Who Said ABA is Not for Adults: Busting Myths and Building Futures

A webinar presented by Dr. Rachel Taylor on June 9, 2026.

Kimberly Ha

00:00:22

And now, without further ado, I am incredibly pleased to introduce today's speaker, Dr. Rachel Taylor. Dr. Rachel Taylor has worked in the field for over 25 years, starting at the New England Center for Children and the Kennedy Krager Institute.

She's the former co-director of research and development for CARD, and the founder and director of CARD's Specialized Outpatient Services.

She has published numerous peer-reviewed articles and book chapters and currently serves on the Scientific Council for the Organization for Autism Research, and on the board of directors for the Council for Autism Services Providers, or CASP.

As the owner and former CEO of the Center for Applied Behavior Analysis, her work is focused on helping practitioners deliver meaningful outcomes for individuals and families across the lifespan. With that, I'll turn it over to you, Rachel.

Rachel Taylor

00:02:12

Thank you, Kimberly, I appreciate it. And thank you all for coming.

I always say when I do a webinar to a blank screen of people, it's really difficult, so I'll try and keep the engagement up, and if I'm fortunate enough to have anyone joining us today that knows me, y'all know that I have a tendency to speak very, very quickly, so I will try my hardest to keep my pace at a decent level, but to be honest, even right now, it might sound fast to you, but my regular pace is about something like this.

I'm really excited to be here today, and I heard that the other two in the series went really, really well, so I really hope that I do just as good as them. I can't wait for you guys to tell me how I did.

So, I promise I will try not to go that fast, alright? And I like to start with an obligatory warm-up and say, is everyone excited to be here, even though I can't see you, so I hope you're sitting awkwardly by yourself saying, yes, I'm super excited.

I always make this joke, because I then like to say, is anyone terrified? And, I... I... yeah, it's probably just me, because I am very socially awkward, and I can readily get very, very terrified.

So please know that, I... if you ever are a speaker, that you're not alone in knowing that you can be scared on these things, so... but my fears, are not just because I'm awkward and don't like presenting, it has a lot to do with what's going on in the field.

So, this is what I am going to cover today in terms of that topic. So, I am going to be talking to you about a little bit of context on the fears that I just mentioned, and beyond just being a nervous public presenter.

I'm gonna jump into some misconceptions. I was actually fortunate enough to be invited to write a book chapter recently on the history of services of ABA services with adults, and I didn't anticipate addressing misconceptions, but as I was going through the entire history, several started to emerge, so I've pulled a few from that upcoming book chapter out to really highlight what I think is important, especially when it comes to the theme of this series, which is around interdisciplinary collaboration.

And part of the reason why I was happy to present on that is that we do have a publication that came out a couple years ago now.

I'm very proud to say it's over the 9,000 mark for how many people have downloaded it, so I think it's about 9,200 it's been downloaded now, so in our little field, that's kind of a big deal.

So I'm excited to talk to you a bit about what we call the risk-driven approach, also known as the RDA, and if you caught me rolling my eyes, I always say I had no interest in coming up with another acronym, so I blame the research lab at CABA, the place that I'm fortunate enough to own and operate, for a coming up with the acronym, I apologize, we have enough acronyms in ABA, but it is an easy way to say it, so...

That's my outline for you, and let me just jump into some of that context. I mentioned being scared, so... I have been scared for almost 30 years.

What you're looking at there is a picture of my cubby at New England Center for Children. Back in 1998, I had a Gina Green standing over my shoulder, if anyone's familiar with Dr. Green, as I worked with a younger learner, and... and yeah, I have been scared pretty much ever since then, and why? It's very simple.

Because, to me, our job as practitioners whether you're in behavior analysis or some other discipline that supports people with neurodevelopmental disorders, our job is to alleviate human suffering, right? Our job is to improve quality of life.

And it absolutely terrifies me. I actually almost just tear up by myself talking to no one. I am weird.

It terrifies me on a daily basis as to whether or not we're effectively doing that. So that's what I mean by my fear, and I also just like that my youngest seemed to get so excited being dressed up as the Grim Reaper, taking my soul, so I just throw that picture in there for y'all, but...

I'm not going to go into too much detail on this slide, but then thank you, Kimberly, for the lovely introduction. But I thought it would be appropriate to just give a little bit of context as to why I'm in a position to talk about services across adults.

I just mentioned the New England Center for Children nearly 30 years ago. Right after that, I went to the Kennedy Krieger Institute.

So, from being in a preschool setting, and then immediately, my first day at Kennedy Krieger, I was on the rooftop of Johns Hopkins Hospital, and I was in full padded gear, and they were... medivacking in a 42-year-old man who had ripped off Fournier and ripped out one eye, and it was our job to... help the nursing staff bring them in from the hospital, roof to the hospital, and I still, to this day, can remember thinking...

Okay, I don't think my token board's gonna help me out in this situation, so my career started right away across ages.

And I was a professor for a very long time. I'm a late-to-the-agency-owner game, but it has been a little over 10 years now, so about 10 years ago, my husband and I launched what we call CAVA, the Center for Applied Behavior Analysis.

This slide's a little outdated, but I always like to show it at a glance, because what didn't occur to me, and I'm from California, but I had trained originally on the East Coast, is that in California in particular, it was very unique to people that we were going to offer all of these service lines.

Again, I'm not going into detail, so you can glance at them there, and that they were all still based on a foundation of ABA.

And they were amazed that most of those service lines really were going to require a heavy level of interdisciplinary collaboration, and that, as a behavior analyst, that I was okay with that. And I thought, what is going on? What's happened here? Because in my training, New England Center for Children, there is an interdisciplinary team on site. Similarly, Kennedy Krieger's at Johns Hopkins Hospital.

So I always had that training, and I was just fortunate enough when we launched our organization that the need was there to be able to go across ages and across service types and maintain that focus. But I did learn quickly that there is some... very serious confusion, and some meaning around what ABA looks like across ages.

And obviously, we know that confusion's paired with some issues around the growing trend. So, it was last April, not this last one, but the one before, that the CDC released their updated diagnostic criteria, and everyone's so fast to say that it's 1 in 31, it's 1 in 31, and I'm always back here going, does anyone know the adult number?

Yeah, it is 1 in 31, and at the same time, they re-released the updated adult number, which is actually 1 in 45. So, when you look at it broken around across ages, I know I'm going quickly through these graphs, my point wasn't to...to be an appropriate former grad student and orient you to my X and Y axes, I apologize, I'm just trying to give you an idea of the trends.

These are those data broken down by age. So we're talking about 5.4 million adults right now that are diagnosed, and interestingly, I'm pretty sure, I still need to check this out, I don't know how many times I said interestingly, by the way, someone should take data on that.

