

The *Listening* Leader

A Program Review Capstone

By: Olubusayo Ola Ajayi

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Program Advisor: Eve Rifkin, Ed.D.



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Dedication

This Capstone is dedicated to my heart, Abimbola Ajayi, my anchor, forever love. None of this would be possible without your unwavering strength, support, and love. Moreover, to my two miracles, my rainbows,—Ayotunji and Simisayo—my heartbeats, I hope you know you three and the rhythm you have created keeps me moving, and I will always love you, always...always.

The reasons I breathe.

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Executive Summary

This capstone was focused on reviewing the Helping Hands Family Autism Services (HHF) new pilot leadership program, which aimed to strengthen the dyadic relationship between Board Certified Behavior Analysts (BCBAs) and Registered Behavior Therapists (RBTs). In January 2025, Helping Hands Family launched a pilot leadership development initiative to enhance the competencies of BCBAs in two focus areas: active listening and trust-building. The program encompassed two training modules: "Rapport Building with RBTs" and "The Feedback Loop." Furthermore, it integrated five principal components: training, competency assessment, knowledge transfer, assessment, and a 45-day follow-up. These foundational elements were anchored in two central tenets: the cultivation of trust with RBTs and the provision of targeted feedback to RBTs, to enhance both retention rates of RBTs and growing client outcomes.

Theoretical Foundations and Framework

The program was designed to leverage the work of Leblanc et al. (2016, 2020), conceptualizing the role of a BCBA not only as a clinical supervisor but also as a mentor. The program aimed to shift the traditional supervisory model from a task-centric, top-down approach to one that focused on high-quality relationships. This paradigm shift was reviewed for this capstone using a program evaluation method with a modified Leader-Member Exchange (LMX) framework (Lloyd et al., 2015), emphasizing listening quality, supervisory satisfaction, job satisfaction, and retention as key outcomes. Listening was defined as active empathetic listening, and trust was reviewed through the actions that create psychological safety and measured with higher satisfaction with the supervisor, job satisfaction, and improved retention outcomes.

Methodology and Evaluation

The evaluation of the program utilized a modified conceptual framework based on Lloyd et al. (2015), positioning listening quality as the independent variable. The dependent variables included job satisfaction and satisfaction with supervision, with retention of Registered Behavior Therapists (RBTs) as the outcome. The

evaluation utilized a mixed-method approach, combining quantitative surveys and qualitative interviews to gather comprehensive data on the program's impact. The study involved four clinics, with two serving as intervention sites and two as control sites.

Capstone Program Evaluation Questions

- How does the improvement of listening quality among BCBAs influence the RBTs' satisfaction with supervisors, job satisfaction, and their retention at Helping Hands Family?
- How do RBTs describe the role of BCBA listening quality in fostering trust and influencing their satisfaction with their supervisor and overall job experience?
- Based on the findings from Questions 1 and 2, what can Helping Hands Family do to enhance the program to develop listening leaders?

Data Collection and Analysis

- Quantitative Surveys: Pre- and post-intervention surveys were administered to both BCBAs and RBTs to measure changes in listening quality, supervisory satisfaction, job satisfaction, and retention rates. Statistical tests were used to compare pre- and post-intervention survey results, examining the relationships between listening quality, supervisory satisfaction, job satisfaction, and retention.
- Qualitative Interviews: In-depth interviews were conducted with RBTs and BCBAs to gather detailed insights into their experiences and perceptions of the program. Thematic analysis was conducted on interview transcripts to identify key themes and patterns related to the program's impact on listening quality and supervisory relationships.

These methods provided a comprehensive understanding of the program's effectiveness and informed the recommendations for enhancing the development of listening leaders at Helping Hands Family.

Key Study Findings

- **Finding 1: Listening Quality and Supervisor Satisfaction:** Enhanced listening skills among BCBAAs resulted in higher RBT satisfaction with supervisors in the Intervention Clinic. Partial or inconsistent implementation hurts outcomes.
- **Finding 2: Listening Quality and Job Satisfaction:** Listening quality had only an indirect effect on overall job satisfaction. Factors such as compensation and peer relationships played a more significant role in RBT satisfaction. Positive supervisory relationships contributed to a reduction in turnover at the Intervention Clinic. However, job satisfaction and retention were influenced more by peer support, mental health, and compensation than by supervisory behavior alone. Partial completion led to feelings of inauthenticity among BCBAAs and eroded the trust that had been built.
- **Finding 3: Peer Relationships and Growth:** Strong coworker support increased job satisfaction, especially when supervisory engagement was limited. Opportunities for professional growth and involvement in clinical practice and care design were associated with increased engagement and lower reported intentions to turnover among RBTs. Peer relationships facilitate sensemaking processes and can have a direct impact on organizational culture and employee retention.
- **Finding 4: Overall Role of a Leader:** Leadership influences organizational culture and peer relationships more significantly than directly affecting job satisfaction or retention. Sensegiving is crucial, for example, in fostering team coherence and building culture.
- **Finding 5: Perceptions of Compensation and Workload Impact:** Team satisfaction and retention are highly influenced by compensation and workload, highlighting the need to address these perceptions separately in engagement efforts.

Recommendations

The capstone establishes that cultivating listening and trust-building as core competencies among BCBAs influences the satisfaction with the supervisor and has an indirect role in job satisfaction and retention of RBTs at Helping Hands Family. Therefore, the recommendations are summarized below:

- **Recommendation 1: Reconfigure the Learning Framework to be Competency-based:** Transition from a role-based framework to a competency-based model, focusing on competencies such as listening quality, supervisory satisfaction, trust-building, and sensegiving.
- **Recommendation 2: Institutionalize Peer Communities of Practice:** Establish structured peer-to-peer networks to enhance knowledge dissemination and mutual support.
- **Recommendation 3: Ensure Full and Consistent Implementation of Leadership Programs:** Establish and enforce a fidelity protocol to ensure initiatives are executed as intended.
- **Recommendation 4: Expand Key Leadership Behaviors Organization-Wide using the Intervention Clinic as a Model:** Use the Intervention Clinic as a blueprint for institutionalizing essential leadership competencies.
- **Recommendation 5: Redesign Workload Systems to Match Motivational Drivers:** Implement a motivation-informed approach to workload and role clarity, incorporating input from RBTs and BCBAs into compensation and recognition programs.
- **Recommendation 6: Institutionalize Listening as a Competency Across Clinical Operations for Habit Forming:** Establish systematic structures to facilitate the habit-forming nature of listening skills.

Introduction

*“When I have been listened to and when I have been heard,
I am able to re-perceive my world in a new way...”*

- Carl Rogers (1980)

Patients need to feel heard by their providers, who, by employing good listening skills, can understand the information conveyed and subsequently diagnose and treat the patient effectively. To manage and treat patients, healthcare providers must carefully listen to both verbal and non-verbal signals, ensuring accurate diagnoses and appropriate interventions are created and executed. I would emphasize that a similar relationship between attentively listening to nonverbal and verbal cues also extends to the dyadic relationship between a supervisor and a supervisee. The research indicates that the same listening skills are associated with improved relationships among healthcare professionals (leaders and subordinates), resulting in better outcomes and greater patient satisfaction. (Bletscher & Lee, 2021; Lun et al., 2008; Simmons, 2011). Scholars of listening in leadership state that caregivers experiencing burnout or grappling with the challenges of caregiving tend to exhibit greater resilience, rather than succumbing to depression, anxiety, and fatigue, when their experiences are acknowledged and action is taken (Jonsdottir & Kristinsson, 2020). The research reveals a direct link between listening and trust-building, highlighting one of the essential actions that leaders must undertake to create environments conducive to employees' flourishing.

More recently, McKay and Dandorff (2024) investigated the significance of listening as a fundamental component for creating environments where employees feel psychologically secure, valued, and acknowledged. They emphasize that leaders with strong listening competencies are pivotal in mitigating burnout, job dissatisfaction, and operational inefficiencies through active listening and fostering an atmosphere where concerns can be openly discussed and promptly addressed (McKay & Dandorff, 2024). Therefore, leaders who engage with their team's concerns through active, empathetic listening (Bodie et al., 2012) are more likely to cultivate trust, promote collaborative environments, motivate team members to express their concerns, and partner in process improvement. These leaders are perceived by their subordinates as competent and engaged, which then moves the subordinates to

collaborate with others through self-motivation (McKay & Dandorph, 2024; Wefald, 2022; Bodie et al., 2012; Gearhart & Bodie, 2011). As healthcare organizations face challenges in care quality and patient outcomes, nurturing supportive, trust-based, and listening-oriented leadership environments is essential to sustain staff engagement and achieve organizational objectives with high-performing teams. An engaged workforce supports workforce stability, care continuity, and better patient outcomes.

This capstone focused on listening as a leadership competency and how programs that train this competency in leaders can influence key factors, such as trust, satisfaction with one's supervisor, and job satisfaction, which could lead to retention.

Meet Helping Hands Family – Autism Services

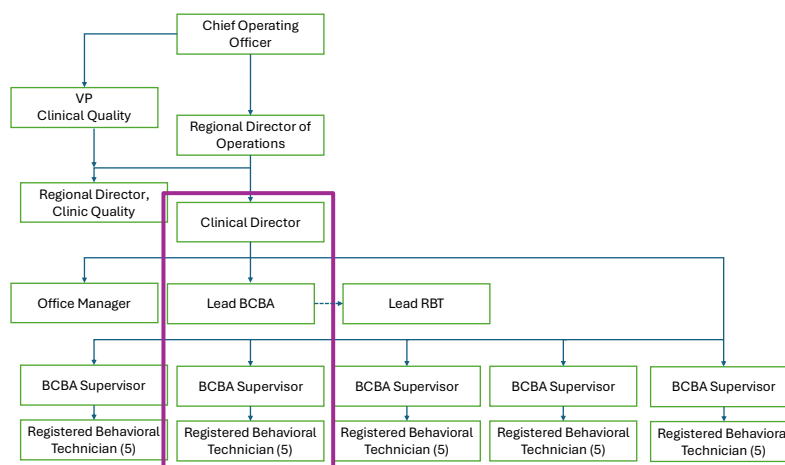
Helping Hands Family -Autism Services (HHF) is a for-profit, mission-driven organization that provides applied behavior analysis (ABA) therapies for children diagnosed with autism spectrum disorder (ASD). Established in 2019, HHF began at the height of the pandemic with the mission of changing the lives of children with ASD. HHF delivers services in client homes, in schools, childcare facilities, or HHF-owned and operated clinics. HHF's service delivery model relies on a highly trained, licensed, and well-supported workforce of Board-Certified Behavior Analysts (BCBAs) and Registered Behavior Therapists (RBTS). HHF aligns its structure with the Council of Autism Service Providers (CASP) guidelines, where an RBT handles the day-to-day delivery of ABA therapy under the supervision of a Board-Certified Behavior Analyst (BCBA).

As of January 2025, HHF is the leading provider of ABA therapy in Pennsylvania and one of the top providers of ABA therapy on the East Coast. It owns over 40 clinics in Pennsylvania, New Jersey, New York, Connecticut, and Maryland, and has over 1,000 clinicians. The HHF team members are deeply committed to the mission of “we change lives” of children with autism spectrum disorder

(Helping Hands Family Autism *Employee Handbook*, p. 2). The HHF leadership framework was built on the principle of “take care of the clients, take care of the team, and the business will take care of itself.” At HHF, each clinic location is headed by a clinical director who reports to a regional director of operations. Within the clinic, the clinical director is the highest clinical authority and manages up to six BCBA’s, depending on the size of the facility. Each BCBA supervises five to six RBTs when a clinic is fully mature. The clinical directors operating each clinic are BCBA’s with both operational and clinical experience. Figure 1a illustrates the regional structure, with the outlined box representing the focus of the Capstone.

Figure 1a

HHF Field Org. Structure



Note: The HHF field organizational structure, including the clinic's core team, is outlined in the purple box.

Fali Sidhva has served as the Chief Operating Officer for Helping Hands Family for the last five years. Under Sidhva's leadership, HHF has experienced significant growth in its operations. With over thirty years of experience steering and expanding successful healthcare organizations, Sidhva posits that establishing a strong organizational culture is fundamental to the success of any healthcare institution. He emphasizes that effective leadership is instrumental in fostering strong cultures and has consequently

invested considerably in leadership development initiatives at HHF. Jeanine Weichelt, serving as Chief Clinical Officer (CCO) and a member of the executive leadership team (ELT), possesses over 20 years of experience as a clinical and operational Board Certified Behavior Analyst (BCBA). Sharing Sidhva's commitment to leadership development and clinical excellence, Weichelt has brought renowned ABA leadership theorists and trainers, such as Tyra Sellers, JD, and Dr. Linda LeBlanc, to provide specialized training for clinical directors and BCBAs over the past two years, along with facilitating round tables and conferences to improve leadership engagement and performance at the clinic level. In addition to offering in-person leadership development training, trainers hosted monthly book clubs to enhance leadership skills with BCBAs. Jeanine's team oversees all clinical and operational training for the organization. Andrew Koczo is the Chief Financial Officer (CFO) with over a decade of experience with Fortune 100 companies and startups. Koczo has been instrumental in supporting the organization's investment in leadership development programs, allocating budgetary resources, and actively participating in the design and implementation of training initiatives. These three individuals comprise the executive leadership team (ELT) of HHF. As the organization has grown, so has the leadership team. HHF's senior leadership team (SLT) has expanded to include functional leads reporting to these core team members.

My journey with Helping Hands Family Autism Services began in 2023, when I transitioned from working at my firm as a principal leadership and HR strategy consultant to becoming an in-house VP of People Operations (HR). I recognize that my connection to HHF in my professional role may introduce bias into the study. To address this, I identify potential areas of conflict or insight during the evaluation process and throughout the study, detailing the steps taken to mitigate my influence and any potential bias. I have maintained a journal to document my interactions and personal reflections, which I hope will provide valuable insights while fostering a constructive and neutral perspective on my work.

Introduction to Applied Behavior Analysis (ABA)

Applied behavior analysis (ABA) is a scientific approach, grounded in the principles of behaviorism, that focuses on understanding and modifying the behaviors of children with autism through systematic techniques and interventions. (Roane et al., 2016). ABA effectively supports individuals with autism spectrum disorder (ASD) to develop essential skills across communication, social interaction, and daily tasks (McCabe et al., 2023). In essence, ABA methods involve breaking down complex behaviors and using data-driven analysis to monitor progress and make necessary adjustments, enabling the client to modify their behavior and develop coping and social skills. (Brodhead et al., 2022).

The Council of Autism Providers (CASP) represents the autism community across the United States. It serves as the primary governing body that establishes standards of practice. According to CASP (n.d.), ABA therapy is delivered through a tiered service-delivery model, in which the Board-Certified Behavior Analyst (BCBA) designs and supervises a treatment program provided by the Assistant Behavior Analyst (BCABA) and or Registered Behavior Therapist (RBT). Although BCBA and RBTs are designations rather than specific careers, I will refer to behavioral analysts as BCBAs and behavioral Therapists as RBTs to differentiate between the two levels throughout this capstone document.

BCBAs

The BCBA is a master-level trained behavior analyst responsible for assessing the client's needs, designing an individualized intervention plan, and overseeing the work of the RBTs in delivering that individualized plan to the client (Roane et al., 2016). BCBAs regularly use data to analyze clients' progress, ensuring that interventions are effective and making necessary modifications. The BCBAs guide the RBTs in implementing the ABA techniques while maintaining ethical standards (Roane et al., 2016). This collaborative structure is a testament to the interconnected nature of the ABA industry,

where each role is integral to the success of the therapy. In the clinic, the BCBA is the primary supervisor for the RBT.

