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Ignorance and Cultural Diversity: The Ethical Obligations of the Behavior Analyst

Alejandro Arango and Nicole Lustig

Abstract

Applied behavior analysis (ABA) has featured an increasing concern for understanding and considering the cultural diversity of the populations behavior analysts serve in recent years. As an expression of that concern, the new BACB's *Ethics Code for Behavior Analysts* is more explicit and comprehensive in its inclusion of ethical obligations concerning cultural diversity. The purpose of this paper is to offer a discussion on the limitations of both our capacity and willingness to know and overcome our ignorance about our own and other cultures. We examine different ways in which our ignorance of other cultures plays out even in willful compliance with the BACB ethics code. We suggest part of the problem is that the BACB ethics code seems to operate under the assumption that practitioners are always aware or can be aware of what they do not know and of their biases. In contrast, we offer a reflection on a more complex picture of our understanding of ourselves and other cultures, where we cannot assume people are aware of what they ignore and of their biases. Ethically, we find that in some cases these blindspots are accounted for by the BACB ethics code and should be foreseen and addressed by the behavior analyst (BA). But in other cases, when a person is not aware of what they ignore, understanding the connection between cultural diversity ignorance and professional behavior requires a different approach. Our analysis suggests an attitude of being thoughtfully diligent and humble while learning about cultural diversity issues and examining the areas where we might be ignorant and not aware of our ignorance. We argue that BAs' obligations to respect the dignity of clients and their families and to provide effective treatment call for this attitude of diligence and humility that goes beyond mere compliance.

Keywords: ethics, cultural diversity, BACB ethics code, ignorance, cultural humility, cultural awareness

The growth and development of the field of ABA over the last few decades (Deochand & Fuqua, 2016; Dougher, 2017) has brought an increase in cultural diversity within the population seeking behavior-analytic interventions. In response, leading publications in the field have featured numerous articles addressing different areas of cultural diversity. These areas include the importance of culture in assessing clients (Rosenberg & Schwartz, 2019; Brodhead, 2019), the adequacy of interventions involving clients from different cultural backgrounds (Wright, 2019), the state of the art in training, fieldwork, and supervision vis-a-vis cultural diversity (Ala'i-Rosales, 2020; Wang et al., 2019; Connors et al., 2019; Connors & Capell, 2020a), and, in general, to gaps in matters of diversity in the practice of applied behavior analysis (Zarcone et al., 2019; Brodhead et al., 2014; Fong et al., 2016, 2017; Luczaj et al., 2020; Weiss et al., 2020).

Cultural considerations matter ethically in the context of behavior analysis because the values and beliefs of clients and stakeholders are expressions of their dignity and right to self-determination (Kant, 1996; Behavior Analyst Certification Board, 2020). They matter also because they affect a behavior analyst's practice and the outcome of interventions, including family buy-in and treatment acceptability, the ability of the behavior analyst (BA) to recognize and understand how the family manages feelings about their child, or the ability of the behavior analyst to design effective and socially significant treatment (Brodhead, 2019; Fong et al., 2016; Rosenberg & Schwartz, 2019). These areas of behavior analytic practice are reflected, to different extents, in the new BCBA ethics code.

The BACB released the new *Ethics Code for Behavior Analysts* in December 2020 (Behavior Analyst Certification Board, 2020), replacing the 2014 *Professional and Ethical Compliance Code for Behavior Analysts* (Behavior Analyst Certification Board, 2014). As we will shortly explore in detail, the new code engages explicitly with cultural diversity in a more extensive and deeper way than the 2014 code (see also Table 1). From now on, we will refer to the 2020 code as the *BACB ethics code*.

Although the BACB ethics code is arguably a step forward on the way to ensuring the highest levels of ethical behavior from BAs, its coming into effect also offer an opportunity to analyze its limitations. Several authors have proposed that the end goal of truly ethical behavior analysis requires practitioners to understand an ethics code (the 2014 one, the new one, or a future one) but that this cannot be the only standard that governs ethical behavior chiefly due to the highly contextual nature of human action (Fong et al., 2016; Slocum et al., 2014; Rosenberg & Schwartz, 2019; Sellers et al., 2016). The lofty end goal the profession seeks can only be understood in the normative nature of ethics and ethical discourse, given it is not a matter of empirical claims and requires the involvement of subjective dispositions (Graber & Graber, 2019; O'Donohue & Ferguson, 2011). The pursuit of such a goal also requires exploring the habits and practices (e.g. cultural humility and cultural awareness) that exceed the narrow scope of ethical codes and help cultivate the attitudes, skills, and readiness to act virtuously in the complex situations that BAs face on a regular basis. In this ethical spirit, Fong and colleagues present a series of considerations and strategies for the development of cultural awareness. The culturally aware BA “should understand their own cultural values, preferences, characteristics, and circumstances and seek to learn about those of their clients” (Fong et al., 2016, p. 84). This understanding, they continue, should make the BA aware of “their own personal biases and how they compare to and may affect their relationship with their client” (Fong et al., 2016, p. 84). To this end, these authors suggested the use of tools like the *Diversity Self-Assessment* or the *Multicultural Sensitivity Scale* (Fong et al., 2016, p. 87) that can help BAs understand their own cultural values and biases, becoming more aware of their culture as well as their clients’.¹

In the same spirit, Fong and colleagues stated that “it is important to be aware of one’s own biases or preconceived notions as a behavior analyst, as well acknowledging limitations in one’s

¹ For other resources in assessing cultural diversity competence or awareness see *Assessing Intercultural Competence* (Fantini, 2009), *Implementing Intercultural Competence Assessment* (Deardorff, 2009), or the extensive test bank on multiculturalism and diversity by Connors and Capell (2020b).

cultural knowledge” (Fong et al. 2016, 86). What are these limitations? Can they all be discovered and addressed? What are the BA’s ethical obligations in areas where the limitations are still uncovered? Or perhaps where they are intractable? These questions have not been fully examined in the behavior-analytic literature. We believe that a deeper reflection on the nature of the limitations of our cultural knowledge and the link between those limitations and our moral lives can illuminate part of the important ethical task before us (Code, 2004; Sullivan & Tuana, 2007). We also situate our contribution as a continuation of the work of several authors like Rosenberg and Schwartz whose discussions of ethics and behavior analysis call for a thoughtful and systematic personal engagement that goes beyond the code as a set of rules, and, more specifically, as a continuation of the work in understanding cultural awareness and integrating it into behavior-analytic regular practices (Fong et al., 2016, 2017).

The purpose of this article is to explore our field’s ignorance of cultural contingencies, how this lack of knowledge impacts a BA’s ethical obligations, and how such obligations call for remedies and strategies to begin thinking about those remedies. Ignorance is often overlooked and under-examined, and so are its ethical consequences. As a result, our ideas about what ignorance is, what causes it and what it causes, as well as how to address ignorance are often incomplete and deficient. In what follows, we first discuss the central connections between ethics and ignorance, and explore different dimensions within the phenomenon of ignorance. We take a look at the diversity-related areas of the BACB ethics code and identify points where ignorance of other (and our own) cultures would affect the proper and effective application of the code. We then explore four hypothetical case examples of behavior-analytic interventions that illustrate how ignorance about other cultures impacts treatment and patient relationships. Lastly, we offer a nuanced discussion of what went wrong in the case examples presented within the proposed framework of ignorance, and consider the types of habits and practices whose cultivation would help develop a behavior analytic practice that is sensitive and responsive to multicultural diversity.

