Psychotherapy Guidebook

Aversion Therapy

Max Mastellone

Aversion Therapy

Max Mastellone

e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

Table of Contents

Aversion Therapy

Max Mastellone

DEFINITION

Aversion Therapy, also known as aversive conditioning, is not in and of itself a discrete form of treatment. Rather, when properly used, it is a technique that forms but a part of a comprehensive behavior therapy.

Very simply, Aversion Therapy is an attempt to establish a durable association between an undesirable behavior and an unpleasant stimulation. Target behaviors may include overt actions as well as private events, such as thoughts or feelings. Implementation of Aversion Therapy may follow either a classical (Pavlovian) conditioning paradigm — simple association by contiguity — or an operant (Skinnerian, instrumental) conditioning paradigm wherein the unpleasant stimulation is made a consequence of the undesirable behavior. The conditioning is designed to create a learned connection between the undesirable behavior and the unpleasant stimulation, which is expected to bring about the elimination, or at the very least, a reduction of the target behavior in question. Presently, aversive conditioning is not frequently or widely used, and its application is limited to certain circumstances.

HISTORY

Clearly it was Pavlov's extensive investigation of the phenomenon of classical conditioning that laid the basis for the therapeutic use of aversive conditioning in humans. In particular, it was his demonstration that conditioned aversion responses could be established in dogs. According to Franks (1977), work by Kantorovich in 1930 in the Soviet Union represents the first formally documented attempt to use aversive conditioning in a therapeutic situation. This investigator treated alcoholics with electrical Aversion Therapy and reported that most abstained from alcohol use for months. While other early work employed electrical stimulation with apparent success, Frank reports that through the 1930s and 1940s Aversion Therapy primarily consisted of the treatment of alcoholism by means of nausea-inducing drugs.

Due to the incorrect application of conditioning principles by ill-informed clinicians, and to the use of sedative drugs with patients of therapists who were unaware that such drugs disrupt the formation of conditioned responses, the use of Aversion Therapy as a treatment for alcoholism lost favor. With the rise of behavior therapy as a distinct field starting in the late 1950s came the resurrection of aversive conditioning. Researchers oriented toward clinical work and knowledgeable about learning theory refined and perfected aversive procedures. Behaviorally oriented

clinicians undertook widespread and diverse application of Aversion Therapy. Through these experiences many behavior therapists were forcefully reminded of the complex nature of humans and found that, generally, aversive procedures had value only within the context of a multifaceted behavioral regimen. When used alone, such procedures often produced only poor or short-term results, unless the target behavior was a relatively circumscribed habit, such as smoking or hair pulling, exhibited by an otherwise well-adjusted individual.

TECHNIQUE

As indicated earlier, Aversion Therapy can be practiced through either classical or instrumental conditioning. Under each of these conditions the technique would vary somewhat, as it would between overt, physical aversion procedures and covert, cognitive aversion procedures. The basic technique involves pairing the undesirable behavior with a noxious stimulation or having the latter occur very shortly after the former. For example, a smoker may be treated by delivering a brief, high voltage, low amperage, harmless shock to the hand holding the cigarette as he begins taking a puff. Treatment might consist of a number of sessions on different days, each comprised of a series of smoking-shock trials. An instrumental conditioning paradigm is illustrated in a study by Meyer and Crisp (1964). They administered electric shocks to two obese patients at some stage during

their approach to, or eating of, favorite foods. The shocks were stopped as soon as the patients pushed the food away or stopped eating it. As avoidance behavior became established, the patient was exposed to the tempting food for progressively longer periods while the frequency of shocks was diminished. This design is an example of instrumental escape learning.

In recent years Aversion Therapy procedures have been adapted and developed for self-administration. Using a pocketsize, battery-operated shock box, an individual can deliver shocks to himself whenever he intends to commit or does commit an unwanted behavior. Such a device gives an individual the freedom to administer noxious stimulation on potentially 100 percent of the occurrences of the behavior in question. In the same vein, the application of a rubber band worn on the wrist can be an aversive procedure (Mastellone, 1974). In one case, a fifteen-year-old girl had the habit of pulling strands of hair from her scalp, one after the other. She was instructed to wear a rubber band, stretch it and snap it on the underside of her wrist immediately after each instance of hair pulling, or whenever she had the urge to pull out her hair if she became aware of this first.

The recent emphasis in behavior therapy on the development of procedures to enhance self-control has coincided with (if not been encouraged by) the reemergence of the view that cognition is an important determinant of behavior. A significant contribution to these events was

Cautela's (1966) introduction of the covert sensitization technique. This is a self-administered, cognitive aversion therapy procedure. It involves having the individual imagine a scenario wherein he experiences a highly aversive stimulation, such as severe nausea and vomiting, in connection with committing the unwanted target behavior. The technique may be extended to apply to covert behavior, such as obsessive ideation, as well.

In addition to chemical and electrical noxious stimulation and the others mentioned above, such things as noxious odors, smoke inhalation, high-intensity auditory signals, and traumatic respiratory drug-induced paralysis have also been used.

APPLICATIONS

In regard to the application of aversive conditioning procedures we need to distinguish between those of the physical, other-administered sort and those that are cognitive and/or self-administered. For many behavior therapists, use of the former type — mainly electrical stimulation — has become limited to those behaviors for which a more desirable alternative does not exist. For example, in cases of head banging or other forms of self-mutilating behavior, sometimes observed in severely retarded or autistic individuals, Aversion Therapy is the treatment of choice. In such instances the potential consequences of the behavior are so dire that they overshadow the

ethical and humanistic concerns over the use of electric shock to modify human behavior. Despite the controversy surrounding it, some workers in the field continue to use electrical aversion therapy in the treatment of homosexuality, transvestitism, and fetishism. Controversy also exists in connection with the abuse of aversive conditioning in certain federal correctional institutions. Punitive measures have been employed under the legitimizing guise of ‘‘behavior modification.” In some state institutions inmates have been involuntarily subjected to Aversion Therapy for the treatment of sexual deviations. In my opinion, any such use of therapeutic technology must be opposed and eliminated.

Ethical questions are essentially avoided by the use of self-administered aversive procedures. There is a qualitative difference between these and externally controlled electrical stimulation that permits a much wider range of application. These techniques may not be as powerful, but deficiencies in power are made up by combining such techniques with other behavioral techniques in a well-rounded therapeutic program.

In general, just about any unwanted behavior is fare for techniques such as covert sensitization or the wrist-worn rubber band. Target behaviors may include more serious symptoms, such as obsessions and compulsions as well as less serious nervous habits, such as nail biting or hair pulling. Hayes, et al. (1978) used covert sensitization in the treatment of exhibitionism and

sadism. I used the rubber band technique to discourage sexual arousal to the sight of men, in a male homosexual. I used other behavioral techniques in conjunction with that one in order to establish sexual arousal in response to women.

Covert and other self-administered techniques have been used with behaviors such as smoking, overeating, substance abuse and tics, as well as numerous unwanted idiosyncratic behaviors. Because these techniques are not amenable to the same rigorous control as is possible with electrical stimulation, some would say that they are really not scientific conditioning procedures. Clinical experience suggests that self-administered aversion procedures enhance the client's view of his ability to control his own behavior. Sometimes just the knowledge that he can invoke the procedure is sufficient to enable the client to inhibit the target behavior. Rather than simply representing an escape or avoidance response, it would appear that the inhibitory behavior is being mediated by changes in attitudes and/or beliefs. More research is needed to elucidate the bases of self-administered aversion procedures.