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WHY NO GUIDELINES FOR BEHAVIOR MODIFICATION?

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This paper reviews the guidelines for behavioral programs published by the National Association of Retarded Children. The review discusses a number of reasons why guidelines should not be enunciated for behavior modification, *e.g.,* the procedures of behavior modification appear to be no more or less subject to abuse and no more or less in need of ethical regulation than intervention procedures derived from any other set of principles and called by other terms. The review recommends alternative methods for protecting the rights of clients who participate in behavioral programs. Specifically, behavioral clinicians, like other therapists, should be governed by the ethics codes of their professions; also, the ethics of all intervention programs should be evaluated in terms of a number of critical issues.

DESCRIPTORS: behavior therapy, ethics, applied behavior analysis, guidelines, behavioral principles, behavior modification, public concern

Numerous agencies, organizations, associations, and states have suggested guidelines specifically for the practice of behavior modification (see, for example, May, Risley, Twardosz, Friedman, Bijou, Wexler, *et al.,* 1975). Various problems, some real, some imaginary, seem to have motivated the development of these guidelines. People are afraid of being controlled, they are increasingly concerned with how society deals with deviance, they are increasingly sensitive to the impact resulting from the therapist's having more power than the client, and they may be reacting to extravagant claims made by some behavior analysts about the success of behavioral interventions.

Although behavior modification is no more subject to these concerns than other types of therapeutic interventions (Stolz, 1975), behavior modification seems to have been a lightning rod (Stolz, Wienckowski, and Brown, 1975) in the midst of current stormy ethical and legal controversies, drawing to it these highly charged issues. Many writers have indicated that their special concern about behavior modification arises because they feel it is relatively effective, compared with other forms of intervention. The explicit use of aversive control in behavior-modification practice has also attracted much critical attention.

In addition, specific abuses have been attributed to behavior-modification programs, justly or unjustly. A program in which prisoners were punished with succinylcholine chloride (Anectine), a drug that produces a brief but total paralysis, including paralysis of the respiratory muscles, was described as behavior modification (Reimringer, Morgan, and Bramwell, 1970); timeout, which is effective only when used in

[1]Various forms of guidelines for the practice of behavior modification are being proposed or adopted in many localities. The Editor invited this article to call JABA readers' attention to some of the key issues involved. The author was asked to use the NARC Guidelines as the chief example, because they are available in an archival source. I thank N. H. Azrin and J. G. Holland, who provided significant stimulalation for some of the ideas represented in this critique, and many colleagues, especially D. M. Baer, S. W. Bijou, A. Chapanis, R. K. Schwitzgebel, and D. B. Wexler, for helpful comments on earlier versions of the manuscript. The opinions expressed here are mine and do not necessarily reflect the views of NIMH. Reprints may be obtained from Stephanie B. Stolz, Small Grants Section, NIMH, 5600 Fishers Lane, Rockville, Maryland 20857.

a setting where behavior is also positively reinforced and when used for short periods of time (*i.e.,* a few minutes), has, in some settings, involved extraordinarily long periods of isolation in small quarters, and has again been described as behavior modification (Opton, 1974). On the other hand, the consultative committees of the Association for Advancement of Behavior Therapy have investigated a few cases in which apparently qualified behavioral professionals were in charge of behavior-modification programs in which punishment contingencies were misapplied and clients' rights were violated.

In short, people have been concerned broadly about any systematic attempt to change behavior, and have been particularly concerned about behavior modification and some procedures mislabelled as behavior modification.

In my opinion, professionals engaging in all types of psychological interventions have, until recently, been remiss in the extent to which their clients were involved in decisions about the means and goals of interventions. In making those decisions, behavioral professionals, like other intervention agents, tended to use their status and its associated control of relevant reinforcers as the rationale for making decisions unilaterally, consulting with the clients little or not at all. Further, psychologists have lacked sensitivity to the issues involved in the decision about which behaviors will be defined as deviant (Stolz, *in press, a, b*).