Two terminological notes are in order. The first one is about the terms cultural sensitivity, cultural competence, and cultural awareness. All three terms have been used in ABA and other disciplines concerned with cultural diversity (Fong et al., 2016, for cultural awareness; Luczaj et al., 2020, for cultural competence; Weiss et al., 2020, for cultural sensitivity). Semantically, each term has advantages and disadvantages. It could be argued, for instance, that cultural awareness has mostly cognitive connotations (knowing), that cultural competence has actional connotations (doing), and cultural sensitivity has more affective connotations (feeling and motivation). Naturally, serious proponents of each term often make sure that the term is not understood narrowly. We find that *competence* implies a talk of mastery that seems not quite apt to include the limitations we will focus on, as others have also noted (Fisher-Borne et al., 2015; Wright, 2019). *Sensitivity*, in turn, runs the risk of being understood by some as having less actionable components. For the rest of this manuscript, we will use *cultural awareness*, although we draw from academic work that uses all three terms. Cultural awareness is defined here as the understanding of one's own cultural values, preferences and characteristics, as well as those of other cultures. This understanding encompasses verbal and overt behavior, and also private events (Luczaj et al., 2020). The culturally aware BA not only has this personal understanding but has the ability "to tact contingencies of reinforcement and punishment" that have been established by members of the culture of the client and their family (Fong et al., 2016, p. 85).

The second note is about the term *culture* and its relation to *diversity*. We share Sugai, O'Keeffe, and Fallon's (2012) evaluation of the term "culture," including the number of ways it is meant and used, and the flexibility required when applying the notions of culture, subcultures, and other groups in research and practice. Culture, in the broad sense, can be defined as "a collection of common verbal and overt behaviors that are learned and maintained by a set of similar social and environmental contingencies (i.e., learning history), and are occasioned (or not) by actions and objects (i.e., stimuli) that define a given setting or context" (Sugai et al., 2012, p. 200). To this definition we add the private

events of a person, in the way Luczaj, Cacciaguerra-Decorato, and Conners, and Fong, Ficklin, and Lee discuss culture. In their discussion, private events should be used as a tool for self-awareness but not in professional practice with clients (Luczaj et al., 2020; Skinner, 1974; Fong et al., 2017). Lastly, we concur that the term culture includes differences in “race, socioeconomic class, age, religion, sexual orientation, ethnicity, disability, nationality, and geographic context” (Fong et al., 2016, p. 84).

Ethics and Ignorance

Ignorance, culpable and non-culpable

Our ethical proposal comes from the following connection: a BA’s ignorance or lack of knowledge of the cultural features of their clients and the cultural features of the BA’s own culture risks, and often impedes, the fulfillment of basic responsibilities toward those clients. Whenever ignorance is the BA’s responsibility, it is also the responsibility of the BA to correct such lack of knowledge. The distinction between non-culpable ignorance and culpable ignorance is crucial for understanding the ethical implications of ignorance. It is a widely accepted principle of ethics that only voluntary actions can be judged right or wrong, and consequently, that we can only be responsible for voluntary actions (Aristotle, 2009). Cases where actions depend on incidental ignorance should be considered non-voluntary because there was nothing the agent could have done better. If I fail to make it to an appointment because I did not know about it, and my ignorance was not my doing, I cannot be held morally responsible. In this case, for instance, someone else could have forgotten to inform me of the appointment. These are cases of non-culpable ignorance.

But not knowing does not automatically absolve a person. The causes of that person’s ignorance must be taken into account. If I am deliberate in not checking my office inbox or a certain board at the office where meetings are posted, then I cannot allege that my actions should count as involuntary because I could have done better: my ignorance did not simply fall upon me (Hoagland, 2007). The classic example the ancient Greek philosopher Aristotle offers is that of the drunken person: although

the drunken person does not know what they are doing, they could have foreseen the situation, and are therefore responsible for what happens while drunk (Aristotle, 2009). This is also the case of a BA who overlooks learning about the ways cultural values might impact treatment choice (Brodhead et al., 2014) and is in consequence unable to include such considerations, hence impacting the client. These are cases of culpable-ignorance.

Other Dimensions of Ignorance

The connection of responsibility and ignorance reveals that we can be morally responsible for actions performed on the basis of things we ignore. But ignorance is not a one-size fits all relationship to existing knowledge and to the things we ignore. The ethical connection will get clearer as we understand ignorance better.

It is common to think of ignorance simply as the negative counterpart to our positive knowledge: gaps to be filled. Acquiring professional knowledge works this way, and you learn what you do not know. But this picture is incomplete. The visual field and blindspots within it are a good metaphor to capture an important aspect of ignorance: just as we do not see our blindspots and believe that we do not have them (unless externally corrected), there are parts of our entire *knowledge* that are not positive possessions, but illusions of *not* ignoring something that we do, in fact, ignore. When it comes to our exchanges with people from backgrounds different from us, different dimensions of ignorance become more relevant. Ignorance, in its complexity, is a fact of our life. Further, ignorance is often treated in everyday life as an omission or mistake where the knower is passive (Bailey, 2007). The agreement among scholars is that this fact of our life is often actively produced (Alcoff, 2007; Bailey, 2007; Code, 2004; Hormio, 2018; Ikuenobe, 1998; Mills, 2007; Sullivan & Tuana, 2007; Wieland, 2017a, 2017b).

False Belief and Absence of True Belief

What we call ignorance in everyday language covers two distinct situations: having a wrong understanding of a phenomenon or being uninformed about it (Mills, 2007; Bailey, 2007; Montmarquet, 1995). In other words, the possession of false belief (e.g., believing that Venezuelans speak a language called Venezuelan) or the mere absence of true belief (e.g., for the authors, a belief about the landscape of linguistic diversity in Nigeria). Although these two types of ignorance are often mixed in everyday life and in behavior-analytic practice, it is important to be able to distinguish the origins of our ignorance because when it comes to addressing it, the remedies are different: either correcting wrong beliefs, acquiring information we did not have (which we probably did not know we did not have), or a combination of both.

Things to Know and Practices of Knowing

We can distinguish between, on the one hand, the *things* we ignore, like facts, scientific principles, evidence-based procedures, or ethical rules, and, on the other hand, the *practices* and habits by which we form and maintain our body of knowledge. In a narrow sense, a BA should want *what they know* to be true and complete knowledge. But as a matter of a life-time endeavor, it is crucial to work on *how* we know, on *practices* of learning and knowing that aim at acquiring new information and form new beliefs (learning histories), and at revising and correcting, if needed, old information and old beliefs. The BACB ethics code registers this distinction between facts and practices. It states that BAs should have certain knowledge and skills (e.g., 2.13, 2.14), and also that BAs should “expand” their knowledge, or “maintain” their expertise, or “evaluate” their abilities to work with clients with diverse backgrounds (e.g., 1.07, 1.10).

Ignorance is a feature of our situation or position as knowers

We simply do not know many things about our world, and this fact is an expression of our jobs, needs, and interests. Many of us did not know that asbestos was used for insulation in buildings, but

now we know it because it has become a public health issue as asbestos is reportedly linked to cancer. In ABA, a BA with a medical background may, on occasion, find it useful that they can know how certain biological aspects influence their clients, whereas someone without that training may ignore those influences and would not be able to take into account those aspects. Similarly, a bilingual BA may be in the position of knowing more readily how a given word that is similar in the two languages may carry connotations that a monolingual BA would not know. Ignorance is part of the fact that our knowledge is situated: our social location and our disciplinary expertise, among others, give us perspectives others do not have (Alcoff, 2007).

