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RESEARCH ARTICLE

Behavior Analysts' Training and Practices Regarding Cultural Diversity: the Case for Culturally Competent Care

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Abstract

The U.S. Census Bureau predicts that by 2044, the United States will become a majority minority nation, meaning no group will have a majority portion of the total population (Colby & Ortman, 2014). Therefore, training on working effectively with individuals from diverse backgrounds is critical. We surveyed Board Certified Behavior Analysts (BCBAs) to assess the amount of training they received during their coursework, fieldwork or practicum, employer training, and continuing education on working with people from diverse backgrounds. In addition, we assessed whether BCBAs thought training on this topic was important, how skilled they thought they were in this area, and whether behavior-analytic course instructors included material on cultural diversity in their courses. The majority of respondents reported that training on working with individuals from diverse backgrounds is *very* or *extremely important*. Interestingly, although the majority of respondents reported they felt *moderately* or *extremely comfortable* and were *moderately* or *extremely skilled* at working with individuals from diverse backgrounds, the majority of respondents reported having *little* or *no training* in this area. We discuss the implications of these results for the field of applied behavior analysis and future directions.

Keywords Cultural assessment · Cultural awareness · Cultural sensitivity · Diversity

The U.S. Census Bureau predicts that by 2044, the United States will become a majority minority nation, which means no specific demographic category will have a majority portion of the total population (Colby & Ortman, 2014). The diversity of children in the United States is increasing at an even faster rate, and projections are that by 2020, the population of children in the United States will be majority minority, and by 2060, one in five individuals will be foreign born (Colby & Ortman, 2014). Providing health care to individuals from diverse backgrounds poses many challenges related to the acceptability of procedures, appropriateness of procedures, and adherence to procedures (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016; Britton, 2004).

Skinner (1971) loosely defines *culture* as the various contingencies of reinforcement prevailing in the environment in which we are born and that we experience throughout our lives. The contingencies can be difficult to identify, particularly social contingencies when the reinforcers are related to social values and ideas that evoke the behavior. An individual's culture offers distinct contingencies that shape and effect behavior, and one's culture directly relates to one's opinions and perceptions regarding socially appropriate behavior (Glenn, 2004; Skinner, 1971).

The behaviors that embody a culture include the way we socialize with others, the language we use and the specific words within a language, our religion or lack of religion, the way we solve problems and make decisions, the gestures we use, the things we eat, the clothes we wear, gender roles, the way we parent, our values, our beliefs, and our priorities. All of our operant behavior, and even some of our respondent behavior, is affected in part by our culture. For example, the sight of a tarantula might elicit a conditioned startle reflex with an American, whereas a tarantula, considered a delicacy to many people in Cambodia, might elicit conditioned salivation when seen by a Cambodian. Because culture underlies much of our behavior, understanding the differences in cultures and how to work effectively with individuals from diverse backgrounds is critical when working in applied settings.

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Cultural variables can include socioeconomic status, race, ethnicity, age, nationality, disability, gender, sexual orientation, and religion. Ignored or unidentified cultural variables may become barriers to the delivery of effective treatment (Betancourt et al., 2016; Kodjo, 2009). Culture intersects with behavior analysis in several ways. From the moment a health care professional accepts a client, cultural variables are operating that might have favorable or detrimental effects with respect to building rapport with a family (Kodjo, 2009; Parette & Huer, 2002). These effects could lead to a family accepting services or early termination, and potentially turning a family away from behavior analysis altogether; however, research on the explicit effects of cultural variables is limited. Cultural variables may also underlie how readily a client accepts diagnosis, clients' preferences for specific targets (e.g., social targets vs. academic targets), and the types of treatments a client seeks out (Betancourt et al., 2016; Kodjo, 2009; Lo & Fung, 2003; Parette & Huer, 2002; Vandenberghe, 2008). The types of treatments we select are impacted by the value we place on Western science, and Western science can be viewed as a culture in itself (Kodjo, 2009; Parette & Huer, 2002). The extent to which we value Western science directly relates to how readily we accept or deny the argument for and benefit of evidence-based treatment. If a client or caregiver does not value Western science, the practitioner may find it difficult to obtain buy-in from the caregiver.

Communication—both vocal and gestural—might be one of the most relevant cultural variables related to developing and maintaining therapeutic relationships with clients and stakeholders. Some researchers assert that our cultural background affects the way we interact with authority figures, which can affect assessment and treatment procedures (Kodjo, 2009; Parette & Huer, 2002). For example, many Asian cultures are more likely to use indirect communication and are less likely to explicitly disagree with an authority figure and instead will actively avoid conflict (Morris et al., 1998). In addition, gestures can have different meanings in different cultures. An individual from an Asian culture may appear to consent to a procedure (e.g., head nodding) even though he or she does not agree with the procedure but was instead head nodding to denote he or she heard the professional (Parette & Huer, 2002). Kowner (2002) found that Japanese individuals viewed communication with Westerners as unpleasant. The Japanese participants also rated the Westerners' communication styles to be similar to that of high-status Japanese, and the author posits that the Japanese participants may have rated communication with Westerners as unpleasant because the behaviors and gestures emitted by the Westerners—who were of equal status to the Japanese participants—were similar to a high-status Japanese person speaking with a low-status Japanese person. However, the results must be interpreted with caution as this study was a descriptive study and did not experimentally evaluate cultural variables. Nonetheless, this study provides some evidence that interactions between cultures can be interpreted very differently across cultures.

