THE APPLICATION OF LEARNING THEORY TO THE TREATMENT OF CASE OF SEXUAL EXHIBITIONISM

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THE APPLICATION OF LEARNING THEORY TO THE TREATMENT
OF A CASE OF SEXUAL EXHIBITIONISM

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This case history describes the apparently successful treatment of a patient who had been an exhibitionist for more than 5 years. The particular techniques combined desensitization and the shaping of a response incompatible with anxiety.

**History**

The patient, a 23 year old, white, single man, was referred to our clinic by the dean of his university because he had been apprehended by the local police for sexual exhibitionism. The police agreed not to press charges if the student would secure treatment.

The patient's parents occupied very prominent places in the social and religious life of the community. In high school and at the time of treatment the patient was an A student, very active in athletics and prominent in the social life of the campus.

The examining psychiatrist diagnosed the patient as Sociopathic Personality Disturbance and noted in his report that the prognosis for behavior change was poor in view of the fact that the patient had a history of exhibitionism dating back to his 13th year.

The patient had shared a room with his two younger sisters during his early childhood and had a problem controlling his masturbation in adolescence. His earliest recollection of overt sexual exhibitionism was standing unzipped in the shadows of a barn whose doors overlooked a highway. In the ensuing years the patient continued to exhibit himself on the average about once a month at windows and while driving his car in strange towns. Complaints had been either "hushed up" or explained away on the basis of indiscretions. Careful questioning revealed that the preferred sexual object was a young (age 8-15 years) immature female. The patient had gone "steady" twice in his life, but had dated many different girls briefly. At the time of the arrest, he had been engaged for two years and was shortly to be married. His fiancee was a senior in a different college and she was apparently quite religiously oriented.

**Pre-treatment Status of Response**

Starting about two months prior to his arrest, the patient had begun to expose himself more frequently and in many more locations (outside junior high schools, in public libraries, in stores, while driving his car close to the sidewalk at traffic lights and stop signs, etc.). Previously he had exposed himself only at his window and driving his car with his pants open through strange towns. Now he was exposing himself consistently in at least seven additional physical locations.

The rate of the response had also increased. Previously he had no recollection of ever exceeding one or two exposures a month, but in the two months prior to the arrest, he had at times exposed himself as many as ten times per week.

He also reported that he was restless most of the time, unable to concentrate and generally "jumpy." He noted that he was considering postponing his approaching marriage due to his "poor health."

Until the time of the arrest, the patient had been able to keep all knowledge of his exhibitionism carefully concealed from his fiancee. Physical contact between them had never gone beyond kissing and holding hands. In fact, he admitted that in all his heterosexual experience he had never touched a female's genitals, though on one occasion he had lightly fondled a girl's breasts through her blouse. The patient firmly asserted that his avoidance of all sexual contact was exclusively due to religious scruples. He denied homosexual contact of any type, either in childhood or adolescence. His masturbatory fantasies,
which were exclusively heterosexual, always stopped short of actual sexual intercourse.

The patient reported that in the past when the impulse to expose himself arose but the location was "dangerous," he would seek relief in solitary masturbation. However, he added that more recently masturbation seemed less pleasant to him.

On the basis of the above information the following diagnostic hypotheses were formulated: (1) The patient was fearful of sexual contact with adult females and specifically of vaginal contact. (2) The alternative masturbatory response was becoming progressively less reinforcing. (3) The religious scruples were rationalizations.

Theoretical Views of the Etiology of Exhibitionism

Psychoanalytic theory asserts that the exhibitionistic response is a defense against castration anxiety. Castration anxiety is among other things traced to the vagina dentata hypothesis (Fenichel, 1963), which may suggest a vaginal phobia. In terms of a 2 factor learning theory, this would imply that certain stimuli configurations (young females in this case), which have been paired in early childhood with aversive stimuli, typically elicit anxiety and the performance of the exhibitionistic instrumental response in their presence is anxiety reducing. This formulation regards young females as having acquired on a contiguity basis anxiety evoking properties for the exhibitionist. The act of self-exposure and the perception of his intact penis has somehow acquired the ability to reduce this drive (anxiety). But the exhibitionistic response probably persists because young females loose their aversive properties, and since the exhibitionistic response is a form of solution learning, it comes to be increasingly maintained by sexual drive reduction. Hence, a response originally acquired on the basis of anxiety reduction comes to be increasingly maintained by sexual drive reduction.

