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Coordinating Behavior Analysis and Psychiatric Services

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The Fundamental Task:

❖ **Building rapport with the
Psychiatrist
(or other prescribing physician)
to improve the long term
Clinical Team Process**

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The Ultimate Outcome

 **To Assist The
Physician in Providing
Medication Management
Services**

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What We Will Discuss

- **Section 1:** History, Current Status & Research Findings
- **Section 2:** Social and Cross-Discipline Influences on Treatment Choices (ABA vis a vis Psychopharmacology)
- **Section 3:** What Behavior Analysts Bring to the Table: Evaluate & Integrate Services for the Best Clinical Outcomes

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Section 1 Where Are We & How Did We Get Here?

Psychotropic Medication,
Developmental Disabilities, & Mental
Health


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Use of Psychotropic Medication For Behavior Management: Scope


How widespread is the use of
psychotropic medication?

These studies have compiled surveys from multiple sources:
*Matson & Neal, 2009; Tyrer et al, 2008; Singh, et al, 2005; Pyles, et al, 1997; Aman & Singh, 1983, 1986, 1988; Gadow & Poling, 1988; Hill, Balow, & Bruininks, 1985; Marti & Agran, 1985).

The 4 most recent compilations of studies show the following:


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- **Institutional Settings:**
30 to 50% of individuals with a DD diagnosis receive medication prescribed to control behavior
- **Community Residential Settings**
19 to 40% receive medication prescribed to control behavior
- In one review, the range in individual facilities ran from 4% to 98%, with about 75% of all individuals who receive medication receiving neuroleptics (Kahn, 1994)
- Aman et.al (2005) reports a "50% increase in psychotropic medication" use with children in the "last 8-10 years".

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Poling (1994) grimly cites Grenier's 1958 prediction:

"In the years to come, the retarded may claim an all time record, of having the greatest variety and largest tonnage of chemical agents shoved into them"

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- "Pharmacological interventions have become the most widely used intervention techniques with persons evincing mental retardation despite the fact that many drugs are ineffective, suppress behavior generally, and cause a number of lasting, deleterious side effects."

Baumeister & Sevin (1990)

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WHY?

Matson offers one answer

Johnny Matson (2008), a leader in this field, refers to an article by Spreat & Conroy (1998) in *Psychiatric Services*:

"They note that over 90% of antipsychotic drug prescriptions for persons with intellectual disabilities in nursing homes are for **'behavior control'**."

(p. 573)

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Matson's 2000 Survey

- Matson (2000) provided an extensive survey of literature regarding use of psychotropic medication with people with developmental disabilities.

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Matson: Findings

Aggression is the primary reason for institutional placement, and is the #1 reason cited when medication is used for "behavioral control".

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Matson (continued)

- Yet Matson's comprehensive literature review yielded the following startling result:
 - **“There is no information in the literature suggesting that anti-psychotic agents are an effective means of treating aggression.”** (Matson 2000)

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On the other hand...

- Peter Sturmey (2002) states in his article “Mental Retardation and Concurrent Psychiatric Disorders: Assessment and Treatment”, in *Current Opinion in Psychiatry...*

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Sturmey (2002)

“Interventions based on ***applied behavior analysis*** have the ***strongest empirical basis***, although there is some evidence that some other therapies have promise”.
(my ***bold italics***)

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Early History of ABA in a Psychiatric Context

ABA Began in the mental health arena!

- **Ayllon and Michael** (1959) in the JEAB article, “*The psychiatric nurse as behavioral engineer*”, used various operant procedures including planned ignoring, Sr+, Satiation, and Sr- with patients in psychiatric wards who were diagnosed with chronic schizophrenia.
- They successfully reduced various problem behaviors including:
 - Entering the nursing station, verbalizing delusional statements, refusing to eat, hoarding
- Ayllon and Houghton (1964) successfully reduced delusional speech, repetitive requests, somatic complaints

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Stahl and Leiterberg (1976)


Wong (2006) refers to a review (by Stahl and Leiterberg (1976)) of 23 articles published between 1959 and 1972.