Ignorance is related to people's social identity

People of a particular social identity share concrete aspects in their lives that make them more knowledgeable about some things, and also ignorant about others. In behavior analytic terms, this is a manifestation of shared learning histories. For instance, in openly sexist societies, many women share knowledge about the time and money burden of beauty and presentation expectations placed upon them socially and professionally in ways that are alien for most men (Isser, 2020). Further, it might even be the case that it is not easy, perhaps impossible, for many men to fully understand these requirements as excessive burdens, or even as burdens. A norm by which people are affected differently, especially in situations of oppression or coercion, looks different to different people, and the dimensions of coercion may be ignored by those not coerced (Tessman, 2017) Along cultural values on gender divisions, we find ignorance on the part of men in such cultures about what it takes (time-wise), and how much it takes (money-wise) to achieve socially accepted standards of personal care that are not always an expression of women's preferences (Medina, 2013).

Ignorance often is a structural feature of social arrangement

People can benefit from their own ignorance of some facts, contexts, or situations because their ignorance might be essential to a person's maintaining a mode of life. In this case, ignorance is actively

maintained, or knowledge is actively refused. As the philosopher Lorraine Code exemplifies, this is the case of 19th century British “historians” of India, such as 1817 James Mill’s *History of British India*, whose ignorance about the costumes and practices of India is essential to their considering themselves to be knowledgeable about India, and whose detached outlook becomes part of the British official version of the colonial occupation of India (Code, 2004). This is a case of “culturally induced ignorance,” which might block people’s possibilities to know better” (Code, 2004, p. 295; Ikuenobe, 1998). In ABA, for instance, reluctance to recognize the role of culture in behavior has been accompanied by ignorance of other cultures and insistence on scientific principles and research and training practices that rely on dominant cultures alone. But this is precisely what is changing. In December 2019, for example, the document “Recent Changes to the BACB’s International Focus” echoed cultural diversity concerns: “We have also received feedback that our ethics requirements are not always sufficiently sensitive to practices across cultures” (Behavior Analyst Certification Board, 2019, p. 2). As one can see, it is the feedback from other cultures that brings our attention to the lack of cultural sensitivity and awareness.

Ethics and Cultural Ignorance in Behavior-Analytic Practice

Part of the difference between culpable and non-culpable ignorance, then, is that there are some things it is permissible for me *not to know*, and others I should absolutely know. There are several reasons for allowing us not to know about many things. Perhaps they are irrelevant to my position in the world, it is harmless if I do not know them, or it is unreasonable to demand that I know them (such as when something is overwhelmingly difficult to learn about without aided training). But adding the distinction between facts and practices, we can now say that it is not always about the things we know and do not know but also, and often, about what we try to know —about our attempts or disregard for expanding knowledge, maintaining expertise, or evaluating abilities (Montmarquet, 1987).

How does culpable ignorance apply to a BA? There are things that are inadmissible to ignore. In behavior analysis, failing to know the BACB ethics code is inadmissible. Failing to know how “scope of competence” works is inadmissible. Part of the reason why it is inadmissible, ethically speaking, is because these gaps clash with obligations the practitioner already has agreed to as a member of the profession. The BACB ethics code must be known and abided by, not simply because it is the BACB ethics code, but because it is an agreed-upon standard reflecting certain values and obligations derived from them. These values and obligations come, ultimately, from the respect due to the autonomy and dignity of patients and their families and the negative consequences that some actions would have for clients and their families. The BACB ethics code, by making diversity very explicit as part of the obligations of a BA, has placed some general diversity-related obligations on the side of things a BA must know, and that is real progress. We now look at the BACB ethics code to frame the type of situations in which BAs are responsible for their knowledge and, consequently, for their ignorance.

Diversity in the 2020 Ethics Code for Behavior Analysts

In comparison to the recently issued code, the 2014 code did not sufficiently address inclusion and diversity. In the 2014 Code, descriptors of diverse populations appeared then only in *Section 1.05 Professional and Scientific Relationships*. Referring to “differences of age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status,” the code stated that BAs “obtain the training, experience, consultation, and/or supervision necessary to ensure the competence of their services” when these factors “significantly affect their work, and do not discriminate, harass, or demean people due to these factors (1.05c, d, e) (2014, p. 5). Besides section 1.05 in the 2014 code, the word “diversity” did not appear in the document and the implications of diversity for practitioners were often more implied than explicitly stated.

As a result, the 2014 code provided insufficient guidance in areas where diversity matters, mainly:

- Scope of competence of BAs: how does lack of knowledge of the cultural particularities of some populations affect professional competence?
- Communication and consent: in what ways, including but not limited to linguistic competency, does multicultural diversity influence the possibilities for successful communication with patients, including issues surrounding informed consent?
- Professional milieu: how should diversity be included in education, training, and research aspects of the profession?

The BACB ethics code makes significant improvements in all the areas just listed. The document addresses diversity in four sections. In the Introduction, the sections “Core Principles” and “Application of the Code.” See Table 1 for a list of the places where diversity is mentioned or implied: all quoted materials are drawn directly from the BACB ethics code.

Table 1. Diversity and diversity-related aspects in the 2020 BACB Ethics Code

Section	Subsection	Content
Introduction	Core Principles	Principles concerning equitable treatment, respect of clients’ self-determination (includes providing the information needed to provide informed consent), to increase “knowledge and skills related to culture responsiveness [...] to diverse groups” (4).
Introduction	Application of the Code	It states the BACB ethics code is not and cannot be exhaustive (“it is impossible to predict...”), and that interpretation and application require “a functional, contextualized approach that accounts for factors relevant to that situation, such as variables related to diversity [...] and possible imbalances in power” (5). Interpretation and application (ethical decision making) require the application of both “the spirit and letter” of the BACB ethics code’s principles and standards. In an ethical decision-making process, BAs should “Consider [their] personal learning history and biases in the context of the relevant individuals.” (5)

<p>Ethics Standards, Section 1 - Responsibility as a Professional</p>	<p>1.07 Cultural Responsiveness and Diversity</p> <p>1.10 Awareness of Personal Biases and Challenges</p>	<p>BAs (and their trainees and supervisees) should expand their knowledge and skills “related to cultural diversity and responsiveness”, and should “evaluate their own biases and abilities to address the needs of individuals with diverse needs/backgrounds” (as well as those of trainees and supervisees). (9)</p> <p>BAs “maintain awareness that their personal biases [...] may interfere with the effectiveness of their professional work” and work to resolve those interferences. (9)</p>
<p>Ethics Standards, Section 2 - Responsibility in Practice</p>	<p>2.13 Selecting, Designing and Implementing Assessments</p> <p>2.14 Selecting, Designing and Implementing Behavior-Change Interventions</p>	<p>In selecting assessments, best meeting “the diverse needs, contexts and resources” of clients and stakeholders, is listed as a criterion additional to those assessments being consistent with the principles of BA and being based on scientific evidence. (12)</p> <p>In selecting behavior-change interventions, best meeting “the diverse needs, contexts and resources” of clients and stakeholders, is listed as a criterion additional to those assessments being consistent with the principles of BA, being based on scientific evidence, being the result of assessment, and prioritizing positive reinforcement procedures. (12)</p>
<p>Ethics Standards, Section 4 - Responsibility to Supervisees and Trainees</p>	<p>4.07 Incorporating and Addressing Diversity</p>	<p>Supervision and training ought to “incorporate and address topics related to diversity” (15).</p>

First and foremost, the BACB ethics code is explicit in several places about the fact that the population is diverse in several dimensions, and that these differences affect ABA practices in different ways. Importantly, it states that practitioners should work to proactively provide services that respond to diverse populations —to their “needs, contexts, and resources.” It is positive that it explicitly mentions “diversity” (Application of the code, 1.07, and 4.07) of related expressions such as “diverse

groups” (Core Principles-Ensuring competence), “diverse needs” (2.13, 2.14), and offers a more comprehensive list of descriptors of diversity (“age, disability, ethnicity, gender expression/identity, immigration status, marital/relationship status, national origin, race, religion, sexual orientation, socioeconomic status” (Core Principles-Treating others with compassion, dignity, and respect). It is noteworthy that the BACB ethics code addresses *knowledge* and skills related to cultural diversity elements in its Core Principles: BAs work “to continually increase their knowledge and skills related to cultural responsiveness and service delivery to diverse groups” (Behavior Analyst Certification Board, 2020, p. 4).

