

6-1-1974

## Of Rights and Reinforcers

David B. Wexler

Follow this and additional works at: <https://digital.sandiego.edu/sdlr>



Part of the [Law Commons](#)

---

### Recommended Citation

David B. Wexler, *Of Rights and Reinforcers*, 11 SAN DIEGO L. REV. 957 (1974).

Available at: <https://digital.sandiego.edu/sdlr/vol11/iss4/6>

This Article is brought to you for free and open access by the Law School Journals at Digital USD. It has been accepted for inclusion in *San Diego Law Review* by an authorized editor of Digital USD. For more information, please contact [digital@sandiego.edu](mailto:digital@sandiego.edu).

# Of Rights and Reinforcers

DAVID B. WEXLER\*

This paper is directed at the intersection between the law and those behavior modification techniques which are clinical applications of Skinnerian principles of learning theory or reinforcement theory. The author has written previously on this subject<sup>1</sup> and it is his hope in the present paper to capsulize and update the previous work, to highlight certain new themes and developments, and to furnish some recent references.<sup>2</sup>

The theory of operant conditioning stresses that behavior is strengthened or weakened by its consequences—that the frequency of a behavior will increase if it is followed by desirable consequences and will decrease, or be extinguished, if the positive consequences are discontinued or if the consequences are aversive.

---

\* B.A., Harpur College, State University of New York at Binghamton (1961); J.D., N.Y.U. (1964). Professor Wexler is currently a Professor of Law, University of Arizona.

This paper is based upon the author's remarks at the Law and Psychiatry Section program of the Association of American Law Schools in December, 1973 and at the Law and Society Research Group Symposium at Florida State University in May, 1974. These remarks will also be published in the proceedings of the Florida State University Symposium.

1. Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81 (1973) [hereinafter cited as Wexler].

2. In the interest of brevity, most references other than case citations and quoted material will not be repeated here if they can be gleaned from Wexler, *supra* note 1.

This article will focus on the process of strengthening wanted behavior patterns through rewards—positive reinforcement—rather than on extinguishing unwanted behavior patterns through punishments. The principal reason for that focus is that the former technique operates more subtly and, in this author's opinion, raises more interesting legal questions. Further, that area is often neglected legally because of the erroneous view—often peddled by behavior modification proponents—that serious legal problems cannot arise in a process that deals with rewards rather than with punishments.

Clinically or therapeutically, behavior modification practitioners seek to shape and maintain appropriate behavior patterns—designated as target behaviors or target responses—by rewarding or reinforcing the desired responses. Typically, rewards are given in the form of points or tokens—secondary or generalized reinforcers—and are later cashed in by the patients for primary reinforcers—i.e., snacks and canteen items. Behavior modification programs relying on tokens are typically referred to as token economies. They seek to arrange and manage reinforcing contingencies so as to create an optimal motivating social learning environment. Token economies are now very much in vogue, and are attractive because they are relatively inexpensive to operate, can be run on a day-to-day level by ward attendants and paraprofessionals, and seem non-punitive in nature.

The pioneering work on token economies was performed in the early sixties by Ayllon and Azrin on a ward of chronically psychotic patients at the Anna State Hospital in Illinois. Disturbed by the apathy and dependency of those long-institutionalized patients, Ayllon and Azrin set out to reverse the institutionalization syndrome by increasing patient activity and neat appearance. Accordingly, self care behavior and performance of institutional work assignments were designated as target behaviors to be encouraged by the payment of tokens. To insure that the tokens would be redeemable for primary reinforcers that would in fact be desired by the patients, Ayllon and Azrin learned of appropriate and effective primary reinforcers by an empirical application of what is known as the Premack Principle (named for its originator, David Premack). Simply stated, the Premack Principle holds that frequently engaged in behavior can be used to reinforce low frequency (target) behaviors.