- They found that “individualized programs for psychotic and chronic mental patients” successfully addressed “incontinence, refusing to eat, eating excessively, repetitive requests for PRN medication, hoarding objects, ‘sick talk’, physical intrusiveness, aggression, uncooperative behavior, and mutism.”
- The procedures used included: “tangible and social reinforcement, shaping, modeling, planned ignoring, stimulus satiation, delay or withdrawal of reinforcement, and systematic desensitization.” (Wong, 2006, page 154)

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Token Economies


- Many **within-subject** experiments have demonstrated the effectiveness of token economies in increasing adaptive functioning in mental hospitals (e.g., Ayllon & Azrin, 1965; Nelson & Cone, 1979)
- Paul and Lentz (1977) conducted an “intensive six-year controlled between-groups study” which also demonstrated the effectiveness of tokens in psychiatric institutional settings

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ASR #1

Recent surveys have determined that psychotropic medication is prescribed for approximately what percentage of individuals with intellectual disabilities in community settings?


- A.About 10 – 15%
- B.About 20 – 40 %
- C.About 40 – 65%

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ASR #1

Recent surveys have determined that psychotropic medication is prescribed for approximately what percentage of individuals with intellectual disabilities in community settings?


- A.About 10 – 15%
- B.About 20 – 40 %** (institutions are listed at 30 – 50%)
- C.About 40 – 65%

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ASR #2

Matson's 2000 survey found that psychotropic medication was primarily used to address...


- A.Agitated Depression
- B.Aggressive Behavior
- C.Delusional Thoughts
- D.Self Injurious Behavior

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ASR #2

Johnny Matson's 2000 survey found that psychotropic medication was primarily used to address...


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- B.Aggressive Behavior**
- C.Delusional Thoughts
- D.Self Injurious Behavior

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ASR #3

Peter Sturmey, in "Current Opinion in Psychiatry", states that the treatment with the strongest empirical basis to reduce behavior problems in this population is found in:

- A.Haldol
- B.Anti-depressants
- C.ABA
- D.All therapies seem to work equally well

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- C.ABA**
- D.All therapies seem to work equally well

ASR #4

A foundational study demonstrating the effectiveness of ABA in a psychiatric institutional setting was written by

- A. Skinner, 1953
- B. Ayllon and Michael, 1959
- C. Sturmey, 1990
- D. Matson, 2000

ASR #4

A foundational study demonstrating the effectiveness of ABA in a psychiatric institutional setting was written by

- A. Skinner, 1953
- B. Ayllon and Michael, 1959**
- C. Sturmey, 1990
- D. Matson, 2000

A Limited Review of Recent Literature!

The major caveat: The number of studies in this area has rapidly increased in the last 10 years, so:

- This review must be considered as somewhat limited in scope.
- Conclusions drawn must be considered somewhat preliminary.
- However, all of these studies cite many other recent studies, and some are replication studies. I have attempted to select a representative sample.

Recent Research Findings: Setting Review Parameters

Sprague and Werry (1971):

- This article is cited in nearly all studies reviewed
- It set the standards for research methods in psychopharmacology and the DD population in research settings (placebo, double blind, etc.)
- But it also discusses some standards for **Non-Research settings**, important for later discussion. These standards are briefly reviewed as follows:

Sprague & Werry (1971) on non-research settings

1. Use medications that have had adequate clinical trial research with the appropriate populations and target behaviors
2. At the start of the trial, those working with the individual should be made aware of possible placebo and "honeymoon" effects
3. Get information from observers who do not know about the trial (blind observers)
4. During the trial, keep all other interventions unchanged-- to control for confounds

What do the findings say?

The Positive Results:

- Many studies report a positive treatment effect in research on Risperidone use with Autism Spectrum Disorder (ASD)

(e.g., Zarcone et al, 2004; Zarcone, Napolitano, & Valdovinos, 2008; Aman, et al 2002, 2005, & 2009)

Recent Findings:

The Not So Positive Results:

Validating Matson's review in 2000, many new studies continue to show that psychotropic medications of many types have very limited if any long term and specific reductive effect on challenging behaviors.

(e.g., Singh et al, 2010, Sturmey et al, 2010, Matson & Dempsey, 2008; Singh et al, 2005)

More Findings

- Matson & Dempsey (2008) also found the following:

NOT A SINGLE STUDY EXISTS in which a functional assessment was completed, a program was implemented, the program failed, and then, ANY MEDICATION was used to successfully reduce a target behavior (p.184)

Zarcone (2008)

- Even in her article discussing measurement of problem behaviors during medication evaluations, which cites her own and others positive findings in Risperdal studies, Dr.Zarcone states:
- **"It is possible they (psych meds) are over used in a population of individuals who may be even more susceptible to side effects"**.
- Moreover, **"Very few studies have shown social validity data such that blind reviewers have rated the participants behavior change as significant."**

From Zarcone to Tyrer (2008)

- Zarcone (2008) also goes on to state: "It appears that participation in medication studies are a positive experience for families although there is no information on whether it is a positive experience for participants."
- Tyrer's 2008 study published in Lancet tells a slightly different story.

