

## ***Issues and implications of operant conditioning: The primary ethical consideration***

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The ethical considerations in operant conditioning are no different from those involved in any other form of therapy: to aim for the maximum benefit to the patient and to society, giving careful consideration to cases where the two may conflict.

If the ethical problems of operant conditioning seem more acute than for other therapies, it is because, for the most part, the skillful use of operant conditioning often modifies behavior much more effectively than do the traditional therapies. Because the techniques are novel to the medical profession at large and are almost always designed and implemented by nonmedical personnel, staff members of medical institutions are less likely to be familiar with the procedures and are thus more likely to raise questions of ethics. The article by Lucero, Vail, and Scherber and the recommendations of the workshop it reports appear to be based on a less than adequate conception of what operant conditioning involves.

Not all programs labeled as operant conditioning are truly operant conditioning. Physical restraints and prolonged seclusion are desperate measures, employed when an overwhelmed staff cannot control the behavior of patients by more effective and humane means. They are antithetical to operant conditioning and are disappearing, frequently because they are being replaced by genuine operant-conditioning procedures.

Although punishment is used in a few special programs, it is only one of many techniques available. It is used very little, to treat a very limited type of behavior in a very small number of patients, almost invariably those who have failed to respond to other approaches. I have used electric shocking rods to decrease self-destructive behavior in an eleven-year-old girl who had

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spent three years tied hand and foot to prevent her from violently banging her head and severely mutilating her face by digging at skin grafts with her fingernails. Physical restraint was the only means the frustrated nursing staff had to prevent her from seriously injuring herself; it was by no means part of an operant-conditioning program.

The electric shock used in such cases is of very low amperage and is usually from flashlight batteries; the shock, although painful, is not much more painful than some injections, and is probably less "brutal" than electroconvulsive therapy and psychosurgery, the ethics of which Lucero and his associates apparently did not question. Every use of shocking-rod punishers in programs familiar to me requires permission from the patient's family members and further requires that each staff member who will use the shock must try it on himself first.

The alternative to such use of contingent punishment may be a life spent in restraint. Moreover, the proper use of shock or other punishers may drastically decrease autistic behavior, which until now has been extremely resistant to treatment. The use of painful stimuli has been dramatically successful in reducing the occurrence of extremely violent behavior, or in completely eliminating it, in patients who have been totally resistant to everything previously tried. For example, Lovaas used shock with a severely retarded girl who had blinded herself in one eye and had bitten her fingers so badly that amputation was necessary, and with a boy who had chewed most of the flesh from his right shoulder, exposing the bone. Both patients had been in restraint for months. Both were given electric shock when they tried to injure themselves, and within a few minutes they stopped the self-destructive behavior (Lovaas, Schaeffer, and Simmons, 1965). Follow-up three years later showed that the behavior never recurred. However, I readily agree that the use of punishment as a behavior deterrent should be extremely well planned and carefully supervised.

The use of operant conditioning should be attempted only after extensive, sophisticated training in the principles and practice of learning theory and the experimental analysis

of behavior. Perhaps those legally responsible for patients should appoint a subcommittee of clinical psychologists who are sophisticated in learning theory and should act on the basis of their recommendations.

Seclusion is not an inherent feature of operant conditioning, but if properly used, it can be very effective in reducing the occurrence of tantrums or other undesirable behaviors; in genuine operant-conditioning programs, seclusion must end soon after the undesirable behavior ceases. Prolonging seclusion is not only inhumane and unnecessary, but is likely to attenuate its effectiveness. The purpose of seclusion is not punishment; rather it is "time out," to allow a tantrum or other behavior to run its course without accidental reinforcement, and without triggering similar behavior in other patients.

In their attack on the use of deprivation and tokens in operant-conditioning programs, the Minnesota workshop participants ignored the fact that we all live under a similar economic system. Without deprivation there can be little or no positive reinforcement. If a man has recently finished a heavy meal, food will have little power as a reinforcer. They overlooked also the outstanding success of hundreds of successful treatment programs that use tokens and deprivation, and arbitrarily declared them unethical. Yet those "unethical" programs have successfully modified behavior so that patients could leave the hospital and live more normal and satisfying lives.