At the Anna State Hospital, the high frequency behaviors that were converted by Ayllon and Azrin into primary reinforcers purchasable by tokens were determined as follows:

It was noted that certain patients often hoarded various items under their mattresses. The activity in this case, in a general sense, consisted of concealing private property in such a manner that it would be inaccessible to other patients and the staff. Since this event seemed to be highly probable, it was formally scheduled as a reinforcer. Keys to a locked cabinet in which they could conceal their private possessions just as they had been doing with the mattresses were made available to patients.

Another activity that was observed to be highly probable was the attempt of patients to conceal themselves in several locations on the ward in an effort to enjoy some degree of privacy. A procedure was therefore instituted whereby a patient could obtain a portable screen to put in front of her bed or access to a bedroom with a door. Another event that had a high probability of occurrence for some patients was a visit with the social worker or psychologist. This was used as a reinforcer by arranging appointments with either of these staff members.<sup>3</sup>

In addition to locked cabinets, portable screens, and therapy sessions, Ayllon and Azrin established as reinforcers such desired items and activities as ground privileges, supervised walks, religious services, personal chairs, writing materials, movies, television viewing, and commissary items. Under the token economy, all of these were available only contingently—that is, they were purchasable by tokens but were unavailable to patients who had not performed sufficient target responses to earn the requisite token purchase price.

The Anna State Hospital program, when measured solely in terms of increased work output, was rather successful, but even there, eight of the forty-four patient participants were wholly unresponsive. Ayllon and Azrin suggested that those eight patients were perhaps so apathetic that they could not even be motivated by the available reinforcers. It was noted that their only high frequency behaviors were eating and sleeping, and it was suggested that future programs might have to resort to controlling the availability of even food and beds in order to establish motivation for engaging in target behaviors. Several programs have taken the advice of Ayllon and Azin and have scheduled food and beds as available only contingently upon token purchase.

Many token economies also operate on a "tier" system, where certain privileges depend upon the patient's place in the hierarchy.

---

3. T. AYLLON & N. AZRIN, *THE TOKEN ECONOMY: A MOTIVATIONAL SYSTEM FOR THERAPY AND REHABILITATION* 61 (1968).

The Patton State Hospital program is one which controls food and beds and also operates on a tier system. Patients progress from an orientation group, through a middle group, and finally to a ready-to-leave group. A psychiatric technician at the hospital, writing in a nursing journal, described the orientation group:

This group sleeps in a relatively unattractive dormitory which conforms to bare minimums set by the state department of mental hygiene. There are no draperies at the windows or spreads on the beds, and the beds themselves are of the simplest kind. In the dining room the patient sits with many other patients at a long table, crowded in somewhat uncomfortably. The only eating utensil given him is a large spoon. The food is served in unattractive, sectioned plastic dishes. So long as he is in this group, he is not allowed to wear his own clothes and cannot go to activities which other patients are free to attend off the unit. He may not have permission for off-the-ground visits, and the number of visitors who can see him is restricted.

During this time, the patient learns that his meals, his bed, his toilet articles, and his clothes no longer are freely given him. He must pay for these with tokens. These tokens pay for all those things normally furnished and often taken for granted. In the orientation group most of the things the patient wants are cheap; for example, it costs one token to be permitted to go to bed, one token for a meal. Patients find it easy enough to earn the few tokens necessary for bare subsistence.<sup>4</sup>

Token economies, both of the tier and non-tier type, have flourished and have been applied to many clinical categories besides chronic psychotics. They have been applied, for example, to populations of the mentally retarded, juvenile delinquents, prisoners, addicts, and alcoholics. At the Richmond State Hospital in Indiana, for instance, non-psychotic civilly committed alcoholics were inducted into a token economy. Prior to the token economy program, alcoholic patients were, after a week or so, placed on an open ward with all available privileges. Under the token system, however, they were obligated to buy their room and board, and they had to work their way up a ladder of two closed wards, then a ward where ground privileges were available by purchase only, and so on.