HALDOL, RESPEDAL, AGGRESSION and the MAGICAL PLACEBO EFFECT

Tyrer et al (2008) published in LANCET

- A large scale international study
- Very well designed
- Group Comparisons: Haldol, Risperdal, Placebo

Tyrer, et al (2008): Findings

1. All three groups (Haldol, Risperdal, & Placebo) showed reductions in the target behavior, aggression
2. ***The Placebo group had the largest decline*** in aggression.
3. **"The absence of any significant differences between drugs on any of the other secondary outcomes...antipsychotic drugs are of no selective benefit"**(p.62)
4. **"No evidence of a delayed beneficial effect** of the active drugs over an increased period of time."(p.62)

Tyrer, continued

Their conclusion:

“Our study...shows that either the placebo effect, the psychological effect of a formal external intervention, or spontaneous resolution, or all three, are substantial and would be difficult to surpass by even the most effective of drugs.” (p.62)

Placebo “Washout”

- In many medication studies, individuals are given placebo for a period of time prior to the actual beginning of the trial period.
- Anyone showing a positive effect is *removed from the subject pool* even before the study is begun. (Wyatt, 2006, p.145)
- Is this Selection Bias?

Identification of Problem Behaviors

- Problem behaviors, the appropriate dependent variables, are often referred to as “CB” in the literature: “Challenging Behaviors”
- Behavior Analysts are well aware of setting operational definitions of such targets as “aggression”, “self-injury”, “agitation”, and “social withdrawal”. BUT...

Where are the target behaviors?

Matson and Dempsey (2008)

Lets let them speak for themselves....

“The hallmark assessment for challenging behaviors are operationalized target behaviors with strong inter-rater reliability.”

They go on: “However in practice, very few research studies on pharmacological treatments of ASD follow this model. Often scales that are more general measures of psychopathology or behavioral disturbance are used in lieu of measures specific to challenging behaviors.”

We will discuss scales as measures shortly, but....

Matson and Dempsey (2009)

On the point of target behaviors, they conclude: “Operational target behaviors in drug treatment research on persons with challenging behaviors and ASD are generally non-existent (*my italics*). We are of the opinion that proper selection and use of dependent variables in the drug research we reviewed is one of, if not the greatest obstacle to accurately addressing pharmacology as a treatment” (P. 185)

What about measurement?

Most studies use Standardized Ratings Scales:

CGI: Clinical Global Impressions Severity Scale (Guy 1976)

ABC: Aberrant Behavior Checklist (Aman et al, 1985)

CBC: Child Behavior Checklist (Asenbach & Rescorla 2001)

NCBRF: Nisonger Child Behavior Rating Form

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Why is this important?

In their update of the Matson 2000 review, Matson & Neal (2009) found the following:

Of the 12 studies which made the methodological cut (re: Sprague & Werry)

- 8 found significant decreases in problem behaviors over placebo
- 4 showed no difference.

BUT...

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Why this *is* importa

“Notably, the four studies that did not find a significant effect were the only ones to employ objective observations in addition to rating scales.” (p. 581)

In other words....

When objective, operationalized behavior measurements are used, apparent improvement in global scales may disappear!

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More on Ratings Scales

Singh, et al (2005) in a review of various Risperidone studies states:

“While findings from global impressions tended to be universally favorable, findings from dimensional ratings were less so. Further, studies that employed ratings scales that could delineate the differential aspects of Risperidone treatments were even less favorable than dimensional ratings. Based on this review, it seems that **more specific measures showed much lower positive drug effects**” (p. 216)

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Which means....

In those studies where behavioral improvement was reported, which was based on improvements measured by the most commonly used ratings scales... **reductions in more carefully measured dimensional quantities**

DID NOT BEAR THIS OUT!

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Medication Side Effects

- These are often underreported because of:
 - “a lack of clear definitions of possible side effects & ambiguity about what side effects should be reported & why.”

