

REQUIRED RELAXATION: A METHOD OF INHIBITING AGITATIVE-DISRUPTIVE BEHAVIOR OF RETARDATES*

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Summary—Institutionalized retardates frequently exhibit agitative-disruptive behavior. Recent experiments have shown that overcorrective training in specific types of behavior can inhibit inappropriate behavior. A procedure was developed in which overcorrective practice in relaxation was given to each of eight adult retardates for their disruptions. The agitated resident was required to spend a fixed period of time in relaxation in his own bed upon each occurrence of agitation. This overcorrective relaxation resulted in a rapid, enduring and almost complete reduction in such behavior as self-injury, threats, physical aggression, screaming, crying, cursing and tantrums. Ward attendants strongly preferred the required relaxation procedure to the time-out technique and other inhibition procedures they had used. The procedure appears to be about as effective as alternative techniques and to have the advantages of ease of implementation and acceptability by ward staff and retardates as a 'reasonable' reaction to agitation.

INTRODUCTION

AGITATIVE-DISRUPTIVE behavior occurs frequently on wards of institutionalized retardates (Hamilton, Stephens and Allen, 1967; Burchard, 1967) and is annoying, may threaten the safety of others and is often resistant to treatment (Barnett and Bensberg, 1965; Thorne and Shinedling, 1970). Retardates with uncontrolled agitative-disruptive behavior are usually excluded from training classes and community placement (Lyon and Bland, 1969). Barnett and Bensberg (1965) suggest that treatment of disruptive behavior often fails because of the delay between the disruptive act and the staff reaction to the disruption. If an inhibitory consequence is to be effective, immediacy (Azrin and Holz, 1966) and consistency (Azrin and Holz, 1966; Sidman, 1970) are of utmost importance. One reason for the delay of a consequence for disruptions is that quite often attendants must seek authorization before applying some types of inhibitory consequences, especially those that are coercive or physically painful (Barnett and Bensberg, 1965). Another reason for delaying the reaction to disruptions may be that even when a definite consequence is at the attendants' disposal for immediate application, the consequence may be so distasteful to them (Bucher

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and Lovaas, 1967) that it may be applied only in exasperation after many disruptions have occurred. In order to minimize the delay between disruptions and the reactions to the disruptions, the inhibitory consequence should not be distasteful, and should not be so stressful or coercive that it cannot be applied without supervision.

One consequence which comes closest to meeting the above criteria, and which is widely used in the treatment of disruptions, is time-out from positive reinforcement. Time-out is a temporary withdrawal of reinforcers (Herrnstein, 1955; Ferster and Skinner, 1957; Ferster, 1958) and is clinically administered as a consequence for undesired behavior. For agitated disruptions, time-out is most often given by secluding the disrupter in a barren room. Time-out seclusion has been used to reduce aggression and property destruction (Wolf, Risley and Mees, 1964; Pendergrass, 1971), screaming (Reiss and Redd, 1970), loud vocalizations (Bostow and Bailey, 1969) and other types of disruptive behavior (Burchard, 1967; Burchard and Tyler, 1965; Tyler and Brown, 1967).

One disadvantage of time-out-seclusion, however, is that it appears sometimes to elicit emotional behavior. In several experiments in which Ss were placed in total seclusion as a consequence for disruptions, it has been necessary to provide extensions to the seclusion period because of tantrums and emotional reactions which occurred during seclusion (Burchard, and Tyler, 1965; Wolf *et al.*, 1964; Wahler, Winkel, Peterson and Morrison, 1965; Burchard, 1965). Pendergrass (1971) found that time-out-seclusion of children elicited freezing, trembling, wetting and other strong negative emotional reactions.

