SIDMAN ON AVERSIVE CONTROL

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There is no way to overstate the importance of Murray Sidman’s contributions to applied behavior analysis. This series of Remarks represents just a few of those. I’d like to take this opportunity to restate some of Sidman’s (1977) comments on aversive control and illustrate why these are particularly relevant to the practice of behavior analysis today. Applied behavior analysts are presented with a daunting challenge with respect to aversive control. Indeed, many persons in the lay community associate behavior analysis with aversive control. This association is both puzzling and deserved. It is puzzling in that some of the most revered behavior analysts have extensively detailed the pitfalls and potential folly of the systematic application of aversive control. It is deserved in that there are numerous instances, both historically and currently, of behavioral practitioners relying heavily on punishment, in general, and the application of painful aversive stimulation, specifically.

Sidman’s (1989/2001) Coercion and Its Fallout is a personal testimonial on how aversive control’s intended and unintended consequences are not to be trivialized. Sidman is not the only behavior analyst to caution us on this means of control. In Science and Human Behavior Skinner (1953) suggests that “punishment, unlike reinforcement, works to the disadvantage of both the punished organism and the punishing agency” (p. 183). Several of Skinner’s and Sidman’s writings describe the problems generated through punishment in educational environments and society as a whole in addition to explicitly detailing the problems with punishing the behavior of an individual.

So why would we even consider punishment? Sidman (1989/2001) suggests that “(t)he most reasonable objective in using punishment is to stop undesirable behavior, to keep someone from doing things that are dangerous, frightening, or that we consider inappropriate, disadvantageous, immoral, or abnormal” (p. 77).

The case of life-threatening self-injurious behavior offers a seemingly clear situation that would justify the use of punishment, even electric shock. However, Sidman (1977) notes that before punishment is chosen as an intervention, a clinician should evaluate all the alternatives. He suggests Goldiamond’s (1974, 1976) proposal of a decision matrix for evaluating the alternatives for treating self-injurious behavior. If the clinician considers all possibilities and punishment is...
selected, they may proceed with justification. Sidman (1989/2001) states that there are two routes. One is to use strong punishment to “beat the devil out of him” (p. 77). The other is to arrange for mild punishers to temporarily halt the behavior and arrange for positive reinforcement for appropriate alternative behavior. Whether either strategy will work is an empirical question.

I recall one of my first extended conversations with Murray when I arrived at the New England Center for Children. I had just completed four years of working with persons who had severe problem behavior, the last three treating pediatric feeding disorders. Although a large percentage of these children responded to positive reinforcement-based interventions, some of the children we treated refused to accept any food by mouth and required intrusive interventions to produce food acceptance. I was embarrassed to talk about this experience with Murray, and the toll of using intrusive procedures weighed heavily on me. The treatments we selected may have been easily justified. We started with reinforcement-based procedures but then moved on. There were no other effective behavioral interventions, and relying on gastrostomy feedings is not a desirable long-term strategy. Nonetheless, it was no different from many cases of intractable self-injury that do not respond to reinforcement-based procedures. A clinician reviews the available alternatives but then chooses contingent electric shock. When treating any problem behavior we have the decision matrix as represented by the published treatment literature to help us, but is that enough? Intrusive treatments may decrease the target responses, but have we provided the optimal learning environment for appropriate alternative responses to meet positive reinforcement? Will lasting change occur? Will we be able to remove the aversive contingency? These are the questions I felt Sidman (1977, 1989/2001) had challenged me to answer.

I felt an obligation to justify my behavior, but through our discussion I learned that this obligation was not something I owed Murray or the field. Rather, this obligation was to myself and the clients that I served and would serve in the future. As Sidman (1977) put it, “Even a single ethically justified application of aversive control may, then, lead to widespread application of such control without appropriate justification” (p. 128). That is, treatment success may result in the behavior of the clinician coming to be tightly controlled by a potent schedule of reinforcement. Had I become reliant on punishing refusal and preventing escape? Did I truly exhaust all alternatives? Was enough attention paid to the contingencies arranged for appropriate behavior? One profound effect Murray had on me was to make me continually question my own behavior.

Every clinician needs to realize that one justifiable application of painful aversive stimulation may lead to “casual” choice of this strategy, and “One must ask whether the indiscriminate use of (painful aversive stimulation) . . .cancels the justification for its use with the first child” (Sidman, 1977, p. 128). When this was written there were far fewer choices for treating severe problem behavior. It might have been easier in the past to throw one’s hands up in the air because no one had encountered the type of problem a client presented. Punishment becomes a default strategy. There were also few techniques for precisely determining the controlling
variables of problem behavior. We could debate the appropriateness of allowing severe problem behavior to go untreated while time is spent systematically identifying the function of the presenting problem. However, there is no debating that the advent of functional analyses of problem behavior as a research tool has led to the development of numerous innovative and effective treatment choices. More importantly, it has been associated with much less reliance on aversive control (Pelios, Morren, Tesch, & Axelrod, 1999).

The time has come for a major overhauling of the decision matrix with respect to treating severe problem behavior. The costs of indiscriminately relying on aversive control affect the client, the clinician, and society. Will there be situations in which the choice of aversive control will be the correct choice? Probably, but selection of this alternative should be rare, and in any case it should not be relied on as a primary treatment modality. Besides the myriad of treatment alternatives, there are serious efforts at both the local and national level to more stringently regulate or explicitly ban certain procedures related to treating severe problem behavior. There is currently legislation before the United States congress (HR4247; the Keeping All Students Safe Act) that would likely prohibit the use of many—if not all—aversive interventions. One of the ironic aspects of this bill is that it would not allow systematic inclusion of restraint and seclusion in behavioral programming. Rather, it would mandate that any such usage of these procedures would have to be unplanned (i.e., used only in “emergency situations”). Sidman suggests that a public mistrust of applied behavior analysts’ use of aversive control will lead to “proscription and banishment” (1977, p. 128) unless behavior analysts acknowledge this dilemma and act accordingly. That day is, perhaps, upon us. Will it come to pass that aversive control will not be available in those dire situations in which it is warranted because of the casual and indiscriminate use of aversive control?

References