Behavior therapy breakthrough in treatment of retarded

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By MANNY STERNLICHT

It began decades ago as an experiment with pigeons in a laboratory. It has been applied successfully over the past number of years in the treatment of a host of disorders that range from sexual impotence to intractable sneezing.

And it is now being used to help the mentally retarded.

It is called "behavior therapy" and it holds out the promise of a new and unprecedented era of psychological treatment for individuals who until recently had been sadly languishing on the wards of large institutions for the mentally retarded, where little could be done for these people beyond keeping them tranquilized until they would eventually fall asleep.

Today these mentally retarded patients are being awakened to a new way of life in which self-fulfillment becomes more than just a perennial dream. And it is self-fulfillment with a twist, for the retarded patients who are the treatment targets of behavior therapy have more than a normal share of problems.

Head-banging. Eye gouging. Chronic vomiting. self-induced seizures. Self-mutilation. Assaultiveness and destructiveness in all their forms. These are the activities that form the unusual repertoire of behaviors among disturbed, severely retarded men and women, boys and girls, behaviors that have almost miraculously been reduced or altogether eliminated by the new techniques of behavior therapy.

What is behavior therapy and what are the techniques it uses to achieve its minor, and in some cases, major miracles?

Behavior therapy is based on principles of learning developed by psychologists over the years which recognize the simple but powerful fact that an individual's behavior can be modified for the better through the systematic and sustained application of appropriate rewards and proper penalties. The individual under treatment is rewarded for those behaviors that are to be cultivated and sustained, while he or she is penalized for those behaviors that are to be diminished and eventually extinguished. Rewards may vary from edibles to praise and penalties from social isolation to electric shock.

A graphic, if not very pretty, picture of what the psychologist encounters when he goes about treating behavior disorders is painted in the case of Stanley, a 33-year-old self-mutilating mentally retarded and psychotic patient who has lived in a residential facility for a number of years.

For seven of those years, it had been ward routine to place Stanley in a restraining chair from the time he awoke in the morning until bedtime. His hands were placed in mittens, which in turn were tied to the arms of the chair. On occasion, he was removed from the chair for a trip to the bathroom, or if he had been incontinent, his clothes were changed. Similar procedures were followed at night when Stanley was securely tied in bed.

These restraints were necessary because of his long history of self-mutilation and overt aggression toward others. In the past, Stanley would hit his head on any available object, such as a table, a chair, or even the floor. Frequently he ran the length of a room, smashing his head against the wall or on table corners.

Although the restraining chair checked his head-banging, it did not prevent other types of self-mutilation. Whenever Stanley was able to slip out of the mittens, he pulled out his fingernails; his fingers, besides showing the effects of being broken, often had only fleshy tissue where the nails should be. If he got hold of a pin, he pushed it into his arm until only the tip was visible. Stanley demonstrated marked proficiency in rolling a piece of cellophane from a cigarette package into a stiff, sharp point, which he then used to injure himself. His arms bore the scars of many self-inflicted cigarette burns.

There are scores upon scores of Stanleys in institutions for the mentally retarded. Take Susan for example. A 32-year-old retarded woman, Susan has a history of chronic self-abusive behavior. She will slap herself, punch herself, and bang her head just as readily as she might sit, stand, or walk. Playing it by ear and using specialized procedures, psychologists and therapy aides working with the patient carried out a treatment plan that utilized two potent techniques of behavior therapy.

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The first technique involved simply rearranging the patient's lifestyle by removing those things that were in fact keeping the undesirable behavior going. Since excessive personal attention is one of the very things that often acts to exaggerate negative behavior in the patient's mind, those who worked with Susan had to learn to ignore her self-abusive behavior, acting even as though the patient were not there. Anytime Susan slapped herself, punched herself, or banged her head on any object, she was ignored. This meant not speaking to her, not touching her or holding her hand, and not even looking at her.

At first, this technique may not always seem to be working. Sometimes, a head-banger who is shown no attention may exaggerate the head-banging. This may actually be the opposite of what it appears to be. It may be a sign that behavior therapy is beginning to work. Just as we will shake a vending machine when it fails to deliver its goods, so the head-banger who does not receive the attention she wants may bang her head a bit harder.

In addition to not paying attention to her, those treating Susan used a second technique. Whenever Susan did not bang her head, she was rewarded with something to eat, especially her favorites: Cookies, candy, and soda.

After weeks and weeks of this kind of treatment, behavior therapy began to do its good work. Susan was beginning to bang her head less and less every day and, while it is not gone altogether, head-banging no longer poses a threat to her physical and psychological well-being.

What has been done for Susan is being done for large numbers of mentally retarded patients who suffer from an assortment of behavior problems at least as serious as Susan's. Retarded children and adults alike have been cured of such disorders as self-kicking, rectal digging, window breaking, hand biting, hair pulling, and chronic vomiting by the use of electric shock, a technique which is as controversial as it is effective. In fact, though it has been opposed by many who claim that it represents an inhumane treatment approach and has even been banned from use in a number of government-operated hospitals for the retarded, electric shock remains probably the most effective technique for controlling serious self-injurious behavior in the mentally retarded.

A variety of novel behavior therapy technique have been used as well. Loud noise, for example, has been employed with a stubborn, oppositional retarded child. The noxious door of aromatic ammonia has been used to suppress self-injurious behavior. Lemon juice and hot pepper sauce have both been tried with patients who have the habit of ingesting inedible susbstances, such as chalk, cigarette butts, and in some cases their own feces. And, interestingly enough, tickling has been introduced as a means of controlling behavior disorders.

What makes behavior therapy so especially appealing as a treatment technique is the fact that it has been able to eliminate almost overnight serious and dangerous behaviors that had been in the making for years and years and in some cases even a whole lifetime.

It may not be a panacea, but behavior therapy has surely worked wonders with patients who were once lying aimlessly in the clandestine corners of large institutional wards and who are today thriving in work activity centers as happy and productive citizens.

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