Against the above factual and psychological background, we can examine the legal questions posed by token economies. At this stage, there is no specific body of law relating to token economies, but there are analogies and clear trends. Token economies and comparable behavior modification schemes pose legal problems both in their designation of target behaviors and in their designation of reinforcers.

---

4. Bruce, *Tokens for Recovery*, 66 AM. J. NURSING 1799, 1800-01 (1966).

With respect to target behaviors, for example, the therapeutic propriety of encouraging patients to perform institutional chores can easily be questioned. Critics charge that the designation of that type of target behavior is more a labor saving device than a therapeutic program. On the other hand, given the background, skill, and prognosis of chronic patients, job training, even of a rather menial type, may have therapeutic value. Yet, a recent study which marshalled the empirical evidence casts considerable doubt on the efficacy of traditional so-called "work therapy" programs.<sup>5</sup> The well known *Wyatt v. Stickney*<sup>6</sup> case, dealing with Alabama institutions, dealt with the issue by banning involuntary patient labor—therapeutic or not—involving hospital maintenance, and permitting voluntary patient labor—therapeutic or not—involving hospital tasks only if that labor is compensated by the legally required reinforcer of minimum wage payments.

The propriety of institutional labor as a target behavior is really only the tip of the target behavior iceberg. At issue, really, is the entire question of therapeutic goals and our right or duty to remake persons. If institutional labor is arguably therapeutic for chronic psychotics, is it also an appropriate goal for juvenile delinquents? Or, if academic proficiency is more important than is institutional labor in reforming juvenile delinquents, as the research indicates it is, would it nonetheless be improper to adopt a law, reportedly being considered by Brazilian officials, that institutionalized juvenile delinquents be kept in custody until they reach an acceptable reading level? The question of goals in the context of behavior modification and other behavior change technologies is extremely complex and important. It has been generally ignored in the literature and was skirted by *Wyatt*. It is believed, however, that certain legal investigators are now turning their attention to the problem.

More clear cut, and equally as important and interesting, is what *Wyatt* and modern legislative enactments and proposals have to say concerning legally acceptable reinforcers. The key to the legal problems associated with reinforcers, of course, is that in order to use items and events as rewards, it is necessary to begin with

---

5. Anthony, et al., *Efficacy of Psychiatric Rehabilitation*, 78 PSYCHOL. BULL. 447, 450 (1972).

6. 344 F. Supp. 373 (M.D. Ala. 1972).

a state of *deprivation*—and that is something which many so-called non-punitive oriented behavior therapists fail to tell us in selling systems of reward therapy.

With particular regard to *Wyatt*, it is noteworthy that the court, as part of the constitutional right to treatment, established the necessity of a humane physical and psychological environment in which patients should be entitled to various specifics as a matter of minimum constitutional right. The probable impact of *Wyatt* on reinforcers may be summed up as follows:

According to the *Wyatt* court, a residence unit with screens or curtains to insure privacy, together with “a comfortable bed, . . . a closet or locker for the patient’s personal belongings, a chair, and a bedside table are all constitutionally required.” Under *Wyatt*, patients are also insured nutritionally adequate meals with a diet that will provide “at a minimum the Recommended Daily Dietary Allowances as developed by the National Academy of Sciences.” *Wyatt* further enunciates a general right to have visitors, to attend religious services, to wear one’s own clothes (or, for those without adequate clothes, to be provided with a selection of suitable clothing), and to have clothing laundered. With respect to recreation, *Wyatt* speaks of a right to exercise physically several times weekly and to be outdoors regularly and frequently, a right to interact with members of the other sex, and a right to have a television set in the day room. Finally, apparently borrowing from Judge Bazelon’s opinion for the District of Columbia Circuit in *Covington v. Harris*,<sup>7</sup> Judge Johnson in *Wyatt* recognized that “patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment”—presumably including, if clinically acceptable, ground privileges and an open ward.

