, because now we're seeing that students are exposed to, these concepts that we're developing and using rubrics to give people performance-based feedback on them, that we recognize that it's important for us to be observing interactions with clients, families, and professionals from other disciplines, that we need to teach these skills to mastery, and that we also need to ensure their generalization to real-world settings. and their authenticity.

We have to hold ourselves accountable from the social validity perspective about how we are being perceived and how people feel about the interactions that they're having with us as professional behavior analysts.

I think, you know, sometimes when we pause and have conversations like Joanne and I are having with all of you here today, it can be a little bit of a bummer, right?

It can be, like, a little bit of a moment of, whew, like, we have some things to work on. We're putting a little bit of a spotlight on some pain points, some need within the field.

At the same time, I think it's just as important for us to highlight that there's a lot of good news in all of this.

This is really a very exciting time in terms of the evolution of these skill sets, the, the emergence of resources that can help us achieve some of these goals, the specification of what the skills are, and the identification of specific ways to go about building those skills, some preliminary evidence that these skills are teachable, trainable, generalizable, associated with good social validity.

So we are, at this moment in time, at a, I think, a very exciting time in this, because we have good sources, we have good starts, we have convergence, and we have consensus.

You don't hear people questioning whether there really is a need for these kinds of directions for us to go in. We have instructional approaches that are emerging to teach these core, foundational, value-based skills in a way that's, I think, very exciting.

At the end of the day, we're focusing a lot more on two questions that are kind of meta-issues, right?

How are we perceived? And how do we behave?

And I think that we are ready, as a profession, to examine those critically, and with humility, and with a focus on ensuring that we improve the outcomes in those areas.

And so, before we move into the questions and answers, I just want to take a moment to thank all of the sources of individuals who have contributed to my individual and our collective wisdom on this. I'm super grateful to all of the members of Allied Professions who have shaped the way I think and talk about interprofessional collaboration. Joanne is a primary influence.

We go back many decades, and I've always had the benefit of her wisdom infused into how I think about this.

But I think that it is so critical for us to recognize that we all need the perspectives and the collaboration from all of these individuals and all of these sources in order to make the kind of socially significant changes that we need to in order to have the kinds of outcomes we hope for.

So, there's our contact information. This QR code will take you, I believe, to these slides. I know they were also made available to you in the chat, but I think Joanne and I are especially looking forward to jointly handling whatever questions, comments, thoughts you might have for us, and so I guess we can turn our attention over to that.

Kristen Essex

00:50:39

Thank you so much, Joanne and Mary Jane. Yes, we'll now begin the Q&A portion of today's session. As a reminder to everybody on the webinar, you can submit questions in the Q&A box at any time.

And we've had had a... we have had a few coming in. Jessica asks,

For the family section with the bullet point norming, what exactly is that referring to? If it's in reference to building rapport with the family, what would be an appropriate responsive discipline in which what is being said is a safety concern of the child regarding the service?

Mary Jane Weiss

00:51:17

That's a really good thing that you mentioned. It comes from the literature in allied professions, like, from the psychology world, and it often references, like, a sense of, yeah, that's common, or, you know, that's... that is something we see quite a bit.

But, in representing Jessica Rohrer in this moment, I have to say that it's the element she feels the least strongly about, and in replications has talked about reducing the emphasis on that, because it is maybe... a more nuanced interpersonal skill, one that somebody with a whole lot of clinical experience might be able to say genuinely in a way that comes off well.

But there could be some risk to a more junior member of the profession, saying that in a way that almost is off-putting.

And so, that is one that in, more recent versions of, attempting to operationally define component skills has been de-emphasized in Roar's work.

Kristen Essex

00:52:24

Thank you. And from another attendee.

What aspects of language are within an RBT-BCBA scope of practice? What are proactive strategies to use before interprofessional conflicts arise?

Joanne Gerenser

00:52:41

So, I'll actually take that one. There's another question I saw, too, about training for RBTs, so I'm going to kind of combine my answer.

To be honest, any aspect of language that is being worked on by the... that is part of the behavioral plan is in the RBT's scope, as long as he has been... he or she has been trained on, you know, how to do it.

But here's an interesting way of looking at it. In the speech world, for us to do speech therapy in private clinics, for example, we are allowed to have speech aides.

And speech aides will carry out the... some of the programs. The difference between RBTs and speech aides is that a speech aide is required to have a bachelor's degree.

And they are required to have a certain amount... almost, you know, a certain amount of training. They take a specific course that's far more than 40 hours, and they're supervised by... there's only 3 speech aides for every SLP.

Now, that can't work in ABA, because you're providing 30 and 40 hours in some cases.

But, the other interesting thing, for example, in my school, My... all my teaching assistants are RBTs, for all intents and purposes. They're the same level of qualification. They're not allowed to work without being in the direct sight of the teacher. The teacher always has to be in the room. And so, to me, the reason being is that they're just... they're not skilled enough, right?

No matter what you tell me, 40 hours, now, I have RBTs that have been with me for 10 years, for whatever reason, chose not to get a degree in anything else. I would leave them alone with anybody. I would have them train and supervise RBTs.

