# Chapter 16
# Ethical Issues in Clinical Behavior Analysis for Children


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The concept of ethics is traditionally defined as a set of rules of conduct, proposed to a given social group and is often used as a synonym for morality (La Taille, 2006). The origin of the words differs – *ethos* comes from Greek and *mores* from Latin – but both refer to "the field of reflection on the customs of men" (La Taille, 2006, p. 25) or "the customs and practices of the group" (Skinner, 1972, 1976a, b, p.107), which justifies the equivalent use of the terms. Skinner (1972, 1976a, b) uses this convention and does not distinguish moral from ethics throughout his work. His reflections on these concepts appear when he discusses cultural practices that contribute to (or hinder) the evolution of a given culture.

For Skinner (1972, 1976a, b), the evolution of a culture is closely related to the adoption of practices that ensure its survival. However, this does not always occur. Acting under control of what is immediately reinforcing for oneself or for others can generate immediate and, mainly, delayed consequences that conflict with the survival of the culture. Examples of products of contingencies of this type are overpopulation, environmental pollution, decreasing resources, and the risk of nuclear wars (Skinner, 1972, 1976a, b).

Planning for a culture must therefore include establishing contingencies that lead individuals to behave in ways that preserve it. One of the ways the group uses for this is assuming the role of determining what is "good" or "bad" and "right" or "wrong." When this occurs, one enters the field of ethics (Ferreira, 2018). It is through the establishment of contingencies of reinforcement and punishment (Skinner, 1953/2000) that a group of people defines and controls ethical behaviors. What is determined as ethical, however, varies according to the context and the historical moment (Gianfaldoni, 2005).

Just as ethical behaviors are culturally defined, so are ethical guidelines for a particular group (Vandenbergue, 2005). In the context of the psychologist's

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A. S. U. Rossi et al. (eds.), *Clinical Behavior Analysis for Children*,
https://doi.org/10.1007/978-3-031-12247-7_16

professional practice, ethical behaviors are delimited and systematized generally in documents, codes of ethics, or even laws and resolutions. Their formats will depend on the regional and historical contexts in which each group is inserted, and it is always essential that the therapist is aware of them, as well as monitor and participate in their construction, review, and change processes.

In part, how each individual will behave when faced with each ethical recommendation will depend on what was selected in his or her life history (Vandenbergue, 2005). However, in order to *ensure* a standard of conduct or to *hold* the individual *accountable*, coercive contingencies are established to punish behaviors defined as unethical.

Noncompliance with the determinations incurs, on an individual level, inspection by peers, which generally take the name of ethics committees and, when deemed pertinent, penalties to the professional, which may be warnings, fines, public censure, suspension, or even revocation of professional practice. The specificity of the documents as well as the coercive consequences delimited for the different occasions will depend on the contexts where the therapist acts, and it is important that the reader knows those in force in his/her region. At the collective level, unethical behavior negatively interferes with the social recognition of the professional category, which ultimately affects its maintenance and harms the individuals who represent it.

A brief analysis of the recommendations contained in documents presented in codes of ethics directed to the psychologist indicates a prescriptive ethics, as defined by Dittrichi and Abib (2004), which describes how the professional *should behave*. However, many of the prescriptions present responses to be issued that will depend on the judgment of the psychologist and their previous analysis in each context. Each professional may interpret differently regulations or recommendations that, for example, describe principles such as "act in the law of least prejudice" or "share strictly necessary information about the client." In most cases, there will be a need for the professional's discretion as to what would be the least harm or what is strictly necessary to be shared about the client, in contexts of multiprofessional teams, judicial order issues, in the care of children and adolescents, etc.

Generic definitions as presented in the different ethical documents reflect, among other aspects, the complexity of the theme. Is it possible to describe point-to-point an ethical behavior to be issued by the professional before each specific situation? Could not information considered strictly necessary in a clinical case to be shared with a multiprofessional team be different in a similar case, but in another context or with another team?

