BEHAVIOR MODIFICATION IN INSTITUTIONAL SETTINGS: A CRITIQUE

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Teodoro Ayllon's article[1] is an attempt to structure the concepts and practices of behavior modification within a framework designed to safeguard the rights of individuals in closed institutions. Ayllon provides an excellent review of these concepts and practices. His outline of the behavioral contract provides a systemized approach for obtaining a patient's informed consent to treatment. Further, Ayllon's suggested procedures are eminently sensible and should be part of every protocol to govern the role of the therapist as administrator. Indeed, the task for the behavioral sciences is to develop standards and procedures to ensure that the administrative and treatment roles of the therapist are clearly defined and are guided by established rules and regulations. Ayllon moves significantly toward this goal, and his recommendations should set the framework for further discussion.

As a psychiatrist, I have used many of the techniques developed through work done in behavior modification programs. Not the least of these techniques are Ayllon's contributions in the area of token economies. I have been firsthand the dramatic changes that occur with chronic patients in hospital wards when the principles of a token economy are implemented. My work in community and forensic psychiatry has, however, made me especially aware of the peril—as well as the promise—of these new behavioral techniques, particularly for the poor and deprived who populate our mental and penal institutions. It is from this perspective that I make the following comments.

Role Conflicts in Behavioral Science Professions

I share Ayllon's desire for explicit standards and protection of the patient. My work has shown, however, that we also need to be

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1. Ayllon, *Behavior Modification in Institutional Settings,* 17 ARIZ. L. REV. 3 (1975).

concerned with the ethical integrity of the therapist. The conflict between societal and institutional goals and the best interest of the patient gives rise to a role conflict between the therapist as healer and the therapist as institutional employee.

My experience at St. Elizabeth's Hospital[2] is typical. In that hospital's community mental health center, I treated numerous persons suffering from depression, hallucinations, and alcoholism. My first response was to offer traditional psychiatric treatment. Shortly, however, I realized that the underlying conditions of bad housing and low income had to be removed. I became an ombudsman for my patients in the city bureaucracies of welfare, housing, health care, legal services, and education.[3] I then moved to the forensic division of the hospital and finally, from there, to the prison system. The patients and the problems, however, were the same.[4] Once again I acted as ombudsman. Often, however, I was required to disclose communications made to me by the patient. The ethical question continued to press itself: whose interests was I really serving—the patient's or the institution's?

I tried to make clear to my patients these ethical conflicts from the outset, especially in my work in the criminal justice system. I warned patients sent for competency and insanity defense evaluations that all information given to me would be available to the court and the prosecutor. I warned the prisoners in my group therapy sessions at Lorton Reformatory, the prison for the District of Columbia, that in-

2. St. Elizabeth's Hospital is a large federal institution serving the mental health needs primarily of the Black urban poor in Washington, D.C.

3. Judge Bazelon of the Court of Appeals for the District of Columbia described my experience this way:

> What, for example, can psychiatry offer a beleaguered mother with no income, bad housing, and children who lack rudimentary care? Is it any wonder she suffers from depression and hallucinations and turns to drugs and alcohol to blot out the grim reality of her existence? Should she be treated with antidepressants for her depression, tranquilizers for her hallucinations, and therapy for her alcoholism? One does not need to be a psychiatrist to see that treatment is doomed to failure unless the conditions fostering such disabilities are ameliorated.

Bazelon, *The Perils of Wizardry*, 131 AM. J. PSYCHIATRY 1317, 1318 (1974).

4. As Judge Bazelon put it:

> His patients and their problems were the same, only the labels were changed to protect the institutional interests. The same patient labeled "schizophrenic" for purposes of the mental health center might be stamped "neurotic" in the forensic division, "sociopathic" in the prison system, and "heroin addict" in the drug treatment system. Labeling is often a convenience for the institution rather than a necessity for patient care. Once the label is properly affixed, a psychiatric syndrome takes on a life of its own in institutional psychiatry. Thus the pincers of legal and psychiatric labels in civil commitment strangle the aged who have no place to live, the children who have no place to learn, the unemployed who have no place to work, and the unwanted and unloved who have no family to care. From a community of despair they come to languish in the care and custody of psychiatrists.

