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Homogeneous or Diverse: Examining the Inclusiveness of Behavior-Analytic Services for the Black Population

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Abstract

Black and African Americans are the second largest minority group in the United States. Studies show that the prevalence of autism in children are similar by race and ethnicity, making Black and African Americans the second largest minority group with an autism spectrum disorder diagnosis. For behavior analyst servicing this population, there is an obligation to address the needs of these individuals and acknowledge their backgrounds and diversities. This study highlights areas that affect the quality of services provided to the Black and African American community and evaluate the inclusiveness of these areas.

Keywords: behavior analysis, diversity, inclusion

Homogenous or Diverse: Examining the Inclusiveness of Behavior-Analytic Services for the Black Population

For the Black and African American population, historically, rates of inclusion in medical research are lower than non-minority groups (Shavers et al., 2000; Shavers-Hornaday, 1997). Outcomes of a recent study conducted by the PEW Research Center on discrepancies in experiences with healthcare contributed the discrepancies in service to less access to quality medical care [in Black neighborhoods] (Pew, 2022). These discrepancies date back to slavery, where Black and African Americans were legally considered property and seen as less human than people of other races and ethnicities (District of Columbia et al., 1862). Thousands of Black people were unwillingly used as test subjects in medical research (Shavers-Hornaday, 1997). In the 1800s claims were made by medical professionals that Black people had "peculiarities [that] include thicker skulls, less sensitive nervous systems, and diseases inherent in dark skin [that make them] insensible to pain when subjected to punishment" (Hoffman et al., 2016).

When slavery was abolished in 1865, owning other humans was no longer legal but the country continued to discriminate against people of color. In the southern United States, the Jim Crow Laws made it legal to discriminate against people because of the color of their skin (Fremon, 2000). The Supreme Court laid out doctrines that they considered "separate but equal" facilitating separate schools, businesses, and rules for Black people (Plessy v. Ferguson, 1896). Although these doctrines did separate populations, there was nothing equal about them. In 1932 researchers conducted a government sponsored medical study, The Tuskegee Study, where Black participants were unknowingly infected with syphilis and left untreated and uninformed of their illness to study the "natural history of syphilis" (Shavers, 2000).

Medical panels allowed The Tuskegee Study to continue until 1972 when a larger audience was made aware of the study. This was well after the passing of the 1964 Civil Rights Act which outlawed discrimination based on race, color, religion, sex, or national origin (Civil Rights Act, 1964). The abolishment of slavery and the ending of legal segregation were almost 100 years apart, showing that the evolution to a more tolerant community did not happen within one generation. Just as medical injustices were still taking place, social injustices continue to be prominent. Cases such as the murder of Trayvon Martin in 2012 and Eric Garner in 2014, shed light on the current state of the overall climate of the U.S and the continued criminalization of people of color, even when they are themselves the victims (Alcindor, 2012; Patton & Leonard, 2018). Similar to the previously mentioned cases, Elijah McClain and Charles Kinsey were both cases involving adult minorities being gunned down (fatally and non-fatally, respectively) by police officers.

The victims in the two aforementioned police shootings were not only black but McClain was also diagnosed with autism spectrum disorder (ASD), while Kinsey was a therapist working with a client with ASD. These two demographics make up an important intersection within our society, an intersection that connects social and medical issues. Crenshaw (2016) addressed the urgency of understanding the role that intersectionality plays in our society. Crenshaw's (1997) concept of intersectionality focuses on the race and gender of black women, how both variables are interconnected, and that both need to be understood to analyze the oppression of black women. In this setting, intersectionality focuses on race and disability. Whereas Black people were oppressed due to race, the U.S. also has an extensive history of institutionalizing and abusing people with mental health disabilities (Novella, 2010).

The historical and current treatment of the Black and African American population within the U.S. has caused years of mistrust in both the medical and justice systems (Pew, 2022; Patton & Leonard, 2018). As a subset of the medical field, behavior analyst providing services to the ASD population need to understand that these intersectional traumas act as antecedents in understanding the current behaviors of these populations. The historical discrimination of these two groups and their behavior as a consequence of these discriminations become a part of their behavior repertories as individual communities.