Skinner proposed a model of ethics defined as relational (Vandenbergue, 2005) and plastic, impossible to be delimited by rigid standards (Dittrichi & Abib, 2004). This position indicates how necessary is the prior analysis of the psychologist who needs to make ethical decisions in the face of each situation in which their behavior should be issued.

For Skinner (1953/2000), deciding is a preliminary behavior to the act about which one decides. Analyzing (and predicting) the possible effects of a given response would increase the probability of achieving maximum reinforcement. Based on this, Dittrichi (2010) proposed a model of consequence analysis

potentially useful for decision-making on some ethical issue. The following steps were considered: (1) categorize the consequences, (2) define the affected persons or groups, (3) define the selective effects of the consequences, and (4) define the temporal sequence of the consequences.

This analysis, conducted in each situation involving ethical issues, provides the psychologist with elements to assess the different controlling variables present in the situation and can contribute to their decision-making process. In this chapter, it is intended to present the ethical recommendations present in normative documents to the psychologist, delimited in the context of child psychotherapy, and raise questions for reflection that may contribute to part of the ethical decision-making process. The prescriptions were gathered and synthesized into five categories of responses, which highlight aspects considered important in the development of the work of the child analytic-behavioral therapist and will be presented below.

## Theoretical and Technical Aptitude

According to the Ethical Principles of Psychologists and Code of Conduct (APA, 2017), it is the psychologist's responsibility to (a) know the guiding principles of the code of conduct and comply with it, (b) adopt methods and techniques that are recognized and grounded by science, and (c) provide service for demands for which he or she has received adequate training, experience, and advice, in order to ensure the quality of the work.

Before discussing the proposed recommendations, we reiterate the importance of psychologists being aware of what is prescribed by the codes of ethics, policies, and laws in force in their work environment and community, consulting them whenever necessary, and contacting the councils, associations, and professional support groups in their region for specific guidance when in doubt about how to conduct a situation. We emphasize that as a scientific community, we guide our work by agreement to the practices outlined in the peer review, and as a professional category acting in different societies, it should be noted that claiming ignorance of these recommendations and regulations is not enough to abolish responsibility, following the principle that to perform the activity is necessary to commit to a community that invested in their training so that their actions were possible.

With regard to the provision of quality services by child behavior analysts, it is important to highlight some aspects. It is necessary that the behavior analyst has a thorough knowledge of the principles and concepts of behavioral science as well as the intervention strategies and procedures recommended by it. If the therapist of this approach does not know, for example, how to correctly identify the possible functions of a behavior, he probably will not be able to perform an appropriate analysis of his client's behavioral pattern (Iwata & Dozier, 2008). Or, still, if he does not know how to predict the possible side effects of an extinction procedure (Skinner, 1953/2000), he may expose his client to an aversive condition, harmful to the treatment and, mainly, to his life.

When it comes to child psychotherapy, it also makes sense that the clinician should be skilled in proposing activities and strategies related to the child's universe, such as knowing how to play, knowing how to talk in language accessible to the child, knowing about potentially reinforcing games and activities, and especially that he or she likes children. What would it be like if a child started intervention with a child therapist and he, for lack of interest or ability, was not a reinforcer? A negative experience with a professional may not only hinder the intervention but also make it difficult for the child to be exposed again to another therapist and, even worse, to other professionals, such as doctors or teachers.

Finally, the importance of the psychotherapist knowing himself stands out. For Skinner (1974/1976a), self-knowledge is the ability of the individual to describe the controlling variables of his behavior. Knowing about oneself, being able to identify abilities or difficulties, contributes for the psychotherapist to be inclined to attend the demands with which he has more interest, facility, or experience, which would increase the probability of a quality intervention. As stated by Banaco, "the psychotherapist is also a person who has his history of reinforcement" (1993, p.75), and his thoughts and feelings should be taken into consideration.

## Action for the Benefit of Children

According to APA guidelines (2017), the therapist should understand who his client is and what relationship to establish with each individual who may be involved with his client. The object of intervention of child psychotherapy is the child, and his protection and care are a priority – including legally provided – but the responsibility for him is his parents or legal representatives. The challenge will always be to act in benefit of the child, promoting practices that ensure their well-being and development, while the therapist should share information and guidelines necessary for parents, caregivers, and teachers, among others, to collaborate in this process.

