The behavior analyst as a team member: Toward a cohesive multidisciplinary approach to treating individuals diagnosed with an Autism Spectrum Disorder (ASD)

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Individuals diagnosed with developmental or learning delays, including those diagnosed with Autism Spectrum Disorders (ASD) present deficits in many areas such as communication, social behavior, play skills, and self-help skills. Furthermore, many children diagnosed with ASD engage in behaviors that may either be dangerous to others or themselves (e.g., physical aggression, self-injurious behavior, property destruction), or interfere with learning (e.g., stereotypic behavior). A large percentage of these children also have difficulties with sleep, and may develop seizure disorders. Often times, the most challenging of these children are not able to be properly cared for at home, resulting in more restrictive placements such as non-public schools or residential placements. In light of this and the various scenarios behavior analysts working with individuals with ASD will encounter, they need to develop a wide range of skills, some of which are not taught as part of their standard training. When addressing behaviors exhibited by individuals with ASD, behavior analysts are often required to collaborate with a multidisciplinary team that may include physicians, psychiatrists, nurses, speech and language pathologists, occupational therapists, mental health counselors, and adaptive physical education specialists. Providing behavior-analytic services in collaboration with others who support and/or provide services to one’s clients is a task identified in the Fourth Edition Task List written by the Behavior Analyst Certification Board (BACB). The goal of the present article is to elaborate on the responsibilities of the behavior analyst when collaborating with other professionals with respect to the treatment of severe behaviors observed in children diagnosed with an ASD.

Key words: developmental and learning delays, Autism Spectrum Disorder, severe behavior, multidisciplinary team.

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“Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior” (Behavior Analyst Certification Board, 2012). ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

ABA is frequently the preferred method for treating individuals with developmental and learning delays. Over the last few decades, ABA has proven to effectively produce significant changes in the quality of life of numerous individuals (Fox, 2008). In the United States, Applied Behavior Analysis is well on its way to becoming increasingly accountable as a treatment option in the legislative realm (Green & Johnston, 2009) and is becoming recognized as a well-established empirical treatment for disorders such as those including Autism Spectrum Disorder (Smith, 2012).

Autism Spectrum Disorder (ASD)

According to the American Psychiatric Association (2013), ASD is characterized by symptoms observed beginning in early childhood and include communication
deficits such as misreading non-verbal cues from others and therefore, responding inappropriately when engaging in conversation. It is often challenging for those with ASD to develop friendships. Other characteristics commonly observed in those with ASD include dependency on routines and difficulty with change in the environment. It is important to note that diagnosis of ASD is on a continuum and symptoms may range from mild to severe. Information provided by the Centers for Disease Control and Prevention (CDC) indicates that the prevalence of Autism Spectrum Disorder among children aged 8 years is 1 in 68 as measured across multiple areas of the United States (2010).

Ahearn and Tiger (2013) described the outcomes of treatments for individuals with ASD as optimized by structured behavioral interventions targeting the core and associated deficits. The authors list four main areas behavior analysts assess and treat: problem behavior, communicative impairments, lack of symbolic language, and social deficits.

**Need for Collaboration with Other Professionals**

Individuals with ASD are often diagnosed with more than one psychiatric disorder, such as childhood anxiety disorders, depressive disorders, oppositional defiant and conduct disorders, attention deficit hyperactivity disorder, tic disorders, obsessive-compulsive disorders, and mood disorders. The identification of additional psychiatric disorders in these individuals is frequent. One study examining 112 children ranging from 10-14 years of age found at least one comorbid disorder in 70% of the sample, and two or more in 40% of the sample (Simonoff et al., 2008). Nebel-Schwalm and Worley (2014) reported a 40% - 70% prevalence of comorbidity in children and adolescents diagnosed with ASD, which included conditions such as encopresis, language disorders and anxiety disorders. In addition to psychiatric disorders, ASD is associated with other neurological comorbidities such as motor impairments (including stereotypic behaviors, motor delays, and deficits such as dyspraxia, poor coordination, and gait problems), sleep dysfunction (difficulty with sleep onset and prolonged awakenings during the night), and epilepsy (Maski, Jeste, & Spence, 2011).