Characteristics of Guidelines that Have Been Suggested

So many different sets of guidelines have been suggested or adopted for the regulation of behavior modification that it would take far more space than justified to described them all here. They range from the somewhat specific to the highly specific, from guidelines reflecting a correct understanding of the manner in which behavioral interventions are applied to those that seem to have been developed in the absence of information about the practice of behavior modification.

The *Guidelines for the Use of Behavioral Procedures in State Programs for Retarded Persons* (May *et al.,* 1975), published by the National Association for Retarded Citizens (NARC) and most easily referred to as the NARC Guidelines, are an extremely detailed set, covering some 73 printed pages. Unlike most guidelines, they are available in an archival source. These guidelines share many characteristics with most of the other, less-accessible sets of guidelines. They:

—involve the establishment of elaborate systems of committees to monitor the behavioral procedures (pp. 35-41, Appendix E);
—emphasize the involvement of the persons whose behavior is to be changed, their representatives, or their attorneys, as well as citizen representatives (pp. 35-41);
—involve potentially long delays between the planning of a new intervention and its implementation in practice (see, *e.g.,* pp. 36-40);
—are based on legal rulings current at the time they were formulated (pp. 3-6, Appendix D);
—are based on the scientific knowledge current at the time the guidelines were formulated (pp. 7-34, Appendix A, Appendix B, Appendix C);
—prescribe or proscribe specific procedures in specific circumstances (pp. 12-34, Appendix A, Appendix B, Appendix C);
—describe in detail the qualifications of intervention personnel (pp. 10-12);
—emphasize a legalistic approach, such as extensive, explicit procedures for obtaining informed consent (pp. 39-40, Appendix F).

Reasons Not to Have Guidelines for Behavior Modification

In my opinion, it is unwise to develop guidelines for the practice of behavior modification, no matter how sophisticated and current the guidelines may be. My reasons for this opinion follow:

The regulation of behavior modification would have unfortunate side effects. If behavior modification is to be regulated by guidelines,

even though no other psychological intervention is so regulated, then, as Goldiamond (1975, 1976) has argued persuasively, that regulation would probably lead to the demise of behavior-modification practices in those settings to which the guidelines applied. Suppose institutional staff could use any other intervention, an intervention that uses the principles of behavior modification but is not labelled as behavior modification, or no intervention at all, without going through the review committees and special consent procedures required for behavioral interventions. Then, they would be likely to use the administratively simpler procedures, that is, those that do not have the additional annoyance, delay, and other costs associated with them. This would have the effect of denying clients the benefits of behavior modification.

Further, specific prescriptive and proscriptive guidelines could have a stultifying or freezing effect on developments within behavior modification (Agras, 1973). This is especially so when guidelines are legislatively enacted, but may also be so for administratively enacted guidelines. Law and science are constantly changing; guidelines drawing on the current legal and scientific situation may be rapidly outdated, as new decisions are made and new data forthcoming.

On the other hand, guidelines can be used to protect practices and institutions that are under attack, that is, they can serve a function opposite from that for which they were originally created. Procedures meeting the letter, but not the spirit, of a set of guidelines may be sheltered from criticism because of the guidelines.

Should the attempt be made to write a set of guidelines that would apply to other sorts of intervention as well? All psychological interventions, after all, confront the same ethical problems of goals and techniques as does behavior modification. The problem then arises that critical aspects of an intervention process vary so widely across settings and populations that it becomes virtually impossible to write something that can adequately cover all possibilities and still be effective. Looked at in the broadest sense, society is replete with behavior-influencing techniques, including public education, advertising, the criminal justice system, and self-help and self-development programs. These techniques too share the ethical problems of interventions identified more directly with psychology and behavior modification.

It is even difficult to construct guidelines suitable for regulating the use of behavior modification and other types of interventions in the simplest of cases, that of a middle-class client who comes to a therapist for treatment on an outpatient basis for a problem defined by the client. Because the therapist and the client in this example are similar in status and culture, because their histories of reinforcement will be similar (Skinner, 1971), they will tend to agree on values, and ethical conflicts will be minimal. Even so, issues can arise about the appropriateness of goals for the treatment.

