Interview between Speaker 1 (Meg) and Speaker 2 (Greg)

[Introductory music]

Welcome to the Two Sides of the Spectrum Podcast. A place where we explore research, amplify autistic voices, and change the way we think about autism in life, and in occupational therapy practice. I'm Meg Proctor from learnplaythrive.com.

Meg: Before we get started, a quick note on language. On this podcast, you'll hear me and many of my guests use identity-affirming language. That means we say, *'autistic person,'* rather than, *'person with autism'*. What we're hearing from the majority of autistic adults is that autism is a part of their identity that they don't need to be separated from. Autism is not a disease, it's a different way of thinking and learning. Join me in embracing the word *'autistic'* to help reduce the stigma.

Welcome to Episode 5 of the podcast. In this episode you'll hear me speak with one of my favorite OT's, Greg Santucci. We'll talk a lot about how OT is *and* should be different from Applied Behavior Analysis, or ABA, even though many therapists really blur the line. And you'll hear a thoughtful and sharp critique of ABA from Greg, coupled with practical advice for what we should be doing instead, and why we already have the skills we need to get started.

So before I play the interview, I wanted to give you a quick history of ABA. It was developed in the 1970s by Psychologist Ivar Lovaas and Robert Koegel. Lovaas famously said things like, *"You see, you pretty much start from scratch when you work with an autistic child. You have a person in the physical sense — they have hair, a nose and a mouth — but they are not people in the psychological sense. One way to look at the job of helping autistic kids is to see it as a matter of constructing a person. You have the raw materials, but you have to build the person."*

Lovaas was simultaneously involved in gay conversion therapy, or teaching gay people not to be gay, using the same approach. The basic goal of ABA was to make the person more *'normal,'* and less autistic. The techniques used for ABA have changed and evolved, in some cases, over the years. And in others they haven't. But the methodology has always been compliance based.

Greg recently posted on Facebook about an early experience he had as an OT in the schools. The teacher, who used an ABA approach, told an autistic child to go in from recess for OT. Greg said, no, it was fine, he could see the child on the playground. But the teacher insisted that since the demand had been placed, the child had to go inside. When the child resisted, they followed the behavior plan and used a *'visual screen'* which, in this case, was a hat pulled over the child's eyes, until the situation escalated and he finally complied. This may sound extreme. And in some ways it is, but in other ways it's really not that different from the way behavioral therapy strategies typically work.

Greg and I will talk a lot about specific strategies in the interview. And check back for the next episode as well. I'll interview Joy Johnson, who is black, autistic, and a behavioral therapist who is actually trained in ABA. She gives a perspective that is quite different from Greg's… But also quite similar. Okay, here's the interview with Greg.

I'm so excited to have Greg Santucci on the podcast today talking about how we choose our occupational therapy approaches. Greg is a pediatric occupational therapist and founder of Power Play Pediatric Therapy. He is a Supervisor of Occupational Therapy at Children's Specialized Hospital in New Jersey. Greg is a huge advocate for best practice in OT, and presents workshops nationally on topics related to sensory processing, challenging behaviors, and improving school-based therapy services. Hi Greg!

Greg: Hi, how are you?

Meg: I am great. I'm glad to have you.

Greg: Glad to be here always.

Meg: All right, Greg. So most of us who are OT's were trained in schools as generalists. Then we got out into the world and we have to be competent in working with so many different populations. I talked to a lot of OT's who are new to OT practice or new to pediatrics, who are trying to navigate through their different choices in OT interventions for autistic kids, and they can feel a little lost and very confused. So since you've navigated through that and come to a good place, tell me a little bit about what your approach is for working with autistic kids and your journey to get where you are now.

Greg: Oh, and being generalist is such a good thing. It's one of the power of OT's. I was, in fact, just reading a curriculum of one of the OT schools on the East Coast and I was just so impressed with the breadth of knowledge that OT's get in their school. I understand as a new practitioner how daunting that can be, but it's just a beautiful thing that we're generalists.