Thus, the usual target behaviors for token economies would be disallowed and the usual reinforcers will be legally unavailable. The emerging law appears to vindicate the assertions of the patients who, at the inception of the Patton State Hospital token economy, “pointed out to the nurses that the state had an obligation to feed them and that the nurses were acting illegally in denying them entrance to the dining room.” Chronic patients at Anna State Hospital who had to work for screens and personal lockers to insure privacy would, under *Wyatt*, have those items provided noncontingently. According to the “least restrictive conditions” rationale of *Covington* and *Wyatt*, it would seemingly be impermissible to house on closed wards those patients clinically capable of exercising ground privileges, such as Richmond State Hospital’s admittedly nonpsychotic alcoholic patients who, before the onset of the token economy program, would have quickly been placed on an open ward. The identical “least restrictive conditions” rationale would presumably also invalidate programs, such as the one at Anna State Hospital, in which ground privileges or supervised walks are available only by purchase, and programs in which outright release from the institution is conditioned upon the accumulation of a set number of tokens or points.<sup>8</sup>

---

7. 419 F.2d 617 (D.C. Cir. 1969).

8. Wexler, *supra* note 1, at 94-95 (non-judicial citations omitted). It

*Wyatt* is currently pending on appeal—it has been so pending for more than a year—but regardless of the outcome in that particular litigation, *Wyatt* seems clearly indicative of a patients' rights trend likely to be followed by other courts and by legislatures. If that trend develops as expected, we should anticipate seeing substantial litigation involving the propriety of utilizing various items and activities as motivating reinforcers.

Though *Wyatt* has so much to say with regard to legally acceptable reinforcers, that case did not challenge head-on any behavior modification reinforcement program. Indeed, it does not appear that any such program was in effect at the institutions in question at the time of the *Wyatt* suit. The only specific litigation to this author's knowledge involving positive reinforcement programs is a federal suit by the ACLU's National Prison Project and others, pending in the Western District of Missouri, challenging the so-called START program at the Medical Center for Federal Prisoners in Springfield, Missouri.<sup>9</sup>

---

is possible, of course, but somewhat unlikely, that since *Wyatt* assumedly involved a hospital at which a token economy was not in operation, future cases could construe the rights mandated by *Wyatt* as being operative only in the absence of a contingency management program. In any event, however, to the extent that *Wyatt*-type rights are cast in statutory form—which is the distinct trend—those rights would be far less malleable. Similarly, it is conceivable that the "least restrictive conditions" rationale of *Covington*, which has been construed to mean a right to an open ward for all patients who could manage ground privileges, could, at least according to the *Wyatt* court's version of the rule, be strained and narrowed to mean less than that, and could be read as not precluding the availability of ground privileges by purchase only. For instance, *Wyatt* recognized the principle in language to the effect that "patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment," 344 F. Supp. 373, 379 (M.D. Ala. 1972). Behaviorists could argue that, even for patients able to manage ground privileges, the *contingent* availability of those privileges is necessary to achieve the purposes of commitment (treatment), and that a less restrictive environment, such as an open ward, would therefore not be required. Though *Wyatt* could of course be interpreted in that fashion, such an interpretation seems to me to be somewhat of a distortion of the clear *Covington* principle.

9. See, e.g., *Sanchez v. Ciccone*, *infra* note 11; Steinman, *The Case of the Frightened Convict*, THE NATION, Dec. 3, 1973, at 590; Civil Liberties, Nov., 1973, at p. 3, col. 3 (ACLU newspaper). Citing "economic" reasons, but also explicitly mindful of the "widespread misunderstanding" of the program, the U.S. Bureau of Prisons has now decided to dismantle START. Tucson Daily Citizen, Feb. 9, 1974, at 14, col. 7-8.