As an entire community, the U.S. is made up of 331,449,281 people and Black and African American people make up 13.6% of the total population (U.S Census Bureau, 2020). Maenner et al. (2021) conducted a study on the prevalence of autism in eight-year-old children in 11 different sites around the U.S. They found that ASD prevalence was similar by race and ethnicity. These finding would suggest that Black and African Americans make up the third largest population of individuals diagnosed with ASD. The Center for Disease Control and Prevention (CDC) provided data showing that these ratios have become more equivalent to population ratios within the last ten years, whereas Black and Hispanic populations had been under diagnosed in the past (CDC, 2019). Just as the U.S. has laws to protect individuals of these minority groups within society (Americans with Disabilities Act, 1990; CROWN Act, 2020), it is important within the behavior-analytic community that individuals receiving these services are protected within these same frameworks.

Throughout the U.S., behavior analysts servicing the ASD community are required to hold certification through the Behavior Analysis Certification Board (BACB), whose main role is to establish guidelines to protect consumers of behavior-analytic services (BACB, n.d, About the BACB). It is governed by a board of directors that is composed of behavior analysts and

representatives of the public. With the continued shift in cultural climate to further decrease discrimination against individuals due to any type of diversity the BACB has updated their ethical guidelines to address cultural diversities. Code 1.07 makes it the responsibility of the board-certified behavior analyst (BCBA) to not only "acquire knowledge and skills related to cultural responsiveness and diversity" but to also "evaluate their own bias and ability to address the needs of individuals with diverse needs and backgrounds" (BACB, 2020).

Updating the code to align with the current culture falls in line with Skinner's philosophy of the evolution of a culture in *Beyond Freedom and Dignity* (1971), in which you must evolve to continue to exist. Because the action of observing behavior is a behavior within itself BCBAs need to be aware of themselves. Skinner (1974) argues that by being aware of oneself that person is in a better position of predicting and controlling their own behavior. This in turn will improve the BCBA's position in the description, prediction, and control of the behavior of their clients.

On the surface these guidelines protect all minority groups because they are ensuring that BCBAs are acknowledging that diversities exist and that they need to consider these diversities in practice. What the code fails to do is to provide a framework on how that should be done. In response to the BACB *Professional and Ethical Compliance Code for Behavior Analysts* (2014) updates, Rosenberg & Schwartz (2019) criticized the new code on the issue of becoming enforceable rules that need to be adhered to, as they had previously been a set of guidelines that did not require adherence. For the new code (code 1.07) this means there needs to be a form of permanent product as proof of adherence. As adherence has become the consequence of these changes, for practitioners in clinics, diversity training has become a mandatory yearly task. This is the permanent product that the BACB is looking for.

As diversity training in clinics has increased, a primary focus of diversity research overall has been placed on this training to understand multicultural differences (Fong et al., 2016, 2017; Conners et al., 2019; Wright, 2019). Conners & Capell (2021) created a framework for connecting multicultural and diversity theory with behavior-analytic practice to ensure application of diversity training. But this is still surface level application of the new guidelines.

On a deeper level this code should call into question the amount of equitability and intentionality that is actually being placed on the diversity of clients. Since the announcement of the updates in 2020, and within the years prior, research and discussions of more specific diversities have increased within behavior-analytic practice. *Behavior Analysis in Practice* published a special issue dedicated to diversity and inclusion in 2019. Articles in this issue focused heavily on gender (Leland & Stockwell, 2019; Li et al., 2019; Sunberg et al., 2019) and linguistics (Kornack et al., 2019; Kunze et al., 2019; Wang et al., 2019) among other diversity topics. Several researchers have focused on specific barriers faced by BCBAs that provide behavior-analytic services (Hill et al., 2016; Cirincione-Ulezi, 2020). With respect to ethnicity, Castro-Hostetler et al. (2021) identified barriers of service for the Latinx population and provided recommendations for systematic change to increase access and quality of services for this population. To date, there has been no research on barriers of services specifically for the Black and African American population.

