Behavior Therapy and Civil Liberties

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For the past two hundred to three hundred years, science has played a major role in the development of western culture. Societies have capitulated to the demands of "progress" and have disregarded the costs as expediends to the industrial revolution (Etzioni, 1968, p. 208). Unfortunately, the costs have mounted quietly, and perhaps because the awareness has been so long delayed, there is a strong feeling today that the excesses of science must be curbed immediately and completely. Current efforts to promote the rights of people over technological advances are an expression of this concern. Because behavior therapy is viewed by many as a machinelike process for use in the suppression of individual freedom, it is being placed at the center of the current controversy when psychology is discussed.

What Is Behavior Therapy?

Rather than being a single unitary approach, behavior therapy encompasses a wide variety of goals and techniques. Some behavior therapeutic efforts are directed toward changing the ways in which the individual responds to forces in the environment. Other approaches aim to change the environment in ways that suit the individual. Person-changing goals are sought through respondent or operant conditioning techniques and cognitive restructuring procedures, singly or in combination. Environment-changing techniques typically rely on operant conditioning and may be targeted to individuals, small groups, or total social institutions (cf. Kanfer & Phillips, 1969).

Despite the range of goals and techniques falling within the rubric of behavior therapy, behavioral treatments have several important unifying characteristics. First, the focal techniques have been derived from, or are consistent with, research in experimental and social psychology. Second, their intrinsic goal is the alleviation of human suffering and the enhancement of human functioning. Third, when responsibly practiced, they always involve a systematic evaluation of treatment outcome using single-subject or group designs. Fourth, they typically involve reeducational efforts intended to facilitate improved functioning as measured by increased skill, independence, and satisfaction. Fifth, the practice of behavior therapy is typically guided by a contractual agreement between both client and therapist specifying the goals and methods of intervention (e.g., Stuart, in press-b).

The techniques used by behavior therapists have much in common with those employed by most psychological care-givers. Some of these techniques involve efforts by the therapist to overcome the client's anxiety or depression and to help to clarify the client's objectives. Other techniques involve efforts by the therapist to strengthen the client's resolve to make specific changes in his or her behavior outside of the therapeutic environment. In selected instances, the therapist may help the client to restructure his or her social environment so that desired changes can be more readily made and maintained.

The goals of properly conducted behavior therapy are always explicit. There are times when there may be differences between the values of the client, significant others (e.g., parents, teachers, spouses), and the therapist. When this happens, treatment efforts are held in abeyance until consensus is achieved. The general goals accepted by most behavior therapists place primary emphasis on the achievement of positive behavioral changes, that is, the acquisition of skills that are positively valued by both society and the client. In many instances, the emergence of these desired
behaviors is itself sufficient to diminish the strength of problematic responses. At times, however, behavior therapists may go on to use extinction procedures, or in extreme cases, aversive procedures, in efforts to overcome recalcitrant problems. This has been well illustrated in the work of Lovaas and Simmons (1969), for example, who showed that a small number of electric shocks to the extremities, as part of a sound, comprehensive treatment program, can terminate the savage self-mutilation of some autistic children. But whether positive behaviors are strengthened or problematic behaviors are weakened, the treatment methods should always be as explicit and negotiable as the goals, and the outcome should always be objectively monitorable. It is this explication of goals, methods, and outcomes that places behavior therapists in a unique position of accountability.

Critiques of Behavior Therapy

There are numerous dimensions to the current stage of siege of behavior therapy. The first—and weakest—results from a confusion in terms. Behavior therapists have at times referred to themselves as "behavior modifiers," and the terms behavior therapy and behavior modification are often used interchangeably. A problem arises, however, when behavior modification is used to refer only to the end product of an intervention, a change in the client's behavior. Every intervention approach—whether psychoanalysis or psychosurgery, pastoral counseling or nude encounter group therapy—has this objective. Therefore, as a result of a definitional error, behavior therapists have been taken to task for some practices that they themselves abhor. Therefore, use of the generic term behavior therapy or specific terms such as systematic desensitization can help to overcome this confusion.