Behavior Modification Plan

Two approaches seemed open, but the second one seemed to have more long term merits.

1. Contingencies could be manipulated to restore even temporarily the reinforcing properties of the masturbatory response. The prediction would be that as masturbation increased in frequency, the more "dangerous" exhibitionistic response would decrease in frequency.

II. An alternative approach would attempt to shift the sexual approach responses from young females to adult females and to increase the amount of associated reinforcement from mere exposure to actual physical contact and intercourse with adult females. The first step in remediation then would be to associate "relaxed" rather than "agitated" responses with the sexual stimuli of adult females. The next step would be to set up contingencies in which the patient's sexual approach responses toward adult females would have a high probability of reinforcement.

Preparation of Patient for Treatment

After the psychological testing was completed and a comprehensive picture assembled of the patient's current life space, a meeting was scheduled to explain the treatment plan to the patient and to secure his consent to implement it. In a matter of fact manner, it was explained to the patient that he had been born in a different time or into a different sex, he could probably have continued to practice exhibitionism and live a productive and profitable life (e.g., as a burlesque artist). But that at the present time and in the present location the penalties for self-exposure were severe, as the patient had found out (he had been asked to drop out of school till "cured.") The therapist then told the patient that he believed that the patient's lack of sexual experience with adult females was due to the patient's fear of sexual contact with adult females. This fear, he pointed out, had lead to a legally prohibited means of sexual expression. The therapist also remarked that he considered the patient's talk about religious scruples rather flimsy camouflage. Initially the patient responded with anger to these observations and vigorously repeated his claim to religious scruples. The therapist then explained that the primary goal of the treatment should be to accept them, would be to desensitize (principle was explained) his fear of sexual contact with adult females and to shape his sexual responses more in the direction of heterosexual intercourse. The therapist predicted that when the patient started having heterosexual intercourse, he would lose interest in his potentially dangerous exhibitionist behavior. The therapist pointed out that the active participation of the patient's fiancee would be vitally important to the treatment procedure. The therapist stressed the fact that since the patient was engaged to be married, the conventional social prohibitions against premarital intercourse were somewhat more relaxed. But he also emphasized the fact that the proposed treatment
procedure was purely experimental, even though it seemed to make good sense. The patient and the therapist also discussed the fact that with the use of conventional treatment procedures the prognosis for recovery was poor and the duration of treatment was indefinite. The patient was also told that if he would prefer to undertake conventional treatment, arrangements could be made for such services either in the present clinic or with a private practitioner. He was then given the names of several private practitioners and directed to go home and think further about this choice. The patient was strongly encouraged to discuss in confidence with his minister his present predicament and the choice he had between the lesser of two imperfect solutions. He was also requested to discuss the treatment plan with his fiancee (who for the first time had learned about his sexual deviation after his arrest.)

A few days later the patient indicated that he was willing to take the experimental treatment and an appointment was scheduled with him and his fiancee. The patient's fiancee felt that before treatment commenced she should marry the patient. This inclination was strongly discouraged by the therapist on two grounds: (1) The treatment was purely experimental and there was no guarantee that it would succeed. (2) There was a possibility that should the treatment succeed, the present basis of their mutual attraction would dissolve and that the patient would develop a wider interest in females.

Initially the patient's fiancee raised numerous objections to the second part of the treatment plan on both religious grounds and the possibility of pregnancy. The therapist admitted that there were serious moral issues involved here. He noted that the discovery of the patient's problems did not seem to have disrupted their plans to marry the patient and she apparently still loved him and was eager to assist with his social rehabilitation. At the close of the interview, both the patient and his fiancee tentatively agreed to try the experimental treatment plan.