When therapist and client disagree on goals and turn to a set of guidelines for guidance, they are likely to find that, for example:

> the client himself, or the advisory committee, together with the mental health worker, should weigh the potential benefits to the client of the change that is expected to result from the proposed behavior modification program, against an evaluation of possible risks from using the procedure. (Brown, Wienckowski, and Stolz, 1975, pp. 20-21)

This rather general instruction implies that the final choice should be up to the client. Yet, several authors have argued that clinicians should seriously question whether the behavior they are being asked to change should in fact be changed (Begelman, 1975; Davison, 1976; O'Leary, 1973; Serber and Keith, 1974), generally on the grounds that the client's goal may be too far from the therapist's own values. As one example, when homosexual clients ask for therapy to become heterosexual, Begelman (1975) and Davison (1976) suggest that the clinician

first consider therapy that would aid clients in dealing with the adverse reactions they receive from society because of their homosexuality. In this case, the critics' recommendation is apparently based on a preference for societal change over individual change (*cf.* Halleck, 1971; Stolz, *in press, b*).

Truly adequate guidelines for interventions should deal with the complex issues that arise when the situation is more complicated than in the example of the middle-class adult outpatient. When the psychologist is paid by someone other than the people whose behavior is to be changed; when those people are, for any reason, not clearly competent to make decisions about the means and goals of the intervention; when their ability to consent freely to the intervention can be questioned for any reason: then the problem of developing adequate guidelines becomes increasingly difficult, if not impossible, to solve.

Offering individuals a choice of interventions, an appealing recommendation and one found in most guildelines (*cf.* May *et al.,* 1975, pp. 39, 71), is, in the final analysis, an illusory solution (Stolz, *in press, b*). If behavior analysts offer their clients a choice of interventions, the very alternatives they choose to present may be considered a reflection of the influences on the behavior analysts' behavior. For example, psychologists working for mental hospitals and prisons have, in the past, tended to select as potential goals for interventions those behaviors that are conducive to the maintenance of good order on the ward or cell block (Holland, 1975; Shaw, 1972). On the other hand, psychologists with other values, *i.e.,* whose behavior is under the control of other sorts of reinforcement contingencies (Skinner, 1971; Stolz, *in press, b*), might recommend interventions designed to foster social change. Behavior analysts whose interventions are part of their research programs will describe the alternatives in such a way that they can get enough subjects for their studies (Barber, Lally, Makarushka, and Sullivan, 1973; Beecher, 1966; Gray, 1972). Finally, the clients' choice among the alternatives offered, likewise, will reflect the contingencies currently controlling their behavior, as well as their histories of reinforcement. In other words, clients' decisions about treatment alternatives are just as much behaviors under the control of environmental contingencies as are the behaviors targeted for change by the intervention program.

Nor is establishing advisory committees (*cf.* May *et al.,* 1975, pp. 35-51, Appendix E) a simple or automatic method of protecting clients' rights. Advisory committees typically include representatives of those whose behavior is to be modified, their guardians, or advocates, as well as mental health professionals. The potential effectiveness of such a committee needs to be seen in the context of the sources of reinforcement for the behavior of the individuals on the committees. The mental health professionals, receiving their income from the institution whose programs are being monitored, are thus subject to the control of that institution. The official guardians of the persons participating in the program may, for example, have a vested interest in controlling them in a way more convenient (and reinforcing) for the guardians than beneficial for their wards (Friedman, 1975). At best, such an advisory committee provides a regularized opportunity for conflicting points of view to be expressed (Stolz *et al.,* 1975); the reinforcement contingencies still function, however, and subtle coercions may well be used to manipulate decisions. A method that may maximize the extent to which the contingencies on the behavior of all parties are made explicit is to have alternative interventions described by individuals who are advocates of those methods (Stolz, *in press, a*).

Alternatives to Guidelines

Serious problems face any attempt to develop guidelines for behavior modification. I do not mean to imply, however, that behavior modification should be left unmonitored or unexamined.