RBTs

The role of the Registered Behavior Therapist (RBT) is that of a frontline practitioner responsible for implementing Applied Behavior Analysis (ABA) intervention under the direct supervision of a Board-Certified Behavior Analyst (BCBA). RBTs are not analysts with a master's degree; they are behavioral Therapists who have undergone specific training and successfully passed the certification examination administered by the Behavior Analyst Certification Board (BACB). The role of the RBT is of the utmost importance, as they engage in daily direct interaction with the client, providing the hands-on support needed to implement behavior plans consistently and effectively. McCabe et al. (2022) emphasize that RBTs are critical in ABA care delivery. They maintain daily records of their clients' behavior and collect data to assess the effectiveness of the treatment. They also carry out the daily interventions designed by the BCBA to change the clients' behavior and ensure that the client's treatment is documented daily with session notes (McCabe et al., 2022). Due to the nature of the work that RBTs perform daily, research indicates a higher level of burnout and turnover (Aarons et al., 2009), as the role is both physically and mentally demanding. As one HHF RBT described it: *"The kiddos will work you out...you are running, rolling, jumping...it is a physical job. I get my steps every day for sure."*

Journey to Identifying Area of Inquiry for Capstone

The biggest problem that affects most ABA companies is the retention of Registered Behavior Therapists (RBTs). In the ABA industry, high turnover among RBTs, who are the frontline staff delivering therapy, is prevalent, ranging from 45% to 75% year over year (Larson, 2023). Larson (2023) discusses that the labor market's competitive conditions, inflation, and the job itself exacerbate the general retention problem of RBTs. Studies have shown that turnover is often linked to insufficient supervision, high job demands, and lack of career progression,

leading to burnout and job dissatisfaction (Gibson et al., 2009; Aarons et al., 2009). A recent survey conducted by Central Reach Autism and IDD Care Market (2024) revealed that Applied Behavior Analysis (ABA) companies experienced an alarming turnover rate exceeding 109% in the past year, with more successful organizations maintaining a turnover rate of around 40%. The importance of supervisory roles within healthcare settings is critical, as they are intricately linked to employee retention and engagement. According to the Central Reach Autism and IDD Care Market's 2024 survey (n.d.), enhanced supervision of Registered Behavior Therapists (RBTs) was identified as one of the top five key drivers influencing RBT retention. Effective supervision creates a supportive work atmosphere that not only boosts job satisfaction but also fosters organizational commitment among healthcare practitioners. Therefore, the examination of supervisory practices and their effects on employee morale and turnover rates merits ongoing investigation and emphasis within the professional landscape (LeBlanc & Luiselli, 2016; Saunders, 2023; Sellers et al., 2016).

HHF has taken significant measures in recent years to address retention, including reviewing and aligning compensation to be competitive in the market, creating a career ladder for RBTs, and ensuring competitive benefits for mental health, maternity, and well-being, which have been highlighted as important for RBTs in many ABA organizations when not addressed intentionally (Sleiman et al., 2020, p. 309). However, examining how BCBAs supported the development and engagement of RBTs is a new approach for HHF in its retention study. Since 2024, the training and development team, led by Jessica McGlone, has been focusing on enhancing the effectiveness of BCBAs as supervisors.

Upon selecting my current employer as my capstone partner, I recognized the importance of exercising caution to avoid concentrating on areas within my direct purview related to retention. As a core part of my role, my team and I were already engaged in actions to address retention. Therefore, it was essential to identify a program outside my purview that did not overlap with the capstone requirements. During the alignment meeting with Weichelt and Sidhva, we determined that an

evaluation of the newly designed BCBA supervision training, scheduled to launch in January, would be the most appropriate program for this capstone project. This decision was aligned with conducting an assessment distinct from my daily operations while contributing valuable insights to the organization and the field. The program was within Weichelt's group, and I did not possess direct oversight regarding the design, implementation, or the team members accountable for the program of study. Although the program was intended to impact turnover directly, it fell outside the scope of my team's responsibilities.

Area of Inquiry: The New BCBA Training Program

In September 2024, Jessica McGlone, Director of Training and Clinical Development, and Kate Dalcour, Regional Director of Clinical Quality, collaborated with four Lead BCBA's to design a leadership development training program for BCBA's. This program aimed to integrate and address clinical and leadership deficiencies identified at various stages of the BCBA's' journey. I participated in this session and contributed my thoughts, drawing on my background in leadership development. My contributions centered on my recent learning about knowledge transfer, advising that any training or development program should incorporate an assessment and knowledge transfer actions. My participation occurred before I selected HHF as a capstone partner. During the session, the working group delineated a comprehensive framework for all BCBA programs and outlined various training topics. After the initial meeting and after securing approval for HHF as my capstone partner, McGlone and Dalcour advanced the training and program design. This included selecting the clinics and determining the initial sessions to be piloted within the program.

The pilot training courses of the program, titled "Rapport Building with RBTs" and "The Feedback Loop," were delivered in January and March 2025, respectively, and served as the focal point for my capstone program evaluation. These training initiatives were developed by building upon the foundational work of Leblanc, Sellers, and Ala'i (2016). They emphasized the critical role of BCBA's as supervisors and mentors in fostering meaningful connections with their RBTs. McGlone and Dalcour hypothesized that improving the competencies of the BCBA's

would have a link to an increased positive perception of supervision and the supervisor, which ultimately would lead to retention.

At HHF, BCBAs are responsible for RBT supervision. Supervision involves clinical program knowledge of each client's case and daily delivery of program care to the client. According to CASP guidelines (n.d.), BCBAs who supervise RBTs are responsible for training them on the skills necessary to work with clients, including the interpersonal skills, or "soft" skills, required to manage relationships with clients, parents, and the clients themselves (Andzik & Kranak, 2020, p. 26). Supervision is “...*immediate oversight over the training, work activities, and performance monitoring of an employee...*” (Leblanc et al., 2020, p. 5) of the supervisee. As noted in this definition, there is a strong emphasis on the relationship between work product and work outcomes. There is a slight mention of a relationship between the BCBA and RBT; however, the definition focuses on the client and the work by the supervisor to manage and support the work for the client's outcome. Leblanc et al. (2020) state that supervisory activities fall into four categories: designing and delivering training, monitoring and evaluating, providing guidance or direction on work, and establishing evaluation and goal setting (p. 6). Therefore, the supervision is focused outward on the client's needs and not inward on the supervisee's needs. BCBA supervision competency directly affects RBTs' competence, ethics, and effectiveness, ensuring that BACB standards are maintained (Sellers et al., 2016; Hajiaghamohseni et al., 2021). Furthermore, the significance of supervision goes beyond just developing skills; it also directly affects the quality of services delivered to clients, which reflects the field of behavior analysis (DiGennaro Reed & Henley, 2015; Sellers et al., 2016).

While the majority of the literature on ABA supervision by BCBAs is focused on the knowledge attainment to meet the needs of the client, recent scholars like LeBlanc et al. (2020) have begun to discuss how supervision relationships through mentoring can facilitate stronger supervisee bonds (pp. 3-64), leading to better care delivery. Their work was likely the most substantial literature on relationship building, although it was examined from a mentor-mentee perspective. LeBlanc et al. (2020) examined the mentor-mentee relationship between supervisors

and RBTs, highlighting its role in developing future BCBAs and enhancing client care quality. Building on this idea, HHF partnered with Linda Leblanc, Ph.D, in 2024 to train all BCBAs as mentors in their supervision relationship.

RBTs and client success at HHF rely heavily on the professional skills they acquire from their theoretical training, provided by HHF, and the hands-on, daily on-the-job training, feedback, and evaluations from their BCBA supervisor (Andzik & Kranak, 2020, p. 26). At HHF, the theoretical training for RBTs is 10 days of onsite asynchronous and synchronous training modules. After these 10 days of individualized learning, RBTs meet a BCBA who conducts a competency evaluation. This BCBA may not ultimately be their primary BCBA supervisor; however, in order to ensure that the RBT is competent to deliver care, an evaluation is completed within fifteen days of hire. While the competency evaluation is occurring, RBTs are "paired" with the appropriate client, overseen by their BCBA supervisor, for on-the-job skill development. In pairing a client with an RBT, Sellers et al. (2016) described this as establishing a positive relationship to increase engagement in the learning process, directly impacting the care delivery for a client (p. 301). The initial meeting between the RBT and their BCBA supervisor at HHF is during the first shadow and pairing meeting, where the RBT observes how to deliver the program to the client. Once cleared to be competent, the assigned BCBA supervisor trains the RBT on the program for the client and evaluates the RBT on time management, organizational, and interpersonal skills, and how to deliver the program modification designed by the BCBA supervisor (Andzik & Kranak, 2020). The BCBA, throughout the client's care, will make modifications to the program, evaluate if the RBT is delivering sessions appropriately, and oversee the client's program. The pairing relationship has historically and in literature focused on the needs of the client and the RBT acquiring the skills to "take care of the client...". A review of ABA studies discusses supervision through competency-based models that set measurable benchmarks for supervisee development, prioritizing task review, feedback, and problem-solving support over interpersonal connection-building (Falender & Shafranske, 2010; Danzi et al., 2019). These competency-based models ensure that BCBAs play an essential role in providing

continuous feedback on performance, fostering ethical decision-making, and enhancing cultural competency in care delivery (Falender & Shafranske, 2010; Kuhne et al., 2019).

The primary distinction between research on supervisor-supervisee relationships and BCBA-RBT relationships lies in the underlying objectives of these relationships. Scholars examining supervisor-supervisee dynamics in healthcare have concluded that such relationships must extend beyond mere occupational interactions. They emphasize the necessity for supportive, high-quality interactions that focus not only on improving job performance but also on fostering a sense of support for the supervisee (Kariuki et al., 2023; McGrath et al., 2022). BCBA-RBT relationship scholars investigate methods to strengthen the dyadic relationship by enhancing self-awareness and improving communication between BCBAs and RBTs, thereby improving client care (insert authors), and making these interactions more transactional and task-focused. McGlone and Delcour advocate for a transformation of the relationship between the BCBA and RBT towards a model that emphasizes relational dynamics.

Figure 1f.

BCBA Leadership Development Training Framework at HHF



Note: Each course in the training program must have all five elements in place prior to the launch of training. This would enable knowledge transfer (Thompson, Gentner, & Loewenstein, 2000), peer support (Martin, 2010; Argote & Ingram, 2000), and ongoing assessment for continuous improvement (White et al., 2011). All areas that reinforce the tools provided during the training

In this proposed framework, interactions are not exclusively geared towards serving the client's interests but also aim to provide reciprocal benefits to the Registered Behavior Therapists (RBTs). Hence, the program's focus is on building trust and listening competencies for BCBAs.

HHF's Pilot Training Program Methodology

According to the Central Reach Autism and IDD Care Market Data Report of 2024, turnover among Registered Behavior Therapists (RBTs) remains a significant challenge for companies providing Applied Behavior Analysis (ABA) services. Top-performing ABA organizations indicate that a critical factor in retaining RBTs is enhanced supervision, which is achieved by fostering strong relationships between RBTs and their Board Certified Behavior Analysts (BCBAs) (insert citation). McGlone and Dalcour sought to evaluate the influence of BCBA training on the quality of BCBA supervision by incorporating the perspectives of RBTs on supervisor listening and rapport building. For them, it was important that the training have an impact and improve the retention of RBTs while enhancing the clinical practice of BCBAs. They established control and intervention groups identified by the clinics where the participants worked. The clinic selection criteria included the number of BCBA supervisors, total RBTs, the number of clients served (and case severity/load), and RBT turnover rate. Additionally, the average caseload and the number of clients assigned to each BCBA were reviewed as part of the selection process. McGlone and Dalcour were keen to ensure that the average caseload was comparable at the program's outset. The four chosen clinics were Clinic A, Clinic B, Clinic C, and Clinic D, each having at least five BCBA supervisors at the program's start. The BCBAs in Clinics A and C were trained, while the BCBAs in Clinics B and D were not trained.

All Registered Behavior Therapists (RBTs) and Board Certified Behavior Analysts (BCBAs) from both sets of clinics completed surveys regarding supervision and the dynamics of the supervisee-supervisor relationship before the training program designed by McGlone and Dalcour. McGlone and Dalcour distributed a survey to the team members of each targeted clinic to evaluate the nature of the relationship between BCBAs and RBTs. The first

survey was sent prior to the initial training of BCBAs on “Rapport Building...” and was completed by both BCBAs and RBTs between January 6 and January 17, 2025. I decided to leverage the surveys conducted by McGlone and Dalcour and map the questions to the capstone conceptual framework. The second training, “The Feedback Loop,” was delivered in March 2025, with the post survey sent to BCBAs and RBTs in April 2025 for completion by April 19, 2025.

Table 1

Table of clinics selected and demographic information at the initial start of the study

Criteria	Clinic A	Clinic B	Clinic C	Clinic D
# BCBAs	5	5	5	5
# RBTs	31	25	28	35

Note: Clinics designated in blue indicate the intervention site, while those without highlighting serve as control sites. It is important to recognize that a reduced client count does not inherently correspond to a decreased workload; in fact, fewer clients may reflect cases of greater complexity or severity. The partner organization undertook a comprehensive demographic analysis encompassing case volume, client acuity, productivity, and utilization to confirm that the selected clinics were matched as closely as possible in relevant demographic characteristics.

HHF Training Course

In January, McGlone led the first of two sessions with BCBA supervisors in two small cohorts of 5 each. Trainings were held in their clinical locations to ensure they were comfortable and could return to the work day post-training. Both clients." McGlone then inquired of the cohort to express how they described their RBTs. In both classes, site clinical directors attended the training as well. *See Appendix A for the Rapport Building training slides.* During the training, McGlone asked the BCBAs, "How do you describe your clients?" The BCBAs in both training classes indicated that they refer to their clients as "my none of the BCBAs described their RBT as “my RBT” rather described them as “the RBT”, “RBT”, “Tech”, or “the Therapist”. In a debrief with the clinical director of Clinic A, she remarked, “That was eye-opening for me because I have never referred to the RBTs as mine, even as a clinic director.”

The initial training course, led by McGlone, focused on applying clinical strategies as outlined by Leblanc et al. (2020) to enhance rapport with the Registered Behavior Therapists (RBTs). Participants were encouraged to practice active listening and trust-building skills during the subsequent two months. Key actions prescribed to Board Certified Behavior Analysts (BCBAs) included:

- Beginning meetings by inquiring about the RBTs personally and prioritizing their concerns before discussing client-related matters.
- Setting a clear meeting agenda and ensuring the RBTs are aware of it before diving into discussions.
- Placing the computer aside to maintain direct eye contact and focus on the RBTs' narratives.
- Demonstrating empathetic listening by asking probing questions and seeking additional context without immediately problem-solving or triaging issues.
- Taking notes during discussions and summarizing key takeaways for the RBTs at the end of the meeting to ensure accurate capture of themes.
- Providing RBTs with opportunities to give clinical feedback without correcting them, thus involving them in client diagnosis and treatment planning.

I had the opportunity to attend one of the final two trainings in March, where McGlone introduced the concept of providing feedback. Before discussing feedback, McGlone asked the BCBAs to provide feedback on whether or not they felt there was improvement since implementing the active listening and trust-building skills. Several participants provided examples, such as not bringing the laptop into supervision sessions or lowering the laptop screen to maintain direct eye contact with the RBT, which had improved their ability to build a connection with the RBT. One BCBA in Clinic A mentioned:

“I would tell my RBT when I needed to take notes, then once I was done, I would set the computer aside so she knew when she was talking to me I was fully engaged, and she remarked that she felt I was listening to her better.”

Dalcour, who was present, noted that even she sometimes forgets to look up when she is focused, emphasizing the importance of bringing one's whole self to the discussion and making eye contact a priority in discussion.

In the Feedback Loop course, McGlone reminded the team that RBTs are new to the field and that BCBAs should always communicate with them in simple terms to avoid making them feel condescended to or, worse yet, incapable due to complex terminology. Other points that McGlone made were around the bidirectionality of communication and how essential it was for clinic directors to invite RBTs to provide them with feedback on how they are doing, how the program they designed is working for the client, and seek areas of improvement. In doing so, it would require the BCBAs not to take personally what is said, but rather to apply their training as analysts, as this is data gathered to make improvements. In the Feedback Loop course, McGlone emphasized that BCBAs should communicate simply with RBTs to avoid belittling them. She stressed the importance of bidirectional communication, encouraging feedback from RBTs on performance and program effectiveness. This feedback should be seen as valuable data for improvement, not personal criticism. McGlone incorporated research into her training and discussed the importance of high-quality dyadic relationships. These concepts will be further explained in the conceptual framework section of this capstone. McGlone was impressed by the research around LMX and felt analysts responded well to grounding the competency development program in research. Each clinical director evaluated their BCBAs' interactions after 45 days post-training, coaching them on improvements and progress. This data was collected over four months for program evaluation and provided to me for this study.

HHF Stakeholder Discussion

I felt it was important to highlight the program's effectiveness, which had a broader impact beyond the RBTs. Bryson and Patton (2015) explore various stakeholder categories: primary, secondary, tertiary, implementation, and decision-makers. Understanding the roles of these stakeholders aids in shaping discussions, determining project progress, identifying whom to engage, assessing the project's impact, and framing its scope of work. The evaluation sponsors and decision-makers for this capstone project include Jeanine Weichelt, Chief Operating Officer, who leads the Quality and Training Department and Operations for HHF. Additionally, Fali Sidhva, Chief Executive Officer, serves as the second evaluation sponsor; he was the one who initially asked about what more could be done to assist our RBTs beyond initiatives from People Operations. Other stakeholders are categorized according to Byron and Patton. (2015), along with their direct and indirect impacts (pp 23–24). Review Appendix B for the Table with full Stakeholders and Impact.