In this context, it is essential to question in whose benefit is the demand brought to psychotherapy. Solomon (2013) investigated several examples of parents seeking intervention for children who do not meet their expectations, among them, homosexuals or transgender people. What should be done in these cases? How to act when the content of the complaint is the product of parental prejudice? Should the therapist, in this case, remain neutral or should he or she position himself or herself in some way?

Conducting interventions that aim to modify behavioral patterns by mere preference may not only diverge from the principles that guide the psychologist's practice but also contradict what is beneficial to the child. Prioritizing the child and its full development should be a basic premise to base any conduct of the child therapist.

Besides this issue, we observed in Holland (1978) the discussion about the specific relationship that a behavioral therapist can live with the people who undergo his interventions; many times the ones who define his objectives are not the clients but third parties. Analyzing these relationships becomes essential for the ethics of care.

It seems unreasonable, therefore, to establish a priori impediment relative to the attendance of people with whom the therapist already has some bond or to the establishment of a personal bond in the course of the intervention. However, it is fundamental that the therapist identifies (before and during) the effects of an intervention with these characteristics. There are situations in which the therapist has a personal bond established with the child's parents before the beginning of the intervention. What is the ethical conduct of the clinician in this context, initiate therapy or refer the child to another professional?

In practice, the therapist can choose how to act, provided that his conduct is the product of previous reflection on the different variables involved in each situation and their likely effects. It may be useful, for example, that by knowing the child's parents the therapist has access to variables of the context which he would not have if this relationship did not exist and whose lack of knowledge would hinder the progress of the intervention. On the other hand, it may be that a previous attachment of the child's parents to the therapist makes it difficult for the child to trust the therapist, for fear that what is open to him will be shared with his parents.

It may also be that the child is under coercive control in his home environment, which could imply at least two problems for the therapist. The first would be the therapist sharing aversive characteristics (Skinner, 1953/2000), due to establishing relationships with figures who adopt coercive practices, and the second would be the therapist having to intervene in the contingencies present in the home environment. Would a personal bond contribute to this intervention or hinder the therapist's management?

When it comes to the therapist-child bond, there are several variables that may interfere with the appropriate conduct of the intervention. In adult psychotherapy, although it is possible that the client establishes a strong bond with the therapist, in general, the adult is able to understand the specificity of this relationship. The therapist is also able to evaluate the possible interference of the bond with the client and may make this one of the objectives of his intervention (Kohlenberg & Tsai, 1991).

In child psychotherapy, however, it can be difficult for the child to understand the boundaries of the relationship. How can someone who is so nice and whom the child likes or trusts so much not be allowed, for example, to attend his home or birthday parties? The therapist may decide, on the other hand, to accept an invitation from the child for his birthday, but should not do so without first analyzing the situation. Variables that may be considered in making the decision are as follows: (a) Where did the invitation come from – are the parents and the child in agreement about the therapist's presence? (b) Does his presence fulfill part of the objectives of therapy (e.g., the child feels valued) or, oppositely, would it go against the intervention proposal, if he is facing a child with difficulties to hear "no"? In cases of this nature, the therapist may act in any direction, as long as he conducts a careful evaluation that foresees the probable effects of his conduct, as proposed by Dittrichi (2010). Again, the fundamental is that the therapist's decision is always based on what is beneficial to the child's therapy (and development).

Despite these considerations, although it is impossible for the therapist to be a *neutral* element, since he will establish a reinforcing history with the child, it will

probably always be of greater contribution to the intervention to deal with variables that are accessible to his observation and evaluation. Experiencing new stories with the child in extra-therapeutic contexts may influence the therapist-child bond in such a way as to make it difficult to properly assess the variables that control the child's behavior and your own behavior.

