GUIDELINES FOR THE USE OF AVERSIVE PROCEDURES

While scientific evidence for the efficacy of aversive procedures for a variety of psychological conditions exists, their use remains controversial (Starker & Pankratz, 1996). These guidelines have been developed in the context of the need to protect human rights to autonomy and dignity. Furthermore, these guidelines have been developed with reference to the Code of Ethics, particularly the imperative to safeguard the welfare of clients (General Principle I), to act within one’s competence and to offer competent services (General Principle II). At times, these guidelines need to be considered together with other relevant guidelines and specific sections of the Code (e.g., Ethical Guidelines Relating to Procedures/Assessments that Involve Psychologist-Client Physical Contact; relationships with clients [section B8 of the Code]; draft Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients). While legal, ethical and social implications abound regarding the use of aversive procedures (Gerhardt, Holmes, Alessandi, & Goodman, 1991), these guidelines are aimed at limiting their inappropriate use.

Aversive procedures involve the presentation of an unpleasant consequence contingent on the occurrence of a targeted behaviour. Aversive procedures are not intended to cause pain or harm to the individual. A distinction can be made between overt and covert aversive procedures, with most controversy focused on overt aversion (e.g., electric shocks, water sprays, Antabuse, pinches, snapping elastic band around wrist) which causes the individual to experience varying degrees of discomfort or distress from an external source. Covert aversive procedures, on the other hand, usually involve an internal noxious stimulus (e.g., imagining an awful contingent event) and are generally self-initiated. Aversive procedures are used in combination with other behavioural and cognitive strategies, and have been found to be useful in the management of impulse control problems (e.g., nail biting, compulsive hair pulling), smoking cessation, weight loss in obesity, binge eating and alcoholism. Aversive procedures are used most commonly in the areas of development disabilities (Repp & Singh, 1990) and to deal with disorders of sexual arousal such as paedophilia and exhibitionism (Eccles & Marshall, 1994; Maletzsky, 1998; McConaghy, 1990). The concomitant use of other strategies, often targeting the development of adaptive behaviour, is an important component of most intervention programs which include aversive techniques (Durand, 1990). Aversive procedures need to be distinguished from electro-convulsive therapy (ECT), a psychiatric treatment used most commonly for severe major depression.

There is debate in the scientific literature as to whether the use of aversive procedures is necessary, although much of this debate is in the area of developmental disabilities. For a discussion of this debate in the developmental disabilities area, see La Vigna and Donnellan (1984), Scotti, Evans, Meyer, and Walker (1991), Repp and Singh (1990), Durand (1990), Gerhardt et al. (1991), and the special issue of the American Journal of Mental Retardation (Issue 2, 1990). However, given that practitioners may choose to use aversive procedures, the following guidelines should be adhered to when using them.
General Principles

- Aversive procedures should be used only if the scientific literature supports their use for a specified condition.

- Aversive procedures should only be used when the targeted behaviours are clearly of danger to the client or others, and there is well documented evidence that non-aversive interventions by competent practitioners have been tried and failed.

- Aversive procedures should only be used within a broad program of intervention and management. In addition to the use of aversive procedures for reducing challenging behaviour, there must be concomitant intervention programs to promote the adaptive skill levels of clients.

- In all instances where aversive procedures are used, informed consent must have been given by the client or a legal guardian of the client prior to commencement of their use. Developmentally and culturally appropriate explanation of the aversive procedure and its objectives must be provided to clients.

- Psychologists using aversive procedures must always be familiar with and comply with any legislative requirements regarding the use of aversive procedures.

- Psychologists who use aversive procedures should have an advanced level of training in the use of behavioural therapies.

- In all instances where aversive procedures are used with developmentally and intellectually disadvantaged populations and children, a broadly based group should monitor the use of such procedures. This group should include specialists in the use of aversive procedures, and people who safeguard the rights of the client. In the case of non-intellectually disadvantaged consenting adult clients, it is advisable that the treating psychologist using aversive procedures seek advice and/or supervision from colleagues.

Specific Recommendations

Assessment

- The first step in the use of aversive procedures must be a clear specification of the behaviour (or behaviours) on which they are to be used.

- A reliable baseline measurement of the target behaviour must be taken, and its status must be evaluated throughout the aversive intervention process.

- The assessment process must include an assessment of the functional behaviour.

- The outcomes of the assessment process must be thoroughly documented.

- In assessing the use of aversive procedures, psychologists should consider not only the nature of their client’s specific target behaviour, but also broader client characteristics. For instance,
psychologists need to consider very carefully whether they should use aversive procedures with clients at risk of self-harm or with clients who might gain pleasure from their use.

**Deciding to proceed with the aversive procedure**

- There must be documentation of the factors that were considered in making the decision to proceed with the aversive procedure.

- Before a decision is made to use aversive procedures, a conclusion must be drawn that all possible non-aversive procedures have been tried and failed, or that other untried procedures would result in unacceptable danger to the clients (e.g., the use of extinction for self injurious behaviour that could result in significant damage to the client before it was effective).

- The baseline rate of the target behaviour ought to be considered as constituting a danger to the client or others.

- If a decision to proceed with an aversive procedure is made, the rate of behaviour required to be achieved for successful intervention must be agreed to by the client or guardian.

**Selection of Intervention**

- The scientific literature about the efficacy of an aversive procedure for a specific targeted behaviour must be considered in selecting aversive interventions.

- The selection of the intervention must take into account all information gathered in the functional assessment of the behaviour.

- The selection of the intervention must generally be based on the Principle of the Least Restrictive Alternative, that is, less aversive procedures must be tried before more aversive procedures are tried. Deviations from this principle must be justified, documented and be guided by informed client (or guardian) consent.

- At the same time as aiming to decrease the target behaviour, interventions must also aim to increase adaptive behaviour.

- The interventions to be implemented must be thoroughly documented, and all significant individuals associated with the client should be familiar with intervention.

**Implementation of the intervention**

- The implementation of the intervention must be carefully monitored to ensure treatment integrity. Such monitoring must be documented.

- The occurrence of the target behaviour must be monitored continuously during intervention.

- If the continuous monitoring shows that the target behaviour is not improving at the desired rate, the intervention must be reviewed and changed or terminated as necessary.
Evaluation of intervention

- A primary focus in evaluating the success of intervention must be the direction and extent to which the target behaviour has changed as agreed with the client or guardian in the assessment process.

- A secondary focus in evaluating the success must be an assessment of the other aspects of the client’s functioning, that is, has the intervention resulted in changes to other aspects of the client’s life.

- An assessment of the client or guardian satisfaction with the intervention must be undertaken.

- All outcomes of the intervention must be thoroughly documented.

References

*American Journal of Mental Retardation* (1990), 95, Special Issue.


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