Literature Review

This literature review defines two key competencies crucial for the training program's success. The first competency is listening, which is examined both in the context of HHF's training and through the perspective of leadership theory. The second involves defining trust and its role in fostering thriving work environments. Since trust building constitutes HHF's secondary program competency, it is essential to comprehend trust through the frameworks of leadership theory and corresponding literature to provide an appropriate context.

Listening

The study and research of listening in leadership theory was initiated by Rogers et al. (1957), who coined the phrase "active listening," which is a process that includes understanding the speaker's ideas and feelings in addition to their words (p. 6). Carl Rogers (1980), a pioneer in humanistic psychology, added to the study by stating that our perception of the world changes when we listen and feel genuinely heard. More recent studies by Meldrum

(2024) and Bodie et al. (2011) highlight that active listening necessitates complete immersion in the speaker's experience and the suspension of judgment, fostering a deeper connection and enabling meaningful change. In addition, researchers hypothesize that listening is a skill that must be cultivated; leaders do not naturally possess it, and acquiring strong listening skills requires significant effort (Bodie, 2011; Bodie & Crick, 2014; Lun et al., 2008). In supervisor-supervisee relationships, Rogers and Farson (1987) suggest that employees are more engaged in problem-solving when they believe their opinions are welcomed in a constructive environment. Listening as a concept in research emphasizes that a leader's capacity to effectively respond to both verbal and nonverbal cues while maintaining engagement in discussions is pivotal in fostering trust and psychological safety, thereby enhancing the supervisor-supervisee dynamic (Bodie, 2014; Bodie & Crick, 2014; Drollinger et al., 2006).

Listening, therefore, is a fundamental leadership competency that requires deliberate development. Supervisors often encounter substantial demands on their time and focus, which can limit their cognitive resources and hinder their ability to engage in active listening during interactions with employees (Jondsottir & Kristinsson, 2020). Furthermore, there exists a prevalent assumption within the business realm that listening is an inherently natural ability of leaders; consequently, there is a belief that its development as a formal competency is unnecessary compared to other skills (Robinson-Walker, 2013). The findings through research have demonstrated that listening is shaped by biases, assumptions, time constraints, identity, and personal narratives, thereby underscoring the necessity of actively cultivating listening as a competency, comparable to other essential leadership skills (Bletscher & Lee, 2021; Robinson-Walker, 2013; Drollinger & Simpson, 2025).

For the program review, the term "listening" is defined as active, empathetic listening (AEL) (Gearhart & Bodie, 2011; Drollinger et al., 2006). AEL consists of three stages: sensing, processing, and responding (Drollinger et al., 2006; Gearhart & Bodie, 2011). These stages work together to ensure that the speaker feels acknowledged while the listener synthesizes and retains the information, exhibiting verbal and nonverbal engagement. In his 2014 research, Bodie further explored how individuals constructed meaning through listening, presenting it as a dynamic

process influenced by various factors, including social norms. He posited that listening transcended basic transactional skills and should be approached as a matter of depth in relationships. Bodie (2014) referred to this depth one attains through listening as “thirdness,” suggesting that listening creates reality through ongoing interactions. His work has been connected to sensemaking—the process of interpreting and constructing meaning (Weick, 1993)—and sense giving—the effort by leaders or organizational figures to shape how others understood and made sense of things (Gioia & Chittipeddi, 1991). Building on Drollinger et al.'s (2006) findings, Bodie (2011, 2014) developed a valuable model for enhancing listening skills. Leaders who developed AEL cultivated environments where employees felt genuinely heard, leading to enhanced engagement, retention, psychological safety, resiliency, job satisfaction, and overall job performance (Qian et al., 2017; van Quaquebeke & Felps, 2018; Brezenger et al., 2020; Jonsdottir & Kristinsson, 2020). Given the definition of listening by McGlone and Delcour, and the organizational context of HHF, AEL is the definition I used to define listening for the program review.

Trust

Rotter (1967) defines trust as “...an expectancy held by an individual or a group that the word, promise, verbal or written statement of another individual or group could be relied upon” (p. 317). Similar to listening, trust has been studied and researched for several years. Leadership theorists define trust as the willingness to accept vulnerability based on positive expectations of another person's intentions or behavior (Rousseau et al., 1998; Meyer, Le Feber, & Robinson, 2017; Dirks & Ferrin, 2002). For example, in transformational leadership relationships, where leaders exhibit competence, honesty, and consideration for their followers, trust is most evident, resulting in better relationships with subordinates, which drive productivity and organizational outcomes (Islam et al., 2021). Leaders whose subordinates had low trust often suffered from disengagement, team members' poor project completion rates, poor communication, and task delays (Badrinarayanan, 2024, p. 2). According to Kramer and Cook (2004), leaders could damage trust by inaction, acting unethically, communicating poorly, and making grave mistakes without accountability. Dirks and Ferrin (2002) asserted that trust necessitated one party's willingness to act

with integrity, reliability, and goodwill in inherently risky situations (Dirks & Ferrin, 2002, p. 611). The critical components for establishing trust encompass a willingness to exhibit vulnerability in response to another individual's actions (Mayer et al., 1995; Rousseau et al., 1998; Meyer et al., 2017), the capacity to foster a psychologically safe environment that enables others to accept one's vulnerability (Chang & Tang, 2013), and the adept utilization of both verbal and non-verbal communication skills to encourage reliance on one's integrity as a leader (Deluga, 1994). Furthermore, trust necessitates that leaders engage with integrity and ethical conduct, irrespective of external observation (Sabatier, 2014), and maintain a perception of fairness and equity in their interactions with team members (Deluga, 1994).

Cultivating trust involves intentional actions that facilitate both the formation and sustainability of trust. This process is characterized by transparency, empathy, competence, vulnerability, and a commitment to follow through (Sabatier, 2014; Meyer et al., 2017). It requires open communication, acknowledging mistakes, and consistently prioritizing the well-being of employees (Sabatier, 2014; Meyer et al., 2017). The literature emphasizes open communication as a fundamental element of trust-building. Effective open communication requires strong listening skills from the supervisor. Employees' perceptions of their supervisors are heavily influenced by their trust in their leaders, which is shaped by their ability to listen and then take action on their needs (Dirks & Ferrin, 2002, p. 625). It is the taking action that is trust-building, a commitment met with action by the leader. Thus, trust-building within the dyadic relationship creates an environment of psychological safety, ensuring employees feel secure, strengthening the relationship, and driving retention (Kramer & Cook, 2004, p. 45). Trust-building is a continuous process because it is so tenuous to keep and easy to lose. What the literature tells us is that trust-building requires leaders to continuously work at maintaining the relationship through open, honest communication, or what HHF terms as 'The Feedback Loop.' For this study, I will focus on two outcomes that the literature supports: the effects of trust on job satisfaction and satisfaction with one's supervisor.

Link Between Trust, Job Satisfaction, and Satisfaction with Supervisor

Trust is elemental in the dyadic relationship between supervisor and supervisee, and its presence can be evaluated through two critical indicators: job satisfaction and satisfaction with the supervisor. In the context of applied behavioral analysis roles, the research underscores that high-quality supportive supervision builds both supervision satisfaction and job satisfaction (Kariuki et al., 2023; McGrath et al., 2022; Hui et al., 2023). When trust is missing—often due to inadequate supervision, neglect of ethical responsibilities, or overburdening of supervisees—the consequences can be severe, including increased risk of professional misconduct, diminished quality of care for clients, and heightened staff turnover (Sellers et al., 2016). These outcomes highlight how a lack of trust in the supervision relationship erodes the foundational elements leading to job dissatisfaction. Supervisors who perceive their role as a bridge between their work and their team are more likely to create environments of psychological safety, where employees feel heard, respected, and valued—core conditions for fostering trust (Lloyd et al., 2017). These relational dynamics contribute to higher levels of job satisfaction.

In leadership theory, the relational aspects of supervisors being viewed as trusted figures are reflected in how they model autonomy-supportive behaviors, which empower employees to take ownership of their work and promote self-determination (Farr-Wharton et al., 2011). While this can be more challenging in clinical settings, there are elements of the work done in Applied Behavior Analysis (ABA) that require self-determination. Leaders who encourage this not only enhance job satisfaction but also demonstrate trust in their employees' abilities, ultimately contributing to employee retention. Therefore, for this program review, I will measure the effect of trust by evaluating job satisfaction and satisfaction with the supervisors by the RBT.

Capstone Conceptual Framework

This capstone is a program review of the training program piloted in two clinics at Helping Hands Family Autism Services, which included two training courses: Rapport Building with RBTs and The Feedback Loop. These

courses were designed to aid BCBAs in building relationships with RBTs by developing listening and trust-building competencies.

Capstone Program Evaluation Questions

Based on the purpose of developing listening and trust building as competencies in BCBAs, the following questions were explored:

- How does the improvement of listening quality among BCBAs, influence the RBTs satisfaction with supervisors, job satisfaction and their retention at Helping Hands Family?
- How do RBTs describe the role of BCBA listening quality in fostering trust and influencing their satisfaction with their supervisor and overall job experience?
- Based on the findings from Question 1 and 2, what can Helping Hands Family do to enhance the program to develop listening leaders.

In a meeting with the partner organization we determined a mixed-method approach to the program review was warranted for the following reasons:

- Behavioral analysts utilize data to demonstrate the program's impact effectively. Thus, establishing a quantitative connection is essential.
- The partner organization is familiar with programs primarily relying on quantitative feedback. Translating qualitative insights into a structured framework and presenting them quantitatively will significantly enhance support for the program's implementation, provided its effectiveness can be demonstrated.
- As a program reviewer, I emphasized the importance of gathering qualitative data, as there are often unknown factors that may be relevant to the study that a survey alone may not capture.

All these points led to the design of a mixed-method program review capstone.

Conceptual Framework Context

To assess the program, I adapted a listening conceptual framework established by Lloyd et al. (2015). The selected framework needed to include listening as an independent variable because job satisfaction and satisfaction with supervisor depend on leaders' developing listening competence. The Leader-Member Exchange (LMX) framework (Lloyd et al., 2015), which focuses on the dyadic relationship between a supervisor and supervisee, along with methods for measuring its impact, became fundamental in evaluating the program.

What is a Leader-Member Exchange?

Leader-member exchange theory (LMX) began in 1970 with Dansereau et al. exploring how leaders build relationships with their subordinates. LMX is a social exchange theory focusing on bidirectional exchanges between the leader and follower (Graen & Uhl-Bein, 1995). At the heart of an LMX relationship lies the quality of exchanges between the leader and the follower. To understand LMX relationships, it is crucial to categorize them into two main categories: high-quality (HQ) and low-quality (LQ) (Graen & Uhl-Bien, 1995; Gooty & Yammarino, 2013).

HQ LMX is characterized by mutual trust, respect, and support, as leaders and followers engage in open, reciprocal communication that benefits both parties, leading to higher job satisfaction, performance, and organizational citizenship (Farr-Wharton et al., 2011; Graen & Uhl-Bien, 1995; Gooty & Yammarino, 2013). Also known as the "in-group," this relationship occurs when leaders intentionally develop individualized relationships with their followers (Graen & Uhl-Bien, 1995; Gooty & Yammarino, 2013). Those in this group enjoy greater opportunities for autonomy and influence within the organization because they are perceived as higher performing, with more significant commitment and engagement (Graen & Uhl-Bien, 1995; Gooty & Yammarino, 2013). This relationship is viewed positively as a partnership between the leader and follower. As noted, HQ LMX incorporates the bi-directional nature of feedback, trust, trust building, and listening as essential to establishing what appeals to the program that McGlone and Dalcour implemented.

Conversely, low-quality LMX exchanges are showing up as a lack of trust, absence of mutual respect, poor communication, and perceptions of unfairness (Deluga, 1998; Graen & Uhl-Bien, 1995; Liden & Maslyn, 1998; Lloyd et al., 2013; Farr-Wharton et al., 2011; Gooty & Yammarino, 2013). These types of leader-follower relationships are transactional, with followers receiving fewer opportunities for growth or development and exhibiting lower performance, job satisfaction, and organizational citizenship behavior (Graen & Uhl-Bien, 1995, p. 222). Gooty and Yammarino (2013) state that LQ LMX is typically associated with a top-down, formal relationship where leader-follower interactions are primarily task-oriented and directive (p. 918). This group is referred to by Graen & Cashman (1975) as the out-group and maintains a more distant relationship with no bond to the organization. These individuals tend to be on the margins, lacking opportunities for advancement, as they are disengaged and transactional due to limited autonomy and resources (Deluga, 1994).

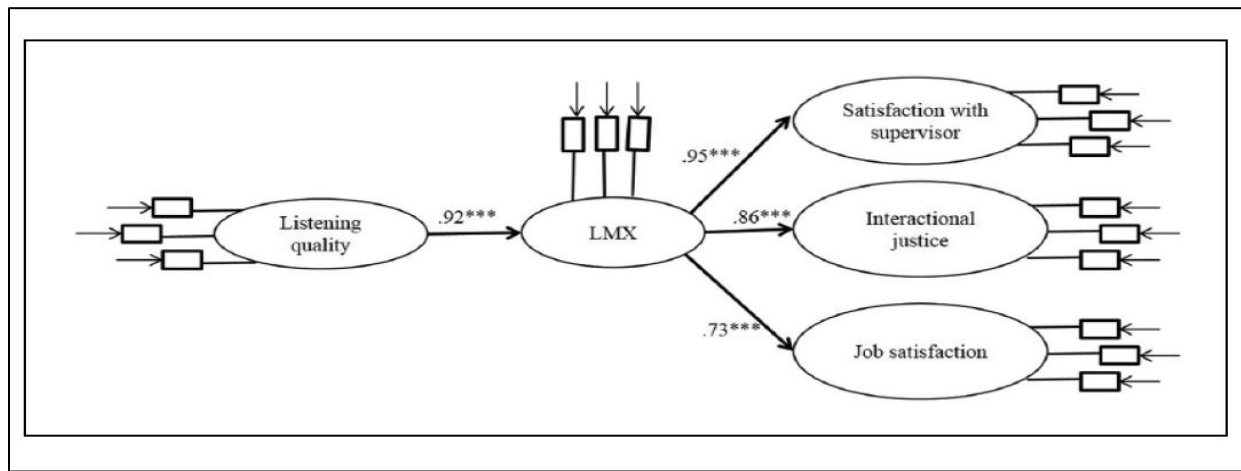
The reason I chose LMX as the conceptual framework is that, given HHF's objectives concerning the newly implemented BCBA program, it was essential to establish a high-quality (HQ) LMX dynamic in the supervisor-supervisee relationship between the BCBA and RBT. Secondly, given that *trust* is crucial in shaping employees' interpretations of leadership behaviors, reinforcing their sense of fair treatment even in challenging organizational times (Kramer & Cook, 2004, p. 41), and is central to the HQ LMX dyad, this framework fits well in the program review for the capstone.

How LMX Supports Listening Leaders

A listening leader, within LMX, is described as one who listens empathetically and utilizes open communication to enhance high-quality LMX (Lloyd et al., 2015, p. 434). Lloyd et al.'s model explores Bodie's (2011) AEL framework by testing the outcomes of listening quality with LMX as the mediator. Proficient listening behaviors enable leaders to understand the needs and aspirations of their followers, providing practical guidance and support for professional development (Lloyd et al., 2015, p. 434). HQ LMX is seen as having increased job satisfaction and satisfaction with supervisor as explored by theorists (Lloyd et al., 2015; Bodie et al.).

Figure 3a.

Lloyd et. al Latent path model of listening effects and relationship with LMX



Notes: Lloyd et al. (2015) assert that scholars' effective listening cultivates trust and mutual respect, essential for HQ LMX (p. 433). They use structural equation modeling (SEM) in Mplus (p. 441), which relates to the outcome variables. The results from the SEM analysis indicate the reported standardized coefficient after controlling for common method factors (p. 443). The rectangles are the measured or observed variables that are assessed as latent variables in the ovals in the model. The single-headed arrows with numbers next to them represent the standardized path coefficients, which indicate the strength and direction of the hypothesized relationship between the variables (Lloyd et al., 2015, p. 443).