The aforementioned research, paired with diversity training, lays a more equitable foundation in cultural responsiveness and intentionality in practice. Although this is a step in the right direction, there are many key components that need to be addressed. Fontenot et al. (2019) addressed one of these components in their research of economically disadvantaged children. They “determine[d] the degree to which applied behavior analysis has included economically

disadvantaged children in educational research" (p. 783). By examining the extent to which a specific demographic is included in different facets of a field researchers are more informed on the needs of that demographic in that specific area of study. Another key component that has not been directly addressed is the accessibility of services in diverse populations, which as previously stated is a barrier to healthcare services in the Black community. Therefore, the purpose of this study is to examine the accessibility of behavior-analytic services in the Black/African American community and identify the rates of inclusion of Black and African Americans in behavior-analytic research.

Accessibility of Services

In speaking on barriers of leadership for black women, Cirincione-Ulezi (2020) argued that "black women are less likely to live in the same neighborhoods, send their children to the same schools, and participate in the same community organizations [as their white counterparts]" (p. 78). This is also true for Black and African Americans living in predominately black neighborhoods as a whole. Before services for clients can even begin, the first step for the client is finding a suitable clinic for them. One major factor that plays into this role is the physical accessibility of clinics. While accessibility can refer to a wide range of measures, this study specifically measures the physical presence of behavior-analytic clinics within a specific area.

Methods

The researcher identified all communities (by zip code) within the state of Florida that have a predominantly Black population (any zip code with a higher percentage of Black residence than any other race in that zip code) and identified behavior-analytic clinics within a 10-mile radius. These zip codes were then grouped into the 8 regions that make up the state of Florida and compared to the top 10 most populated zip codes (that were not predominantly black) in the state. Population information was obtained from Florida Demographics

(https://www.florida-demographics.com), and clinic locations were obtained using Google Maps (https://www.google.com/maps).

Results

The state of Florida consists of a total of 972 zip codes. Figure 1 illustrates the areas within Florida that have a predominantly Black/African American population. Seventy-three zip codes make up these areas.

Figure 2 illustrates the number of predominantly Black zip codes within the 8 regions of Florida and the average number of behavior-analytic clinics within a 10-mile radius for each zip code. Each region consists of 1 to 12 zip codes, except the Southeastern region which consists of 26 zip codes. The average number of behavior-analytic clinics within each region is between 2 and 15. The last bar in the graph illustrates the average number of clinics (12) within a 10 mile radius of the 10 most populated zip codes that were not predominantly black.

Inclusion in Research

Code 1.06 of the BACB ethical code makes it the responsibility of the BCBA to remain competent in the field by obtaining current knowledge through research literature, conferences and conventions, and other trainings (BACB, 2020). Although most literary research focuses on methods for intervention and skill acquisition it is also important to understand the demographic information of participants included in studies.

Methods

The researcher reviewed all issues of the *Journal of Applied Behavior Analysis (JABA)*, *Behavior Analysis in Practice*, and *Behavioral Interventions* from 2018 through 2022 to identify what demographic information was available in the studies, what percentage of research included any racial demographics and of those studies what percentage included Black participants.

Articles were categorized into five categories (discussion, acquisition, behavior reduction, survey, and assessment).

Results

The initial search resulted in a total of 1,124 articles. Researchers excluded all discussion and review articles and any articles that did not include human participants. 779 articles met the criteria and were included in the analysis.

Table 1 list article type and racial demographic inclusion by journal. 127 articles referenced the race of their participants and 58 of those articles included at least 1 black participant.

Figure 3 illustrates the percentage of articles that included racial demographics within the study, and within that number, the amount that did and did not include Black participants. Only 16% (127) of articles included the racial demographics of their participants and within that small group 46% (58) included at least 1 Black participant.

The percentage of articles including Black participants by category is illustrated in the top panel of Figure 4. 48% (28) of these articles were acquisition and behavior reduction made up 24% (14) of articles. The bottom panel of Figure 4 breaks down the percentage of articles within each category that included black participants. Behavior reduction and surveys both had more than 50% of articles that included at least 1 Black participant.

Figure 5 illustrates the percentage of Black participants used in studies that identified the race for participants. There was a total of 1,504 participants used in these studies and 182 (12%) were Black.

Conclusion

The current study evaluated the accessibility of behavior-analytic clinics and inclusion in behavior-analytic research for the Black and African American population. These are important issues to examine as they have been cited in other research as barriers to service. As the Black and African American population make up the second largest minority group within the U.S., their representation and access to services should reflect these statistics.