**Treatment Techniques**

The first step in the treatment plan was to train the patient in relaxation and this was largely accomplished with the use of a tape and relaxation instructions. From here on the desensitization procedure described by Wolpe (1958) was used consistently. Instruction in the tensing and relaxing of his muscles were also recorded on a tape the patient purchased and the tape was used as a guide to his practice of relaxation at home. The relaxation training period took approximately three one-hour sessions. But between clinic sessions, the patient engaged in distributed practice of these exercises 1 to 1½ hours daily. Even after the desensitization proper had begun, the patient continued to practice muscular relaxation at home.

The construction of the anxiety hierarchy provided additional evidence of the patient's aversion for the sexual stimuli of adult females. For example, one of his homework assignments was to construct in rough form a hierarchy starting with strictly social contact between himself and adult females and terminating in sexual contact. He was also required to construct a similar hierarchy for young females. The scenes covering social contact with adult females were on the average 25 words long, but those covering sexual contact with adult females were on the average only 3 words long. During hierarchy refinement the patient was observed to be sweating and restless as the sexual imagery of adult females was approximated.

As the desensitization procedure approached its middle phase (in the 7th session) it was decided to start the shaping of an additional response incompatible with the anxiety evoked by the sexual stimuli of adult females. The patient was assigned selected readings with progressively more heterosexual erotic content (care was taken to avoid material containing reference to young females). This was perceived as the first step in shaping bolder heterosexual approach responses to adult females. For example, the first step was reading a lightly sexually toned passage from Steinbeck for five minutes in the sixth session. After he had completed reading it, he was reinforced with verbal approval "very good," "fine," etc., and a smile. These reading sessions were seldom in excess of ten minutes and he typically read two to three passages with continuous reinforcement ("very good," "fine," etc.). At the termination of this technique in the 12th session, he was reading passages from books like "Fanny Hill," etc., and did not seem to need verbal reinforcement to keep up this type of reading at home. Previously he had reported being unable to read even moderately heterosexual erotic content for presumably religious reasons. The purpose of this step was to direct his mediating responses (verbal behaviors or thoughts, etc.) into the area of the sexual stimuli of adult females.

The next step was to set up a series of trips with his fiancee to both neighboring towns and to distant large towns for recreational purposes (ball games, plays, movies, zoos, etc.) and these were scheduled towards the
terminal phase of the desensitization procedure. The first of these trips was scheduled in between the 12th and 13th session of treatment. Before each trip, the patient was explicitly told how far his petting behavior should go and strictly forbidden to go beyond the prescribed points. These points were fondling of breasts, stomach, legs, thighs, and finally genital areas. Before these trips were scheduled, the therapist explained to the subject’s fiancée the rationale of the treatment and the importance of consistently and clearly reinforcing his limited sexual approach responses. For example, on the first trip the patient was explicitly restricted to kissing and the fondling of his fiancée’s breasts. These restrictions on the extent of his sexual responses were generally reduced as he continued to report greater comfort and feelings of competency in his sexual relationship. After the initial stages of this shaping procedure, both the patient and his fiancée began to take an active interest in the treatment.

As the desensitization and shaping proceeded concurrently, the patient spontaneously reported a phasing out of his impulse to exhibit himself and his exhibitionistic ruminations. However, at least on two occasions during the initial stages of treatment (between the 2nd and 4th sessions) the patient reported that while returning home from a distant town where he had searched fruitlessly for employment, he had driven a number of blocks with his pants unzipped. On both occasions the exposures had occurred in areas where young females were at play.

During the 14th session of the treatment phase the therapist recommended that the patient move out of his parents’ home and attempt to support himself independently. This recommendation was made because it was the therapist’s judgment that the patient’s parents and particularly his mother were reinforcing what seemed to be his dependent attitudes. When this recommendation was first made in the 2nd session of treatment it was ignored, but when it was repeated in the 14th session of treatment, it was quickly implemented.