For this program review, the relevant leadership conceptual framework needed to be precise, measurable, and well-defined. I sought to underscore the dual foundational objectives of the training initiative: enhancing listening skills and fostering trust. As demonstrated in the research, the elements that show trust are increased job satisfaction, increased engagement, and satisfaction with a supervisor. Dialogues with the client necessitated that the theoretical framework resonate within diverse sectors of the organization, particularly if they opt to engage in ongoing measurements of the program and implement it globally. I updated the framework to investigate the role of *listening quality* as the independent variable and its influence (if any) on job satisfaction and satisfaction with supervisor, which are the primary dependent variables. These outcomes are further examined about the impact they have on retention. While this is a slight modification—removing LMX as a mediator, removing interactional justice, and adding retention as an outcome—it aligns better with the program outcomes than the original by Lloyd et al.

(2015). Refer to Figure 3b for the updated framework. The new model is undergoing both quantitative and qualitative evaluations to assess whether enhancements in listening quality among BCBAs can positively impact the retention outcomes of RBTs. I decided against including SEM concepts in my updated model, as my process is more simplified in its quantitative and qualitative assessment.

The modified framework is representative of program impact theory, as discussed by Rossi et al. (2019), which outlines how a program's activities intended to enhance listening quality in BCBAs lead to social benefits such as job satisfaction, satisfaction with supervisor, and retention. Program evaluations typically use logic models. However, I opted for a conceptual framework as the program under review was a pilot. This framework is akin to the program model design and includes key elements. For an established program needing changes, a detailed model would have been created. However, this program review was a pilot; therefore, the conceptual framework was a better approach for the study. Below are definitions for the modified conceptual framework.

Listening quality (LQ): Lloyd et al. (2015) investigated listening as an essential competency, highlighting the listener's actions in conversations. Serving as the independent variable for my program review, the concept of listening, as proposed by Bodie et al. (2012), highlights behaviors that demonstrate the listener's responsiveness, understanding, and attentiveness to the speaker. Actions during dyadic discourse are making eye contact, nodding, using facial expressions, paraphrasing, and avoiding interruptions, exemplifying listening as a competence (Bodie et al., 2012).

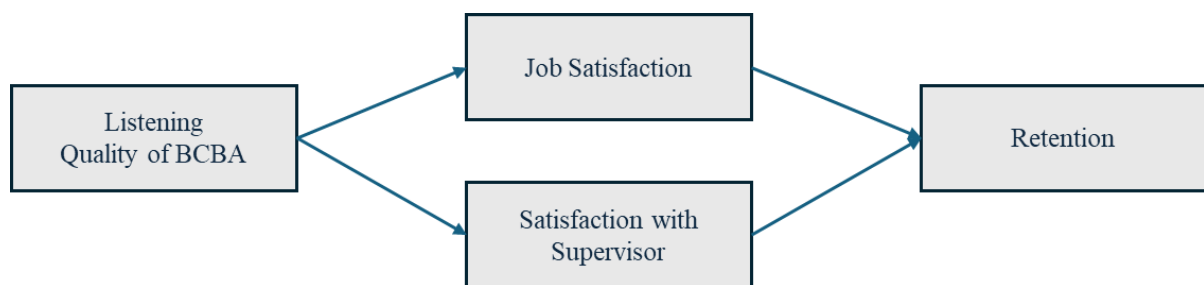
Job Satisfaction (JS): Lloyd et al. (2015) assert that job satisfaction is both connected to and influenced by a leader's ability to engage their supervisees (p. 433). Further research conducted by Gutermann et al. (2017), Saphier (2018), and Feng & Adams (2023) emphasizes that job satisfaction is mainly associated with leaders who are attuned to the emotional and psychological well-being of their team members and who actively participate in discussions aimed at enhancing productivity through the cultivation of trust. In the context of Lloyd et al.'s (2015)

model, the emphasis on job satisfaction pertains to the role that leaders assume within the Leader-Member Exchange (LMX) to promote trust and psychological safety, which in turn contributes to job satisfaction (p. 433).

Satisfaction with supervisor (SwS): According to Lloyd et al. (2017), an employee's satisfaction with their supervisor hinges on how well the leader listens and fosters trust through fair actions. At HHF, satisfaction with the supervisor has historically been measured in two ways: through an eNPS score and a satisfaction survey. For this program review, I utilized Lloyd et al. 's (2017) definition of SwS.

Figure 3b

Modification of Lloyd et.al (2015) Listening Quality Conceptual Framework



Notes: Modified conceptual framework with a focus on HQ-LMX as measured by increased job satisfaction and satisfaction with BCBA supervisor

Retention (R): Retention was evaluated using the current data of Helping Hands Family. During four months, as my team managed the exit interviews, I was unable to add any additional questions or influence the collection of specific supervision-related statements, nor could I have any influence over the exit interview data. Therefore, I examined it through a pure numbers-driven approach. I analyzed the month-over-month attrition rate, which measures the number of employees present at the beginning of the month and determines how many exited by the end of the month. I intentionally did not factor the total number of additions during that month. Therefore, retention for the purpose of this study is the attrition rate of RBTs.

Project Design and Methodology

In partnership with the Helping Hands Family’s team, I identified four clinics that possessed comparable characteristics, including clinic size, maturity (as determined by revenue), number of clients, number of Registered Behavior Therapists (RBTs), number of Board Certified Behavior Analysts (BCBAs), severity of client cases, the clinical experience of the Clinic Director, supervision hours provided by BCBAs, and utilization hours for RBTs. These factors were instrumental in selecting a subset of clinics for the pilot program.

Sample Identification

In December 2024, four clinical directors responded positively to participating as the control and test clinics. As illustrated in Table 3a, the identified clinics and their corresponding data are presented. Clinics A and C served as the primary test clinics, while Clinics B and D were designated as the secondary control clinics. A total of 20 BCBAs and 119 RBTs were identified for the program review. The entire identified sample was 139 employees.

Table 3a

Demographic data for clinics identified for program review in January 2025

Criteria	Clinic A	Clinic B	Clinic C	Clinic D	Total
# BCBAs	5	5	5	5	20
# RBTs	31	25	28	35	119
Total # of Employees for Program Review					139

Note: The demographic data were collected at the beginning of the program review period (January 2025) and evolved, as evident in the month-over-month retention data.

As previously discussed, this program review is leveraging a previously identified sample size. Below are the criteria used to determine the appropriate clinic to partner for the program training launch:

- Number of BCBA Supervisors: Each of the four clinics had to have employed four BCBA supervisors as of December 2024.
- Turnover Trend in Quarter 4 of 2024: Each of the four clinics experienced a significant turnover rate in Q4, with averages exceeding 18% by the close of the quarter.

- Tenure of Clinical Directors: The partner organization emphasized the importance of selecting clinical directors who possess a longer tenure, both as directors and within the organization itself.
- Average BCBA caseload: Each BCBA must have a minimum of 7 client cases in full-service
- Average RBT Productivity: Each RBT should be scheduled to achieve an average productivity of 80%, which translates to providing direct client services for approximately 34 hours per week.
- Minimum Number of RBTs: As of December 2024, each clinic was required to maintain a minimum of 25 Registered Behavior Therapists (RBTs), which corresponds to a ratio of at least five RBTs per Board Certified Behavior Analyst (BCBA).
- Number of Clients in Full-Service Therapy: Full-service clients are those engaged in clinical therapy full-time. HHF has established that the sample clinics must include at least 30 full-service clients. It is important to note that this number does not represent the total client count in a clinic, as some clients may be transitioning out of services or are only receiving part-time care.

One of the challenges I encountered shortly after starting my data collection in March was the limitation imposed by using my organization as the capstone project. Given the nature of the program, I was unable to utilize my positional authority within the organization to encourage participation in the feedback survey. Therefore, I relied on my partner organization's data to align with the model framework. I adjusted the timeline and the modalities for data collection as outlined below:

- Partner Organization Data Collection (Quantitative and Qualitative): Map RBT survey questions to capstone conceptual framework, utilizing partner organization pre- and post-survey data.
- Capstone 1:1 Interviews (Quantitative and Qualitative): Visit clinics and meet 1:1 with RBTs and BCBAs from May 8- May 15 who agree to meet with you. Fill in the blanks by asking in-person qualitative questions that were not already captured via the partner organization survey and quantitative questions

Table 4 presents the full map of the capstone questions, mapped to the conceptual framework, data collection method, and the timeline used for data collection.

Table 4

Research Questions, Conceptual Framework, Method of Data Collection, and Timeline

Research Question	Conceptual Framework	Method of Data Collection	Timeline
How does the improvement of listening quality among BCBA's influence the RBTs' satisfaction with supervisors, job satisfaction, and retention at Helping Hands Family?	Listening Quality	Survey (HHF)	Pre-January Post – April -May
	Job Satisfaction	Quantitative Survey and Qualitative Interview	Pre-January Post – April -May
	Retention	Report (HHF)	Jan-May
	Satisfaction with Supervisor	Survey (HHF)	Pre-January Post-April
How do RBTs describe the role of BCBA listening quality in fostering trust and influencing their satisfaction with their supervisor and overall job experience?	Listening Quality	Qualitative Interview + Notes in Quantitative Survey (HHF)	Pre-January Post – April -May

Quantitative Survey Design

To gather data, the partner organization modified two previously validated tools focused on listening quality and satisfaction with supervisors. *The Supervision Monitoring and Evaluation* survey, created by Turner et al. (2016) and utilized by Leblanc et al. (2020) in their published work, was adopted by the partner organization. All questions are detailed in Table 5 of the Sample Survey Questions for RBTs. Furthermore, the questions from the *Active Empathetic Listening* (AEL) scale directly correspond to those identified by the partner organization. The AEL scale has been used by Bodie (2011). Additionally, several questions relate to perceived job satisfaction, satisfaction with supervisor, and retention, as noted by Lloyd et al. (2019). Refer to Table 5 for the mapped survey questions for RBTs.

Table 5*Survey Questions for RBTs and Alignment to Conceptual Framework*

Conceptual Framework	HHF Survey Question	Related Validated Survey
Listening Quality	When my supervisor listens to me, I feel they are genuinely interested in what I have to say.	Measurement from Lloyd et al. (2017) Perceived Supervisor Listening (p. 447) Scale
	When my supervisor listens to me, I feel my supervisor accepts me for who I am.	
	When my supervisor listens to me, I feel my supervisor accepts me for who I am.	
	When my supervisor listens to me, I feel my supervisor cares for me.	
Satisfaction with Supervisor	I feel my supervisor makes me comfortable, so I can speak openly.	Measurement from Lun et al. (2008)
	My supervisor is approachable.	
	My supervisor shows support and positive regard.	
Job Satisfaction	In general, I feel positive about my experience with my BCBA.	Measurement from Lloyd et al. (2017)
	On a scale of 1-5, I feel included in clinical practice and am very fulfilled in my work.	

To evaluate the impact of listening quality, Lloyd et al.'s (2019) listening quality scale was adapted based on the Leader-Member Exchange (LMX) theory, alongside Lun et al.'s (2008) scale, which assesses the feelings of being understood and integrated into the work environment by supervisors. These scales have been validated through previous studies, lending credibility to their use in this context. Minor modifications were made to the language of the scales to ensure comprehension by the target population and alignment with the modified framework. The scale ranged from 1 (strongly disagree) to 5 (strongly agree) per question for a total per participant score of 45 points as broken out below:

- Listening Quality maximum score per participant is 25 points
- Satisfaction with Supervisor, maximum score per participant is 15 points
- Job Satisfaction maximum score per participant is 5 points

Qualitative Survey Design

Prior to the qualitative interviews, all employees were informed that my role in the clinic was that of a researcher rather than the leader of People Operations. Participation in these interviews was voluntary. Data from these sessions were categorized into themes like listening, satisfaction with supervisor, job satisfaction, and retention (see Table 8). Discussions occasionally shifted to people operations and my leadership role. During such moments, I would pause and redirect employees to the right resource, sometimes involving the HRBP, before returning to the topic of listening and its impact on their feelings within the company and clinic. The themes identified are detailed in Table 8. Interviews with BCBAs covered their opinions on the program and their experiences participating, while interviews with RBTs reviewed progress since January, focusing on three key questions outlined in Table 8.

Table 8
Qualitative Questions used in general during interviews

Question	Conceptual Framework	Source
Discuss how satisfied you are with your job. What contributes to your response? Have you seen a change in the last four months?	Job satisfaction	Zhou & George, 2001
How likely are you to decline an employment offer and remain at HHF? What contributes to your response? Have you seen or felt a change in the last four months?	Retention	
Discuss how you feel and are included as part of the clinical team. What contributes to your response? Have you seen a change in the last four months?	Listening	Lun et al. (2008)

Notes: Responses were categorized into themes without ratings

Data Analysis and Review

This section is separated into two main parts: quantitative data analysis and findings, and qualitative data analysis and findings.

Quantitative Data Analysis and Review

The surveys, as outlined in the *Methods* section of this capstone project, were administered in January, prior to the training intervention, and in April, following the delivery of the training content. Consequently, the primary objective was to evaluate any alterations in the satisfaction levels of RBT employees. Table 9a presents the total number of respondents for the pre-survey, while Table 9b illustrates the total number of respondents for the post-survey. Each table categorizes respondents by clinic. The pre-intervention sample consisted of 119 individuals, whereas the post-intervention sample comprised 108 individuals.

Table 9a.

Pre-Intervention respondent data by clinic

Clinics	# of Respondents	# Surveyed	% Respondents
Clinic A	27	27	100%
Clinic B	13	25	52%
Clinic C	18	28	64%
Clinic D	19	32	59%
Total Sample	77	112	69%

Table 9b

Post-intervention respondent data by clinic

Clinics	# of Respondents	# Surveyed	% Respondents
Clinic A	25	30	83%
Clinic B	12	26	46%
Clinic C	11	26	42%
Clinic D	13	26	50%
Total Sample	61	108	56%

During the testing period, I became aware that the leader of Clinic D had undergone a listening intervention prior to completing the program review. Therefore, to ensure the validity of the test, I decided to exclude Clinic D from the quantitative study, as an intervention had already been implemented. Furthermore, I discovered that Clinic C had not completed the final competency review and evaluation, which were required components of the program. I opted to retain this clinic in the program review to ascertain whether a partial intervention would yield comparable results. It is important to note that this modification to the sample data was intentional, aiming to determine if a partial completion of the framework designed by the team would have the same or similar effect on RBTs. Table 9c subsequently delineates the respondents and sample size of the quantitative program review: intervention clinic, partial intervention clinic, and control clinic.

Table 9C

The sample was evaluated both pre- and post-intervention by the identified clinic

Type	Clinics	# of Respondents	# Surveyed	% Respondents
Pre-Intervention Data	Intervention	27	27	100%
	Control	13	25	52%
	Partial	18	28	64%
Post Intervention Data	Intervention	25	30	83%
	Control	12	26	46%
	Partial	11	26	42%

The capstone review question, currently under analysis, is quantitative: How does the enhancement of listening quality among Behavior Analysts (BCBAs) influence the satisfaction of Registered Behavior Therapists (RBTs) with their supervisors, their overall job satisfaction, and their retention rates at Helping Hands Family? Consequently, individual tests were necessary due to the correlation between listening quality and all independent variables. The subsequent subsections encompass the variable analysis and results for each of the relationships. Following this, a comprehensive review based on the data is presented quantitatively is presented.

Perception of BCBA Listening Quality

The initial qualitative focus was to assess whether perceptions of BCBA listening quality improved in the intervention clinic after the intervention, compared to the control clinic, where no improvement was noted. *Review Table 10 for a summary of the analysis.*

Intervention Clinic

H1a: The perception of BCBA listening quality will increase after the intervention compared to before the intervention within the clinic.

H0a: There is no significant difference in the perception of BCBA listening quality before and after the intervention within the clinic.

An independent samples t-test, assuming unequal variances, was conducted to examine whether the perceptions of BCBA listening quality significantly increased following the intervention by RBTs. The results indicated that the post-intervention group ($M = 0.93$, $SD = 0.10$) reported significantly higher listening quality than the pre-intervention group ($M = 0.74$, $SD = 0.07$), $t(48) = -7.55$, $p < 0.05$ (one-tailed). These findings support the hypothesis that the intervention improved perceived BCBA listening quality; therefore, I rejected the null hypothesis for H1 for the intervention clinic. Using Cohen's $d = .213$, the intervention had a substantial impact on participants' perceptions of BCBA listening quality.

Control Clinic

H0b: There is no difference in perceptions of BCBA listening quality from pre-to post-intervention in the control clinic.