When analyzing accessibility to clinics no correlation was found between the percentage of Black and African American people in an area and the number of clinics in that area within the state of Florida. The average number of clinics in these areas was similar to largely populated areas within the state. These findings indicate that behavior-analytic services are just as accessible for the Black population within the state of Florida as they are for other demographics. Although these findings were favorable, analyzing the accessibility of clinics using zip code allowed for many areas to have overlapping data, as they were in close proximity to one another. Analyzing this data from a different perspective, such as by county or city, these results may be vastly different. These favorable results also do not provide any indication of the availability of services in these clinics as different areas will have differing amounts of necessity for these services.

The rate of racial demographic information provided within research in the past five years was low; furthermore, the rate of inclusion of Black participants within research that does report race was miniscule. Overall, less than two Black participants were used per study within research that included racial demographics. While these rates are low, they are statically equivalent to the overall population breakdown within the United States. This does not, however, equate to equity. Because Black and African Americans have historically not been included in research or mistreated during research, the only way to eliminate preconceived notions or bias

created by historical research is to amplify the representation of this population in current research.

While the argument can be made that no definitive conclusion can be reached due to the small number of articles that report the race of their participants, the exclusion of race is not an equivalence of equitability. Making an effort to include diverse participants would not, in most cases, create hardship for the researchers. By including a diverse group of participants in all types of studies (behavior reduction, acquisition, etc.) researchers can help to effortlessly reduce racial bias of the consumers of their work.

Notably a few articles reported on the race of only a portion of their participants, and it was noted in this research that the other participants' race was not reported by the participant. One behavior reduction article, which focused on the reduction of noncompliance, reported only on the race of one-third of the participants (a Black participant) and the race of that participant's teacher (also Black), but made no reference to either of the other participants or their teacher's race, only their age, gender, and education level was included. Highlighting the race of one participant in this manner creates a sense of forced diversity into research. Forced diversity within ABA is not a solution that would align with the BACB code of ethics when acquiring knowledge related to cultural responsiveness and diversity.

The exclusion of racial demographics in a high rate of research is a direct barrier of service. By pinpointing that this is a barrier the efforts of practitioners and researchers can be increased to be more intentional to not only provide ethical services but to ensure that these services are equitable. Continuing to provide accessible services in diverse populations helps to ensure that the entire population that needs these services are more likely to receive them.

Limitations within accessibility of services include the possibility of clinics overlapping between zip codes due to their close proximity to one another and only including clinic-based services, as private services are less likely to appear in the data used for data collection. Limitations to both areas of focus include only focusing on one demographic, which may not be reflective of the diversity of ABA as a whole.

The researcher of this study focused on two areas within ABA that can affect the services provided to the Black population. Methods used in this study can be replicated for any diversity group and data can be used to increase representation in those areas. Surveys can be administered to families within these areas to better identify the perception of accessibility by the community. This research can be expanded by examining demographic information in other behavior-analytic journals or analyzing the accessibility of diverse groups in other states or worldwide. Furthermore, future research can focus on other components that are pivotal to the quality of behavior-analytic services, for both the Black population and all other diversity groups. These components include but are not limited to: representation within behavioral clinics (examining the demographic information for BCBAs within a given area) or the types of behavior-analytic services available in an area (early intervention, school-based services, or adult services).

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Table 1

Racial Demographic Inclusion in Research by Journal

		JABA	Behavior Analysis in Practice	Behavioral Interventions	Total
		n	n	n	
Article Type	Aquisition	187	144	106	
	Behavior Reduction	88	22	51	
	Survey	2	24	2	
	Assessment	88	30	35	779
With Race Listed	Acquisition	29	19	26	
	Behavior Reduction	9	7	10	
	Survey	0	10	0	
	Assessment	8	2	5	127
Black Participants	Acquisition	11	14	3	
	Behavior Reduction	6	3	5	
	Survey	0	8	0	
	Assessment	4	2	2	58