Unfortunately, few behavioral studies have evaluated the effects of cultural variables on behavior, but the few that have been conducted have demonstrated notable results. One such study conducted by Lang et al. (2011) observed increases in challenging behavior and decreases in correct responding when instruction was delivered in the participant's second language (English) and subsequent decreases in challenging behavior and increases in correct responding when instruction was delivered in the participant's first language (Spanish). Similarly, Rispoli et al. (2011) evaluated the effects of the language of implementation of functional analysis (FA) conditions on the levels of problem behavior emitted by a participant from a Spanish-speaking home. The authors observed increases in problem behavior when the FA was conducted in English, thus demonstrating that the language used to implement FA conditions can impact levels of problem behavior. These studies support the need to identify and consider linguistic backgrounds (i.e., cultural variables). However, in a review of the literature, Brodhead, Durán, and Bloom (2014) found only 6% of language studies in the *Journal of Applied Behavior Analysis* and 3% of language studies in *The Analysis of Verbal Behavior* disclosed cultural and linguistic backgrounds.

Cross (1989) asserts that cultural competence is a developmental process that encompasses the capacity to address the distinctive needs of populations whose cultures are different from the mainstream United States. Culture is always evolving; therefore, becoming culturally competent is a lifelong endeavor that needs continuous improvement (Fong & Tanaka, 2013). Other helping professions are further ahead than behavior analysis with respect to cultural competence. The American Psychological Association (2008), the American Speech-Language-Hearing Association (2017), and the American Academy of Pediatrics (Britton, 2004) have task forces on diversity, training requirements, policy statements, and/or guidelines with respect to serving diverse populations, but the field of behavior analysis has yet to adopt a formal set of guidelines. Fong and Tanaka (2013) propose a comprehensive list of guidelines on cultural competence for the field of behavior analysis to consider. However, these guidelines have not been formally adopted by the Behavior Analyst Certification Board (BACB); therefore, many behavior analysts may not be aware of them.

Furthermore, some of our professional guidelines appear to be incongruent with incorporating cultural variables. One rather contentious example is whether behavior analysts should accept gifts (Witts, Brodhead, Adlington, & Barron, 2018). There is no consensus across areas of psychology; however, Simon (1992) asserts that although some therapists are fine with accepting gifts of small monetary value,

compensation of one's services should be received from the fee received from the patient and professional gratification from providing high-quality services. This stance appears to be echoed in behavior analysis by Bailey and Burch (2016), who state behavior analysts should not accept gifts of any kind. However, Hoop, DiPasquale, Hernandez, and Roberts (2008) provide a more culturally impartial discussion on the topic of receiving gifts. They discuss the importance of considering the implications of refusing gifts during cross-cultural treatment but also warn of the potential issues of relaxing boundaries with those of different cultural backgrounds and how this could result in relaxing other boundaries as well. Unfortunately, there is no research with respect to how receiving and giving gifts affects treatment (Hoop et al., 2008). However, to get a sense of how many behavior analysts accept gifts from clients, Witts et al. (2018) conducted a survey on this very topic. Of the 57 respondents, 40% reported they accepted gifts of small monetary value, 12% accepted gifts of moderate value, and 77% reported their clients would be offended if they refused the gifts. If behavior analysis wants to become more sensitive to cultural variables, it seems important to evaluate the effects of refusing all gifts on therapeutic relationships with people from cultures where refusing gifts is disrespectful and modify (if needed) our professional guidelines to reflect a culturally sensitive model that allows for the delivery of effective treatment.

Another important variable that impacts the level of training on cultural diversity is the coursework requirements for behavior analysts, which will be based on the BACB's Fifth Edition Task List in the year 2022 (BACB, 2017b). The Fifth Edition Task List includes various principles and concepts of behavior and how these principles and concepts relate to the assessment and treatment of behavior. Although cultural diversity is not included in the Fifth Edition Task List, there are components of the BACB's *Professional and Ethical Compliance Code for Behavior Analysts* that relate to cultural diversity training. Specifically, guideline 1.05, Professional and Scientific Relationships (c), states,

> Where differences of age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect behavior analysts' work concerning particular individuals or groups, behavior analysts obtain the training, experience, consultation, and/or supervision necessary to ensure the competence of their services, or they make appropriate referrals. (BACB, 2017a, p. 5)

In other words, if practitioners are working with people from diverse backgrounds, they should be obtaining the necessary experience and training in this area, which raises the important question, are behavior analysts trained to work with individuals from diverse backgrounds and are there opportunities for them to access this type of training? Kelly and Tincani (2013) asked a related question and surveyed 302 behavior analysts to identify how many received training in collaborating with other professionals. Although learning to collaborate with other professionals is not identical to cultural diversity training, collaborating with other individuals involves learning how to work with others who are different from you or your background. Sadly, they found that the majority of respondents received little to no training in working collaboratively with people from different professional backgrounds, which demonstrates a need for this type of training in behavior analysis.

Becoming culturally competent behavior analysts is critical if we want to deliver effective behavioral treatment and reduce the known disparity of health care to individuals from diverse backgrounds (Flores & Tomany-Korman, 2008). The purpose of our study was to answer the aforementioned questions. We conducted a survey to assess the extent of training Board Certified Behavior Analysts (BCBAs) received on working with individuals from diverse backgrounds, the opportunities for such trainings, the importance of cultural diversity training, and the degree to which practitioners felt comfortable and skilled in this area. In addition, we assessed the implementation of various practices related to the delivery of culturally competent care.

