Control of Access to Sensory Stimulation at a Partial Hospitalization ABA Clinic

There is an increasing understanding that people with autism process sensory stimuli differently from their neurotypical peers, supported by both scientific studies and autistic lived experiences (Clément et al.). Applied behavioral analysis Therapy (ABA Therapy), the most widely practiced form of autism therapy, often seeks to modify these sensory sensitivities and "extinguish" negative self-stimulatory behaviors. However, interviews with previous ABA patients conducted by UCSF reveals criticism of how therapy restricts access to regulatory behaviors and does little to help patients manage overstimulation (Gardner). While there are many studies from a cognitive psychology lens affirming sensory focused behavior interventions and emerging disability studies research studying long term effects from prior patients of ABA therapy, there are few ethnographic studies from within the ABA clinic setting. This ethnography studied how a partial hospitalization ABA clinic dictates access to sensory stimulation for patients. The main aims were to determine what sensory stimulation is allowed, gated or denied for the patients and hypothesize on the underlying methodology dictating these splits. Focus was also paid to the methods by which access is controlled and how patients responded or adapted to this environment. The ethnography was conducted over the course of four weeks at the ABA clinic site, with observations such as a catalogue of the toys available during free play time, specific cases of explicit control of sensory input from therapists, patients' self stimulatory behaviors and how therapist responded to them, and directed patient protocol. I used a neuroaffirmative lens to assess how therapists support the expressed needs of patients. Preliminary findings show considerable restriction in sensory access. Toys are often hard wood or plastic, offering little deep pressure, tactile or kinesthetic input. Therapists push for functional, imaginative play and dissuade more simple, repetitive actions which may provide soothing sensory regulation.

Sensory toys such as stress balls, putty or plushies are not readily accessible and are only used during therapist-led activities or as rewards for positive behavior. Self-stimulatory behavior such as putting fingers in mouth, looking at lights, babbling or flapping arms is often corrected quickly with a verbal prompt or physical prompt. Categorization of acceptability often falls outside what is harmful or helpful for the wellbeing for the child but rather what is more socially unacceptable. Lastly, there is a new patient which has specific sensory preferences such as leaning on adults and tickles. Particular attention has been paid to how sensory input is often spontaneously provided to him during free time or structured time, an anomaly among other patients. This ethnography further lends understanding to how ABA therapy enforces normativity and corrects superficial behavior without addressing the underlying sensory needs of patients. It demonstrates how neuroaffirming therapies should be accepting of self-stimulatory behavior and provide ample opportunities for patients to express and fulfill their needs.