

Let's Take Another Look at Punishment

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When Bill was 12 he became sexually aroused watching girls go down a playground slide with their panties exposed. His fantasies during masturbation soon centered about this incident, and probably because of the powerful reinforcing effects of orgasm, the association between panties and sexual arousal soon became habitual. His fetish for women's panties persisted for more than 20 years. Even when Bill was in his early 30s, his sexual thoughts centered around panties—he would buy panties or steal them from department stores or clotheslines, and he would wear them and fondle them while he masturbated.

Bill's relations with women were strained; he was impotent, and very unhappy. He went for help to Malcolm Kushner, then psychologist at the Veterans Administration Hospital in Coral Gables, Florida. Bill agreed to participate in an unusual therapy program that used electric shock.

During therapy sessions when Bill held panties or looked at pictures of women in panties he received a painful electric shock in his forearm. He would tolerate the shock for as long as he

could. When he wanted the shock to end, he would say "stop" and simultaneously put the panties or pictures aside.

Bill and the therapist repeated this procedure 12 times in every 20-to-30-minute session, with three such sessions per week. Gradually Bill's obsession with panties decreased, and after 14 weeks he reported that panties no longer aroused him.

At this point, the therapist concentrated on Bill's impotence. With the help of a considerate and patient girl friend, Bill gradually overcame his anxieties about being with women.

Once, after the conclusion of therapy, Bill had to appear in court for a traffic violation. He became anxious and apprehensive, and reported that thoughts of women's panties began to recur—although he could dismiss them from his mind if he tried. Such mild recurrences occurred twice in three months after the punishment sessions ended. Both times the therapist gave him booster sessions, and the impulses promptly disappeared.

Eighteen months later Bill remained

free of his fetish and no substitute symptoms had appeared. He was married, a new father, and reported that his sexual life was normal.

Quick. In recent years, many behavior therapists have studied punishment as a therapeutic tool. Behaviorists define punishment in terms of behavior: a punisher is any stimulus that reduces the frequency of the behavior that precedes it. Electric shock very often acts as a punisher, but in cases in which it does not, it is a contradiction to say "I applied punishment but the behavior did not decrease." In general, behaviorists have found punishment to be one of the fastest, most effective techniques available for helping people rid themselves of troublesome behaviors.

By the usual standards of science these findings ought to evoke admiration: scientists successfully applied research findings to problems that had not responded to therapy and they relieved patients of misery. Had the findings been a vaccine against some disease, there would have been headlines and congratulations. But the treatment is not called "vaccination," it is called "punishment." The word brings with it images of anger, whips, screams. So instead of celebrating a new scientific advance, we feel apprehensive; we look for a hint of sadism.

Punishment is a natural part of everyone's learning history. A child learns to walk in part to avoid the pain of falling down. Everyone learns to avoid doing those things that result in pain. This process operates even while we sleep. A small boy who rolls off the bed is punished immediately by colliding with the floor; he soon learns to limit his nocturnal tossings.

But we have a peculiar ambivalence toward pain. We can see that pain is a good teacher as long as it is inflicted by inanimate objects—hard floors, hot radiators, sharp knives. But somehow, pain inflicted by a human being seems different—barbaric and repellent.

Annals. I think that much of our revulsion regarding the use of punishment is based on a reaction against the truly inhumane conditions of many years ago that recur in literature—headmasters with canes, slave masters, prison turnkeys with whips, bullies, orphanage overseers, snake-pit mental hospitals. We like to think of such practices as long past, so when a therapist speaks objectively about the uses of punishment, we react as if he

were asking us to forget all the years of progress and humane reform.

Another source of resistance is the Freudian notion that where there is neurosis there was some early trauma. We assume that the long-range side effects of punishment must be disastrous. Also, we assume that neurotic behavior is the symptom of some deep, underlying conflict. We assume that even if the symptoms are removed, the underlying conflict will remain and will manifest itself in other symptoms. But among hundreds of studies, only a few have found evidence for anything like symptom substitution. The concept appears to be a myth.

For six months June could not stop sneezing. The 17-year-old girl's case was one of the most baffling her many doctors had ever seen. June had consulted neurologists, endocrinologists, allergists, urologists, psychiatrists and hypnotists; she had tried a pharmacopoeia of medicines, but she kept sneezing.