Method

Participants and Setting

Participants were recruited via an e-mail sent out through the BACB e-mail list. The e-mail was sent to 20,553 BCBA certificants (including those with the BCBA-D [Doctoral] designation) worldwide and was completed by 707 respondents. Four respondents reported they were not BCBAs; therefore, their data were excluded from the analysis, and 703 respondents were included in the results. Demographic data of the participants are presented in Table 1. This study was approved by an institutional review board, and all participants were required to complete an informed consent to participate. The survey was completed online via the Qualtrics website (https://www.qualtrics.com).

Materials

The survey consisted of 40 multiple-choice questions (5-point Likert scale) and was hosted by Qualtrics. The survey included questions on the demographics of respondents; the importance of receiving training on working with people from diverse backgrounds; the comfort level and skill level of respondents regarding working with individuals from diverse backgrounds; and the amount of cultural diversity training respondents received via behavior-analytic coursework during their

Table 1 Participant Demographics

Age	*N*	Percentage
Under 30	77	12
30–39	312	49
40–49	165	26
50–59	59	9
60–69	22	3
70–79	4	1
Greater than 80	0	0
Total	639	100
Gender		
Female	531	83
Male	97	15
Nonbinary/third gender	6	1
Self-describe	0	0
Prefer not to say	4	1
Total	638	100
Race		
White	554	84
African American	22	3
Asian	41	6
Native Hawaiian	3	1
American Indian	10	1
Self-describe	30	5
Total	660	100
Ethnicity		
Hispanic	67	11
Non-Hispanic	544	89
Total	611	100
Current nationality		
U.S. citizen	548	86
Dual citizen	25	4
Other	65	10
Total	638	100
Field of master's degree		
Applied behavior analysis	208	32
Behavior analysis	38	6
Psychology	127	20
Education	191	30
Other	75	12
Total	639	100
Field of PhD		
No PhD	485	79
Applied behavior analysis	24	4
Behavior analysis	18	3
Psychology	32	5
Education	21	4
Other	31	5
Total	611	100

master's and doctoral degrees, non-behavior-analytic coursework during their master's and doctoral degrees, fieldwork or practicum during their master's and doctoral degrees, continuing education, and employer training (see Appendix for exact survey questions). In addition, the survey included questions regarding whether the respondent considered various cultural variables (e.g., asked clients if they were religious, if they had dietary preferences, or about their preferred forms of communication). These questions were selected based on a review of the literature on cultural competence (e.g., Carrillo, Green, & Betancourt, 1999; Tanaka-Matsumi, Seiden, & Lam, 1996). The survey also included three additional questions for verified course sequence instructors that asked about the importance of training students to work with individuals from diverse backgrounds, the amount of material they included in their coursework, and the amount of material they included in their practicum or fieldwork. A complete list of survey questions is included in the Appendix.

Procedure

Participants were given 1 month to complete the survey and could only take the survey once. The 40-question survey took approximately 10 min to complete. Participants could stop the survey and complete it at any time during the 1 month. Approximately 2 weeks after the initial recruitment e-mail, a reminder e-mail was sent to all certificants reminding them about the survey. Participants received no compensation for completing the survey.

Results

Participant Demographics

Table 1 depicts the demographic information reported by the respondents. The majority of respondents were non-Hispanic (89%) White (84%) female (83%) U.S. citizens (86%) between the ages of 30 and 39 (49%). Minorities made up 16% of respondents, with no single minority reaching above 6%. The majority of respondents had a master's degree in applied behavior analysis (32%), followed by education (30%) and psychology (20%), and 21% of respondents had a PhD in psychology (5%), other (5%), applied behavior analysis (4%), education (4%), or behavior analysis (3%).

Table 2 depicts the employment characteristics of the respondents. The majority of respondents worked in clients' homes (32%), centers or clinics (22%), or public schools (20%), and respondents' primary roles as BCBAs were as supervisors (45%) or practitioners (28%). Respondents primarily worked with individuals diagnosed with autism spectrum disorder (68%), which was followed by working in special education (10%). The majority of respondents (57%)

Table 2 Participant Employment and Education Characteristics

Proportion of diverse clients	*N*	Percentage
Less than 10%	67	10
10%–19%	48	7
20%–29%	62	9
30%–39%	67	10
40%–49%	51	7
50%–59%	124	18
60%–69%	71	10
70%–79%	66	9
80%–89%	59	8
Greater than 90%	87	12
Total	702	100
Primary work setting		
Public school	130	20
Private school	39	6
Client's home	205	32
Center/clinic	138	22
College/university	47	7
Residential facility	26	4
Hospital	5	1
Community	15	2
Other	36	6
Total	641	100
Primary role as a BCBA		
Practitioner (direct services)	181	28
Supervisor	290	45
Administrator	74	11
Lecturer/instructor	10	2
Professor/researcher	37	6
Other	49	8
Total	641	100
Population of primary work		
Autism spectrum disorder	433	68
Intellectual disability	56	8
Special education	66	10
Emotional or behavioral disorders	33	5
Mental health	12	2
General education	4	1
Brain injury	3	1
Typically developing	7	1
Gerontology	1	>1
Employees	4	>1
Child welfare	1	>1
Other	21	3
Total	641	100

reported that more than half of their clients were from diverse backgrounds.

Importance, Skill, and Training

Table 3 depicts the respondents' comfort level and skill level with respect to working with individuals from diverse backgrounds, the importance of cultural diversity training, and the amount of training respondents received with respect to cultural diversity. The majority of respondents reported that training on working with individuals from diverse backgrounds was *extremely important* (58%) or *very important* (30%), and they felt *extremely comfortable* (49%) or *moderately comfortable* (43%) working with individuals from diverse backgrounds. In addition, the majority of respondents reported being *moderately skilled* (63%) or *extremely skilled* (23%) at working with individuals from diverse backgrounds.