H1b: There is a difference in perceptions of BCBA listening quality from pre-to post-intervention in the control clinic.

The independent samples t-test, assuming unequal variances, was conducted to examine whether there was a significant change in perceived BCBA listening quality in the control Clinic. Results indicated no statistically significant difference between the pre-intervention group ($M = 0.82$, $SD = 0.13$) and the post-intervention group ($M = 0.73$, $SD = 0.29$), $t(16) = 1.08$, $p = 0.15$ (one-tailed). Based on the findings, I failed to reject the null hypothesis.

Partial Clinic

H1c: The perception of BCBA listening quality will increase after the intervention compared to before the intervention within the partial intervention clinic

H0c: There is no significant difference in the perception of BCBA listening quality before and after the intervention within the partial intervention clinic

In the independent samples, which assumed equal variances, the results indicated no significant difference between the pre-intervention group ($M = 0.91$, $SD = 0.12$) and the post-intervention group ($M = 0.85$, $SD = 0.12$), $t(27) = 1.32$, $p = 0.10$ (one-tailed). This finding suggests that the intervention did not result in a statistically significant change in listening quality for this subgroup undergoing partial intervention. Therefore, we fail to reject the null hypothesis.

Table 10
Summary Data Values Table

Summary Data Values Table											
		Mean	Standard Deviation	Kurtosis	Skewness	Variance	f-test	t-test	df	p-value (one tail)	t-critical (one-tail)
Intervention	Pre Intervention	0.74	0.076	-1.029	-0.758	0.00583	0.0853	-7.55	48	5.24E-10	1.677
	Post Intervention	0.93	0.107	-0.73	-0.843	0.011456					
Control Clinic	Pre Intervention	0.821	0.134	-1.073	0.05	0.018	0.012	1.075	16	0.149	1.75
	Post Intervention	0.726	0.29	2.068	-1.32	0.084					
Partial	Pre Intervention	0.9	0.118	-0.97	-0.78	0.014	0.984	1.32	27	0.099	1.0703
	Post Intervention	0.85	0.117	-1.28	0.13	0.014					

Summary of Listening Quality

Based on the data and statistical analysis, the intervention demonstrated efficacy in enhancing Registered Behavior Therapists' (RBTs) perceptions of the listening quality of Board Certified Behavior Analysts' (BCBAs), specifically within the fully implemented clinic Intervention Clinic. In contrast, the Control Clinic and the Partial Clinic showed no statistically significant changes, indicating that complete implementation of the intervention is likely more beneficial for achieving clinical success in improving the listening perceptions of BCBAs. The results from the Intervention Clinic align with previous research on LMX, highlighting that meaningful changes in leader listening behavior, as perceived by group members, require completing the intervention and providing enough practice time to enable noticeable shifts through deliberate, ongoing practice paired with reinforcement. (Wefald, 2022). The absence of sustained reinforcement may explain the lack of statistically significant changes in the Partial Clinic, where the intervention was only partially executed. Furthermore, Khorakian and Sharifirard (2018) contend that without reinforcement from organizational norms and accountability frameworks, leadership interventions will lack sustainability. The findings from Partial Intervention substantiate Khorakian and Sharifirard's (2018) assertions. Additionally, leaders within the Leader-Member Exchange (LMX) framework underscore the necessity for followers to perceive genuine change, which is seen over an extended period (Sheer, 2014).

BCBA Listening Quality and Satisfaction with Supervisor

An examination of the relationship between BCBA Listening Quality and Satisfaction with Supervisor to see if improvements in the Listening Quality of BCBAs have an impact on Satisfaction with Supervisor. The following hypothesis was tested:

Intervention Clinic

H2a: There will be a high positive correlation between perceptions of BCBA listening quality and satisfaction with the supervisor within the intervention clinic.

H0a: There is no significant correlation between perceptions of BCBA listening quality and satisfaction with the supervisor within the intervention clinic.

The linear regression analysis examined the relationship between perceptions of BCBA listening quality and satisfaction with the supervisor in an intervention clinic before and after a targeted intervention. Before the intervention, results showed a significant positive correlation, with satisfaction predicting perceptions of listening quality ($R^2 = .52$, $F(1, 25) = 26.59$, $p < .001$, $b = .84$). After the intervention, the relationship was even stronger ($R^2 = .61$, $F(1, 22) = 34.23$, $p < .001$, $b = 1.21$). These findings support the hypothesis (H2a) that increased satisfaction with the supervisor is associated with higher perceived BCBA listening quality, suggesting the intervention may have enhanced this relationship. Therefore, we reject the null hypothesis.

Control Clinic

H0b: There will be no significant correlation between perceptions of BCBA listening quality and satisfaction with the supervisor in the control clinic.

H2b: There will be a correlation between perceptions of BCBA listening quality and satisfaction with the supervisor in the control clinic.

After the analysis, a weak and statistically non-significant relationship between listening and satisfaction with the supervisor was revealed in the control clinic prior to intervention ($R^2 = .14$, $F(1, 11) = 1.84$, $p = .20$, $b = 0.53$), indicating that listening quality did not predict satisfaction with the supervisor. However, in the post-intervention phase, the relationship became substantial and statistically significant ($R^2 = .67$, $F(1, 10) = 20.46$, $p = .001$, $b = 1.14$), leading to the rejection of the null hypothesis. The post-intervention findings suggest a positive increase in listening quality and satisfaction with the supervisor over time or due to other factors without intervention. This warranted further exploration using

additional data such as turnover rates of RBTs and BCBAs, and qualitative interviews. Therefore, I failed to reject the null hypothesis.

Partial Intervention

H2c: There will be a correlation between perceptions of BCBA listening quality and satisfaction with supervisor in the partial intervention clinic.

H0c: There will be no significant correlation between perceptions of BCBA listening quality and satisfaction with supervisor in partial intervention clinic.

Before the intervention, the analysis showed a strong and statistically significant positive correlation between listening quality and satisfaction with supervisor ($R^2 = .78$, $F(1, 16) = 55.90$, $p < .001$, $b = 1.33$) with a 95% confidence interval. However, after the intervention, the findings differed, with the correlation between variables decreasing significantly and no longer being statistically significant ($R^2 = .007$, $F(1, 9) = 0.06$, $p = .81$, $b = 0.12$) with a wide confidence interval that included zero. These results lead to rejecting the null hypothesis after the intervention and indicate that the partial intervention may not have enhanced the relationship between listening and satisfaction with supervisor as perceived over time.

Summary

The statistical analysis indicated a positive correlation between perceptions of the listening quality of Board Certified Behavior Analysts (BCBAs) and satisfaction with the supervisor. This correlation was particularly evident within the full intervention clinic and, to a lesser extent, in the partial and control clinics. However, the relationship did not demonstrate consistent robustness across all settings. For instance, the partial intervention clinic exhibited a strong correlation prior to the intervention, which subsequently diminished over time. This decline suggests that partial or inconsistent

implementation may have disrupted the relationship between perceived listening quality and satisfaction with the supervisor. Conversely, the control clinic revealed no significant relationship in the pre-intervention phase. However, it showed a robust correlation following the intervention, prompting inquiries about external factors that might have impacted satisfaction with the supervisor. The positive correlation regarding satisfaction with supervisor noted in Intervention Clinics is consistent with Lloyd et al.'s (2015) assertions within the Leader-Member Exchange (LMX) model, highlighting that active listening by supervisors fosters high-quality exchanges and enhances employee commitment and satisfaction. In contrast, the decline observed in Partial Intervention may be attributed to the detrimental effects of inconsistent implementation, which could erode trust and diminish perceptions of the leader's listening authenticity (Moin et al.; Sheer, 2014), further indicating low-quality LMX (Lloyd et al., 2015). This variability across clinics underscores the dynamic nature of leader-member exchange, suggesting that leaders must actively engage with and continuously apply the training to facilitate the trust-building essential for sustaining LMX (Sheer, 2015).

Table 11
Analysis of Perception of BCBA Listening and Satisfaction with Supervisor

Analysis	Intervention Results	Control Results	Partial Results
R-Squared = Pre (R^2)	0.515	0.143	0.78
R-Squared = Post (R^2)	0.609	0.672	0.007
F – Statistic (ANOVA) = Pre (F)	26.59	1.84	55.897
F – Statistic (ANOVA) = Post (F)	34.23	20.46	0.0613
P-value = Pre (p)	0.640	0.35	0.56
P-value = Post (p)	0.226	0.38	0.15
Beta Coefficient Pre (β)	0.836	0.53	1.33
Beta Coefficient Post (β)	1.213	1.14	0.123

BCBA Listening Skills and Job Satisfaction

The final review of quantitative data involves comparing BCBA listening quality and job satisfaction as measured before and after the intervention. Similar to the satisfaction with supervisors, three hypotheses were evaluated as detailed below.

Intervention Clinic

H2a: A high positive correlation is expected between perceptions of BCBA listening quality and job satisfaction within the intervention clinic.

H0a: There is no significant correlation between perceptions of BCBA listening quality and **job satisfaction** within the intervention clinic.

Based on the linear regression analysis conducted prior to the intervention, the results revealed a weak and statistically non-significant relationship between BCBA listening and job satisfaction, $R^2 = .04$, $F(1, 23) = 1.01$, $p = .33$, $b = 1.26$. The 95% confidence interval $[-1.33, 3.86]$ included zero, indicating no meaningful predictive effect. Post-intervention results were similar with a near-zero negative effect, $R^2 = .04$, $F(1, 23) = 0.97$, $p = .33$, $b = -0.06$, and a 95% confidence interval $[-0.17, 0.06]$ showing that the perceptions of BCBA listening quality did not significantly predict job satisfaction at either point in time therefore we fail to reject the null hypothesis. Therefore, I failed to reject the null hypothesis.

Control Clinic

H0b: There will be no significant correlation between perceptions of BCBA listening quality and job satisfaction in the control clinic.

H2b: There will be a correlation between perceptions of BCBA listening quality and job satisfaction in the control clinic.

There was a positive moderate relationship between BCBA listening quality and job satisfaction in the pre-intervention results, $R^2 = .22$, $F(1, 10) = 2.81$, $b = 1.35$, $p = .12$. However, the effect size supports rejecting the null hypothesis in favor of the alternative because in the post-intervention the relationship weakened while remaining non-significant, $R^2 = .06$, $p = .46$, $b = 0.51$. Therefore, the way to view this is that while there was a moderate relationship pre, this did not persist over time.

Partial Intervention

H2c: There will be a correlation between perceptions of BCBA listening quality and job satisfaction in the partial intervention clinic.

H0c: There will be no significant correlation between perceptions of BCBA listening quality and job satisfaction in the partial intervention clinic.

Prior to the intervention, the model revealed a weak, non-significant negative association between BCBA listening and job satisfaction, $R^2 = 0.08$, $F(1, 15) = 1.26$, $p = 0.28$, $b = -0.97$. However post intervention the association effectively disappeared, $R^2 < .001$, $F(1, 8) < 0.001$, $p = .99$, $b = 0.01$. While not statistically significant, there is a drop in the effect size that may suggest a decline in the perceived connection, potentially indicating disengagement or other factors introduced over time.

Summary

Across all tested hypotheses, the data failed to provide statistically significant evidence indicating that the quality of BCBA listening independently predicts job satisfaction. The observed disappearance or weakening of this relationship post-intervention—while not statistically significant—in both control and partial intervention groups may reflect a deteriorating relational dynamic potentially caused by either the partial implementation of the intervention or the lack of sustained support over time. The absence of a consistently strong relationship between BCBA listening and job satisfaction—despite moderate gains in satisfaction with supervisors—may suggest that

additional factors influencing job satisfaction lie outside the leader's control. As discussed by Lloyd et al. (2015) and Moin et al. (2021), while listening helps build the psychological foundation for Leader-Member Exchange (LMX), other structural supports such as fair compensation and role development also significantly impact job satisfaction and are not directly related to listening. Furthermore, LI and Zhang (2022) and Tews and Stafford (2020) note that in high-burnout environments, listening may be present; however, if additional measures do not support it, it can lead to fractured trust and engagement, which significantly affects job satisfaction. Finally, in high-burnout roles, Deluga (1994) argues that compassion fatigue embodies the weight of unmet emotional labor demands, which can erode job satisfaction. This is another external factor that impacts job satisfaction and may not be comprehensively addressed through the LMX dyadic relationship.

Table 12
Analysis of Perception of BCBA Listening and Job Satisfaction

Analysis	Intervention Results	Control Results	Partial Results
R-Squared = Pre (R^2)	0.042	0.219	0.078
R- Squared = Post (R^2)	0.041	0.061	1.18
F – Statistic (ANOVA) = Pre (F)	1.01	2.81	1.26
F – Statistic (ANOVA) = Post (F)	0.97	0.59	9.42
P-value = Pre (p)	0.697	0.25	0.11
P-value = Post (p)	2.57	0.94	0.78
Beta Coefficient Pre (β)	1.26	1.35	-0.97
Beta Coefficient Post (β)	-0.06	0.51	0.01

Retention of RBTs

The inquiry I intended to incorporate involved a Likert scale, akin to those employed in previous evaluations, aimed at assessing whether Registered Behavior Therapists (RBTs) were contemplating leaving their positions. However, this particular question was presented as open-ended for the Helping Hands team. I pivoted and was able to delineate the attrition rates by clinic, utilizing turnover data from

before and after the implementation across each clinic. While it is challenging to explicitly correlate attrition with job satisfaction and supervisory satisfaction within a statistical framework, the data suggest that attrition consistently declines in both the intervention and partial intervention clinics during the months following the program intervention, while it remains high and increases in clinics where no intervention occurred. Including questions about retention would strengthen the statistical testing of the full model, enhancing the

Review of Quantitative Results

The primary research question investigates the extent to which enhancements in listening quality among Board Certified Behavior Analysts (BCBAs) impact the satisfaction levels of Registered Behavior Therapists (RBTs) regarding their supervisors, overall job satisfaction, and retention rates within Helping Hands Family. The analysis reveals a partial, yet significant outcome as derived from the quantitative evaluation of data across intervention, control, and partial intervention clinics, summarized as follows:

In the Intervention Clinic, where the intervention was fully executed, there was a notable improvement in listening quality, which correspondingly led to higher satisfaction with the supervisor reported by RBTs. This finding is congruent with the Leader-Member Exchange theory, which posits that a high-quality dyadic relationship between leaders and their followers culminates in greater satisfaction with supervisors (Lloyd et al., 2015; Deluga, 1994).

Moreover, the Intervention Clinic demonstrated a decrease in RBT attrition throughout the intervention period. Although not statistically definitive, this suggests that targeted leadership behaviors may play a relational role in enhancing follower retention. Conversely, Control Clinic and Partial Implementation exhibited varying findings contingent on the metrics employed. The data indicates a potentially detrimental impact of inconsistent leadership communication arising from incomplete implementation, a concern articulated by Sheer (2014), who notes that such inconsistencies can be more

harmful than beneficial. While improved listening quality was consistently correlated with higher satisfaction with the supervisor, it did not translate to job satisfaction. This discrepancy may be attributable to other variables; without assessing alternative factors such as compensation and caseloads, a comprehensive understanding of job satisfaction within this framework remains elusive. Therefore, the findings of the quantitative data review are as follows:

- Listening alone is insufficient to influence job satisfaction. While listening is a necessary component, it may not have a significant impact on key areas within the conceptual framework, such as job satisfaction and retention. The literature identifies other mitigating factors that could influence these outcomes, including the availability of work-life balance, self-care strategies, collegial support, balanced workload, training opportunities, adequate resourcing, compensation, well-being programs, and increased organizational commitment to paraprofessional skill enhancement (Kuijpers et al., 2020; Slowiak & DeLongchamp, 2021; McGrath et al., 2022; Plantiveau et al., 2018). All of these factors contribute to job satisfaction beyond the scope of the model and the intent of training.
- Partial implementation may erode impact and lead to adverse implications: The initially strong correlation between the Partial Intervention clinic's BCBA listening and satisfaction with the supervisor diminished due to inconsistent delivery. This finding supports the critique of the Leader-Member Exchange (LMX) theory by Sheer (2014), indicating that it is not static but dynamic, necessitating ongoing action. Furthermore, this finding reinforces HHF's assertion that the complete five-pronged leadership model of competency training must be fully implemented.
- The relationship between listening and satisfaction with supervisor: The most significant results of the quantitative analysis emerged from improvements in both BCBA listening skills and

satisfaction with supervisor in the intervention clinic, thereby supporting the LMX listening leader model.

