Debate over use of aversive therapy is heated

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professionals believe there is a "universal" non-aversive, mainstream technology which will work with both developmentally disabled and non-handicapped people, "this is not demonstrated and constitutes a denial of the special problems of autism reminiscent of the denial of autism manufactured by the psychoanalysts [in the past]." While "psychoanalysts believed people with autism were essentially normal and needed only psychotherapy," he says, some individuals today "seem to want to go them one better by suggesting they only need normal experiences. This seems to bring us full cycle for denying their special problems and needs."

In a 1987 article, Alan Kazdin, editor of the American Psychological Association's *Journal of Consulting and Clinical Psychology*, commented, "Some people say [aversives] fit nowhere [in the hierarchy of behavior modification techniques], but they are naive." He notes that non-aversive methods of controlling self-injury may take so long that severe injury can occur before the behavior is stopped. A related concern of many parents and teachers is that an autistic child's severe behaviors, if not stopped quickly, may cause injury to other children or adults.

Holmes says, "I feel very strongly that all treatment options must remain available . . . it is shortsighted of us to disregard the years of supportive data for the use of certain aversive interventions that enable people with autism to live productive lives."

An opposing view was recently taken by the Autism Society of America and The Association for Persons with Severe Handicaps; both have issued statements asking for cessation of all treatments causing "potential or actual physical side effects" or even "emotional stress."

Aversives opponents hailed the resolutions as humane and enlightened, while critics noted that parents and teachers of normal children routinely use procedures causing either physical side effects (e.g., extra laps in gym) or emotional stress (e.g., grounding for bad behavior).

Are aversives ethical?

A new organization, the International Association for the Right to Effective Treatment (IARET), believes aversives are humane and ethical under certain circumstances, and feels it is unethical to *withhold* aversives when non-aversive approaches are not effective in controlling serious behavior problems.

"Cosmetic attractiveness is not an acceptable substitute for demonstratable clinical effectiveness," say IARET representatives. "The tolerance of non-treatment, mistreatment, inappropriate treatment, or inadequate treatment of severely impaired individuals violates the precepts of, and cannot be acceptable to, a highly developed, enlightened society. Our objective and obligation must be to provide effective treatment – meaning a procedure or combination of procedures which most efficiently produces the greatest magnitude of change in a direction which allows the individual to function most adaptively in the greatest number of situations, and which benefits the individual most over the course of his or her lifetime. For some persons the right to the most effective treatment is tantamount to the 'right to life'; for all persons it is the 'right to a better life.'"

LaVigna and Anne Donnellan, however, argue in their book, *Alternatives to Punishment*, that "while effectiveness is an important consideration, other values should be considered as well. The intrusiveness, restrictiveness, and social acceptability of an intervention are also among the standards that should be considered in selection.

"One could argue, for example, that a locked iron mask would prevent nail biting," they add, "but the law and common sense would argue against such an intrusive intervention. It is, perhaps, the use of effectiveness as the sole criterion for selecting a procedure that partially accounts for much of the public outcry against behavior modification in general and punishment in particular . . . "

While Dr. B. F. Skinner, the father of behavior modification, has been considered a leading critic of aversive treatment, he commented this year in a "Statement on Punishment" that "if brief and harmless aversive stimuli, made precisely contingent on self-destructive or other excessive behavior, suppress the behavior and leave the children free to develop in other ways, I believe it can be justified."

"When taken out of context, such stimuli may seem less than humane, but they are not to be distinguished from the much more painful stimuli sometimes needed in dentistry and various medical practices," he added. "To remain satisfied with punishment without exploring non-punitive alternatives is the real mistake."

"I hope that we shall eventually discover methods that will make it possible to avoid punishment, but they do not exist at the present time and it is a mistake, I think, to oppose punishment if it can be shown to have an important future benefit to the person punished," Skinner commented in a 1988 letter.

A very different view, outlined in a 1987 manual from the Research and Rehabilitation Training Center (RRTC), is that there are "two important criteria for managing severe behavior problems:

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SIBIS UPDATE:

The makers of SIBIS (Self-Injurious Behavior Inhibiting Device), which controls severe head-banging using a very mild shock, report that the device has been used on 25 children and has proved helpful in all cases to date. Most of the children stopped head-banging entirely. (See SIBIS article in ARRI Vol. 1, No. 3.)

They also report that six of the original wearers no longer wear the device and have not resumed their head-banging.

HOTLINE :

Current information about non-aversive behavior modification techniques is available to parents and professionals free of charge from the RRTC (Research and Rehabilitation Training Center) hotline, 1-800-451-0608.

To the Editor:

Your last issue reported that Burd and Kerbeshian found "behavior modification" aggravated symptoms of Tourette Syndrome. The article did not report what procedure was used, but it inferred that behavior modification wouldn't work with persons with Tourette's.

There is one symptom of Tourette Syndrome, swearing, that gives a clue that a behavior modification program should not include direct attention to symptoms of this syndrome. The "inhibitory energy" the authors suggest is responsible for increasing the frequency and intensity of the behaviors is more likely the reinforcement received from negative attention, whether from systematic consequences or from the normal reactions of disapproval toward a child's learning to swear.

An effective approach to modifying behavior established by negative attention is the systematic reinforcement of appropriate behaviors combined with an extinction procedure for the inappropriate behaviors, plus the use of distraction when possible. It will not bring quick results, but it will not, unless flawed in application, bring about an increase in the target behaviors. This procedure is also behavior modification!

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