With respect to training and coursework on working with individuals from diverse backgrounds during the respondents' master's degrees, the majority of respondents reported their master's degree behavior-analytic courses included *a little* (47%) or *none at all* (35%) material; their master's degree non-behavioral courses included *a little* (41%), *a moderate amount* (23%), or *none at all* (18%) material; and their master's degree hands-on training included *none at all* (39%) or *a little* (28%) material. With respect to training and coursework on working with individuals from diverse backgrounds during the respondents' PhD degrees, the majority of respondents with a PhD reported their behavior-analytic courses for their PhD degree included *none at all* (32%) or *a little* (32%) material, and their non-behavioral courses for their PhD degree included *a little* (27%), *a moderate amount* (17%), or *a great deal* (18%) of material. Respondents reported their PhD degree hands-on training included *none at all* (31%), *a little* (26%), or *a moderate amount* (20%) of material.

With respect to employer trainings on working with individuals from diverse backgrounds, the majority of respondents reported their employer provided *none at all* (42%) or *a little* (29%) training. In addition, the majority of respondents reported participating in *none at all* (40%) or *a little* (38%) continuing education opportunities related to cultural diversity and seeing *a little* (55%) or *none at all* (29%) continuing education opportunities on diversity at conferences or online continuing education opportunities.

The majority of respondents who were instructors of BACB-approved courses reported it was *extremely important* (57%) or *very important* (30%) to teach students to work with individuals from diverse backgrounds during their graduate studies, and respondents included *a little* (32%), *a moderate amount* (27%), *a lot* (15%), *a great deal* (13%) or *none at all* (13%) material in the courses they taught. The majority of respondents who taught practicum or fieldwork courses included *a moderate amount* (31%), *a little* (23%), or *a great deal* (21%) of material on working with individuals from diverse backgrounds.

Culturally Competent Practices

Table 4 depicts practices related to delivering culturally competent care. The majority of respondents reported being *moderately* (40%) or *somewhat familiar* (31%) with the process of delivering culturally competent care. With respect to culturally competent practices, the majority of respondents educated themselves on a client's culture if the client immigrated from another country *most times* (32%), *sometimes* (28%), or *every time* (28%); however, the majority of respondents *never* (32%), *rarely* (25%), or *sometimes* (21%) asked their clients about their religious

Table 3 Importance of and Training on Cultural Diversity

Comfort level working with individuals from diverse backgrounds	*N*	Percentage
Extremely uncomfortable	10	1
Somewhat uncomfortable	12	2
Neither comfortable or uncomfortable	36	5
Moderately comfortable	302	43
Extremely comfortable	342	49
Total	702	100
Skill level working with individuals from diverse backgrounds		
Not skilled	1	>1
Slightly skilled	24	3
Neither skilled or unskilled	71	10
Moderately skilled	446	63
Extremely skilled	161	23
Total	703	100
Importance of cultural diversity training		
Not at all important	2	>1
Slightly important	12	2
Moderately important	66	9
Very important	212	30
Extremely important	411	58
Total	702	100
Master's ABA coursework on diversity		
None at all	244	35
A little	327	47
A moderate amount	80	12
A lot	21	3
A great deal	17	3
Total	689	100
Master's non-ABA coursework on diversity		
None at all	99	18
A little	234	41
A moderate amount	132	23
A lot	63	11
A great deal	40	7
Not applicable	121	18
Total	689	100
PhD ABA coursework on diversity		
None at all	47	32
A little	46	32
A moderate amount	34	23
A lot	7	5
A great deal	11	8
Total	145	100
PhD non-ABA coursework on diversity		
None at all	15	11
A little	35	27
A moderate amount	22	17
A lot	16	12
A great deal	19	15
Not applicable	24	18
Total	131	100
Master's hands-on training on diversity		
None at all	272	39
A little	194	28
A moderate amount	132	19
A lot	60	9
A great deal	31	5
Total	689	100
PhD hands-on training on diversity		
None at all	40	31
A little	34	26
A moderate amount	26	20
A lot	18	14
A great deal	11	9
Total	129	100
Employer-offered training		
None	281	42
A little	193	29
A moderate amount	111	17
A lot	48	7
A great deal	34	5
Total	667	100
CE completed		
None at all	271	40
A little	255	38
A moderate amount	101	15
A lot	26	4
A great deal	17	3
Total	670	100
Observed CE offerings on diversity		
None at all	197	29
A little	369	55
A moderate amount	86	13
A lot	11	2
A great deal	7	1
Total	670	100
Importance of teaching diversity (instructors)		
Not important	0	0
Slightly important	1	1
Moderately important	12	12
Very important	31	30
Extremely important	59	57
Total	103	100
Dedication to diversity in coursework (instructors)		
None at all	13	13
A little	33	32
A moderate amount	27	27

Table 3 (continued)

Comfort level working with individuals from diverse backgrounds	*N*	Percentage
A lot	15	15
A great deal	13	13
Total	101	100
Dedication to diversity in hands-on training (instructors)		
None at all	4	5
A little	20	23
A moderate amount	27	31
A lot	17	20
A great deal	18	21
Total	86	100

Note. ABA = applied behavior analysis; CE = continuing education

or spiritual beliefs. Only approximately 1 in 10 respondents reported asking clients about their religious or spiritual beliefs *most times* (11%) or *every time* (11%). The majority of respondents reported asking clients about nonmedical treatments *sometimes* (26%), e*very time* (23%), or *most times* (19%) and about dietary preference *every time* (42%), *most times* (26%), or *sometimes* (21%).