START is an acronym for Special Treatment and Rehabilitative Training, a program which involves a token economy and a step system. Its announced goal is not to prepare prisoners for their return to society, but rather to make good prisoners out of bad ones! Inmates can be transferred to Springfield and to START from federal correctional institutions across the nation. At the first level, at least, visitation rights, reading materials, and exercise opportunities are apparently severely restricted. START is being attacked on two separate grounds, one procedural and one substantive.<sup>10</sup>

The procedural due process attack involves the involuntary transfer of inmates to Springfield and to the program without the procedural niceties of notice and hearing. It is argued that being placed in START is easily akin to being placed in segregation without a hearing, and that since the law now finds the latter procedure constitutionally offensive, the former is an *a fortiori* case.

With respect to the petitioners' assertion that START deprived them of many substantive rights, the Government argued in response that, therapeutically, it was necessary to strip the inmates of various rights in order to utilize their reacquisition as carrots or behavioral incentives. Then, with genuine sleight of hand, the Government claimed that the fact that the petitioner inmates were concerned enough to sue over the denial of those rights indicates that those denied items and activities are in fact desired by the inmates and are therefore powerful psychological reinforcers.<sup>11</sup> While the Government's position may make some psychological sense, it surely creates a legal Catch 22: if you complain of the denial of certain rights, you are not entitled to them; you are entitled only to those rights the denial of which you do not challenge.

---

10. The challenge might well have had a third or even fourth prong: the propriety of the therapeutic goal, and the extent to which the selection system was particularly fond of inmates who were vocal in their exercise of political and First Amendment rights.

11. [I]t is obvious that the overall incentive to the participant to be returned to open population as the basic reinforcer is valid, as all Petitioners desire such relief herein.

Further, . . . as stated by Dr. Levinson and in essence by Dr. Menninger, . . . a reduction of any privileges which [the petitioners] may have had in such units on admission to the START Program was necessary to provide a basis from which incentives or reinforcers could be provided, and obviously, if Petitioners complain of their loss, then these privileges must be incentives.

Respondent's Memorandum of Points and Authorities in Opposition to the Petitions for Habeas Corpus Relief, *Sanchez v. Ciccone*, No. 20,182-4 (W.D. Mo.), at 2.

Catch 22 or not, many behavior modification proponents are seriously concerned that *Wyatt* and related developments entitling patients to various desired items and activities as a matter of right will sap the therapeutic strength from operant conditioning procedures. The behavior therapists claim that, at least with respect to apathetic chronics, motivation to learn desired behavior patterns can be engineered only through the *contingent* availability of rather *basic* items and events. If those items and events are freely available to the patients as a matter of right, there will, those behavior therapists claim, be no motivation and no improvement, and the patients will be able, with all their rights, simply to stagnate in the back wards of public institutions.

The recently published case study of a patient at the Nevada State Hospital nicely illustrates the asserted psycho-legal dilemma.<sup>12</sup> LM was a thirty-three year old extremely obese woman who had been hospitalized for the third time for a severe psychotic depressive reaction. It was apparent both to LM and to her therapists that her obesity was the major factor contributing to her self-concept of extreme worthlessness and to her poor relationships with other persons. Yet, she had never been able to maintain an effective diet, and traditional therapies had proven fruitless in reversing her depression or her obesity. Finally, six months into her third hospitalization, she and her therapist decided to try to motivate her dieting through a token economy system. It was agreed that the target behavior of weight reduction would be rewarded by tokens which could be expended only for the rental of a private hospital room. According to the therapist, the availability of a private room as a reinforcer

. . . proved crucial to the target behavior plan since LM had several times confided to staff members that the most excruciating moment of her day came in the evening when she was obliged to undress for bed in the bare six-patient dormitory to which she had been assigned. At that time she was forced to expose her obesity in all its abject ugliness to the disapproving eyes of the five other women who shared her sleeping quarters.<sup>13</sup>

As expected by the therapist, the contingent availability of a private room did indeed operate as a powerful dietary motivator, and

---

12. McQueen, *The Token Economy and a Target Behavior*, 32 *PSYCHOL. REP.* 599 (1973).

13. *Id.* at 601.