Looking at the 2020 list of diversity descriptors, the changes in the list of descriptors are: the list is now in alphabetical order, gender has been replaced by gender expression/identity, and immigration status and marital/relationship status have been added. The deletion of gender should raise questions because gender is often used to refer to *cultural* attitudes, feelings, and behaviors about a person’s biological sex, whereas gender identity refers to a person’s felt sense of their gender (American Psychological Association, 2019).

Interestingly, both “culture” and “language” were dropped from the descriptors list. This is a notable change. It would be interesting to know what is the rationale behind this change. It seems implausible that the reason is to not take language and culture into account when addressing diversity because the spirit of this 2020 BACB ethics code is explicitly open to acknowledging different kinds of diversity, as it were. Section “1.07 Cultural Responsiveness and Diversity” connects the two directly. Why the change? Are they perhaps now assumed to be included in another category? But which one would that be? Ethnicity? This may be a point that calls for correction so that they are included again, explicitly, in this list. As a matter of fact, linguistic and cultural diversity are some of the aspects of diversity more often explored by authors working in this area. It is arguably inconsistent with other parts of the Ethics Code that culture and language are not in the list of diversity descriptors.

A notable improvement is the mention of “biases” in the BACB ethics code. Biases appear in three places: in the section on Ethical decision making (as a factors practitioners are to take into account when making decisions), in the section on Cultural responsiveness and diversity (as something to evaluate), and in the section Awareness of Personal Biases and Challenges (as something to maintain awareness of).

For our purposes, we summarize the BACB ethics code’s changes in diversity-related matters as follows:

1. It makes diversity more explicit as an area of concern.
2. It makes explicit the point that diversity-responsiveness requires action.
3. It changes the list of diversity descriptors, adding significant ones but deleting “culture” and “language.”
4. It includes mentions of biases and bias-awareness.

Problems with the BACB Ethics Code in Practice

In this next section, four case examples are provided and their main features summarized in Table 2. For each example, cultural factors impact both the BA’s decisions and the family or the client’s acceptance or responsiveness to the ABA services being delivered. In some cases, these cultural factors impact treatment in obvious ways, but in other cases, cultural factors impact treatment in more subtle ways.

We would like to note that we use identity first language (IFL) to refer to autistic clients, as it has been requested by autistic voices. We agree with the discussion of Botha, Hanlon, and Williams (2021) that centers the autonomy of autistic populations in the language choice about autism and autistic people, as well as their examination of the negative consequences of person first language (PFL) in autism, which has often led to the dehumanization, stigmatization, and marginalization of this population.

Case Example 1: Chi

Culturally and linguistically diverse parents bring their 3-year-old autistic son, Chi, with level 2 support, into a local ABA clinic with concerns of delayed communication, hand-flapping (Kapp et al., 2019), and disruptive behavior such as being destructive with his toys during play. The family is from Vietnam and speaks two languages (Vietnamese and English), primarily speaking in Vietnamese at home. A young, white behavior analyst (BA) was assigned to the case. This BA has some previous acquaintance with people of Southeast Asian descent: the BA had grown up in a relatively diverse city and, during high school, the BA interacted often with people of this cultural background. They also thought of themselves as quite open to other cultures. Because of this personal history, the BA assessed that they were qualified to treat this client. An interpreter was used when the BA provided parent training because the BA did not know any words in Vietnamese. But no interpreter was used when delivering 1:1 intervention to Chi. To address the disruptive behavior during play, a play skills intervention was used. The BA provided high-energy and almost continuous attention during the play intervention. During the play intervention, the BA was on the floor with Chi, using several preferred and nonpreferred toys, often making a mess on the floor. The intervention was highly successful in the clinic, but the parents were unable to replicate the intervention at home.

The play intervention failed to generalize for a variety of reasons, both obviously and subtly. First, the parents were unable to deliver such high-energy, continuous attention perhaps due to other children and adults in the home or the living room space. But perhaps there were other factors related to culture. The more obvious cultural variable is that the BA used an interpreter to make adjustments for linguistic diversity during parent training but not with the child during the intervention. A more subtle factor is that it may be culturally inappropriate to play on the floor with a child or make a mess playing with several toys at one time. The BA may have simply chosen the specific play intervention because it was an effective play intervention that is frequently used in the clinic (Meehl, 1956). During

the consenting process and initial interview with the parents, the BA did not ask about barriers to treatment at home, or offer choices or assess parent preference in treatment options (Wilczynski, Henderson, et al. 2016). One problem in this example was the BA was ignorant of the family's cultural values, customs, and norms to adequately provide effective treatment, and this lack of awareness, or ignorance, impacted the family's dignity by not asking the parents about any barriers or their preferences in treatment and their right to effective treatment due to the inability to replicate the intervention in the home context. This BA had had some acquaintance with cultural differences of this population about the social respect due to elders, religious differences, and other differences due to everyday customs. But the BA did not think that less evident values and norms could make an impact in this case, and they did not think that making a mess with the toys would be an issue. This example shows that the BA may be aware of some aspects of the family's culture, and may have assessed themselves as appropriately informed to take on a client, but blindspots could potentially be identified.

Case Example 2: Kema

Another BA with 5 years of experience accepts a 4-year-old girl, Kema, diagnosed with level 1 ASD who had a history of difficulty falling and staying asleep. The family is from Nigeria, speaking both Yoruba and English in the home. Several people are living in the household including mother, father, their five children, and paternal grandmother and aunt. During the intake interview, the BA gathers information on Kema's medical and developmental history and previous and current strategies used to address the sleeping concerns, one of which was co-sleeping. The BA cued into co-sleeping and developed a plan for Kema to sleep in her own bed. The plan included consistent bedtimes, a bedtime routine, a special alarm clock with the sun and moon to signal when she can get out of bed, scheduled times when an adult could check on her, systematically fading the scheduled check-in times, and reinforcement for staying in her bedroom all night. Kema showed improvements across several weeks of implementing the plans every night and the improvements consisted of Kema staying in her

room, falling asleep earlier, and staying asleep during the night. After seeing the improvements, the BA praised Kema for doing so well and was surprised that Kema was not more proud of herself. Kema expressed to the BA that she missed sleeping with her family because she was missing the father's stories that he would tell to her siblings to help them fall asleep. Upon further questioning from Kema and her parents, several other children were also co-sleeping with the parents.