In several recent experiments, intensive training in appropriate behavior was given as a way of inhibiting undesirable behavior without emotional side effects. Foxx and Azrin (1972) have developed a procedure called 'Overcorrection' or 'Restitution' in which a disrupter is required to rectify the effects of his disruption through overcorrective training. For example, when furniture was turned over, the disrupter was required to restore that furniture, and then clean and straighten all the other furniture in the room; when a person was injured, an aggressor was required to clean and bandage the wound and apologize for the attack; when unhygienic objects were mouthed, a cleansing of the mouth with antiseptic followed. Overcorrective training applied to incontinent retardates (Azrin and Foxx, 1971) reduced their incontinence when they were required to mop up their own urine, shower, change clothes and wash and dry their dirty clothes when incontinent. Stereotyped self-stimulation of retarded and autistic children was eliminated by Overcorrection procedures that required the child to practice functional forms of the behavior and to reverse the deleterious effects of the problem behavior (Foxx and Azrin, *in press* 1972). Similarly, Surratt, Azrin and Sulzer (1972) eliminated mealtime infractions of retardates by an Overcorrection procedure in which the retardates were required to clean up food they had spilled, to obtain a clean utensil when one was dropped, to clean themselves when they spat or drooled and to replenish another's food supply after stealing.

The above-noted applications of the Overcorrection procedure have always been specific to a particular disruptive behavior. Some of this behavior apparently was not preceded by an agitated state, such as self-stimulating, the spilling of food and the soiling of clothes. There seems to be a possibility that in instances where the disruption was a result of an agitated, distraught state, the Overcorrection could be directed towards that agitated state, rather than towards the disruptive act itself. Examples of disruptive behavior which are preceded by an agitated state are self-injury, physical aggression, threats, screaming, crying, cursing and tantrums. The Overcorrection procedure for agitation would be overcorrective practice in being calm, composed and relaxed. Following an agitated disruption,

the disrupter would be required to spend an extended period in relaxation, such as in his own bed. This extended period of relaxation would serve both to correct the state of agitation, and give others a period of quiet and peace in recompense for the disruption. The place where practice in relaxation is given should provide both immediate physical removal from the disruptive situation and have connotations of quietude which would enhance learning to relax. The relaxation practice situation should also not be so removed from the normal environment as to cause concern about sensory deprivation from seclusion and isolation. Indirectly, a period of time-out from reinforcement would result from the enforced absence from the disrupted locale. Finally, relaxing might be of value in its own right because a relaxed person is less likely to develop physical abnormalities which may be caused by stress and emotional behavior (Selye, 1956). Foxx and Azrin (1972) used a required relaxation procedure as part of a more complex program to control the agitation of a mental patient; the relaxation procedure was not evaluated when used as the sole reaction, nor with other patients.

The following experimental investigation of required relaxation practice for agitative-disruptive behaviors was designed to answer several questions: (1) Does required relaxation practice produce an enduring inhibition of agitative-disruptive behavior? This question was answered by giving required relaxation practice to adult retardates for such agitative-disruptive behavior as self-injury, threats, physical aggression, screaming, tantrums, cursing and crying. (2) Does being in bed have an intrinsically calming effect on agitated persons? The retardates were observed during relaxation practice to see if the state of agitation rapidly subsided. (3) How do the attendants who apply required relaxation compare the procedure with others they have used, such as time-out seclusion? Ward attendants responded anonymously to a questionnaire designed to sample their attitude about the required relaxation procedure.

METHOD

Population

Eight mentally retarded adults from three wards of a state mental hospital were chosen for the study because they exhibited behavior that was dangerous or especially annoying and disruptive, and which prevented their training and discharge from the hospital. Their mean age was 31, mean IQ 27 and mean length of hospitalization was 19 yr. Two residents did not speak. One resident had family contact approximately once every 2 months; the others had averaged less than one family contact per year. All of them were receiving one or more psychoactive medications prior to the study, and these medications were not changed during the study. Five residents had received time-out in a padded room prior to this study, and each of them had violent tantrums and attempted to escape from the room. Time-out by seclusion was not effective for these five residents, possibly because it was applied inconsistently. Two other retardates were agitated but were excluded from the study because of the anticipated difficulty in keeping them in bed without constant physical restraint.