LM achieved a dramatic and permanent weight loss, accompanied by a remission of her depression, and is now functioning well beyond the walls of the institution. The crucial point to keep in mind for the purpose of the present discussion, however, is that under *Wyatt*, LM would be entitled as a matter of right to the privacy provided by a room divider or curtain, and hence would presumably not be as motivated to secure a private room as she would be in the absence of the rights provided by *Wyatt*.

In light of *Wyatt's* potential for drastically curtailing the craft of behavior modification, it is not surprising that, many behaviorally oriented clinical psychologists are concerned with the entrance of the courts in this area, resulting in, they claim, the prohibition, without any psychological expertise of some very well accepted therapeutic tools. This concern is easily answered, however, by pointing out that *Wyatt* was not decided in a psychiatric and psychological vacuum, but instead was molded by testimony presented by an array of eminent experts. Indeed, the American Psychological Association (APA) participated in *Wyatt* as an *amicus curiae*, as did several other professional organizations, and agreed to the bulk of the rights ultimately announced by the *Wyatt* court. This, however, raises a far more difficult question to answer: Why is it that the American Psychological Association agreed to a position so damaging to the traditional institutional practice of behavior therapy? Was the Association unaware of the implications (perhaps because no token system was operative at the Alabama institutions in question)? Or did the APA, perhaps still rather Freudian in its outlook, simply sell out the behaviorists and the behavior therapists? Although the answer is not known, it is clear that the question raises the important issue, deserving of future discussion, of the role of prestigious professional organizations in law reform litigation, the formulation of policy positions by those organizations, and the communication between the organizational policy makers and the organizational membership.

Despite the apparent acquiescence of the APA in *Wyatt*-type rights, it is clear that many psychologists feel frustrated over the emerging restrictions on their use of reinforcers. As an anecdotal aside, one instance of the extent to which behavior therapists are seeking to avoid *Wyatt's* wrath might be mentioned. Now that, under *Wyatt* at least, nutritious meals are required to be provided patients as a matter of right, a therapist who previously used the contingent availability of meals as reinforcers is grudgingly complying with *Wyatt* and offering all his patients nutritious food by

taking all the courses, blending them together in an electric blender, and serving the mush-like product at mealtime! The "mush meal" is freely available to all patients, but those patients desiring more flavorful meals (and segregated course offerings) must still pay for them with earned tokens.

If the behavior therapists are correct in their contentions—that is, if it could be proven that society's assumedly compelling interest in reforming the mentally ill and other deviants could not be achieved by any means less restrictive of liberty than the traditional token economy system and its reliance on rather primitive reinforcers—perhaps the emerging law in this area could properly be rethought. The efficacy of the traditional token systems and the therapeutic necessity for relying on basic reinforcers are, of course, ultimately empirical questions. Yet, although the matters for empirical inquiry are still largely open, it seems doubtful, on the basis of the existing evidence, that the resort to basic reinforcers and full-blown traditional token systems are in fact necessary.

Surely, to the extent that the basic systems have been slothfully and mindlessly transplanted wholesale to clinical populations other than apathetic chronically psychotic patients (juvenile delinquents, prisoners, alcoholics, etc.), it is difficult to believe that only primitive reinforcers can operate as effective motivators. Even with regard to the chronics themselves, the success of traditional token systems, at least when measured in terms of release and community adjustment (which may be the only permissible measure, for measures of success unrelated to release and community adjustment may be viewed as legally inappropriate goals) is not all that high. Indeed, traditional token economies surely seem no more effective than George Fairweather's impressive system, combining social psychology and behavior modification principles, for returning chronics to community life.<sup>14</sup> Moreover, Fairweather's system, which employs only money and passes as reinforcers, and which provides patients with food, beds, ground privileges, and recreational activities as a matter of right, seems to involve far less deprivation than the traditional token economies.<sup>15</sup>