Limitations of Quantitative Analysis and Review

Firstly, uneven post-analysis attrition at clinics B and C may have affected statistical generalizability. Secondly, excluding clinic D due to an unrelated intervention could have added variability as a control. External factors, such as new BCBA recruitment, RBT turnover, new leaders, and organizational initiatives, were uncontrolled and may have influenced RBT perceptions independently of the intervention. Additionally, the time between the pre- and post-intervention periods was too short for a comprehensive evaluation of the long-term effects. The quantitative Review is not generalizable due to the small program review sample size relative to the overall HHF population, and the low response rate further limits the statistical significance of the results. Finally, there was no direct correlation between the attrition of RBTs and the stabilization by the clinic, and the intervention or lack thereof.

Qualitative Analysis and Review

This section presents the qualitative data collected between April and May, after the training delivery. No pre-training data was gathered. The objective was to enhance the understanding of the outcomes observed during the quantitative phase and to address any emergent gaps in the Review. Participants were invited to voluntarily sign up for individual sessions that lasted between thirty minutes and one hour, contingent upon their availability and the flow of the dialogue. Each interview was structured around four open-ended questions derived from the conceptual framework, designed to foster reflective dialogue and encourage candid feedback. A total of 15 Registered Behavior Therapists (RBTs) from Clinic A and 8 RBTs from Clinic C engaged in these sessions. Due to the lack of participation from Clinic B and limited engagement from Clinic D (as indicated in 1 RBT), data from these sites will not be utilized (refer to Table 12 for a comprehensive distribution of participants). Furthermore, this section will

exclude the interviews with Board Certified Behavior Analysts (BCBAs), as they do not align with the conceptual framework aimed at assessing the impact of the training on RBTs.

I employed a thematic analysis approach to code the interview responses. Each response was meticulously reviewed to identify recurring patterns and themes aligned with the core constructs investigated in the training program, consistent with the conceptual framework—namely, satisfaction with the supervisor, job satisfaction, retention, and a general category to encompass other elements not explicitly identified within the framework. The synthesis of the primary emerging themes from the data is substantiated by supporting quotations and my contextual interpretation. Due to clinic recording protocols, team members were interviewed, and notes were documented during the interviews. These notes were subsequently transcribed into an Excel spreadsheet. Additionally, notes from written survey responses were examined, organized into themes, and incorporated into the qualitative analysis discussion.

Table 13

Clinic	RBT Interviews	BCBA Interview
Clinic A	15	3
Clinic B	0	0
Clinic C	8	5
Clinic D	1	1

Note: The lack of participation in Clinic B and the low participation in Clinic D were the reasons I eliminated them in the qualitative analysis

BCBA Listening

During site visits, employees were surveyed regarding their relationship with supervisors and their perceptions of supervisory listening practices. The majority of participants evaluated their supervisors' listening skills positively, indicating a sense of being genuinely heard. In Clinic A, Registered Behavior Therapists (RBTs) reported a progressive enhancement in their supervisors' listening abilities over the past six months, while newer team members observed improvements within the last three months. Conversely, employees in Partial Intervention

provided instances of effective communication with their Board Certified Behavior Analyst (BCBA) but did not specify particular moments of change. The feedback predominantly highlighted active listening by supervisors rather than passive listening.

Instances of active listening included statements such as:

“My BCBA is highly responsive to my emails and provides prompt solutions” (Intervention Clinic, RBT 5).

“You can always share anything with your BCBA supervisor; they listen and respond” (Intervention Clinic, RBT 3)

“I feel very involved and valued; my input is recognized” (Partial Intervention RBT 2).

“BCBAs here seem eager to assist; they are very responsive” (Intervention Clinic, RBT 7).

These narratives are consistent with the definitions of active-empathetic listening as described by Bodie et al. (2012) and Lloyd et al. (2014), which involve interpreting and responding, thus supporting high-quality leader-member exchange (LMX) relationships that enhance psychological safety and employee voice (Lloyd et al., 2015). In addition, Ladkin (2008) and Brownell (2012) inform us that leadership listening contributes to cultural improvement, particularly when subordinates feel they can contribute to organizational decisions. For example, one RBT commented as follows:

“Our voices are heard, I write ideas all the time and the BCBA works with you on them... you see it in the progress of the clients, and we ask what can we do more, ... now I am doing curriculum development” (RBT 3, Clinic A).

The feedback aligns with high-quality Leader-Member Exchange (LMX) relationships, which reduce knowledge hiding and enhance organizational engagement. The RBT indicated that, due to her ability to offer insights on curriculum design and contribute ideas for her client, her client is making progress. The incorporation of the RBT's perspectives and suggestions is indicative of High LMX relationships between the BCBA and RBT. Consequently, employees exhibit reduced withdrawal behaviors and heightened engagement behaviors, leading to improved performance outcomes (Zhao et al., 2019).

BCBA Listening and Satisfaction with Supervisor

At the core of care delivery is the supervisory relationship between the BCBA and RBTs. Through evidence-based practices, program evaluations, and supervisory guidance, BCBAs aim to enhance client outcomes (Falendar & Shafranske, 2010; Gibson et al., 2009). To achieve this, they require RBTs to provide daily behavioral data that informs the decisions made by BCBAs. When an RBT is invited into the feedback loop and can contribute, it fosters a reciprocal dynamic essential for high-quality client care and HQ LMX (Graen & Uhl-Bien, 1995). Listening, specifically, is foundational in this dynamic, as Reis et al. (2017) posit, that “feeling understood” by one’s supervisor is empirically linked to psychological well-being and work engagement. HQ LMX relationships form when supervisors consistently demonstrate trust-building and respond to concerns through active empathetic listening (Lloyd et al., 2015; Wefald, 2022). As one RBT in the Intervention Clinic explained,

“BCBAs provide supervision and are supportive of our ideas and hearing us out, and any of them will tell us what is wrong and they will always listen and always want to listen and hear our ideas. Moreover, other RBTs out there, you can see it like when people go to school programs and they never see their BCBA and then have to have a session, they are struggling..., ours are always there for you...like if you are struggling, you can go to them and they like listen and help and give ideas and stuff...” (RBT 11, Clinic A).

This illustrates the strength of dyadic active empathetic listening, as defined in the literature review, because listening is not just an auditory action. Active empathetic listening requires responsiveness, consistency, and action, which are all elements of the high-quality LMX model adopted for this capstone (Lloyd et al., 2015). When supervisors are overextended and lack the time to engage in the behaviors that are characteristic of high-quality LMX, the relationship between the supervisor and supervisee can deteriorate (Maslach & Jackson, 1986; Moin et al., 2021). Listening is not enough; there must also be action and feedback. For example, during the more recent period of no clinical leadership, where BCBAs are stretched by absorbing additional responsibilities in Partial Intervention, this shift impacted the perceived quality of LMX. One RBT stated:

“As an RBT level 5 fellow, most likely, I will not stay at HHF much longer, and I am exploring other options for my fellowship. Feels like I am not getting what I observed other fellows get when I started. ...I saw other fellows before I became a fellow get pulled into things like intake. Moreover, they got to train with the BCBAs better than I have been. I feel like my training now will hurt my ability to be a good BCBA. Like I

should have been pulled into doing things like the PEAK or reassessment for one of my clients, but the BCBA didn't involve me. But I know when (insert name of Clinical Director) was here, she would make sure that the fellows were involved. I just feel like they are doing things I can learn, but I am not given an opportunity because they are so busy (RBT 2, Partial Intervention)."

This example highlights the vulnerability in the leader-member dynamic (Moin et al., 2021). As BCBAs assume more responsibilities, their interactions with RBTs decrease due to limited availability and LMX behaviors (Lai et.al, 2016; Moin et al., 2021). High-quality LMX requires structural support for BCBAs to maintain communication with RBTs. Failures in relational expectations can lead to a "trust violation spiral," where minor breaches result in lasting negative perceptions (Amabile & Kramer, 2013). This has led one RBT to seek other employment due to feelings of exclusion and lack of recognition. Declining learning and support at Partial Intervention have worsened satisfaction with supervisors, increasing the risk of turnover. Amabile and Kramer (2011), in their seminal work *The Progress Principle*, describe this phenomenon as the "Progress Loop." They assert that when managers fail to prioritize the daily progress of their employees, a dynamic akin to a pendulum is created, fostering an environment of distrust (Amabile & Kramer, 2011, p. 99). Conversely, Intervention Clinic showcases stable leadership that fosters high-quality LMX and trust. According to Kramer (2009), high-trust environments are cultivated when leaders are accessible and supportive: "I am not going anywhere; there are so many positives here and a great group of leaders who are very accommodating..." (RBT 2, Intervention Clinic). Therefore, it is my observation that high-quality relationships and satisfaction with supervisors are cultivated through sustained behaviors that meet employees' emotional needs (Kramer, 2009; Lloyd et al., 2015).

BCBA Listening and Job Satisfaction

During the review of quantitative data, it was notable that there was no statistical link between BCBA listening and job satisfaction. Additionally, a decline in job satisfaction was observed over the program review period in the Partial Intervention clinic. The RBTs' reflections during interviews reveal a complex array of factors influencing job satisfaction, as well as why it did not correlate with the listening leader model. Their narratives highlighted several key themes, including burnout stemming from high turnover and inadequate staffing schedules,

compensation disparities, peer-to-peer relationship issues, and a lack of guidance from the clinical director. These findings align with existing research on major factors driving burnout and turnover among healthcare workers and caregivers.

For example:

“When (insert name of Clinical Director) was around we maybe lost like one or two people but like now, ... all our team is just leaving, and then like you get called in to cover, and ... you don’t get given a break. Moreover, I love the kids and my fellow RBTs but like it would be nice like if the ... BCBA’s could like jump in... or like we could stop like adding kids until we like add more people...” (RBT 3, Partial Intervention).

Participants' expressions regarding the escalation of responsibilities and scheduling challenges, which have contributed to increased dissatisfaction with their roles, align closely with the findings of Novack and Dixon’s (2019) systematic review. The review examines how high employee turnover affects the morale of the remaining staff, leading to workload overload or the delegation of tasks to untrained personnel, and perpetuating a cycle of further turnover and dissatisfaction.

Compensation and time off were a common theme in both clinics. In the Intervention Clinic, where full competency training was implemented, there was a tendency among the RBTs to discuss feeling satisfied with their leader and their experience. The main driver for them wanting to leave was compensation. They did not feel that the compensation model and the workload aligned. In the Partial Intervention clinic, there was also a feeling that the work done and the compensation model did not align.

“I was going to leave for a different rate of \$26 an hour...I’m sitting here at \$21 an hour. Please revisit the compensation scale for RBTs on our team because I love the team, and my BCBA’s, but I know I could be making more and working fewer hours”.(RBT 9, Intervention Clinic)

“RBTs don’t make enough compensation, and I think for the work that we do, the reason I feel like most of the people that have left have left for more money, the cost of living is crazy...” (RBT 10, Intervention Clinic)

“Not that I want it to matter, the compensation that other places are getting paid is higher than have left here...and there are other companies that do similar things that I know our friends who left are getting a pay increase but I like it here but then you are asked to do more...and then you have to ask why should I stay?” (RBT 2, Partial Intervention)

All of these experiences and statements are examples of how satisfaction with pay and reports of being overutilized can impact job satisfaction, as discussed by Novak and Dixon (2019). An interesting future review of RBT sentiment would be to see if there is a correlation between job satisfaction, retention and compensation. According to Novak & Dixon (2019), when employees feel underpaid, they feel undervalued, and are more likely to disengage and be less participatory in advancing organizational goals. Employees view pay inequity as a lack of fairness and this sentiment may lead to a greater intention to leave an organization (Kazemi et al., 2015). These are all elements of job satisfaction that are not necessarily driven by the leader but rather are institutional.

In addition to compensation and burnout, peer-to-peer dynamics have a significant influence on workplace culture. Long-tenured employees often form cliques and receive preferential treatment from managers, such as the Office Manager. at the Intervention Clinic, staff members reported that the Clinic Director and BCBA supervisors would address issues of cliques when these were observed among the more senior employees on the team.

“The only issue I have is that I can get clicky with other RBTs and I have run into some issues where I have been like we are supposed to be a team because we are working together as a team and as adults and there is a way to talk to people and like and if you have an idea or suggestion and let's bounce ideas and suggestions off each other ... There was an issue where I had a client who was always chewing, I lovingly call him something, and he had dropped his chewy, and - another RBT yelled at me, so that's what I think, she ran to the Ambassadors. I went immediately to (insert Clinic Director name) and she jumped in and it never happened again...” (Intervention Clinic, RBT 4)

The divisive nature of team members forming cliques contributes to job dissatisfaction owing to exclusionary behaviors. Brown (2021) asserts that fostering a collaborative environment characterized by professionalism and positive work experiences, where all individuals perceive themselves as integral members of the team, leads to improved retention and reduced burnout. Notably, the role played by the Clinic Director in proactively addressing this issue exemplifies a crucial aspect of leadership within high-quality Leader-Member Exchange (LMX). The relationships cultivated through effective leadership create an environment that discourages exclusionary conduct and promotes inclusive team cultures, thereby ensuring that all members feel engaged and are less inclined to leave due to feelings of exclusion and disengagement (Deluga, 1994; Li & Zhang, 2022; De Jong et

al., 2016). Although the leaders in our program review were not found to exert direct influence over job satisfaction, their actions indirectly contribute to both job satisfaction and employee retention. For instance, the clinic director at the Intervention Clinic promptly addressed a misaligned behavior once it was brought to her attention. Additionally, the team dynamic has contributed to retention, particularly in areas where team members perceive difficulties with their work. Although a formal supervisory relationship is always preferable, some RBTs have indicated a greater reliance on their peers or informal support due to existing gaps leadership. For example,

“...The newer BCBA is so new at being a BCBA and new to our company and so doesn't know how to do it well. This December will be my two years with this company and... I love the team around me, the RBTs, ... There is one supervisor here that I don't think she has supervised me in a few months, and I have four clients. And two clients are hers and I probably need her to support but she doesn't know how...the team is so supportive and helps me out...” (RBT 2, Partial Intervention)

According to Lun et al. (2018), individuals within social environments who feel understood and included exhibit greater job satisfaction, particularly in team-oriented settings such as the clinical environment at Helping Hands Family. Bodie and Crick (2014) discuss the importance of building strong relationships through active empathetic listening, which encompasses mutual understanding and support within a communicative environment. These reviews suggest that relational listening among peers can mitigate the negative impacts of inadequate formal supervision. These examples also suggest that the relational aspects of the leader-member relationship do not solely drive job satisfaction and retention. The reliance on peer support in environments where supervisory relationships may not meet emotional needs suggests that, while listening may not originate from supervisors, peer-based listening and actions still play a significant role in job satisfaction. The relational aspects of Leader-Member Exchange (LMX) between peers are encompassed within a form of LMX not examined in this program review, known as coworker relationship exchange (Sias & Jablin, 1995; Kim et.al., 2022), whereby high-quality peer LMX contributes to elevated job satisfaction. Afshari and Gibson (2022) further elaborate on this research by asserting that mutual trust and psychological safety are enhanced through

sustained peer-to-peer relationships. This appears to be an area of LMX that warrants further exploration for HHF.

Review of Qualitative Analysis Results

The interviews indicate that listening—whether from a supervisor or a peer—serves as a mediator to enhance engagement, alleviate burnout, and promote retention. As emphasized by Bodie and Crick (2014) and Lun et al. (2008), feeling understood and supported at work is essential for psychological safety and organizational commitment. Other significant reviews include:

- Indicators of active-empathetic listening were apparent, such as responsiveness to emails, validation of ideas, and inclusion in clinical decisions—all core behaviors aligned with active-empathetic listening traits described by Bodie et al. (2012) and Lloyd et al. (2014).
- RBTs expressed a sense of being heard and valued, which fostered their feelings of psychological safety within the work environment, contributing to a more engaged team—key characteristics of high-quality leader-member exchange environments (Reis et al., 2017; Lloyd et al., 2015; Kramer, 2009).
- The lack of leadership and the overextension of BCBAAs weakened supervisory relationships, resulting in feelings of exclusion and decreased trust, which are key indicators of low-quality LMX and LMX deterioration (Maslach & Jackson, 1986; Moin et al., 2021).
- Job satisfaction was more significantly influenced by overarching themes such as burnout and workload, leading to exhaustion and high turnover (Novack & Dixon, 2019), while low compensation also contributes to feelings of inequity, undermining morale and commitment (Kazemi et al., 2015).
- While peer support can serve as a buffer against poor or inexperienced leadership, it is not a sustainable model unless intentionally developed as put forth by Sherf et al. (2017), where peers become, similar to the dyadic LMX, a coworker high-quality relationship driving job satisfaction.

