Ethical Considerations in Interdisciplinary Treatments

David J. Cox

Introduction

The etiology of autism spectrum disorders (ASD) likely involves a complex interaction between genes and the environment (Engel & Daniels, 2011). The resulting complexity of ASD etiology leads to a wide range of variability in skill deficits and excesses. The wide range of behavioral excesses and deficits often leads individuals with ASD to receive treatment from varying combinations of people spanning a variety of professional disciplines (Brodhead, 2015; Cox, 2012).

Collaboration between professionals spanning varied professional disciplines affects members of the helping professions and the individuals they serve (e.g., Fewster-Thuente & Velsor-Friedrich, 2008). However, increased benefit to the client from interdisciplinary collaboration is far from automatic. Outcomes resulting from interdisciplinary collaboration may be considered beneficial when overall treatments are enhanced and the individual with ASD is better off than if they would have received the same treatments independent of professional collaboration. In these instances, members of the collaborating professional disciplines also are likely to benefit because they learn more about other disciplines and the areas of knowledge those expert professionals bring to the treatment context. Outcomes resulting from interdisciplinary collaboration may be detrimental if treatment from one or more disciplines contradicts or undermines treatment implemented by one or more other disciplines.

Effective interdisciplinary collaboration requires a variety of key competencies. These include communication, understanding one's professional role, knowledge of the professional role of others, leadership, ability to function within a team, and conflict resolution (Drotar & Sturm, 1996; MacDonald et al., 2010). While much has been written on the practical and institutional barriers to interdisciplinary collaboration (e.g., Hinshaw & DeLeon, 1995; Mellin & Winton, 2003; Tovian, 2006), this chapter focuses on the ethical issues that are likely to arise from interdisciplinary collaboration in treatment for individuals with autism spectrum disorders. Specifically, this chapter focuses on general areas of practice that may lead to ethical disagreement and that can be mitigated through effective communication and conflict resolution. Developing an interdisciplinary environment that fosters respectful communication allows for proactive identification of potential ethical disagreements and the opportunity to collaborate on an ethical resolution. In turn, effective collaboration will likely result in improved outcomes for the individuals we serve (e.g., Rogers, Anthony, & Danley, 1989).

This chapter includes three sections. The first section highlights areas of practice that may

D. J. Cox (✉)
Behavioral Pharmacology Research Unit, Department of Psychiatry & Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD, USA
e-mail: david.j.cox@ufl.edu

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lead to ethical disagreement—especially when effective communication is minimum or absent. The second section discusses the importance of understanding codes of ethics from other disciplines. This section also provides a brief overview of the commonalities and differences spanning Western ethical codes for helping professionals. Finally, the third section discusses strategies that increase the probability of effective interdisciplinary collaboration and ethical care for each individual client. Although many examples are provided from the author's area of clinical expertise (i.e., applied behavior analysis), examples abound from all disciplines and should be voiced through ongoing interdisciplinary dialogue.

Areas for Potential Ethical Disagreement

Members of helping professions likely chose and continue to work in their profession because of the positive impact they have on the lives of others. That is, to engage in actions intended to benefit and promote others' welfare (i.e., beneficence; Beauchamp, 2016). However, benefit and welfare are broad terms that can encompass a variety of specific outcomes depending on one's audience and the situation the term is used. Conflict about what constitutes beneficence is less likely when speaking and working with people that share a similar background and training in how to view health (e.g., members of one's own health profession). However, interdisciplinary treatment teams can involve a variety of perspectives on what constitutes health as well as how specific health outcomes are prioritized to maximize beneficence.

Treatment provided by one discipline is not isolated from the treatment provided by other disciplines. For example, a new drug regimen will likely have an effect across the individual's entire day including academic and therapeutic environments (e.g., ABA therapy, speech and language therapy, occupational therapy). Similarly, a plan for reducing aggressive behavior developed and implemented by a behavior analyst is only as good as the consistency with which it is implemented before and after aggression. In turn, behavior plans with generalized benefits necessitate involvement of people across the individual's entire day.

