Behaviourist therapy knowledge organiser: Aversion Therapy

Behaviourist therapy knowledge organiser: Aversion Therapy (description)

Linking the assumptions to the therapy

The behaviourist approach assumes that the underlying cause of all normal behaviour is through learning (**conditioning**).
Classical conditioning - new behaviour is learnt through a process of association, whereby an unconditioned stimulus becomes associated with a neutral stimulus, learning the same response to both. **Operant conditioning assumption** - behaviour is learned through reinforcement.

This approach assumes that the cause of abnormal behaviour is a result of maladaptive faulty learning; for example, a person with an addiction could become addicted to drugs through **classical conditioning**. The person may 'pair' the pleasures associated with drug taking with environmental cues.
The enjoyable effects of taking drugs acts as a **positive reinforcement**; therefore, it is something we would wish to repeat again.

As a result, the aim of aversion therapy is to break down faulty maladaptive learning and help the person re-learn a more functional response. Aversion therapy is designed to cause individuals to develop an intense dislike or feeling of disgust – an *aversion* – to the addicted behaviour. This is achieved using the principles of **classical conditioning**. Aversion therapy aims to gradually and systematically break down the faulty association (i.e. pleasure) and replace it with a more functional response (i.e. aversion). This is known as **counter-conditioning**.
Operant conditioning is also key to this therapy as the client experiences unpleasant consequences and, as such, no longer wants to repeat the addicted behaviour.

Main components of the therapy

Aversion Therapy (AT) is designed to cause individuals to develop an intense dislike or feeling of disgust – an *aversion* – to a particular stimulus. It can be used to treat a variety of addictions. AT involves 3 key steps:

Step 1: AT begins with the client undergoing a medical examination and health check to ensure they are fit, well and able to proceed with the therapy.

Step 2: The therapist then works with the client, educating them on how the therapy will work and what they can expect throughout the therapeutic process. It will be explained that:

AT is based on **classical conditioning** and involves the client creating a **learned association** between an **aversive stimuli** (something very unpleasant such as an electric shock OR a drug that has a disgusting taste and/or unpleasant sickness-inducing side effects) and the client's **addictive behaviour** (such as alcoholism).
For example, an individual with an addiction to alcohol will engage with AT where they are prescribed a drug called Antabuse which, when combined with alcohol, results in extreme vomiting and headaches, e.g.

UCS (unconditioned stimulus) = Antabuse drug leads to **UCR** (unconditioned response) = feelings of intense nausea and discomfort as well as a desire to avoid feelings of sickness.

UCS (unconditioned stimulus) = sickness inducing drug + **NS** (neutral stimulus) = a drink of alcohol leads to UCR (unconditioned response) = feelings of intense nausea and discomfort as well as a desire to avoid feelings of sickness.

CS (conditioned stimulus) = a drink of alcohol, leads to **CR** (conditioned response) = feelings of intense nausea and discomfort as well as a desire to avoid feelings of sickness.

After a number of pairings, the addictive behaviour (e.g. drinking alcohol) will elicit the desire to avoid feelings of sickness, thus reducing the addictive behaviour.
Covert sensitisation can be used – this is where the aversive stimulus is delivered by suggestion rather than in reality, e.g. imagine receiving an electric shock now.

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Behaviourist therapy knowledge organiser: Aversion Therapy (evaluation)

Effectiveness of Systematic Desensitisation SD (PEEL)
P – AT appears to be an effective treatment for certain addictions.

E – Evidence to support this was carried out by Smith et al. (1997) who treated 249 patients addicted to alcohol with AT using either shock treatment or nausea-inducing drugs. Smith et al. found they had higher abstinence rates after one year than those who had undertaken counselling alone.

E – If patients who engage with AT show higher abstinence rates compared to patients who do not complete AT, then this is evidence that AT therapy works.

L – This evidence shows that AT is a very effective treatment for addictions such as alcoholism and the effects are apparent immediately as well as some time after therapy is completed.

P – There is evidence to suggest that AT is not effective for all types of addictions in the long term.

E – Some mental health professionals would argue that the individual could easily start to engage in the unwanted behaviour again once their use of the unpleasant stimulus has finished. In most or if not many cases, it would be impractical and also unrealistic to make ongoing use of the noxious stimulus.

E – This evidence illustrates that AT is NOT appropriate for ALL addictions and the results do not have any longevity thus showing AT has some limitations in terms of effectiveness.

L – This means that AT is ineffective.

Ethics of drug therapy (PEEL)
P – One weakness of aversion therapy is that it may breach some ethical guidelines.

E - One of which is risk of stress, anxiety, humiliation or pain. This guideline outlines how, during therapy, nothing should happen that may physically or psychologically harm the patient.

E – The client is often exposed to noxious substances such as Antabuse, which results in extremely unpleasant side effects such as sickness and headaches.

L – In conclusion, aversion therapy causes both physical and psychological harm, which are major ethical issues. Nevertheless, the physical harm from nausea-inducing drugs and electric shocks may not be as damaging, in the long term, as the addiction itself.

P – There are strict ethical guidelines in place when working with vulnerable individuals, such as those with an addiction that may influence their understanding of being able to withdraw from therapy at any point during the process – this may not always be expressed by the therapist.

E – The client has a condition that may impede their understanding of what the therapy will entail and are unable to give valid consent.

E – Those experiencing aversion therapy may not always be aware of their rights, including their right to withdraw if the therapist does not inform them.

L – As a result, there are numerous ethical issues associated with this therapy.

In conclusion, AT can be an effective therapy; however, ethically, AT is questionable and other therapies should be considered before it. Questions are raised regarding the effectiveness of AT in the long term, e.g. critics argue that it does not address the root cause of the addiction and thus this limits its long-term success. AT can offer a solution to a problem that, if left untreated, could cause serious harm to the individual in terms of health and wellbeing.