I think that numbers people who have been diagnosed as adults, so I always like to orient everyone to these trends, because, sure, 1 in 31, we now know what we're going to be looking at 5, 10, 15, 20 years from now in terms of the potential need for support.

I hope that my early intervention colleagues, I offer early... I don't like saying intervention, I offer services for younger children as well. I hope we all do such a great job that no one needs support, but at the same time, kind of not. I love working with individuals that would benefit from support their entire lives.

And we know that number's gonna keep going up. And we also know that we really only have around, what, I think it's a little over 80,000, board-certified behavior analysts in particular.

And while not every service and support needs to be offered from the behavior analytic lens, I am a behavior analytic dork, and everyone knows that about me, we are typically the ones that are responsible for the support plan that should be following that individual across the different phases of their life and their days, so...

So, we're a little off in our balance in terms of the number of available practitioners to meet the growing need.

I'm sure everyone knows that that is watching this right now, but I'll give you a little bit more data if I didn't manage to scare you enough, though.

So this was a publication that we put out a few years ago now, so maybe it's changed, but it was concerning, so we surveyed, I think it was close to about 200 that answered, and then by the time we did all of our good researcher stuff. I think we ended up with about 130 respondents that met the criteria, which is not a bad sample size.

And those were currently board-certified behavior analysts, and we asked a number of questions, and I'm gonna just jump you through these.

I'm not even gonna note the first two bullets, which are concerning. For today's purposes, I'll just go to the third bullet, which is only 5 respondents said that they were supporting an individual that was 19 years or older.

So, when we think about those data, and then we look at trends like this, that's when I get to make my joke. Is anyone scared now? No? Not scared yet? You already were? You knew all of this?

Alright, okay, alright, well, then that's a good time for me to jump into my misconceptions.

I mentioned before that I was fortunate enough to write a book chapter, and actually 6 misconceptions emerged in that book chapter, and I'm not going to cover some of my favorite today.

But if anyone's listening that wants to geek it out with me later, some of my favorite actually have more to do with this notion of what it means to provide medically necessary ABA services, and some confusion that I think has come up.

Around that, language, but to talk about ABA across ages and to emphasize the need for interdisciplinary collaboration and effective collaboration, I thought I would just focus on three in particular.

But I wanted to get anyone's interest so you keep an eye out if the book chap... when the book chapter comes out. It's in really fine print at the bottom there, so keep an eye out for that book, but...

These are the three that I pulled out of the six that I thought would be important to talk about today. So one is that ABA is just for young children diagnosed with autism. Second is that ABA only works when you stick with specific procedures. And third, the goal of ABA is to bridge the gap between chronological and functional age.

And... Why do I think these are the most important for this topic?

It seems likely that a lot of the attendees... you might all go, okay, I already know, especially the first one, Rachel, clearly you're here, and we saw that, but then again, the top... the title of the talk was Busting Myths, right, so I have to go through some of these, but...

I think it's really, really important for whenever we're in a scenario, working in an interdisciplinary collaboration, that we're not, you know, shoving it down somebody's throat of, oh, hey, ABA's across age...
But we're making sure, especially if we are in a position that we're only supporting a younger individual, and we're working collaboratively with a team that only works with younger individuals, that we're orienting the other members of the team to the amazing work that has been done across the lifespan, so that those professionals moving forward don't end up with this misconception.

And when I present in public, I usually scan the audience and I ask how many people have heard this misconception, and it sounds like I'm right on saying that it is one.

For me, it came out of, when I was going through the history of ABA services, and I was like, let's just take a step back here, and let's talk about the history of ABA.

And again, I mentioned that I wasn't trying to talk about misconceptions, but it really dawned on me when I was taking a look at our entire history, and I'm not going to take you through this whole timeline that I was like, well, we have a serious problem here.

First of all, let's make sure that, sure, ABA can often be referred to as a relatively new field.

That happens because of funding changes that have occurred in terms of the attention that people now know about what's possible to get services. It's not that we're necessarily that new, obviously, because we are an established domain of psychology.

Also, something that I think is unbelievably important in any type of interdisciplinary collaboration is don't talk about yourself all the time, I have a tendency to do that just because I'm nervous, and so I do it.

You know, so don't do that, but if the opportunity presents itself, to make sure that whoever you're fortunate enough to be working with is aware of the fact that ABA is from an established domain of psychology, and in the end, that, well, of course, we're not going to say that it is just for children in the same way that we wouldn't say that therapy is just for adults or children.

The concepts and principles remain the same. Your techniques might change given the age of who you're supporting.

For us, those are the concepts and principles of learning and instruction, right? Why people think, feel, behave, and act the way that they do, and under what conditions those thoughts, feelings, emotions, and actions are more or less likely to occur. That's the foundation of our science.

And when we look at it that way, the notion that it's specific to an age type, I hope, goes right out the window, right? So that's what we're talking about.

And so, those are the same concepts and principles, right? Reinforcement's reinforcement if you're 6 years old or you're 60 years old. Now, of course, there's a lot of differences.

But I always like to comment on that, and then when it comes to whether or not there's any research supporting it across ages, that one always gets me too, because I'm like, alright, hold on, pop quiz, everyone.

Do you know what the first study was that... or when the first study came out that showed actually, the first time somebody took those concepts and principles of learning and said, hang on, let's go ahead and apply these to improving socially meaningful behavior, socially significant behavior, quality of life, alleviating human suffering.

The first time that happened was actually a long time ago, and it was not that super little popular journal that came out that everyone knows about, okay? It was not, alright, in that little 1968 prompt that was there for you.

It was actually a few years before that, and the first study that showed the positive effects of implementing procedures based on the science of human behavior was done with adults.

It was done in hospital settings, primarily, but Allyon and colleagues conducted many studies, and these were all occurred, again, before the inaugural Journal of Applied Behavior Analysis issue came out, with some unbelievably important articles, I'm not denying that.

But I'd like us to take a step back, and interestingly, a lot of those studies, they actually trained the hospital staff to implement the procedures they were doing.

So, in that sense, it was kind of the beginning of this whole caregiver-led thing, but I'm not going to get into that for anyone that wants to think about that, but that literally is how far back we're talking about in terms of ensuring some

type of 24-hour-a-day, 7 days a week consistency of supporting an individual with respect to what's going on in their environment.

I often say it's not the job of a behavior analyst to decrease or increase someone's behavior.

I know, that sounds weird. Stay with me, alright? Take a moment, okay? Did she just say that? Yeah, I did say that. We don't increase or decrease someone's behavior.

What do we do? We change the environment, right? We do that to set the occasion for a potential increase or decrease in behavior.

But we're not doing that. We're changing the environment. A prompting procedure, a teaching strategy, an assessment procedure.

That's what our job is. And we've seen the foundation that taught us how to do that go back many, many, many decades.