For me, my passion has always been kids. But I started having really strong opinions when I began working in the schools. Everything was about control — sit here, sit like this, morning circles were 30 minutes or longer, do this, don't do that, lose a token, move your clip, lose a privilege. And it just seems like the more controlling teachers got, the more challenging behaviors they saw. So for me as an OT — and I know a lot of OT's can relate to this — I never saw the challenging behaviors that the teacher saw. And I would hear things like, *"Oh, it's because you're fun, and you don't do any work. You don't place any demands on them."* And I would hear that and I'd say, *"Well, that's not necessarily true. I have goals just like you and I have to show progress just like you."* It was a lot more than that. So it wasn't just that the kids liked me, it was that they trusted me.

That's a big part of my treatment approach of working with all kids. They felt safe. And I respected them. Groundbreaking concept! I respected their sensory preferences and their sensory needs. Kids — and again, working in the public schools, kids weren't necessarily a collection of behaviors that needed to be extinguished or changed. I saw their strengths. Which, again, is groundbreaking because we work in a deficit model in the schools. We celebrated those strengths and identified some lagging skills, and got to work on those skills. So in my journey as I was pursuing more and more of the literature behind this, it actually led me out of the OT literature and into more of the psychology literature.

And then while this was happening on my journey, I had something great happen to me. In fact, the best thing that's ever happened to me — I became a new dad. So my worlds collided as I was looking for the science behind the power of connecting with kids. And then also reading some of the parenting literature, which can be kind of fluffy. A little kumbaya-ish. [Laughs] It led me to a group of clinicians and researchers and innovators, and they're bringing all of this amazing brain research over the past 30 or 40 years, and putting it into everyday practice for professionals and parents to use. It's just wonderful and validating and so important for OT's to know. So books that helped hone my clinical practice, like *'The Whole-Brain Child'* and *'The Yes Brain'* that were written by Daniel Siegel and Tina Bryson; books like *'The Explosive Child'* and *'Raising Human Beings'* written by Ross Greene; *'The Boy Who Was Raised As A Dog*' by Bruce Perry, and most recently the book *'Beyond Behaviors'* by Mona Delahooke. And I hope I can talk a little bit about Mona's work later.

All of these non-OT's were presenting information that is so useful in the world of OT! And they all have one thing in common — they all loved OT's, and they all need us to help further their work. So, to your question, the model of treatment that I use focuses on building trust and safety first, then addressing regulation skills and any sensory

processing issues that may be getting in the way. And, when we're able to, then work on the motor skills, the practice, the activities that are part of a more traditional OT treatment plan.

Meg: I love that. It sounds very aligned with what a lot of people are learning now in trauma-informed practice and how prevalent trauma is in the lives of children, starting with trust and respect, and then looking at their strengths rather than their deficits, which we talk about on this podcast a lot because it's one of the most important shifts we can make.

Greg: Yes.

Meg: And I'll admit, I love hearing you say that your parenting journey informed your OT journey, because when I read your OT pages, half the time I take the articles and I send them to my husband and I say, *"We need to remember this with our kids."*

Greg: Yes. My wife is an OT, and even when I write it, I'll sit down with her and be like, *"We've got to remember to do this with our kids!"*

Meg: Yeah, I'll link to all of your places where you post in the show notes so other people can inform their parenting and their work.

Greg: Awesome, thanks.

Meg: Okay, so I want to talk specifically about how we are the same or different from ABA and behavioral approaches, because many OT's find themselves increasingly working in ABA settings, or being trained in behavioral approaches. And I've never worked in an ABA setting, but I know when I started in the schools, I did get some training with some kids by their BCBA's on what exactly I was supposed to do with those kids. And the

behavioral models that I was taught were Antecedent Behavior Consequence. Very behavioral, and that's what I was expected to use in the schools, and I know that's the experience of a lot of OT's. Many are saying, *"Should I go get my BCBA if this is the practice I'm going to do?"* So I was wondering if you could talk a little bit about what does, or what should, distinguish OT practice from ABA practice?