A second dimension of the current problem has been exacerbated by occasional intertemporal statements by behavior therapists. Behavior therapy has achieved notable success in relieving psychological problems that had hitherto been essentially immune to intervention efforts, for example, the management of obesity (Stuart, in press-a). But the technology of behavior therapy remains, and doubtless always will remain, limited in its effectiveness (Davison, 1973). Unfortunately, some behavior therapists seem to have become giddy because of their achievements and have lost sight of their limitations. For example, one of our former colleagues has said: "We should reshape our society so that we would all be trained from birth to want to do what society wants us to do. We have the techniques now to do it" (McConnell, 1970, p. 74). Many behavior therapists would question whether we should be so shaped, and virtually all of us realize the futility of such an effort, given the incompleteness of our knowledge and the imprecision of our ability to apply that knowledge. But the damage done by statements such as this is inestimable, and their very occurrence may be seen as evidence of our inability to achieve the powers claimed by the self-appointed spokesmen.

A third dimension of the attack upon behavior therapy is an outgrowth of concern with the social regulation of individual behavior. Many of us object to the increasingly obvious intrusions upon individual thoughts, feelings, and actions by governments and industry through legislation, environmental management, the mass media, and the vast increase in the monitoring of individual actions through computerized data banks (see Miller, 1971). Reacting to the seemingly unchecked growth of these influences, many citizens have come to adopt positions that are highly critical of any and all behavior influence efforts.

But it is essential that advocates of individualism not lose sight of the determinism that is basic to a lawful society. This notion has been pointedly stated by Szasz (1970), in the following terms:

Among the many foolish things Rousseau said, one of the most foolish, and most famous is: "Man is born free, and yet everywhere he is in chains." This highflown phrase obscures the nature of freedom. For if freedom is the ability to make uncoerced choices, then man is born in chains. And the challenge of life is liberation. (p. 1)

Szasz has observed that in every social organization the interactions of individuals are self-limiting in the sense that the actions of one constrain the reactions of the other in predictable ways. The perpetuation of social organization depends on an orderliness in these mutual behavioral influence patterns.

This natural regulatory process often operates to the advantage of all concerned. But there is no assurance that the spontaneous pattern will always achieve the most beneficial possible option. When organizational influences do go astray, efforts to correct them are often the object of greater concern than the original abuse. Albert Bandura, past-president of the American Psychological Association and a leading figure in behavior therapy,
has characterized the attacks on behavior therapy as follows:

It is interesting to note that... the conditions that are undesirably imposed upon others are generally regarded with favor, whereas identical conditions created after thoughtful consideration of their effects on others are often considered culpable. There exists no enterprise [other than psychotherapy] which values incognizance so highly, often at the expense of the client's welfare. (Bandura, 1969, p. 81)

Behavior therapists have often called for change when societal practice deviates from ethical values and goals. For example, (a) in schools, they have directed their efforts toward the introduction of more humanistic procedures in order to make learning both more pleasant and more fruitful (Ulrich, Stachnik, & Mabry, 1974); (b) in public assistance programs, they have sought to reverse contingencies that result in sustained social dependence and the disruption of family life (Miller & Miller, 1970); and (c) they have sought to replace institutionalization with community treatments when possible (e.g., Phillips, Phillips, Fixsen, & Wolf, 1971) or to humanize institutional practices while awaiting the development of alternative services (e.g., Ayllon & Azrin, 1968). Hopefully, this sense of social consciousness and responsibility will continue inasmuch as it represents the best present hope for institutional progress.¹

Another attack on behavior therapy relates to its underlying model of human behavior. Some of the principles of learning on which contemporary behavior therapy rests have been derived from laboratory research with infrahuman organisms. Other principles have been derived from experimentation in social psychology laboratories. Based upon both avenues of research, hypotheses about the biological and environmental determinants of human behavior have been formulated for testing in applied research settings. Theories useful in the prediction of human behavior have been developed, and it is upon the regularities suggested by these theories that current behavior therapeutic practices are founded.

