FABA QUARTERLY

Florida Association for Behavior Analysis

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Gordon L. Paul To Keynote The Third Annual Conference

Gordon L. Paul, Cullen distinguished Professor of Psychology at the University of Houston, will deliver a keynote address to the Florida Association Third Annual Convention on September 15th and will also participate in a symposium as well as other convention activities. For the past 15 years, the primary focus of Dr. Paul's professional activities has been on the development and evaluation of residential and community treatment programs for severely disabled adult mental patients. As a major component of this work Dr. Paul and his colleagues have also developed and evaluated observational assessment systems that provide objective information useful for administrative, clinical, and research decision making within mental health service delivery systems. Dr. Paul's keynote address will describe the nature and empirical status of these residential and community treatment programs and observational assessment systems.

The symposium, in which Dr. Paul will be a participant, will discuss the nature of the multitude of decisions made daily in mental health systems and the role of objective and accurate information in optimizing the outcomes of those decisions. Other participants in this symposium include Donald J. Hevey, Alcohol, Drug Abuse and Mental Health Programs Staff Director; Bob Williams, Adminstrator, Florida State Hospital; Dr. Mark H. Licht, Department of Psychology at Florida State University; and Dr. Gary Smith, Psychology Standards Specialist, Florida State Hospital.

* * *

Further Information on Third Annual Meeting and Two-Day Worksession September 15-16, 1983 Hilton Inn Florida Center 7400 International Drive, Orlando, Florida 32809

Special Invited Presentation by
DAVID PINGREE
Secretary of the Department of HRS

Keynote Address by
DR. GORDON PAUL
University of Houston
"The Severely Disabled Adult Mental Patient: Social Learning Treatment Programs and Observational Assessment Systems"

Presidential Address by
DR. JERRY MARTIN
District I, HRS
"Ecobehavioral Analysis: Rats, Pigeons, and People"

A New Addition To The FABA Conference Behavioral Film Festival

Under the direction of JoAnn Bauman, Ph.D., Leon County Schools, and Laura Palasezzi, Leon County Public Library, films and video tapes have been selected for presentation at the 1983 conference.

A special program insert will be available at registration. The program insert will give you a description and schedule of each of the film and videocasettes available for review during the conference.

See pages 4 and 5 for further information on invited presentations

Plan to Spend Two Stimulating Days With FABA in Orlando

Hotel accommodations at the Hilton Inn Florida Center on International Drive.

The 1983 Third Annual FABA Conference will be located at the Hilton Inn Florida Center on September 15-16. In order to ensure the specially arranged rates, $38 per night for up to 4 persons in each room, you must register by August 22nd. More terrific news!!! The Hilton has agreed to extend this fabulous rate for three days before and following the conference. Plan to bring the whole famiy and enjoy all of the attractions that surround our convention hotel.

Complete the enclosed hotel registration card and mail today! You may also make your hotel arrangements directly with the Hilton by calling (305) 351-4600. Be sure to mention that you will be attending the FABA Conference so that you will receive our special rates.

Save money and register by August 22nd to receive the conference rates.

Orlando: A World Of Fun Attractions

Make this year's FABA Conference a vacation for the whole family. The Hilton Inn Florida Center will extend our convention rates 3 days before and after the conference. Now you can take advantage of our exciting program and have a fun time with the entire family.

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1980, 13, 367-371 Number 2 (Summer 1980)

A Review of Paul and Lentz's Psychological Treatment for Chronic Mental Patients: Milieu Versus Social-Learning Programs[1]

Robert Paul Liberman

Clinical Research Center, Camarillo, California

Combining elegant experimental design with rigorous pursuit of relevent clinical goals, Paul and Lentz have given a precious gift to clinicians, researchers, and teachers in psychology and psychiatry. Working for more than 6 years with 102 of the most refractory and neglected chronic mental patients, Paul and his colleagues demonstrated the superiority of a systematic, inpatient social learning program over milieu therapy and custodial hospital comparison treatments. Although the overall results will replenish the morale of behaviorists who lately have been hard pressed to document the differential effectiveness of their treatment procedures, this monograph more importantly provides—in its comprehensive and complete description of the project's development and execution—a bold and clear model for all clinical researchers to strive to emulate.

Paul began by thoroughly reviewing the literature with a critical eye. He discovered four major reasons why long-stay schizophrenic patients fail to leave the hospital, or if they do, fail to survive in the community: They lack self-maintenance and social skills, instrumental role performance, and community support; and they display high rates of bizarre behavior. Such patients comprise an increasing proportion of hospitalized cases, reflecting the hard-core, residual, institutionalized cases plus the accumulation of acute patients who don't get discharged after one or more admissions. These behavioral deficits and excesses, then, became the targeted goals for the comparison study. The clinical literature also pointed the way to the two psychosocial treatment strategies for the study that had the greatest promise for rehabilitation of chronic mental patients—token economy based on social learning principles, and milieu therapy based on the assumptions of therapeutic community.