Comorbidities of diagnoses have a significant impact on the behavior and cognitive functions of children with ASD and as such, should also be targeted for treatment. Severe or dangerous challenging behaviors such as aggression, self-injury and property destruction are common in individuals diagnosed with ASD (DeoHRING, Reichow, Palka, Phillips, & Hagopian, 2014). When severe behaviors escalate to the point at which a public school or family environment cannot care for the children they are referred to non-public schools or residential treatment facilities. These extreme behaviors are often correlated with severe deficits in other areas, most notably functional communication (Durand & Moskowitz, 2015).

Once an individual is identified as requiring individualized treatment, often they are placed in specialized classrooms at public schools, at non-public schools or at residential facilities. These establishments are responsible for all care provided to the student. As a result, students requiring this specialized treatment require a team composed of professionals such as behavior analysts, nurses, pediatricians, dentists, neurologists, psychiatrists, speech and language pathologists, occupational therapists, neuroscientists, psychologists, mental health counselors, and social workers. The collaboration among all these professionals can be described as multidisciplinary services, which may be defined as “combining or involving several academic disciplines or professional specializations in an approach to a topic or problem” (Oxford Dictionaries, Retrieved 2015). Most of the professionals work on a consultative basis and very often the supervisor of these programs is a behavior analyst. The behavior analyst is responsible for developing and implementing most skill acquisition and challenging behavior reduction systems, but may also be responsible for working with other professionals to develop programs to increase other specific appropriate behaviors such as posture, appropriate walking, appropriate sleeping, and acceptance of medication.

Since 2000, behavior analysts have been certified by the behavior analysis certification board (BACB). The BACB is a nonprofit corporation established to meet professional credentialing needs identified by behavior analysts, governing bodies, and consumers of behavior analytic services. In order to become a board certified behavior analyst (BCBA) one must undergo extensive training and be supervised by experienced board certified behavior analysts. The unfortunate reality though, is that such training may or may not encompass steps on how best to interact with other professionals who are not familiar with behavior analysis. In an effort to address this, the BACB has created task lists to better guide behavior analysts and their supervisors for training in identifying the crucial skills to be learned within the scope of working with professionals outside behavior analysis. In the third and fourth editions of the task list (both available online at the BACB website at www.bacb.org) one will find the topic of
multidisciplinary collaboration, which is defined in the following manner: “To provide behavior-analytic services in collaboration with others who support and/or provide services to one’s clients” (BACB Task List, item 10-6 in third edition and G-06 in fourth edition).

The BACB task list has been largely accepted as the standard for specific training in Applied Behavior Analysis. It is interesting that although it specifies the need for a multidisciplinary team in assessment and treatment, the collaboration among different disciplines has seldom been described in its scientific publications. Moreover, issues in how to train a behavior analyst to be part of a multidisciplinary team have not been adequately addressed. For example, when the authors conducted a word search using the key word multidisciplinary, no articles using the term were found in the two main journals in the field of Behavior Analysis: Journal of Applied Behavior Analysis (JABA, http://seab.envmed.rochester.edu/jaba/) or the Journal of the Experimental Analysis of Behavior (JEAB, http://seab.envmed.rochester.edu/jeba/). The term was cited by only 28 articles published by the American Speech and Language Hearing Association (ASHA, http://www.asha.org/), yet when the authors searched a medical source (PubMed) they found 20,743 articles.

The results of our search raised the question: are behavior analysts not collaborating with professionals in other fields? Our experience tells us that collaboration with other professionals is not an option, but rather a necessity. Our conclusion is that behavior analysts are indeed collaborating with professionals working in different fields. However, they are not publishing the results of such collaboration and they are not publishing the results of how best to train a behavior analyst to become an effective collaborator nor the results of how collaborating may produce better outcomes as opposed to working in isolation.

Issues with communication are well documented in children diagnosed with ASD. In the U.S.A., many students diagnosed with ASD receive services from a licensed Speech and Language Pathologist (SLP). Some programs provide consultative services while other programs provide direct services combined with consultation in this area. The consultative model includes a SLP who conducts assessments and writes curricula, provides direct services and/or trains the staff members but also works a for a designated period of time per week directly with the student.

Although behavior analysts have some training in verbal behavior and as such could arguably write curricula and train staff members to deliver the instructions, the SLP has extended training in language development and their training include areas that the Behavior Analyst has no training such as articulation, language position, and the formation of the mouth palate. The collaboration between behavior analysts and SLP therefore adds to the knowledge of verbal behavior training and could benefit the individual. Although the behavior analyst and the SLP may have share some similar skills, they are not redundant.