**Termination**

Treatment was terminated after the 18th session. At this time the patient and his fiancée reported a very satisfactory sexual relationship between them. According to the patient’s report at termination, he had not exposed himself since the 4th session of treatment (a period of approximately 2½ months). The frequency of his sexual relationships with his fiancée had risen from nearly zero to a mean of two relationships (mainly petting and coitus) per week. There was no evidence of “symptom substitution,” even though a deliberate effort was made to look for it in the final interview. There were no indications of homosexual preoccupations or other deviant preoccupations. The patient reported an increased ability to concentrate and freedom from the pre-treatment restlessness. Also both he and his fiancée reported their relationship was “deeper and more real” to them now. At termination the patient had secured employment and was making tentative plans to complete his education and get married.

**Follow-up**

In the first follow-up six months after treatment the patient and his fiancée were separately asked: 1. Has there been any recurrence at all of self exposure? 2. (a) Have you had any new disturbing thoughts, feelings, or motor responses? (b) Have you re-experienced any old disturbing behaviors of the above type? 3. How frequent and satisfying is your present sexual relationship? 4. How often do you have thoughts and feelings about self exposure? The patient responded to the first and second questions in the negative. He reported that his sexual relationships with his fiancée have increased to a mean of about three intimacies a week since the termination of treatment (this was confirmed independently by his fiancée) and he described their relationship as “extremely” satisfying. In response to the 4th question, he stated that just after the termination of treatment he had sporadically had thoughts and feelings about self exposure and particularly at times when he felt “low.” But recently these thoughts and feelings had become “very infrequent.”

The patient’s fiancée, to the extent she could, confirmed his descriptions. They were to be married very shortly.

In an identical follow-up procedure ten months after termination (the patient had now married his fiancée) both persons’ responses were substantially the same as four
months previously. The only difference being that the patient could not recall any thoughts or impulses to self exposure in the last four months.

**CONCLUSION**

The unique feature of this treatment consisted in that the extinction of the anxiety associated with the sexual stimuli of adult females was accomplished by training the patient in not merely one but two responses incompatible with anxiety. The sexual stimuli of adult females was paired with relaxation responses and sexual approach responses. The interference theory of extinction (Kimble 1961) would seem to predict more lasting extinction under such conditions. The brevity of the treatment was probably due to at least three factors. One, the treatment procedure involved the manipulation of very powerful reinforcement contingencies (sexual stimuli).

Two, the desensitization procedure was run nearly concurrently with shaping of an incompatible response (heterosexual approach response). Three, it is our experience (Wickramasekera, 1967) that changes in cognitive and affective responses are most effectively induced by first changing the patient’s motor responses. The self evident nature of the patient’s changed motor behavior may increase his feeling of “hope” and reduce his resistance to cognitive manipulations. Hence, treatment may be accelerated by a snowballing “placebo” effect.

Nearly all published studies of the behavioral treatment of sexual deviations up to date have used one form or another of “aversion therapy” (Feldman, 1966). These have been either “punishment” (Azrin and Holz, 1966) or avoidance conditioning procedures. The present study suggests that sexual deviations may also be treated through the shaping and positive reinforcement procedures. This study illustrates an alternative approach which may have some merit, but the lack of proper controls makes it impossible to draw any firm conclusions from the data.

It seems relatively inefficient to provide “insight” into a patient’s insecurities and immaturities till we have been able to set up contingencies of reinforcement that help patients to emit more mature behavior and secure reinforcement for it. After “symptomatic recovery” has been induced, any sort of plausible rationale (Freudian, existential, Adlerian, R.T., etc.) of the etiology of the disturbance, which will hopefully function to prevent further unadaptive learning, may be explored with the patient, particularly if the therapist feels an obligation to “explain” and the patient a need to “understand how it all got started in the first place.” But the matter of etiology would seem peripheral to the immediate problem of behavior modification.

**REFERENCES**