The model of human behavior that has emerged stresses the dynamic interplay of biological factors and experiences in the past and present environments. The units of measure in this study of human behavior are observable events, of which some are monitorable psychophysiological reactions and overt actions and others are verbal reports about the individual's feelings, goals, interests, and desires. Further, it is recognized that although the individual is the focal point of persistent patterns of social influence, he can also respond with "countercontrol" so that emergent behavior is a consequence of the interplay between the behaviors of the individual and those with whom he or she interacts (Bandura, 1969; Davison, 1973).

Behavior therapy utilizes a mechanistic language, conceptualizing behavior in terms such as stimulus, response, reinforcement, and shaping. These metaphors convey a detached, objective, even cold-hearted orientation to human beings, suggesting to some that behavior therapy prevents or at least discourages practitioners from relating to other people as human beings. Inasmuch as behavior therapists are themselves only human beings, it would be rash to assert categorically that there are not some people using behavior therapy procedures who do not care about the feelings and integrity of the people with whom they are dealing. However, the basic point is that words like stimulus and response are best viewed as scientific metaphors useful in understanding behavior so as to increase our ability to help people. The principles arising from a functional analysis of behavior have been used to identify environmental events that control human behavior, focusing attention on efforts to change these events so that actions can be more personally satisfying and socially constructive.

Because many behavior therapy principles are derived from laboratory research with animals, some observers mistakenly infer that behavior therapists regard people as nothing but animals. This unfortunately misses the point of experimental work in a science. Laboratory experiments by definition attempt to isolate a phenomenon and study it under conditions that are more controlled than is the case in everyday life. To use a pigeon in an experiment rather than a human being and then to extrapolate the findings from the pigeon to human beings is to engage in analogue work. Based

¹ The authors recognize that some social institutions such as prisons and mental hospitals are symptomatic of the breakdown of social processes. Some attorneys, such as those in the National Prison Project of the American Civil Liberties Union, argue cogently that such institutions should and must be closed at the earliest possible moment. However, it seems to us that we do not yet have the technological competence to make this possible and that every effort must therefore be made to create the most humane and socially constructive institutional environments possible while alternative approaches are being developed. It should also be borne in mind that existing institutions already are strong shapers of behavior. The question is not whether to influence the behavior of involuntary residents but how and to what ends.
on these experiments, inferences are drawn about human behavior. When these inferences are validated in clinical experiments with humans, they contribute to our increased clinical competence. When cross-species validation does not occur, the results of the animal research are ignored. Animal studies therefore have heuristic rather than literal implications for behavior therapists.

**Behavior Therapy and Human Rights**

As a group, behavior therapists subscribe to the codes of ethics of the professions from which they are drawn. But the existence of ethical guidelines does not negate the need for constant sensitivity to ethical issues any more than it guarantees that all decisions by behavior therapists will always be in keeping with ethically responsible practice.

Perhaps because of their novelty, their potency, or their accountability, behavior therapy practices have been the subject of more vocal ethical questioning than has been true of other intervention techniques that have had similar aims. Although most prominently directed toward institutional practice, many of these concerns apply equally to the practice of behavior therapy in open settings. Because of their great importance, we would like to discuss four of these issues.

**ABSOLUTE VERSUS CONTINGENT RIGHTS**

When an individual is convicted of violating the law or when a judgment is rendered that he or she is mentally unfit for life in the open community, a process of involuntary institutionalization is often the consequence. We are among the many who seriously question the utility and justice of involuntary mental hospitalization (Davison & Neale, 1974; Ennis & Siegel, 1973; Stuart, 1969; Szasz, 1963). But society is painfully slow to recognize that institutions expected to reduce deviance often maintain or even intensify misconduct and self-defeating behavior by prisoners or patients. This delay, combined with a covert but ever present willingness to employ punitive strategies, a reluctance to draw on more expensive alternatives to institutional care (such as the establishment of greater socioeconomic equity), and the current unavailability of clearly validated alternative intervention methods, conspires to sustain the continued use of institutions. Therefore, scores of thousands of people will be denied their freedom through institutional confinement for many years. Thus, it is now essential to develop rehabilitative methods that are consistent with the protection of the rights of prisoners and patients. (We assume that the purpose of imprisonment is not merely to punish and deter. If rehabilitation, however defined, is truly an important goal, then one necessarily is concerned with the most humane, effective, and efficient ways to change behavior.)