The co-dependence between professionals and interaction between treatments suggest interdisciplinary teams should regularly and proactively communicate information related to their view of beneficence. Developing interdisciplinary environments that regularly practice respectful communication and collaborative routes to conflict resolution will, in the long run, lead to effective and efficient collaboration between members of an interdisciplinary team. Regular communication and collaboration may also result in professionals viewing their work more as a member of a treatment team rather than as an independent and isolated practitioner. In turn, simply establishing an environment where everyone perceives their work as a member of an interdisciplinary team can mitigate many differences that may arise (Kobayashi & McAllister, 2014). Nevertheless, differences are still likely to arise in how different members view beneficence. These differences are likely to occur across three areas: *what* exactly a practitioner is targeting through a treatment; *how* they are planning to implement a treatment; and *why* a treatment has been chosen among available alternatives.

What Is Targeted for Treatment?

The first area that conflict may arise is *what* should be targeted for treatment. For example, stereotypy includes responses that are repetitive, rigid, and invariant and includes simple body movements such as rocking and flapping arms, finger posturing, and sometimes complex patterns of movement (Joosten, Bundy, & Einfeld, 2009). Although a variety of interventions have been developed to successfully decrease stereotypy (see Lanovaz & Sladeczek, 2012—for review of behavioral interventions), whether stereotypy is something that should be reduced without question can be debated. Relatedly, others have argued that approaches seeking

normality as the end goal for individuals with ASD are not appropriate and may even be detrimental (e.g., Shyman, 2016). Given the interdependence of interventions and reliance on all caregivers to maintain treatment protocols, treatment fidelity is likely to be subpar unless everyone is on board with *what* the other professionals are targeting for change.

How professionals prioritize treatment targets is also relevant to discussions of *what* different professionals target for treatment. For example, everyone may agree that a client needs to learn how to communicate their wants and needs, learn how to socialize with peers, and learn how to cope with events that make them frustrated or angry. However, time is a notoriously limited resource, and events may arise where practitioners must choose how they will prioritize the above skill targets. If each practitioner chooses a different target to prioritize, then overall progress may be slower than if all prioritized similar skill targets and generalization across settings and people.

Disagreement about *what* to target may be of greater concern than mere differences in opinion. For example, the Behavior Analyst Certification Board (BACB) Professional and Ethical Compliance Code obligates behavior analysts to target only observable and measurable behavior (BACB, 2014). Philosophical positions aside, requests from other members of an interdisciplinary team for the behavior analyst to work on emotion regulation immediately place the behavior analyst in a precarious situation. Do they work on emotion regulation and risk the repercussions that may arise from violating one's code of ethics and the scorn of their behavior analytic colleagues? Or do they refuse to work on emotion regulation or target it in a different way and impact the collaborative and cooperative relationships needed for interdisciplinary teams to maximize effectiveness?

In sum, interdisciplinary team members should engage in ongoing and active communication with all members of the interdisciplinary team relative to *what* they are targeting with active and future interventions. Active and continuous interdisciplinary communication allows for discussion of prioritizing intervention targets and provides an opportunity for team members to voice any potential concerns they may have about what interventions they may be asked to support and work on directly.

How Is Treatment Implemented?

The second area that conflict may arise is *how* treatment is implemented. For example, all parties may agree that high rates of aggressive behavior should decrease, the amount of engagement with academic tasks should increase, and a client should better communicate their wants and needs. However, different professionals may disagree about *how* best to reduce problematic responses and teach skills. For example, the use of extinction is an effective approach to reducing aggressive behavior (e.g., Lerman, Iwata, Shore, & Kahng, 1996). However, this may involve an extinction burst that not every interdisciplinary team member wants to, or physically can, withstand. By engaging in proactive and ongoing communication with other members of an interdisciplinary team, the behavior analyst can likely get a sense of what will or will not work with other team members, and they can subsequently tailor the prescribed intervention. Similar situations may arise for prescribed interventions from all members of the interdisciplinary team due to limitations in the abilities or time of other members on the interdisciplinary team.