Figure 1

Predominantly Black Areas in the State of Florida

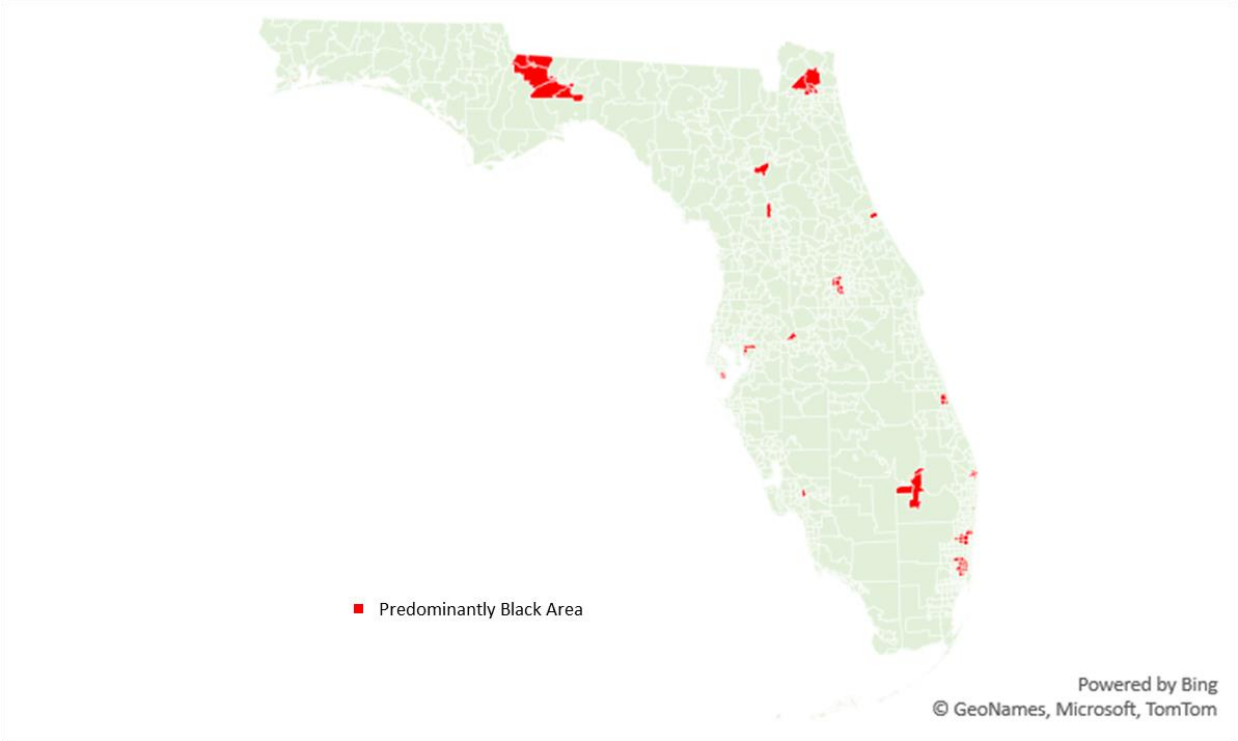


Figure 2

Average Number of Clinics by Region

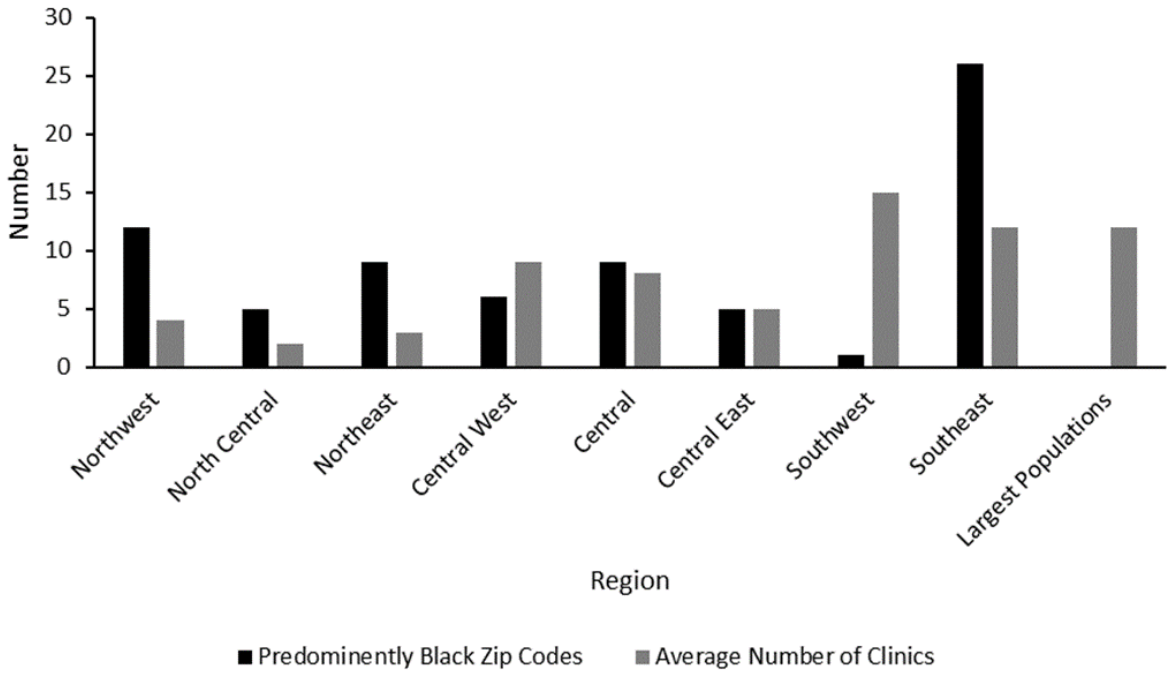


Figure 3

