A TECHNIQUE FOR CONTROLLING A CERTAIN TYPE OF SEXUAL EXHIBITIONISM

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The following paper describes a provisional experimental technique for the control of sexual exhibitionism. The technique is brief (2-4 sessions and the duration of each session is approximately 50-60 mins.) and relatively objective. It appears to be applicable only to a subset of sexual exhibitionists. For example, neurotic patients with high manifest anxiety, fundamentalist religious backgrounds, and strong motivation. It is our impression that even patients as select as those above cannot reliably control their impulse to exhibit themselves when involved in a conventional cognitively focused psychotherapy. Procedures very similar to the present one have independently been developed and are reported to be highly effective (Serber 1970, Reitz & Keil 1971). The uniqueness of the present procedure resides in its incorporation of both cognitive and behavioral strategies, in a context of video feedback to increase the probability of a more total (motoric, affective and cognitive) and durable form of behavior change.

Observational and Speculative Origins of the Technique

In the last eight years we have experimented with several techniques of controlling sexual exhibitionism. For example, I have tried systematic desensitization and behavior shaping procedures (Wickramasekera, 1968), hypnosis and certain Gestalt techniques, and more recently electric shock used as a straight punishment (Azrin & Holz, 1966) procedure. The technique or combination of techniques I selected were influenced by my diagnostic hypotheses concerning what had originally caused and more importantly what was currently maintaining the deviant behavior.

Aversion Therapy

Through clinical experimentation with electrical aversion, we stumbled on two interesting observations. (1) Aversive methods appear very quickly and reliably to inhibit (follow-ups ranging from 6 months to 3½ years) deviant sexual behavior in certain males. Clinically these males are recognizable, even though I know of no objectively validated and reliable method of identifying them. I speculated and Eysenck (1968) recently suggested that these are the types of patients who would demonstrate the “Nepalkov phenomenon.” This phenomenon refers to an increase in the magnitude of the CR when the CS is presented without the UCS. This procedure typically produces extinction but in some animals it has been shown to produce an increase of the conditioned emotional response (Rohrbaugh & Riccio, 1970). I have suggested (Wickramasekera, 1970), that the rare phenomena of “resensitization” in systematic desensitization is probably related to the “Nepalkov phenomenon.” Resensitization appears to be associated with a rapid deterioration of the patient’s symptoms and appears to be caused by high anxiety stimuli prematurely introduced into treatment. (2) We also noticed that for the majority of sexual exhibitionists treated with aversion therapy the behavioral rehearsal of their deviant act in the consulting room appeared to be far more aversive than the actual electrical aversion which was paired with this behavioral rehearsal.

The following is a description of the electrical aversion method we used. First, we required the patient to form a clear subjective image of the deviant act. When the image was clear he was requested to raise his left fore-
finger and immediately an unpleasant electric shock was delivered to his leg. Typically after several such pairings the patient will report an inability to form a subjective image of the deviant act. The treatment next shifts to an overt behavioral sequence. The deviant act is divided into ten parts. For example, behavior one may involve unzipping his pants and behavior ten may involve masturbation with full erection. So that in the second stage of the technique the patient was actually behaviorally, and not simply cognitively, rehearsing the deviant act in the consulting room. The aversive stimulus was first applied to only behavior ten. On the next day if behavior ten could not be elicited with verbal instructions and persuasion, aversion was applied only to behavior nine, and so on down the chain to behavior one.

I found that persuading even highly motivated patients to go through the second part (behavior rehearsal) of the treatment sequence was extremely difficult. The patient became shaky, nauseous, reported headache, cramps, lightheadedness and palpitations. This led me to wonder if rehearsing the deviant act in the consulting room was not more aversive to some patients than the electric shock itself. If the behavioral rehearsal of the deviant act in a clinical situation was highly aversive in itself, it seemed to have at least one major advantage over externally originating electrical aversion: the patient’s active participation in generating within himself the aversive consequences. It would be interesting to know if such internally generated aversion, which probably involved interoceptive conditioning and visceral changes would be less susceptible to discrimination learning. Currently discrimination appears to be the major factor reducing the generalization of the conditioned emotional response (Mowrer, 1958) from the consulting room to the patient’s natural habitat.

Hypnotherapy

While experimenting with hypnotic techniques in controlling sexual exhibitionism we made the following observations. Certain exhibitionists, it appeared, would frequently, spontaneously and unknowingly enter a dissociated or trance-like state prior to an exhibitionistic episode and while in that altered state of consciousness (Tart, 1969) would cognitively rehearse the highlights of the anticipated episode several hours prior to the actual event. This cognitive rehearsal of the event within a presumed altered state of consciousness prior to its actual occurrence, appeared to be a type of self-induced post-hypnotic suggestion. Also the deviant act itself is frequently described by this sub-set of exhibitionists as if it were enacted in a trance state. For example, it is enacted compulsively (or quasi-automatically) it is enacted with apparent reduced critical judgment (e.g. patient will use his own car with identifiable number plates, etc.), narrowed focus of attention, a partial or total amnesia and after completion of the act there is a subjective feeling of tension release or closure. There are clearly certain striking resemblances between the above subjective experience of certain exhibitionists and certain known parameters of hypnotic behavior in general (Hilgard, 1965) and post-hypnotic behavior in particular (Orne et al., 1968; Wickramasekera, 1971).