Limitations of Qualitative Analysis and Review

The qualitative analysis was conducted with a select subset of participants. It is important to acknowledge that my position as Vice President of People Operations may have influenced the willingness of individuals in the control clinics to participate, thereby limiting the diversity and depth of data that could have enriched this analysis. Notably, the clinics that did take part generally provided more favorable assessments of their leadership. A more comprehensive perspective might have emerged had there been greater engagement from the other clinics. Additionally, the participating clinics represent some of the more established sites within Helping Hands Family, which are familiar with providing feedback. Future research should explore outcomes in less-established clinics or those led by individuals who are relatively new to leadership roles. Lastly, the limited sample size precludes any broad generalization to the wider population.

Findings

This capstone project evaluated the HHF's newly implemented program, designed to enhance the dyadic relationship between BCBAs and RBTs by developing the leaders' competency in active listening and trust building. These two trainings, Rapport Building and the Feedback Loop, were assessed using these three program review questions:

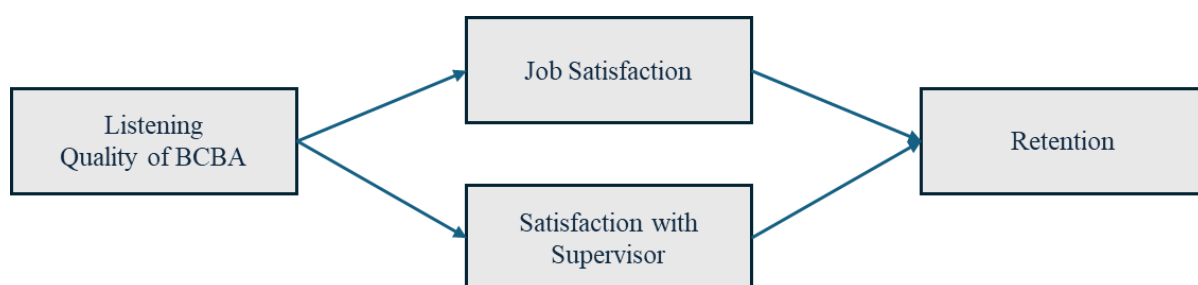
- How does the improvement of listening quality among BCBAs, influence the RBTs satisfaction with supervisors, job satisfaction and their retention at Helping Hands Family?
- How do RBTs describe the role of BCBA listening quality in fostering trust and influencing their satisfaction with their supervisor and overall job experience?

As a reminder, the program review was conducted by adopting a modified LMX framework set forth by Lloyd et.al (2015) and testing data both quantitatively and qualitatively. The findings are organized by construct, integrating insights from the analysis, literature review, and additional literature sourced based on the acquired data.

I utilized the modified Lloyd et al. (2015) Listening Quality Conceptual Framework to both qualitatively and quantitatively respond to the program review question, as seen in Figure 5.

Figure 5

Modification of Lloyd et.al (2015) Listening Quality Conceptual Framework



Summary of Findings

Overall, the response to the questions posed in this study is summarized as follows:

- **Finding 1: Listening Quality and Supervisor Satisfaction:** Enhanced listening skills among BCBAs resulted in higher RBT satisfaction with supervisors in the Intervention Clinic. Partial or inconsistent implementation hurts outcomes.
- **Finding 2: Listening Quality and Job Satisfaction:** Listening quality had only an indirect effect on overall job satisfaction. Factors such as compensation and peer relationships played a more significant role in RBT satisfaction. Positive supervisory relationships contributed to a reduction in turnover at the Intervention Clinic. However, job satisfaction and retention were influenced more by peer support, mental health, and compensation than by supervisory behavior alone. Partial completion led to feelings of inauthenticity of BCBAs and eroded trust built.

- **Finding 3: Peer Relationships and Growth:** Strong coworker support increased job satisfaction, especially when supervisory engagement was limited. Opportunities for professional growth and involvement in clinical practice and care design were associated with increased engagement and lower reported intentions to turnover among RBTs. Peer relationships facilitate sensemaking processes and can have a direct impact on organizational culture and employee retention.
- **Finding 4: Overall Role of a Leader:** Leadership influences organizational culture and peer relationships more significantly than directly affecting job satisfaction or retention. Sensegiving is crucial, for example, in fostering team coherence and building culture.
- **Finding 5: Compensation and Workload Impact:** Compensation and workload volume significantly affect satisfaction and retention, warranting separate analysis in engagement efforts.

Below are the detailed findings from our program review.

Listening Quality and Satisfaction with Supervisor

An evaluation of feedback from the Intervention Clinic revealed that enhanced listening skills among Board Certified Behavior Analysts (BCBAs) were associated with higher levels of satisfaction reported by Registered Behavior Therapists (RBTs) regarding their supervisory relationships. Notably, this trend was absent within both the Partial Intervention and Control Clinic groups, thereby underscoring the critical role of comprehensive training models in fostering listening competency. Conversely, the absence of sustained, active empathetic listening in partial intervention settings was associated with a detrimental effect on outcomes.

These findings align with the LMX theory, which posits that high-quality relationships between supervisors and subordinates are characterized by strong listening, open communication, and trust-building (Graen & Uhl-Bien, 1995). The model we selected and used for measurement shows that active empathetic listening is foundational to strengthening the dyadic relationship between the two groups (Lloyd et al., 2015). Weger et.al (2014), who found

that a supervisor's ability to improve listening behaviors has a significant relational impact on employees' engagement and perception of support, aligns with what was observed in this program review. The absence of such behaviors as a sustained model in the Partial Intervention and Control clinic groups also aligns with our model of low-quality LMX (Lloyd et al., 2015).

These results are consistent with Leader-Member Exchange (LMX) theory, which posits that high-quality supervisor-subordinate relationships are defined by effective listening, transparent communication, and the cultivation of trust (Graen & Ul-Bein, 1995). The evaluative framework employed in this study confirms that active, empathetic listening is essential for enhancing the dyadic relationship between BCBAs and RBTs (Lloyd et al., 2015). This finding is further corroborated by the work of Weger et al. (2014), who demonstrated that improvements in supervisory listening behaviors exert a significant positive influence on employee engagement and perceptions of organizational support.

Conversely, an important finding is that the partial implementation of the intervention may have actively undermined satisfaction with supervision between BCBAs and RBTs at the Partial Intervention clinic. This deterioration suggests that exposure to a change that is not maintained could weaken the trust being developed. As Moin et al. (2021) and Sheer (2014) emphasize, there is a risk associated with inconsistent leadership communication and the failure to sustain trust-building efforts, as this exacerbates employees' uncertainty. Therefore, it is crucial to avoid partial engagement and to ensure that, if such engagements are undertaken, they are fully developed and consistently maintained.

Listening Quality and Job Satisfaction

Notably, the quantitative data did not show a direct link between listening quality and overall job satisfaction, contrary to initial expectations. It was expected that increased satisfaction with supervisors would be associated with higher job satisfaction among RBTs; however, the results revealed a more complex relationship. Specifically, survey items related to job satisfaction mainly focused on the nature of the work itself, which tended to

produce more positive responses. However, factors outside the dyadic leader-member relationship appeared to influence these outcomes, leading to different trends in the quantitative and qualitative data.

The central insight is that, while leader listening quality has an indirect effect on job satisfaction, the main factors influencing RBT job satisfaction lie outside direct supervisory behavior. Instead, elements like compensation and peer relationships, which were emphasized in the qualitative data but not in the quantitative data, emerged as key contributors to dissatisfaction. This highlights the importance for Helping Hands Family to understand the leader's role as more indirect, focused on sensegiving¹—rather than as a direct driver of job satisfaction as outlined in this review. Interestingly, the peer-to-peer LMX (Sherf et al., 2017) emerged as a more prominent theme in both qualitative clinics, offering insight that workplace dynamics with coworkers play as significant a role in the workplace as the leader, and is a key area that Helping Hands should consider addressing.

This discussion extends into the domain of organizational culture, with a particular emphasis on the role of sensemaking in reducing ambiguity, clarifying expectations, and fostering a shared understanding among team members. By anchoring interpretive processes in collective narratives, rather than the fragmented approaches currently observed, the organization can cultivate a more coherent and supportive cultural environment. This is what is observed in the Intervention Clinic, where the sensegiving by the Clinical Director provides continuous clarity, enabling the RBTs to make sense of the work and the expectations through consistent and similar interpretations. Despite the absence of a measurable improvement in the quantitative data, this finding highlights the ongoing importance of strong leaders in shaping peer-to-peer relationships and the cultural experiences within their clinics.

¹. Sensegiving is the deliberate effort by a leader or influential actors to shape how individuals understand and make sense of situations (Gioia & Chittipeddi, 1991). Sensemaking in contrast, is how individuals interpret the world and make meaning of the situations that are sometimes complex in the world (Weick, 1995).

Retention

Although we could not quantify the relationship between job satisfaction, supervisor satisfaction, and retention, the qualitative interviews and the month-over-month decrease in turnover for these clinics suggest a potential relational element.

Satisfaction with Supervisor and Retention

Helping Hands Family (HHF) occupies a distinctive position, as employee feedback indicates that the quality of supervisory relationships serves as a pivotal factor in decisions to remain with or depart from the organization. Specifically, employees have articulated that positive supervisory interactions are a primary reason for retention, while a lack of meaningful supervisor engagement motivates some to seek alternative employment opportunities. This observation is particularly salient in light of the relational framework advanced by McGlone and Delcour, which emphasizes the foundational importance of the BCBA–RBT relationship.

Empirical trends within the Intervention Clinic reinforce this notion, as a marked reduction in turnover followed the implementation of the enhanced supervisory program, in contrast to increasing attrition observed in other clinics. The qualitative statements provided by staff underscore the intertwined nature of supervisory relationships and retention decisions, suggesting a substantive-if not yet fully quantifiable—connection. While the current analysis could not establish a direct statistical association between supervisory satisfaction and retention, these findings nonetheless echo extant literature indicating that high-quality leader–member exchange (LMX) relationships are associated with greater organizational citizenship behaviors and, consequently, improved retention outcomes. Including the employees' thoughts and ideas signals that they are seen as a valuable member of the team (Amabile & Kramer, 2011).

Thus, the evidence calls for further systematic investigation into the mechanisms by which supervisory relationships influence employee retention, to inform best practices in organizational management and staff support.

Job Satisfaction and Retention

A significant discovery arises from the prominent emphasis that employees place on peer-to-peer relationships, mental health, and compensation as primary motivators affecting their intention to depart from the organization. Although these elements are crucial to job satisfaction, the current analysis suggests that the relationship between job satisfaction and retention does not predominantly operate within the traditional dyadic leader-member exchange model identified in this program review. Instead, leadership influences job satisfaction indirectly, whereas the primary factors determining employee satisfaction are organizational in nature.

Consequently, the connections between listening quality, job satisfaction, and retention appear to be diminished within the context of Helping Hands Family, diverging from patterns observed in other organizational environments. This observation does not negate the existence of a relationship; instead, it highlights that the pathways are more complex and are mediated by broader organizational factors. The findings suggest that senior leaders who demonstrate effective listening can address organizational issues that drive dissatisfaction, thereby potentially improving employee retention. Moreover, the indirect impact of leadership on organizational culture and peer-to-peer dynamics constitutes a noteworthy and unexpected insight, meriting further investigation.

Job Satisfaction and Peer Relationships

The qualitative data illuminate the influence of coworker relationships on job satisfaction, drawing attention to the coworker member exchange facets of leader-member exchange theory (Sias & Jablin, 1995). For Registered Behavior Therapists (RBTs), support from peers exerts a notable impact, even in the absence of direct supervisory involvement; consequently, leaders should be encouraged to cultivate environments that facilitate positive peer interactions. Peer relationships have functioned as a mitigating factor for diminished job satisfaction observed in the partial intervention clinic, where limited supervisory engagement was offset by robust team support. Amabile and Kramer (2011) refer to this concept as “affiliation.” They describe how team members develop stronger emotional bonds through activities such as socializing outside of work, providing mutual support during projects to achieve

goals, and assisting one another as part of the organizational culture. These factors collectively foster a strong sense of affiliation within the group and the larger organization (p. 151). Afshari and Gibson (2022) underscore that psychological safety and trust are strengthened when peers actively contribute to a constructive organizational climate. Thus, a key insight emerging from this program review is the value of integrating peer-to-peer dyadic relationships within leadership development frameworks, acknowledging their substantial role in fostering employee satisfaction and organizational cohesion.

Job Satisfaction and Growth

A notable avenue for further exploration concerns the perceived professional growth of Registered Behavior Therapists (RBTs) who engage in activities that extend beyond their routine responsibilities, such as participating in intake processes or contributing to program design. The absence of such growth-oriented tasks has been associated with diminished job satisfaction and elevated turnover intentions, as evidenced in the partial intervention clinic. Conversely, when RBTs are provided with opportunities to assume meaningful clinical responsibilities, there is a corresponding increase in engagement and a decline in intentions to leave the organization. Sherf et al. (2017) argue that involvement in substantive tasks, even in the absence of formal advancement, enhances leader–member exchange (LMX). Furthermore, the work of Lloyd et al. (2015) has established that higher quality LMX relationships foster both employee retention and organizational commitment. Consequently, it is imperative that opportunities for meaningful professional growth are systematically integrated into organizational practices and not overlooked in future program development.

Recommendations

The following are the recommendations for the program that was reviewed for this capstone. These recommendations are grounded in answering question number 3 of the program review: Based on the findings from Questions 1 and 2, what can Helping Hands Family do to enhance the program to develop listening leaders?

Recommendation 1: Reconfigure the Learning Framework to be Competency-based

Findings from this program review demonstrate that competencies such as listening quality, supervisory satisfaction, trust-building, and sensegiving are important and should be positioned as the central outcome of the model. Refer to Figure 6a, where each action during training is framed around the role. This original five-pronged framework, organized based on role, does not account for the goal of each training session. When there is a failure in one of the elements, as observed in the partial intervention clinic, it underscores that role-based exposure does not guarantee comprehensive skill development.

Figure 6a

Current HHF framework with role central and actions as prongs



The recommendation is to transition to a model focused on competency mastery. The structure should have competency as its central element, with the prongs representing the interconnected ways in which the role will develop this competency. This new proposed framework aligns with literature on mastery and transfer of didactic knowledge (Brownell, 2012; Lloyd et.al, 2015). The proposed new framework (see 6b) should have three parts:

- Competency Training – Foundational knowledge and skills are imparted through standardized training modalities, which may include in-person sessions, digital platforms, or recorded materials. Leaders have the discretion to select the format that best suits their needs.
- Competency Knowledge Transfer – The development of skills on the job is systematically evaluated by a supervisor, utilizing structured timelines, tools, coaching, and feedback within a predetermined timeframe. Gollwitzer’s (1999) concept of implementation intentions, a form of

microlearning and a type of nudge, forms part of the framework for competency knowledge transfer. Employing devices and visual cues to reinforce targeted leader competencies within the daily workflow helps to embed these behaviors. For example, a tool such as a sticker on a laptop bearing a slogan like “Have you been listened to today?” serves as a visual reminder for leaders to pause and engage in active listening with their team members, thereby fostering this practice as a routine.

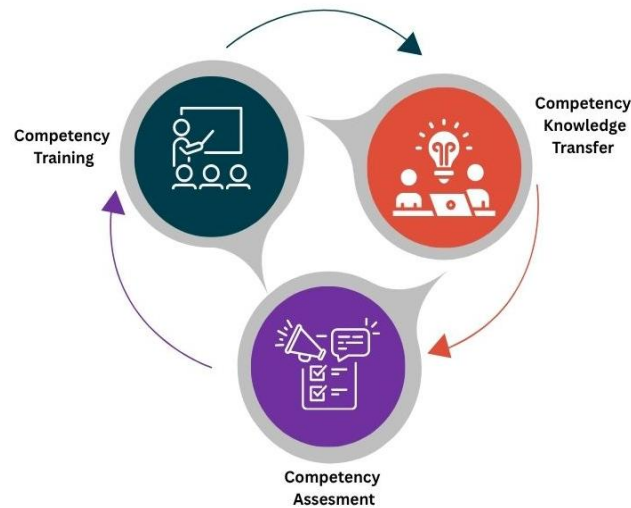
- Competency Assessment – This evaluation is conducted after the training, typically around 30 days after the completion of knowledge transfer activities.

