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Aversion Therapy

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Aversion Therapy. Aversion therapy uses a number of techniques and stimuli to weaken or eliminate undesirable responses such as deviant sexual behavior and substance abuse. In theory punishment is used to directly reduce the frequency of undesired behaviors through contingent presentation or removal of a stimulus, while aversion, or aversive counterconditioning, seeks to change the undesirable response indirectly by altering the functions of the discriminative and reinforcing stimuli. In practice this distinction is somewhat blurred, since many aversion procedures have both punishing and stimulus-altering effects.

In some forms of aversion, no behavior need occur. Rather, the discriminative and reinforcing stimuli that maintain the problem behavior (e.g., sight or smell of alcohol, deviant sexual stimuli) are presented to the person, and an unpleasant stimulus (e.g., electric shock) is presented simultaneously. The discriminative and reinforcing stimuli acquire the properties of the aversive stimulus through association. The goal is to weaken the link between the controlling conditioned stimulus (e.g., children) and undesired response (e.g., sexual arousal). Wolpe's theory of reciprocal inhibition provides one explanation for this process. Wolpe theorizes that arousing a strong competing response such as nausea or fear inhibits the undesired response.

Aversion uses electrical shock; chemical and olfactory stimuli such as emetine hydrochloride (which causes nausea and vomiting); valeric acid (which smells like rotten eggs) and ammonia; covert sensitization by aversive imagery; and shame induction (McAnulty & Adams, 1992). The ideal stimulus is one that permits rapid onset, prompt termination, controlled intensity, and quick recovery so that repeated trials may be administered in a brief time. Electric shock and noxious smells are readily controlled in these ways, but drugs are not. Drug administration also requires medical personnel and sometimes hospitalization, is medically contraindicated for many individuals, and may have side effects that impair conditioning. Shock is widely applicable except for persons with heart conditions. For all these reasons shock replaced drugs as the principal aversion technique in the 1970s. More recently covert sensitization has become preferred.

Aversion takes three basic forms: escape training, avoidance training, and presenting the unpleasant stimulus without permitting either escape or avoidance. Often escape training is used initially, then modified into avoidance training.

In escape training the target stimulus is presented; then an unpleasant stimulus such as electric shock occurs. After brief exposure to the two stimuli, the individual escapes from the stimuli by making a specified response. For example, a transvestite is given an article of women's clothing to put on and then administered electric shock. Once the clothing is removed, shock is terminated.

In avoidance training the individual is presented with the stimulus that elicits the problem behavior. If an avoidance response is made quickly enough, the aversion stimulus is avoided. The avoidance response typically removes the stimulus for the undesired response. For example, turning off pictures of women's clothing quickly enough may avoid shock for a fetishist. An advantage of the avoidance procedure is that the client learns to be anxious in the presence of the target stimulus and is positively reinforced for actively avoiding it.

Covert sensitization is a form of aversive counterconditioning in which the client imagines an unpleasant event following the undesired stimulus response complex rather than experiencing overt aversive stimulation. For example, persons may imagine taking a large bite of hot fudge sundae topped with whipped cream and nuts and then imagine becoming grossly fat, unable to fit into their clothes, and socially ostracized. In the avoidance phase they imagine becoming increasingly anxious as they approach the ice cream shop. They then imagine turning away and experiencing immediate relief.

Effectiveness of Aversion. Research on the outcomes of aversion treatments has produced mixed results. Aversion is quite effective with transvestism and fetishism. Aversion techniques are the most common approach to treatment of pedophilia. Aversion with sexual reconditioning has shown favorable short-term effects with pedophiliacs, but reductions of long-term recidivism have not been demonstrated. Results with homosexuality are modest; they are better for homosexuals voluntarily seeking treatment and for those with prior heterosexual experience. Aversion has been found effective with transvestites and fetishists with prior heterosexual experience; and a few gender identity problems also show favorable outcomes (McAnulty & Adams, 1992).