Disagreement about *how* to target skill deficits and excesses may be of greater concern than differences in opinion. Examples that may raise ethical objections within and across disciplines are the use of aversive control to reduce problematic behavior (e.g., time-out, response cost), pharmaceutical approaches to behavior change as opposed to skill acquisition programs (e.g., Newhouse-Oisten, Peck, Conway, & Frieder, 2017), sensory-integration therapy for reducing problematic behavior (e.g., Lang et al., 2012), and providing contrived reinforcers for the completion of academic tasks (e.g., Goswami & Urminsky, 2017; Levy et al., 2017). In each of the above instances, the code of ethics for one or

more interdisciplinary members would put them in a situation where tension exists between one's professional code of ethics and cooperation within an interdisciplinary team.

In sum, even if members of an interdisciplinary team agree on what skills to target for acquisition and reduction, disagreement may still exist relative to *how* those responses are targeted for acquisition or reduction. Some of these disagreements may be the result of the code of ethics meant to guide the behavior of each practitioner. Active and continuous interdisciplinary communication will allow all team members to voice concerns they may have about *how* treatment is implemented by another professional and what they may be asked to do themselves.

Why Is a Treatment Selected?

The third area that conflict may arise is *why* a given treatment is selected among available alternatives. This area of conflict is likely where conflict negotiation skills are most needed. Every profession trains their members in basic philosophical assumptions regarding causes of behavior, epistemological assumptions regarding how we know something is true, and assumptions about the research methods sufficient to demonstrate a high likelihood that something is true (e.g., that an intervention is effective). Graduate and postgraduate training relative to these assumptions influences *why* interdisciplinary team members choose the intervention they do and what evidence they are likely to consider influential for interventions proposed by other professions. Two specific topics highlight this potential disagreement.

Where does behavior originate? The answer to this question has been debated among thinkers for centuries (Hankinson, 1998). Two ends of the spectrum of answers include behavior originates within the organism via the mind, brain, or other internal cognitive structures (e.g., Churchland, 2002) and behavior originates in the environment surrounding the organism (e.g., Skinner, 1953). Each professional in an interdisciplinary setting likely received graduate training emphasizing the origin of behavior lies somewhere on this spectrum. Recognizing that other team members were trained in a different perspective is important because interventions chosen from the opposite perspective will likely appear limited and superficial compared to one's own perspective (e.g., Baum, 2012; Ryan & Deci, 2000). In turn, ethically justified disagreement relative to maximizing benefit and minimizing harms is likely to be offered from both sides because the other side is failing to target the "cause" of behavior. These differences are likely to remain unresolved in the time needed to make treatment decisions for most clients. As such, open and honest communication and conflict resolution skills may be needed to get all team members on board for a treatment plan everyone feels ethically comfortable with.[1]

What counts as sufficient evidence for a recommended treatment? Disagreement in answering this question also is likely to remain unresolved in the practical time needed for treatment decisions. Although most helping professions increasingly espouse an evidence-based approach to clinical decision-making (e.g., Bennett & Bennett, 2000; Bernstein Ratner, 2006), what exactly constitutes strong evidence differs between professions. For example, behavior analysts have long placed significantly greater weight on research demonstrating behavior change using within-subject designs compared to results from group-design research (e.g., Johnston & Pennypacker, 2009; Roane, Ringdahl, Kelley, & Glover, 2011). In contrast, medical doctors have long placed significantly greater weight on research using group designs and randomized controlled trials in particular (e.g., Burns, Rohrich, & Chung, 2011). Recognizing this dif-

[1] It is recognized many professionals practice and implement the findings of their respective science in the absence of any philosophical commitment to the originating cause of behavior (McDowell, 2012). Nevertheless, this is an area the author has observed as the root cause of much discomfort in agreeing to interventions recommended by other professionals from differing disciplines. As such, it seems important to note this area of potential disagreement even if practitioners do not openly espouse one position or recognize its influence on their daily practice.

ference is important because several codes of ethics for helping professionals require practitioners use evidence-based practices (e.g., American Psychological Association (APA), 2010; BACB, 2014). However, different professions may not agree with the evidence offered by another discipline. This may place a professional in the same position of tension between their profession and interdisciplinary collaboration.