Individual resident descriptions

S1—Screaming and crying: *S1* was a profoundly retarded, 51-year-old female who had been hospitalized for 29 yr. She had minimal verbal behavior and could not engage in functional conversation. She frequently stood by a window and screamed and cried. Her

screaming could be heard throughout the building, and her crying consisted of body-shaking sobs accompanied by tears. This resident's sister wanted the resident to live with her, but after numerous home visits said she could not tolerate the screaming and crying.

S2—Self-injury and screaming: S2 was a profoundly retarded 21-year-old female hospitalized for 8 yr. She had some receptive language, but never spoke more than 10 words. She had been hospitalized because of self-injury and screaming. Her screaming could be heard at a distance outside the building when the windows were closed. She kicked and hit herself, banged her head on the floor while lying down and would run into walls and door jams in order to injure herself. Her face was constantly bruised and bleeding, and she had detached the retina of one eye, blinding that eye. She seldom socialized with other residents, and her disruptions were invariably started when she was denied food or objects. The hospital administration was reluctant to consider the use of pain-shock as a deterrent, in spite of its known effectiveness in reducing this type of self-injurious behavior (Bucher and Lovaas, 1968).

S3—Tantrums, threats, aggression and agitated questions: S3 was a moderately retarded 22-year-old male who had been hospitalized 5 yr ago because his family could not manage him. He was functionally verbal and formed an acquaintanceship with many staff members and residents throughout the hospital. He was hyperactive and easily excited, leading to tantrums, threats against staff, physical aggression and a barrage of repititious, non-functional verbalizations which annoyed both staff and other residents. He had previously been enrolled in training classes, but his disruptions became so severe that the instructors terminated his enrollment.

S4—Screaming, aggression, threats and cursing: S4 was a moderately retarded 27-year-old female who had recently transferred from another institution after 15 yr of hospitalization. She attempted to dominate the ward upon arrival and met opposition from both the residents and staff. All but one resident was afraid of her, and she created numerous situations which ended in her screaming, physically and verbally aggressing, threatening and cursing both staff and residents. She was judged relatively more intelligent than most of the residents on her ward, but could not be included in educational programs because of her frequent outbursts.

S5—Tantrums, aggression, arguing, cursing and screaming: S5, a severely retarded 28-year-old female hospitalized 16 yr, was liked by the staff on her ward because she spent a considerable amount of time helping them with various duties. Her social and work skills belied her residence on a ward for the profoundly and severely retarded, and she was the butt of numerous jokes from residents of an adjoining ward, which caused her to have tantrums and episodes of aggression, threats, cursing and arguing. She was considered an excellent candidate for discharge to a shelter care home if her disruptions could be curbed.

S6—Self-injury, aggression, stripping and crying: S6, a severely retarded 52-year-old female with 46 yr of hospitalization, could not be considered for discharge to a shelter care home since she was hyperactive. She bit and hit herself, hit other residents, stripped her clothes off and destroyed them and cried. Unlike many other residents, there was no readily apparent reason for her disruptions. Her verbal skills were so low that questioning her about her agitation provided no clues to the reason for the disruptions. When she was not engaged in disruptive behavior, she usually paced about the ward and muttered to herself.

S7—Tantrums, aggression, crying and stripping: S7 was a profoundly retarded 29-year-old male who had been hospitalized 22 yr. His only verbal behavior was echolalic, and he was highly excitable, jumping up and down pointing to himself and laughing when visitors came

to the ward. He preferred relating with staff members, and became agitated when other residents attempted to play with him. When agitated, he had tantrums, physically aggressed against others, cried, stripped his clothes off and ran about nude.

S8—Aggression: S8, a profoundly retarded 20-year-old male, had been hospitalized 15 yr. He had no functional verbal behavior and no social relationships with other residents except when he aggressed against them. Many of his disruptions occurred when staff members gave him directives; he then engaged in physical aggression against both staff and other residents by hitting and shoving them.

