Aversive Behavior Rehearsal for
Sexual Exhibitionism

IAN WICKRAMASEKERA

University of Illinois

The aversive behavior rehearsal (ABR) technique is a specific procedure for the
management of chronic sexual exhibitionism. The in vivo ABR (I-V-ABR) makes
an appointment for the patient to come into the clinic and expose himself at a
specific time and place to people who know of him. The vicarious aversive behavior
rehearsal (V-ABR) technique arranges for a chronic exhibitionist to observe via
video tape the I-V-ABR treatment of a fellow exhibitionist. Twenty chronic
exhibitionists have been treated with one to four sessions with the above methods,
and none has relapsed to date in follow-ups ranging up to 7 years.

Aversive Behavior Rehearsal (ABR) (Wickramasekera, 1972) is a
technique for the management of chronic (repeated offenders as defined by
police records) sexual exhibitionism in a specific subset of exhibitionists.
The technique or a variant has been independently replicated (Serber, 1970;

METHOD

In Vivo ABR (I-V-ABR) Procedure

It is indicated for patients who are introverted, anxious, moralistic, and nonassertive, and
probably contra-indicated for the extroverted, sociopathic type of patient whose trait anxiety
level is low. It elicits the patient’s symptom (exhibitionism) under conditions which overlap
substantially with the naturally occurring event, but with certain critical alterations. (1) The
“exposure” is deliberately planned by therapists and patient several weeks in advance. (2) The
“exposure” is enacted under conditions of reduced anonymity. (3) During enactment, the
behavior is subjected by the patient and therapist to cognitive-verbal exploration of
associated affect, bodily sensations, and fantasy. The goal is to elicit and “demythologize” any
autistic fantasies that may cognitively mediate the exhibitionism in the natural habitat.
Conditions are arranged to increase the probability that the patient will take a pedestrian,
critical, and analytic view of what he is doing during the act of “exposure.” It has been
hypothesized (Wickramasekera, 1972) that sexual exhibitionism occurs under internal condi-
tions of increased fantasy involvement (Sarbin & Coe, 1972) and reduces critical judgment
(Hilgard, 1965). These patients show reduced critical judgment when they use public places,
compulsively return to the same place with their car license plates clearly visible, and in
numerous other ways temporarily ignore situational dangers. A cognitive shift from fantasy
involvement to a critical pedestrian view may alter the future probability of exhibitionism
under the internal (moods of self-pity, boredom, anger, failure) and external (warm weather,
parks, girls in short skirts) conditions which set the stage for exposure. In some respects, the above intervention is equivalent to reducing the probability of "hypnotic" behavior under specific internal and external conditions which may operate as discriminative stimuli, for hypnotic behavior as it has been conceptualized by some writers (Sarbin & Coe, 1972; Wickramasekera, 1976).

Vicarious ABR (V-ABR) Procedure

A promising variant of the ABR procedure, Vicarious Aversive Behavior Rehearsal (V-ABR), is based on instructing and situationally arranging for an exhibitionistic patient to observe a videotape of a real exhibitionist being processed in vivo through the ABR procedure. The V-ABR procedure is probably indicated for the same type of patients who benefit from the in vivo ABR procedure, but who cannot be processed through the entire 1-V-ABR for one or more of the following reasons: (1) deficient in the motivation necessary to go through the in vivo ABR; (2) medical contra-indications which require that the patient be exempt from the severe stress of the ABR procedure (e.g., positive history of cardiovascular or CNS complications; e.g., angina pectoris, cardiac decompensation, hypertension, epilepsy, etc.); (3) patient with weak reality contact, marginal adjustment, or who is prepsychotic or acutely

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<td>Flow Chart of ABR Procedure</td>
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I. Initial Diagnostic Interview
   A. Collect following facts and formulate relationships
      1. First event (age, circumstances), frequency (in remote and recent past and present), locations, time of day or night, duration of episode, ages and sex of observers (special features).
      2. Masturbation, ejaculation, associated rituals, and fantasies; triggering events (e.g., conflict, failure, weather, female clothing, daydreams, and fantasies).
   B. Present treatment plan and alternatives with prognosis. Present intervention as research, not routine treatment. State side effects, patient reads article on ABR. State restriction on intercourse for 3 weeks following Procedures I and II.

