Debate continues over use of aversives (from page 6)

a) It is unacceptable to harm people, even when that harm is perceived as being in the person's best interest; and b) procedures used in response to severe, excess behaviors should be acceptable for use with nondisabled people in typical, age-appropriate, community settings."

Critics of this position argue that under RRTC's criteria of not "harming" people, heart surgery and appendectomies should be forbidden, as well as painful physical therapy, dental work, and vaccinations. Matson and Taras add that not using aversives may limit alternatives to institutionalization and drugs, and that "drugs, often used as restraint in place of behavioral treatment, frequently contribute to the fact that these persons often die from their condition."

Matson and Taras note that organizations calling for a ban on aversives are in some cases arguing "that it is contrary to the rights of the individual to interfere with his autonomy, even if the client is severely mentally impaired and even if that autonomy results in disfiguration, mutilation or sometimes, death."

Psychologist Beatrice Barrett points out that "100 years ago . . . a 'retarded' deaf and blind child with what today would be called severely atavistic or 'autistic' behaviors began her training with a devoted and inspired teacher named Annie Sullivan. The skilled author and lecturer who emerged from the forceful and often punitive but loving tutelage was, of course, Helen Keller. We should remember that this legendary success in first taming and then teaching Helen Keller came not because of prohibitions or restrictions on her treatment but because of the freedom given to the skilled teacher, Annie Sullivan, by Helen Keller's parents." A number of Sullivan's techniques – which included isolation, withholding of food, and "takedowns" – are among those now considered unethical by aversives opponents.

While Donnellan and LaVigna comment in *Alternatives to Punishment* that "one could hypothesize . . . that severe, self-injurious behavior might, in some rare case, justify the use of a highly intrusive, aversive contingency," LaVigna notes elsewhere that "strongly established ethical tenets in the field require us to use the least intrusive procedure effective in reducing a problematic response." He comments that an aversive "invariably sets up a roadblock to active listening and invalidates the person's right and attempt to communicate."

Better control needed?

In a recent article, Thomas Zirpoli and John Wills Lloyd note that "for many years, intrusive intervention strategies were employed to decrease inappropriate behaviors before less intrusive procedures were tried. Many of these treatments were conducted without appropriate assessment of the antecedents and consequences maintaining the maladaptive behavior. Moreover, many restrictive treatments were conducted without appropriate approval and monitoring by independent observers."

The researchers say that because the use of aversives has not always been properly controlled, "it is recommended that guidelines for the approval, use, and monitoring of all behavior reduction programs be established within all educational settings." They add that "it is important that provisions be made for substitution of less intrusive aversives whenever possible."

IARET concurs that aversives need to be carefully monitored, saying that "we also endorse the principle that treatment which is potentially intrusive should only be administered when appropriate informed consent has been obtained from the client, guardians, or (if required by local law) a court."

David Holmes agrees that monitoring is necessary, but says that "punishment and reinforcement procedures are simply tools; no more, no less. As with any tool, the potential exists for abuse. The challenge therefore is the control of the abuse, not the elimination of the tool."

Holmes recommends having Human Rights Committees and peer groups review aversives, and requiring parental consent. He feels that aversives should be used only when there is:

– documentation of unsuccessful attempts to use non-aversive techniques;
– adequately trained staff and appropriate staffing ratio;
– adequate baselines and ongoing data monitoring;
– criteria for generalizing across staff and different settings; and,
– criteria for ending the aversive procedure when the behavior stops or the school year ends.

Holmes worries that over-regulation will lead to an increase in "custodial care", and to denial of program services to children whose behavior cannot be controlled by other means.

Scott TenNapel, of Alternatives for People with Autism, Inc., believes that "given past and potential abuses, there is no doubt that the rights of this society's vulnerable individuals must be protected [but] there is a need to avoid fanaticism in establishing such guidelines, if 'throwing the baby out with the bathwater' is to be avoided. Decisions must be made which consider the need for effective treatment as well as human rights."

References available from ARRI upon request. Please send a stamped, self-addressed envelope.

The AUTISM RESEARCH REVIEW INTERNATIONAL is a quarterly publication of the Institute for Child Behavior Research, 4182 Adams Avenue, San Diego, California 92116.

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ISSN No. 0893-8474

Institute for Child Behavior Research
4182 Adams Avenue
San Diego, CA 92116

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PERMIT NO. 887

Autism Research Review International
Vol. 2, No. 3

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