

TECHNIQUES OF CHANGING UNCOOPERATIVE BEHAVIORS:
SOME CASE STUDIES AND CONSIDERATIONS

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I had thought seriously about titling or sub-titling this paper, "a beyond freedom and dignity for the speech pathologist" because the paper deals, in part, with how two techniques were used to change behaviors of two different patients. It, then, goes on to consider the ethical and moral issues inherent in the use of these techniques.

The first case concerns J.C., a 25-year-old veteran who had been a senior at the local university. He had intended to enter law school in the coming semester, but an automobile accident interfered with his plans. As a result of the accident, he suffered diffuse brain damage -- his medical diagnosis read "trauma due to brain-stem contusion." J.C. was referred to the Speech Pathology Department of the Kansas City Veterans' Administration Hospital because he was "verbalizing inappropriately and communicating inconsistently." Members of the hospital staff and rehabilitation team had labeled him "uncooperative". J.C. sat in his wheelchair with his head tilted backward, and when instructed to participate in various activities, he replied, "I can't see anything out there." Indeed, this was true - with his head in that position, he could see nothing but the ceiling.

Attempts to ignore or punish J.C.'s behavior had proven to be unsuccessful. The speech clinician decided to employ a utilization technique reported by Milton Erikson. With this technique, the behavior is not ignored or punished, rather it is utilized. The clinician encourages the patient to engage in the uncooperative behavior, to do what he is already doing to resist, but to do it under the clinician's direction. Later, the clinician shifts the direction of the patient's behavior into a more cooperative activity.

In the first session in which the technique was tried, the patient was wheeled to a table that held the testing materials. He sat in his usual position with his head tilted backward; his eyes staring at the ceiling. The clinician instructed the patient to perform a specific task; the patient replied that he could not see the materials necessary to perform the task. The clinician ordered the patient to keep his head back and to continue to stare at the ceiling. The patient responded by pulling his head forward and performing

the required tasks until the session ended. In subsequent sessions, when the technique was applied again, the patient pulled his head forward protesting that he could see neither the clinician nor the materials when he held his head tilted backward.

All went well until one day when the clinician arrived a few minutes late for a session. She saw J.C. in the waiting area, sitting with his head tilted back. When questioned, the secretarial staff answered that nothing unusual had happened -- they remembered, however, that they had commented to J.C. about how nice he looked now that he held his head forward. To this, J.C. had responded by staring at the ceiling, just as he had before.

So, once again, the clinician ordered J.C. to stare at the ceiling. Once again J.C. resisted, and, once again, the clinician and the patient were able to proceed with the task at hand.

The second case involves a behavioral technique used with Mrs. G., a 79-year-old patient, who, due to embolism, had sustained a left hemisphere CVA with resultant right hemiparesis. Mrs. G. communicated very little with people in her environment. When asked to respond minimally, by nodding her head, for example, or when otherwise prodded by members of the hospital staff, Mrs. G. either closed her eyes or obliged with a loud, piercing scream.

Mrs. G.'s husband was a resident of the extended care facility that adjoined the medical center in which his wife was a patient. Three times daily, hobbling on crutches, he went to his wife's room to feed her and to attend to her various other needs. Often he would anticipate her wishes and communicate them to the staff.

Medical center personnel asked the speech pathologist to determine the most efficient methods of communicating with Mrs. G. It was obvious to the clinician that Mrs. G. was not interested in participating in therapeutic activities inasmuch as the patient engaged in behaviors that allowed her to escape from the responsibility of communicating. Therefore, the clinician bargained with Mrs. G., and agreed to end the session and leave the room after Mrs. G. pointed to one item when it was named. Mrs. G. complied. During subsequent sessions the clinician increased the number of required responses until Mrs. G. was not only pointing to a number of items and pictures, but was also responding to questions such as, "Is the room too dark?" and "Would you like another blanket?". The clinician kept her word; she ended the session and left the room each time the patient made the required number of correct responses.