The effectiveness of aversion with sexual deviations is influenced by a number of factors. Most studies have used electrical aversion; smell aversion shows promise and has been widely adopted but needs further study. Although drug aversion studies have sometimes yielded promising results, shock and unpleasant smells are more commonly used with sexual behaviors. A major concern with sexual disorders is the need to assess sexual arousal to appropriate heterosexual stimuli. When appropriate sexual arousal patterns are absent or weak, developing or strengthening them is essential to lasting effects of aversion.

Electrical aversion does not appear effective for alcohol abuse. Nausea aversion is generally effective for several months, but as time passes an increasing percentage of clients resume drinking. Compliance may be as low as 20% when voluntary; thus administration in a supervised setting is important. Additional treatment of psychosocial problems is widely recommended and may help to maintain gains. In a recent review Emmelkamp concludes "aversive therapy, if applied at all, should be part of a more comprehensive cognitive-behavioral program" (Emmelkamp, 1994, p. 400).

Covert sensitization is appealing for both theoretical and practical reasons. Covert sensitization appears promising for those who can visualize well and are well motivated. However, there remains a lack of clear empirical evidence of treatment effectiveness for covert sensitization when it is used alone. Thus it should be used as part of a more comprehensive approach that also addresses the psychosocial aspects of the problem behavior. Adams notes that a number of biblical teachings are consistent with the idea of replacing responses rather than simply eliminating them (Adams, 1973).

Ethical Issues. Aversion therapy has often been opposed on ethical and moral grounds. However, aversive consequences are a natural feature of the social and physical world. Behaviors treated by aversion usually produce immediate rewards followed by delayed pain. For example, the sexual gratifications of paraphilias are immediate, but the costs of broken relationships and sexually transmitted diseases are delayed. Aversion therapy helps persons forego immediate rewards so they can avoid these delayed aversive events.

Guidelines for aversion emphasize informed consent and minimal exposure to painful stimuli. Persons voluntarily seeking treatment respond better than those sent by the courts or family members. For both these reasons, use of aversion on reluctant patients is questionable. The individual will avoid treatment if the experience is sufficiently unpleasant. Aversion to the target stimulus or elimination of the problem behavior must thus be accomplished without causing aversion to treatment.

Research evidence indicates that problem behaviors are most effectively eliminated when constructive alternatives are developed simultaneously. This raises two concerns. First, many (especially laypersons) use aversion techniques without establishing suitable alternatives; developing these is essential. Second, problems arise in selecting alternatives, especially for sexual behaviors like homosexuality, voyeurism, and transvestism. From a Christian perspective most sexual activity outside of marriage is unacceptable, and alternative goals have not been clearly articulated. For many sexual contact appears to have become a sole form of intimacy. Erotic intimacy substitutes for familial, fraternal, and spiritual closeness. The biblical concept of love suggests a direction for consideration. Learning to experience and express love, especially God's love, may be the key.

Reorientation treatment of homosexual behavior is highly controversial and is not widely practiced. Since 1973 homosexuality has not been considered a mental disorder by the American Psychiatric Association. Some contend that any sexual reorientation treatment is abusive, a result of homophobia—fear of and hostility toward homosexuality. Others, such as Nicolosi (1991), contend that reorientation treatment can be ethically conducted within the guidelines of informed consent when it is consistent with the values and goals of the individual seeking treatment.

Summary. Aversion therapy uses aversive counterconditioning and covert sensitization to eliminate undesired behaviors. Research indicates that aversion is effective for some problems and under some conditions. Because of legal, ethical, and practical concerns, covert sensitization has gradually become the preferred approach, at least for outpatient psychotherapy. Empirical support is limited for covert sensitization alone but indicates that more comprehensive treatment packages that include covert sensitization along with strengthening of desired alternative responses are quite effective. The precise contribution of covert sensitization in these treatment approaches is not known. Finally, as applied to sexual behavior, aversion therapy poses a number of unique problems from a Christian perspective.

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See Punishment; Cognitive-Behavior Therapy; Behavior Therapy.