Summary

Graduate and continuing education influence the way helping professionals approach and think about *why* they choose the interventions they choose. Helping professionals each have unique and varied educational and training experiences. These experiences result in philosophical and epistemological assumptions that differ from one another and are unlikely to be resolved through brief discourse. Many of these assumptions are implicitly or explicitly expressed in the profession's code of ethics. Conflict negotiation is likely the best (or perhaps only) route to resolution of disagreements regarding *why*. However, it can be helpful to remind ourselves that every interdisciplinary team member is there with the same shared goal of benefitting the client. We should work from that area of common ground and maintain client benefit as the focus of conflict negotiation.

Codes of Ethics[2]

The influence of ethical codes on behavior is likely to vary by individual and is still widely debated (e.g., Helin & Sandström, 2007; Kaptein & Schwartz, 2008). However, compliance with one's code of ethics is emphasized in most graduate training programs. In addition, the ability to maintain the credentials required to practice within one's discipline has been increasingly tied to ethical conduct for some professions (e.g., BACB, 2016). As highlighted above, this can make interdisciplinary collaboration particularly tricky as the treatment target, method, or theoretical assumptions underlying treatment by one professional may require a collaborating professional to violate or bend their own ethical code. Consequently, the conflicting contingencies likely place a strain on successful interdisciplinary collaboration.

Most helping professionals on an interdisciplinary team are there because they want to help that client. However, beneficence is not the only common value underlying practitioner conduct or the supporting codes of ethics spanning members of an interdisciplinary team. Interdisciplinary communication and conflict resolution can be aided by understanding the common values all interdisciplinary team members bring to the treatment context. This can be accomplished by developing a working understanding of the fundamental ethical principles central to most Western helping professions' codes of ethics and the specific language in ethical codes from other disciplines.

Four Principles of Western Bioethics

Most codes of ethics for helping professionals in the United States make use of the four primary principles of Western bioethics (Beauchamp & Childress, 2012). These include respect for autonomy, nonmaleficence, beneficence, and justice. As many authors have noted, regardless of how one orders these principles in text, it is generally assumed that all four principles are

[2]NB: The author recognizes that a variety of disciplines and relevant professional associations may be involved in an interdisciplinary setting for individuals with Autism Spectrum Disorders. To make this chapter tractable, the author chose to include codes of ethics from the American Speech-Language-Hearing Association, the American Psychological Association, the American Occupational Therapy Association, the Association of American Educators, the Behavior Analyst Certification Board, and the American Medical Association. However, the offered analysis is not meant to be exhaustive. Rather, it is meant to demonstrate general considerations that should be made when working with members of different professions in an interdisciplinary setting.

used in concert and with equal consideration when determining how to behave in a given situation (e.g., Beauchamp & Childress, 2012; Office of the Secretary, 1979).

The first principle of Western bioethics is respect for autonomy. Respect for autonomy refers to behavior that is free from both controlling interference by others as well as the absence of limitations such as by providing inadequate information (Beauchamp & Childress, 2012). Relative to interdisciplinary intervention settings for individuals with autism spectrum disorders, this generally takes the form of obtaining informed consent from the legal guardians and/or the individual client before an intervention is implemented. Theories may differ between practitioners relative to what constitutes choice free from controlling interference as well as how much information should be provided so that the limitation criteria are met. However, most helping professionals agree that the client (and legal guardian where necessary) should be involved in the treatment decision process and must agree to participate before an intervention can be implemented. Remembering this principle may be helpful toward conflict resolution in situations where helping professionals disagree on *what* is targeted for intervention, *how* an intervention is implemented, or *why* an intervention is prescribed. In addition, respect for autonomy may provide a route toward ranking outcomes relative to nonmaleficence and beneficence for each specific client. Put succinctly, client preference may aide in resolving ethical disagreement about *what*, *how*, and *why* certain goals are targeted for intervention.