Article Inclusion of Participant Racial Demographics

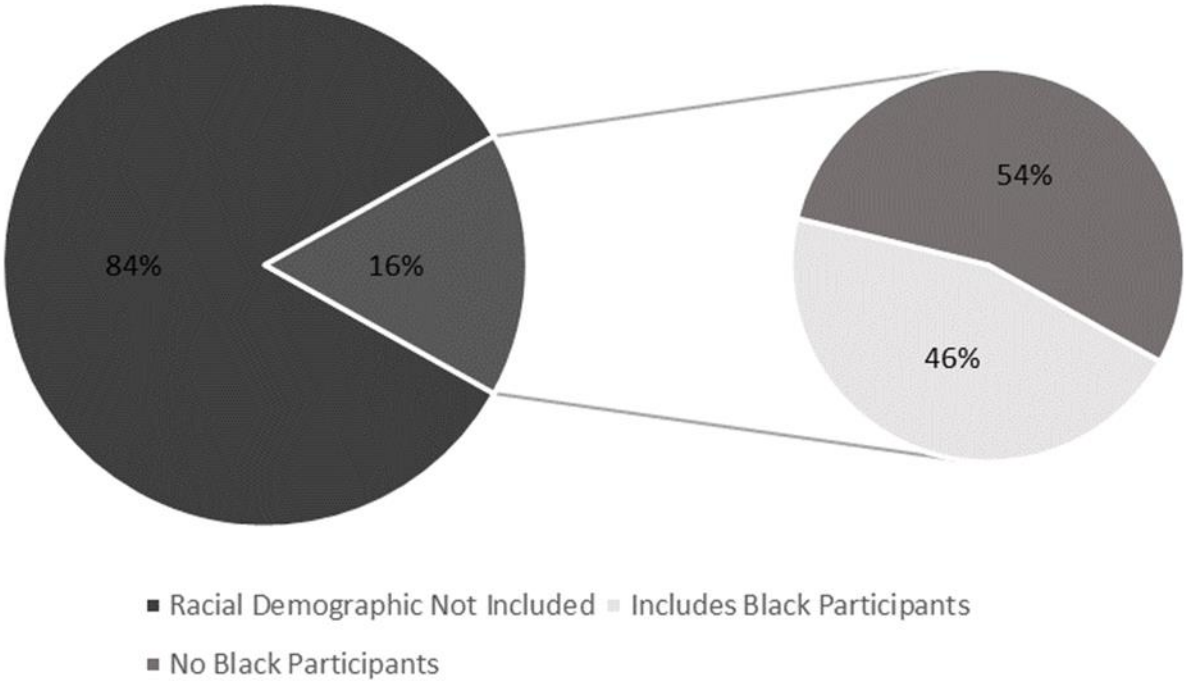
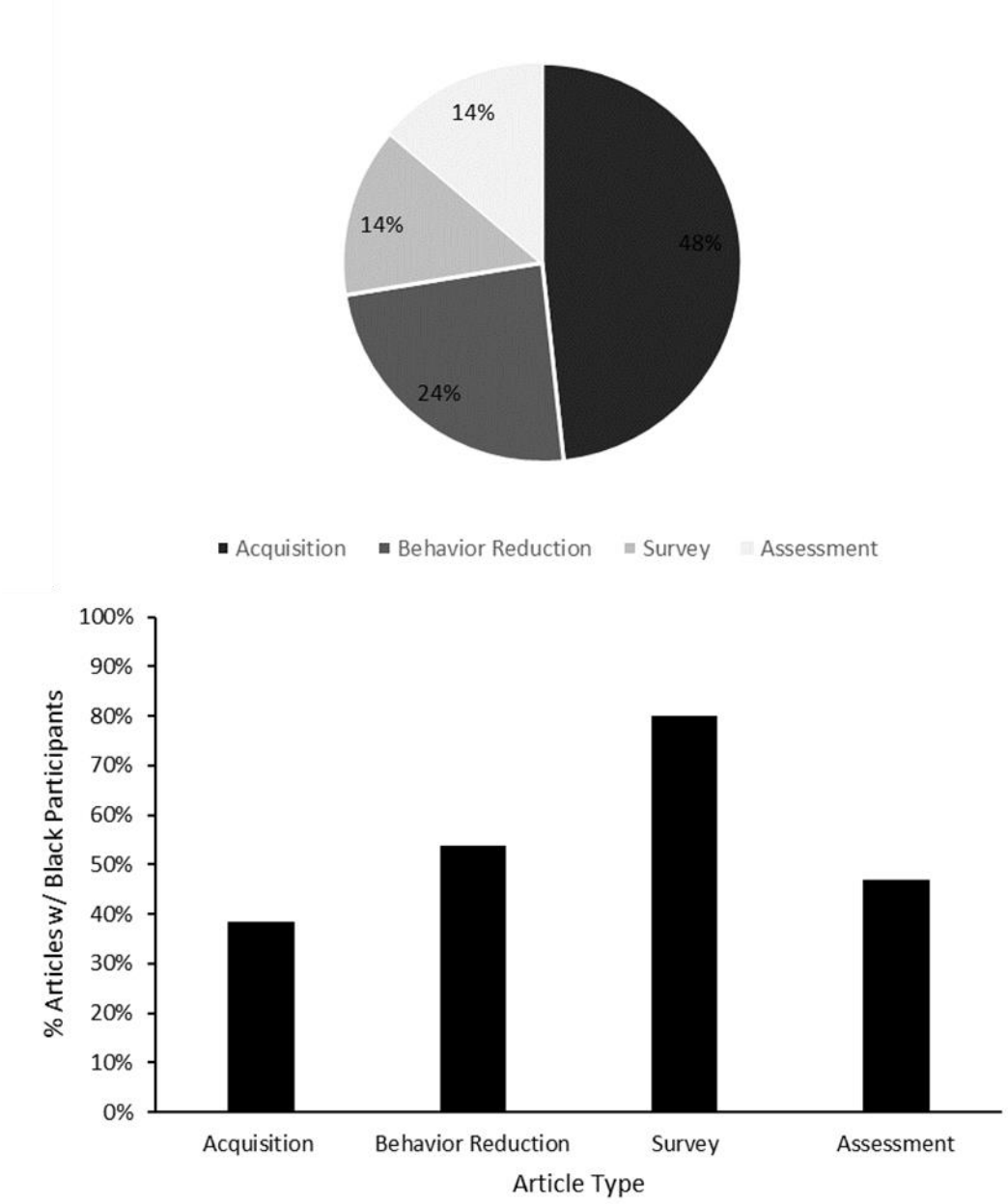


Figure 4

Black Participants Included in Research by Article Types



Note. Percentages calculated using the total number of articles including racial demographic of participants for each article type.

Figure 5

Percentage of Black Participants Used Within Research