Experimental design

The design allowed a comparison between two conditions: (1) when there was no consequence for disruptions, and (2) when required relaxation was given following each disruption. The baseline method of evaluation was used (Sidman, 1960) in which the no-relaxation condition was in effect for several days, then the relaxation condition was put into effect. Baseline length was determined by the frequency and stability of disruptions, and ranged from a minimum of 5 days for one resident who screamed regularly to 5 weeks for another who aggressed sporadically. Residents were included in the study one at a time over a 6-month period. Baseline recording on a new resident was not begun until the previous resident was receiving required relaxation; this controlled against the possibility of a resident's baseline rate being influenced by the initial application of required relaxation to another resident. Extended, full-day relaxation periods were given during the baseline to observe the intrinsically calming effect of the relaxation period both during relaxation itself, and on the subsequent day to see if any lingering effect was present. Each resident had two of the extended relaxation days during baseline, with a minimum of one unrestricted day separating these days. The reasons residents were given extended, full-day relaxations during baseline, as opposed to the shorter relaxation period given during treatment, were to give them practice in relaxing at various times of the day, and to ensure that a maximum amount of relaxation occurred to facilitate a lingering effect the next day.

Response definition and reliability

The categories of disruptive behavior were physical aggression, verbal aggression, self-injury, screaming, crying, tantrums, cursing, stripping, threats against staff, arguing and non-functional verbalizations. Examples of behavior in each category are given under the description of the individual retardates. Each of the categories was explicitly defined with examples so the staff could easily differentiate them.

Reliability was provided by requiring two attendants to agree that a disruption had occurred. There was always a minimum of two attendants on duty. The gross audible characteristics of nearly all of the disruptions further enhanced reliability, ensuring that they would be detected immediately. The experimenter never disagreed with staff judgements of the many disruptions he observed.

Apparatus

Since staff members were frequently busy with normal duties and could not constantly observe the residents receiving relaxation, a mechanical means of monitoring each resident's relaxation practice period would be very useful. An apparatus was devised that was firmly attached to a leg of each resident's bed to signal staff members that a resident was out of bed.

An alarm was contained in a metal box measuring 4 × 5 × 6 in. and consisted of a battery-powered speaker activated through a micro-switch by a springed plunger supporting the bed leg. A force of approximately 75 pounds was required to keep the switch open. The apparatus was activated with a key by the attendant when he placed a resident in bed; a tone would then sound whenever the resident got off the bed and thereby removed his weight from it. This tone signalled the attendants that the resident was not in bed.

Baseline

Baseline recording was conducted in such a manner that the residents did not know they were being observed. Attendants ignored all disruptions during baseline except for physical aggression; when this occurred, the combatants were separated and verbally admonished, just as were all the other residents of the ward who were not included in the study.

Treatment

The major features of the relaxation procedure are summarized by the following printed instructions to the attendants.

WHEN A DISRUPTION OCCURS: Put the resident to bed immediately. Take his data clip board with you so you can turn the alarm on with the key fastened to it. Be sure the resident takes his clothes off and puts on a hospital gown.

WHAT TO SAY: Do not be verbally abusive. You may say: "You are disturbed and upset, and need to relax. You need to lie down for a while. I will tell you when you've relaxed enough and may get up".

LENGTH OF RELAXATION: Each relaxation practice period will be for 2 hr.

CONTINUED DISRUPTIONS: If there are disruptions during the last 15 min of a relaxation period, extend the period for another 15 min, and tell the resident why you are doing it. If they still continue, tell him he should remain in bed until he has had at least 15 min of relaxation.

WHEN THE ALARM SOUNDS: Tell the resident he has not relaxed enough and put him back to bed. He may go to the toilet once an hour.

RECORDING: Be sure to record the disruption, and the time in and out of bed, noting any extensions.