Only approximately 1 in 10 respondents (12%) asked clients about preferences for nonverbal communication, such as specific preferred greetings or gestures they find offensive, *every time*. The majority of respondents reported *sometimes* (28%), *rarely* (25%), or *never* (20%) asking clients about preferences for nonverbal communication. Whether respondents asked caregivers why they thought the client had the disorder/diagnosis was relatively split across categories, with the majority selecting *sometimes* (25%), which was followed by *rarely* (22%), *most times* (21%), *every time* (18%), and *never* (14%). The majority of respondents *never* (28%), *sometimes* (22%), or *rarely* (19%) asked about preference for male or female therapists (which can vary depending on religious beliefs).

When asked whether respondents asked clients if the treatment goals aligned with the family's values and beliefs, only approximately two out of five respondents reported they asked *every time* (39%), whereas approximately two out of three respondents reported asking this *most times* (31%), *sometimes* (16%), *rarely* (8%), or *never* (6%). When asked how often respondents worked with a translator if English was a second language, the majority of respondents reported *never* (28%) or *sometimes* (26%), which was followed by *every time* (16%), *rarely* (15%), and *most times* (15%). Finally, most respondents reported being *moderately knowledgeable* (47%), *slightly knowledgeable* (29%), or *very knowledgeable* (15%) with differences in parenting across cultures.

Discussion

We found that the majority of respondents (88%) agreed that training on working with diverse populations is *very* or *extremely important*. Interestingly, 86% of respondents reported they felt *moderately* or *extremely skilled* at working with individuals from diverse backgrounds, even though the majority of participants reported they had *little* to *no training* in their coursework (82%, behavior analytic; 59% non-behavior analytic), hands-on training (67%), continuing education (78%), or employer training (71%) on working with individuals from diverse backgrounds.

Although our survey does not allow us to definitively identify why respondents selected particular responses, we propose some possibilities as to why respondents might have reported they were moderately to extremely skilled with little to no training. First, although respondents may not have had formal training, perhaps respondents had a lot of experience working with individuals from diverse backgrounds. This is supported by the survey results, because 57% of respondents reported that 50% or more of their clients were from diverse backgrounds. However, the idea of becoming skilled at delivering culturally competent care simply by working with individuals from diverse backgrounds is concerning. The notion of being skilled by simply experiencing something with no formal training is antithetical to applied behavior analysis and is akin to thinking one becomes skilled at discrete-trial teaching with no formal training or one becomes a skilled practitioner without any specific training. Perhaps we are incorrectly labeling our *comfort* with a process as *skill* implementing a procedure. This, of course, can be quite dangerous not only for the clients we serve but also for our field's reputation as a whole. We would not allow a therapist to conduct discrete-trial teaching without formal training, so why are we not affording the same care to working with people from diverse backgrounds and receiving training on how to best identify and incorporate cultural variables?

Demographic data on certificants are not publicly available (BACB, personal communication, March 15, 2018). However, such data could help identify whether our field is representative of the population because it is critical to have practitioners that represent the population being served. In addition, a limitation of the current study is that our results should be interpreted with caution because only 702 BCBAs completed the survey (approximately 3% of all BCBAs). We collected demographic data on respondents; however, the extent to which our sample represents the population of BCBAs is not clear. One important aspect of the validity of survey data is ensuring the data are from a representative sample of the population. Although demographic data on certificants are not publicly available, Nosik and Grow (2015) reported that 82% of BACB certificants are female, thus suggesting our sample was at least representative with respect to gender. Our respondents were primarily non-

Hispanic (89%) White (84%) female (83%) U.S. citizens (86%) between the ages of 30 and 39 (49%). In a survey conducted by the American Psychological Association, they found that 88% of psychology providers were White and 59% were female (American Psychological Association, 2016). It is not clear why the field of psychology is predominately White and female, but it is clear that we should become better at recruiting people from diverse backgrounds. Behavior-analytic providers should consider assessing the demographics in their service areas to determine whether their staff are representative of the demographics and, if not, identifying ways to recruit staff from diverse backgrounds (Fong, Ficklin, & Lee, 2017).

We did not ask respondents whether they delivered culturally competent care. Instead, we asked how familiar respondents were with the process of delivering culturally competent care and then asked various questions that related to practices of delivering culturally competent care. Approximately two out of three respondents (60%) reported that they educate themselves on a client's culture *every time* (28%) or *most times* (32%) if their client immigrated from another country. Although it is good practice to learn about other countries and cultures, we must be cautious with this practice to avoid developing gross generalizations or stereotypes of a culture and applying them to our clients. There are many subcultures within cultures; therefore, identifying gross generalizations will not help us understand our specific clients and their individualized backgrounds. Instead, we should learn how to gather valuable information about the cultural backgrounds of our individual clients and use a culturally competent approach with all of our clients. Triandis (2006) asserts that all humans are ethnocentric—we assume that what is "normal" in our culture is normal everywhere—to a degree. Triandis (2006) further describes how some behaviors emitted by one culture (e.g., loud talking) may be perceived as offensive to another culture, but by understanding these idiosyncrasies of cultures, we can alter our behaviors to enhance our relationships with others from different cultures. Triandis (2006) urges us to be empathic and attempt to engage in exercises that put ourselves in the shoes of other cultures to help reduce ethnocentrism; however, there are limited empirical data to support the efficacy of such tactics. Perhaps future research could evaluate methods to reduce ethnocentrism and improve relationships with diverse clients through these methods.

