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*Parents Speak*

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**REACTIONS TO "EMPLOYING ELECTRIC  
SHOCK WITH AUTISTIC CHILDREN"<sup>1,2</sup>**

**Introduction**

The ethical issues related to the use of behavior modification, particularly the use of electric shock, appear far from settled. There are parents and professionals (in law, as well as in medicine and education) who espouse the view that behavior modification in any form is an intrusion into the individual psyche, an abridgment of individual rights, and, at best, produces flesh and blood robots. For these reasons behavior modification is perceived as dangerous even when applied to populations with some psychological defenses (e.g., prisoners or "normal" school children); it is seen as even more threatening to the psychologically vulnerable child with autism.

But even when behavior modification is accepted as a legitimate treatment modality, there are reservations about the use of aversives, especially electric shock.

When the Lichstein-Schreibman paper was accepted for publication in JACS, it seemed to provide an appropriate forum for parent-professional dialog on this issue. Interestingly, no parent or advocate could be found who would present an unqualifiedly negative reaction to the thesis of the paper. It may also be of interest that all parent respondents are also professionals.

It is, therefore, the editors' hope that this parent column and the paper on which it is based will stimulate further reactions which we will present in future issues.

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<sup>1</sup>The article discussed in this column is Lichstein, K. L., and Schreibman, L. Employing electric shock with autistic children: A review of the side effects. *Journal of Autism and Childhood Schizophrenia*, 1976, 6, 163-173.

<sup>2</sup>Requests for reprints should be sent to National Society for Autistic Children—U.S.A., 169 Tampa Avenue, Albany, New York 12208.

## COMMENTS

My experience with the use of electric shock has demonstrated its effectiveness in suppressing dangerous behaviors. I have also observed misapplications of the technique obviously not reported in the literature. The need for precautions and guidelines for the decision to use and administer shock cannot be overstated. Issues of safety as well as ethical and legal concerns are reported in *Behavioral Engineering* (1975) articles with extensive bibliographies.

The decision against shock is not only made on "emotional grounds." While the article suggests that there are not "well-founded fears" that should cause one to avoid the use of the procedure, there are well-founded behavioral and educational principles as well as data supporting other tactics. While it cannot be denied that shock is painful, we have found that its effects seem more dependent on its alerting or interrupting value than on a high degree of pain. It is a unique experience which registers immediately. When behaviors are not dangerous and the need for intervention is not imminent, procedures maximizing positive learning and contact are preferred and valued for long-term effects. Such procedures, of course, require competent behavioral analysis and creative teaching techniques. An appropriate behavioral contract and a responsive reinforcing environment must be designed for each child. I am *concerned* that the simple count of reported effects is taken to imply the feasibility of shock to obtain the identified positive side effects directly. The authors' stress on careful analysis of objective criteria is to be heeded.

My colleagues and I would include clinical judgment and interpersonal values among our criteria. Shock would be advocated for severe self- and other-directed aggressive and dangerous behaviors and only in conjunction with training for appropriate alternative behaviors, including affective expression. Evaluation of each child's behavioral repertoire would determine the tasks, play, resting or slowing-down skills to be taught. The learning paradigm for aggressive behaviors has been described in the literature and observed with teachers and parents. The child still has a right to express his emotional state, physically and verbally; this may be frustration, anger, anxiety, boredom, etc. Interveners may choose not to interpret; behavioral assessment of appropriate response patterns is sufficient. Criteria for implementation of shock administration and suggestions for alternative behavior training are described in an article printed elsewhere (Creedon & White, 1975).

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## REFERENCES

- Behavioral Engineering*. Safety, ethics and legal series on aversive shock. 1975, 3, 1-5.
- Creedon, M. P., & White, W. J. The use of electric shock and development of alternative behaviors. In M. P. Creedon (Ed.), *Appropriate behavior through communication* (2nd ed.). Chicago: Dysfunctional Child Center Publication (Michael Reese Medical Center), 1975.

Kenneth Lichstein and Laura Schreibman have performed a valuable service in this most interesting paper, which summarizes the existent literature about the positive and negative side effects resulting from the use of contingent electric shock for reducing maladaptive behaviors in autistic children. Their review of the literature demonstrates that the use of shock as an aversive stimulus is an effective treatment procedure, and that the reported side effects are generally positive. The authors conclude that the decision regarding the therapeutic use of shock should be based on an objective assessment of the child's needs and the available alternatives, rather than on the therapist's emotional reaction to the use of the shock device.

Lichstein and Schreibman make no specific mention of any restrictions that should be set up around the use of shock. While a discussion of restrictions is admittedly outside the scope of their paper, I am nevertheless uncomfortable with this implied (and probably unintended) *carte blanche*. Precisely because it is a controversial therapeutic procedure, electric shock requires the establishment of very carefully articulated safeguards to prevent its abuse.