The design of the project married the best features of clinical intervention with those of scientific methodology. Operationalizing the essential elements of social learning and milieu therapy procedures, a single treatment staff—principally nonprofessionals with a staff/patient ratio not different from existing custodial institutions—were trained to objective criteria of competence in both procedures. The same staff members, imbued with an optimistic, active treatment ideology, rotated between two identical, adjacent units of 28 beds each at a regional mental health center in central Illinois. Three patient groups, carefully equated on most variables connected to outcome, were placed in the two experimental psychosocial programs and in a 28-bed unit at a comparison state hospital. The patients, leftovers from previous "total push" and discharge efforts at state hospitals, were the "most severely debilitated, chronically institutionalized adults for whom systematic treatment efforts have ever been studied." On a declining contact basis, similar aftercare was provided for 6 months to patients discharged from all three programs.

Regular assessments of patients were made using time-sampled behavioral observations, structured interviews, and standardized rating scales. Assessment was an unprecedented, heroic enterprise with reliably trained observers sampling behavior on the inpatient floors 50% of waking hours over 4½ years! The massiveness of the assessment process was also reflected by the use of a regular, triple-check data reduction system, involving keypunching, verifying, and computer summarizing of over 5,000 IBM cards per week, and the feedback of this information to the staff for their clinical use and correction of staff behavior. Staff attitudes, staff-patient interactions, and staff personal and social characteristics were carefully monitored as checks on the *fidelity* of staff in using the two, differentiated psychosocial programs. Despite high turnover which necessitated almost constant recruitment and training, the mostly young non-professional staff's efforts reflected the ideal assumptions underlying the psychosocial programs. For example, the differential requirements specified by the respective treatment manuals were met by over 90% of directly observed staff-patient contacts, a remarkable documentation of fidelity to therapeutic modes by the rotating staff. Such careful attention to the independence of treatments being compared in a "horse race" outcome study is sadly absent in most clinical research, and thus makes the findings from this study even more robust.

The comparative efficacy of the psychosocial programs was evaluated by changes in specific and global functioning and by discharges that led to at least 90 consecutive days of community tenure. Each released patient received a minimum of three follow-up assessments during an 18-month period and some were followed for 5 years. The results were astonishing, given the refractory nature of the patients: Improved functioning enabling long-term community placement occurred in 97% of the social learning patients with some maintaining themselves for over 5 years which was the longest period of follow-up possible in the study. The milieu therapy program was less effective, but its 71% release and maintenance rate was still a favorable outcome when compared to the patients treated in the state hospital of whom less than 45% were discharged.

The amazing rate of enduring discharges was mirrored by the significant clinical and behavioral improvements corroborated by the multi-level battery of evaluation instruments. For example, by the end of the first 14 weeks of treatment, every resident in the social learning program showed dramatic improvements in overall functioning, regardless of usual prognostic indicators such as duration of hospitalization and pretreatment level of regression. By the end of the second year of programming, fewer than 25% of residents in either experimental program were on maintenance psychotropic drugs and this proportion was further reduced as the programs went on. Together with a clever triple-blind experiment using placebos conducted early in the project, the overall conclusions by Paul and his team that chronic mental patients, in contact with active psychosocial treatment, have little or no need for long-term neuroleptic drugs alone justifies the investment of research dollars by NIMH in this study. This is particularly important as evidence accumulates regarding the harmful side effects of neuroleptics, including the insidious and irreversible tardive dyskinesias.

Although the book can satisfy even the most ardent and meticulous methodologist in the highest ivory tower with its countless tables and graphs of data and sophisticated statistical analyses, Paul and Lentz also provide rich descriptions of significant clinical anecdotes which confirm the view of this project team as balancing the importance of clinical events with experimental methods. The authors, using data to support their contentions, point out the significance of events such as the accidental death of a resident, changes in administrative rules, securing donations for reinforcers, politically motivated attacks on the mental health center by a local state representative, the 6-month illness of the unit supervisor, and the sexual abuse of a resident.

The monograph with its 528 pages of double columns and small print may put off a potential reader at first glance. However, the authors provide easy to follow guidelines for perusing the book, and clinicians as well as researchers can absorb material relevant to their interests without laborious effort. Each of the chapters has an excellent summary and each of six sections of the book, reporting on process and outcome data, has an introductory overview and a summary.

This is a book that one can take small bites into, digesting the huge fund of data and conclusions over a long period of time.