When Kushner first saw her, June was sneezing at a rate of once every 40 seconds. It did not affect her eating or sleeping, which suggested that the sneezes may have been psychological. Kushner decided on an unusual therapy program. He placed a microphone around June's neck and connected it to a voice key and a shock source. When the girl sneezed, the sound relay triggered a brief but painful electric shock through electrodes connected to her fingers.

At the end of only one day's therapy, after she had worn the apparatus only four and a half hours, June stopped sneezing.

From then on, therapy sessions helped her develop more appropriate ways of dealing with her environment.

Five years have passed since June's six-month sneezing jag. She is now 22 and since that day in Kushner's office, she has not been bothered again by her singular compulsion.

Immoral. Our resistance to the use of punishment is based on moral grounds, not scientific ones. But the moral position that pain is bad and should always be avoided becomes itself immoral when it prevents us from helping persons who have learned behavior that puts them in even greater pain. Unfortunately, many of our public institutions promote just that kind of learning.

Jimmy, a retarded seven-year-old, functioned at the level of a two-year-old. He bit his hands repeatedly, until

they were swollen, bleeding and infected. Nurses finally made him wear boxing gloves or arm splints that prevented him from bending his elbows. The child's hand-biting problem intensified when he was on the hospital ward. He would cry in pain, yet continue to tear the flesh from his hands until nurses held his hands away from his mouth.

I suggest that Jimmy was taught his behavior. He was rewarded for hand-biting, rather than for more desirable behavior, because the nurses and caretakers were busy. They could ignore Jimmy when he was engaged in acceptable behavior, but they had to respond whenever he bit himself. Eventually they became accustomed to Jimmy's continuous hand-biting; they would intervene only when he was more destructive than usual. In this way, they reinforced self-destruction that got progressively worse. They could not have done a better job if they had purposely designed a training program to instruct Jimmy in his own self-mutilation.

Of course, the nurses had no such intention—they were just doing their jobs, reacting with professional care and attention toward their patient, and with human sympathy toward a child in pain.

My indictment is only a hypothesis, of course, and it will probably never be proven directly. No behavior therapist would train a child to bite the flesh off his hands just to prove how easily it can be done by social influence in an institutional setting.

Cruel. Jimmy's behavior probably would have died out if the nurses had

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attended to him systematically when he was not biting his hands and had ignored him when he was. But this would have worked only if everyone had participated 100 per cent of the time. When Malcolm Kushner suggested this to the personnel on the hospital ward, he found most of them reluctant to go along with such a program. They felt it would be inhumane and cruel to ignore a child who was in pain.

Kushner decided that the fastest way to relieve Jimmy of his pain would be to subject him briefly to even more

pain. He applied electrodes to Jimmy's leg, and shocked him every time he put his hand in his mouth. After only two sessions of less than an hour each, the boy quit biting his hands. His infections began to heal, and the nurses were so impressed with the sudden change that they readily assisted in later booster sessions to maintain this behavior and they cooperated in a broader therapeutic program to help the boy develop more desirable social behavior.

Swap. Jimmy's case is extreme. Behavior therapists usually work with patients who are not so disturbed and whose pains are more mental than physical. But whether the therapist deals with self-mutilation, drug addiction, alcoholism, or such quirks as excessive blinking, the moral formula remains the same: a small number of brief, painful experiences is a reasonable exchange for the interminable pain of a lifelong maladjustment. If people think someone looks silly blinking his eyes every couple of seconds, they may decide to stay away from him, especially when they find themselves beginning to blink with him. Enduring a few brief shocks may be a small price to pay to rid oneself of a socially disruptive habit.

Of course, there are alternative therapies—one therapist might prefer to use positive, painless methods; another might want to get at the underlying dynamics of the problem, not just the symptoms.

But how long will it take? That, in my opinion, is the critical question for the moralist. For as one therapist tries his ostensibly more benevolent or more basic methods, the patient continues to undergo daily punishment while he awaits a cure. Not to rescue a person from his unfortunate habits is to punish him, to leave him in a state of recurrent punishment.

The therapist who humanely avoids inflicting pain on his patients has no moral superiority over another therapist who gives a patient electrical punishment so that he may escape social punishment. The basic questions are which punishment is tougher, and which lasts longer? We have a bookkeeping problem here, not a moral one.