The BA was ignorant of the cultural appropriateness and acceptability of co-sleeping and was not aware that Kema's siblings were co-sleeping too. Although the BA was promoting a behavior that promotes autonomy by teaching Kema how to self-soothe and fall asleep on her own, the BA's ignorance about the cultural role of co-sleeping impacted Kema's dignity, in this case understood as self-determination, by not giving Kema a choice or a voice in the treatment. The BA may have assumed co-sleeping was not appropriate or may have discriminated against co-sleeping. This discriminatory behavior could be imperceptible to the BA, a blindspot of sorts. They might think that it cannot be a bias to do everything possible to ensure independence on daily living skills at her age. The point is that the BA can explain away a bias as a reasonable stance consistent with some "self-evident values" because they were evident to them, as if it were not a bias. Further, the BA had not considered all the reinforcers that were available during co-sleeping and the depth of the family experience with her siblings and parents that potentially outweighed the possible reinforcers that would be available to Kema and her parents for addressing Kema's sleep with the program that was being implemented. In this case, however, it seems relatively straightforward that the BA is failing to consider basic aspects that belong to a client's culture, such as family sleeping arrangements and a sense that "autonomy" has different particular connotations in different cultures. This is a case that could be explained and addressed within the explicit provisions of the BACB ethics code since it pertains to best meeting "the diverse needs, contexts and resources" of clients and stakeholders (Behavior Analyst Certification

Board, 2020, 2.13, 2.14). This is a more straightforward case of “culpable ignorance” and could be addressed within the BACB ethics code.

Case Example 3: Victor

Another BA with 15 years of experience accepts a 5-year-old boy, Victor, diagnosed with level 3 ASD who showed severe deficits in adaptive skills (e.g., communication and daily living skills) and problem behavior, including self-injurious behavior (SIB). Although English was the primary language spoken at home, the family is Native American living in rural Washington state. During the intake interview, the BA asked routine questions about Victor’s skill development across domains, topographies of SIB (e.g., hand-biting and head-banging), common antecedents associated with the SIB, and preferred items. Victor’s mother reported that he wears diapers because he is not toilet trained. After the intake interview, the BA writes a toileting program to implement on the first day of therapy. The toileting program consisted of scheduling trips to the bathroom every hour, using visual stimuli to support him through the bathroom routine, and edibles for voiding on the toilet. Similar programs had been theoretically effective for the majority of children that the BA had worked with in the past. On the first day, every time the BA said “Time to go to the bathroom,” Victor immediately began to engage in SIB and the SIB persisted throughout the entire bathroom routine. An extinction and blocking protocol was implemented, not allowing escape from the transition, entering the bathroom, or sitting on the toilet, and the BA assisted Victor through the entire toileting program. SIB continued to occur on every trip to the bathroom with little improvement.

During the first week of Victor’s therapy, the BA conducted a thorough skill assessment in order to write the skill acquisition programs, during which ABC data were collected to design a behavior intervention plan (BIP) to address Victor’s problem behavior. During the skill acquisition assessment, ABC data were collected on following instructions, task completion, and nonresponding because no overt problem behavior was observed and the antecedent associated with the two target

behaviors occurring was when Victor was presented with a demand (e.g., “point to the cup” or “match orange”). The BIP included antecedent strategies (e.g., using warnings, timers, and visual schedules), consequence strategies (e.g., planned ignoring, blocking SIB, and using hand-under-hand guidance to support Victor through demand), and teaching a replacement behavior through a differential reinforcement procedure (e.g., functional communication training to request a “break”). The BIP was not written until two weeks of ABC data collection were collected. Even after the BIP was written, BIP support strategies were not used for going to the bathroom due to the hypothesized reason for problem behavior occurring was to escape from the demand of going to the bathroom and extinction was deemed the best protocol as it was considered a “non-negotiable” demand. This begs the question of clinical decision-making: is it a procedural error, is care being impacted by culture, or is it considered an error at all?

From the BA’s point of view, the appropriate technical skills were implemented, effective programs were written, and the management of safety issues that may have occurred fell within her scope of competence. However, a level of ignorance of the family's values, preferences, and cultural norms regarding priorities of what behaviors to change and how to change the targeted behaviors influenced the BA decisions about the chosen interventions (Wilczynski, Henderson et al, 2016). The BA may have assumed that it would be socially significant and beneficial for all children to be toilet trained, thus overgeneralizing that worldview to Victor without considering other factors like culture. As in previous examples, the BA manifests a target behavior that, while perhaps willing to be attuned to the family’s culture, judges that some behaviors are not or should not be culturally relevant. In this case, the BA was not just ignorant of some aspects of the family’s culture but, more concerning, rationalized their stance on the behavioral concern as one that is beyond culture, missing the “the goodness-of-fit” between the selected procedure and cultural context (Wilczynski, Trammell, et al., 2016). The BA may think that they possess a knowledge that is scientifically supported, while it really

is a mindset of their own culture. Traditionally scientifically supported conclusions can be and have been, expressions of the culture of those producing scientific results.

Further, parents often are not fully aware of several aspects of behavior analysis, including what could likely happen during an extinction burst, what is involved in an extinction protocol, or that behavior often gets worse before it gets better. This potentially impacts autonomy in several ways. Although the BA was attempting to respect Victor's autonomy by teaching him a critical adaptive skill, choosing to address toileting above all else, risking harm to Victor by implementing extinction to reduce problem behavior, and not executing the BIP during the toileting program was not truly respecting his or his parents' autonomy. This may appear to be a problem with BAs and the delivery of ABA service in general. However, we run into a similar problem area where the application of extinction has traditionally been used and explained with scientific results from the dominant culture.² Again, similar to example #1, the example of Chi, it appears that the BA is competent or aware of some aspects of the family's culture, but blindspots could potentially be identified (Sue & Sue, 2002).

Case Example 4: Amanda

Another experienced, Spanish-speaking BA accepts a culturally and linguistically diverse 13-year-old girl with level 1 ASD, Amanda, who is having difficulty interacting socially and maintaining relationships due to her circumscribed and perseverative interests in talking about and drawing mythological characters. The parents speak Spanish as well as English at home, but they encourage Amanda to speak English as that is the language for which all instruction is delivered at school. Despite both of the parents working full time, one of them was always home when the BA was providing therapy. Amanda and her family live on the outskirts of a small town in rural Idaho and the BA travels two hours one-way to the family's home. To further complicate the situation, the family lives in conditions not ideal for 1:1 therapy: a small mobile home with no yard with a variety of livestock

² For a systematic review on escape extinction see Chazin, Velez, and Ledford (2021).

roaming freely. The house was not clean and laundry covered the couch, dirty dishes on the counters and table in the kitchen, and a few uncaged chickens were living inside the home. The BA was specifically assigned to work with Amanda because they were both Spanish-speakers. However, Amanda's parents were migrant workers from Mexico, and Amanda was considered a first-generation U.S. citizen. The BA was a 3rd generation U.S. citizen from Spain who was middle to upper class in regards to socio-economic status. Although typically not unsurmountable, lexical and pronunciation differences between Spanish speakers from different groups should be taken into account.

While training and completing her coursework, the only training opportunities to which the BA had access was working with young children with ASD from White, middle-class families teaching skills based on the ABLLS-R© (Sundberg & Partington, 1998). The homes of previous families had been relatively well kept and organized and the parents had an area where the BA could work 1:1 with their child. The BA had difficulty finding a workspace that was free from distraction in the home for Amanda's therapy. Further, the BA was often uncomfortable with the living conditions, and going into the home grew more and more aversive to her across the weeks. As a result, the BA began arriving late and leaving early because she was uncomfortable, possibly biased against the difference in socio-economic status.

The BA conducts assessments and develops interventions in accordance with their training using the ABLLS-R©. The BA developed a social skills intervention involving turn-taking in conversations and Amanda was making progress with the intervention in 1:1 therapy with the BA. Although Amanda was making progress in 1:1 therapy administered in both Spanish and English, there were no attempts to train the parents to implement the intervention, impacting generalization of the intervention by interacting with her family. Despite being able to make linguistic adjustments to the intervention, the BA is possibly engaging in rule-governed behavior that is consistent with her training, past experiences, or operations within her organization. Rule-governed behavior is the behavior that is

occasioned by verbal stimuli (e.g., instructions and rules) that occurs without reinforcing consequences (Hayes, 1989). Often, BAs have a standard way of practicing that they learned through training (e.g., coursework and supervised experience) or guided by their organization, likely being reinforced for following the rules, they often do not question their training or recommended guidelines for a variety of reasons (Meehl, 1956). In this case, it seems as if the BA is competent, and they are to an extent, but is engaging in a very rule-governed practice that can potentially thwart true effective, compassionate treatment.