The process of learning within leadership development is inherently cyclical and does not culminate with the conclusion of training, the transfer of knowledge, or initial assessment. Instead, the cultivation and integration of competencies necessitate ongoing reinforcement, which may be facilitated through periodic retraining and structured feedback. For example, the acquisition of foundational knowledge related to effective listening, followed by formal assessment, should be succeeded by subsequent, iterative opportunities for skill enhancement and practice.

This dynamic model of knowledge transfer is substantiated by extant literature, which maintains that the advancement of leadership competencies unfolds within the broader organizational milieu, rather than in isolation (Day, 2000). The continuous assessment and cultivation of skills are indispensable to sustained professional growth. Further, Rousseau and Tijoriwala (1999) emphasize that when leaders perceive developmental initiatives as personally salient, socially endorsed, and institutionally embedded within daily work routines, the likelihood of authentic adoption and integration of such competencies increases significantly. This underscores the importance of aligning leadership development processes with the contextual realities of organizational practice to ensure meaningful and lasting behavioral change.

Figure 6b

Recommended amendment to the training model with a cyclical nature of learning and competency



Recommendation 2: Institutionalize Peer Communities of Practice

Argote and Ingram (2000) underscore that the transfer of knowledge within organizations confers a sustainable competitive advantage, particularly when facilitated through formalized peer networks (p. 153). Within the context of Helping Hands Family, the deliberate establishment of a structured peer-to-peer network is posited to substantially enhance the dissemination of procedural tools, knowledge, and task-related expertise, thereby cultivating a culture of mutual support and professional collaboration (Argote & Ingram, 2000, p. 154). The findings from the program review elucidate a pronounced need for such communities of practice. From a human resources perspective, it is prudent to acknowledge potential concerns regarding organizational dynamics should RBT needs remain unaddressed, as the potential for external agencies to create these communities exists, thereby leaving HHF with limited control. Nevertheless, the implementation of peer learning communities offers a mechanism by which employees like RBTs and BCBAs may independently access collegial guidance, thereby reducing overreliance on hierarchical leadership structures.

Significantly, the utility of peer communities extends beyond the roles in this program review, which require forums for the practical application of acquired knowledge, collaborative problem-solving, and the reciprocal exchange of best practices. I would posit that other roles, such as office managers, clinical directors, and members of

leadership, may also benefit from peer communities of practice. Consequently, it is recommended that Helping Hands Family develop and institutionalize peer communities of practice designed to facilitate the acquisition, refinement, and reinforcement of professional competencies while fostering a robust support network among colleagues. Such communities should be distinguished from traditional employee resource groups by their explicit focus on collective learning, structured outcomes, and the advancement of professional practice through intentional knowledge sharing and collaborative engagement.

Recommendation 3: Ensure Full and Consistent Implementation of Leadership Programs

It is evident from the Partial Intervention data that incomplete or inconsistent implementation may undermine not only the intended impact of an intervention but also the relational dynamics established within the organization. As articulated by Sheer (2014) and further supported by Moin et al. (2021), inconsistent leadership behaviors erode the foundation of trust and connectedness, thereby contributing to heightened dissatisfaction among stakeholders. The data from the Partial Intervention phase demonstrated that initial progress was observed when structured supports and processes were in place; however, these gains dissipated rapidly in the absence of sustained leadership and an accountability framework to reinforce and maintain the learned behaviors.

Accordingly, Helping Hands Family (HHF) needs to establish and enforce a fidelity protocol as an integral component of program implementation, thereby ensuring that initiatives are executed in their entirety and as intended. In instances where a clinical leader is unavailable, as was the case due to medical leave, mechanisms should be instituted to transfer responsibility for leadership observations and formalized documentation to a qualified designee. Kramer (2009) further contends that competency development, if approached in a fragmented or piecemeal fashion, may signal a lack of authenticity or organizational commitment to the stated objectives, thereby diminishing the likelihood of meaningful change.

Recommendation 4: Expand Key Leadership Behaviors Organization-Wide using the Intervention Clinic as a Model.

The pivotal role of leadership competence is exemplified within the Intervention Clinic, where the clinical leadership exhibited by BCBAs and the Clinical Director proved instrumental in reinforcing desired organizational behaviors and shaping institutional culture. Observations from the program underscore that leadership behaviors benefited substantially from structural reinforcement by regional leadership (Dalcour as the Regional Director of Clinica Operations), coupled with consistent modeling by the Clinical Director that contributed to the habitual reinforcement of best practices throughout daily operations. Drawing on the Intervention Clinic as an archetype, it is recommended that this setting be utilized as a blueprint for institutionalizing essential leadership competencies, such as effective listening, across the organization systematically and programmatically.

A primary strategy to achieve this involves ensuring that the standardized process for BCBA and RBT check-ins—successfully implemented within the Intervention Clinic—becomes the normative standard for leadership practice across all clinical operations. Furthermore, clinical operations would benefit from shifting away from an exclusive reliance on quarterly and monthly surveys and reviews, in favor of fostering real-time feedback mechanisms as established in the Feedback Loop training. For example, feedback prompts such as, “Did you feel heard this week?” or “Did you have the opportunity to contribute this week?” and “What is one challenge affecting your work that I can assist with?” serve as actionable tools for ongoing engagement. It is essential to emphasize that gathering this data necessitates action, as posited by Lloyd et al. (2015) in the active empathetic listening model studied in this program review. Adopting the “pause and listen” approach, rooted in the Rapport Building training, should be formalized as a core leadership competency rather than treated as an ancillary skill. This integration is designed to incorporate effective listening into clinical operational practices. However, this model is not limited to listening competency; it can also be applied to other competencies and aspects of clinical practice. The structure of the Intervention Clinic may serve as a reference for establishing a standard approach across all clinics, a blueprint for what the organization would like the clinic's operations and leadership to be.

Additionally, on-the-job microlearning, whether facilitated by Clinical Directors or BCBAs for their supervisees, supports the continuous development of competencies and skills. Microlearning is embedded in knowledge transfer ideology and is within the recommended new leadership competency framework. It is therefore recommended that Helping Hands Family transition from episodic, event-based training toward what Gollwitzer (1999) defines as “implementation with intention”—the principle that, “when situation X arises, I will enact behavior Y”—to cultivate behavioral automation in competency development.

Taken together, these programmatic and formalized approaches guarantee that established competencies are reinforced consistently within daily clinical operations, rather than maintained through isolated training events. Such a commitment ensures that professional learning remains dynamic and ongoing, contributing to the cultivation of a continuous learning culture within the institution. The pivotal role of leadership competence is exemplified within the Intervention Clinic, where the clinical leadership exhibited by BCBAs and the Clinical Director proved instrumental in reinforcing desired organizational behaviors and shaping institutional culture. Observations from the program underscore that leadership behaviors benefited substantially from structural reinforcement by executive leadership, coupled with consistent modeling that contributed to the habitual reinforcement of best practices throughout daily operations. Drawing on the Intervention Clinic as an archetype, it is recommended that this setting be utilized as a blueprint for systematically and programmatically institutionalizing essential leadership competencies, such as effective listening, across the organization.

A primary strategy to achieve this involves ensuring that the standardized process for BCBA and RBT check-ins—successfully implemented within the Intervention Clinic—becomes the normative standard for leadership practice across all clinical operations. Furthermore, clinical operations would benefit from shifting away from an exclusive reliance on quarterly and monthly surveys and reviews, in favor of fostering real-time feedback mechanisms as established in the Feedback Loop training. For example, feedback prompts such as, “Did you feel heard this week?” or “Did you have the opportunity to contribute this week?” and “What is one challenge affecting

your work that I can assist with?” serve as actionable tools for ongoing engagement. Adopting the “pause and listen” approach, rooted in the Rapport Building training, should be formalized as a core leadership competency rather than treated as an ancillary skill. This deliberate integration ensures that effective listening becomes embedded within clinical operational practices.

Additionally, on-the-job microlearning, whether facilitated by Clinical Directors or BCBA's for their supervisees, supports the continuous development of competencies and skills. It is therefore recommended that Helping Hands Family transition from episodic, event-based training toward what Gollwitzer (1999) defines as “implementation with intention”—the principle that, “when situation X arises, I will enact behavior Y”—to cultivate behavioral automation in competency development. Such a commitment ensures that professional learning remains dynamic and ongoing, contributing to the cultivation of a continuous learning culture within the institution.

Recommendation 5: Redesign Workload Systems to Match Motivational Drivers

A foundational tenet articulated in Pinder's (1998) theory of work motivation posits that sustained effort and organizational commitment are determined by three principal factors: perceived fairness, the meaningfulness of work, and the presence of reinforcement. Within Helping Hands Family, the notion of meaningful work occupies a central position, encapsulated in the organization's guiding philosophy: “Take care of the client, take care of the team, and the business will take care of itself.” This ethos is widely internalized across the organization and constitutes the cornerstone of operational practice.

Despite this, program evaluation findings—particularly from the Partial Intervention Clinic and, to a lesser degree, the Intervention Clinic—suggest a potential misalignment between Registered Behavior Therapists' (RBTs) perceptions of their work effort and the recognition or reinforcement afforded to them. Such a disparity may have a negative impact on both employee engagement and job satisfaction. Although the present analysis does not explicitly address compensation frameworks, it is critical to acknowledge that perceptions of fairness in the acknowledgment, structuring, and distribution of effort are essential for fostering adaptive organizational behavior.

As supported by research (Novack & Dixon, 2019; Kazemi et al., 2015), perceived inequity is likely to precipitate disengagement, independent of the quality of interpersonal relationships or the intrinsic value derived from the work itself.

To remediate these concerns, I recommended that Helping Hands Family implement a motivation-informed approach to workload and role clarity, emphasizing effort-based, equitable, and transparent systems of reinforcement. Central to this redesign is the suggestion to introduce “scheduling pods,” which empower employees to allocate their workloads with greater agency. For instance, BCBAs could collaborate in assigning RBTs to clients, or RBTs within each pod could collectively structure their work schedules. Another example concerns the structure of compensation and recognition programs. Incorporating input from RBTs and BCBAs into the design of these frameworks can have a positive impact, much like effective work design, as it empowers RBTs to feel involved in how they are rewarded and recognized for their contributions to the organization.

Moreover, as articulated in Lloyd et al.’s (2015) Leader-Member Exchange (LMX) framework, it is imperative to recognize that organizational efforts concentrated solely on enhancing supervisory relationships, in the absence of broader structural equity, may undermine both engagement and trust in leadership systems themselves. Thus, a holistic approach, integrating both relational and structural dimensions of fairness, is requisite for promoting optimal organizational functioning.

Recommendation 6: Institutionalize Listening as a Competency Across Clinical Operations for Habit Forming

In synthesizing the reviewed data, it becomes apparent that enhanced listening competencies among BCBAs within the Intervention Clinic were associated with statistically significant and qualitatively meaningful improvements in the dyadic relationships between BCBAs and RBTs. In contrast, clinics that received either no intervention or only partial implementation exhibited either a decline or a lack of measurable change in these relational dynamics. HHF aimed to assess whether the pilot demonstrated improvement in the dyadic relationship between BCBAs and RBTs, and, if so, to expand the training to the entire clinical operations team. The results,

while aligned with the goal, highlight the importance of ongoing leadership behaviors, particularly effective listening, which requires continuous reinforcement.

Consequently, the recommendation to institutionalize listening as a core competency across clinical operations should be accompanied by the establishment of enduring, systematic structures that facilitate the habit-forming nature of this skill. Only through continuous reinforcement and integration into daily practice can listening competency transition from an isolated intervention to an ingrained organizational habit, thereby enhancing both relational quality and overall clinical effectiveness.

Summary and Conclusion

This capstone project evaluated a program implemented by Helping Hands Family over five months, designed to enhance the dyadic relationship between supervisors and employees (BCBAs and RBTs) in their clinics by developing listening and trust-building competencies in leaders. The evaluation, which applied the LMX framework, produced several key findings as outlined in Table 14.

Building upon these findings, several recommendations were formulated to reconfigure the professional development framework and embed the cultivation of listening competencies and peer communities of practice as organizational priorities to enhance retention. Each recommendation is accompanied by a request for Helping Hands to systematically monitor behavioral changes and the perceptions of Registered Behavior Therapists (RBTs), as well as retention data, in order to assess the sustained impact of these initiatives. The success of the Helping Hands Family's (HHF) program depends on the comprehensive, consistent implementation and diligent follow-through of these initiatives. The data from the partial clinic illustrate that insufficient follow-up can undermine the trust-building and leader-member exchange (LMX) that the organization has endeavored to establish. Furthermore, job satisfaction is influenced by factors beyond the LMX relationship; notably, the impact of peer groups warrants further exploration as a mechanism for improving retention, thereby promoting continuity of care and organizational success. Future research should examine the long-term effects of these interventions at the enterprise level, with

ongoing assessment of employee sentiment and organizational culture. There is also an opportunity to examine how Peer Member exchange affects retention as a strategy for workforce stability.

Table 14

Summary table of recommendations, findings, framework, and recommended partner lead

Recommendation	Framework and Focus Area	Findings	Lead
Recommendation 1: Reconfigure the learning framework to be competency-based	Leader-Member Exchange Trust Building	Finding 1: Listening Quality and Supervisor Satisfaction: Enhanced listening skills among BCBAs resulted in higher RBT satisfaction.	McGlone and Dalcour
Recommendation 2: Institutionalize peer communities of practice.	Communities of Practice Peer LMX	Finding 2: Listening Quality and Job Satisfaction: Listening quality had only an indirect effect on overall job satisfaction Finding 3: Peer Relationships and Growth	McGlone and Dalcour
Recommendation 3: Ensure full and consistent implementation of the leadership program.	LMX Consistency Implementation fidelity	Finding 1: Listening Quality and Supervisor Satisfaction: Partial or inconsistent implementation hurts outcomes.	McGlone
Recommendation 4: Expand key leadership behaviors organization-wide using the Intervention Clinic as a model.	Psychological safety LMX Organizational citizenship behavior	Finding 4: Overall Role of a Leader: Leadership influences organizational culture and peer relationships	McGlone
Recommendation 5: Redesign workload systems to match motivational drivers	Work motivation theory	Finding 5: Compensation and Workload Impact: Compensation and workload volume significantly affect satisfaction	Regional Leadership Teams
Recommendation 6: Institutionalize listening as a competency across clinical operations to foster a habit.	Behavior habit formation Active Empathetic Listening	Finding 1: Listening Quality and Supervisor Satisfaction: Enhanced listening skills among BCBAs resulted in higher RBT satisfaction with supervisors in the Intervention Clinic.	Regional Leadership teams and McGlone

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Appendix A

To review the Training Slides, slides are proprietary. To request, please email HR@hhfamily.com

Appendix B – Stakeholder Stable with Impact and Grouping

Type of Stakeholder	Stakeholder at HHF	Impact on the Stakeholder Group	Stakeholder Impact (Direct vs. Indirect)
Primary: Those directly influenced by the program	BCBAs	The training is delivered to the BCBA supervisors of RBTs	Direct
	RBTs	Following the training, the RBTs will receive improved supervision, which will increase their sentiment of the supervisor-subordinate relationship and enhance job satisfaction, leading to higher retention rates and lower turnover.	Direct
Secondary: Those indirectly influenced by the program's outcomes	HHF Clients	Reduced turnover and more informed and “satisfied” RBTs will improve the quality of ABA services they receive from the RBTs	Indirect
	HHF Quality and Training Team	The data from the program will help the quality and training team to design practical training and supervision models that will continuously impact care delivery	Indirect
	HHF Clinical Operations team	The clinic's unit economics will improve, and the clinical team can redirect its work and efforts to other areas of clinical operations.	Indirect
	HHF Talent Acquisition Team	When there is a reduced turnover, the talent acquisition team will be able to reduce the volume of work, thereby freeing up time for them to focus on the quality of the candidate, not the quality of the candidate	Indirect
Tertiary: Those interested in the outcomes but not directly affected by the outcomes.	HHF Leadership Team	The financial impact will enable the organization to invest in other areas of resources to recruit talent, given the large number of existing team members.	Indirect
	The HHF Board of Directors		Indirect
	The ABA Industry	Success in implementing the HHF's BCBA supervision program will set new guidelines for supervision in	Indirect

		ABA work, and the ripple effect is driving change in the industry.	
Implementers and Operations: Those involved in the day-to-day execution of the program	Quality and Training Development team	The team implementing the program will also gain insights from my academic exposure during the LLO program, which they can use to refine and evaluate its effectiveness.	Indirect