

THE TREATMENT OF BEHAVIOR: DRUGS OR BEHAVIOR ANALYSIS?

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The papers by Wong, and by Wyatt and Midkiff cover similar themes, the extensive use of drugs to change and control behavior across the lifespan in the United States. The data and position of these two papers are discouraging. They address the billion-dollar lobbying industry and advertising campaigns among drug companies, which claim the only scientific precursor to behavior change, maintenance, and control is drugs. The papers discuss how the lobbying and drug campaigns dismiss the evolutionary fact that all human behavior is subject to behavior change through learning.

Both papers address the importance of observing contingencies and stimulus control that maintain behavior and those that can be used to change behavior for improved outcomes. Specifically, Dr. Wong's paper addresses serious medical mental health messages which are portrayed to the general public as established science, yet are not substantiated by science. One example is the vagueness of the unverified DSM labels. He also points to the omission of applied behavior analysis in medical mental health settings; how the proper use of behavior treatment in clinical settings can effect positive change; and how improper use of behavior (e.g., contingencies; reinforcers) can lead to failure. Dr. Wong does very well bringing to the reader's attention how activities of daily living (ADL), psychophysiology issues (e.g. somatic complaints) and social issues (e.g., interacting well with others) can be treated with effective stimulus control techniques (such as designing an environment to help shape schizophrenic behavior) and staff time (such as with token economies).

The paper by Drs. Wyatt and Midkiff speaks to active refusal by medical and scientific associations and individuals to evaluate the influence of environmental stimuli on behavior, and how chemical analyses and genetics are used to explain behavior, though its causality cannot be explained, and/or it lacks scientific merit in many cases. The author clearly describes the effective manipulation of population control in clinical trials, and the effective and expensive lobbying phenomenon on people and the federal government, especially on the regulatory agencies whose sole mission is to protect the public. Drs Wyatt and Midkiff address how learning appropriate skills and behavior directs future behavior, thereby reducing the opportunity for bad consequences such as long term stress and its subsequent influence on health. However, these inexpensive and easy-to-learn behavior models are replaced by the dispensing of prescriptions and drugs. The author shows the reader how behavior education and training are effective in reaching desired goals.

Ironically, for hundreds of years, humans have tried to understand people; to explain why people behave the way they do. For example, psychology is one of the most popular undergraduate majors, and psychology courses are required or recommended in many

other majors. Outside of college, millions of dollars are spent each year on seminars and workshops presenting information on how to identify successful behaviors to earn jobs, promotions, lose weight or become athletes. However other “education” materials used for many years in attempts to understand people and behavior may appear more exciting than a behavioral approach. For example some of these exciting explanations are dreams, witchcraft, superstition, being a zombie or a werewolf or having a multiple personality.

Yet, courses that are titled understanding people and that strictly address how humans can change their own behavior are not popular and in some cases viewed negatively. This could explain at least in part why people persist in bad behaviors (Matrosovich, 2006). For the layperson, education on understanding people is not a difficult subject. Learning enough to take control over your own behaviors or those over whom we have control such as children, students, and the sick, does not take much time. A few hours explaining behavior analysis and stimulus response can have positive—and permanent—effects on behavior. For example, the popular media recently ran an article about behavioral therapy used for insomnia in the elderly.

Ironically, drug companies are very adept in using knowledge about understanding people to change people’s behavior, for example through full page color ads in national newspapers about the effects of drugs, and running ads during prime time televisions to discuss how drugs can cure depression. The general public is not only bombarded with claimed causes of behavior such as brain chemistry, brain damage or heredity (e.g., cholesterol drugs), but have become convinced that drugs are necessary for children to function properly in public settings as young as pre-school age. Drugs such as those for depression and hyperactivity now sit along side lunch boxes as back-to-school essentials.

The papers point to the necessity that behavior analysts must pass on their knowledge to the lay public. For the most part, education and training on behavior analysis and applied behavior analysis is presented within groups—to other behavior scientists. Meanwhile, lay people are spending billions of dollars annually to control behavior with drugs, behavior that could otherwise be controlled through education and training with the proper use of behavior management and applied behavior principles.

In addition, the teaching of understanding people should begin in early grades in school, similar to the beginning teaching of computers and science. This is evident when we look at the strides made in computers, and medicine because of the exposure to these disciplines early in child’s learning. As with the knowledge of fire by our early forefathers, which spread from cave to cave, so too could the knowledge of behavior principles spread. Change can begin in all school settings whether preschool, medical school, or graduate or residency programs. The lead person in each setting must behave enthusiastically towards the application of behavior principles in mental health. To quote Charles Reade, “Example is contagious behavior.”

Happily, there are a variety of positive signs, and help may be on its way. The media have sometimes discussed how behavior programs used in school settings teach successful behaviors for activities of daily living, learning, social interactions and emotional well-being. This is certainly much safer than drugs used for behavior management control in the classroom and family.

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In medical settings, behavior treatment programs are being investigated as “part” of a drug program—at least a start. The Cincinnati Children's Hospital Medical Center has begun incorporating behavior treatment along with their clinical program for children with migraines, and a recent study presented in the Archives of General Psychiatry (Poling et al., 2006) discusses a contingency treatment program for cocaine use among opiate-dependent addicts. The contingency was either monetary-based voucher for a clean urine sample or a voucher for providing a urine sample only. There were four randomly selected groups: clean-urine contingent voucher plus an anti-depressant, clean-urine contingent voucher plus placebo, voucher for providing a urine plus antidepressant, and voucher for providing a urine plus placebo. The findings indicated that the contingency program contributed to reduced use of cocaine, though best improvement was in conjunction with the antidepressant and least improvement was with the voucher. It is important to note that the contingency program did work. There is also an exclusive 12-week behavior treatment program in San Francisco in which addicts are being paid to stay off drugs following a clean urine sample, drawing on data from studies of the community reinforcement approach. In another small example, the media have also reported that a simple behavior change, such as slowing down breathing, can reduce blood pressure and increase baroreflex sensitivity. Awareness of the issues raised by Wong, Wyatt, and Midkiff is especially critical in clinical mental health settings where teaching individuals to take ownership and control of their lives may be overtaken by chemical adjudication to change behaviors.

Future papers could include the physical health consequences associated with drugs, such as the recent reports of fatalities and diseases among children taking anti-hyperactivity drugs, and suicides among children and adolescents taking certain antidepressants, or how frequent drinking behavior influences reproductive activity. However, Wong, Wyatt, and Midkiff's papers stand well without this discussion.

REFERENCE

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