Greg: Yes, I would have loved to be a fly on the wall when somebody asked you if they should go get the BCBA as an OT. Or maybe it's better that I wasn't there. [Laughs]

Meg: It was in a Facebook group, I'll tag you next time.

Greg: So I'm going to be I'm going to be a little blunt here. I feel like this is a safe space. There is an incompatibility with ABA and OT. I have worked in ABA settings, I've worked in Verbal Behavior settings, I've worked in public schools that have, you know, their autistic classrooms are ABA classrooms. So there is an incompatibility there. And also being blunt, I can say that ABA does not own behavior. That OT's can be just as much of a behavior specialist as they are, especially with our knowledge base. Again, going back to being a generalist and learning about neuro — they don't have any training in neuro.

The biggest difference for me between OT and ABA is that OT focuses on the person and ABA focuses on the behavior. Another huge difference for me, again, it goes back to our education, is that we're dealing with a neurodiverse population, but they don't have any training in the neurosciences, and we do. So we understand kids from the inside out. They're looking at observable behavior and starting there.

I always question how someone can work with a neurodivergent population and not have any training in how the brain works, and that's troubling to me. Again, I'm 20 years deep of watching ABA and more frustrated than ever, especially with all of the

neuroscience literature that's coming out. What are the issues I have with ABA, and distinguishing it against OT and, again, how we chase the why?

ABA practitioners are taught that every behavior is either attention-seeking, escaping, avoiding, or trying to get something tangible. Those four things. If it was only that simple. To me, that's a shallow analysis. And the problem is it puts you — when you see everything as either attention-seeking, escaping, avoiding, or to get something tangible — that puts you on a trajectory of compliance. It completely ignores the *'Why'* a behavior is occurring. Why are they attention seeking? Why are they avoiding work? And I — again, I'm getting blunt in my old age — I have pressed BCBA's and registered behavior technicians on this. And eventually in their frustration, they will admit that they don't care about the why! That they are truly looking to change observable behavior. To me, that's horrifying.

So I encourage OT's to *be* OT's. Don't conform, be you. Because the *'You'* is awesome. So to advocate for chasing the *'Why,'* to advocate for themselves and their profession and for the kids, we are such a unique profession. We have to get that unique perspective into the classrooms because there's such a huge focus on behavior. So yes, there's a lot of ABA in the schools, there's a lot of ABA and EI, but there needs to be more OT. And our knowledge base is not going to infiltrate this ABA world unless we stay true to us and not just be pseudo-behaviorists because that's what's everywhere.

Meg: I love that. So really thinking about how that generalist training and that background knowledge should and can inform what we do. I hear the arguments from the audience; the future audience will say, *"But I know BCBA's. They're so nice. They care so deeply about their kids."* And I know that you aren't talking about whether they're nice and whether they care about their kids. We're talking about the framework that ABA comes from versus the framework that OT comes from. Does that resonate?

Greg: Yes. So as we always talk about presuming competence, I presume that every person working with children is dedicated to helping children and they feel that they are doing the best for kids. And so, all of my critique is never of the individual person. Unless there's, you know, there's bad in every profession. But what I am talking about is the antiquated knowledge base, not the people who are just, you know — they went through this course of study to try to help children. I'm upset with Skinner and Lovaas, not the people who go to work every day and try to do their best for the kids.

Meg: Yeah, I think one thing that's happening for a lot of therapists is there's sort of a void of concrete skills informing what to do. And the behavioral strategies are so prevalent that they kind of step in to fill that void. Whereas we should be looking for training opportunities, mentorship opportunities, books, whatever it takes to fill that void with something that's more aligned with the OT's we set out to be when we went to school.

Greg: Right.

Meg: So we've also heard a lot of critique of the ABA approach from the autistic population. We heard this from Sarah Hernandez in Episode 1 of the podcast. Can you talk a little bit about some of the specific strategies and their impact? And I'll say, we had a full episode. Episode 1 was all about why we should reconsider using hand-over-hand or using our bodies to move a child's body for compliance. So we have talked a lot about that but we haven't really talked about things like planned ignoring, using reinforcers, using token boards. Can we talk about that?