The authors’ experience has been that the SLP become invested in behavior analysis when open communication is established across disciplines and, in fact, in some settings in which we have worked, it is common that SLPs seek training in behavior analysis and pursue certification as behavior analysts themselves.

The training of functional communication as an alternative to problem behavior, for example, is well understood by SLP who write curricula to teach these responses and train the staff members to run the programs. Figure 1 displays a simulated example of the effects of communication training. We recommend that the behavior analyst establishes an open line of communication with the SLP assigned to their cases by sharing data, learning about articulation training (a skill that SLP may have more training than the behavior analyst), and developing interventions together in a collaborative manner.

Use of Protective Equipment to Prevent Self-Injurious Behaviors (SIB)

Some individuals diagnosed with ASD display problem behaviors such as severe SIB, for example, in the form of head hits. Given the propensity for head-directed self-injury to cause both external and internal damage, the occurrence of such severe behaviors may result in the need to use protective equipment. Consider an example of a student who punches his own face area thousands of times per day. One way that behavior analysts have addressed this problem is by initially, for safety reasons, preventing the response from occurring. This can be done, for example, with the use of arm
limiters (Fisher, Piazza, Bowman, Hanley, & Adelinis, 1997) or the use of soft helmets, the purpose of which is to protect the face and head, given the occurrence of head-directed self-injury. The rigidity of the arm limiters is faded over time and eventually the limiters may be faded out completely (Figure 2 presents fictitious data on the use of arm limiters).

The discussion we would like to raise in the spirit of collaboration is the need for the behavior analyst to collaborate in examples such as this with occupational therapists (OT) and the medical department when using this type of procedure. It is our experience that the OT prescribes a series of exercises that should be conducted with the student using arm limiters several times per day in order to prevent injuries such as decrease in blood flow and deterioration of the skin. The OT prescribes the number and type of exercises as well as the frequency with which to conduct them. The medical department prescribes checks to be conducted by the staff members to ensure that circulation and skin conditions are not affected by the use of the arm limiters. We pinpoint the need for such collaboration because once again, although the behavior analyst may be the supervisor of the case, the need for collaboration with the OT and medical professionals in a case such as this cannot be overstated.

Functional Analysis (FA)

It is best practice to conduct an experimental functional analysis when attempting to identify the function of problem behaviors (Iwata, Dorsey, Slifer, Bauman, & Richman, 1982; Sidman, 2011). Sidman
wrote that the widely effective applied principle called “functional analysis” (e.g., Iwata et al., 1994) grew directly from knowledge gained from basic research on reinforcement.

It is understood that in order to assess the function of some extremely severe problem behaviors, the behavior itself must be allowed to occur and along with this, one must weigh the risks and benefits. Consider an example of severe self-injurious behavior such as head banging on hard surfaces. In attempting to identify the function of such head banging, the behavior analyst has to analyze the relationship between the behavior and the environment and in order to do that, the behavior must be allowed to occur. Head banging on hard surfaces, however, may produce injury. The severity of injury depends on many variables, which include the frequency and intensity of the behavior. Hitting the head on the floor once with very little intensity may not produce substantial injury but hitting the head 500 times with the same intensity may produce long lasting injury. It is also important to consider the very real possibility that one hard hit may in and of itself produce irreversible damage. Behavior analysts have attempted to establish some methods for identifying or quantifying damage produced by SIB (Iwata, Pace, Kissel, Nau, & Farber, 1990). The behavior analyst, however, does not have the medical training required to evaluate the injury. In our experience, collaboration with the medical department has been an important part in determining FA session termination criteria as well as criteria to examine for injuries that may result from the occurrence of severe problem behaviors; such as SIB.

