TOWARD A SOLUTION: A CRITIQUE

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Several issues of general concern to all are raised by Jim Holland's laudable examination of the overall direction of the learning therapies.

Is aversive therapy "reserved for acts viewed as despicable" and used as for social retaliation? The answer can be obtained empirically by counting instances in journal reports. My initial judgement is that it is not reserved for such acts. Shock has been reported as used for nailbiting, obesity, muscular tics, smoking, writer's cramp, obsessional thoughts, and many other actions that are of concern only to the individual, non-institutionalized, and freely receiving it on an outpatient basis.

Can "special clinic procedures . . . solve behavioral problems which are maintained by conditions in the natural environment". The literature in behavior therapy says it can and does. Treatments for alcoholism, marital problems, fears, phobias, stuttering, obesity, and a host of other problems are typically treated in the outpatient clinic, and the evidence does show that benefit or cure can result.

Learning therapists should not "blame the victims" for adaptive behaviors that were caused by society. This admonition is generally heeded by learning therapists who instinctively, as behaviorists, attempt to remedy the patient's behavior and not to condemn his "flawed personality", nor to tinker with "fictional mental causes".

Learning therapy should "focus on the maintaining contingencies in the behavior of the criminal or the drunk" that prevail in societal institutions. Indeed, learning therapies have done this, and to an extent unrivalled by other helping professions. Alcoholics are taught "social drinking" with their peers; they are given

marital, vocational, and social-skills training. In mental hospitals, the institutional environment is changed from an indifferent custodianship to a program-oriented, actively reinforcing staff arrangement by the token economy. For students in school, the learning therapist attempts to change the manner in which the teacher relates to the student. Similarly, problem behavior of a child is approached by parent training in the institution of the family. In the institution of marriage, the learning therapist deals with both partners, teaching each to be more positive. In prisons, the learning therapist teaches prosocial alternatives to the inmate, but also involves the prison staff in a more positively oriented interaction. Learning therapists characteristically have assisted individuals by trying to make their social milieu more supportive and positive.

To summarize, the learning therapies are oriented toward noncoercive treatment. Aversion therapy is used as one of a large number of available treatments, and not as a concealed form of punishment of an individual. Treatment is directed toward behaviors and not toward mental states. We need no reminders of the inequities that are inherent in societal institutions. We need solutions, and learning therapists have long since been developing such solutions and are evaluating them experimentally. We recognize that our solutions still leave some inequities intact, and that the solutions may have some coercive elements. But the actuality is that the situation was more coercive and less equitable before our efforts. I welcome the concerned reexamination of these issues. I would welcome even more an examination of how much progress the learning therapies have made in reducing problems.