Greg: Ah, planned ignoring. Sure, let's talk about that. Oh, this is exciting because I get to talk about Mona Delahooke like I said before, so here's my chance. She actually wrote an amazing piece on this, and I think she called it, *'The hidden costs of planned ignoring'*. So let's just think of the message of planned ignoring, or in behaviorist-like jargon, they'll even call it tactical ignoring. Tactical sounds very militant.

Meg: Yes, it does.

Greg: So the message it's sending is, *"Well, I'm not interested in what you're trying to communicate, I'm only going to pay attention to you when you do what I say."* That's mean. It also assumes that an autistic child's behavior is accurately representing their intentions, which is not fair. So if a child's hitting, biting, throwing, breaking, their intent is not to hurt you. They're telling you something is wrong, in the only way they know how to at the moment. So those are two big issues with with planned ignoring.

I think the last thing that I would say about it is that it's really unnatural for a parent to ignore their own child. I would say that it's unnatural for a teacher and a therapist to ignore a child. So what's the alternative? The alternative is to pay more attention to the child and try to find the *'Why'* of the challenging behavior, and not just ignore it. Or help them communicate in a less aggressive manner. Again, support, as opposed to ignoring. I'll choose that any day of the week in a way to help kids.

So, as for reinforcers — Ross Greene has a soundbite that I love. He says that, *"Stickers don't solve problems."* And we use extrinsic motivators a lot to get compliance. And they work, but they work temporarily. In the long run, they can be disastrous. I can give you a little story about a boy I was working with in a school. Autism, limited verbal language when he was young, and they started out with him working for food rewards. Over time, they had to increase the reward to keep him motivated. So he went through school and he had stickers and classroom books. And he still had a hard time doing his work and he was still aggressive in school. The aggressiveness was a real problem. Again, with everybody looking at the outward behavior, not really looking at the *'Why'* that behavior was happening.

So by late middle school, his parents had sent in the brilliant idea that he was working for an iPhone if he didn't get aggressive with anybody. So we went from M&M's to an iPhone, which screams that that approach doesn't work. And again, it may work temporarily. But in the long term, you're not making durable changes in behavior. Lots of rewards, but everyone's goal is to have durable changes in behavior.

Meg: I think, too, you said that fields outside of OT had really informed your approach. I think about psychology, they talk about the valence split of, *"If I'm only doing A to get to B, then A is not valuable and B is,"* and as soon as we add that reinforcer, it's just teaching them that there's no intrinsic value in what you're doing. You're only going to do it to get a reward, and we've robbed them of the opportunity to learn to like and love that activity through our skilled strengths-based intervention.

Greg: Absolutely.

Meg: So for those in the schools, it sounds like Positive Behavior Interventions and Support, or PBIS, which is the National Behavior Plan for schools in the United States, does fall into this compliance-based model. Is that what you're seeing?

Greg: Yes.

Meg: [Laughs] You said that reluctantly.

Greg: And what you said was perfect. The National Behavior Plan for schools, which means there's money behind it, which is why this got so popular. I have been in schools that have tried to implement PBIS. I have yet to see it be this magical solution to behavioral challenges. What I do see is a lot of B.F. Skinner. So, to me, PBIS is lipstick on a pig. In the districts that I've been in, it's a lot of rewards. It's rewards on top of rewards, and if you get enough rewards, you get a prize. What I have seen — and again, I have yet to

see good PBIS — what I've seen is rewarding getting rewards with more rewards, which seems rewarding, but again, it's not making durable changes in behavior, which is what the intention of the program would be. So I am not a fan of that model. Can I tell you what I'd rather see?

Meg: Please do.