Moving on from those original studies, then we start to see some, topographies, obviously, that we're still continuing to look at, in terms of, actually, one of my first publications was with Pat Freiman, and it was almost 25 years ago, and it was evaluating the effects of a diaper for an adult, and we actually conducted it in a natural setting.

Because this was an adult that was in a day program at the University of Nevada, Reno, where I went to grad school, and we realized that every day when the residential staff came home, that they were putting this individual in a diaper, even though all day long, he had not been.

And so, he was kind of living in a mini-reversal design for all the grad students here, alright? It really drives me crazy that we say experimental design is in your research methods class, okay?

And we replicated that. I bring that up now only because I like to say... well, we replicated what he was living in to demonstrate that the diaper was setting the occasion for increasing continence, but that... that work that we did, even though it was 25 years ago, was based on work that was all the way back in the 70s.

From there, we move on to some more community-based applications. I always like to say, most importantly, of course, dancing in public, which is something that I probably need a pretty solid intervention on, just so you know.

And I also can't... I'd be remiss not to comment on when functional analysis first came out.

This was really the beginning of, alright, we are in a position to actually stop and say, can we manipulate these environmental contingencies in a way that's going to tell us what conditions these thoughts, feelings, emotions, and actions are more or less likely to occur? And that was a game changer.

Regardless of what type of FA you like to conduct now, the foundation still comes back to this beginning here, and again, was across ages.

So, I always like to give that history a little bit more, and make sure that even though I was saying, I'm sure most people that came to this talk knows that it was not for young children with autism.

But I hope some of that history is something that you can bring back when you're supporting some of your... maybe there might be some, clinical directors here, some parents, whoever it is, to make sure that you're continuing to orient people to that long history that we have.

When it comes to this next one, that it only works when you stick with specific procedures.

I'm gonna go with a couple quick stories for you, that seems the best way to do it, instead of flashing a bunch of references at your screen that you're scrambling.

Oh, I should tell you that the slides will be available, so if you want any of those references, and the amazing team here between Endicott and OAR do a wonderful job of making sure they're keeping up with the Q&A and letting you know what you need.

So, I'm sorry that I'm going fast through those. My point wasn't to get into those studies, it was just to demonstrate that timeline.

And this story, if you've already been reading ahead while I'm talking at you, is I'm actually going to focus on, the first one second, so meaning I'm going to jump into the don't do ABA, it's all about drills, rewards, and punishers, but for a moment, heads up that that first quote has nothing to do with aging out of services.

I bring up the second quote because, looking back, in my almost 30 years, I'm gonna keep saying that, I'm proud of it. I don't know why I keep saying it.

Back then, the first time I was on the phone with a parent was probably closer to about 25 years ago when I was in a position to really be on the phone.

And I would say back then, there was really two types of parents that we were talking to, and one of them was they had absolutely no idea what ABA was, had never heard of it, were obviously in a great deal of crisis if they were on the phone experiencing this.

Whatever, it was a new diagnosis, usually if I'm talking to someone, it was an adolescent, a younger adult, or an adult that was experiencing significant crisis.

And we knew exactly what to say to them if they had no idea what it was.

And then the other side of parents said this, even 25 years ago, so those of you who think that any type of potential contention with ABA has been recent, it's been going on a long time in different ebbs and flows.

And we knew pretty much, I like to think what to say to them, clearly, we're a pretty successful field at this point, so I think we did the right thing.

Fast forward, when I was fortunate enough to launch my agency, this is about 10 years ago now, and I'm back on the phone with parents, have left academia, I'm back in, I'm on the phone, I'm doing the call, and I'm hearing this.

So suddenly, it was like a third type emerged, right? It was no longer the other two. This is what I heard. And they're on the phone with me, so they're talking to... they probably got referred.

I'm in California, so it's a regional center system, so it was probably a service coordinator that said, you should talk to this weird, fastly talking lady that can help you through this, and...

And again, as I mentioned, it was usually somebody who was a parent or a care provider for an adolescent and a young adult or adult who was in pretty significant crisis.

And this is what they would say to me. So, they knew they were on the phone with somebody who's for the Center for ABA, so they knew that this is what I'm going to be talking about.

Interestingly, they loved it.

So let's stay with that, right? That's odd, okay? And then they'd say, but my kid got too old.

I start with the obvious questions of, do you not think funding's available, blah, blah, we go through that.

And I tell you what, more often than not, when I would dig and probe a little bit to find out where this was coming from, especially because clearly they had someone who supported them that set the occasion for them to feel that they had a good rapport, they... I'd like to think if they loved it, that the individual made some progress. So what's going on here?

And nearly every single time, when I would probe a little bit more, it came real clear, real fast, they thought we were going to come into their home and sit down at their dining room table with a 24-year-old and run discrete trial.

We have a problem.

How did that happen? How was an individual supported, likely by a credentialed practitioner, for that many years, and they walked away thinking the entire discipline was defined based on a given procedure?

Sure does make sense that we might have some problems when it comes to interdisciplinary collaboration as well. If I were an SLP or an OT or something, I'd be like, that's great, you know how to run discrete trials.

don't get me wrong, I'm not saying a screen trial is inherently evil, and for some learners, that might be the best possible procedure for them, but ABA is not defined based on that procedure.

The only reason why that procedure works, or may work for a given learner is because of this thing called the concepts of principles and learning and instruction, right?

Reinforcement, generalization, extinction. These are the things that define our field. Extinction's not a procedure, by the way.

This is a concept and principle of learning, the conditions under which our behavior occurs in the natural setting, and our job is to manipulate those conditions to try and capitalize on those concepts and principles of learning. It's got nothing to do with the given procedure.

And a given procedure is going to be more or less likely... to be likely useful for someone, given the unique needs of that individual learner in their unique context and given their learning history.

And I think that's the most important message that... any behavior analyst can bring forward, and it's not that we know how to do all the things either.

I would say the number one thing that we're probably really good at is measurement, and let's make sure that they don't think that that's all we do as well, all right? But measurement is obviously the only way that we know whether or not what we're doing is working.

So, I always like to say this notion of that misconception that it's based on a procedure is because I hear so often people thinking that a particular assessment procedure or a particular teaching procedure is defining ABA, and that's not the case.

And actually, the reason why that procedure works is what defines it.

And similarly, there might be some, confusion around this... I don't know if I gave an interpretable right now, and I actually had an audience, which I've done.

I did it recently. I did it recently at a conference, actually, with a lot of people who had worked, back in 1987, so anyone knows why I'm saying that number.

And it was a couple hundred people in the audience, and I said, alright, I'm gonna do an introverbal, Ivar Lovaas, how many hours? And everyone said, 40, right? Okay.

First of all, just side note, fun fact, it was an average of 40 hours, alright? Also, fun fact, that did come from the fact that you would drop off your kid and pick them up at the time of work, so it's fascinating to see what has happened with that.