Id.

formation regarding possible prisoner uprisings, for example, would be disclosed to prison authorities. I felt compelled to develop these ad hoc personal guidelines to put my patients on notice that many of my institutional obligations ran counter to the confidentiality of the physician-patient relationship.

The Application of Behavior Modification Techniques

In focusing on an individual's behavior, behavioral modification programs may too easily ignore the underlying social problems that foster objectionable behavior and fail to recognize the conflicts of interest for the behavioral therapist. The "clients" of behavioral programs within penal and mental institutions are people whose problems stem from social and economic deprivation. Especially in these institutions, behavior modification must be applied with a view toward each individual's particular social environment. The behavioral therapist's focus should be on the individual's interest rather than on shaping behaviors that further the interest of the institution employing him.

Behavior modification programs lend themselves to promoting institutional goals rather than patient interests because their approach is pragmatically responsive, often to institutional demands. Goals are defined not in abstract psychic terms, but in terms of desired institutional behavior. Thus, the emphasis is on symptoms rather than social causes, and, additionally, the desired change in symptoms is often oblivious to individual circumstances. Emphasizing institutional goals conflicts with individual interests.

For example, a "school phobia," according to Allyon,[5] is defined as low or zero school attendance. The phenomenon of school phobia may, in my experience, be completely misread if one believes that the problem is remedied merely by achieving 100 percent school attendance. The problem is not merely one of performance but of continuing environmental influence and individual needs.

Working in the schools in the District of Columbia, I was confronted with the problems of the Black child in an urban school system. Once again I faced role conflicts. The schools continually sought psychiatric evaluation and diagnosis for the problem child. Additionally, instead of fashioning a program to meet the child's needs and instead of trying to eliminate the conditions creating the child's problems, they preferred psychiatric treatment.[6] If, in trying some other

5. Ayllon, *supra* note 1, at 3-4.
6. My experiences are related in Bazelon, *"The Problem Child"—Whose Problem?*, 13 J. AM. ACADEMY CHILD PSYCHIATRY 193, 195-96 (1974).

approach, I refused to give a psychiatric label to the child's problem, he was referred to the juvenile court. Once again the child was referred to a psychiatrist, but this time the court's interests dominated. If the child was placed on probation, the scenario was repeated, with the probation department's interests dominating. The child became a product of each institution's assembly line, without a change in institutional goals to fit the needs of the child.

My concern is that wittingly—or unwittingly—the therapist in a behavior modification program may serve society's assembly line and not the child or adult whose behavior does not "fit" stated institutional goals. Whether termed school phobia or zero school attendance, the problem does not lie solely with the child. The behavioral therapist must first determine what is best for the patient and then confront ever-present interest conflict before behavioral intervention is considered.

Guidelines for Behavior Modification

Although making an individual's interest the first consideration of the behavioralists will serve to protect those interests, it is not absolute protection. The patient must have sufficient knowledge to make decisions regarding waiver of those interests. Ayllon presents guidelines for the therapist treating inmates in closed institutions which are intended to ensure that the patient has complete knowledge, from inception to completion of treament, including knowledge of an unconditional right to refuse treatment.[7] There are, however, many pressures which can vitiate the effects of Ayllon's requirements. Those who have worked in a mental or penal institution know only too well that a number of subtle—or not so subtle—pressures can be utilized to obtain "voluntary and knowing consent." For example, as a psychiatric resident in the emergency room, I frequently saw people who in my judgment needed to be hospitalized because I believed them likely to injure themselves or others.[8] Many of these patients who were initially unwilling to be admitted voluntarily frequently agreed to admission when confronted with the alternative of civil commitment. It has been suggested that many "voluntary" admissions to mental hospitals are obtained in this way.[9]

I now question whether my judgment that a patient was dangerous to himself or others rested on objective grounds. Furthermore,

7. Ayllon, *supra* note 1, at 11-13.

8. In the District of Columbia, a person may be committed if he "is mentally ill and, because of that illness, is likely to injure himself or other persons." D.C. CODE ANN. § 21-545(b) (1973).