Zarcone (2008)

This is a large area for additional review.....

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ASR #5

The article which sets the methodological standard for psycho-pharmacological studies with persons diagnosed with a developmental disability was authored by:

- A. Ayllon and Michael
- B. Matson and Dempsey
- C. Pratt and Whitney
- D. Sprague and Werry

ASR #5

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- B. Matson and Dempsey
- C. Pratt and Whitney
- D. Sprague and Werry**

ASR #6

Tyrer, et.al (2008), in Lancet, found that the most effective treatment for reducing aggression in a large group of subjects with ID (intellectual disabilities) was:

- A. ABA
- B. Haloperidol
- C. Placebo
- D. Risperidone

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- B. Haloperidol
- C. Placebo**
- D. Risperidone

ASR #7

All of the following are ratings scales used in medication research, except:

- A. ABC
- B. CGI
- C. NRBQ
- D. NCBRF

ASR #7

All of the following are ratings scales used in medication research, except:

- A. ABC
- B. CGI
- C. NRBQ**
- D. NCBRF

ASR #8

Ratings scales are typically as accurate and effective at evaluating the impact of medication as are operationally defined measurements of dimensional quantities.

- A. True
- B. False

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ASR #8

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A. True
B. False

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Section 2

Cross Therapeutic and Social Influences

ABA and Psychopharmacology
Opposite sides of a great debate?

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First, some positive signs

- In *Cognitive & Behavioral Practice*, Donat (2002) reported using ABA in a psychiatric hospital setting, effecting a significant reduction in the facility's **“reliance on seclusion, restraint and psychotropic PRN medication”**.

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Pyles et al (1997)

In an important article on building an interdisciplinary team approach between medical, psychiatric, and behavioral staff, Pyles quotes Reudrich (1992) in *Current Opinion in Psychiatry*, stating that by using graphic displays and single subject design, “the developmental field may take the lead in expanding this practice to more traditional psychopharmacology with the non-retarded people”. (p. 671)

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An Broad Social Analysis of ABA & Psycho-Pharmacology

- The journal *Behavior and Social Issues* dedicated its Fall/Winter 2006 issue to a review of the current status of behavior analysis vis a vis the biomedical / pharmacological model.
- The lead articles are written by Wong (2006) & Wyatt and Midkiff (2006)

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The Bad News

- They conclude that the “biological explanations have gone too far—well beyond the data” (Wyatt and Midkiff). Worse, in the last few years, behavior analysis has been effectively “obscured by the biomedical model” (Wong).

WHY is this happening?

- **Wong, & Wyatt and Midkiff** analyze the social, political, corporate, and media environment for clues to the cause.
- To paraphrase Warren Zevon, its:

**Lawyers, drugs and
money**

(and politics, and media)

Wong (2006) on Wong (1986-1993)

The story of funding at a state psychiatric facility:

ABA versus Neuropsychology

- Who got funding who did not
- Who published who did not (e.g., Wong, Martinez-Diaz, Massel, Edelstein, Wiegand, Bowen, & Liberman, 1993)

But what about more immediate contingencies?

1. Two parallel approaches with strong advocates: ABA & Psychopharmacology
2. Insufficient trained staff makes ABA intervention difficult in many settings
3. Intervention during serious behavioral episodes can lead to injuries to all parties and/or potential allegations of abuse

--Matson & Wilkins (2008), p.9

Immediate contingencies (continued)


4. "Additionally, for antipsychotic medication, a psychiatrist, neurologist, or other medical professional takes primary responsibility for care, whereas a behavior intervention requires coordination in planning and implementation by various staff who may not want that responsibility" --Matson & Wilkins (2008) p.9

"The 7-Year Pinch".

The Most Likely Driving Force

"At times of severe behavioral crises, there may be excessive pressure on the prescribing physician to do something. (quote continues)


To do nothing may give the appearance of neglect, even when it is the most prudent course". (Sturmey, 1998)

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ASR #9

Reudrich (1992) (in *Curent Opinion in Psychiatry*) posited that the use of which of the following would potentially transform the evaluation of medication in the general population?