There's a whole other presentation. I'm happy to geek it out anytime. It kind of ties to that thing I was mentioning earlier about this medical necessity thing.

For today, I'm on the misconception that ABA only works if you use a particular procedure.

And I would say, similarly, a procedural-based misconception is this notion of how many hours. And I always like to clarify the questions, not how many hours.

I know it is, and I understand from a practical provider standpoint it needs to be.

But it's really important to me, when I'm fortunate enough to be supporting a practitioner, to say, when you're making these recommendations, this needs to be based on everything that's going on for that unique learner in their un... I don't like saying learner, I've been saying that more too. Sorry, Peter, he doesn't like that term either.

That unique individual in their unique context.

What's most likely to set the occasion for a 24-7 improvement in quality of life? How many hours does that take?

And for those of you who know Peter Gerhardt, I keep saying that because I'm fortunate enough to work with him at OAR.

And I actually reached out to him about 8 years ago, 7 years ago, and I've known him a long time, and I said I'd like some guidance for you, because I was being asked to present more on talking about adults, and I said, I don't want to just show up and just do the, hey, make sure you have an age-appropriate goal, right?

Or I don't want to just show up and steal all of Peter's cool stories about using Velcro shoes, right? I'm like... can we talk about this?

And we really dug into this whole issue here, about this notion of the hours, and the example that I was giving back then that I think is even more important now is the notion of going to a physical therapist, and that physical therapist saying that that half an hour session with them is what's going to fix you, or what's going to make it all better.

No, a physical therapist at the end of that half an hour session, and I still remember talking to him about this way back then, is going to tell you, here are my recommendations for how you need to stand up, sit down, go to sleep, do all the physical things.

And they're gonna say that the more often you adhere to these recommendations, the lower your treatment dosage is going to be, the quicker you're going to get better, right?

So, meaning, the more that you change your environment to set the occasion for an improved and in your behavior, that's where the difference is.

So that half an hour session is encouraging you to try and do it 24 hours a day, 7 days a week, okay? I understand that people who are fussy about 40 might not like that I'm saying 24 hours a day, 7 days a week.

If you caught the first slide, I do operate, actually, the first community-based living homes in the state of California, through the DDS system that are based on a foundation of ABA.

So, we do provide 24-hour services. I'm not saying that's what everyone needs. My main punchline would be, let's all make sure that when we're talking about this, we're definitely not saying that you're running discrete trials for 24 hours a day, 7 days a week, or for 40, for that matter.

So those are those first two misconceptions that I wanted to make sure I drove home for you.

To jump into this last one, more often than not, I think a lot of people would say that the misconception would be, if I was talking to no behavior analyst, I don't know who I'm talking to, but that the ABA people are just there for the problem behavior, or challenging behavior, or dangerous behavior, insert term that makes you most comfortable here.

Well, more importantly, should be that makes the individual you're supporting most comfortable in their immediate circle of support, but...

I want to get in... I want to go not on the problem behavior lens, and more on this notion that the goal of ABA is to bridge the gap between chronological and functional age, and we'll come back to that in one minute for you.

Hopefully I got through those first two and I'm not going too fast. Give me feedback later, I love to hear it. And the way I'm gonna do this one... is jumping in to describe this risk-driven approach.

And I should clarify, this is an open access article, we're not, you know, I got nothing to sell here, let me clarify.

The RDA really was a culmination of... 25 years of working in the field, and then seeing the current need for practitioners that were working primarily in interdisciplinary teams as well, and trying to support people that, even when I was a professor, that I knew were going to be coming on up and being released into the wild, as I say, or amongst the civilians, with potentially very limited support, right? Y

ou saw that from the survey that we did as well. If you caught the first two bullets that I didn't go through, those were practitioners saying, no, I'm not getting any support when I'm assigned my first severe case.

That survey was replicated amongst RBTs, and I'm forgetting the name of the author right now, I apologize.

If anyone knows it, please feel free to put it in the Q&A, but it was a survey with RBTs, and it was similarly terrifying.

It was how many times their supervisor had modeled the new... a new program to them, or had supported them in the field, and... and I try not to pull the ageism card, I've said it, what, five times already? I'm gonna do it again.

Those of us that were practicing decades, I know how annoying that is, I'm sorry, but let me clarify.

It was different. My professor was on top of me in the field for hours upon hours upon hours for years, so we were trying to think of a way to equip practitioners with more readily accessible supports that could help guide the case conceptualization process from the beginning of services, so from the intake through eventual transition.

Not a fan of saying graduation. If there's anyone here that says that, please stop saying that, and I'll explain why later, but it is that.

Alright. So, risk. What do I mean by risk? And now I'm gonna look at my time, I'm doing okay, alright.

Yeah, I probably shouldn't have called it risk, but I'm gonna stick with it! I'm gonna stick with it!

It's caused some confusion, because a lot of people automatically think, if I'm talking about risk, I'm talking about traditional risk-benefit analyses, and there is definitely nothing wrong with traditional risk-benefit analyses, and a ton of great work that's been done in that area.

Doetschins and colleagues, I never say that name right, I apologize, D-O-E, I gotta get that right. Shane Spiker has a great risk-benefit analysis framework.

We should obviously be looking at whether or not a given procedure potentially causes harm. Please, let's make sure we're doing that.

I'm pretty sure that causing harm is not gonna set the occasion for an improved quality of life. I don't mean to sound so snarky, it's kind of my baseline.

So let's make sure we're doing risk-benefit analyses, of course, but this little thing called the BACB, every once in a while they do something that's pretty cool, okay? I know there's some controversy, but every once in a while, in the updated ethics code, the last paragraph of the intro section is what you're looking at right now.

And they very clearly state that the job of a behavior analyst is to put clients' interests first, which right there is very important, obviously, this whole thing called compliance with the law.

But then they say to actively maximize desired outcomes and minimize risk. And that's the closing paragraph.

And we were already doing our work in the risk-driven approach area when I came across this, and I was like, yay, thank you, I can anchor this in something.

Because it really dawned on us then that you really have to take that sentence in. That's not just saying risk with respect to safety or harm.

That's risk to desired outcomes. So that's any possible risk that's going to set the occasion for this individual not accessing an improved quality of life, right?

Failure to identify an effective reinforcer is a risk. Having a staff member that doesn't know how to effectively implement a procedure is a risk.

Those are risks to effectively providing services, and so our ethical obligation as behavior analysts is to identify and minimize all potential risks, even those that don't present with an immediate safety or harm issue risk to actually doing our job, to making sure that this individual is in a position to breach their own personal goals.

So, we really kind of jumped in on this sentence. And then I've literally built an entire agency on this sentence.

I think we provided around, a little over 90,000 direct hours in my company last year. But we're not... I say that, and we're, about 250 employees and about 25, management-level team members.