A number of sacred cows are slaughtered by the rapierlike, sharply honed data collected by Paul and his team. For example, environmental psychologists will be disappointed to learn that simply transferring chronic patients from an old state hospital to a modern mental health center with the latest in psycho-architecture and design elements does not result in significant behavioral improvements. One cannot build clinical remediation with bricks, mortar, and furniture: One needs contingencies of reinforcement as well. Another common assumption—the importance of staff-patient contact and attention to patients' needs—is qualified by the finding that it is not *how much*, but rather *how* attention is given that makes the clinical difference. Residents in the milieu therapy program received more attention but improved less than their compatriots in the social learning program. Even behaviorists will be disappointed to discover the failure of reinforcer sampling-exposure procedures in enhancing these chronic patients' involvement in off-ward, "therapeutic" activities such as movies, bowling, sewing, games, and a snack bar.

There is little to criticize in this volume. With the recent "revolution" in psychiatric diagnosis—operationalizing diagnostic entities and making them reliable—it would have been helpful to know the specific diagnostic types represented in this study for generalization purposes. But even a research wizard like Paul could not be expected in 1967, when the plans for the study began, to foretell the innovations brought about by the new Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association. It is likely that the 102 patients in this study consisted of mainly chronic schizophrenics with active or residual symptoms, plus a sprinkling of retardates, affective disorders, and substance-induced organic mental disorders.

Practical problems facing managers and directors of token economies are addressed by Paul and his team. An elaborate treatment manual for this effective token economy appears as a chapter in the book and examples of recommended procedural memos are given in an appendix. The authors also describe a special purchase plan that enabled residents with large token fines who were on restriction to buy their way into positive reinforcers, thereby avoiding a common problem in token economies where some residents accumulate huge fines, cannot purchase reinforcers, become demoralized, regress, and stop functioning. Paul and his colleagues found that eligibility to purchase reinforcers contingent upon a proportional payoff of accumulated fines successfully returned residents to active participation in the program without weakening the response-cost procedure for controlling inappropriate behavior. Other procedural pointers and assorted clinical wisdom are distributed throughout this book and in related publications by Paul and his team. Because of the great importance of training and maintaining staff competence, program directors will want to read the detailed description of experiences and strategies used during the long course of this study (McInnis, 1976).

Not all clinical problems were solved, however. The most recalcitrant problem—one that faces all workers in institutions—was aggression. Evidence is presented from the milieu therapy program that suggests that focusing the staff's and patients' attention on "intolerable behavior" via community meetings or even through "expulsion" from the community inadvertently may reinforce assault and property destruction. Even in the token economy, only a minimum of 72 hours of time out seemed to control aggression—a duration that is incompatible with current guidelines on human rights. Paul and his team reluctantly encountered natural experiment with a withdrawal design, finding a tremendous increase in "intolerable behavior" when the duration of permissible time out was reduced by administrative fiat to 2 hours. Even when this limitation was rescinded and up to 24 hours of time out was allowed, the average weekly incidence of aggressive acts remained above that occurring during the baseline period before the token economy was begun!

The project team experimented with a variety of methods to control aggression, none of which was found to be fully satisfactory. Even with 72 hours of time out, certain residents appeared to seek out the privacy and no-demand environment of the time out cell. The reinforcing nature of time out was only partly countered by blowing gusts of air or loud noise into the cell to disturb the offender's nap. High-dose neuroleptic drugs used as "chemical straightjackets"; two-way telereceivers; part-time male college students hired to study at night on the units; and even beefed-up security patrols were all given a try. The best control procedure seemed to be the scheduling of senior male staff for extraordinary amounts of evening and weekend time on the units for the protection of the mainly female staff and residents. If employment opportunities for psychologists continue to constrict, perhaps Paul and his colleagues have found a new role for at least male, preferably large, psychologists—but woe to affirmative action!

The failure to control aggression led to more serious "ripple" effects. During the period when time out was limited to 2 hours and aggression markedly increased, the continuous data collected on the units revealed a serious regression among the patients on both psychosocial programs in all levels of performance. In fact, during this period patients in the milieu program experienced a washout of almost all the gains they had acquired since the start of the project. During the last 6 months of the project when time out was again lengthened, patients on both programs again showed progressive improvements in self-care, interpersonal skills, instrumental role performance, and bizarre behavior. It is worrisome and unexplained by Paul and Lentz why the clinical frequencies data, collected and summarized daily by the treatment staff, failed to alarm the staff that significant clinical deterioration was occurring during the period when aggression escalated. It was only somewhat later, when the time-sampled data collected by the research observers were examined, that the staff realized the threat to the programs of the steady worsening of the patients. One possible reason for the semming failure of the feedback loop intended for the clinical frequencies data might have been its complexity—with records being kept on 35 forms for each patient, it is easy to see how information overload could set in.