Prior studies have shown that using a non-native language influences behavioral outcomes for clients (Neely et al., 2020; Padilla Dalmau et al., 2011; Rispoli et al., 2011). Further, using a nonnative language in the consenting process may limit the parents to make a fully autonomous decision about accepting treatment (Brodhead et al., 2014; Dennison et al., 2019). Although language is relatively easy to correct in many cases by using interpreters, it should not be the only cultural variable to be considered or corrected. No linguistic adjustments were made when the BA was working with Chi in Example 1 and this may have limited the BA's ability to respond appropriately to Chi's parents or others in the household that spoke Vietnamese. But, as described in the case example of Amanda, there may be other cultural biases of which the BAs needs to be mindful and aware, even when accounting for language.

Table 2. Summary of Case Examples

Client/Dx/ Age	Area of intervention	Aspects that show ignorance of the clients' cultural world	How ignorance impacts client and treatment
Chi 3 yo, ASD, level 2 support	delayed communication, disruptive behavior	<ul style="list-style-type: none"> ● The BA thought that previous acquaintance with persons of a similar cultural background with the client was enough to be culturally competent ● Interpreter choices (yes with parents, no with clients) ● Assuming that floor play was a good strategy ● Communication with parents about the play skills intervention decision 	<ul style="list-style-type: none"> ● Replicability of play skill intervention on the floor at home ● Cultural preferences and values were not assessed prior to implementing assessment and treatment
Kema 4 yo, ASD, level 1 support	sleep difficulties	<ul style="list-style-type: none"> ● Relative value of sleeping alone as expression of autonomy vs. cultural practice of co-sleeping and its value as promoter of fraternal bonds 	<ul style="list-style-type: none"> ● Potential absence of reinforcement when falling asleep ● Cultural preferences and values were not assessed prior to implementing assessment and treatment ● Failed to ask Kema preference on treatment options and gain assent.
Victor 5 yo, ASD, level 3 support	adaptive skills (toileting), delayed communication, self-injurious behavior (SIB) & other problem behavior	<ul style="list-style-type: none"> ● Assuming that toileting program including extinction for SIB would be effective based on experience with previous client without considering client's and his family's culture ● Did not explain extinction or inquire about the acceptability of extinction for the family or the broader Native American culture ● Possible clinical errors regardless of culture <ul style="list-style-type: none"> ○ ABC data were collected on other forms of problem behavior as opposed to SIB ○ Toileting began on the 1st day of therapy 	<ul style="list-style-type: none"> ● Cultural preferences and values were not assessed prior to implementing assessment and treatment ● Victor's and the family's autonomy were impacted by not incorporating the family into decision-making ● Lack of effectiveness and repeated risk of harming Victor

		<p>and the BIP was not completed until 2 weeks later</p> <ul style="list-style-type: none"> ○ The BIP was not used for toileting 	
<p>Amanda 13 yo, ASD, level 1 support</p>	<p>social interaction, maintaining relationships</p>	<ul style="list-style-type: none"> ● Assuming that linguistic competency is enough ● Feeling uncomfortable with class &/or SES ● Rule-governed behavior on BCBA’s part can become a straitjacket and limit adaptability 	<ul style="list-style-type: none"> ● Lack of generalization due, in part, to no parent trainings leading to potential absence of reinforcement at home ● Session becoming shorter ● Cultural preferences and values were not assessed prior to implementing assessment and treatment ● Failed to ask Amanda preference on self-identification when gaining assent.

Cultural Ignorance in Behavior-Analytic Practice: What Went Wrong in the Case Examples?

With these considerations in mind, let us now analyze how ignorance plays out in the case examples presented. The critical distinction is between culpable and non-culpable ignorance. We have relied on the BACB code and the overarching moral principles of respecting the dignity of clients and stakeholders, and of providing effective treatment. As we examine what went wrong in the case examples, it is important to keep in mind that culpable ignorance does not require that the BA was aware of what they ignored. Culpable ignorance can be a matter of ignorance, regardless of whether the BA was aware of it or not. In both cases, families and clients might be affected if the BA remains ignorant, and the effect can include violations to families and clients' autonomy, respect, and dignity, as well as failure to provide effective care.

The case example of Kema (#2 above) is a situation where the BA fails to take into account the cultural context of the client (see specifically sections 1.07 and 2.14 of the BACB ethics code). Ignorance of cultural aspects of the client, and disregarding them as a criterion ("additional to scientific principles") are barriers for providing culturally sensitive assessments and treatments to the client, their immediate family, and broader community. This kind of disregard goes against the BACB ethics code and would constitute a case of culpable ignorance. But the responsibility is not only the BA's because they may not have had the opportunity to "incorporate and address topics related to diversity" in their training (Ethics Code 4.07). There is culpability for the BA's ignorance that is not only the BA's but, at least partly, systemic and the responsibility of the professional system of ABA. In most cases, training in cultural competence is provided in field experience supervision because there are no coursework task requirements in a verified course sequence to become a BCBA. No training on interviewing or engaging with families from diverse backgrounds (e.g., interpersonal skills, relationship-building, empathizing, or providing compassionate care) is required in coursework and this, again, is also left up to supervision (LeBlanc et al., 2020; Taylor et al., 2019). Depending on the training program, limited supervision may

be available to an aspiring BA to receive experiences and knowledge that allow them to build and master skills in cultural competence and awareness.

The case example of Victor (#3 above) shows a failure in the selection, design, and implementation of the behavior-change intervention (see BACB ethics code 2.14). The BA had the technical skills needed for the BIP, theoretically effective programs were written and possible safety issues well within the scope of the BA's competence were considered. On the one hand, the BA did not take into account values and cultural norms regarding priorities about what behaviors to change and rationalized their stance that some behavioral concerns are beyond culture. Perhaps this aspect is one in which the BA thought they took cultural differences into account but did not think that the priority of toilet training was part of relevant cultural differences.

What is more concerning in that example is that the BA proceeded in a way that ignored well-established practices that also have to do with the culture of the client and their family. According to Taylor, LeBlanc, and Nosik (2019), building relationships directly impacts family buy-in and treatment acceptability and, therefore, cultural competence will also affect family buy-in. And since family buy-in will affect the effectiveness of the intervention, it is important to recognize how the family is managing their feelings about their child's (the client) disability, progress in intervention, and other family stressors. Do BAs do a good job at listening to parents and changing treatment options when they do not like what we are doing? Should a BA continually check in with families about how they are feeling about BA-child interaction, and be more sensitive and open to the family's feedback when the family comes from a culture foreign to the BA's? Particularly in the face of diverse cultural backgrounds, the perspective of the clients and their family before and during the intervention cannot be ignored both because it affects the implementation of the BIP over time and implementation is one of those areas where the BACB ethics code demands taking into account the stakeholders' contexts.

In this line of examination, the BACB ethics code represents unequivocal progress for ABA because it makes explicit diversity-related areas that BAs should know about or take into account. Disregard for diversity-related areas is now explicitly a case of culpable ignorance, and the specifics fall both within things and facts a BA ignores, and within the practices a BA follows to evaluate, maintain, and expand their expertise. Insofar as ABA as a field includes training and supervision, the ethical responsibility of what BAs in general know or ignore also falls upon training and supervision.