Rat. Critics of punishment say that it doesn't actually weaken behavior—it only suppresses behavior for as long as the punishing stimulus is present. This criticism at first seems valid, be-

cause a response that has disappeared after punishment often returns when the punishing stimulus is removed. But frequently this event is an artifact of the experiment and not an inherent characteristic of punishment itself.

For example, if a rat usually receives food when it presses a bar, but gets no food while a red light is on, it will soon learn to stop pressing the bar while the red light glows. Similarly, if when punishment is present a behavior does not receive its usual reward, the response may decrease because the

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punishing stimulus has come to act as a red light—as a signal that no reward is forthcoming. When the punishing stimulus is removed, the behavior may resume quickly, giving the impression that the punishment effect was only temporary.

There are recurrent, dramatic findings that the effects of punishment are often permanent and irreversible. A behavior that has been punished only a few times may never recur. Such dramatic success is a blessing to therapists, but a headache to theorists. If the experimenter decides to stop punishing a certain response, a subject who has ceased responding anyway will have no way to find out about this new contingency. So it is often hard for the theorist to tell whether a behavior has really been unlearned or merely suppressed. Of course, this distinction is of little importance to the patient concerned—as long as a troubling behavior is gone, it makes little practical sense to argue over why it is gone. The effects of punishment are often quick and long-lasting.

Ivar Lovaas, Benson Schaeffer and James Q. Simmons report on their work with five-year-old identical twin boys who had been diagnosed as schizophrenic. The boys would not speak or respond to other persons. They each spent 70 to 80 per cent of their time rocking back and forth, fondling themselves, or moving their hands and arms in repetitive, stereotyped movements. At other times they would go into tantrums—screaming, throwing objects, and hitting themselves.

Lovaas and his colleagues punished

the boys with brief electric shock for their self-stimulation and tantrums. Although they scheduled three punishment sessions, the self-stimulation and tantrums virtually ceased after the first session and did not recur for 11 months. By then the experimenters were concentrating on therapy designed to train the boys to be more socially responsive.

Prods. Punishment works. The technique is simple, and so is the technology. Anyone with a hand to swing is equipped with a punishing device. Mail-order catalogs list a number of inexpensive and reliable cattle prods that deliver punishing but undamaging electric shocks.

Because punishment is so efficient and simple, there is danger that it could become the first or even the exclusive behavioral technique of carelessly trained therapists. That would indeed be tragic. For one thing, punishment is painful, and the essence of my argument is that we should have as little pain as possible. Punishment should only be used when it will eliminate a behavior that produces even greater punishments. It is essential, I believe, that therapists who use punishment learn a wide range of other behavioral techniques so that they will use punishment only in limited cases, when it is clearly the treatment of choice.

No. Another danger in the indiscriminate use of punishment is a phenomenon called secondary punishment. Any stimulus that is associated consistently with punishment and with nothing else tends to acquire a punishing function itself. If a dog jumps up on the couch and someone yells "No!" while slapping him on the snout, the word "no" itself will soon act as a punisher. This principle also applies to the persons administering the punishment. If the therapist, teacher or parent who applies punishment becomes himself a punishing stimulus, he should expect all the typical responses—escape, avoidance, aggression, and attempts to have him removed. Kushner, Lovass, Todd Risley and other behavior therapists take extensive—monumental—care to limit punishment, and they always combine it with repeated positive reinforcement of other behaviors.

In recent years, researchers have reported successful results using punishment to cure such diverse problems as smoking, tics, suicidal ruminations, jealousy, thumb-sucking, nail-biting,

(Continued on page 111.)

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homosexuality, exhibitionism, alcoholism, dangerous wall-climbing and habitual coughing.

But punishment works better with some problems than with others. For example, some cases of stuttering, phobia and avoidance behavior have actually intensified when therapists attempted to use punishment.

Thus, there are many unanswered questions. We need to know when punishment is likely to work well and when it is not. We need to know what conditions are likely to help a person retain at home the lessons learned with punishment in the therapist's office. To answer these questions, we will have to do research on punishment. And to do the research, we will have to allow responsible researchers to use punishment. And to do that we will have to overcome our unreasoned revulsion to the whole idea. Punishment is not a barbaric atavism that civilized men must always avoid. It is a legitimate therapeutic technique that is justified and commendable when it relieves persons of the even greater punishments that result from their own habitual behaviors. 