9. Szasz, *Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud*, 287 NEW ENGLAND J. MEDICINE 277 (1972).

many people in the behavioral sciences now recognize that the techniques for predicting dangerousness are woefully inadequate.[10] These decisions, however, vitally affect human and civil rights. To counterbalance the potential for subversion of the patient's will, we must, therefore, strive to ensure that our decisionmaking is reasoned, deliberate, and fair. For that to occur, we must rigorously define our standards and procedures for evaluation and treatment.

Since behavioral modification techniques rely on objective behavioral signs for treatment, they lend themselves better to standardization. Token economy programs and the other techniques that Ayllon describes can be standardized for use in institutions, and procedural guidelines can be set forth to facilitate implementation. For example, in token economics the therapist can define the target behaviors and the contingencies to be associated with their achievement. Rules of behavior can be stated, and rewards can be granted for observing those rules. Thus, the patient can have notice and the opportunity to select alternate courses of action.

Much work needs to be done. Ayllon lists a number of treatment techniques that especially infringe on human rights, including punishment, seclusion, aversive or noxious stimuli, and chemical restraints of behavior. His premise is that each of these may be used, but only under circumscribed conditions.[11] Criteria, however, must be defined to determine which of these procedures are appropriate for which behaviors. This categorization is essential to the discriminate use of behavioral techniques that invade individual autonomy. Furthermore, while the literature on behavior modification is replete with the successes of these techniques, reporting of their failures is scarce.[12] In order to make explicit the limitations on these techniques and thereby avoid their unnecessary and intrusive application, we need to know their failures.

Scrutiny and Structure for Decisionmaking

In addition to standardizing treatment, another safeguard that Ayllon has overlooked is a mechanism for independent review and

10. *See Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 96-100 (1971); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1240-45 (1974).

11. *See* Ayllon, *supra* note 1, at 14-18.

12. It has been contended that in the reporting of behavioral modification research, there has been selective publication of studies favorable to a given technique and the suppression of unfavorable results. Russell, *The Power of Behavior Control: A Critique of Behavior Modification Methods*, 3 J. CLINICAL PSYCHOLOGY 111, 113-14 (1974). One technique subject to significant failure has been aversive conditioning. *Id.* at 125-30.

scrutiny to ensure that the human and civil rights of those receiving applied behavior analysis are being observed.[13] Scrutiny from within the profession and from society will serve to promote openness. In order to foster the basic trust that is essential for therapeutic success, the behavioral science professions must strive to make closed institutions as open as possible, at least in the treatment process. Decision-making in the behavioral science profession must not and cannot remain behind closed doors. Administrative and treatment decisions by the therapist must be based upon findings and reasons openly stated and upon recognized procedures. Research protocols, mechanisms for peer review, and application of professional codes are only a few instruments available to expose the process from within.

Conclusion

A balance must be struck between the administrative and treatment discretion of the therapist and the individual's right to autonomy. The task of lawyers and behaviorists is to address the tension between such therapeutic goals and individual rights, both from within and without the behavioral sciences. All share a harmony of aims—if not an identity of opinion—on the means to achieve them.

13. This safeguard was suggested in Wyatt v. Stickney, 344 F. Supp. 373, 376-78 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See also* Friedman, *Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons*, 17 ARIZ. L. REV. 39, 96-100 (1975); Roos, *Human Rights and Behavior Modification*, 12 MENTAL RETARDATION, June 1974, at 3, 5-6; Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1974).