Finally, Skinner (1953/2000) stated that psychotherapy aims to "reverse the behavioral changes that occur as a result of punishment" (p. 404) and that the therapist should configure himself as a nonpunitive audience. As stated by Vermes et al. (2007), the therapist should welcome the client without any criticism or judgment, and the selection for strategies involving positive reinforcement should be sovereign (Sidman, 1995; Skinner, 1953/2000). As Skinner (1953/2000) defined, in addition to the response reinforcement effect, the pleasure effect is also part of positive reinforcement contingencies. Thus, creating a context in which the child can have fun is an important step for both therapy and therapist to be reinforcing sources.

Exposing the child to potentially aversive situations, such as talking about difficult subjects, for example, requires careful planning by the therapist about the contingencies to be arranged. If the aversive effect is unavoidable, it is essential that the therapist plan additional strategies that potentiate alternative positive effects.

## Share Information

Confidentiality and information sharing are issues of primary relevance in clinical practice. To address potential conflicts in situations of information protection or exposure, the APA (2017) states as guiding principles: "The primary obligation to take reasonable precautions to protect confidential information obtained, through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional, professional, or scientific relationship rules" (APA, 2017, art. 4.01). However, it is reserved the possibility of exposing the information in cases of patient consent, unless prohibited by law, and, when there is no consent, it is possible that this occurs in cases that the law requires or allows sharing in criteria of relevance. The Code of Conduct in 4.05, item b, lists four possibilities: (1) to promote necessary professional services; (2) to obtain appropriate professional consultation; (3) to protect the client/patient, psychologist, or others from harm; or (4) to obtain payment for services from a client/patient, in which case disclosure is limited to the minimum necessary to accomplish the purpose.

In child psychotherapy, issues regarding confidentiality tend to be frequent, first, because the therapist establishes a direct relationship with the child's parents, who expect frequent feedback from the therapist about aspects of the intervention. In general, parents seek therapy for their child because they identify something that concerns them and want it to improve. Parents have a right to information about their children. However, when starting the intervention in child therapy, the therapist makes a commitment to the child that whatever is talked about in that context will be a secret between them.

In addition, it is not uncommon that the therapist needs to relate to professionals from other areas who are part of the multiprofessional team. The exchange of information is common practice in these cases. But, what makes sense to share? How does one define what is strictly necessary information, following the recommendation of the Codes of Conduct?

Millenson (1967/1975) defined process as "what happens over time with significant aspects of behavior as a procedure is applied" (p. 56). Differentiating the content of what the child does in therapy, such as what he or she draws in front of an instruction, what he or she tells in a fantasy story, and comments he or she makes during play, from functions of these behaviors in relation to the chief complaints may help the therapist decide what to share with parents. It will probably always be more useful to share aspects of the process than to present data about the content of the activities performed. When a child verbalizes that "he doesn't like daddy because he is very angry or because he grounded him," the therapist can talk to the parents, for example, about the effect of coercive parenting practices, without necessarily describing the content of what the child did or said.

One must agree, however, that in situations in which psychotherapy is carried out with children with easily manageable complaints and cooperative parents, deciding on the confidentiality of information is usually a relatively simple task. On the other hand, there are situations in which the breach of confidentiality is mandatory, as a way to preserve the physical and emotional integrity of a child. In general, we observe that for decisions of this type, it is chosen to start from the principle of the least risk or harm and, especially, to ensure the protection of the child.

Examples of some situations like these are those involving suspected or confirmed sexual abuse and/or physical violence, neglect, maltreatment, and parental alienation. Although the decision is not always easy, either because the therapist is not sure of the facts or because it may involve precisely those people who are responsible for taking care of the child's life, the time variable for decision-making is primordial, since in these cases it determines the time of exposure of the child to the observed violence.

Acting quickly does not mean acting without caution. It is up to the psychotherapist to analyze the situation before choosing to break confidentiality and other measures. This analysis should include (a) a survey of the maximum possible variables that may contribute to the therapist's evaluation; (b) contact with members of the multiprofessional team (if any), in order to probe if there is similar suspicion; (c) contact (via telephone or website) with the body or association representing the professional class in the region, for guidance; and (d) supervision with an experienced therapist (if the therapist considers it necessary) or dialogue with colleagues who have experience with similar cases.