II. Psychological and Psychophysiological Tests
   A. MMPI, Eysenck Personality Inventory, Taylor Manifest Anxiety Scale, Spiegel Eye Roll Test of Hypnotizability, SHSS Form A, Hypnosis Attitude Scale, Protestant Ethic Scale.
   B. Respiration, GSR, EMG, Heart Rate. Baseline and response to standardized stimuli.

III. Medical Tests and Physical Examination (any contra-indications?)

IV. Discuss Treatment Plan with Significant Others and Lawyer. Read and Sign Consent for Treatment and Vodie Tape Forms.

V. Procedure I (40 min of self-disclosure, intensive self-exploration, and confrontation of which approximately 20 min is action physical exposure).

VI. Procedure II (40 min of intensive self-disclosure, self-exploration, and confrontation of which approximately 20 min is actual physical exposure).

VII. Follow-up (3 weeks later) with Observation of Video Tape of Procedure I while monitored psychophysiological (heart rate, EMG, GSR, respiration). Retake MMPI.

VIII. Follow-ups at following Intervals: Three weeks after treatment (view neutral and aversive video tapes). Thereafter, 2, 6, 9, and 12 months, and once each year.
disturbed. The V-ABR is offered only to those patients who have carefully considered and refused the in vivo ABR procedure or to those who are judged likely to be hurt by the in vivo ABR.

Components I-IV have diagnostic utility but also appear to potentiate certain active ingredients in the behavior influence process. These ingredients include self-disclosure, self-exploration, commitment, structuring of positive expectations, and giving the patient responsibility for making the technique work (demand characteristics), etc., which have been empirically demonstrated to be effective variables in both the psychotherapy and the social psychological research literature (Strupp & Bergin, 1972; Goldstein, Heller & Sehrest, 1966).

Component I, section A, elicits and shapes the patient's self-exploratory and self-monitoring behaviors from very specific topics (e.g., first events of exposure, age) to a very general form of self-monitoring and exploration (identification of triggering events). At this more general level, the patient is attempting to relate the onset of his symptom to internal events (e.g., conflict, failure, self-pity, boredom) and external events (e.g., the warm weather, specific location, length of women's skirts, types of female clothing). The identification of these internal and external antecedents or trigger events is important in terms of helping the patient develop an "early warning" system for his post-therapy prophylactic use.

Component I, section B, essentially involves selling the patient on the ABR technique, but doing so in a cautious and ethical manner. Previously observed side effects are described (repeated nightmares, temporary anxiety or depression, secondary impotence) and the requirement of abstinence from sexual intercourse for 3 weeks after treatment is presented.

Components II and III are mainly intended to enable an eventual more precise and objective specification of the type of patient for whom this procedure is indicated or contra-indicated. It has been hypothesized (Wickramasekera, 1972) that trait anxiety, hypnagogic imagery, the degree of socialization, and autonomic lability are implicated in the probability of certain sexual deviations. In addition, the combination of extensive psychological, psychophysiological, and medical tests may create the therapeutic expectation in the patient that grave and healing events are about to occur. The psychophysiological tests currently involve: (a) a 15-20 min adaptation period, (b) a 10-min baseline period, (c) the discharge of a cap pistol from 3 ft. behind the subject at about the level of his head, (d) instructions to solve simple mental arithmetic problems and to read aloud the titles of the books in the bookcase across the room from him, (e) instructions to the subject to visualize with his eyes closed a pleasant and relaxing scene (e.g., soaking in the bathtub, sipping a martini while relaxing by a fire, etc.), and (f) instructions to visualize with eyes closed the last time he was arrested for indecent exposure.

