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EDITORIAL: MENTAL ILLNESS, MENTAL HEALTH, AND CULTURAL ANALYTIC SCIENCE

This special issue of *Behavior and Social Issues* is dedicated to an examination of serious mental illness and its treatment. The authors of the lead articles, Stephen E. Wong, W. Joseph Wyatt and Donna M. Midkiff suggest that behavior analytic approaches to treatment have been largely abandoned in favor of psychopharmacological intervention, mostly for nonscientific reasons rooted in professional competition and corporate profits. The commentaries on their papers by others in related fields are quite varied, and elaborate a number of perspectives on the issues. The authors of the lead papers then respond to those commentaries. In some cases, common ground is reached and arguments are refined, in others, the level of disagreement is profound. We also are privileged to have a final response from Gordon Paul, whose earlier work was discussed at some length in the materials in this issue. The overall package should be quite thought provoking; messy as it is, this is how the self-correcting process of science is done.

The materials included in this issue discuss intervention in serious mental disorders largely in terms of medication or highly structured behavior analytic approaches (or in some cases, some combination of the two). There are other related, and potentially even larger, issues for behavior and cultural analysis, as well. Research sponsored by the World Health Organization (Barbato, 1998; Sartorius, Gulbinat, Harrison, Laska, et al., 1996) consistently has indicated that persons suffering from schizophrenia in premodern societies (who typically receive neither medication nor structured behavioral intervention) do better than those in the developed world. Incidence (proportion of new cases per unit of time) is similar around the world, although rates are apparently very low in societies without a system of wage labor. Prevalence (proportion of existing cases, new and old), however, varies substantially, with a major advantage for the *less-developed societies*. As summarized by Castillo (1997), "In the economically developed countries, only 25 percent of the patients were classified in the best two outcome categories, and 65 percent were classified in the worst two outcome categories. In contrast, in economically less developed countries, 39 percent were classified in the best two categories, and only 38 percent in the worst two categories" (Castillo, pp. 248-9). Results for levels of impairment in these studies were similar, with 43 percent of patients in developed countries showing no or mild impairment, while 65 percent of patients in less developed countries fell into those categories.

These data certainly suggest that cultural factors are involved; Castillo suggests that, "Modernization brings with it increasing individualism, the breakdown of traditional social support systems such as family and religious structures, and injects the influence of market-driven values into all aspects of life" (p. 211). It has long been recognized that high levels of stress and of "expressed emotion" in the social world of persons with psychotic disorders increase severity and frequency of relapse. Halford (1991)

persuasively argued that the active factors in expressed emotion are verbal negativity and high levels of coercive exchange.

Hanson, in his commentary in this issue, cites the Soteria project, recently reviewed by Bola, Mosher, and Cohen (2005), in which patients were assigned either to standard treatment (inpatient stabilization with medications, and post-discharge medication) or the experimental treatment (in a “small, homelike, intensive, interpersonally focused therapeutic milieu with a nonprofessional staff,” generally with no medication). The experimental treatment proved more effective, with a large effect size advantage for patients with schizophrenia. There are a number of other non-medical and non-behavioral approaches that seek to normalize and empower persons with psychotic disorders, including the clubhouse model (e.g., Fountain House), which have produced promising results (Dickerson, 1998). (Empowerment is defined by Dickerson in terms of personal competence, self-determination, and social engagement.)

Personalizing this discussion may also be useful. Some time ago, I did mental health work in Alaska for several years. One of our patients, an Athabascan man with schizophrenia, lived in a small, largely Native village, accessible only by small plane or boat; another patient, demographically and diagnostically similar, lived in the city of Fairbanks. The first had a small cabin (no one is homeless in such villages), was collectively monitored by the people of the village, carried simple responsibilities in certain community events, participated in ceremonies, and was viewed as simply one member of the community who had certain problems but could be fun to visit with. His occasional relapses were mild, and immediately recognized by his neighbors, who contacted professional help as needed. The patient in Fairbanks, by contrast, was often physically homeless and consistently socially placeless, was regularly arrested, was preyed upon by others on the street and in jail, and experienced regular and often severe relapses. Obviously the comparison is merely anecdotal, and there were many differences between the two men. The most apparent differences, however, were their social and cultural settings, and their ease in life.

There is a consistent message in the cross-national data, the results of programs that emphasize the construction of health-enhancing cultures, and such anecdotal experiences. That message relates to Wong’s suggestion in his response to Hanson of the potential for “looser and more indirect” approaches that more closely approximate community realities. Recall that Stokes and Baer recommended that, under certain circumstances, behavior analysts might find it useful to “train loosely” as a means of enhancing generalization (1977). Such flexibility reduces tight stimulus control, maximizes sampling of relevant dimensions for transfer, and is also likely to lead to intermittent schedules of reinforcement, thus potentially enhancing both maintenance and generalization.

There is also emerging interest in the behavior analytic prevention community on the use of “evidence-based kernels”—irreducible, simple practices with research support that can be widely embedded within a cultural network without the need for complex controls—rather than on complex programs that are difficult to establish, and often impossible to maintain (Embry, 2004). Perhaps something of the sort should be

investigated for supporting mentally healthier behavior and quality of life among those with psychotic disorders in relatively natural settings. Combining this approach with flexible administration may offer an alternative strategy for intervention, challenging to evaluate, but potentially important to pursue.

As the contributions in this issue make clear, strong arguments can be made that neither universal prescription of marginally powerful, often aversive, and potentially dangerous drugs, nor widespread application of tightly structured token economies, is an ideal strategy for helping persons with psychotic disorders to live safe and fulfilling lives in the contemporary world. By contrast, there is, as noted above, at least intriguing evidence that small-scale cultural arrangements that ensure high rates of exposure to carefully defined but loosely administered positive social transactions known to enhance success and patient empowerment (programs from which evidence-based kernels might be isolated), and low rates of exposure to social aversives, might be an important alternative for further behavior analytic and cultural analytic study. Such work would be an important step beyond bemoaning the current, admittedly discouraging situation, but of course would not negate the structural political and economic realities discussed by many of the authors in this issue.

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