Recent court decisions have recognized that residents in correctional and psychiatric institutions possess a set of constitutionally protected rights. With regard to prisons, Rothman (1973) observed that: "court rulings reflected . . . an awareness that inmates were not fundamentally different from citizens" (p. 15). *Rouse v. Cameron* (373 F.2d 451, D.C. Cir. 1966) initially affirmed mental patients’ rights to treatment, and *Wyatt v. Stickney* extended this doctrine to the establishment of guidelines for therapeutic services. For example, the latter decision required that individual treatment plans be prepared for all patients, that the use of aversive procedures be reviewed by a Human Rights Committee, and that basic privileges be offered without the requirement that they be earned through participation in an institution-maintaining work force. The force of these rulings promises to guarantee to institutional populations those minimal rights that permit life with at least a modicum of dignity.

In their attempt to expedite the rehabilitative function of institutions, some behavior therapists have sought to offer inmates and patients access to the amenities of life as consequences for constructive behavioral changes. This has meant the denial of these resources at earlier stages of the program with a gradual restoration of privileges as a consequence of progress. If these programs require participation in the institutional work force as a means of securing such amenities of life as the institution provides, they may be construed as involuntary servitude and would be in violation of the principle set forth in *Jobson v. Henne* (335 F. 2d 129, 2d Cir. 1966) and supported in *Wyatt v. Stickney*. Moreover, when the entry level of privileges in these programs falls below the level at

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2. 344 F. Supp. 387 (M.D. Ala. 1972), aff’d *sub nom* *Wyatt v. Anderholt*, 493 F. 2d . (5th Cir. Nov. 8, 1974).

3. The major right to treatment case, *Donaldson v. O’Connor* (493 F. 2d 507, 5th Cir. 1974), is currently before the Supreme Court. Whether the Court upholds or reverses this trend remains to be seen.
which human dignity can be maintained (admittedly a subjective judgment in some instances), these programs will require immediate reformulation.

As a general rule, it can be stated that every therapeutic intervention should begin with the least intrusive procedure from which a positive outcome can reasonably be expected. This principle of "least severity" would apply to both community- and institution-based services (Morris, 1966). In both settings it would require the exposure of clients to the least possible risk and discomfort relative to the greatest possible expected benefit. In institutions it would require that inmates or patients enter intervention programs with a level of comfort no more severe than the institutional practice which it is intended to replace. This would require a careful judgment to which client groups, institutional administrators, laymen in the community, and professionals would all have to contribute. And as Wexler (1973; Note 1) has noted, behavior therapists would be called on to use increasing ingenuity in their efforts to find meaningful incentives for behavior change within the context of the evolving guidelines for ethically and legally acceptable practice.

CHOICE OF GOALS

Working in institutional settings, behavior therapists have often been called upon to develop incentive systems that would increase the productivity of inmates and patients in prison industries and hospital maintenance programs. This has presumably been done to provide rehabilitative experiences and to offer some distraction from the monotony of institutional life. Following the Wyatt v. Stickney decision, and consistent with many advocates of bills of rights for prisoners and patients, two changes would appear to be necessary: first, the servitude implicit in these programs would have to be replaced by compensation at or above the federal minimum wage; and second, participation would have to be voluntary. If adopted, the tasks could remain the same but the compensation and consent process would be changed.