MEALS, ETCETERA: If a relaxation period spans a meal time, hold the food until the resident is out of bed. No smoking, eating, listening to personal radios or playing with objects is permitted while in bed.

Staff and other resident behavior during treatment. The experimenter and staff always referred to the procedure as relaxation. None of the resident's beds was moved to a special location, nor was traffic in and out of the sleeping area restricted. The staff ignored residents in bed, but no special instructions were given to any other residents about the procedure unless they were observed talking with someone in bed; they were then told that the person in bed needed rest and should not be disturbed. After the procedure had been in effect for 6 months, the staff members anonymously responded to a questionnaire about required relaxation. The questions dealt with their reactions to the procedure in comparison to other inhibitory procedures they had used, and its effectiveness and ease of application.

RESULTS

Figure 1 shows that during the last 5 days of baseline the retardates averaged about 7 disruptions per day. On the first day of relaxation practice, they averaged about 4 disruptions, or a 60 per cent reduction from baseline. By the second day, disruptions averaged less than 2 per day (70 per cent reduction); by the third day slightly over 1 disruption per day (85 per cent reduction); by the fourth day about 0.5 disruptions per day (90 per cent reduction), and on the fifth day about 0.2 disruptions for a 95 per cent reduction from baseline. Applying a Wilcoxin matched-pairs signed-ranks test (Siegel, 1956) to these data shows that by the second day, and every day thereafter, the reduction of disruptions was statistically significant ($p < 0.005$).

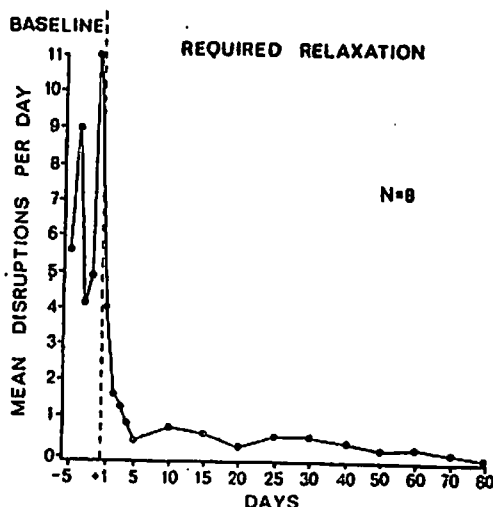


FIG. 1. The effect of required relaxation on agitated disruptions for 8 retarded adults. The data are for the last 5 days of baseline and the first 80 days of relaxation practice. Mean disruptions under treatment are shown for each day to the fifth day, for every 5 days to the 30th day, and for every 10 days to the 80th day.

After 8 weeks, the average reduction was about 95 per cent, and ranged from 84 to 99 per cent for individual residents. By the 12th week (84th day), S2 was accounting for nearly all of the disruptions, but after 10 months of relaxation practice her disruptions had been reduced by 97 per cent from her baseline rate, or to about 3 disruptions per week. The other 7 residents were averaging virtually zero disruptions per day by the 84th day.

Even when disruptions were not totally eliminated, the quality of the remaining disruptions seemed much less severe. For example, S2 had injured herself severely prior to the study, even blinding one eye. After approximately 10 weeks of required relaxation, her self-injurious behavior was practically symbolic, being limited to hitting her temple lightly with the heel of her hand. Also, her screaming changed from loud screeches to subdued and brief yelp-like sounds.

No disruptions occurred during the full-day relaxation periods. On the day following the full-day relaxation, there was a 10 per cent mean reduction in disruptions from the day

preceding the full-day relaxation. A Wilcoxin matched pairs signed-ranks test (Siegel, 1956) showed that this reduction was not statistically significant ($p > 0.25$).

When S5 was given her full-day relaxation period, she stated that it was a consequence for her misbehavior of the previous day. Although the ward attendants honestly assured her that such was not the case, a 60 per cent reduction in disruptions occurred during the next 11 days of baseline. After an additional 5 days, her mean daily disruptions had increased to 60 per cent of her previous baseline rate. She was given required relaxation practice without another baseline relaxation day. No other resident exhibited this modelling effect.