Things We Do Not Know We Do Not Know: Where a Special Attitude is Required

Although the BACB ethics code represents very significant progress, we propose a reflection about its limits. Are BAs aware of their cultural diversity limitations? Can a BA, despite all their best intentions, always discern when they (and their colleagues, supervisees, and trainees) are adequately assessing the “needs, contexts and resources” of culturally diverse clients?

Let us consider Chi (case example #1), which shows a situation where the assessment of the BA regarding their competence was not straightforward or blatantly wrong. The BA was not disregarding the client and their family’s culture. The BA’s previous personal history with this broad cultural background gave them a reason to think they were qualified enough. This BA would argue that they followed the ethical decision-making process the BACB ethics code proposes, especially when it asks BAs to “consider [their] personal learning history and biases” (Behavior Analyst Certification Board, 2020, p. 5). Confronted with the BACB ethics code 1.07 on “Cultural Responsiveness and Diversity” and 1.10 on “Awareness of Personal Biases and Challenges,” the BA could argue that they thought they had a reasonable amount of awareness of the other culture, and second, that they evaluated their biases and concluded that because the target behavior did not touch upon religious or gender issues, the intervention was sufficiently culturally sensitive. Further, the BA may explain that their intervention was compliant with 2.13 and 2.14 on assessments and interventions that best meet “the

diverse needs, contexts, and resources” of clients and their families. But it turns out that the BA in example #1 did not have the tools to properly assess their own awareness.

Let us also consider Amanda (case example #4) here too. The agency specifically assigned a Spanish-speaking BA to Amanda, being responsive to the linguistic aspect of cultural diversity and abiding by BACB ethics code 1.07 in this way. However, the BA was perhaps unaware of her personal biases in regards to socioeconomic status (e.g., from a middle upper-class background to a rural, migrant worker background), or to many other cultural norms where the difference between a 3rd generation U.S. citizen (great-grandparents were from Spain) and an immigrant family (from Mexico) can be quite dramatic. Language can help in delivering culturally appropriate assessments and interventions but it is not enough. The language competency may help hide deeper differences and lead the BA and others to actively disregard those differences. In particular, “Hispanic” or “Latinx” populations are so culturally diverse internally that these differences can be easily disregarded unless someone is aware of those differences.³

These two cases seem unproblematic from the point of view of the BACB ethics code and the idea of culpable ignorance. Many BAs may see their own situations reflected: although they do not know everything that there is to know about other cultures, they are not careless. This is precisely our point: we need to make sense of what is wrong in these examples. To that end, let us examine in particular biases and bias-awareness (BACB ethics code, 1.07 and 1.10). As a working definition connecting the things we ignore with biases, it is understood that we have biases because we ignore some facts that would make us unbiased (a cognitive error), or because we are unable to apply some

³ We acknowledge that the terms “Hispanic,” “Latinx,” “Latino/a” and “Latine,” among others, are contested among the populations they are supposed to label. The objections include the colonialist connotations the term “Hispanic” may be seen to carry, the non-binary excluding elements of “Latino/a”, the perceived foreignness of the “x” in “Latinx” and the difficulty some have in pronouncing it, or the ungrammatical nature of the “e” in Latine that makes wide adoption very highly unlikely. At a deeper level, some members of communities that would fall under the Latinx group object to the very idea of such a group, pointing to profound differences different “sub-groups,” for instance, Chicanos, Cuban-Americans, Latin American immigrants, U.S.-born descendants of people from Latin American, and people of indigenous descent. We recognize that the views in these areas vary greatly across communities and individuals.

facts we know to situations (a practical error), or a combination of both. The second case — we know but are unable to apply — is a case of bias-awareness.

The BACB ethics code seems to mirror two common assumptions of thoughtful people in their everyday life about our biases and prejudices:

- Ideally, we would have no biases.
- But reality is not ideal, and we do have biases. However, we are aware of them, and if we are not aware of them, we can become aware of them and control them.

These two assumptions seem at work in the BACB ethics code and are part of a logic of mastery that, possibly based on ABA's self-image as deeply rooted on strong scientific principles of universal scope, aims to treat ethical behavior as a subject that should be, and can be, put under control. It seems, however, that, as knowers and as moral agents we are in a less lucid position—and one that is not easy to see because bias often eludes detection and examination from the person who has the bias or prejudice. We offer an analogy to demonstrate why this is a point worth problematizing. A bias is like the blind spot when driving a car: people need to be taught about the blind spot. Requirements for new drivers do not assume that drivers are aware of blindspots: they demand that new drivers learn about those blindspots. In particular, for the case of cultural diversity, it seems that the BACB ethics code assumes that a BA is generally able to determine when these differences affect their work. But cultural differences are often ignored and underestimated, and their influence downplayed. This is often done without willful intent: sometimes cultural differences simply do not register or do not register as they should (Bailey, 2007; Shotwell, 2011; Medina, 2013; Sullivan & Tuana, 2007). This is why ABA should not simply assume that people know about their blindspots.

Instead of the assumptions above about how good our knowledge is and about our capacity to see our own blindspots, we should look at ourselves in a more humble perspective as knowers and as moral agents: (i) We are aware of some of our biases and try to control them, sometimes successfully,

(ii) we are aware that some biases are unknown to us but make efforts to uncover them and try to control them, and (iii) we recognize that we will inescapably have some biases that might remain invisible and impervious to examination and correction.

In this context, there are more tools to analyze problems like those surrounding scope of competence and practice to which Brodhead, Quigley, and Wilczynski (2018) recently called our attention. They describe several reasons why a BA would practice outside of their scope of practice, one reason being the inability or difficulty discerning situations that are actually outside their scope. New BAs might accept a new client from a culturally diverse family with which they have no prior experience working. However, outside the cultural layer, the BA feels confident that the client's problem behavior and skill deficits fit within their scope of competence as they have worked with similar topographies of behavior before (e.g., like in example #1). If the novice BA feels competent and engages in strict rule-governed behavior, following the steps and procedures outlined by the governing system (e.g., agency, school, or hospital) and relies on previous learning in their coursework, training experience, or supervision, then issues could emerge (e.g., example #4). There could be issues because those rules, steps, procedures, coursework, training experience, and supervision may still be unfit for the case at hand—perhaps because they are still not culturally aware enough—and their reliance on them seems to cover for deeper difficulties.

Recent contributions to ABA literature have discussed strategies to overcome these deficits through curriculum changes and supervised experiences (Taylor et al., 2019; Wright, 2019). For example, Wright provided practitioners with a self-reflection questionnaire to assist BAs in identifying potential biases by evaluating their own private events and discussing them with a supervisor. This questionnaire may help the BA recognize potentially problematic or culturally incompatible interactions between the BA and the family, allowing the BA to address specific issues on an ongoing basis. However, this requires that the BA and the supervisor are able to discern potential problems and

biases to avoid practicing in ignorance. Being ignorant, or not being able to discern these potential problematic biases, will limit the BA in thinking about other, perhaps more culturally appropriate, alternatives. Further, this ultimately impacts the BA's obligation to provide the client and their family an effective treatment.

Conclusion

There are central elements of a BA's ethical values and responsibilities in which cultural awareness often impacts practice. For example, autonomy, defined as self-determination, is at the heart of the BA's obligations to clients, as well as of professionals in health-care and mental health-professions (Koocher & Keith-Spiegel, 2008, pp. 6–7). However, cultural factors often limit the client and the caregivers' full ability to make autonomous decisions due to language or belief systems. However, the BA may not always be aware of these limiting factors as they relate to culture. It is also a central obligation of a BA to provide effective treatment. Taking into account that cultural contingencies are part of the factors that influence a client's behavior, a BA that is ignorant of some cultural differences and their significance may provide less effective treatment. Becoming aware of cultural differences facilitates the odds of treatment by improving parent buy-in and subsequent adherence.