And are able to have relatively low caseloads because we offer services across ages, so we're not trying to fit everyone in from 3 p.m. to 6 p.m, but I want to give an idea.

So, the RDA we do across all of our service lines, and I always like to throw this up as a goal, just because I know everyone sees this. My prompt is obviously there, I'm saying it's incomplete.

If you are training people and teaching people to write goals, please make sure they can first do this before you start tearing them down, because this is correct, alright?

Sounds like a perfect goal, right? X behavior will decrease, and X functionally equivalent replacement behavior will decrease by X amount over X time, settings, people... yay, yay, right, we're done, we're done. Let's check that ethics code again.

We're not done, right? There's really two separate questions that need to be on top of this in terms of what we now call socially meaningful case conceptualization.

And the first is, well, let's just make sure that whatever goal we're working on here is actually going to improve quality of life.

I know that sounds silly, but a lot of the original work in the RDA was coming from that, because I started to notice quickly that there was a lot of focus on our procedures, and far less focus on our goals and how we are coming up with goals, meaning the focus within even some of our regulatory guidelines and our ethics standards in the publication that you have, I think we provided a link to it or shared the PDF for you.

We actually broke down some numbers in terms of the number of times the word goal was mentioned in, at the time, the BHCOE guidelines, now ACQ guidelines, and it's minimal, and anytime the word risk came up, it had to do with traditional risk-benefit analyses.

So, we were really focused on saying, hold on, let's make sure that we are equipping practitioners with a structured approach to make sure that we're working on the right thing in the first place, right?

Is this genuinely a risk to an improved quality of life for this individual? And a lot of this came up for me around the topic of stereotypy. I'm the first person to say, let's talk about that. I have no problem talking about that.

Why? I know it can be a really hot topic, and everyone gets like, oh my gosh, she's gonna go there this quickly? Yeah, I'm gonna go there this quickly, because guess what?

The only time you're gonna set... you're gonna consider decreasing stereotypy is if it's been identified that stereotypy is impacting an improved quality of life for this individual.

And more often than not, I'm going to argue it's probably likely that it's not, right?

For so me individuals, it might be, though. And that's the conversation that needs to be happening, right? Is whether or not we are addressing something that's genuinely a risk to an improved quality of life.

And, obviously, the next one, how are we minimizing and identifying all potential risks?

So, this is a glance at the publication here. That is outdated. I like seeing this every time I checked earlier. It was, like, 9,100 downloads, so I'm excited about that. I hope they're all liking it. I don't know, their tag as downloads don't really mean much if no one likes it, but we're hanging in there with it.

I'm not going to go through the development process for you, but I just leave this on your slides here so you know this was not just me sitting in my office.

There's a lot of wonderful people involved, and we did, a lot of rounds of a lot of, as Dr. Wallace, my master's thesis advisor, and so my mentor for my thesis, who's now the director of research at my company. So for us, 25 years later, to still be arguing, I mean, healthy conversations about stuff, but...

There was a lot of wonderful conversations around this, but this is the publication, and really, when it comes down to talking about what the RDA is, it's best to talk about it in terms of these three prongs, which is the domains, the levels, and the framework, so I'm going to take you through that in a moment.

First, I want to pause to clarify that not only am I not the first person to talk about risk, I'm also obviously not the first person to talk about ABA across the ages.

So, this is just one glimpse of I quickly, when I was first putting together this talk, thought, okay, what's come across my desk in the last year, couple years, for a few of these things?

That I wanted to make sure I gave a shout-out in terms of things that have recently inspired me that are across ages or are specific with respect to risk.

In the upper right-hand corner, you're actually seeing, it was a screenshot of a research lab where I have a colleague who was working on assessment guidelines that were released in conjunction with both APBA and CAASP.

They recently came out and I was happy to see that she had some quality of life measures in there as well, so that's all that is, is a list of some of the suggested quality of life measures. There are more than that. There's one out of Kansas, I'm forgetting the name of it now, too.

And I'm really on this guy. I gotta call Peter Gerhardt, for anyone who's listening right now, and be like, I want us to come back to this, how are we defining quality of life, because I think this is gonna... I know the topic's always been there, but I feel like it's coming back up very strongly right now.

And more often than not, I see it in this, like, side bubble with a bunch of other targets, and I always look at it, and I think, I'm pretty sure that all those other targets are the definition of quality of life, so what are we doing?

Anyway, I just wanted to make sure I gave that shout out to say that I'm not the first person to talk about risk or adults.

The difference with the RDA, and this is in the publication, is we did not see anything that had been published at the time that was specifically with respect to that ethical obligation that was across the entire progression of services.

So that's what you're looking at on the left there, is us talking through, saying, alright, let's look at this in terms of how are we going to support practitioners to be engaging in a collaborative discussion with all involved parties, from the point of initial intake through potential transition, I shouldn't say potential, everyone should transition from more restrictive services.

What we should have said differently here, though, is that that should say initial assessment.

I think the arrows fix it, but I don't have time to wrap my head around it again. Why am I saying that? Because I also worry, and this would be one of my misconceptions that people think assessment is something you do at the beginning of services, and you're done, and it's an ongoing process.

We have to constantly be engaging in assessment and seeing whether or not what we're doing is effectively identifying and minimizing all potential risks.

And now what you're looking at are the four risk domains.

And I'm going to dig into those more in a moment, but that's what emerged in terms of the work that we did with the work groups, is we said, okay, how can we have a framework that can outline all the potential risks so that practitioners, when they are sitting down with the individual themselves and or their immediate circle of support, are saying, look, these are all of the things that I, in a unique position to support you, are going to need to be looking at.

Now, I don't have time for it today, but one part of the publication, and I give a huge shout out to Dr. Susan Wazinski, because she saved me. She was the action editor.

And she had seen me present, and she said, Rachel, I just want to give you a heads up, the original version of the publication, I had spent the whole first half talking about my concerns with managed healthcare and medical necessity and this whole other topic that I keep mentioning.

Sorry, I can't stop myself, especially right now.

And the second part was the framework and the domains and the levels that I promise I'll show you a bit more on in a moment.

You're not gonna know what all this is in a brief... if I could do this in an hour, let alone 20 minutes of my presentation, then it wasn't worth the years we spent on it, right? My goal is just to orient you to it in hopes that you'll go back and look at it.

But she said to me, Rachel, shocker, I'm too much.

She said, this is really two separate papers, you need to do, right, write this paper, which is the medical model stuff that I'm concerned about.

And she said, but it sounds to me like we really want to introduce the RDA. And then she said to me, and I've seen you present, and I think you really need to revisit the defining features of social validity.

So, when I mention it's beyond the scope of my presentation today, but I just want to point out to you that if you look at the article, the bottom of the image here, referencing goals, procedures, and outcomes, and the top of the image here is we did take the time, and I actually had noticed I'd been engaging in some observer drift when she said that to me.