Staff reactions

The attitude questionnaire data of Table 1 shows that the attendants preferred the relaxation procedure by a 4:1 margin over other procedures, which included time-out and sedation. Perhaps most indicative of the reasonableness of the procedure is that 81 per cent of them said they would rather be seen administering required relaxation than any other procedure if visitors were on the ward. All attendants (100 per cent) recommended the procedure for future use and feasibility.

TABLE 1. TREATMENT PREFERENCES OF ATTENDANTS

| Question | Percentage of Responses | | |
|---|-------------------------|--------------|-------------------------------|
| | Required relaxation | Time-out | Other (including sedation) |
| 1. Which procedure do you prefer? | 74 | 17 | 9 |
| 2. Which is easiest to use? | 52 | 36 | 12 |
| 3. Which is most effective? | 75 | 20 | 5 |
| 4. Which would you rather be seen doing by visitors? | 81 | 7 | 11 |
| 5. Which is most humane? | 76 | 12 | 12 |
| | $\bar{X}=71$ | $\bar{X}=18$ | $\bar{X}=11$ |
| | Yes | No | |
| 6. Did required relaxation produce obvious behavior changes? | 96 | 4 | |
| 7. Would you recommend required relaxation for future agitated disruptions? | 100 | | |
| 8. Is required relaxation an economical procedure that doesn't interfere with other duties? | 100 | | |

Resident reactions

There was little difficulty keeping most of the residents in bed. The disruptions which occurred in bed were generally continuations of the agitative-disruptive behavior for which the residents were being given relaxation practice. For example, the behavior of S4 that caused her to be placed on required relaxation was so violent that it continued during the initial 15-20 min of the relaxation period, but only for the first 4 applications. It was necessary to restrain her at those times. Restraint was not required on the subsequent 5 times she received required relaxation. She was a recent transfer from another hospital where there had been no consequences for her violent behavior, and she had been used by the staff at the other hospital to subdue other unruly residents. She said to the staff at the beginning of this study that she would take orders from no one, and that she could not be forced to do anything. On the 5 subsequent applications of relaxation mentioned, she went to bed at first request and apologized for her behavior. All residents calmed during required relaxation, and all residents went to their beds at normal bed time; the three residents who had regularly taken naps before the study continued to do so.

Extensions to the required relaxation period were used repeatedly only with S2. Her self-injury and screaming was invariably elicited through social interaction, and the passage of attendants or other residents by her bed while she was on required relaxation would often be followed by outbursts of self-injury and screaming. Only one other resident required an extension to a relaxation period because of continued disruptions.

TABLE 2. SPECIAL BENEFITS TO RESIDENTS ALLOWED BY THE ELIMINATION OF DISRUPTIONS

| Resident | Benefit |
|----------|--|
| 1 | Discharged from the hospital to family. |
| 2 | Greatly increased family visits. |
| 3 | Resumed training classes, greatly increased family visits. |
| 4 | Resumed training classes. |
| 5 | Discharged from the hospital to a shelter care home. |
| 6 | Discharged from the hospital to a shelter care home. |
| 7 | Reduced disruptions. |
| 8 | Reduced disruptions. |

Table 2 shows the training and placement outcome of the treatment. Residents 1, 5 and 6 were discharged from the hospital because their disruptions had been virtually eliminated. Family members of S2 and S4 greatly increased the frequency of their visits and began planning with the staff for eventual discharge. S3 resumed training classes because his behavior was again acceptable to the instructors. S4 began attending training classes and working in a rehabilitation workshop in the hospital because her disruptive behaviors were eliminated.