Clinically it seems that for a sub-set of exhibitionists the reinforcement properties of the behavior stem significantly from the secrecy, “privacy” and anonymity with which the deviant behaviors are enacted. It also appears that the deviant act is maintained by several very autistic, unverbalized phantasies and primitive affects which require accidental contact with a certain type of female, in a certain environmental context to be potentiated. It would be interesting to know if the reinforcing consequences of the deviant behavior would alter and sate if the act was repeatedly elicited under conditions identical to those prevailing in the natural context in which the deviation occurred, but altered in two ways. (1) Without the element of anonymity; (2) If the patient could be induced to attend, to verbalize and to reflect on the thoughts and feelings which were passing through him as he enacted the deviant behavior. For example, if the patient were to expose himself to several women who were attractive to him but who knew who he was and to whom he would verbalize and talk about the thoughts and feelings that passed through him while he was engaged in the exhibitionistic act.
The above observations and speculations led me to abandon the use of electrical aversion and concentrate exclusively on arranging contingencies to maximize the internally generated aversion the patient experienced and to attempt to alter the "meaning" of the deviant behavior for the patient by changing the context and conditions under which it was enacted.

Description of Technique

The experimental treatment consisted of persuading the patient to actually rehearse the deviant sexual act in an environmental context as close as possible to that in which the deviation naturally occurred, and in the presence of at first one, then two and finally three carefully selected (for convergence with his ideal deviant sexual object) females. The females make no comment but sit expressionlessly observing him and moving the focus of their attention on cue from me, from his penis to his eyes and to other parts of his body. The present therapist was always present guiding the procedures. The patient was told that the females knew his name and had read his case record. The females we used were primarily interns or trainees in psychology or social work. Only patients who were chronic offenders (from police records) who had not responded to conventional psychotherapy and who volunteered for the treatment were accepted. They were carefully briefed as to what they would be expected to do, and informed that this method of treatment was purely experimental, but that it seemed quite promising compared to other long-term conventional interventions. The patient was also asked to sign a paper indicating that he understood that this was an experimental method of treatment. If the patient had a lawyer, the lawyer was also involved in making the decision to participate with this experimental method of treatment. To date we have used this intervention with six patients and none of them have appeared to need or be willing to go through the procedure more than four times. Each actual deviation rehearsal session has typically not exceeded 20 minutes. After the females were dismissed I have spent 20 to 40 minutes encouraging the patient to verbalize any feelings, thoughts, and sensations he did not verbalize while enacting the deviation. Behavioral rehearsal appears to increase the probability of self-recognition of important private events (cognitions and emotions).

In using this procedure we noticed that certain subjects appeared to dissociate or slip into a trance-like state while rehearsing the deviation in the clinic. To try to discourage this we adapted certain Gestalt therapy techniques which instruct the patient to conduct verbally and aloud an introspective dialogue between himself and his penis while enacting the deviation. We also encourage him to verbalize aloud the specific subjective feelings in his body while enacting the deviation, e.g., dry mouth and throat, weak legs, light head, speeding heart, pounding sensation in stomach, tightness in chest. In addition, we also invite him to verbalize aloud to himself and to the females his assumptions and his phantasies regarding what he thinks the females are feeling, seeing and thinking about him. He is also invited to switch roles and having personified his penis to give it a voice so that it can verbalize aloud what it is feeling and thinking about him and the females who are observing it. I have found that this procedure in addition to maintaining the anxiety at a high level, disrupts any phantasies of privacy and occasionally produces some very remarkable personal references and "insights" which patients report are very meaningful to them.

Recently we have begun to video tape the treatment (and encourage the females to ask him brief pointed questions; e.g. What are you thinking? What are you feeling?). These changes appear to increase the impact of the procedure. The following appear to be plausible reasons for the increased impact. (1) Several patients stated that viewing their deviant behavior on a TV screen with the therapist was even more aversive than actually engaging in it at the time it was taped. (2) Patients have suggested the video tape viewing and discussion be used as "booster" if they would ever feel a weakening of self-control over the symptom in the future. (3) The video feedback may have an impact on patients who dissociate during behavior rehearsal in spite of the verbal and instructional interventions. (4) The thought that someone, somewhere, has a visual record of their deviant behavior may be a sobering
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(1) High pre-treatment patient anxiety, (2) Brief, rather than extended exposure to the aversive aspects of the treatment procedure. The duration of the exposure being the critical factor. The effective implementation of the technique assumes a good and open relationship between patient and therapist that enables the therapist to lead the patient through a procedure that can be really quite harrowing to both of them.

REFERENCES