Component IV is the culmination of a series of progressively more tightly interlocking tacit behavioral commitments to change. It requires the patient to make a full disclosure of his deviation, its frequency and chronicity to significant others (parents, wife, etc.), and his lawyer. It also challenges him to persuade them of the wisdom of undergoing the ABR procedure and, in the process of doing so, he appears to strengthen his own commitment. This component closes with the patient signing a release to videotape his naked body for the "advancement of science" and releasing me of all responsibility for possible negative consequences. Components I-IV may take as many as four to eight 50-min sessions.

Components V and VI involve approximately two, 40-min sessions of full self-disclosure, self-exploration, and self-confrontation in the presence of five mental health professionals (social workers, senior medical students, psychiatric nurses, psychology interns) in a large room with a one-way mirror and videotaping of the entire proceedings. It is sometimes hinted at this point that there may be other authorized observers (e.g., referring probation officer, arresting law officer, etc.) on the other side of the mirror. I open the session in a kind, but grave manner and become progressively more obnoxious and confronting as the session progresses. I begin by putting a series of rapid questions to the patient (Please state your name, age,
address, marital status, occupation, children (names and ages), wife, religion, specific deviant sexual acts, associated rituals and locations, objects of exposure, etc.).

The patient is instructed to cue specific acts of exposure and masturbation. The use of numbers appears more effective in securing compliance under stress than verbal requests. The patient is told, “When I say one, you will unzip your pants and lower your underpants; when I say two, you will get a firm grip on your penis (use patient’s own word); when I say three, you will start to masturbate (“jack-off”).”

During and between exposures the patient is pointedly questioned by all the team members individually and requested to attend to different parts of his body or their legs, breasts, crotches, hips, etc. For example, he might be asked to respond to all or some of the following questions and instructions: What is your mood when you expose yourself? What triggers the mood? What do you see now as you look at yourself in the mirror? Describe what you think we see as we look at you right now. What do you think we are feeling, thinking, etc. as we look at you now? How do your hands feel? How does your head, legs, penis, stomach, etc., feel? Give your penis a voice; let it talk to us. Tell us about the man you are in your public life. Tell us about your private life. What are your masturbatory fantasies?

During components V and VI, the patient is asked to disrobe and robe several times while encouraged to explore the relationship between current feelings, moods prior to exposure, during exposure and their relationship to antecedents, consequences and immediate situational factors. He is frequently relieved to be asked to “zip up,” or pull up his pants, but this relief is short-lived because, soon afterwards, he is asked to disrobe again. At the close of the session, the patient is frequently in tears, trembling, weak, and nauseous. I dismiss the team and change abruptly into a warm, kind, supportive figure who wipes his eyes and fetches him a drink of water. I express, sincerely and freely, my admiration for the courage and strength he demonstrated during the previous “hell;” and I leave him in doubt for a few days as to whether another procedure will be required.

The primary contraindications for another procedure are massive sympathetic arousal during the first procedure, “insightful” verbalization with active patient participation, and any (rare) evidence of bizarre behavior during or after the procedure. The primary indication for a second procedure is marginal arousal and “unauthorized” psychological escape behavior while physically present (disassociation). If a second procedure is scheduled, we begin by asking specific details about cognitive, affective, and motor reactions during and after the first procedure, particularly, immediate and delayed reactions. The session continues with some variation on previous material, any new material, or loose ends from the previous session. To disrupt any persisting disassociation, team members approach the patient physically and ask him to describe physical details about other team members, their clothing or body, etc.