"How nice", you may say, "to hear two stories of success". Unfortunately, they are not success stories. Although in both cases behavioral change was demonstrated in the speech pathology clinic, there was no transference of the modified behavior from one setting to another. Other people in J.C.'s environment continued their attempts to punish his uncooperative behavior, thereby attending to and reinforcing it. As for Mrs. G., it seemed that as she communicated for herself more, she needed Mr. G. to communicate for her less. Eventually Mr. G. ordered that speech therapy be terminated for his wife.

These two case studies have several characteristics in common; therefore moral and ethical considerations related to the studies also have common characteristics. First, we are dealing here with two patients who are capable of communicating, but, who, it appears, have chosen not to do so. Several questions can be asked: 1) Does an individual have the right not to communicate - to remain silent if he chooses? 2) Does one person have the right to say to another, "You must communicate?" 3) Do members of families, or physicians, or speech pathologists, the behavioral scientists, the "changers of behavior" have the right to say to a patient, "You must change?". If one subscribes to the theory of B. F. Skinner, the answer to all these questions is an unequivocal "yes" for in Skinner's view, it is always the environment that builds the behavior with which problems are solved even when the problems are to be found in the private world inside the skin. "Man" says Skinner, "may be controlled by his environment, but it is an environment which is almost wholly of his own making". The speech pathologist who is comfortable with this position may have no problem with this moral issue that arises in his profession.

However plausible Skinner's theory may seem to some of you, and however convincing it may be, to some, the fact is that it is not impressive to others. Recently financial support has been withdrawn for various behavior modification programs. Perry London of U.S.C. Monitor in which he states that "whether or not behavior scientists really can control much behavior, they have convinced the public that they can. Many are sorry now that they have done so", says London, "for instead of getting Nobel prizes and gratitude, they have been viewed with increasing suspicion and threatened with restriction of funds, sponsorship, even of access to subjects for their experiments and objects for their therapeutic benefits." The social control of behavior control it seems is underway.

Many of you here today have been affected by the first big intrusion of public policy into professional practice, the intrusion known as "informed consent". However, as restricting

as informed consent may turn out to be for the behavioral scientist, its primary aim is to protect the subject or the patient, which in either case, of course, is the human being.

I'd like to turn to another consideration here and that is the problem of convincing others. How can others in the patients' environment be persuaded to apply a technique once it has been proven to be successful? In both cases presented, the clinician demonstrated that incompatible behaviors could be eliminated when relatively simple procedures were employed. In one case, you order the patient to do what he is already doing; in another case, you offer to withdraw from the situation. Yet, others concerned with the rehabilitation of these patients could not be convinced to use these simple procedures.

Perhaps you would like to know what ultimately happened to these two patients. When his behavior was difficult to control, J.C. was placed in a dark room, sometimes, for hours. This was not effective; he continued to be uncooperative. Eventually J.C. was sent to a hospital designated for long-term mental patients. He is still there, today.

Mrs. G. no longer attempts to communicate with people. Her husband spends a great deal of time with her, anticipating her needs and attending to her wishes before she communicates them.

So, what can the speech pathologist do to convince others to use a procedure that has achieved results? What do you do when you are a speech clinician who has demonstrated that a particular method will help a non-communicating patient begin to show that he is in touch with his world? There are, it seems, three options you may consider: You can 1) do nothing 2) wait for a disaster or 3) find a few people who are willing to listen to you, convince them, and hope that they will convince a few others to try the method. The first option is an easy one to act upon; you simply sit back. However, this seems rather unsatisfactory if progress is to be made. The second, though slow to evolve, may be more satisfactory. Pasteur, for example, had to wait for an epidemic of anthrax to occur before he could convince others that one could inoculate effectively against the disease. Most of us, however, do not want to wait for an epidemic to happen in order to be able to help our patients.

The third option may turn out to be the most satisfactory, after all. We may have to try to convince a few in the patient's environment, and hope that they will convince a few more, until the technique is being used by some. Perhaps, this is the one option that will prove to have the longest lasting effects, after all.