She said, you've been presenting on this, Rachel, and you're doing it differently. And I thought, what am I? I'm Wolf1978. I'm not doing it differently, what are you talking about? And I went back to the original publication, and I was like, oh.

Oh my gosh, she's right! So we do have an updated version of Wolf's definition of social validity, for those of you that are familiar with what I'm talking about.

So, I was mortified, it says Wolf, and then it says Taylor, it's like, I'm like, no, I... Obviously, it's a wonderful definition of social validity.

But what I didn't notice over the years is that the individual is not included at all three levels, and obviously risk was not, but... so that's why we did the update.

So I just want to give you a heads up on what those images are for those of you that are familiar with that work. But my goal for my next 10-15 minutes as I shove things out here...

Kimberly told me I need to leave at least 7, so I'll shoot for 10, is to take a closer look at these risk domains.

I should mention, though, that this is in the article, this image, and we do sit with... with caregivers, is the term that I use, by the way, when I say stakeholder and clients, that is concerning language.

I use that language because that is the language that's endorsed by the BACB, but I always like to point out that we should tread carefully with that language.

I, myself, am a parent of a child that was in services, and when you're going through it on that side of the... it was a long time ago for me, but when you're going through it on that side of the lens, I can guarantee you calling me a stakeholder didn't feel quite right, nor was he a client, but it is what it is, right?

Here is the framework that I keep mentioning to you. So, you're seeing those risk domains again at the top there, but before I dive into those, I just want to point out that the framework is broken down on the left there according to the purpose, the definition, the description, and the measures.

And your risk domains are across the top, and I'll show those a little closer, because I do like to emphasize that, even though I'm covering it up here, how important the definition is.

I worry that the first image, and even some of the practitioners at CABA, we all end up just defaulting to just showing the four domains.

Sometimes we show these questions. That's what the domains are supposed to do, is saying, okay, am I asking? How do safety concerns influence risk to optimal outcomes?

As a practitioner, am I asking throughout the entire sequence of services? How do resource deficiencies influence this? How do presenting characteristics? How do efficacy concerns?

And we sit, and we show this exact framework to the individuals we support in their immediate circle of support, just to point out how much needs to go into the work that we do.

I do like to say, though, let's not get away from looking at the rest of the framework, because it's kind of important to shift some of these questions sometimes, because there's a big difference between, for example, saying, how do resource deficiencies influence risk to optimal outcomes, versus asking the question, do we have the assets necessary for a person or organization to function effectively?

So, we really spent quite a bit of time trying to make sure that we were giving directive questions that can be posed, and then further on down, giving examples of the types of measures that would correspond with that.

And while this wasn't crisis-specific, hopefully I made that clear in my harping to you that risk isn't just about safety and harm, we did start our work right before COVID, and so a lot of people, I think, thought when we were doing this and heard Rachel doing this risk stuff, that it was all COVID.

I will say that the resource domain in particular became real loud and clear to me during COVID, because I am a family-owned and operated company that operates community living homes, and those are the individuals' homes. They're not my homes.

Those are those individuals' homes. There's nowhere for them to go. There's no question of pausing services for us.

And now I can giggle about it a little bit, but I have no problem going back and reliving the terror that came along with being like, oh my gosh, am I not gonna have any staff.

And that dawned on me, and I thought, what am I gonna do? It's gonna be, like, me and my husband and my brother that are direct staff in these... I guess I hope we're down for it, like, I hope some of my grad students are not dead yet.

Like, I mean, it was terrifying. Are we calling in the National Guard? That's when it dawned on me, and we were doing our beginning of our work here, oh, resources are a risk to maximizing desired outcomes.

The other example I always give is I hope people aren't conducting an entire assessment, and then afterwards asking for the parent's availability.

And if you are, I hope you change that moving forward. Why am I saying that? That was a risk that needed to be known at the beginning of the assessment, because that likely would have potentially changed... should change how it is that you're looking at things and seeing what the potential appropriate goals, procedures, and targeted outcomes would be for this individual. So there's an example of the resources.

Why do we do all of this? Honestly, in the end, it's because of this. I am convinced and concerned, and I think hopefully this tool will help in interdisciplinary collaborations as well. A lot of people, I think, erroneously think that the job of a behavior analyst is all in this domain, right?

That our job is to come in and increase behavior and decrease behavior, right? Increase appropriate skills, functional replacement skills, decrease severe challenging behaviors, and we do it based on preference assessments, and here's our procedures, and we're done and done.

And why are we doing it? Usually that language comes from bridging the chronological to functional age gap.

What do I mean by that? And I used to teach it this way, too, so when I was a professor, I remember, I hope it was a long time ago when I taught it this way, but I did, I definitely probably did, which was, okay, you're gonna have... let's go with a younger individual, we're gonna do our battery of assessments.

Side note, we don't have an agreed-upon way in our field right now to summarize the outcomes of all of those assessments, so I will briefly touch on risk levels, because that's really my passion with this work that we're still digging into, but stay with me if you can, I circle back, I promise.

And our job is to say, okay, this individual is chronologically, let's say, 7 years old, okay? But functionally, the results of all of these things tell us that they're functionally 3 years old.

And income, good BCBA, my job is to build a program that's gonna bridge that gap.

No. That's not what we should be doing. Maybe, in some situations, and why would we know if it's an appropriate situation for that unique learner in their unique context.

If bridging that gap is going to set the occasion for an improved quality of life. That's the question. And for many learners, that might not need to be the focus, and I can guarantee you, the extent to which bridging the chronological to functional age gap is useful goes down with age, alright?

Meaning, the extent to which I'm going to come in and say, here's a 26-year-old who's functioning as a 15-year-old, I'm going to do programming to bridge that, we're likely not picking up on individualized risk to an improved quality of life for that individual.

So, hopefully, starting to look at these different domains helps orient people to that.

I'm not going to spend a ton of time on safety, hopefully that one is the obvious one. And efficacy, I always like to say as well, this is just as much of a risk.

Even if everything looks great, all of your programming looks wonderful, and let's say it is an adult, and they have mastered all their goals, and everything's great, but they live with a direct support worker who's going to be with them all the time, and that person's terrified and doesn't know what to do.

Well, then you're... then you're not done yet. Your job is to identify and minimize all potential risks to that individual accessing an improved quality of life.

Whenever I have, people in the room that work with younger individuals, I always like to say, and let's be real, I'll give you another example. What about the staff member, excuse my language, that has crappy play skills, right? And it's like, oh, and they all start laughing at that one. Usually, I'm like, right, okay, right there, okay.

That's a risk, especially if you know that's the only staff member that's going to be available to support that learner.

So, efficacy needs to be equally weighed. So, all of these are equally weighed.