We should avoid considering culture only when progress *is not* being made with an intervention or skills are not generalizing to other contexts, like the home environment with the parents implementing intervention with Chi in Example #1. It is our ethical obligation to revisit ineffective teaching approaches, but considering culture should be a proactive part to assessment, not an afterthought. This is almost a cookbook approach and proactive approaches to assess cultural variables to assist BA's clinical judgment is critical (Meehl, 1957). Allen and Warzak (2013) suggested conducting a functional assessment of the multiple, remote, and co-occurring contingencies that impact parental adherence to interventions. Perhaps this can also be done with culture. In Example #2, a more

culturally aware BA may have chosen to conduct a different, more culturally sensitive, intervention that addressed the concerns without restricting Kema's access to a variety of reinforcers from being with her family. Further, even if BAs disagree about the pertinence of cultural differences in matters specific to the goals of treatment, a fundamental concern for the effectiveness of treatment requires that BAs inform themselves on how such differences may have an adverse impact on outcomes. For instance, gaining the acceptance and cooperation of family members for treatments, and their sustainability over time, will be directly related to cultural differences. However, it is difficult to think that one learns about such differences and comes to remain unchanged about at least some of the goals of all interventions.

Conversely, we should avoid disregarding culture when progress *is* being made. It is easy to miss the importance of culturally sensitive adjustments if the child is making progress on a skill that the BA deems to be a socially significant problem. This progress may lead to dismissing important questions: If the client is making progress with the intervention without thinking about cultural adjustments, is it good enough? Are BAs considering cultural diversity factors when they identify and evaluate socially significant behavior changes? BAs are asked to recognize when to make culturally appropriate adjustments to assessment and treatment procedures, but the lack of cultural awareness and the inability to discern between culturally relevant factors risks that the BA would not make adjustments at all, especially when the client is making progress. Although culturally diverse clients may show improvements from the standard assessment and treatment procedures with no cultural adjustments, could they make more improvements with cultural adjustments? Because the client has the right to the most socially significant (Wolf, 1978) and effective treatment available designed by a competent BA (Van Houten et al., 1988) can we afford to ignore cultural variables when progress is being made? Even though several BCBA programs do have coursework or supervision requirements in making culturally appropriate modifications, our point is that it is important to notice that there is a

tension, with no obvious or self-evident resolution, between client progress as evidence of effectiveness and the need for cultural adjustments to maximize effectiveness.

We accompany this discussion with the recommendation to adopt an ethical attitude. First, this attitude calls our attention to the fact that there are many things we do not know in matters of diversity, which we are not aware that we do not know, or which we downplay as unimportant to know. It is an invitation to recognize our ignorance and to incorporate an appreciation and willingness for self-examination. Second, this attitude calls us to learn about what we do not know and to work on the habits and procedures by which we expand our knowledge, maintain our expertise, and evaluate our abilities. This is a continuous exercise of detecting blindspots, being sensitive to clients and their families.

This attitude implies continuous, gradual growth. Knowing that one does not know everything but tries to learn about the impact of cultural diversity implies, among other things, that even in matters in which there is concrete “ignorance” —which there will be for every practitioner— one is not looking for gaps in knowledge as *excuses*. For the BA who exhibits the attitude of working to inform themselves on culturally diverse issues, even cases of specific ignorances would not be harshly judged as failures. This would give us a nuanced perspective of the complex and slow process ABA and BAs are going through in incorporating multicultural insights.

Similarly, Wright has argued that incorporating the *cultural humility* framework would help ABA improve its outcomes such as health disparities and access to care. Cultural humility is presented as an alternative to cultural competence, and the rationale for its adoption is derived from the need to act against “power imbalances” that fosters the marginalization of certain communities and creates injustices (Wright, 2019, p. 805). We agree that these are good reasons to incentivize more diversity and multiculturally aware practices. Overcoming ignorance is an obligation to others —to clients and their families— but it depends on a type of self-awareness. The work of Fong and her colleagues in

two different articles (Fong et al., 2016, 2017) emphasizes that cultural awareness is, partly, a work of becoming aware of one's own culture. But here we need to be careful. Although cultural self-awareness may help someone have a better perspective on their own outlook on life, and even help them understand in a general sense that other cultures organize life differently, the goal in the context we are discussing is understanding others correctly and in a way that leads to effective treatment. In short, it requires self-work for the sake of others.

In this context, cultural humility is a goal for the BA as a set of attitudes. But we are cautiously sympathetic to it as a framework to address individual and institutional behavior. Cultural humility works through self-reflection. But without a strong requirement to overcome ignorance about others, self-reflection can remain self-serving. Wright's self-reflection is an example of a self-evaluation that could, or will, be limited. Perhaps we as BAs can have a reciprocal understanding of cultural awareness through attending to the therapeutic relationship, much like Taylor, LeBlanc, and Nosik's framework for providing compassionate care. Compassionate care has the virtue of being very straightforwardly directed to the other party—in this case, the client and their family. There is still much to recommend in Wright's proposal, provided that it is oriented not only at understanding one's own culture at the individual and systems levels but going further to ask questions that attempt to identify power imbalances and potential barriers.

Combining the contributions of Wright's (2019) cultural humility self-reflection and Taylor, LeBlanc, and Nosik's (2019) method of providing compassionate care, a suggested future study would be to evaluate the growth of the BA in cultural humility by, for instance, the frequency of power imbalances identifying as the independent variable using multiple baselines across participants. Another future study could involve developing task analyses (TA) or checklists of attending, interpersonal, and empathizing skills to train behavior analysts using Behavioral Skills Training (BST) as the independent variable using a changing criterion design to demonstrate improvement in

compassionate care. This could be accomplished in two ways. The BST using the TAs could first be implemented in a training context, like supervision, with mock scenarios and then generalized into live situations after the BAs have shown mastery in the training context and after the TA or checklist has been faded. As an alternative, the scenarios could increase in cultural complexity. All of these ideas could also collect information on treatment integrity and/or acceptability as a secondary dependent variable.

We have suggested that an attitude that takes ignorance seriously and calls for vigilance and humility is important in fulfilling the BA's obligations. But it would be a mistake to suggest that the overcoming of ignorance is solely the task of individuals. ABA as an organized profession with scientific principles and methods of knowledge development, training and supervision, and practice is also responsible for the knowledge and the ignorance that is allowed and transmitted. There is also a shared, communal —and professional— responsibility. The central element of this link is that individuals develop their ethical character inside communities. Moral formation occurs this way in childhood, and in general, within the socio-historic circumstances each person grows and continues developing their moral orientation. The obligations for behavior analysis about cultural diversity depend, in part, on ABA providing practitioners the tools to be aware of and respond to the culturally diverse specificity of all situations. At the same time, ABA is composed of individual behavior analysts and institutions of education, training, evaluation, supervision, research, and dissemination of knowledge and these instances are also reinforcers, propagators, and improvers of the ethical traits that our communities practice and should continuously try to improve. It is a two-way, complementary ethical framework, supplementing personal ethical responsibility with social ethical responsibility, in this case, placed on the profession and its organs as a social institution. Whether practitioners know it individually or not, and are persuaded of the relevance of cultural differences for matters relevant to

treatment or not, it is incumbent upon the profession as a whole and its educators, researchers, and editors, to bring these points into curricula, studies, publications, and other practices.

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