What of the patient's civil liberties? How can it be ethical to prohibit the use of devices that can result in successful placement of chronic patients in the community? The real deprivation with which we should be concerned—the one most ethically suspect—is the deliberate deprivation of potential benefits to the patient, when the alternative clearly amounts to a life sentence in a mental institution.

The authors assume that deprivation in and of itself reduces the patient to a subhuman level—at best a questionable assumption. Punishment and deprivation are standard techniques in our child-rearing practices, and few people question the ethics of sending a child to bed without his meal as a

punishment, or insisting he earn his allowance. While those practices may not be the best, objections should be directed not toward the deprivation itself, but to the degree of sophistication with which it is employed and the reasons for its use.

However, the most important aspect of almost all operant-conditioning programs is using positive reinforcement, even when punishment happens to be part of the individual program. Punishment is used to decrease the occurrence of a behavior; to build an appropriate behavior, positive reinforcement is necessary. No psychologist I know is content merely to use a shock punisher to stop a child from killing or maiming himself; the shocks last but a fraction of a second, and constant positive reinforcement follows.

Meyerson, at Valley of the Sun School for Handicapped Children in Phoenix, Arizona, immediately punished a child when she hit herself. He used a noisy slap from his cupped hand, accompanied by loud, angry shouting—a sharply contrasting change in his otherwise permissive behavior. But he also stayed with the child sixteen hours a day, reinforcing her with very warm attention, hugs, and many other rewards every moment in which she did not hit herself (Meyerson, 1968). Is such dedication unethical? Despite the severe punishment, the child was probably happier during this time than at any other known time in her life. To assume that the use of punishment or deprivation implies inhumane treatment is simply to admit ignorance of the vast amount of literature describing how operant conditioning is being used.

Anyone who has worked with mentally ill and mentally retarded individuals must sooner or later accept the fact that people are not hospitalized because they are retarded or schizophrenic or paranoid. They are hospitalized because they require extensive nursing or medical supervision or because they are “behavior problems.” The majority would not be in the hospital, despite their diagnosis, if someone in the community were not frightened, annoyed, repulsed, or angered by their behavior. And the criterion for discharge is seldom whether they are still retarded or schizophrenic or paranoid, but rather the answers to such questions as

“What is the probability that this patient will behave himself properly in the community? Will he remain toilet-trained? Will he steal? Will he expose himself in the local movie theater? Will he beat up his kid brother?”

I have witnessed and filmed innumerable instances in which staff members and parents have unwittingly reinforced tantrums, aggressiveness, feces-smearing, and self-injury by well-intentioned but naive concern, attention, and other rewards, while desirable behavior went unnoticed or ignored. I have recorded the immediate marked increase in response. For example, when a parent was permitted to hug a child who slapped herself, the child’s face slaps very quickly increased from about three slaps a minute to about forty-eight. Nevertheless, TLC [tender loving care] continues to be used indiscriminately and often incorrectly.

Operant conditioning, like any other human process, may fail to produce the desired result on occasion. But in what area of therapy do we demand guarantees of success? If such a guarantee were demanded of mental hospitals and private practitioners, not one would be treating patients today. According to this criterion, psychoanalysis—to consider a specific modality—would be prohibited in Minnesota.

I agree that we must all be concerned with the ethics of our treatment and experimental programs. But deliberately attenuating the effectiveness of treatment by prohibiting the use of powerful and effective tools is not only naive and short-sighted, but is actually inhumane and cruel. I see nothing particularly ethical in arbitrarily denying maximum benefit to hundreds or thousands of patients, and to society, merely because of fear that someone might misuse effective techniques. The antidote for possible misuse of the techniques is not eliminating them, but giving a more thorough training in their use.

Rather than proscribing techniques because of unreasonable fear and misunderstanding, we should first learn what is really involved in operant conditioning. We should thoroughly acquaint ourselves with the extensive and rapidly growing experimental and clin-

ical literature, including the excellent objective and controlled studies that have evaluated the rather meager alternatives. Finally, we should insist that those who plan and implement the programs, and those who regulate them, have a thorough background in psychological learning theory and the

experimental analysis of behavior. The ethics of operant conditioning are no different from the ethics involved in any other procedure that can be misused. The primary ethical consideration must always be the well-being of the patient and the society from which he comes, and to which he may return.