Greg: So I already mentioned Dr. Ross Greene. I'm a big fan of his work, and his evidence and his mission, his model — the Collaborative and Proactive Solutions model. His website *livesinthebalance.org* talks about his model. He has a checklist, the Assessment of Lagging Skills and Unsolved Problems, which is an amazing tool especially for Tier 1 in RTI, those early interventions. And what the CPS model, Collaborative and Proactive Solutions, does is that it breaks down challenging behaviors into lagging skills and unsolved problems. And when you do that — so a lagging skill would be difficulty transitioning. We have a lot of kids who have difficulty with transitions. The unsolved problem would be more specific, difficulty transitioning from reading recess back to the classroom. When you do that, we start realizing that our kids have a lot of unsolved problems. And it really helps us focus our interventions. The primary focus of the model, and it says right in there, is collaborative. Collaborative is to work collaboratively with the students.

I think we know that as parents that solutions to a problem are most successful if both parties actually agree on the solution. When you've got parents coming down on a kid to solve the problem, usually that's when power struggles happen. You know, if you just impose a solution, the the other person (said child), they may not feel heard and they certainly may not comply with our imposed solution.

Meg: Definitely.

Greg: Yeah. So for autistic children who don't have language, where they're not able to collaborate, that's when we need our clinical reasoning and observation skills to make those informed guesses about what may actually work for the child. So for a kid who you can have a back and forth with, you can very easily, when you subscribe to this model, pull out what the underlying problem is, express your concern as an adult, and come up with a solution together, and have some sort of bargain so that you can move forward. For a child who doesn't have language or can't have that back and forth, I have found it is certainly easy to use our clinical observation skills to try to come up with a solution that both the child and the therapist feel works for everybody involved. I have used this model in entire classrooms, both regular education classrooms, LD classrooms, where you can do what Ross Greene calls in his book, *'Lost at School'*. He'll call it *'Whole Class Plan B',* where you create a community of problem solvers and you all work together to make circle time more efficient to help kids stay on task.

So, first of all, it's an evidence-based approach, but it feels right and I think that's the thing that I love the most about it. Because it is validating and respecting kids, and at the same time it is validating the adult concerns, because that matters too. This isn't just letting the kids do whatever they want. And then collaboratively coming up with a solution to a problem. That just sounds lovely. As opposed to, *"Do what I say or I'm moving your clipper,"* taking away a privilege.

Meg: It does. It's a much better life skill. If our goal isn't to teach children to turn into compliant adults, we want them to turn into thinkers and problem solvers because that's the people we need in this world.

Greg: Yes.

Meg: Even the language that you use or that is used in the book, lagging skills and unsolved problems, that automatically shifts how I look at a problem from a challenging behavior,

which frames it as there's something that kid is doing wrong, to something that we can work together to figure out. You teach lagging skills, you solve unsolved problems. I love the effect of that shift in language.

Greg: And OT's teach skills. We're talking about behavioral challenges, and again, we're talking about transitions and some of these self-regulation skills, are skills that need to be taught. When you teach those skills, behaviors improve because again, going back to Ross Greene's mindset, *"Kids do well if they can."* That's the other soundbite that he uses, and I love that kids do well if they can, because every kid ever in the history of the world would prefer to do well because doing well always works out better for them than doing poorly. So when you talk about these lagging skills, you're just saying that that child is having a hard time, and that implies helping them which is what we're all about. The heck with looking at just the behavior. They're having having a hard time — help them!

Meg: I feel like that's the shift we are here to hear. When OT's are going, *"What is my role here? Should I learn behavioral strategies? I don't know what to do when I write a behavioral goal,"* and you're saying, *"Yes, you do, actually."*

Greg: Yes, you do.

Meg: 'Cause you know how to be a detective and learn about a child, and teach them new skills, and that is how you address a behavior or rather a lagging skill and unsolved problem.

Greg: I can trigger an entire profession by saying we're better behavior analysts that behavior analysts. Just gonna leave that out there.

Meg: I'm glad there's no comments section on my podcast.

Greg: Close the comments! [Laughs]

Meg: Alright. So if we are to leave behind some of these compliance-based behavioral strategies, are there any other interventions that you want to put on the table for us to use instead?