A. Single Subject Methodology
B. Behavior Charts
C. The CGI rating scale
D. Both A and B

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ASR #9

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A. Single Subject Methodology
B. Behavior Charts
C. The CGI rating scale
D. Both A and B

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ASR #10

The authors most responsible for providing a social and historical context for the radical increase in the use of behavioral medication in the last 20 years are:


A. Matson and Neal
B. Sturmey et al
C. Tyrer et al
D. Wong, Wyatt and Midkiff

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ASR #11

Wong's co-author on his paper, "Conversational skills training with schizophrenic inpatients: A study of generalization across settings and conversants" in *Behavior Therapy*, 24 (1993) was:

A. Aman
B. Martinez-Diaz
C. Matson
D. Wyatt & Midkiff

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Wong (2006) on Wong (1986-1993)

The story of funding at a state psychiatric facility:

ABA versus Neuropsychology

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- C. Matson
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ASR # 12

According to Matson and Watkins, All of the following are reasons ABA has had difficulty in being implemented in many settings (in comparison to medication), **except**....

- A. Behavior intervention can result in injuries
- B. Behavior interventions require trained caregivers
- C. Many caregivers prefer to allow M.D.s to bear all the responsibility
- D. None; all of the above are reasons



ASR # 12

According to Matson and Wilkins, All of the following are reasons ABA has had difficulty in being implemented in many settings (in comparison to medication), **except**....

- A. Behavior intervention can result in injuries
- B. Behavior interventions require trained caregivers
- C. Many caregivers prefer to allow M.D.s to bear all the responsibility
- D. None; all of the above are reasons**



So, Are Medications BAD?

- **Aman and Singh (1991) warn those who might eliminate the use of medication to, "maintain an open mind about the use of such therapeutic procedures, lest they otherwise inadvertently adopt extreme positions that are counter to the interests of those they wish to serve". (P.350)**



Are Medications BAD?

- Even Wyatt and Midkiff (2006) who excoriate the recent dominance of the biological model as careless science driven by profit, state:

"Nor is it our purpose here to claim that psychotropic medications are never of any help"



Perhaps Tyrer (2008) says it best

"Our results should not be interpreted as an indication that antipsychotic drugs have no place in the treatment of some aspects of behaviour (sic) disturbance in people with intellectual disability. Evidence suggests that such drugs are effective for autistic behaviour in children...and in prevention of further aggressive behaviour in those given anti-psychotic drugs as an emergency measure..."

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Tyrer (continued)

“But we conclude that the routine prescription of antipsychotic drugs early in the management of aggressive challenging behavior, even in low doses, should no longer be regarded as a satisfactory form of care”

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What does it mean for a medication to “work”

Two general classes of behavior targeted for change

1. Reduction of problem behaviors
2. Increase in functional behaviors

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Now think: Have **you** ever seen data which demonstrate* effective use of psychotropic medication to:

- (1) decrease aggression, or self injury &
- (2) increase functional skills in a person with a developmental disability ?

(* an experimental design with adequate controls and internal validity)

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2 valid points of view

- Too many medications do get used (often for too long),
--but--
- Sometimes they do seem to help!

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ASR # 13

In general, ABA considers medication for use in treating problem behaviors inappropriate at best, and strives to eliminate them as quickly as possible.

A. True
B. False

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ASR # 13

In general, ABA considers medication for use in treating problem behaviors inappropriate at best, and strives to eliminate them as quickly as possible.

A. True
B. False

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ASR # 14

When a mediation treatment “works” this generally means that it...

- A.Reduces problem behaviors
- B.Increases functional behaviors
- C.May be needed for life
- D.A and B but not C

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ASR # 14

When a mediation treatment “works” this generally means that it...

- A.Reduces problem behaviors
- B.Increases functional behaviors
- C.May be needed for life
- D.A and B but not C**

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Section 3 What We Can Do To Help!

What Behavior Analysts
Bring to the Team,
Some Additional Skills To Build,
& How to Get Along

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Everybody wants to help. So what’s the problem?

- Behavior analysts and doctors not only know about different things, but see different things

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The Diagnostic Problem

- **Office Visits vs. Continuous Observation**
 - Doctors see the consumer for brief periods only; must often make rapid assessments and treatment decisions
- **Example:**
The Rash vs. Aggression
 - One can be evaluated quickly, not the other

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How Can We Help?

- **Our Typical Skills:**
 - Clearly define target behaviors
 - Collect data and graph it
 - Analyze (environmental) functions (vs endogenous causes)
 - Educate team members about ABA.