Session termination criterion is a safeguard that should guide the clinicians conducting the analysis. The criterion is established in collaboration because the behavior analyst has the data on the history of the individual and on the topography of the response while the medical professional has data on what types of hits would produce what type of damage and the medical professional would know by virtue of his or her experience, what signs to look for. Working collaboratively, behavior analysts and medical professionals agree upon very specific guidelines for the clinicians, for example, “If Johnny hits his head on the side more than 10 times within a 10-minute period you should terminate the session and prevent or block further occurrences of the behavior”. Consider the scenario of Johnny hitting his head on the side 9 times in the beginning of a 30-minute session, then 7 times on minute 12, and 9 more times in minute 26. Johnny would have engaged in the behavior, which is considered severe, 30 times in one 30-minute session. Perhaps this could cause injury, and a nurse could check for soft or red skin in the area. If the behavior analyst works closely with the medical professional, they may decide that if the student hits himself on the side of the head for a total of 15 times
Food Selectivity and Food Refusal

It has been reported that approximately 80% of people diagnosed with intellectual disabilities including ASD present problems related to food intake (Munk & Repp, 1994) and that children with ASD exhibit more food refusal than typically developing peers (Bandini et al., 2010). In our experience, collaboration with nutritionists, occupational therapists, and other health care professionals is fundamental in treating and managing such problems. We have worked with clients who, for example, presented extreme food preferences and food refusals sometimes requiring such intense interventions as feeding tubes (a procedure which requires the intervention of medical doctors). Collaboration with an OT specialist and medical professionals resulted in the development of assessments of different types of foods (texture, color, smell, etc.) and the development of a preference hierarchy among different food items. A program in which less preferred food intake was followed by reinforcement by more preferred items was then introduced and the client started eating a larger array of food items.

In these situations, the behavior analyst has the opportunity to shape and reinforce the behavior of other professionals by developing clear steps of a desensitization program, creating data sheets to record data, analyzing the data, presenting results and revising treatment protocols. During all steps of the intervention there are great opportunities to collaborate, which will certainly be in the client’s best interest.

Epilepsy or Seizure Disorders

According to the National Institute of Neurological Disorders and Stroke, epilepsies are a spectrum of brain disorders ranging from more severe and life threatening, to less severe and benign (National Institute of Neurological Disorders and Stroke, 2015). Seizure activity can be identified via measurement of electrical activity in the brain (e.g., magnetic resonance imaging or computed tomography) and by direct observation of the paraprofessional working with the individual.

Approximately 30% of children diagnosed with ASD develop seizure disorder during their lifetime. Seizure disorder is often well controlled by the intake of certain medications prescribed by neurologists (e.g., Keppra, Lorazepam, and Depakote). The neurologist working on a case also conducts the analysis of results of MRI and other exams in order to determine when to increase or decrease doses of medication. The behavior analyst needs to be trained to identify seizures so he/she can train other staff members to recognize the occurrence of seizures. The training behavior analysts receive in this area in our experience is typically delivered by registered nurses, who are trained to identify and treat an individual having a seizure.

Regarding seizures, there are data that the neurologist may not have access to and that the behavior analyst may want to share. For example, the number of hours slept and the quality of sleep (number of hours a client wakes up per night) are data that when shared by the behavior analyst with the neurologist may prevent the occurrence of seizures. It is reported by the National Institute of Neurological Disorders and Stroke that lack of sleep can be directly related to increases in seizure occurrence. Residential settings should have systems in place to collect, analyze and share data such as sleep data with neurologists and psychiatrists. Figure 3 shows an example of a data sheet which can be used by overnight staff members to record the quantity and quality of sleep. With training and effort, an overnight professional may obtain data that can be used to make many important decisions regarding treatment for the individual. These data can be summarized in order to help evaluate sleep onset, quality of sleep (measured as the sleep/awake periods throughout the night), and total duration of sleep. Figure 4 shows a sample of sleep data for one of the students we have worked with in a residential setting. This is the type of data that may be shared with
physicians, neurologists, psychiatrists, nurse practitioners, and other health care professionals.

Sleep Data

<table>
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<tr>
<th>Date: xx/xx/xx</th>
<th>15min</th>
<th>30min</th>
<th>45min</th>
<th>60min</th>
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<tbody>
<tr>
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<td>S</td>
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<td>8pm</td>
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<td>9pm</td>
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<td>6am</td>
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<tr>
<td>7am</td>
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<tr>
<td>8am</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

A= Awake  
S= Sleeping

Figure 3. Sample data sheet for recording sleep.