Wexler (1973) has argued, however, that the enactment of this requirement might work to the profound disadvantage of many mental patients (and, possibly, of inmates as well). They could suffer if institutional directors, interested in maximum efficiency, were to call upon outside employees to perform essential institution maintenance services, thus denying patients access to opportunities to acquire some skills that could enhance their employability upon discharge. Although Fairweather, Sanders, Maynard, Cressler, and Bleck (1969) have shown that patients with higher level abilities can successfully participate in more demanding work efforts, a large number of chronic patients do not function beyond a very minimal level. Therefore, implementation of the Wyatt v. Stickney provision could have the stultifying impact of dooming patients to continued idleness and the odious consequences of the stimulus deprivation that this implies.

The role of work programs in institutional settings can be considered from another viewpoint. Stuart (1971) has argued that two clusters of goals exist in correctional and psychiatric settings: (1) "minimal goals—those which seek to remove the problematic response which led to identification of the individual as deviant in the first place . . . [and (2)] optimal goals—those which seek to enhance the social functioning of the individual identified as a deviant" (p. 110). More recently, Robinson (1974) has suggested that offenses can be roughly dichotomized as to whether they cause harm to others. When there is such harm, he believes that the individual "can lay no moral claim to the right not to be changed" (p. 236). Combining these two views, changes in the aggressive behavior of those who have harmed others would seem to be a minimal goal, while changes in other behaviors of these individuals or behavior change for those who have not harmed others would seem to be optimal goals.

Given these dichotomies, some would argue that patients or prisoners can be required to undergo rehabilitative treatment aimed at the attainment of minimal goals. The logical conclusion of Robinson’s argument, for example, is that the commission of an offense against society denies the offender of his or her rights to remain aloof from treatment. Others, however, would argue that institutionalized persons have a right to accept or reject treatment, recognizing that the rejection of treatment would often lead to the completion of a mandatory period of incarceration. This is likely, to remain a hotly debated issue in the next several years as institutional services are subjected to ever more careful scrutiny. And clearly, every therapeutic decision would require careful attention to evolving moral and legal principles.
THE RIGHT TO THE BEST POSSIBLE VALIDATED TREATMENT

A series of recent court decisions promises to establish the "patient's right to treatment." The logic of these decisions is unquestionable: If society denies citizens their freedom, it is the responsibility of society to offer such intervention as can be reasonably expected to prepare them for the resumption of lawful, socially acceptable behavior in the community upon their release. The fact that institutional programs have been catastrophic failures (Stuart, 1970) is strong evidence that this service requirement has not been met.

In order to determine treatment effects, it is necessary to define precisely all relevant dimensions of service programs as well as their short- and long-range effects. This requires a continual process of descriptive and evaluative research extending beyond the end of confinement. But descriptive research, of obvious importance (albeit infrequent occurrence), is insufficient because positive results offer no assurance that a particular program is the most effective, least drastic alternative, nor do negative results suggest alternative strategies. Therefore, responsible program administrators may have an ethical responsibility to seek and compare the effectiveness of alternative programs.

Although the right to treatment may no longer be an issue, the concept of evaluative program research is very much under attack at this time. The guidelines for research that have been proposed by the National Institutes of Health (1974) would slow research efforts because of their very broad categorization of the risks associated with participation in research. The result of enactment of these guidelines in their present form would be unfortunate indeed because countless thousands of youths and adults might be detained in institutional settings in which they are exposed to profoundly deviance-producing conditions. Research that could yield new knowledge would be virtually stymied.

Therefore, it is our judgment that rather than regarding institutional evaluative research as a potential violation of resident rights, these descriptive and comparative research efforts should be mandatory aspects of responsible institutional management. Thus, contrary to the present thrust of public opinion, we regard the monitoring of existing programs and the search for more beneficial alternatives as activities necessary to ensure the basic rights of patients and inmates.