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What We Can Do

- Develop additional skills:
- Coordinate w/ prescribing physician
 - Identify & clearly define behaviors targeted by meds
- Provide physician w/ information
 - Single subject design: graphs
 - Change only 1 variable at a time

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ASR # 15

In general, behavior analysts and M.D.s, see the same problems exhibited by the individual in treatment, but believe the causes are different.

A.True
B.False

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ASR # 15

In general, behavior analysts and M.D.s, see the same problems exhibited by the individual in treatment, but believe the causes are different.

A.True
B.False

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ASR # 16

Behavior analysts bring the following skills to the treatment team that are generally different than the M.D., or Psychiatrist, except:

A.Analytical skills
B.Data Collection
C.Graphing Data
D.Operationally define target behaviors

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ASR # 16

Behavior analysts bring the following skills to the treatment team that are generally different than the M.D., or Psychiatrist, except:

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C.Graphing Aata
D.Operationally define target behaviors

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Specific Actions

- **Identify and track clearly defined target behaviors**
 - Ask the doctor what exact behaviors he or she needs for you to track, **and report back**
 - Suggest objective, clear, and **measurable** target behavior definitions

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What Do Psychiatrists Want?

→ Sleep Data. → Activity Level
→ Weight Data → Social Isolation

E.g., Tsiouris et al(2003) found that core conventional symptoms of depression were strongly associated with each other, but challenging behaviors were NOT associated with depression as had been previously thought (Sturmey et al 2010)

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Specific Actions

- **With deference to the M.D., request treatment coordination: ABA & Medical**
 - Try to change only 1 variable at a time (see Sprague & Werry 1971)
- **Present graphs with clear condition & phase change lines**
 - Indicate both program & medication changes on the chart.

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AGAIN...

- **Phase change lines**
 - Major environ change; intervention (IV)
 - Medication introduction
 - Medication discontinuation
- **Condition change lines**
 - Change in parameter of intervention
 - Change in dosage

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ASR # 17

Among others, Tsouris (2003) has reported multiple studies demonstrating that:

- Behavior problems are symptoms of underlying psychiatric illness
- Challenging behaviors are not related to mental illness in persons with ID
- Sleep data are generally unreliable and not indicative of problems
- Psychiatrists are not interested in behavior data

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ASR # 17

Among others, Tsouris (2003) has reported multiple studies demonstrating that:


- Behavior problems are symptoms of underlying psychiatric illness
- B. Challenging behaviors are not related to mental illness in persons with ID**
- Sleep data are generally unreliable and not indicative of problems
- Psychiatrists are not interested in behavior data

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ASR # 18

Introduction of a new medication is indicated on a behavioral chart by a


- Condition change line
- Label
- Phase change line
- Star or Asterisk to mark the date

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ASR # 18

Introduction or discontinuation of a psychotropic medication is indicated on a behavioral chart by a


A. Condition change line
B. Label
C. Phase change line
D. Star or Asterisk to mark the date

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ASR # 19

A change in dosage of a medication should be indicated by a


A. Condition change line
B. Dosage levels are not indicated
C. Level indicator on the Y-Axis
D. Phase change line

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ASR # 19

A change in dosage of a medication should be indicated by a


A. Condition change line
B. Dosage levels are not indicated
C. Level indicator on the Y-Axis
D. Phase change line

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What We Can Do


Learn Additional skills:

- Become fluent in uses and side-effects of medications
 - “One way to decrease underreporting is to provide patients or carers with a list of possible side effects associated with each medication being used” (from Corso et al 1992 in Zarcone 2008)
 - MEDS: Matson Evaluation of Drugs Side Effects Scale (Matson et al, 1998)
 - AIMS: Abnormal Involuntary Movement Scale (NIMH 1985)
- Also learn their secondary effects

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Some Key Side Effects

Anticholinergic effects —THIRSTY! (see “secondary effects”)
Akathesia — I have to MOVE (Haldol)
Tardive Dyskinesia — Tics, Rolling tongue, abnormal movement; Increased risk over time
Neuroleptic Malignant Syndrome — Looks like Flu; Fever with Rigidity; Possibly fatal
Weight Gain — Risperdal!
Heart problems — Mellaril


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A Note on Side Effects of NON-Psychotropics

- NSAIDS


The story of Angie and her joint pain

The story of Michael and his joint pain

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Secondary Effects of Medications


- Effects on the target behaviors (e.g., SIB and proprioceptive feedback)
- Effects on other behaviors (e.g., sedative effects in teaching contexts, attention span)

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Secondary Effects

- Changes in the effectiveness of specific stimuli as evocative or consequating variables (e.g., light sensitivity, sound sensitivity, loss of or increase in appetite; anti-cholinergic effects)


--Wilson and the water fountain

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ASR # 20

Which side effect increases in risk over time in use with neuroleptics?