The excellence of this comparative study and the clear preeminence of the social learning program also provoke a disquieting reaction to the authors' reporting to the program's termination. A change in administration in the governor's office unexpectedly led to a budget slash and the untimely dismantling of the social learning program just at the time it had demonstrated its overwhelming clinical effectiveness. Despite Paul's considerable political savvy and connections—amply demonstrated by the contortions required to mount and complete this complicated and ambitious study—he and his battle-hardened staff stood by helplessly as 6 years of prodigious accomplishment went down the drain. The hopes of idealistic behavior therapists everywhere are diminished by this display of the prepotency of politics over empiricism. After almost 20 years of behavioral analysis and therapy, workers in the field must realize that political, personal, and social factors determine upwards of 90% of the success and survival of technical procedures (Liberman, 1979). Colleagues from overseas have voiced the complaint that, after reading glowing reports in the research literature about innovative behavioral programs, they journey to America to observe and learn only to discover that the programs have ended. More often than not, the termination of an effective program coincides with the end of extramural funding from a grant. Implantation, survival, and dissemination of empirically validated interventions require much more than data and journal publications; unfortunately, the political know-how that is required is not taught in graduate training of psychologists and psychiatrists. The behavioral programs with proven efficacy that have endured and spread can be counted on the fingers of one hand—the teaching home model for delinquents being the example par excellence. We cannot count on administrators' need for accountability and program evaluation to serve as "coattails" for our behavioral programs. More likely it will be the behavioral analysts whose zest for measurement will be exploited and misused by mental health administrators and politicians. If we want our work to live beyond a library bookshelf, we will have to jump into the political mainstream and get our feet wet as administrator-researchers.

Reprints may be obtained from the author, Clinical Research Center, Box 'A,' Camarillo, California 93010.

[1] Paul, Gordon L., and Lentz, Robert J. Cambridge, Massachusetts: Harvard Univ. Press, 1977, 528 pp.

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Liberman, R. P. Social and political challenges to the development of behavioral programs in organizations. In P. O. Sjoden et. al. (Eds.), *Trends in behavior therapy*. New York: Academic Press, 1979.

McInnis, T. Training and maintaining staff behaviors in residential treatment programs. In R. L. Patterson (Ed.), *Maintaining effective token economies*. Springfield, Ill.: Charles C. Thomas, 1976.

Featured Invited Presentations

Dr. John Lutzker
Southern Illinois University

"Project 12-Ways: Four levels of Assessment of an Ecobehavioral Approach to the Treatment and Prevention of Child Abuse and Neglect"

Dr. John Lutzker received his Ph.D. at the University of Kansas in 1973 and is currently Professor and Coordinator of the Behavior Analysis and Therapy Program in the Rehabilitation Institute at Southern Illinois University at Carbondale. Dr. Lutzker has published and presented over 100 articles on behavior change. He is Editor of *the Behavior Therapist,* is Associate Editor of the *Education and Treatment of Children,* and has had extensive Editorial Board and review experience with many behavioral journals. He is author (with Jerry A. Martin) of a book, *Behavior Change.* Dr. Lutzker's current major research interests are in the prevention and treatment of child abuse and neglect, and behavioral medicine.

Dr. Brandon Greene
Southern Illinois University

"Behavior Analysis in the Public Interest"

Brandon Greene is currently on the faculty of the Behavior Analysis and Therapy Program of Southern Illinois University. Dr. Greene earned his Ph.D. at Florida State University and is currently serving on the Editorial Board of the *Journal of Applied Behavior Analysis.* His practical and research interests pertain to the role of behavior analysis in promoting community-action and consumer advocacy groups. His presentation will be relevant to all concerned with how a technology of human behavior might improve the conditions affecting large segments of the community.

Dr. Barbara Melamed
University of Florida

"Behavioral Medicine: A 'test-bed' for Psychologists"

Barbara G. Melamed is Professor of Psychology in the Departments of Clinical Psychology, Psychology, Psychiatry, and Basic Dental Sciences at the University of Florida where she is also *Director of the Fear Clinic and Behavioral Medicine Laboratory.* Dr. Melamed serves as Associate Editor of *Health Psychology* and co-authored a textbook with Dr. Larry Siegel, *Behavioral Medicine: Practical Applications in Health Care.* She has made many research contributions in the area of preparation of patients for surgery and dental treatment and has been a recipient of a National Institute of Dental Research grant for the study of behavioral approaches for pain response. Additionally, she is Program Director for a training program for dentists and other psychologists and medical professionals wishing to do research in the area of behavioral medicine and dentistry. Dr. Melamed has been selected as a Master Lecturer of the American Psychological Association for 1983 and has given invited lectures at several European Universities. Dr. Melamed's current research focuses on defining coping in families involved in acute health problems. Research on the emotional development of fear in children and adults is studied through a bioinformational theory.

Dr. Luke Watson
Therapeutic Homes

"An Almost Non-Physical Approach to Managing Extremely Disruptive Clients"

Dr. Luke Watson is Executive Director of Therapeutic Homes and Chairman of the Board of Therapeutic Environments. He is in private practice in the Ft. Myers-Tampa area and has taught at Case Western Reserve and Ohio State University. His main interests are mental retardation, autism and managing disruptive behavior.

