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Thoughts About Aversive Treatments Of Children With Disabilities

Lou Brown

Emeritus Professor, University of Wisconsin

A small number of children manifest extreme behaviors that are deemed harmful to themselves and/or others. Such behaviors cannot be allowed to occur unchecked.

There may be chemical, biological, neurological, physical, environmental and other factors that determine or contribute to the manifestation of extreme behaviors.

There are safe, effective and nonaversive ways to constructively address extreme behaviors. Unsafe, painful, inhumane and otherwise aversive intrusions into the lives of children with disabilities cannot be tolerated.

Comprehensive biomedical and sensory analyses

I assume all behaviors are caused. Thus, I must ask "What are the causes of the extreme behavior?" I assume many behaviors are communicative. Thus, I must ask "What is the child trying to communicate with the extreme actions?"

I knew a woman who was not verbal and functioned with multiple disabilities who would not eat. She lost much weight and those responsible for her well being started putting food in her mouth. When they did, she regurgitated it. As her health and life became in danger, they decided to put food in her mouth and then give her an electric shock at the first overt signs of regurgitation. This did not result in swallowing, so the intensities of the shocks were systematically increased. She still did not swallow. Finally, someone arranged to take an x ray of her upper body. Anyone who looked at the x ray film could clearly see an open safety pin stuck in her esophagus. It was removed and the eating problem was solved.

There was a young man with significant autism who was acting in a very agitated manner. He would not sit. He moaned loudly and made a variety of other disturbing sounds. He hit himself in the head and bit the back of his hands. Restraints, seclusions and electric shocks were tried, but did not suppress the problematic behaviors. Fortunately, a general anesthetic was administered and a dentist discovered four seriously infected wisdom teeth. After they were removed, he still had autism, but the problematic behaviors were no longer observed.

I know a man who as a child was pinched, forced to eat foods he hated, slapped, shaken and isolated when he did not do what he was told to do by professionals. Occasionally, unknown to his parents, ice cubes were placed on his testicles. When he grew older, he would not let anyone touch him and some of his behaviors became dangerous to himself and others. Eventually, his parents arranged for him to be given a general anesthetic and examined by a team of three competent and concerned physicians. It was determined that he had a tumor on one of his testicles, an excess of fluid in his lungs, a stomach ulcer and a severe sinus infection. His biomedical problems were treated effectively and the extreme behaviors were no longer observed.

I enjoy riding my bike when it is raining and jogging when it is snowing. Rain and snow feel good on my skin. Some individuals with autism tell us that when rain or the shower water in their bathrooms contacts their skin, it feels like needles are being stuck in their bodies. To some individuals the physical touches of others are painful. To others the intensities of normal room noise are extremely upsetting. Some individuals need pressure applied to much of their bodies in order to calm down or relax. I believe them. Perception is unique and individualistic.

I know of many other situations of this nature, but I certainly do not know them all. When behaviors become extreme, comprehensive examinations by competent and experienced professionals are critical. Examination techniques that work for verbal individuals without disabilities or histories of abuse are simply not good enough. Sometimes general anesthetics are the only or the best ways to conduct much needed comprehensive biomedical examinations. If someone acts in an agitated manner in the rain, should we deliver electric shocks of increasing intensities until they stop or become unconscious? Absolutely not. Humane biomedical and sensory interventions, including evidence based and carefully administered and monitored drugs, can be effective components of treatments of extreme behaviors.

On science

No university that I know of would allow research on extremely aversive interventions with children. No state or federal funds that I know of could be used to study the effects of extremely aversive interventions on children. I know of no direct and credible research in the past forty years that supports the use of extremely aversive interventions with children with disabilities. If there is such research, I stand informed and corrected. Please refer me to the primary sources.

Some argue that relatively mild contingent electric shocks are sometimes effective and produce few, if any, discernable negative side effects. I am not aware of research that informs us of the invisible psychological and emotional effects of contingent aversive stimulation on children with disabilities. As most of the children who receive such treatments do not talk, I always felt that I should put myself in their position as much as I could. If someone treated me with painful or otherwise aversive stimuli, I would be a devastated and angry psychological wreck. I would be substantially different than if I was treated with compassion, tolerance, social justice, love and attempts to understand that I need help. Neither visible nor invisible agony can be tolerated.

Prevention - minimization

The United States contains at least three hundred million individuals; about eighty million are under the age of eighteen. In 2010, other than individuals with disabilities, how many are receiving extremely aversive treatments? I do not know, but I suspect fewer than those who did so in the past. Early Childhood Special Education, deinstitutionalization, respite services and other forms of in home assistance, improved teacher training, inclusive education, much better instructional and behavior management practices and many other phenomena have resulted in substantial reductions in the number of children who develop extremely problematic behaviors. Thus, each year the use of aversive interventions becomes less and less bearable.