Use of Psychotropic Medication

According to Autism Speaks’ Autism Treatment Network (ATN, http://www.autismspeaks.org/science/resources-programs/autism-treatment-network), approximately 27% of children diagnosed with ASD receive psychotropic medication to treat problems correlated with the diagnosis. It is plausible to assume that the percentage in individuals who engage in severe problem behaviors is higher than others. Among the more common medications used are stimulants such as Ritalin and Guanfacine (prescribed for ADHD like symptoms), anti-psychotic drugs such as Risperidone (prescribed for irritability, and behaviors such as physical aggression and self-injury), and mood stabilizers such as Depakote or Zyprexa. Some of these drugs may also be prescribed primarily for other reasons, with the effects on a targeted behavior being ancillary. For example, Propranolol, a drug used to treat high blood pressure and prevent migraines in adults, has been studied as a potential drug to treat aggressive behavior in individuals diagnosed with ASD. When prescribed to affect certain behaviors such as aggression, it is fundamental that the data be taken on aggression (frequency, intensity, etc.). Informal reports such as the perception that “things are better” should not guide the decision of a psychiatrist to increase or decrease medication dosages. Informal reports have tendencies to be influenced by isolated examples and often are not representative of the overall trend observed across multiple days and weeks in an individual. Non-public schools and residential settings are known for collecting large amounts of data on problem behavior; data collection and data analysis are part of the behavior analyst responsibilities. What is not clear is if every residential setting shares the data with the psychiatrist who is prescribing medication.

It is also not clear if the psychiatrist is willing and trained to analyze the data collected by the behavior analyst. Close monitoring of the data may facilitate separation of effects from multiple treatment components. Communication and collaboration between psychiatrist and behavior analyst is essential; the psychiatrist needs to have access and to understand problem behavior (e.g., frequency and intensity) in order to prescribe and evaluate the effectiveness of medication. In our experience in residential setting, the psychiatrist comes to the residential setting as a consultant.

Whenever possible, we have also delayed changes in the behavior treatment plan so as to eliminate such change as confound on medication changes. This approach allows the team to make data driven, evidence-based decisions while isolating variables to the furthest extent possible.

This practice was described in a case example presented as part of a symposium at a local conference in Massachusetts (Berkshire Association for Behavior Analysis and Therapy - BABAT) by Braga-Kenyon, Karsina, Bourret, Perhot, Kenyon and Steinhilber (2007). Figure 5 shows the effect of a taper of Zoloft on problem behavior that resulted in timeout procedures for one of the students we worked with in a residential setting. In this example, timeout procedures were used contingent on the occurrence of severe aggression. Due to a decrease in
the frequency of aggression, a decrease in Zoloft was indicated as was, logically, the need for timeout procedures. Upon decrease of the medication, an immediate increase in aggression was observed, and as a result there was a subsequent increase in the need for the timeout procedure. The reinstatement of the medication at the previous dosage would not have been as systematic as in this case were it not for the close collaboration of data collection and data analysis between the behavior analyst and the psychiatrist.

Many drug effects on behavior occur over time. The behavior analyst responsible for the individuals in a residential setting (and other settings) should display the most up-to-date behavior data for every behavior in which a medication has been prescribed. Together, the psychiatrist and the behavior analyst can evaluate the effects of different doses of different types of medication on different types of problem behaviors. Without the data analysis proposed by the behavior analyst, the decision to increase or decrease medications will be based on anecdotal staff or parental report. Although there is value to such reports, they are often subjective and not always an accurate way to tackle the problem. With respect to working closely with the psychiatrist, transparency and clear dialogue should guide the two professionals to agree on a data collection and data analysis system that works for both.

Sleep Difficulties

It is estimated that between 56% (Clements, Wings, & Dunn, 1986) and 83% (Richdale & Prior, 1995) of the children diagnosed with ASD present some problems related to sleep. Health care professionals such as pediatricians, neurologist, and psychiatrists are typically involved with sleep treatments because often this issue affects other areas of development such as growth, development of seizure disorders, and mood disorders.

Behavior analysts develop behavioral treatments and measurements of overall quality of sleep which may include: sleep duration (e.g., hours slept per night) and sleep quality (e.g., number of times awake during each night; latency to sleep after placed in bed). Behavior analysts and health care professionals (Ferber, 2006; Piazza & Fisher, 1991) have also prescribed some behavioral treatments that when successful, may curb the necessity for the use of medications.