The second principle of Western bioethics is nonmaleficence. Nonmaleficence is the obligation to avoid harming others or, if avoidance is impossible, to take a course of action that minimizes harm (Beauchamp & Childress, 2012). Relative to interdisciplinary intervention settings for individuals with autism spectrum disorders, this generally takes the form of prescribing interventions that reduce the likelihood of continuing current harmful behaviors (e.g., self-injurious behavior) or that increase the likelihood of avoiding harmful behaviors in the future (e.g., developing age appropriate social skills). Remembering this principle may be helpful toward conflict resolution in situations where helping professionals disagree because it may be the primary basis for objection to a prescribed intervention. That is, one professional may believe avoidable harm is being done to the client by targeting one goal or failing to target another. Labelling disagreement as founded on nonmaleficence can put the conversation into terms most are familiar with and support as valuable in the intervention setting.

The third principle of Western bioethics is beneficence. Beneficence refers to a general obligation to engage in behaviors that result in helping others (Beauchamp & Childress, 2012). Relative to interdisciplinary settings for individuals with autism spectrum disorders, this generally takes the form of prescribed interventions that advance the skill set of the individual in a way that improves their well-being. What constitutes well-being and how it is measured may result in disagreement between helping professionals. Nevertheless, labelling disagreement as founded on differing views of beneficence can help remind all involved that they share the common goal of maximizing benefits gained through the interdisciplinary treatment setting. In turn, reframing the dialogue around this common value may help toward conflict resolution.

Finally, the fourth principle of Western bioethics is justice. Justice in a healthcare context generally refers to fair allocation of resources and services to persons of a certain class to all members of that same class (Beauchamp & Childress, 2012). Stemming from the principle of equality (i.e., equals must be treated equally and unequals treated unequally—Beauchamp & Childress, 2012), this might take the form of providing the same amount of effort, care, and access to technology and resources for all clients of the same funding level. For example, all clients who have received funding for 1 h/week of speech and language therapy should receive the same amount of attention, treatment planning, access to technology, etc. However, these same clients should also receive more attention and resources than a client who has received funding for 15 min/week of therapy and less

than those who have received funding for 3 h/week of therapy. As noted elsewhere (e.g., Beauchamp & Childress, 2012; Carter, Gordon, & Watt, 2016), determining fair allocation of resources and clinical attention is far from being a black-and-white decision, and using only the principle of equality can result in many seemingly unethical practices. Nevertheless, conflict resolution might be enhanced by remembering that just allocation of resources is an underlying ethical justification for *what*, *how*, and *why* an intervention may be prescribed by other members of an interdisciplinary team.

Other Code Commonalities

In addition to the four principles of Western bioethics, many other ethical principles and obligations are common to codes of ethics for many helping professions present in an interdisciplinary setting for individuals with autism spectrum disorders (Cox, 2012). Generally, most codes of ethics for helping professionals in the United States include recommended behavior relative to four broad categories. These include conduct toward the client/student/patient, conduct relative to practice/therapy, conduct relative to one's profession, and conduct relative to the larger community and public (see each code of ethics for more details—e.g., AAE, 2013; AMA, 2007; AOTA, 2015; APA, 2010; ASHA, 2016; BACB, 2014). Examples of conduct toward the client include maintaining client confidentiality, fiduciary responsibility, and using evidence-based approaches to intervention. Examples of conduct relative to one's practice are engaging in profession recognized assessment and intervention practices. Examples of conduct toward one's profession include maintaining professional competence and peer communication. Finally, examples of conduct toward the public and society include accurate communication with public and providing equal access to services.

Recognizing these similarities is important for several reasons. First, these principles provide other avenues of common ground that may be useful in resolving potential conflict between members of differing helping professions. For example, while professional competence typically involves only one's own profession, claiming to be an interdisciplinary setting (in contrast to a multidisciplinary or transdisciplinary setting; Cohen, 2014; Klein, 2010) increases the breadth of knowledge areas required to claim clinical competence (Cox, 2012). That is, interdisciplinary settings extend professional competence beyond the borders of one's own professional activities to include the interaction of one's professional activities with the other members of the interdisciplinary team. In turn, reduced disagreement and more efficient conflict resolution between team members may occur through establishing basic competency across other disciplines and interdisciplinary collaboration. Second, identifying and labelling these common principles and obligations continues to highlight and focus on common goals of the involved disciplines. Cooperative behavior has been shown to increase by focusing on common goals that identify each member as part of a single group compared to differences that identify each member as part of a separate group—especially when team members are interdependent as in interdisciplinary settings (e.g., Balliet, Wu, & De Dreu, 2014).