The authors say that the "evidence . . . that response-contingent shock is a powerful, effective technique for suppressing undesirable behaviors . . . is not necessarily a blanket approval for its use," but they cite no instance where they *disapprove* its use. Instead, they (quite properly) stress the need to use shock correctly if it is to be effective. Solely in the context of the fact that some therapists refuse to use shock "because of their own strong adverse philosophies," they mention the desirability of developing effective alternatives to the shock procedure, and describe some other aversive consequences which have already been developed.

It is, of course, beyond the purview of their paper for Lichstein and Schreibman to outline a specific class of target behaviors for which, because of the harmful potential of the behavior, the use of shock should be the treatment of choice. The same limitation applies to their delineation of circumstances or situations where the shock procedure would be clearly inappropriate. But the omission of any mention of suitable and/or unsuitable

target behaviors for the use of electric shock leads to the inference that the authors give their unqualified endorsement to the use of shock for the suppression of a wide variety of undesirable behaviors in autistic children.

We ourselves have found it necessary to use electric shock with a severely self-destructive Rimland School client. As a consequence, I am convinced that there must be very specific guidelines governing the use of shock. I believe:

1. Electric shock should be used only to extinguish or suppress severe self-injurious behavior, or other forms of hazardous behaviors which hold the imminent potential for extreme and irreversible bodily damage.
2. The target behavior must be clearly and specifically described in writing.
3. Concurrent with the use of shock, there must be an ongoing program which is designed to teach the child more appropriate alternative behaviors for the expression of his negative emotions.
4. Shock should never be used in any situation where a less powerful intervention is effective (even though accomplishing the desired result is a much slower process than it might be with the use of shock).
5. Shock should never be used without medical approval and ongoing medical consultation and supervision.
6. There should be an impartial review board which periodically reviews the continued use of this procedure, to determine whether the child may have progressed to the point where a more moderate alternative may prove equally effective.

Still other safeguards to prevent the abuse of the shock procedure would require that every person who administers a shock should first experience it himself, that there be an informed consent from the child's parents or guardians, that there be carefully maintained written records, et cetera.

I agree with Lichstein and Schreibman that electric shock is an effective treatment procedure. I believe, however, that it should never be used unless and until every more moderate alternative has been explored and has proved ineffective.

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The Lichstein and Schreibman article makes a number of important points about the use of a specific punishment with autistic children: electric shock. Unfortunately, the article suffers from serious flaws in both clinical judgment and scientific merit. First, the authors ignore one of the most troublesome negative "side effects" of continued use of electric shock—public revulsion and resultant backlash on behavior modification techniques in general. Second, Lichstein and Schreibman do not mention the inherent biases of publishing. Would researchers or clinicians be inclined to report ineffective use of electric shock, or cases where negative effects outweigh the positive? Third, the authors, in an offhand comment, note that misapplication of shock could be a problem but fail to offer detailed guidelines for its "proper" use. Although our experience may be atypical, we know four families which, in desperation and without professional guidance, have resorted to use of electric shock on their developmentally disabled children. In none of the cases have the long-run effects been positive. In our opinion, the critical issue is failure to teach other, more appropriate behavior no matter what specific punishment is used. Fourth, the authors overstate the emotional difficulty experienced by those who administer shock, and display no awareness that dramatic changes in a child's behavior may reinforce a therapist to use electric shock again for yet a wider range of behaviors. As a result, the therapist's attention is more likely to continue focused on punishment rather than teaching. Fifth, the discussion of conditions under which use of electric shock may be justified is woefully inadequate.

Lichstein and Schreibman note the occasional lack of generalization and offer as a solution more use of electric shock in nonclinical settings. Since the use of shock is considered by most members of our society to be dehumanizing, and since it is subject to abuse, we urge an emphasis on alternatives and tighter guidelines when it is used. We suggest electric shock be used only in those rare cases where (1) the client is severely self-destructive or aggressive, and (2) no other effective intervention is feasible. With imagination and present know-how, instances for the appropriate use of shock would be rare. Even then, (1) each use of shock should be reviewed in advance by an ethics committee composed, in part, of parents and members of the public; (2) at least two responsible adults should be present whenever shock is administered; (3) the therapist should shock himself each time he shocks a client; and (4) use of shock (or, for that matter, any punisher) should be accompanied by commitment to positive teaching and to a strategy to occupy the client's time appropriately.

In summary, electric shock should be treated as a last resort and used with great care. With rare exceptions, the application of other response costs (e.g., overcorrection) will suppress maladaptive behaviors and bring about the same beneficial "side effects" that apparently stem from use of electric shock or, for that matter, any strong intrusion. Behavioral technology has reached the point where several specific uses of electric shock reported in the literature of the 1960s and early 1970s can no longer be ethically justified.

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