- Anticholinergic effects
- NMS
- Tardive Dyskinesia
- Weight gain

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ASR # 20

Which side effect increases in risk over time in use with neuroleptics?


- Anticholinergic effects
- NMS
- C. Tardive Dyskinesia**
- Weight gain

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ASR # 21

Which of the following is true about NMS?

- Body Rigidity
- Fatal if not treated quickly in some cases
- Generally High Fever
- All of the above

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ASR # 21

Which of the following is true about NMS?

- Body Rigidity
- Fatal if not treated quickly in some cases
- Generally High Fever
- D. All of the above**

The Real Challenge: Treatment Ethics

- When the prescribing physician does not accept the behavioral model, what must one do when confronted w/ medication being used for environmentally mediated behaviors?

In Other Words

- Medications used for the convenience of the caregiver, or due to a lack of resources in the treatment environment are effectively chemical restraints.

Who Decides?

- The behavior analyst has no direct clinical responsibility for the decision to medicate or not to medicate.
- The doctor has the license!**

The Big Question

- **How can we influence without alienating?**

What Works: Priority #1

- We must attend medication management appointments
- THERE IS NO OTHER WAY
- WE MUST ATTEND

Do What Works, Not What Feels Good

- Despite our view of environmentally mediated operants, the psychiatrist may remain convinced that an “underlying mental state” causes the problem

and still agree that specific behaviors must be tracked!

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Do What Works, Not What Feels Good

Regardless of philosophy of approach to the etiology of the problem...

Everyone will agree that we need to determine whether the medication is working or not, regardless as to why

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What Works

- The behavior analyst must be prepared to withhold arguments as to likely operant or respondent causes of the problem
- Our primary job is to become a useful participant in the doctor's decision making process

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What Works

- First we must become a source of information. A reliable resource.
- Establish rapport
- Get good data to the doctor. Ask for ideas. Operationalize.
- Establish yourself as an Sr+ (you are there to help, not critique)

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What Works

- Save philosophy for later, after you have become colleagues.
- Let the DATA and the GRAPHS do the talking.
- That's why good condition/phase change lines are vital. The M.D. will see it right there on the chart!


What Does NOT Work

- Preaching behavior analysis from the outset. Trying to convince the MD you are RIGHT!
 - Do ABA, don't TALK ABOUT IT
 - (See Eli Wallach: The Good The Bad and the Ugly)

What does NOT work

- Questioning the M.D.s reasoning
- Suggesting Medication Changes.


**A VERY BAD IDEA
NOT SMART
SHOW ME YOUR LICENSE!**

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ASR # 22

Certified Behavior Analysts are highly trained specialists who may become responsible for advising the M.D. as to necessary medication changes based on behavior.


A. True
B. False

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ASR # 22

Certified Behavior Analysts are highly trained specialists who may become responsible for advising the M.D. as to necessary medication changes based on behavior.


A. True
B. False

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ASR # 23

Behavior Analysts _____ to work together with Psychiatrists and M.D.s, in the interest of person in treatment.


A. Should consider trying
B. Should take responsibility for finding a way
C. Will probably never be able

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ASR # 23

Behavior Analysts ? to work together with Psychiatrists and M.D.s, in the interest of person in treatment.


A. Should consider trying
B. Should take responsibility for finding a way
C. Will probably never be able

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ASR # 23

Behavior Analysts _____ to work together with Psychiatrists and M.D.s, in the interest of person in treatment.

A. Should consider trying
B. MUST take responsibility for finding a way
C. Will probably never be able

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What Works

- “The Individual will benefit most when the members of a collaborative or inter-disciplinary team combine their expertise and consider all the possible interventions and outcomes.” Zarcone (2008)

Conclusion: It's Our Job!

- The behavior analyst is the team member who is best prepared to demonstrate a direct link between the behavior and the environment. This will reduce the likelihood that psychotropic medications will be incorrectly used to address operant processes.

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