First, like other interventions, behavior modification falls under the general ethical principles to which all practitioners subscribe, so that behavior analysts, like other therapists, should be

expected to follow the ethics codes of their professions. For psychologists, the current version of the ethics code is the Revised Ethical Standards of psychologists (American Psychological Association, 1977). Other official policy statements of the American Psychological Association that are relevant to psychological interventions include the Standards for Providers of Psychological Services (American Psychological Association, 1974*b*), a statement on psychology as a profession (American Psychological Association, 1968), Ethical Principles in the Conduct of Research with Human Participants (American Psychological Association, 1973), and the Standards for Educational and Psychological Tests (American Psychological Association, 1974*a*). Each of these codes and standards includes provisions relevant to any type of psychological intervention, including behavior modification.

Second, as an alternative to prescriptive and proscriptive guidelines, I recommend the use of checklists of issues like those adopted by the Association for Advancement of Behavior Therapy (AABT) and recommended to the American Psychological Association (APA) by the APA Commission on Behavior Modification. These checklists of issues were designed to be used in evaluating the ethics of any type of intervention. Both the AABT and the APA Commission chose wisely, in my opinion, in phrasing their checklists in general terms. Each checklist was formulated to continue to be applicable even as legal and scientific standards change, and they are intended to be useful across a wide range of populations and settings.

Both checklists phrase the issues as questions. This was done to emphasize their function as reminders to program personnel and other professionals about practices that are of central importance to ethical interventions and about key issues. Using a set of questions avoids the coercive tone implicit in prescriptive or proscriptive guidelines.

A checklist of issues is, of course, subject to the criticisms discussed above with regard to the development of guidelines for behavior modification; it would even be possible to treat the questions in the two checklists as if they were a set of guidelines, prescriptions, and proscriptions. However, the intent of the APA Commission and the AABT is that the checklists should function to raise issues, not to resolve them, and that consideration of the issues should focus attention on aspects of the therapeutic process where clients are potentially at risk. If the checklists are viewed within the context of the complexity of the issues involved, and if the relevant risks and benefits are balanced, the resulting evaluation of interventions may generate increased attention to clients' rights. It does not, of course, assure that interventions involve nothing illegal.

Topics covered by the portion of the APA Commission's checklist meant to apply in all settings include selection of goals, selection of methods, right to terminate an intervention, outside review, type of intervention, generalization, accountability, confidentiality, and competence of the psychologist or other individual conducting the intervention. To give an example of the sort of issues raised, the questions under "right to terminate an intervention" are: Has the client been told that at all times during the intervention program, the intervention can be refused or terminated without prejudice of any kind? Does the client understand that this right is available and know how to exercise it?

The AABT checklist is divided into eight sections, with the following headings: Have the goals of treatment been adequately considered? Has the choice of treatment methods been adequately considered? Is the client's participation voluntary? Does the therapist refer the clients to other therapists when necessary? Has the adequacy of treatment been evaluated? Has the confidentiality of the treatment relationship been protected? Is the therapist qualified to provide treatment? When another person or an agency is empowered to arrange for therapy, have the interests of the subordinated client been sufficiently considered?

Each of those questions has several sub-questions. For example, under "Has the adequacy of

treatment been evaluated?" are the following: Have quantitative measures of the problem and its progress been obtained? Have the measures of the client's problem and its progress been made available to the client during treatment?

If the questions in these checklists were applied to ideal interventions, the answers would reveal maximum involvement by the person whose behavior is to be changed, and the fullest possible consideration of societal pressures on that person, the professional, and the professional's employer. Practicalities of actual settings may require trade-offs among competing values and exceptions based on the exigencies of a particular case, and each checklist acknowledges that some exceptions can be consistent with ethical practice. The overall intent of the checklists is that intervention programs might benefit from consideration of the issues raised, even though something less than ideal practice may eventually be adopted.

Conclusion

In my opinion, prescriptive and proscriptive guidelines like the NARC guidelines carry many disadvantages and implicit dangers for the practice of behavior modification. An approach like that of the AABT and the APA Commission, a checklist of questions about key issues, seems much more likely to protect clients, without at the same time threatening the adequacy of the intervention or possibly restricting or eliminating the use of behavior-modification methods, and hence denying clients an effective intervention.

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