In spite of this, it is fundamental that the therapist knows that the investigative function of the cases does not fall to him/her. This function is generally performed by other social organs, public, or, if they exist in their realities and communities, by the Guardianship Councils and the Child and Youth Courts. The excess of caution, proper of the nature of the profession, can put the child at greater risk or even incur in punishment to the psychologist.

In situations in which the child therapist is requested to testify in court, it is important that he/she only provide information that is the result of objective procedures of data collection and analysis and that he/she only takes a position in favor of one side when he/she has sufficient information to justify his/her conduct. Otherwise, it is recommended that he or she be descriptive and neutral, so that the case can be investigated and judged by the responsible bodies.

## Documents: Preparation and Care

Some associations and bodies responsible for the profession of psychologist may make it mandatory to record the intervention performed, in the form of a medical record. The medical record is a common document for health professionals and its purpose is to "facilitate patient care" (Farina, 1999, par.1). The information contained in it can be accessed by the patient, whenever requested, since the medical record belongs to the patient (Farina, 1999). In child psychotherapy, it does not make sense for parents to access all the information of the intervention, so the information that can be accessed at any time should be included in the record.

The recommendations of codes of ethics and conduct are usually concerned with talking about documentary records. In the publication of the APA (2017), we observed that functions are defined for the record that should guide the therapist's practice of recording. The documents produced from the notes and information collection in professional activity should have a scientific character and the purpose of: "(1) facilitate the provision of services by them or by other professionals later, (2) enable replication of planning and research analysis, (3) meet institutional requirements, (4) ensure billing and payment accuracy, and (5) ensure compliance with the law (APA, 2017, Art 6.01)." A good example of a medical record or the documentary record should contain a set of information whose purpose is to succinctly describe the work, covering the following items: (a) identification data, (b) assessment of the complaint and establishment of work objectives, (c) record of the evolution of the case and the procedures adopted, and (d) record of referral or closure (Conselho Federal de Psicologia, 2005). It should also contain the copy of additional documents that were written by the psychologist throughout the intervention.

The fundamental thing is that the therapist records the evolution of the case in a medical record or documentary record. The update of the record is decided by each therapist, depending on the criteria they use to define objectives and to evaluate the evolution of the case.

On this topic, it is worth mentioning the seminal study by Baer et al. (1968), which offered fundamental dimensions for applied research in behavior analysis and that could guide any intervention in this approach. Among the proposed guidelines are the selection and description of procedures based on science, the recording of the measures used, and the constant evaluation of the effects of the intervention on the individual's behavior. Child behavior-analytic therapists should consider these recommendations in the daily exercise of their work.

With regard to other documents that may be requested by the child's legal guardians or by judicial requests, it is necessary for the psychologist to follow the structures defined by the bodies that regulate the profession in their region. In general, the bodies define the types of documents and how the structure of the document should be in different cases. If, by chance, this does not occur in the reality of the therapist's profession, it is recommended that the therapist contact these bodies or associations, formally requesting guidance. Some examples of different documents are (a) statement, (b) attestation, (c) report, and (d) opinion (Conselho Federal de Psicologia, 2011). Each of these documents serves a specific purpose and should be written in clear and precise language, including only the information that is essential to fulfill the purpose of the requested document.

It is also reiterated that the documents produced by a psychologist must meet the scientific parameters of the area. To this end, it is strongly recommended that the therapist collect data in the most diverse situations and be parsimonious. Describing what was observed is different from inferring data from mere observation. Even if the therapist establishes working hypotheses, it only makes sense for him/her to describe them as a conclusion if he/she has obtained the data from experimentation, as described by Iwata and Dozier (2008). Otherwise, the therapist should record his observations and present possible hypotheses (when based on hard data) without subjective judgments.

The professional should also take care that the documents are stored in an appropriate place, preserving the confidentiality of the information. The information can be registered on paper or in computerized media, but it is essential that the access to it is protected. The documents must be available for inspection by the professional regulatory bodies, when requested. Finally, it is recommended, and for some regulatory bodies of the profession, mandatory, that the psychologist be responsible for the final destination of the confidential files, in order to ensure the privacy and identification data of his or her client (example: Conselho Federal de Psicologia, 2011).