Only 39% of respondents reported they asked whether the treatment goals aligned with the values of the family *every time* (31% reported *most times*), and surprisingly, roughly one in three respondents (30%) reported they *never*, *rarely*, or *sometimes* asked whether the treatment goals aligned with family values. This is surprising considering applied behavior analysis is defined by the selection of socially significant behavior (Baer, Wolf, & Risley, 1968), which should be measured through social validity assessments. In other words, applied behavior analysts should always be asking relevant stakeholders if the behaviors are important, the treatment procedures are acceptable, and the effects are socially significant (Baer et al., 1968; Wolf, 1978). By conducting social validity assessments and asking caregivers about the acceptability of behaviors, procedures, and effects, we are removing our biases developed through our experience in our culture. For example, a U.S. practitioner following safe sleep guidelines outlined by the American Academy of Pediatrics may think it is important for a child under 1 to be sleeping in his or her own bed (Moon & AAP Task Force on Sudden Infant Death Syndrome, 2016), but a family bed (i.e., the child sleeping in bed with the parents) may be more acceptable to the family based on their cultural background. By asking families whether the treatment is socially valid, we will gain valuable information as to whether it is culturally appropriate as well. Creating a more culturally appropriate intervention might help increase the integrity of implementation by caregivers as well.

Furthermore, we found the results were mixed with respect to behavior analysts incorporating culturally competent practices into their service delivery. The majority of respondents reported they asked clients about dietary preferences and use of nonmedical treatments. However, the majority of respondents reported they *rarely* or *never* asked clients about their religious beliefs, why the client had his or her diagnosis (which may help the practitioner determine the client's willingness for implementation of applied behavior analysis), and the client's preferred gender of therapist (which may vary for some religions), and the majority *rarely* or *never* used translation services for clients whose second language was English. However, our question regarding translation did not ask how often the practitioners asked whether the client wanted interpretation or translation services and instead asked how often they interpreted materials. The wording of this question limits our ability to analyze it because perhaps practitioners were not using the services because the clients were declining their use.

If behavior analysts agree that cultural diversity training is important, and the majority have received little to no training nor do they see many behavior-analytic opportunities for such training, how should we proceed? At the molar, or field, level, we suggest the BACB adopt guidelines on working with individuals from diverse backgrounds similar to the guidelines proposed in Fong and Tanaka (2013) and incorporate revisions into future versions of the Task List that would require universities to incorporate cultural diversity training in their coursework requirements. Graduate programs should ensure that education and training on working with individuals from diverse backgrounds is weaved thoughtfully through the curriculum. Coursework on culturally responsive practices could include topics such as identifying one's own culture and how it may impact practice, content on the cultural biases implicit in applied behavior analysis, and practicum experiences on how to conduct culturally responsive functional behavioral assessments and home assessments. Conference planners should identify experts in cultural diversity training and invite

Table 4 Culturally Competent Practices

Familiarity of culturally competent care	*N*	Percentage
None	29	4
Little	77	12
Somewhat familiar	203	31
Moderately	264	40
Extensively	87	13
Total	660	100
How often you educate yourself on immigrants' culture		
Every time	183	28
Most times	208	32
Sometimes	185	28
Rarely	61	9
Never	21	3
Total	658	100
How often you ask clients about spiritual beliefs		
Every time	75	11
Most times	76	11
Sometimes	136	21
Rarely	163	25
Never	209	32
Total	659	100
How often you ask clients about nonmedical treatments		
Every time	149	23
Most times	128	19
Sometimes	175	26
Rarely	124	19
Never	83	13
Total	659	100
How often you ask clients about dietary preference		
Every time	273	42
Most times	174	26
Sometimes	140	21
Rarely	47	7
Never	26	4
Total	660	100
How often you ask clients about nonverbal communication preferences		
Every time	77	12
Most times	97	15
Sometimes	180	28
Rarely	162	25
Never	132	20
Total	648	100
How often you ask caregivers why the client has the disorder/disability		
Every time	116	18
Most times	138	21
Sometimes	160	25
Rarely	141	22
Never	93	14
Total	648	100
How often you ask about preference for male or female therapists		
Every time	94	15
Most times	101	16
Sometimes	145	22
Rarely	122	19
Never	185	28
Total	647	100
How often you ask if treatment goals align with values		
Every time	249	39
Most times	203	31
Sometimes	100	16
Rarely	54	8
Never	41	6
Total	647	100
Translator use when English is the second language		
Every time	102	16
Most times	94	15
Sometimes	166	26
Rarely	99	15
Never	182	28
Total	643	100
Knowledge of parenting across cultures		
Extremely knowledgeable	21	3
Very knowledgeable	92	15
Moderately knowledgeable	300	47
Slightly knowledgeable	188	29
Not knowledgeable at all	39	6
Total	640	100

them to speak in prominent places at conferences (e.g., keynote addresses) and offer workshops on becoming culturally competent behavior analysts. Employers should hire diverse clinicians similar to the populations they serve, provide employees with trainings on cultural diversity, modify paperwork to be more inclusive of diverse family structures (e.g., using the term *caregiver* as opposed to *mother* and *father*), and offer professional translation and interpretive services.

At the molecular, or individual, level, behavior analysts can seek out education on this topic through continuing education opportunities or self-education via the research literature. The delivery of culturally competent care is a process. The first step to delivering culturally competent care is self-awareness and identifying how one's own culture impacts one's behavior. Members of a dominant culture (e.g., White, Anglo-Saxon, in the United States) may not see themselves as having a culture at all and instead think being culturally diverse means nondominant or minority. Therefore, those practicing applied behavior analysis in the United States who come from a White, Anglo-Saxon cultural bias may not see that they are lacking information or knowledge of other cultures because of this cultural "blindness."