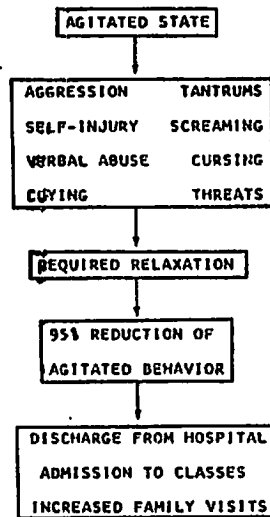


FIG. 2. A flow chart showing the types of behavior treated by required relaxation, and the treatment outcomes of the required relaxation procedure.

Figure 2 is a flow chart representation of the overall problem, treatment and outcome.

DISCUSSION

Required relaxation practice produced a rapid, nearly complete and enduring inhibition of several types of agitative-disruptive behavior in adult retardates. By the fifth day of treatment, disruptions were reduced by about 95 per cent. The inhibited behavior included self-injury, verbal and physical aggression, screaming, crying, tantrums and threats. There was virtually no recurrence of disruptions above this mean rate during the several months after the procedure was put into effect. Although disruptions were not totally inhibited in all residents, the quality of the remaining disruptions seemed much less severe after required relaxation was used.

There are three distinctive features of the required relaxation procedure for agitated disruptions which differ from other response inhibition procedures. (1) Required relaxation practice was not accompanied by emotional behavior as were response inhibition procedures using time-out seclusion (Burchard and Tyler, 1965; Wolf, *et al.*, 1964; Wahler, *et al.*, 1965; Burchard, 1967) or painful stimulation (Risley, 1968; Bucher and Lovaas, 1967). Instead, required relaxation practice had a calming effect on agitated retardates. (2) The overcorrective practice was not specific to a particular type of disruptive behavior as it was in previous Restitution studies (Azrin and Foxx, 1971; Foxx and Azrin, 1972; Surratt, Azrin and Sulzer, 1972) but was instead directed towards the agitated state of the retardate which occasioned the agitative-disruptive behavior. (3) The attendants who applied required relaxation preferred the procedure over any previous disruption inhibition procedures they had used, including time-out seclusion, sedation, injections of tranquilizing drugs, physical restraint and verbal admonishments.

The inhibitory power of required relaxation may be attributed to several characteristics of the procedure. First, relaxation calmed all residents following an agitated disruption. This calming effect was probably due to both the conditioned connotations of quietude from

being in bed, and from having been removed from the situation in which the agitated disruption occurred. Second, required relaxation provided an acceptable alternative behavior to disruptions. When a resident was relaxed, he was not provoking physical and verbal retaliation or reprimands from others, nor was he under the pressure of his own emotional state. Third, required relaxation was given only when a disruption had occurred, so there was some heuristic value to the procedure in that the residents were informed immediately of the unacceptable nature of disruptions and shown an acceptable alternative behavior. Fourth, required relaxation was an interruption of both the disruption and any other concurrent activities, so it could have functioned as a period of time-out from positive reinforcement. Numerous previously mentioned studies demonstrated that a period of time-out from positive reinforcement could inhibit disruptions.

Limitations to the relaxation practice procedure seem to be restricted to instances when agitative-disruptive persons are so violent and resistive to directives that they will not remain in bed without physical restraint. Two such persons resided on the wards where the present study was done, and they were not included in the study because physically restraining them would have violated one of the major reasons for developing the procedure, to find an inhibitory consequence which did not elicit emotional behavior from the disrupters nor cause adverse reactions from therapists or observers. One possible solution to this problem would be to use a graduated guidance technique (Foxy and Azrin, 1972) in which the disruptive person would be restrained in bed by hand with a gradual fading of restraint until the disrupter remained in bed unattended.

The three distinctive features of required relaxation mentioned earlier suggest that the procedure has advantages over other disruption inhibition procedures. Since the attendants who applied relaxation practice preferred the procedure over others they had used, and the residents did not exhibit emotional behavior as has been reported with other response inhibition procedures, it seems that relaxation practice would be more acceptable than other procedures. If attendants are comfortable with a procedure, the procedure is more likely to be applied consistently than would one which is distasteful to them.

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