We recommend behavior analysts make sure students placed in residential settings have their sleep monitored closely, as hours of sleep and quality of sleep are two very important factors influencing the day time behavior. There are several interventions which can improve duration and quality of sleep, including modifying one’s diet, altering the light exposure and the types of lighting one receives during the day and night time, creating nighttime routines, systematically adjusting bedtime, setting up stimuli that signal sleep time, and other manipulations of contingencies of reinforcement. As noted earlier in this paper, sleep medication is also often administered to alleviate the problem, hence the need to work in collaboration with medical professionals in this area as well clearly comes to bear.

Figure 4 shows the effects of Melatonin (left) on sleep quality (measured as sleep/awake periods throughout the night, top) and sleep duration (bottom) for one child. This child had been waking up during the night and attempting to aggress toward staff, often being extremely loud and disturbing his housemates. It was clear from the data for this child that an increase in Melatonin had no effect on sleep and a behavior treatment was developed. The treatment substantially improved his sleep quality and duration, which allowed the psychiatrist to evaluate a systematic taper of Melatonin. The data on the top and bottom right panels of Figure 4 (labeled “Post Behavior Treatment”) shows sleep pattern and total duration after taper of Melatonin and implementation of a behavior plan.

Skill Acquisition

In the United States, special education teachers are required to be part of the educational team and therefore the behavior analyst can learn by collaborating with these professionals when developing skill acquisition programs. Behavior analysts should work with special educators to write objectives for the students, to develop curriculum for each objective, and to evaluate progress of the students on their caseload.

The trainings behavior analysts and special education teachers receive are very distinct. Although special educators have extensive training in content based age appropriate and mainstream curriculum, they do not have the training behavior analysts have in, for example, discrimination training. Behavior analysts and special educators may easily agree on a certain objective for a child, for example, object recognition. From the time they agree on an objective, the teaching procedures preferred by each professional may be very different. For example, the special educator may want to teach one object at a time while the behavior analyst has learned that to teach conditional discriminations one will need to have more than one item at a time (McIlvane, 2013). The standards among areas of expertise also vary. For example, most special educators have been trained to
Figure 4. Sleep data for a student placed in a residential setting.

Figure 5. Analysis of the effect of different doses of Zoloft on the behavior producing the implementation of time-outs: physical aggression for a student in a residential setting.
obtain data probes from time to time and to report on the results of the probes. Behavior analysts on the other hand, are often trained to collect data on every trial and to analyze data frequently in order to better make data based decisions regarding skill acquisition and if progress is not made, to modify the program. Each approach has its merits.

Our recommendation here is no different than in other areas previously discussed in this article: the behavior analyst should establish a relationship with these professionals, and learn from them as well as offering to teach them what we have been taught. Examples may include sharing access to some peer-reviewed articles, establish reading groups and inviting professionals who are not behavior analysts to participate in research projects. The hope would be that knowledge sharing would become a reciprocal exercise. These are just some ideas of how the relationship may be established and fostered so that collaboration can be initiated and maintained, which is clearly in the best interest of the client.

**General Discussion**

It is vital that the behavior analyst strives to develop a repertoire of how to work with professionals from other disciplines in order to effectively promote best practices in behavior analysis. This should come as no surprise to the behavior analyst, as it is described under the task list put out by the BACB. The professional literature does not reflect an attempt to publish training tips on how to “get along” with other professionals, hence it is very much up to the behavior analyst to facilitate and to “set the occasion” for meaningful collaboration with professionals outside of behavior analysis, in the name of maximizing treatment options for students in restrictive settings such as non-public schools or residential settings.

As pointed out by Bailey and Burch in 2005, “The behavior analyst is unique, as compared to those of the other helping professions. Although other fields may represent that they base their treatment methods on science, behavior analysis is the only human services approach to actually take the next step and require that the treatment itself use this method” (p. 25).

**Future research**

More research should be conducted on how to effectively collaborate with other professionals. Behavior analysts have researched and described the steps for effective training in areas such as managing direct-care staff (Burgio, Whitman, & Reid, 1983), implementing discrete-trial training (Sarokoff & Sturmey, 2004), and how to respond appropriately to lures from strangers (Fisher, Burke, & Griffin, 2013). It would be important for future research to also try and identify the effect collaboration across disciplines has on treatment outcome data for clients as would identification of key steps in fostering this collaboration.

**REFERENCES**