CONSENT TO TREATMENT AND RESEARCH

Much scientific experimentation involving human subjects involves a trade-off of basic values: expected gains for the community are traded off against potential injury to individuals. Progress in the alleviation or prevention of human suffering is the community good. Exposure to experimental injury and the denial of necessary services or compromise of the subjects' rights and/or dignity are the individual risks. On the other hand, the larger community faces the risk of the erosion of morality, "possibly caused by too ruthless a pursuit of scientific progress, [which] would make its most dazzling triumphs not worth having" (Jonas, 1970, p. 28). And gains can accrue to the individual in terms of satisfaction derived from the opportunity to participate in social and scientific progress and/or direct gains from the experiments themselves. Therefore, both the community and the individual face the prospect of benefit and detriment resulting from scientific research. The outcome of the process depends on the rigor with which experiments are conceived and the ethical responsibility with which they are carried out.

Although behavior therapists and researchers may not always have used the best judgment with respect to ethical decision making, their record of responsibility is at least the equal of professionals working within other theoretical perspectives. One of the cornerstones of the rights of therapy clients and research subjects is the right to offer or to withhold informed consent to treatment or research participation. This protection has been expressed by the Nuremberg Code, by the Declaration of Helsinki, and by other more recent statements by professional associations throughout the world. Behavior therapists have been in the forefront of those offering protection to clients, having pioneered the use of behavioral treatment contracts (e.g., Stuart, in press-b). In contrast, some difficulty has been experienced in applying the doctrine of consent to research participation because the blanket protection does not contain within it sufficient precision to permit individual decision making. An absolute dichotomy between consent or nonconsent to research participation has made difficult the kinds of discriminations that would allow this vital protection to be guaranteed. To help in providing guidelines for implementation of the consent doctrine, we would like to suggest the following framework. It consists of a hierarchy of constraints upon the giving of consent and a set
of institutional dimensions that would point to the use of each level in the hierarchy.

The first element in this approach is *a hierarchy of protections of the consent-giving process*. Identification of the steps at each level of the hierarchy should be discussed by all concerned. One possible delineation of key points on this hierarchy, ranging from minimal to maximal protection, could take the following form:

1. *No consent by the subject is necessary.* It is sufficient to assume that the investigator, abiding by ethical research guidelines, will assure protection of the subject’s rights. For example, the nonobtrusive observation of traffic flow in public places or other public behavior might fall into this category. Use of this procedure and the next are permissible only when a review panel has determined that the potential risk of harm to the anonymously observed subjects is nil.

2. *Subject is simply asked to sign a consent form for participation in research as a subject of observation—without no explanation of the nature of the study.* One example might be an observational study of the supermarket shopping behavior of individuals in which an explanation of the objectives of the study might change the relevant behavior.

3. *Subject is asked to sign a consent form for participation in research with “debriefing” following participation.* Such a study might involve an examination of interpersonal behavior in public places in which prior disclosure of the hypotheses could change the behavior under study. For such a procedure to be used, however, a panel of experts would have to determine that there is little potential risk to the subject (including humiliation following debriefing) as a result of participation in the research.

4. *Subject is asked to sign a consent form for participation in a project, following a full disclosure of the objectives and methods of the research.* This procedure would be applicable in efforts to evaluate services by randomly assigning some subjects to experimental, placebo control, and no-treatment control conditions. In these situations a review panel must judge that the procedures are of potential benefit to the experimental subjects, with the risk of harm to control subjects being equal to or less than the dangers that would have existed if there were no experimental.

5. *Subject is asked to sign a consent form for participation in a project, following a full disclosure of the objectives and methods of the research and in the presence of at least one witness who is not involved in the research.* This procedure would be appropriate any time the presumptive danger of coercion to participate is deemed to exist by a review panel. For example, experimental services to adjudicated offenders could fall into this category.

6. *Subject is asked to sign a consent form for participation in a project, following full disclosure of the objectives and methods of the research, in the presence of witnesses, with his or her consent reviewed by an independent human subjects’ committee to protect the rights of subjects within the institution.* This procedure might be used in the experimental evaluation of programs intended to contribute to the subject’s development of skills relating to the attainment of institutional objectives, for example, vocational training in prisons or mental hospitals.