Some Notable Differences

Despite the many similarities in the behavior promoted by codes of ethics for helping professionals, some differences exist. Interdisciplinary collaboration may be aided and improved through awareness of the differences in value claims made by members of other helping professions. Generally, these differences fall into categories of additional recommended clinical behaviors, the omission of recommended clinical behaviors, or the enforceability of the code of ethics.

Additional recommended behaviors are behaviors outlined in codes of ethics that are not explicitly included in other codes. Interdisciplinary practitioners should be aware of these behaviors because other interdisciplinary team members may have obligations, responsibilities, or behav-

iors they must avoid that are not readily considered by members of disciplines without those obligations and responsibilities. For example, the Association of American Educators (AAE) explicitly recognizes the role and importance of educators in the "moral education" of students (AAE, 2013). In turn, skill acquisition targets involving moral development may be recommended by educators and seem inappropriate to members of other disciplines. However, the educator would be acting in accordance with their ethical code by recommending work on such behavior. Other examples of additional recommended behaviors include obligations regarding education and training of other psychologists (e.g., APA, 2010), appropriate supervision of others (e.g., AOTA, 2015; BACB, 2014), appropriate use of social media (e.g., AOTA, 2015; BACB, 2014), and disallowance of the use of testimonials (e.g., BACB, 2014).

Omitted recommended behaviors are behaviors common to many other codes of ethics that are not explicitly included in a specific discipline's code. Interdisciplinary practitioners should be aware of these omissions because members of a specific discipline may have not been required to think about those aspects of the interdisciplinary setting and may lack clear guidance from their respective profession. For example, the AAE, APA, and BACB codes of ethics do not make explicit statements or guidance regarding telemedicine/telepractice (AAE, 2013; APA, 2010; BACB, 2014). The expansion of the Internet and telecommunication technologies has led to increasing research on and use of telemedicine (Cartwright, 2000) including for individuals with autism spectrum disorders (e.g., Higgins, Luczynski, Carroll, Fisher, & Mudord, 2017; Lee et al., 2015). The use of telehealth practices may begin to be incorporated by some members of an interdisciplinary team leaving those without clear guidance from their discipline in a professional gray area. Other examples of omitted recommended behaviors include the absence of guidance for accepting gifts (e.g., AAE, 2013; APA, 2010), the absence of guidance about advertising and the use of social media (e.g., AAE, 2013), and the absence of guidance on interrupting or discontinuing services (e.g., AAE, 2013).

A final important difference between codes of ethics is the extent to which the members of a profession are held accountable for complying with a code of ethics. At one end of the spectrum are codes that are not enforceable (e.g., AAE, 2013; AMA, 2007). Social and professional contingencies may place pressure on members of these professions to adhere to their code of ethics. However, the ability to continue to practice as a member of these professions is not explicitly tied to compliance with the code of ethics unless specified by a separate local or regional entity. At the other end of the spectrum are codes that are enforceable (e.g., AOTA, 2015; ASHA, 2016; BACB, 2014). For members of these professions, compliance with the code has a direct bearing on their ability to continue practicing as a member of that profession. Recognizing the varying enforceability of codes of ethics is important because it will directly influence how flexible each interdisciplinary team member can be during conflict negotiation. Increased enforceability does not equate to increased justification for being uncooperative and inflexible during conflict negotiation. Nevertheless, recognizing the contingencies operating on everyone's behavior in an interdisciplinary treatment context will likely aide interdisciplinary collaboration.

Summary

Codes of ethics often form the foundation for value claims made by the members of helping professions. Although the influence of a profession's code of ethics on helping behavior will vary, training relative to these codes often occurs during graduate education and continues over the course of a career. Interdisciplinary treatment teams for individuals with autism spectrum disorders include members from health professions that all share many of the same values and goals. Interdisciplinary collaboration and conflict negotiation can be improved and aided by remembering and reframing discussions relative to the values and goals shared by all while remaining cognizant of the differences between codes and the varying degrees of enforceability.