To be culturally competent, we must recognize our own culture and see other cultures as equally valid to our own. Fong, Catagnus, Brodhead, Quigley, and Field (2016) provide strategies for behavior analysts to become more culturally aware. The authors discuss methods to engage in self-assessment to identify one's own culture and the impact one's cultural background has on one's practice of behavior analysis. Once we begin to see how our own culture impacts our behavior, we can better identify cultural variables that affect others.

However, it is imperative that we do not cease our journey to cultural competence after becoming aware. Kodjo (2009) states the second step of culturally competent care is to accept cultural differences and foster a value for diversity. We should provide culturally competent care to all of our clients, not just the ones that may appear different from us, because many cultural variables are not easily visible (e.g., religion, education, socioeconomic status, sexual orientation). We should be incorporating social validity measures with all of our clients and caregivers and incorporating their feedback (i.e., valuing diversity). We should be reminding ourselves that our treatment selections must be based on data and caregiver input (BACB, 2017a, guideline 2.09) and not our values of whether a treatment looks "good" or "bad." Many treatments in the medical field do not look "good" and often have side effects (e.g., chemotherapy, some forms of physical therapy, which can be painful), but the treatments are used because they work and the patient has chosen that treatment option. The same applies to behavior analysis. In other words, if you avoid a particular evidenced-based procedure (e.g., extinction) because you do not like the procedure or the potential side effects it produces, it is akin to your doctor withholding a very effective treatment from you because he or she does not like the way it looks. Instead, let us empower our clients by giving them a few choices of empirically validated treatments with full disclosure of side effects and let them decide what "looks" best for their family, the same way you are allowed to make that decision in your doctor's office. Some families may want the faster treatment that has potential side effects, whereas another family may opt for a gentler approach that takes longer to see effects but minimizes potential side effects. By giving them these choices, we are becoming more sensitive to cultural variables, which may enhance treatment adherence.

Third, we should evaluate the dynamics of difference that may present themselves given the power that is given to those who deliver medical treatment. Fourth, we should assess our cultural knowledge to better understand our limits and seek out assistance when we are working with a population that we are less familiar with so we can determine core principles for a particular culture. Last, Kodjo (2009) recommends fostering the ability to adapt to the diverse needs of our clients and assessing whether we are open to different solutions for the same problem (i.e., providing different treatment options), and perhaps peer review could be helpful in this regard.

Incorporating cultural variables into the delivery of behavior-analytic services is essential, but in order to do so, we must identify a method to capture these variables. One method is through conducting cultural assessments that involve asking clients various questions related to their family, background, and beliefs (Tanaka-Matsumi et al., 1996). Behavior analysts are experts at assessment and we should be employing this expertise as we learn about our clients' culture and background to ensure we can mitigate barriers to the delivery of effective treatment. As many assessment tools do not specifically ask about potentially important cultural variables including religion, family structure and hierarchy, important family events or celebrations, and preferred modes and style of communication, behavior analysts will need to modify existing assessments to include these questions. Open-ended indirect assessments can be an excellent way to gather information about a client's individual background to help the practitioner identify potential barriers and prevent issues. In a way, this type of assessment can be considered analogous to many elements of a functional behavioral assessment. The behavior analyst is attempting to identify target behaviors of the family that facilitate or hinder clinical success, the antecedent conditions under which the behaviors occur, and the reinforcers maintaining these behaviors. Carrillo et al. (1999) provide a list of questions to assist clinicians in gathering information on cultural variables. Some questions may need to be adapted for behavior-analytic services, and it is important to keep in mind that more research is needed to empirically identify best practices for working with individuals from varying cultures and whether gathering information described in Carrillo et al. (1999) will lead to better outcomes.

In summary, we strongly encourage the behavior-analytic community to take cultural variables into consideration when delivering behavior-analytic services. We also encourage researchers to experimentally evaluate the role of culture in behavior and best practices for delivering culturally competent behavior-analytic services. Training on working with individuals from diverse backgrounds is critically needed from our degree programs, behavior-analytic employers, and continuing education providers.

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Compliance with Ethical Standards

Conflict of Interest The authors do not have a conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

This article does not contain any studies with animals performed by any of the authors.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Appendix

Appendix

1. Are you a Board Certified Behavior Analyst (BCBA)?
   - Yes
   - No

2. Which proportion of your clients have diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - Less than 10%
   - 10% to 19%
   - 20% to 29%
   - 30% to 39%
   - 40% to 49%
   - 50% to 59%
   - 60% to 69%
   - 70% to 79%
   - 80% to 89%
   - Greater than 90%

3. How *comfortable* do you feel working with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - Very uncomfortable
   - Uncomfortable
   - Fairly comfortable
   - Moderately comfortable
   - Very comfortable

4. How *skilled* do you feel working with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - Very uncomfortable
   - Uncomfortable
   - Fairly comfortable
   - Moderately comfortable
   - Very comfortable

5. How *important* is it to receive training and education on working with individuals with diverse backgrounds?
   - Not important
   - Somewhat important
   - Neutral
   - Moderately important
   - Very important

6. During your *master's degree* education, how much material in your *behavior-analytic coursework* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - None
   - Little
   - Some
   - Moderate
   - Extensive

7. During your *master's degree* education, how much material in your *non-behavior-analytic coursework* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - None
   - Little
   - Some
   - Moderate
   - Extensive

8. During your *doctoral degree* education, how much material in your *behavior-analytic coursework* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - None
   - Little
   - Some
   - Moderate
   - Extensive
   - Not applicable (I do not have a PhD.)