7. *Subject is asked to sign a consent form for participation in a project, following full disclosure of the objectives and methods of the research, in the presence of witnesses, with the consent reviewed by an independent human subjects’ rights committee within the institution, this ruling to be reviewed by a similar committee outside the institution.* The procedure could be relevant when the research concerns behavior changes that are not strictly related to institutional objectives. This might be illustrated by efforts to train mental patients in a concept acquisition task.

8. *No consent is possible because conditions are kicking that can adequately protect the rights of subjects.* Such a hierarchy is not exhaustive. There may be several midpoints that have been omitted, just as more permissive or more demanding protections could be designed for use at either extreme. But the hierarchy may serve to stimulate thought about a range of suitable possibilities, depending on the character of the research that is being contemplated. Such a continuum could replace the absolute dichotomy that is commonly discussed.

An analysis of the institutional factors bearing on the research would determine which level of the hierarchy is appropriate. We have identified four such factors, each of which is also a continuum. Like the hierarchy of protections just proposed, each of the following dimensions is proposed as a topic for discussion (see Table 1).

The first of these dimensions is the **level of potential benefit to the subject/client.** This can
range from a high level of direct benefit to the individual to primary benefit accruing to the larger society with low direct benefit to the individual. The second dimension is the level of risk. This continuum ranges from the very low risk of harm associated with the nonobtrusive collection of anonymous data about a subject/client to the application of procedures that might eventuate in serious harm to the individual. The third dimension is the validational status or novelty of the procedure to be used. At one point on the continuum are found procedures that have been fully established and are considered to be the "treatment of choice," while at the other extreme are interventions that are purely experimental. (In institutional research, this dimension can reflect a range of programs from those that are routinely present, ethically acceptable, and empirically validated to those that are considered radical departures.) Finally, it is necessary to assess the extent to which subjects can freely offer their informed consent to participation. In open community settings, free consent is more likely than in total institutional settings. Therefore, greater care must be taken in the protection of the right to refuse participation in the latter settings: When the guarantees have been met, an emergent contract between the parties assures the protection of the interests of both (Schwitzgebel & Kolb, 1974).

Table 1 offers one possible arrangement of these variables. The values assigned to each cell are arbitrary and should be replaced by the judgment of a great many researcher/clinicians of varying orientations and from far-ranging scientific disciplines as well as from lawyers, community leaders, laymen, and representatives of the subject/client populations. When consensus has been reached on the appropriateness of these or similar guidelines, and when they are utilized in all basic and applied research, they may help protect the rights of individuals on the one hand and yet permit the essential continuation of the discovery process on the other hand.

**Totalitarianism or Pluralism**

Much of the foregoing discussion applies equally to the entire field of biological and behavioral science. One concern which has been expressed primarily about behavior therapy deserves particular mention, namely that behavior therapy seeks to achieve a cultural and societal "leveling" that would produce conformity and limit creativity (Kittrie, 1971). We believe that this fear is exaggerated. Rather than reducing the diversity of our cultures, behavior therapists have been willing to assess the impact of alternative methods of social influence and forms of social organization, thereby fostering diversity rather than uniformity.

Behavior therapists recognize that patterns of social influence reach into almost every quarter of our lives. They also realize that unless the process of this influence and its goals are made known, we will continually be subjected to covert manipulations that are planned by groups with vested interests. Drawing upon a scientific approach to the study of human behavior, behavior therapists hope to make valuable contributions to pluralism by generating a body of data describing the operation of influence processes and their consequences. Thus, if people are to make their own decisions about how to conduct their lives, is it not reasonable to provide as much knowledge as possible about how behavior is developed, maintained, and changed (London, 1964, 1969)? Based on these data, individuals and society will be able to choose alternative focuses, license the use of some techniques of persuasion, and proscribe the use of others, and to do all of this in the arena of full public discourse through a fully democratized decision-making process. Conversely, to allow these forces to remain beyond public scrutiny and to neglect the responsibility of providing direction is to allow the co-opting of these forces for potentially antisocial ends.

**REFERENCE NOTE**


**REFERENCES**


Stuart, R. B. Treatment contract. Champaign, Ill.: Research Press, in press. (b)