And when it comes to the levels, this, as I said before, there's an image for you of what I mentioned about the battery of assessments and us not having a mutually agreed upon way to summarize all of these things.

I am not endorsing any one of those. I literally just pulled up several of them that just came to the top of my mind at one point, and really was thinking about the newer practitioners that are faced with needing to go and meet the increasing demand, potentially under the conditions of relatively limited support from what I like to call a more seasoned practitioner.

I try not to pull the age card, just because you've been practicing for 20, 30 years does not necessarily mean that you're better. I'm sure there's a bunch of people watching that know some pretty crappy behavior analysts that are older.

But I do think that having somebody who's there to help orient you can be helpful.

But either way, our punchline is that we know there's no way to summarize the outcomes of these, so part of my... the work for me, and I say that in not contrast to the lab that I'm... that I support, but I know I'm the one that's pushing this, because I'm convinced that the metric of risk could also help us in terms of giving us a way to make sure that we are keeping individualization.

Even though everyone's pushing for standardization. The bottom line is it's impossible to standardize ABA services. I would like to say that loud and clear. That is one of the misconceptions that I usually include in this talk, by the way. It is impossible to standardize ABA services. What is needed is a standardized approach to providing individualized services.

And that really, I think, has been exacerbated lately because of this notion of tying things to getting medical treatment.

It's very different. A doctor can say, okay, I'm here, I'm going to do things based on normative samples. You're a 50-year-old woman, you're this height, you're this weight, here's the medication I'm going to give you, and I'm okay with that.

I am fine with them saying that they're looking at these physiological barrier, or variables, snd they are barriers, because I can't see right now, sorry, they're physiological variables, and they are making a decision about a physiological intervention.

That's not our job, right? Our job needs to be individualized, because I can tell you what, preferences change. Function of behavior changes.

So that's why it's so important to me to make sure that we can have a metric that can talk about these things. So those are the risk levels.

I'm not going to spend a ton of time, but it has been unbelievably useful language for us, because we can look at different individuals that are with different presenting characteristics, but given their unique needs for the service line that they're in, we can now say that this individual is progressing from a low, moderate, or high... or sorry, hopefully they're progressing from a high to low risk for achieving, an improved quality of life.

And similarly, I joke, I do say that I am convinced that there's a way to take a lot of our standard tools and ask the experts to break them down into what are all the possible outcomes.

Could we all agree that these ones are low, moderate, or high risk? I'm like, I'm gonna call Kyle McGill and be like, tell me all the VB MAP scores, and just tell me, and get another expert. I joke, I'll take the Vineland, okay? It's a pretty easy flip, that's a good one, right?

I don't know if we'll get our work there for now. I can tell you guys that the language around sitting with individuals and looking at progress and being able to summarize the outcomes of things according to this language has been incredibly useful.

And then finally, I mentioned that book chapter, so here it is again, and I was just giving an example here.

What we ended up doing is we ended up using, essentially corrective language, for lack of a better descriptor, meaning we went through all the misconceptions, which... really, this is the only one that I've showed you guys today that is exactly the same language, but...

And then at the end of the chapter, we went back in and gave, like I said, some corrective language. So, for this one example in particular, we said, no, no, no, the goal is not to bridge the chronological to functional age gap.

Instead, and I have to move things to read it, practitioners are ethically obligated to engage in socially meaningful case conceptualization to improve quality of life for each unique individual within their own personal context.

And doing so may or may not involve focusing on reducing diagnostic symptoms and or targeting more age-appropriate goals.

In the end, this is how I closed out that chapter, so I'll close it out the same with you all. I usually don't like to read things, but I thought this one was pretty good, and I have to give a shout out to my colleague, Dr. Columbo, who helped me with this one.

And it was talking about concerns around the infrastructure for adult support, specifically the number of competent and confident behavior analysts prepared to work with adults, and I hope that that framework that I showed you goes to show you we're not responsible for everything that goes into that.

There are other people that are supporting this individual in other disciplines, but we are the one that's coming up with a behavior plan that needs to roll across all those settings, all those potential risk levels, so I just want to clarify that again.

So, some shared language on how to establish a consensus for whether or not we're looking at the right things is our main goal.

As policies around insurance coverage and other funding sources expand to include adult services, ABA practitioners must be ready to enter this space. However, such preparation should not wait for changes in reimbursement structures.

While the field does need more practitioners trained to work directly with adults, it is equally, if not more, important to have practitioners who prepare children, adolescents, and young adults for the realities of adulthood.

Skills such as self-control, choice-making, self-management, flexibility with routines, and other adaptive behaviors can and should be targeted early. These skills are crucial for adult success and should inform the development of socially meaningful goals in collaboration with the team.

To this end, all ABA service providers should approach the case conceptualization process with respect to one guiding question. What does this individual, child, adolescent, or adult need right now to thrive in the future.

And oh my goodness, Kimberly, you should be proud of me. I'm never... I had 9 minutes, 9 minutes. It might be because I spoke too quickly, but there you are, 9 minutes.

And there's some contact stuff there for you. I'd recommend the info at Center for ABA. I am communication challenged, there's no doubt about that, so I'm sure there's someone watching me right now that sent me some message that I never answered.

Please know it's not personal, I'm trying my hardest, but there's some ways to get ahold of us, and I will stop babbling now in case there's any questions or comments, and thank you again for having me.

Kimberly Ha

00:51:44

Alright, thank you so much, Rachel, for that information-packed presentation. We'll now begin the Q&A portion of the session. As a reminder, you all can submit questions in the Q&A box at any time.

Our first question comes from Ashley. How do you balance adult-directed goals with clinical judgment about minimizing risk?

Rachel Taylor

00:52:05

Interesting. I wish I could ask some follow-ups on that, but let me see if I can follow it.

How'd it say it again to me? Sorry, one more time.

Kimberly Ha

00:52:13

Yeah, sure. How do you balance adult-directed goals with clinical judgment about minimizing risk?

Rachel Taylor

00:52:22

well, honestly, I don't think I'm getting probably what the question is, but more often than not, I try to talk to the individual themselves about it, so I don't know if that's too quick or easy of an end.

I know that's not always necessarily possible with some individuals, but for me, I take a great deal of pride of saying, I'm not going to be the one that's going to decide something's a risk unless it's an obvious safety or harm one, right?

But that's part of the nature of me wanting to emphasize that collaborative process. The example that we give in the article, I believe, is actually showing how important it is to go through the process of identifying the potential risk, because that could change what the goal is.

And actually, I'll give a little fun fact, if you do read the article.

I wrote that when my now 22-year-old was, was doing his driving test, and, that was terrifying, and when we were in the... and that poor kid is in a co-parenting situation, and out of his parents, three are board-certified behavior analysts, so that kid's screwed no matter what, right? So anyway, so all four of us have to make decisions together, or had to back then.