## Relating to Other Professionals

In most cases the child therapist will relate to other professionals, psychologists, or from other professions throughout the interventions. Therefore, the assumptions of multiprofessional teamwork are relevant repertoires of support and guidance to therapists' conduct. It should be emphasized that teams should ensure constant communication and organize their activities based on scientific methodology. In addition, it is part of the work to contact a previous professional, if there is one and if it is possible, either by request of those responsible for the child or by decision of the psychologist himself; in the latter, those responsible for the child must agree. The collection of information about the case, including what was the complaint that led the child to the previous clinician, what was the methodology of his work, what effects he observed during treatment, and what was his general view about the case, can contribute to the current therapist's analysis and planning for the intervention.

In the context of child care by multiprofessional team, communication with professionals should be constant, respecting the limits of confidentiality of the intervention. As already presented, one should share only the information that is relevant to the general understanding of the case, without providing details that unnecessarily expose the child or communicating aspects of the therapist-client relationship that will not lead to any benefit for the progress of the intervention.

Finally, the recognition of the specificity of their work and the scope of their intervention is necessary so that psychotherapists do not assume responsibilities for which they are not qualified, and, if they observe that they are facing a demand for which their specific knowledge is not adequate, they should take responsibility for referring it to the appropriate professionals. In cases of children with difficulties in different areas, it is important that the therapist evaluate which professional can best meet the demand and make the referral.

## Conclusion

This chapter aimed to present some ethical issues pertinent to the context of child psychotherapy. The main recommendations from normative documents were synthesized in the following categories: (a) being theoretically and technically able; (b) acting for the benefit of the child; (c) sharing information; (d) drafting, keeping, and forwarding documents; and (e) relating with other professionals. An attempt was made to define these actions of the therapist, considering the way they relate to the daily life of the child psychotherapist.

The aspects raised demonstrate the importance of the psychologist being aware of which behaviors are defined as ethical within their category and professional regulatory body and demonstrate, above all, the need for an analysis of the multiple variables involved in each ethical decision-making situation. As Vandenbergue (2005) highlighted, analyzing contexts "imposes a relational ethic on the therapist, in which the clinician has responsibility not only for the client, but also for the contexts in which their actions and the effects of their actions have relevance" (p. 64).

In the face of ethical conflicts, the professional will benefit from guidance from councils, associations, and other bodies that come to regulate the profession in their context and region, from contact with other colleagues who have experience with similar situations, and with members of the multiprofessional team (if any). Monitoring news on related themes contributes to the improvement of the clinician's repertoire. Newspapers, bulletins, and communications from professional support and regulatory bodies, as well as the websites of these institutions, generally contain constant and updated information on ethical issues in the daily life of the professional. A varied repertoire on the part of the therapist develops in the exposure to different contingencies and contributes to their conduct being.

The survey of issues that may contribute to therapist decision-making suggests that Skinner's proposals for psychotherapy (1953/2000) and for situations involving the teaching of skills (1968/1972) may assist child therapists in acting ethically in

the different circumstances of their daily professional life. Examples of these proposals are (a) the indication of the use of massive positive reinforcement in detriment to aversive control as the basis of intervention strategies, (b) the suggestion for the therapist to evaluate the effects of the client's behavior in the context in which he/she is inserted, (c) the recommendation for the therapist to establish himself/herself as a nonpunitive audience, (d) the notion of multidetermination of behavior and the need for the identification of the several variables that control behavior, (e) the indication of performance recording, and (f) the constant measurement of the intervention effects, to name a few.

Knowing the guiding principles of behavioral science and basing application strategies on them will increase the likelihood that the child therapist will adopt ethical conduct. And finally, as stated by Dittrichi and Abib (2004) "if behavior analysis is supported by a philosophy – radical behaviorism – which includes an ethical system, it is expected that analysts seek in this system the guidelines for their interventions" (p. 432).

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