RESULTS

The in vivo ABR procedure has been offered to 25 patients. Five have refused at the onset or not completed the I-V-ABR or V-ABR. Sixteen have been treated with the in vivo ABR, and four with the vicarious ABR. The number of treatment sessions with the in vivo ABR have varied from one to four. In the last 2 yr we have never used more than one treatment session. Prior to treatment, the 16 patients had been symptomatic for 4 to 25 yr with rates of exposure varying from 1 to 20 per month. The follow-up ranged from 3 months to 7 yr. Patients in the vicarious ABR group had been symptomatic for 7 to 13 yr. No patient treated with the ABR procedure has reported exposing himself, nor have we detected any relapse. All patients
aversive behavior rehearsal

report having between one to four brief and easily terminated thoughts of exposure at least once in 3 months. Eight reported mild to severe anxiety when thoughts of exposure occurred, the rest reported “neutral” feelings. Frequency of exposure fantasies reduced dramatically, with quality and duration “feeling” vastly different from the pretreatment fantasies. The follow-ups for the vicarious ABR are too brief for inclusion here.

The follow-ups are based on four kinds of data: (1) Verbal report during the periodic individual interviews. Many patients report that, prior to their follow-up treatment, their anxiety level increases and the previous ABR procedure is reactivated in memory. These regular follow-up sessions strengthen the ABR procedure and should be regarded as part of it. (2) Private interviews with significant others (wife, employers, parents, etc.) or telephone calls are used at the time of the patient’s follow-up interview to check on the patient’s verbal report. (3) Search of police records of indecent exposure in the three surrounding counties are used to verify the patient’s verbal report. (4) The patient is shown the results of a video–physio evaluation procedure which is done 3 weeks after the ABR treatment. Immediately after the video–physio evaluation procedure (explained in detail later), the patient is shown the chart records of his psychophysiological reactions to the ABR technique. This increases the credibility of the treatment effects. Routine psychophysiological testing (heart rate, GSR, respiration) during the periodic follow-up interview is presented to the patient “to detect how much of the previous conditioning persists.” Some patients perceive this new procedure as a “lie detector test” and this may contribute further to the inhibition of the deviant behavior. During this procedure, the patient is instructed following a baseline determination to expose himself in fantasy and casually asked, while still connected to the instrument, the number of times he exposed himself since the last follow-up.

The in vivo ABR appears to have side effects observed between in vivo ABR procedures I and II or immediately after treatment. These include moderate to mild anxiety, tension, and depression of 1 to 4 weeks duration, and these disappear after 5 weeks. Repeated nightmares in which the ABR procedure or a variant of it is rehearsed in sleep, have been reported by three patients. Secondary impotence of brief duration has been reported by three patients. Temporary loss of interest in sex has been reported by approximately 10 in vivo ABR patients. All symptoms appear to have cleared up 2 months after treatment.

To reduce secondary impotence we prohibit sexual intercourse for 3 weeks after in vivo ABR procedure I. The mechanism of erection is primarily parasympathetic and, hence, a temporary state of massive sympathetic arousal (post-treatment anxiety and tension) is probably antagonistic to effective sexual functioning. Residual anxiety usually subsides by the third
week after treatment. About one-half the patients will disassociate during procedures I and II to avoid the impact of the aversive reality that has been carefully arranged for them. They will not attend or become “numb” to the full impact of the aversive reality. This “unauthorized form of escape behavior” (Azar and Holz, 1966) has been terminated by insisting forcefully that the patient describe the present physical reality (color of female’s eyes, hair, shape of their breasts, legs, clothes, etc.), his own physical reactions, his current autistic fantasies, and his speculations about the thoughts and feelings behind the females’ faces. I can usually estimate the intensity of the aversion generated by how severe is the exhaustion or tension headache I feel after the procedure.