On parents

Talk to anyone who works for any agency that deals with abused and neglected children or read your local newspaper. It will be clear that there are exceptional instances in which parents do not and should not have the inherent and sole right to determine the treatment afforded their children. I do not believe that parents have the right to determine that their children will have lobotomies, clitorectomies, experience extreme exorcism practices or be denied reasonable medical care.

Certainly, many parents punish their children with physical aversive stimulation. However, there is a big difference between a pat on the rear and electric shock. There is a big difference between natural contingencies such as touching a hot stove and thus learning not to touch it again and the premeditated, systematic and painful burning of tissue. Indeed, most parents take comprehensive precautions to prevent their children from experiencing painful and dangerous natural contingencies. Holding hands when crossing streets, blocking electric sockets and locking up kitchen chemicals and guns are examples. When parents sanction or do dangerous and harmful things, the needs and rights of a child supersede their wishes, beliefs, choices and inclinations.

"I tried everything"

Some teachers, parents and others say "I tried everything and nothing worked. Extreme behaviors excuse my use of extremely aversive and painful interventions."

They may have tried ten, twenty, thirty or more interventions, but unfortunately they did not try them all. Every day professionally defensible principles of functional assessment, nonaversive applied behavior analysis, positive behavior support, individualized curriculum development and other systems are being used safely, publicly and effectively. The number of reasonable and effective nonaversive intervention possibilities is infinite. Thus, there is no excuse for painful and demeaning aversive practices.

The laws of learning

Laws of learning are operative whether or not we know them or use them. I assume that if a child has learned to perform extreme behaviors, she/he can learn to perform social, functional, academic, communication, vocational, shopping, travel, recreation/leisure and a variety of other skills. When extremely aversive interventions are used, almost all other laws of learning are overpowered or suspended, environments and activities are restricted, positive alternatives are denied, disallowed or suppressed and approaches to the development of children become circumscribed, simplistic and primitive. It is not fair to disallow a child opportunities to benefit from all the laws of learning in all the settings and activities feasible.

Public scrutiny

Children with disabilities are safest, learn the most and develop to the fullest when they function with natural proportions of individuals without disabilities who are and are not paid to be with them. All treatments of children who manifest severe behavior problems must be public and scrutinized carefully by concerned and informed peers and adults in authority. The history of abuse in segregated, homogeneous, isolated and nontransparent settings is abominable. Painful and other aversive interventions are not tolerated in integrated settings and activities.

Alternatives to aversive treatments

Assume we are considering two mutually exclusive ways to deal with the unfortunate reality of extreme behaviors: painful and otherwise aversive interventions and those that are nonpainful and otherwise nonaversive. Which would you choose? There is no doubt that intense electric stimulation and other extreme interventions can suppress behavior. The electric chairs used in prisons, the taser guns used by some police and cattle prods are examples. Nonpainful and otherwise nonaversive practices should be our choices. Why? Because they work. They result in better generalization. They are more humane. They can be implemented in integrated settings and activities. They allow the search for and the teaching of constructive alternative actions. They are likely to cause little or no visible or invisible emotional harm. They can be changed at little cost if evaluated as ineffective. They compel us to search for communicative intent. They...

In short, I am not a slippery slope extremist. I realize that each of us has a breaking point. However, before we become overwhelmed by powerful and valid local circumstances and succumb to the regressive temptation to administer electric shock, break ammonia capsules in her nose, pull out bits of

her skin with nail clippers, put ice cubes on his testicles, slap her face or engage in similar extremely aversive activities, give someone else a chance. Contact TASH at www.tash.org; the National Technical Assistance Center on Positive Behavioral Interventions Support at www.pbis.org; Mental Disability Rights - International at www.mdri.org or another source of nonaversive assistance.

In May of 2010 I was contacted by Laurie Ahern and Eric Rosenthal of Mental Disability Rights - International. They were seeking individuals to address the topic of the painful and otherwise aversive treatment of children with disabilities on the American Broadcasting Company's television program - Nightline. I considered the possibility and recorded my thoughts on the subject which evolved into this article. However, someone else was selected to be on the program. Connie and Harvey Lapin, whose son with significant autism has been abused by aversive intervention strategists, Wayne Sailor of Kansas University, Alice Udvari Solner and Kate Ahlgren of the University of Wisconsin, Barbara Trader, the Executive Director of TASH, Eileen McCarthy of SUNY Old Westbury and several others provided valuable assistance, but I am responsible for the contents. A version will be published in TASH CONNECTIONS.