Dr. Brian Iwata
Johns Hopkin University

"Punishment in the Treatment of Severe Behavior Disorders: Empirical, Ethical and Practical Considerations"

Dr. Brian Iwata received his Ph.D. in Psychology in 1974 from Florida State University. He is currently Associate Professor in Psychiatry at Johns Hopkins Medical Center in Baltimore where he is Director of Training and Clinical Services in the Department of Behavioral Psychology at the Kennedy Institute. He is the newly appointed Director of the Center for Study and Treatment of Self-injurious Behavior and also the new Editor of the prestigious *Journal of Applied Behavior Analysis.* Brian is also on the Editorial Board of *Applied Research in Mental Retardation* and *Education and Treatment of Children.* His research interests are in developmental disabilities, behavioral medicine and research methodology. This is Dr. Iwata's third visit to Florida to attend and present at F.A.B.A.

Dr. Judy Favell
Western Carolina Center

"Current Research Findings in the Treatment of Self-Injurious Behavior"

Dr. Judy Favell received her Ph.D. from the University of Kansas in 1970 and is currently Director of Psychology at Western Carolina Center in Morganton, N. Carolina. She was chair of the A.A.B.T. Task Force on Self-Injury and is coordinator of the A.A.B.T. Peer Review Committee for Controversial Treatments. Judy is the Editor of the Division 25 Recorder, the newsletter of Division 25 of A.P.A. and is an Adjunct Association Professor with the University of Kansas and the Greater University of North Carolina. Her research interests are in the development of treatment for self-injurious behavior, management systems and human services and professional psychological services in retardation and quality assurance systems.

Dr. James Favell
Western Carolina Center

"Roadrunner: A Model Program Serving Non-ambulatory Severe and Profoundly Retarded Residents"

Dr. Jim Favell received his Ph.D. from the University of Kansas in 1970 and is currently Director of Research and Evaluation at Western Carolina Center, Morgantown, N. Carolina. He holds Adjunct Associate Professor positions at the University of Kansas and the Greater University of N. Carolina. He is on the Editorial Board of *Analysis and Intervention in Developmental Disabilities.* His research interests are in management quality assurance systems and the delivery of services for the severely and profoundly retarded multiply handicapped. He is also one of the leaders in the use of microcomputers in monitoring the delivery of client services.

Dr. William Pelham
Florida State University

"An Integration of Behavior Therapy and Psychopharmocology in the Treatment of Hyperactive Children in School Settings"

Dr. William Pelham received his Ph.D. in Clinical Psychology from the State University of New York at Stony Brook. He is an Associate Professor in the Department of Psychology at Florida State University where he is also Director of the Child Study Center. Dr. Pelham is currently on leave and is serving as a Visiting Associate Professor in the Department of Psychiatry at the University of California at Irvine

Medical Center. His research has won him many awards and is published regularly in highly regarded journals in psychology and medicine. He has been involved in evaluating the effects of drug and behavioral therapy techniques with hyperactive children for the past 10 years.

Dr. Stephen Breuning
University of Pittsburgh

"Behavioral Effects of Psychotropic Drugs Used with the Mentally Retarded: Analysis and Implications for Behavioral Treatment and Vocational Training"

Stephen E. Breuning is currently an Assistant Professor of Clinical Psychiatry and Special Education and the Acting Director/Research Director of the John Merck Program for Multiply Disabled Children at Western Psychiatric Institute and Clinic at the University of Pittsburgh School of Medicine. Over the past several years Dr. Breuning's research has been in the area of pharmacological and behavioral treatment of severe behavior disorders. In addition, he has conducted research on the effects of commonly used medications on performance on educational and habilitation tasks. Dr. Breuning has been a consultant for the Justice Department in law suits concerning improper medication of retarded persons. His presentation will be of interest to those professionals working with mentally retarded clients who have behavior disorders and/or are receiving psychoactive medication.

Dr. Robert Klepac
Florida State University

"Behavior Therapy for Acute Pain"

Dr. Robert K. Klepac received his Ph.D. in clinical psychology from Kent State University in 1969. Since that time he has served on the faculty of Western Washington State University, and as chairman of the Department of Psychology and Founder of Programs in Health and Behavior at North Dakota State University. He is currently Director of Clinical Training at Florida State University, and Director of the Dental Behavior Research Clinic. Klepac was Founder and First President of the Red River Association for Behavior Therapy, has served as the President of the North Dakota Board of Psychologist Examiners and has served as a committee chair for the Behavioral Medicine Special Interest Group of AABT.

His research interests lie in the areas of social learning theory and behavior therapy, especially as applied to health and illness. Current research projects include evaluation of stress inoculation and other behavioral strategies to overcome avoidance of dental and medical interventions; assessment of iatrogenic, laboratory, and clinical pain; and self-directed smoking cessation. A secondary interest is the use of microcomputers in clinical research, assessment, and treatment.