Greg: You know, I'm super proud to be an OT. And OT is still OT. So occupation should still go at our practice, including play. One thing I will say is that there's a lot of literature about data driven decision making, and how the data should drive our interventions. Now data is important. It is vital for our survival as a profession, but it has to be good data. And I think that's one of my frustrations with ABA and some of the behavioral approaches, is that they're very good at taking data, but is it the right data? So I feel that before we start talking about data, we have to have that strong relationship with the child based on trust and safety. I would say that a relationship-driven decision making model should precede a data-driven decision making model. Now I get that OT's feel the pressure every day to get the data, do the activities, get at those IEP goals. What I would say to them is not only staying true to the profession and OT and occupation — slow down.

That if you take the time to build that relationship in the beginning, you're gonna get the outcomes that you want, and you're probably going to get them faster than if you just jumped right in with trying to kind of circle within a quarter inch of the boundary 80% of the time. And, you know, forcing the kid to do it and doing that over and over and over again — compliance is not the goal. If you start with the relationship first and just stay true to OT, we're going to do fine, and we're going to do amazing things for these kids.

Meg: I love that advice to slow down because, like you said, the relationship should be the foundation for everything if we're working directly with the kid. But also if we're moving

more slowly and feeling less anxious to perform, especially for people who work in a clinic or home with parents who feel the need to show that they are doing therapy really quickly. I think this happens especially for newer therapists. We might have some anxiety about, *"Do I know what I'm doing?"* but when they slow down, and when we slow down, we can actually learn from the child because we aren't the expert on the child. Even if you're an expert on whatever intervention you've learned, you don't know anything about the child until you give them the opportunity to teach you. So I love that advice to slow down.

Greg: Yes. And I love talking to parents in the heat of the moment. And it's been really fun as we've all dove into this Telehealth platform to have parents right there and explain to them, *"Oh, did you see that? Did you see how we use that hand? Did you see — oh, he's not looking right now,"* and to to kind of walk them through clinical reasoning when they just see their child performing and they can they can hear our brains working. Use that as a validation tool, that you actually are using your clinical reasoning skills as you're completely fascinated watching this child just do.

[Intermission begins]

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[Intermission ends]

Meg: So I want to ask you one last question. People listening today might be kind of grappling with, *"What am I doing? What should I be doing?"* If there was one change you'd like to see OT's make in their clinical work with autistic kids, what would that one change be?

Greg: You know, it kind of goes back to what we were talking about before. Be an OT. Don't drink that behavioral Kool Aid. Don't just conform to behavioral approaches and Skinner because that's what's all around you. So for example, when you pick a kid up and it's your time and it's your session, and they hand you that box of chips or M&M's or tokens. Say, *"No, thank you. I don't need them."* Offer them an alternative, and explain to them what worked for you, and how you were able to keep him on task, and have him engaged in the activities. Explain to them how you had success with the child and don't just feed into the food rewards.

And if they push, push back and offer that alternative. A more compassionate evidence-based alternative. So my biggest advice to OT's is, just be you. Don't try to be them. Don't be afraid to have professional debates. Keep it respectful. Keep your job. Also keep asking, *"Why?" "Why is he attention seeking? Why do you think he's avoiding this work?"* And, you know, don't just settle for those canned phrases. Push. You're helping a kid. Go for it.

Meg: That is such wonderful advice, and one of the best things about it is everybody who is working as an OT already has the tools to do that. They don't have to get a new certification or take a new training, they can do that right away. That's awesome. Okay, tell us where we can find you online.

Greg: I'm right here! Well, the easiest and quickest way to find me is Facebook because that is easiest for me. I can throw something out there really fast. So my Facebook page is Power Play Pediatric Therapy. My website, *powerplaytherapy.com*, has a blog where I tell some stories. There's also a really cool handwriting resource on there if you go

digging, there's my little teaser. And then there's a webinar I have coming up for parents that will be posted on the Power Play Pediatric Therapy Facebook page that I'm doing with Tina Payne Bryson actually, she's one of the speakers, also the co-author of *'The Whole-Brain Child'*. So Facebook, my website, message me. I'm around and I love talking shop.

Meg: Awesome. And I'll link to everything in the show notes as well. Thank you so much, Greg.

Greg: Thank you. Fantastic talk.

[Ending music]

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