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Aversives: Are they needed? Are they ethical?

By Alison Blake

"The Autism Society of America calls for a cessation of treatment and/or intervention which results in any of the following: obvious signs of physical pain . . . potential or actual physical side effects, including tissue damage, physical illness, emotional stress, or death; dehumanization of an individual with autism by the use of procedures which are normally unacceptable for non-handicapped persons in all environments; ambivalence or discomfort by family, staff, and/or caregivers regarding the necessity of such extreme strategies. . . and revulsion or distress felt by . . . peers and community members who cannot reconcile extreme procedures with acceptable human conduct."

– 1988 Statement of the Board of Directors of the Autism Society of America

"The banning of aversives will result in a resurgence of the use and abuse of psychopharmacological agents, state institutional services, and more neglect of those for whom we care so much. [It] will eradicate twenty years of progress in effective treatment of severe behavioral disorders associated with autism and stop the growth of community-based services capable and willing to meet the challenge of serving these very special people."

– David Holmes, Executive Director, The Eden Family of Programs

An "aversive" is an unpleasant stimulus intended to reduce undesirable behavior – for instance, a spray of water squirted at a child when he head-bangs or bites himself. Aversion therapy is used with self-injurious and aggressive autistic and retarded people, as well as in programs for smokers and alcoholics.

In the past several years, major disagreement has arisen over the use of aversives with autistic and other developmentally disabled individuals. Aversives supporters and opponents generally agree that positive techniques are preferable, that they should be tried first (and exhaustively), and that positive reinforcement works for the great majority of autistic and retarded children, including many with severe behavior problems. But the two groups are sharply divided over several key questions:

- Are aversives necessary, or can all behavior problems in all individuals be controlled by positive reinforcement only?
- Is it unethical to use aversives even if positive reinforcement fails? and,
- Can aversives be adequately monitored to ensure their safe use?

Are they necessary?

In 1985, Deborah Gorman-Smith and J. L. Matson reviewed approximately 40 studies done over a seven-year period and found that while non-aversive techniques worked in most cases, self-injury did not always respond to this approach.

"Obviously, positive treatments would be preferred over punishment procedures," the authors note. "However, the recalcitrant nature of the problems argues for punishment procedures when they are the only recourse for effective treatment."

Saying that "a hierarchy of procedures from positive to aversive is the preferred approach except in extreme [cases of self-injurious behavior] or life-threatening situations," they note that "in most instances when punishment was used, the authors [of the studies reviewed] have described other treatment attempts that were made, but which did not prove to be effective."

Many professionals disagree and are calling for the banning of most aversives, saying that aversives are an outdated approach and that positive techniques can handle virtually all children. Among them is Marcia Datlow Smith of Community Services for Autistic Adults and Children (CSAAC) in Rockville, Maryland.

"We have been able to successfully integrate adults with severe autism, and severe behavior problems, into the community using positive, non-aversive behavior management procedures," says Smith. "The clients we serve have a variety of behavior problems, including life-threatening self-injury (head-banging, self-scratching, self-kicking, self-mutila-

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ICBR data bank, ARRI pass major milestones

On Friday, the 24th of June, two long-awaited milestones were reached in the ICBR office:

1. ICBR has been collecting the Diagnostic Checklist (Form E2), completed by the parents of autistic children, for approximately 25 years, and now the total has exceeded 10,000.

The checklists have been submitted primarily by the parents of autistic children, although a substantial portion have been submitted by over 700 professionals from around the world with whom we cooperate.

The checklists which pushed the total over the 10,000 mark included a group of 60 from Korea, sent to us by Dr. Choi, vice president of the Korean Society for Autistic Children.

Each parent or professional who submits a completed checklist to ICBR receives, within a few days of receipt of the checklist, a computer-generated report form indicating whether or not the child is a case of classical early infantile autism (Kanner's syndrome). There is no charge for this service.

In addition, a number of studies are underway at ICBR which involve analyzing the 10,000-case data base in various ways to shed light on many of the questions that have been asked about autism for years, but for which insufficient information was available for scientifically sound answers. The results of these studies will appear in the ARRI, as well as in scientific and medical publications.

2. The subscriptions list for the ARRI reached 2,500 – our financial "break even" goal!

We are delighted that our newsletter has been so well received by parents and professionals, and and we thank all of our subscribers for their support. We hope you will continue to find the ARRI a very informative and helpful publication.