Dr. Walter P. Christian
The May Institute

"Behavioral Administration of the Human Service Program"

Walter P. Christian, Ph.D. is Director of the May Institute, a community-based residential educational center for autistic children located on Cape Cod. Dr. Christian received his Ph.D. in Clinical Psychology from Auburn University. He previously held positions at the National Asthma Center in Denver from 1974-76 and at Children's Behavioral Services in Las Vegas from 1976-78. Co-author of numerous books (including *Effective Management in Human Services*), Dr. Christian also holds adjunct faculty appointments at several universities. His current research interests include behavioral approaches to the treatment of autism and to management in human service systems.

Dr. Denny Reid
Western Carolina Center

"The Non-Existence of a Technology for Training and Managing Staff Performance"

Dr. Reid received his Ph.D. in Psychology from Florida State University in 1975 and is currently Director of Intensive Training and Specialized Services at Western Carolina Center, Morganton, N. Carolina. Denny is co-author of a new book entitled *Behavior Modification with the Severely and Profoundly Retarded,* published by Academic Press and is a newly appointed Associate Editor of the *Journal of Applied Behavior Analysis.*

His area of interests are staff training and management and treatment of severely and profoundly handicapped persons.

JOIN FABA NOW!

FABA Job Line

Behavior Specialist and **Behavioral Psychologist** — Bainbridge State Hospital, Southwestern Developmental Center, an ICF/MR facility serving 200 clients on 12 cottages. Client diagnoses range from mild to profound retardation.

Behavior Specialists participate as members of an interdisciplinary team and are responsible for: designing and conducting behavioral assessments, designing, conducting and training staff to conduct behavioral programs (acquisition and reduction). Supervision is provided by a behavioral psychologist and other senior behavioral staff. Close professional relations are maintained with nearby Florida State University and some research opportunities are available. Candidates should possess a solid background in behavior analysis and either a B.A. or M.A. in behavior analysis or closely related field. Salary is commensurate with experience.

Behavioral Analyst/Behavioral Psychologist directs all behavioral/psychological services. The psychologist functions as an interdisciplinary professional responsible for: supervising behavioral specialists; designing, conducting and training staff to conduct behavioral programs (acquisition and reduction); interpreting and implementing Georgia's Guidelines for conducting behavioral programs; formulating policy pertinent to the use of restrictive programs (e.g., time out, restraint); maintaining a liason with state officials for the purpose of providing and receiving input pertinent to issues of right to treatment, least restrictive treatment alternatives, the use of psychotropics to manage behavior, etc. The facility maintains close professional relations with Florida State University and some opportunity for research is available. Candidates should possess a Ph.D. in behavior analysis or related field (e.g., human development) and should be anxious to remain abreast of the field through reading the literature, attending conferences, etc. Salary commensurate with experience.

Applicants for both positions should submit a vita to: Steve Willis, Unit Director, South Developmental Center; Bainbridge, Georgia, 31717. Inquiries are welcome (912) 246-6750.

From the Editors

It is with a heavy heart and a sad demeanor that I write a few closing thoughts on making this the last issue of the FABA newsletter that I will co-edit after two years of this interesting task. If that sounds like I'm running for office, I'm not! The pressures of completing a dissertation require it. So actually, it is with a clear mind and a Chesire cat grin that I leave the task of quarterly deadlines and editing out favorite phrases to my co-editor, Gary Jackson.

Behaviorally disposed practitioners must continue to use every information spreading tool they can fashion to convey the message that applied behavior analysis has broad applications across everyday life and many fields. This FABA newsletter is a good place for you to tell FABA members (and our wider circulation of 800+) what is going on in your particular program. And your attendance or active participation in FABA's Third Annual Meeting and Work-session is another beckoning opportunity to accomplish this same goal. This is not to even mention some of the side benefits that can accrue to the faithful FABA conference goer. Just two years ago, at the 1st Annual Meeting I had the opportunity of meeting a most kindred spirit and beautiful lady. One year later of exchanging reinforcers and negotiating major personal goals, Judy Bloomer and I took that public step of commitment around which so many quaint customs have abounded.

So I urge you to continue to involve yourself with FABA and to note that this has been a year when hardcore FABA members have made a special effort to reach out to our colleagues in mental health work. The research of Dr. Gordon Paul, keynote speaker for this 3rd Annual Meeting, is the best evidence that I can present to mental health colleagues that applied behavior analysis can vastly improve mental health service delivery systems when it is consensually applied by social workers, nurses, psychologists, counselors, psychiatrists, occupational therapists, etc.