---

14. Fairweather's work is cited and discussed in Wexler, *supra* note 1, at 104-09.

15. The Fairweather system does, however, pose one kicker in gauging

Furthermore, behavior therapists have never been forced to explore creatively for effective non-basic reinforcers. One beneficial result of *Wyatt* may be to induce those therapists to seek reinforcers falling above the *Wyatt* baseline. It is quite possible that an exploration for such reinforcers will reveal a sufficient number of non-basic desired items and activities to motivate even chronic psychotics. Some of the existing literature has already indicated that even chronic patients sometimes have preferences for such idiosyncratic activities as feeding kittens and eating soft-boiled rather than hard-boiled eggs and that the patients will perform target behaviors in order to engage in those idiosyncratic preferred activities.

The law, or at least the legislatures, can assist the effort of making non-basic reinforcers available by considering the removal of certain legal impediments that now exist with respect to some of them. The contingent availability of conjugal visits, for instance, might prove to be powerful incentives for many categories of institutionalized persons. Similarly, in juvenile correctional institutions, authorities are now presumably precluded from offering cigarette rewards even to those juvenile offenders who are already smokers, though there is general agreement that cigarettes would have a considerable motivating force on those individuals.<sup>16</sup> There are, of course, a number of countervailing considerations to be taken into account in removing legal obstacles to the availability of given reinforcers, but the issues need to be fully ventilated in order to balance appropriately the competing considerations.

An important legal advantage that can accrue from resorting to idiosyncratic or non-basic reinforcers is that "to the extent that effective reinforcers are in fact idiosyncratic, it follows almost by definition that their contingent availability could not conflict with

---

its relative deprivation. Fairweather's approach relies on patient task force groups which are charged with controlling their own members and recommending the amount of pass or monetary privileges deserved by each member. In order to promote group cohesiveness, Fairweather's system permits occasional promotions or *demotions*, in pass and monetary terms, of the group as a whole. Thus, unlike the traditional token systems, Fairweather's approach has an explicitly punitive aspect—and an aspect of *group* punishment at that. Since these elements seem incapable of easy quantification, it may be impossible to compute mathematically whether the punitive aspects of the Fairweather model in fact convert that model into one which is objectively *more* drastic or restrictive of liberty than traditional token systems which rely wholly on positive reinforcement. Presumably, however, that question is better answered by subjective patient preference or by philosophers than by mathematicians.

16. The author is indebted to Ms. Rhoda J. Keppel, Assistant to the Dean at the University of Arizona College of Law, for calling to my attention this information acquired during her tour of an Arizona juvenile facility.

the legally emerging absolute general rights of patients."<sup>17</sup> In other words, since there is no constitutional or statutory right to feed kittens or to eat soft-boiled eggs, the use of those sorts of reinforcers would avoid the deprivation issues that would arise if food, beds, ground privileges and other basics were employed as contingently available reinforcers.

Moreover, although the legal trend is to the effect that drastic therapies, presumably including behavior modification techniques resorting to reinforcers falling *below* the *Wyatt* baseline, cannot be performed in an involuntary fashion and in fact require the patient's informed consent,<sup>18</sup> operant conditioning therapy resorting to idiosyncratic reinforcers or to other reinforcers falling *above* the *Wyatt* baseline can seemingly avoid the tangled informed consent question<sup>19</sup> because such therapy can, in a sense, be conducted *involuntarily* without raising serious legal problems. Put another way, if a behavior modification program is operating with legally acceptable reinforcers—extra monetary rewards, conjugal visits, mail order items, soft-boiled eggs, etc.—a patient, even without consent, could simply be offered those reinforcers, contingent upon target behavior performance, on a take-it-or-leave-it basis. And if the patient chose to leave it, it would be most difficult for that patient then to assert a denial of the right to treatment and to sue for release or alternative treatment. That is because, apart from the case where it could be shown that the offered behavior modification treatment program was wholly inappropriate on therapeutic grounds, sustaining a right to treatment claim in that context would bring us perilously close to the legal position, never seriously advocated,<sup>20</sup> that the right to treatment enables a patient to select his own brand of therapy.