And, he... the driving test only happened, though, because he had wanted a job, and when we went through the potential risk to him accessing a job, it was transportation.

And so we give that as an example. I know some people are like, oh, the funder's not gonna pay for, you know, learning to drive.

Like, please don't go there with me. It's just a conceptual moment of saying, so the goal was getting a job, but by going through the process of identifying the risk per what he had self-identified, so again, there's only certain individuals that are in a position to do that, but...

Going through the process of identifying what would be possible to achieve that goal then brought up those other risks.

So I hope that was a semi-helpful way of doing it, but I'm not sure if I caught it. If not, feel free to write back and say she didn't get it, and I'll try again.

Kimberly Ha

00:54:07

Okay. Our next question is from Rebecca.

How do you assure adults who have been diagnosed with autism that ABA is more than just teaching them to, quote-unquote, mask? How do you navigate that discussion?

Rachel Taylor

00:54:22

Oh, yeah. Honest, quick answer is, I rely on the autistic supervisors that I'm fortunate enough to employ at CABA, so I know that's not what everyone's in a position to be able to do, but I hope some of you will start to look at ways to be able to do this.

So I had, when my organization started, one of my first hires as a direct staff member was somebody who self-identifies as... well, was diagnosed, but is open about their diagnosis. I should clarify, it's not my place to talk about someone's diagnosis.

And she was autistic, and I quickly asked her to be my autistic advisor, so that was about 10 years ago now that she was my autistic... well, still is.
And over time, actually left, CABA. We have a lot of people that leave and then come back. I know that happens at other agencies. I'm proud of that fact sometimes, but anyway, came back after finishing her master's degree, and she's actually one of three, supervisors that we employ that are autistic.

And so I really... I try my hardest not to... to spend time on my opinions about what it means to mask. I'm fortunate enough to have those individuals working through that.

So, we are from a... we use the RDA, as a lens for our case planning process, so... meaning in terms of matching and scheduling, so, we talk about potential risk to this being an appropriate match within whoever gets assigned to the case.

So, if there are indicators that this is somebody who's struggling with either feeling comfortable with ABA, for good reason, given a lot of stuff that's out there, and or somebody who's struggling around specifically the topic of masking, I give them somebody who goes through masking.

And not that I should clarify, though, masking for one person is not the same as the other, but we have learned over time that having that conversation with someone who's gone through it has been helpful.

So that might not be easy for... if you're not in a position, so I'm very lucky that, I guess I'm not lucky. We worked hard at it. So, I recommend you get an autistic advisor, support them to go get a master's degree, and then hire them to work for you, I guess is my answer on that one.

Find consultation, yeah. Interdisciplinary consultation.

Kimberly Ha

00:56:28

Well, I think we have time for one more question. This also comes from Ashley, and I didn't hear from her, so I think you answered her last question.

Do you think ABA could replace coaching for late-diagnosed and high-masking autistics and other neurodivergent adults?

Rachel Taylor

00:56:43

Yeah, okay, so, how do I do this? Good question, by the way. Sorry, I wasn't saying that each time.

I already... I already wore my clothes, I'll say it again, I am a hardcore behavior analyst, right? And I have been one for a long time.

So, I am from a time when I definitely worked closely with some people where it was, everything's behavior analysis, and I'm kind of known for that, people will say that, they'll make fun of me, they'll be like, Rachel's gonna say everything's behavior analysis.

But at the same time, I don't mean that. I mean that my worldview and my lens sets the occasion for me to identify

what it is about some type of approach or technique that might make it more or less effective. Why? Because it's about the concepts and principles of learning and instruction and human behavior.

There are a lot of coaching techniques that are phenomenal, and the reason why they work, right, in the same way... interestingly, coaching actually is a perfect example, because that is a procedures-based phenomenon in many ways, right? You're gonna learn, you're gonna even become certified as a coach, you are learning procedures.

So, I would argue, I'm not going to say it should replace it, because I don't want to ever be one of those behavior analysts that's like, we should do everything, because I think that's caused us so many problems.

But I love that you actually did the example that way, and the more I think about it, I started processing while I'm answering you, because that's a perfect example of saying, hey, coach, keep coaching, and they probably know a lot more techniques than we do.

And then, hey, here's this thing that the science of human behavior can offer us right now, which is, more often than not, it's probably going to start with measurement, right?

Meaning, like, we have this expertise in this area for you to be able to start to identify whether or not some of your coaching techniques are more or less likely to work. Since we have two more minutes, and you said it was the last question, Kimberly, I'll go off on this for one more second.

I went to the University of Nevada, Reno, and I studied directly with this man named Steve Hayes, if anyone knows who Steve Hayes is. So I am a weird behavior analyst, okay? I've had a lot of training from a lot of different... people, I'm not saying Steve's weird, but he is, and he knows that too, so I guess I am.

What I will say is that Steve wrote a little book 20-something years ago called The Scientist Practitioner Model, and if you go back and read it, there's a subtitle to that book, and it says, in the age of managed healthcare.

He was talking to traditional couch therapists, so similar to a coach, meaning a different discipline.

And he knew that managed healthcare was going to make people need to start demonstrating their outcomes, so he wrote a whole book about the value of single subject design.

I'm sure there's a lot of people in this webinar that have no idea what I just said, but hopefully a few of you are picking up on what I'm trying to put down, which is, let's talk about how to infuse what aspects of the science and human behavior can be helpful for other disciplines that know a ton more than us, though.

So that's not what we're saying. We're not saying here that it's teaching you magic because you don't know anything. It's, hey, is there a way that we can build on this so that you can effectively demonstrate your outcomes?

So, that said, shortly, yeah, I'd love to replace coaching with ABA. Sorry, I'm kidding, but we do a lot of coaching services. All of my services are called ABA.

But I know that that's confusing, so... I'm hoping that... that someday it won't be, but we'll see, right?

Let's just all keep doing good work and trying to help people, I guess, but... I hope that made sense, Kimberly, and I know you... don't start with the... that was an information-packed one. I'm gonna give you a hard time for that later, Kim. I had 6 misconceptions that I usually cover in an hour, okay? And I did. So, give me a break.

Kimberly Ha

01:00:00

Well, thank you so much for sharing your expertise and valuable insights with us today. As OAR, representative of OAR, we truly appreciate the depth and knowledge, practical perspective you brought to the 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.

And if you all found this event helpful, we encourage you to register for our next webinar event, Collaborative and Compassionate Care: Best Practices for Autism Intervention Teams with Drs. Joanne Gerenser and Mary Jane Weiss. on Wednesday, June 17th, at 2 p.m. Eastern Time. And for that one, we also offer both ASHA and BACP BACB credits.

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. Thank you again, Rachel. We appreciate you.

Rachel Taylor

01:00:51

Thank you guys, bye!