Lastly, keep in mind that the *FABA Quarterly* is published four times a year (Nov.,-Feb.,-May,-Aug.). Members and non-members (but behaviorally oriented) are urged to submit brief articles, book reviews, job openings, news or major job changes, and just about any bit of information that furthers behavior analysis in Florida that you would care to call or to write about. Copy deadlines are generally the 20th of the month in which a newsletter is due to come out. Publication of items in the *FABA Quarterly*, of course, does not imply endorsement by FABA; and the editors reserve the right to edit all copy. Please submit articles and news for the next issue by October 20 by writing or phoning: *Gary Jackson, Ph.D., 8404 Del Ray Ct., Apt. 419, Tampa, Florida 33617 - bus. ph.: (813) 974-4483.*

Bob Wehr
Florida State Hospital

Essential Elements of Behavioral Consultation

by Judith Bloomer
Florida State University

As research supporting the effective utilization of applied analysis becomes more well known to the public at large, there have been increasing requests for behavioral input in a variety of settings. Currently many organizations request behavioral assessment, documentation, and intervention strategies and these requests often precede mandates from governmental agencies for behavioral documentation of program objectives. To be effective in their role as consultants, special skills are required - not only technical skills in applied behavior analysis, but also, interpersonal communication skills.

The importance of exploring the interpersonal aspects of consultation becomes evident when two phenomena are noticed: 1) Equally technically skilled consultants often have differential success rates in obtaining their objectives, and 2) Second generation programs are often not as successful as first generation ones in which the consultant has actively taken a part.

To understand why there is this differential degree of effectiveness, it is necessary to recall the primary cause of failures in behavioral programs: that is, a misunderstanding of the functional relationships involved. For this reason it is important to expand the realm of phenomena available to the behavioral consultant in performing a functional analysis of behavior.

Two models of consultation are useful to the effective behavioral consultant: the traditional Behavioral Consultation Model (Bellack & Frank, 1975; Russell, 1978) and the Generic Problem-Solving Model (Kalafat, 1981). The Behavioral Consultation Model emphasizes the technical aspects of carrying out a functional analysis of existing behavioral contingencies and developing an intervention strategy for the setting. The Generic Problem-Solving Model emphasizes the interpersonal aspects of consultation. The best elements of both models are included in a proposed third model, the Composite Consultation Model. This composite model stresses that, to be effective, behavioral consultants need to incorporate both technological skills and interpersonal skills. They need to not only focus on observable behaviors, but also to attempt to sense the other variables in the "black box", variables that might not be readily observable -but ones that can be identified through intentional exploration.

The Composite Consultation Model includes the following steps in the consultation process:

1. Establish a relationship.
2. Identify the problem.
3. Observation - Establish a baseline.
4. Functional Analysis - Identify all elements: antecedent events, consequences, systematic & nonsystematic reinforcers of behavior, feelings & attitudes of participants.
5. Review past attempts to solve problem & "deal with" attitudes and feelings regarding these.
6. Propose alternatives.
7. Choose & implement an intervention strategy.
8. Evaluate Outcome - Re-evaluate if necessary after repetition of process & after withdrawal of consulting services. If objectives were not met, there is the possibility of blaming between the consultant & client, so it is important to focus on the relationship at this point. If the objectives were met, there is the opportunity for positive mutual reinforcement between client & con-

(See *Behavioral Consultation* on page 7)

Message From

It is with some sadness that I write my last presidential column for the *FABA Quarterly*. At the same time I am very proud of FABA activities during the past year. These have been made possible by a large number of people. This publication is a tribute to the hard work of Bob Wehr and Gary Jackson. Unfortunately, Bob has decided to "retire", but I am certain that Gary will keep *FABA Quarterly* a publication we can all be proud of. Most of you have received your Membership Directory I'm sure. This has been the pet project of Darrel Bostow and I hope you will find it as useful as I have. Please let Darrel know that it was worth all the hassle. Those of you who attended the Spring Workshop know that FABA is no longer a "once a year conference." I have been encouraged by the response to this workshop and have had many FABA members say they hope we plan a Spring event in 1984. Now comes our 1983 and Third Annual Conference.

Please plan to attend the FABA Conference in Orlando on September 15-16, 1983! You can't imagine what a fantastic event this is going to be. For a very small cost you will be able to hear some of the top researchers and practitioners in the country. It is unprecedented for so many noted behavior analysts to be participating in a state-level conference. We have tried very hard this year to be certain that a broad range of areas and topics in behavior analysis are covered. I believe that Maxin Reiss, Program Chairperson, has eminently succeeded. There is, truly, something for everyone! Some of you may know that I will be moving from Orlando to Pensacola soon. If Don Pittman were not handling the local arrangements for our Annual Conference, I might have some concern. However, Don has things well under control and has arranged for an extremely attractive sleeping room rate at the Hilton Inn on International Drive. I know that you will find it a first class hotel and an excellent place for our conference. I encourage you to make your reservations as soon as possible. We want to make this the largest FABA conference ever. Do your part; spread the word among your colleagues. Support FABA, the voice of behavior analysis in Florida.