To determine the psychophysiological consequences of being processed through the ABR procedure and being reminded of it (memory stimulated by observation of the video tape record of their treatment), the following instructional and situational arrangements are made: The patient, told to return to the therapist’s office for “a test” approximately 3 weeks after the last in vivo ABR procedure, is connected to a physiograph (screened from the patient) while he sits quietly on a comfortable recliner. In front of the subject, approximately 8 ft. away, are two videotape monitors. The monitor above is programmed to show a portion of the videotape (aversive tape) of the patient’s treatment. The monitor below is programmed to show a “neutral” or control tape (a portion of the initial diagnostic interview by the present therapist of the patient). After connection to the physiograph, the patient is given 20 min to adapt and “relax.” The control tape is then activated remotely for 8 min. The aversive tape is activated remotely and allowed to run for 8 min. The subject, previously instructed to observe both tapes carefully, is not informed about the contents of the videotapes or the order in which they will be shown. After 8 min of exposure, the aversive tape is switched off and the subject is instructed to relax for 10 min prior to disconnection from the physiograph which has been monitoring and recording his heart rate (BPM), respiration, and GSR during the adaptation, observation, and relaxation periods.

The purpose of the control tape is to determine the psychophysiological consequences of simply orienting to and observing a videotape of one’s self while connected to a physiograph. Inspection of the physiograph

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**TABLE 2**

Flow Chart of Video-Physiograph Assessment Procedure

1. Adaptation and baseline (20 min)
2. Control TV tape (8 min)
3. Aversive TV tape (8 min)
4. Return to baseline (8 min)
record during the exposure to control and aversive tape sequences indicates clear and significant differences in heart rate, Galvanic Skin Response (GSR), and respiration.

The figures show psychophysiological changes occurring in a white male.
adult during two baseline periods and while observing an aversive (a videotape of himself behaviorally rehearsing sexual exposure and masturbation in the presence of three females and two males) tape. The upper trace is of heart rate (BPM), the middle trace of GSR, and the bottom trace
is of respiration. Paper speed is 6 in./min. This patient's record was selected because he demonstrates physiological changes in all three response systems (heart rate, GSR, respiration). Not all subjects tested to date demonstrate clear changes in all three response systems. As implied by Lacey (1959), individual patients appear to show response profiles.

**DISCUSSION**

Instructionally and situationally, the ABR procedure arranges for the elicitation of strong aversive internal consequences (typically patients report or manifest one or more of the following before, during, or immediately after the procedure: trembling, nausea, lightheadedness, palpitations, weakness, cramps, butterflies in stomach, headaches, tightness in chest, etc.) in the patient. "Voluntary" participation (Wickramasekera, 1971) ensures that the patient actively generates the aversive consequences in himself. The aversion is installed inside the subject and outside his control, so the aversive contingency cannot be easily dismantled by the patient, as for example, with a portable and remotely controlled shock generator. It has been speculated (Wickramasekera, 1972) that the procedure may involve interoceptive conditioning. The suggestion that, if aversion is attached to internal cues, the gradient of generalization will be flatter (Miller, personal communication, 1973) may explain the apparently reliable transfer of the suppression of exhibitionism from the clinical situation to the patient's natural habitat.

If the ABR technique is continued over several sessions, the patient will desensitize to the technique. Hence, treatment should cease with a brief "resensitization" (Wickramasekera, 1970).

Many exhibitionists are quiet, nonassertive, moralistic individuals who take few risks in their "public" lives, but become daring figures during their "private" exhibitionistic episodes and fantasies. Their public image may be one of respectability, caution, reliability, and industry, whereas in their private feelings they are desperately bored, resentful, self-pitying individuals whose fantasies are defiant and dangerously exciting.

During procedures I and II, the patient frequently develops "insight" into this inconsistency between his public and private lives and is strongly encouraged to act in more adaptive risk taking and assertive ways in his public life (e.g., asking for a raise or promotion, speaking back to his wife, boss or a peer, changing jobs, trying a love affair). It appears likely that the inhibition of aggressive, sexual-novelty, and excitement needs increases episodically the probability of maladaptive expression (indecent exposure) of such deprivations.

**REFERENCE NOTE**

REFERENCES