If, then, effective reinforcers falling above the *Wyatt* baseline

---

17. Wexler, *supra* note 1, at 103.

18. *E.g.*, *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973) (vomit-inducing drug apomorphine cannot be administered as aversive therapy absent informed consent).

19. The most extensive judicial discussion of the complicated informed consent concept in the context of mental health law appears in the recent unreported Detroit psychosurgery case, *Kaimowitz v. Department of Mental Hygiene*, Civ. No. 73-19434-AW (Civ. Ct. of Wayne Cty., Mich., July 10, 1973).

20. Dix, *Book Review*, 11 ARIZ. L. REV. 322 (1969) (discussing various interpretations that can be given the right to treatment concept).

can be uncovered, the procedure of positive reinforcement to achieve agreed upon therapeutic goals would not seem to pose serious legal problems. But what if, after a legitimate effort, it is concluded that such reinforcers cannot be found? This is a difficult area that requires far more thought, and thus, a simple sketch of some of the conceptual and empirical questions that come to mind will suffice for the purposes of this article.

Should the use of traditional token economies (involving *below-baseline* reinforcers) be permitted *without* informed consent? If we assume that commitment is proper, and that a token economy is therapeutically effective, should a patient be able to *refuse* this or any therapy (assuming it is not, like psycho-surgery, experimental, irreversible, etc.)? Once we have deprived someone of the most basic right to liberty, is it worth quibbling about whether that person should be entitled to other rights absolutely or only contingently?<sup>21</sup>

Should the use of traditional token economies be permitted without informed consent at least for those patients who have already failed under a "less drastic" system, such as Fairweather's approach? Would the threat of being subjected to the token economy as a last resort actually provide an additional incentive to improve while undergoing the less drastic therapy? On the other hand, if traditional token economy entrance is restricted to those who have already experienced failure under other treatment schemes, might the effect of previous failure operate as an *independent* psychological force to make treatment in the token economy more difficult than it would have been if the patients had entered the token economy directly and without having experienced previous therapeutic failures? What about patients who do not improve even under the token system? For how long should they be denied the basics? If token economy "failure" patients are, after a time, provided the *Wyatt* basics non-contingently, and if that general rule is widely known, will token economy patients be *encouraged* to fail for a stated period so that they will then be assured of receiving the basics indefinitely without effort on their part?

Should operant conditioning procedures that resort to basic reinforcers be treated like other drastic therapies and be permitted only with informed consent? Can we expect apathetic long-term patients to consent to give up the standard benefits of hospital

---

21. Cf. *United States v. Robinson*, 94 S. Ct. 488, 494 (1973) (Powell, J., concurring) (Once Fourth Amendment rights are infringed by an arrest, the affected individual retains no further right to privacy in his person to prevent an incidental search).

life and agree to participate in a therapeutic system where those standard benefits will have to be earned? If they do consent, should they be permitted to revoke their consent at any time, as the Eighth Circuit in *Knecht v. Gillman*<sup>22</sup> recently required of informed consent to the use of the vomit-inducing drug apomorphine as an aversive stimulus? If consent is freely revocable in a token economy setting, so that contingent reinforcers can be converted to absolute rights by the mere say-so of the patient, does not that defeat the motivating force of the reinforcers?

This virtually endless stream of questions ought to be sufficient to convince most people that the black-letter law hornbook on operant conditioning law or the law of scientific manipulation of behavior will probably not be written this year.<sup>23</sup> The field is an embryonic and fascinating one, requiring conceptual and empirical research of a multidisciplinary nature. Endless work lies ahead. It is hoped that this paper points to some legitimate areas of inquiry for those interested in the field.

---

22. *E.g.*, *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973).

23. *But see* the provocative and thorough article by Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 So. CALIF. L. REV. 237 (1974), which appeared while the instant article was in press.