Strategies for Ethical Interdisciplinary Collaboration

Proactive Strategies

Proactive strategies can be implemented before conflict arises in the interdisciplinary setting. The purpose of these strategies is to establish consistent patterns of effective communication between interdisciplinary team members. In turn, these strategies may decrease the likelihood that disagreement from misunderstanding and miscommunication occurs. In addition, these strategies may establish patterns of respectful and effective communication that may prove helpful if conflict occurs.

The first proactive strategy is to practice jargon-free communication. Each member of a helping profession likely has received several years of coursework and supervised training in their area of expertise. With this academic and clinical training comes field-specific language (i.e., jargon). Although jargon is helpful for efficient communication between members with similar training backgrounds, jargon can be off-putting and confusing to clients as well as members of other disciplines (Becirevic, Critchfield, & Reed, 2016; Critchfield, Becirivec, & Reed, 2017). In turn, miscommunication and misunderstanding arising from the use of jargon can make collaboration more difficult and perhaps contentious (e.g., Shyman, 2016). A first step toward improving interdisciplinary collaboration and conflict resolution is practice effective jargon-free communication with audiences other than one's own profession.

A second proactive strategy is to develop consistent and formal relationships within the interdisciplinary team network (Haines, Godley, & Hawe, 2011). Specifically, this involves specifying frequent and coordinated interactions between members of an interdisciplinary team in a way that is proactively structured and organized (e.g., weekly clinical meetings, documented case consultations). In turn, developing consistent and formal relationships between interdisciplinary team members allows the organization to take advantage of social network analyses (e.g., Scott, 2013) and systems analyses (e.g., Diener, McGee, & Miguel, 2009). Briefly, social network analyses monitor, track, and collect data on the interactions between individual people within a group. Systems analyses identify the components of an organization in the context of how value-adding work is currently, or could be, accomplished (Diener et al., 2009). Within interdisciplinary intervention settings, relatively simple social network and behavioral systems analyses can be used to monitor, track, and improve interdisciplinary collaboration over time. Most importantly, analyses of the formal relationships between members of an interdisciplinary team can examine how the quality and quantity of interdisciplinary collaboration influence client outcomes.

A third proactive strategy is to develop agreed upon institutional guidelines and joint codes of ethics for collaboration (e.g., Cox, 2012). As outlined in the first two sections of this chapter, differing value claims or competing methods in support of values are likely to be the most challenging aspect to interdisciplinary collaboration. Interdisciplinary organizations can proactively determine what set of principles and guidelines all team members are comfortable with relative to their own code of ethics. This may include developing a hierarchy of principles, outlining general decision-making processes for times when values conflict, or establishing an ethics committee/coordinator within the organization (e.g., Brodhead & Higbee, 2012). A related important note is that research on the effectiveness of various guidelines for interdisciplinary collaboration does not currently exist (e.g., Van Royen et al., 2013). Consequently, each interdisciplinary organization will likely have to develop institutional guidelines that fit their setting, employees, and clientele. Social network and systems analyses can, in turn, aide in modifying and improving these guidelines over time.

Reactive Strategies

Reactive strategies can be implemented after conflict arises in the interdisciplinary setting. The

purpose of these strategies is to structure interactions between interdisciplinary team members once disagreement has occurred. In turn, these strategies may increase the likelihood that the positive relationships developed between team members before the conflict remain intact.[3]

The first reactive strategy is to use values espoused from the codes of ethics for all team members to approach and frame the conflict. For example, the conversation can be reframed in terms of language familiar to all involved such as the short- and long-term benefits and harms resulting from various actions or inactions (i.e., beneficence and nonmaleficence). Team members could use client preference and choice to guide selection among treatment alternatives (i.e., respect for autonomy) and use science and single-subject empirical methods to determine what is most effective for an individual client (i.e., reliance on evidence-based practice). Shifting how the conflict is framed will focus communication on the outcomes most desired by the client (or their caregiver) and how progress toward those outcomes is measured (i.e., forging a shared mission—Brown, Deletic, & Wong, 2015). This contrasts with approaching the conflict with a focus on professional disagreements in methods and philosophical assumptions.