But... so, to me, I worry that there's not enough, protocol-based supervision that's mandated by the system, as it is in the speech world.

Mary Jane Weiss

00:54:47

I would second that. I'm a particular fan of the CFY year that speech and language pathologists have, where they're already credentialed but still under close supervision.

I think there are some really interesting models in allied professions that embed more prolonged supervision, which, as we kind of mature as a profession, who knows, might be, you know, discussed.

Joanne Gerenser

00:55:14

Yeah.

Mary Jane Weiss

00:55:14

I don't know, yeah.

Joanne Gerenser

00:55:15

I guess the other thing is, if you think about it, Mary Jane, you've got RBTs working in home, with families, with nobody there, right? They're just working with the families.

Mary Jane Weiss

00:55:26

It's such a hard context

Joanne Gerenser

00:55:27

That means... they're interacting with the families, they're providing them with information and answering questions, so it's... that, to me, is, like, I almost feel like you should have a year or two under your belt in a center-based program before I'd let you go in a home, on your own, but...

Kristen Essex

00:55:45

Great, and then we have a question that came in, actually, during your response, Mary Jane, during your first answer.

How can we track who follows these guidelines so families know which providers are the best quality?

Mary Jane Weiss

00:56:01

That's a great question.

You know, I do know that in recent years, there's been, movements for accrediting organizations, that I think are probably designed to look at some of these broad issues of quality and variability in quality, and that's probably part of the solution. Joanne, do you have something to add?

Joanne Gerenser

00:56:27

Yeah, no, I think accreditation pretty much... can be the only solution in the long run, it's just we have to make sure we get it right.

I think there has to be a way that we are committed to certain standards that, you know, I get that the BACB has standards, but their standards aren't about how we talk to people, per se. They're about how many hours of supervision, they're about this. And they're not even, by the way, fully required for everybody, because there are programs that don't use RBTs. They use something different.

So, I think, honestly, I think the number one thing that has to happen in the world of ABA is that some national association has to be responsible.

I don't know whether it's APBA, they're not big enough right now to be the organization, but ASHA is gigantic. And they, number one, they are responsible for ensuring that all academic college programs meet a set of standards. If they don't meet those standards, they get dis-accredited.

So, it means you can't... you aren't ASHA certified if you graduate from an unaccredited program.

Asha has very clear CFY standards.

The BACB does not have very clear, at least I don't think, clear enough supervision during your first year as a BCBA.

So, I think there needs to be some national association that steps up and says, we will be responsible for ensuring that, number one, there's solid accreditation, number two, there are very consistent and clear training programs that are mandated.

Number three, academic training is... it covers these 25 things, right?

Mary Jane Weiss

00:58:15

Yes.

Joanne Gerenser

00:58:16

So there's some consistency.

I don't know if that helps, but... This might be.

Kristen Essex

00:58:24

And I think we have time for one more very quick question.

Is there a case for requiring collaboration-focused CEUs for recertification? Is there a similar requirement for SLPs or OTs?

Joanne Gerenser

00:58:39

So there is no... I can only answer for SLPs and... there is no real required areas.

I mean, obviously, what you want to do is, you know, scope of... Competence is... where I would focus my personal CEUs. So, for example, I'm not getting CEUs in... traumatic brain injury, because I'm not working with kids with TBI, nor will I, you know, but...

I... so I think it's, unfortunately, right now, up to the individual to recognize, but I don't think that's a bad idea, to... to think about, specificity once you've sort of declared your scope of competence.

Meaning, you know, my scope of competence is pediatric, behavioral, whatever, right? Versus, you know, so I don't think it's a bad idea. Somebody else also mentioned, CEUs for RBTs. I think that's a great idea. I think that...

Mary Jane Weiss

00:59:38

They have to get them now.

That's a new requirement. But, you know, I have, like, a related thought, which is, it's occurred to me recently that because the industry itself has changed with the, you know, evolution of insurance reimbursement and autism clinic models, that actually a lot of people aren't being exposed to interdisciplinary care models in their early training in a way that I think is a novel, unintended consequence of some of the changes in the industry.

So I think we need to look at both initial training and continuing ed in terms of how do we accomplish these goals, how do we make sure it's an area of emphasis initially, and long-term.

Kristen Essex

01:00:23

Amazing. Thank you both so much for sharing your advice on how we can better collaborate and serve autistic clients. We truly appreciate the valuable insights you both brought to today's session.

And thank you, everyone, for joining us today. I'd also like to thank our partners Endicott College and Eden 2 Programs for making this free program available.

If you found today's event helpful, we encourage you to register for our last and final webinar event, Ascent as a Human Right: Interdisciplinary Applications for Ethical Compassionate Care, with Dr. Nora Saeed on Thursday, June 25th at 2 p.m. Eastern Time.

On behalf of OAR and its amazing partners, thank you again for joining us today. We hope you have a great rest of your day!

Mary Jane Weiss

01:01:08

Thanks for having us.

Joanne Gerenser

01:01:09

Yep, thank you so much.

Mary Jane jumped off.

Okay, bye everybody, thanks