Finally, the end of my term of office means that it is time to elect new officers for the coming year. You will find information concerning nominations elsewhere in this issue. Additionally, I encourage all Full Members of FABA to attend the business meeting at the conference so you will be able to vote for next year's officers.

Jerry A. Martin, Ph.D.
Sunland Center at Orlando

(*Behavioral Consultation* - continued from page 6)

sultant.

There are various barriers to effective consultation that are likely to confront the behavioral consultant in practice. These barriers include: resistance by the consultee, interdisciplinary role conflict and differences in basic frame of reference, and unrealistic expectations about program goals and time limitations. Additionally, Bellack and Franks (1975) warn about the frequent rejection of the behavioral approach because of philosophical differences held by others regarding treatment. Their answer to this dilemma is to suggest that the behavioral consultant should avoid self-application of the behavior modification label, but rather should offer professional identification (i.e., psychologist, social worker, psychiatrist, educator) whenever possible. In a similar vein they recommend that excessive technical terminology should be avoided whenever possible. An example of such excessive technical jargon might be: ". . . the child's thumb sucking is an operant maintained by attention on a thinned VR or variable reinforcement schedule." A recommended alternative would be using language that is normal to everyday use as possible, for example: ". . . I think that child gets secondary enjoyment out of thumb sucking because of his parent's increased, although inconsistent attention to him when he does it."

There are various strategies for refining the interpersonal and communication skills used in the consultation process. Role playing, behavioral rehearsal with colleagues, the use of videotape for self monitoring and traditional on-the-job-training with an experienced consultant are all methods used for self improvement. For those interested in further reading in this area, the following references are recommended:

1. Bellack, A. S. & Franks, C. M. Behavioral consultation in the community mental health center. *Behavior Therapy*, 1975, Vol. 6, pp. 388-390.
2. Kalafat, J. Training in crisis intervention. In L. H. Cohen, G.A. Specter, & W. L. Claiborn (Eds.) *Crisis Intervention.* New York: Human Sciences Press, 1981.
3. Russell, M. L. Behavioral consultation: Theory & Process. *Personnel and Guidance Journal*, 1978, Vol. 56(6), pp. 346-350.

(Editor's note: this summary is based on a presentation by the author with Dan Boroto, Ph.D., at the first Annual FABA Conference, September 25, 1981)

Nominations For FABA Officers

In order to allow the membership to more fully participate in the election of officers for the coming year, the following process will be used. I have appointed Don Pittman to serve as Chairperson of the Nominating Committee. I am asking all Full Members of FABA to submit nominations to Don for the offices of President-Elect, Secretary-Treasurer, and Member-At-Large. Any Full Member of FABA may serve in one of these offices. To submit your nomination(s), write the name of the member(s) next to the office(s). Mail your nomination(s) to Don Pittman, 305 W. Par, Orlando, Florida 32804. *Please sign the back of your envelope* so that your status as a Full Member of FABA may be verified. Nominations will be accepted until September 1, 1983. This is your opportunity to have some influence on FABA as an organization. Please send your nominations to Don.

Jerry A. Martin, Ph.D.
FABA President

AVOID STANDING IN LINE! SAVE $$$
REGISTER IN ADVANCE BY SENDING FORM & CHECK BELOW:

. . . If you do pre-register, you will receive your badge and program in the mail. You will not have to stand in line and you will be able to proceed directly to the meetings.

Conference Pre-Registration and Membership Application

Pre-registration for the conference is highly recommended and must be mailed by August 19. Fill out this form and send with your check to the address indicated below. Circle your payment category. Save money by becoming a member TODAY!

	Pre-Registration	At Conference
Student Member with ID	$15 ($10 - one day)*	$20 ($15 - one day)
Student Non-Member with ID	$25 ($20 - one day)*	$30 ($25 - one day)
Professional Member	$25 ($20 - one day)*	$40 ($20 - one day)
Professional Non-Member	$50 ($30 - one day)*	$60 ($40 - one day)

For special Group Rates for four or more members from the same facility write to Jon Bailey at address below:

Name: _____

Address: _____
(Street) *(City)* *(State)* *(Zip)*

Affiliation or Facility: _____

Position Title: _____

☐ I have paid my FABA dues for 1983

☐ I would like to apply for, or renew my membership with FABA:

_____ A Student Member - $5 (you must be currently enrolled in a degree program in Florida)

_____ A Professional Member - $15

_____ A Sustaining Member - $100

Enclosed check to: **Fla. Association for Behavior Analysis** and mail by August 19 to:

*(If pre-registering for one day, please indicate which day on this form.) Thursday 9/15 _____ or Friday 9/16 _____

Jon S. Bailey, Ph.D.
FABA Pre-Registration
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