A second reactive strategy is to use the conflict to develop "T-shaped" practitioners (Brown et al., 2015). This involves each team member using the conflict as an opportunity to both cultivate their own discipline as well as expand the boundaries of their competency to other disciplines. For example, if modifications need to be made to an evidence-based intervention for successful collaboration, the member of that profession can use the opportunity to explore (and ideally research) how well the altered intervention continues to result in desired skill change (e.g., St. Peter Pipken, Vollmer, & Sloman, 2010). Such research is likely to advance the evidence-based practice of the discipline as well as provide important data for future situations involving similar conflict. In addition, gaining knowledge from outside one's discipline can lead to advances within one's own discipline that may not have been considered otherwise (e.g., Mace et al., 1988).

A third reactive strategy is to seek out and provide institutional support to promote and maintain the agreed upon resolution (Brown et al., 2015). All behavior is maintained by prevailing contingencies. Any resolution will require organizational support to ensure all interdisciplinary team members can implement the agreed upon resolution. This may include training, feedback, goal setting, follow-up meetings, and/or the use of incentives to increase and maintain behavior consistent with the resolution (e.g., Jessup & Stahelski, 1999; Langeland, Johnson, & Mawhinney, 1997). All of which will likely require resources to sustain and, thus, institutional support. All members of the interdisciplinary treatment team should collectively reach out to the relevant decision-makers within an organization to ensure adequate institutional support.

Summary

Ethical conflict is likely to occur in interdisciplinary treatment settings. Proactive and reactive strategies can increase the likelihood that positive interactions between members of interdisciplinary environments are established and maintained. Three proactive strategies that can aide interdisciplinary collaboration are (1) practicing jargon-free communication, (2) practicing formal and consistent interdisciplinary interactions, and (3) developing institutional guidelines for ethical collaboration and resolution. Three reactive strategies that aide continued collaboration are (1) reframing conflict to focus on agreed upon values, (2) using conflict to advance one's own competency and the knowledge base of one's discipline, and (3) ensuring institutional support for agreed upon resolutions.

[3]Conflict resolution is a relatively large area of active research with dedicated books and journals to the topic (e.g., Kelman & Fisher, 2016; *Journal of Conflict Resolution*). Readers particularly interested in conflict resolution within interdisciplinary settings are highly encouraged to review this literature as conflict resolution is given only a cursory glance in this chapter.

Conclusion

Each helping professional within interdisciplinary settings comes from a unique educational and training history. The first section of this chapter outlined where varied educational and training histories are likely to result in disagreement. Despite these differences, the motives behind the behavior of interdisciplinary team members working with individuals with autism spectrum disorders are similar. Although some philosophical positions regarding *how* and *why* interventions should be implemented may not be reconcilable, the fundamental goals and values of most Western helping professions are the same—to benefit the client. Learning how to respectfully and collaboratively discuss *what*, *how*, and *why* certain treatments are prescribed will provide an understanding of why a practitioner is doing what they are doing. In turn ethical considerations in interdisciplinary treatment settings can be identified before significant issues arise.

Interdisciplinary collaboration can also be enhanced by learning about the ethical codes meant to guide behavior of other practitioners. The ethical codes of other disciplines provide information for why a given practitioner is doing what they are doing and why they may be unable or unwilling to do other things. The second section of this chapter outlined similarities and differences in the values and goals espoused by the ethical codes of interdisciplinary team members. Reframing conflict negotiations through shared values, while recognizing differences and limitations to flexibility for some members, may aide interdisciplinary collaboration and conflict resolution.

Ethical conflict is likely to occur at some point within an interdisciplinary treatment settings for individuals with autism spectrum disorders. The final section of this chapter discussed six strategies for that may aide effective interdisciplinary collaboration. Previous authors have provided strategies that promote collaboration with people outside of one's profession (e.g., Brodhead, 2015; Newhouse-Oisten et al., 2017; Reed, 1984). The final section of this chapter focused on strategies that can be used by interdisciplinary teams as a team. The success of specific strategies will likely be dependent on the organizational setting and will require continuous monitoring, analysis, and revision. In the end, recognizing and addressing ethical considerations in interdisciplinary treatments will lead to greater outcomes for the practitioners, the organization, and—most importantly—the client.

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