9. During your *doctoral degree* education, how much material in your *non-behavior-analytic coursework* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
   - None
   - Little
   - Some
   - Moderate
   - Extensive
   - Not applicable (I do not have a PhD.)

10. During your *master's degree* education, how much *hands-on training (e.g., fieldwork, practicum)* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
    - None
    - Little
    - Some
    - Moderate
    - Extensive

11. During your *doctoral degree* education, how much *hands-on training (e.g., fieldwork, practicum)* was dedicated to teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
    - None
    - Little
    - Some
    - Moderate
    - Extensive
    - Not applicable (I do not have a PhD.)

12. Since becoming certified, how much *continuing education* have you received teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
    - None
    - Little
    - Some
    - Moderate
    - Extensive

13. Since becoming certified, how many continuing education (CE) *opportunities* have you seen offered at behavior-analytic conferences or online teaching you how to work with people with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
    - None
    - Little
    - Some
    - Moderate
    - Extensive

14. How much training does your employer provide you on working with individuals with diverse backgrounds (e.g., different cultures, races, ethnicities, nationalities, religions)?
    - None
    - Little
    - Some
    - Moderate
    - Extensive

15. How familiar are you with the process of delivering culturally competent care?
    - Not at all
    - Little
    - Some
    - Moderately
    - Extensively

16. When working with clients who have immigrated from another country, how often do you educate yourself on their countries' customs, values, beliefs, and behaviors?
    Every time
    Most times
    Sometimes
    Rarely
    Never

17. How often do you ask your clients about their spiritual beliefs?
    Every time
    Most times
    Sometimes
    Rarely
    Never

18. How often do you ask your clients about their use of natural (nonmedical) treatments?
    Every time
    Most times
    Sometimes
    Rarely
    Never

19. How often do you ask your clients about their dietary preferences?
    Every time
    Most times
    Sometimes
    Rarely
    Never

20. How often do you ask your clients about gestures or nonverbal communication that is important (e.g., specific greetings) to them or offensive to them?
    Every time
    Most times
    Sometimes
    Rarely
    Never

21. How often do you ask the caregivers or clients about their beliefs of the client's disorder or diagnosis?
    Never
    Barely
    Occasionally
    Most of the time
    Every time

22. How often do you ask the caregivers or clients their preferences for male versus female therapists or BCBAs?
    Never
    Barely
    Occasionally
    Most of the time
    Every time

23. How often do you ask whether the treatment goals and procedures align with the families' values and beliefs?
    Never
    Barely
    Occasionally
    Most of the time
    Every time

24. How often do you work with a translator if English is a second language?
    Every time
    Most times
    Sometimes
    Rarely
    Never

25. How knowledgeable are you with differences in parenting across cultures?
    Very knowledgeable
    Moderately knowledgeable
    Somewhat knowledgeable
    Not very knowledgeable
    No knowledge

26. How often do you reflect on your own culture and how that may impact your assessment and treatment process?
    Not at all
    Little
    Some
    Moderately
    Extensively

27. When working with families or individuals who have immigrated to your country, how often do you educate them on local laws regarding definitions of abuse and neglect?
    Never
    Barely
    Occasionally
    Most of the time
    Every time

28. What is your primary role as a BCBA?
    - Practitioner (direct services)
    - Supervisor
    - Administrator
    - Lecturer/instructor
    - Professor/researcher
    - Other: _____

29. What population do you primarily work with?
    - Autism spectrum disorder
    - Intellectual disability
    - Special education
    - Emotional or behavioral disorders
    - Mental health
    - General education
    - Brain injury
    - Typically developing
    - Gerontology
    - Employees
    - Child welfare
    - Other: _____

30. What is your primary work setting?
    - Public school
    - Private school
    - Client's home
    - Center or clinic
    - College or university
    - Residential facility
    - Hospital
    - Community
    - Other: _____

31. Which field is your master's degree in?
    - Applied behavior analysis
    - Behavior analysis
    - Psychology
    - Education
    - Other: _____

32. Which field is your PhD in?
    - I do not have a PhD.
    - Applied behavior analysis
    - Behavior analysis
    - Psychology
    - Education
    - Other: _____

Other: _____

33. Select your age.
    Under 30 years old
    30–39
    40–49
    50–59
    60–69
    70–79
    Greater than 80

34. Select your gender.
    Female
    Male
    Nonbinary/third gender
    Prefer to self-describe: _____
    Prefer not to say

35. Select your race (select all that apply).
    White
    Black/African American
    Asian
    Native Hawaiian/other Pacific Islander
    American Indian/Alaskan Native
    Prefer to self-describe: _____

36. Select your ethnicity:
    Hispanic, Latino, or Spanish origin
    Non-Hispanic, Latino, or Spanish origin

37. There are BCBAs all over the world. What is your current nationality?
    U.S. citizen
    Dual citizen (please specify): _____
    Other (please specify): _____

For instructors who teach in BACB-approved course sequences:

38. How important is it to teach students during their graduate studies how to work with individuals with diverse backgrounds?
    Not important
    Somewhat important
    Neutral
    Moderately important
    Very important

39. How much material do you dedicate to teaching your students how to work with people with diverse backgrounds during *behavior-analytic coursework*?
    None
    Little
    Some
    Moderate
    Extensive

40. How much material do you dedicate to training your students how to work with people with diverse backgrounds during *behavior-analytic training experiences (e.g., fieldwork, practicum)*?
    None
    Little
    Some
    Moderate
    Extensive

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