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Comment

Reply to Reader Comments on "Employing Electric Shock with Autistic Children"[1]

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A few years ago, while working at a mental health agency, I met the parents of an autistic child. The child had passed his fifth birthday, had no communication skills, and avoided interpersonal contacts even within his family. The child had been exposed to several well-planned, conventional interventions in previous years including behavior modification and chemotherapy, which, in aggregate, provided negligible improvement. Based upon a review of the literature, I advised the parents that (1) the prognosis for their child was extremely poor, and (2) even with a very intense behavior modification program focusing on language development, given the child's age and symptomatology, the prognosis remained poor. This response was, of course, disappointing to the parents. Furthermore, there was no treatment facility in the area which offered an educational program designed for autistic children. After considerable thought and preparation, I proposed an intervention that included the use of electric shock. Very low levels of electrical stimulation, approximately 1.5 mA, were to be employed as a negative reinforcer in an escape-avoidance paradigm to sequentially teach attending skills, nonverbal imitation, verbal imitation, and spontaneous language. Natural reinforcers supplied by the parents would replace the artificial, aversive therapy as early as maintenance of an effective therapy would allow. The treatment plan was approved through a stringent peer review process and included the support and understanding of the parents. It

[1]This article is a reply to reader comments on *Employing Electric Shock with Autistic Children: A Review of the Side Effects,* by Kenneth L. Lichstein and Laura Schreibman, which appeared in the June 1976 issue of *Journal of Autism and Childhood Schizophrenia* (Volume 6, Number 2). The comments were published in the September 1976 and June 1977 issues (Volume 6, Number 3 and Volume 7, Number 2).

seemed as though an intervention partly composed of mildly aversive procedures was justified and necessary.

Nearing the completion of a lengthy baseline period, a community advocate stalled treatment implementation by pointing out that we would be inducing severe emotional damage, and would even be making the autistic child "psychotic" if we administered electric shock. To summarize the tense events of the next half year, the intended program was aborted in response to a threatened child abuse lawsuit with the psychology department in which I was enrolled, myself, and the child's parents as codefendants. The efficacy of the procedure was never challenged. It was the feared side effects of the procedure which formed the basis of the suit.

The article in question here (Lichstein & Schreibman, 1976) was written to clarify this point: Are the unintended effects of employing electric shock with autistic children undesirable, and of such magnitude as to preclude the use of this type of intervention? Based on our sincere attempt to objectively appraise the literature, the answer to this question was an emphatic *no*.

The reactions to our paper criticized our neglecting ethical and procedural issues (Creedon, 1976; Oppenheim, 1976; Shea & Shea, 1976). Although our paper was intended only to review the literature, I can well see the appropriateness of the questions raised by the respondents. In retrospect, I think the paper would have been enhanced by a more thorough consideration of these matters. The recommendations by Oppenheim (1976) adequately stated what appear to be emerging as consensus guidelines for the implementation of all forms of controversial interventions, and I would certainly endorse these with one reservation. Oppenheim (1976) states that "electric shock should be used only to extinguish or suppress severe self-injurious behavior." I would advocate an extension to include behaviors that meet the following criteria: deceleration of undesirable behaviors or acceleration of desirable behaviors that critically influence the health functioning of the child, e.g., less aggressive forms of self-stimulation and language. Of course, this would only be considered when less restrictive therapies have exhaustively been attempted and have failed, and there is a sound basis for expecting success with an aversion approach.

The criticisms of Webster (1977) evoke a much less conciliatory response from me. The emergent issue that may be extracted from his paper regards behavior therapy as a whole, and electric shock as a case in point. For scores of years, mental health practitioners have been providing treatments resulting in subtle outcomes, assessed by techniques concerned with ethereal influences. In sharp contrast, behavior therapy squarely confronts the issues of *efficacy* and *accountability*. Dramatic changes may be produced, objectively measured, and causally linked to intervention proce-

dures. Thus, when we are acting as professionals offering a service of *demonstrated* value, behavior therapists are accused of being Machiavellian by critics like Webster.

The lapses of judgment and faulty procedure admitted by Webster in his own practice do not represent the routine standard of quality for behavior therapy. Certainly, behavior therapists will show evidence of human fallibility but this is neither inherent nor characteristic, as intimated by Webster.

His example of the autistic child suffering from dental discomfort raises issues unrelated to the problem of using electric shock. He criticized this instance of using electric shock where it was later shown to be inappropriate. The issues here concern professional caution and comprehensive, meaningful assessment, not the efficacy of electric shock or behavior therapy in general.

Despite the undeniable effectiveness of electric shock with autistic children, and the absence of major undesirable side effects, there exists a very strong spirit in this country which abhors punishment with this or any other patient population (e.g., Maurer, 1974; Shea & Shea, 1976). In the end, the force of community opinion will prevail over research evidence whenever the two are incompatible. Despite the extremely encouraging clinical research employing electric shock with autistic children in the mid and late 1960s, the demise of one effective intervention may occur. Throughout the country, some state legislatures are concretizing this trend. The behavior therapist who advocates the judicious use of electric shock with autistic children under highly specified, restricted circumstances (e.g., Oppenheim, 1976) is acting in accordance with an ethical imperative: to provide the best treatment for his client. Given the restrictions imposed upon us by some of our colleagues and portions of society at large, the thoughtful behavior therapist is confronted with a serious ethical dilemma. All of us would prefer the development of comparably effective, nonaversive treatments. But what are we to do till then?

REFERENCES

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