Cognitive-Behavioral Therapy with an Incarcerated Exhibitionist

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Abstract: *Successful approaches to the treatment of exhibitionism, an important paraphilic disorder with respect to offense frequency, are limited in the recent literature. The use of individual cognitive-behavioral treatment with a long-term, incarcerated exhibitionist is presented. Emphasis was placed on the development of insight through informed decision making, as well as improvement in communication style and social network enhancement. Deviant sexual fantasies were targeted for change and more appropriate fantasies encouraged. Phallometric data showed a decrease in deviant responses over therapy and an increase in appropriate arousal.*

Exhibitionism, the paraphilic disorder that involves the public exposure of one's genitalia for sexual gratification, appears to be viewed most often as a "nuisance" sexual offense. Setting aside the question concerning the severity of trauma for victims of exhibitionists (see Cox & Maletzky, 1980), the sheer frequency of the offense demands attention. Cox (1980) noted that roughly one-third of all sexual offenses reported in Canada, Great Britain, and the United States involve exhibitionism. He also pointed out that exhibitionists rank second to child molesters in their number of total convictions. Although it may have been the case that, prior to the mid 1960s, exhibitionism received "more attention in the professional literature [than other paraphilias]" (Mohr, Turner, & Jerry, 1964), such a claim can no longer be supported. Certainly the research and clinical literature continue to grow, but at a very reduced rate.

Both the quantity and the quality of treatment efforts with exhibitionists are lacking. Marshall, Eccles, and Barbaree (1991) concluded that "with few exceptions, treatment of exhibitionists has not been remarkably successful" (p. 129), and a number of more recent studies of both chemotherapy and psychotherapy attest to the validity of such a conclusion (e.g., Veenhuizen, Van Strien, & Cohen-Kettenis, 1992). New therapeutic approaches require examination.

I have been concerned in recent years with applying particular cognitive-behavioral assessment and treatment techniques for use with child molesters (see Horley, 1988; Horley & Quinsey, 1994, 1995), and there is reason to believe that such approaches can be employed effectively with exhibitionists (Marshall, Eccles, & Barbaree, 1991). A key assumption of cognitive-behavioral therapy is that each individual has his or her own world-view and, while we may share beliefs and values, we all operate with a unique set of personal beliefs (cf. Kelly, 1955). One client recently

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provided the opportunity for examining the efficacy of a cognitive-behavioral treatment approach in the treatment of exhibitionism.

METHOD

PARTICIPANT

A 34 year-old male (T.C.) who was incarcerated in a provincial maximum-security correctional facility in Ontario, Canada, agreed to participate in individual counseling to address a longstanding problem with exhibitionism. His previous contact with mental health professionals consisted of intermittent visits to psychiatrists for renewal of a prescription for antiandrogen medication. He was on and off antiandrogens, generally Provera, for three or four years. He discontinued the antiandrogen therapy prior to the present treatment. He had received neither general counseling nor psychotherapy prior to the present treatment.

T.C. was from a large city located in Ontario, Canada, and had a 15-year history of sexual offenses. His most frequent offense (five convictions) was for committing an indecent act (i.e., public masturbation), and he had three convictions for indecent exposure. He had, in addition, three convictions for indecent and sexual assault for offenses where he apparently touched the victim either prior to or during an exhibitionistic offense. He also had prior convictions for drug possession, theft, and common assault.

He reported that he had been committing exhibitionistic offenses since the age of 16 at a rate of one per week. His offenses tended to occur when he experienced negative emotions (especially anxiety, depression, and anger), the result of conflicts with family and friends. His deviant behavior was fueled by sexual fantasies concerning genital exposure, at least two or three per day, which led to daily masturbation to the deviant fantasies. His "typical" offense would be the result of an argument with a family member or girlfriend, and it would involve him leaving home, perhaps on his way to work. He would then find an attractive female, typically a teenager, alone on the street or on a bus/train, unzip his pants to expose his genitals, and often masturbate. During recent years, he learned to approach women with a prior "business proposition" (e.g., "Would you let me pull out my cock here and now if I paid you 20 bucks?") before exposing himself in order to avoid arrest.

TREATMENT

Therapy with this client was presented in two phases. The first involved an explicit relapse prevention approach (e.g., see Laws, 1989) in an individual treatment format. The program involved weekly meetings over a 12-week period. A number of topics for discussion were presented that

included the role of negative emotion in sexual offending, victim impact, developing helping networks, informed decision-making, and avoiding high-risk situations. Homework in the form of mock letters to victims and decision-making exercises was an integral component of this phase of the treatment.

The second phase of the treatment program, again with a strong cognitive emphasis, targeted inappropriate sexual fantasies and deviant sexual responses. Following phallometric assessment to determine his level of appropriate and inappropriate arousal, an intensive two-week treatment with daily one-hour sessions was arranged. Most sessions included monitoring of penile responses to a set of audio descriptions of both consenting (heterosexual) and nonconsenting (exhibitionistic with an adult female) depictions either before or after discussion of a relevant issue. The second phase of treatment included some further examination of negative emotions, family relations, and communication style within a sexual relationship, but sexual fantasies were targeted. Deviant fantasies were discouraged using covert sensitization (Cautela, 1966). Appropriate fantasies were elaborated using imaging and verbal reinforcement during the presentation of the audio stimuli.

RESULTS AND DISCUSSION

Relapse prevention may be seen as an important addition to any therapy involving exhibitionists although, interestingly, the most complete volume on the subject of relapse prevention with sex offenders (Laws, 1989) devotes little attention to exhibitionists. In the case of T.C., he reported that he benefitted from the issues and material covered in the first phase of the treatment, but it is difficult to determine if he took away information that will help him avoid his problem in the future. We can turn to recidivism data for some assurance that some positive message was conveyed, and in T.C.'s case he has not been charged with any further offenses involving exhibitionism since his release 16 months ago. This 16-month period is one of the longest gaps in his sexual offense history in the past 15 years.

This individual did reveal more interest in audiotaped descriptions of exhibitionistic encounters than in consenting heterosexual depictions (see Figure 1). This was the case even after relapse prevention, but the goal of the first phase of therapy was not reduction of deviant arousal. The second treatment phase that focused on altering deviant fantasies and deviant sexual preferences appears to have accomplished this aim. As Figure 1 shows, T.C. was able not only to decrease his level of inappropriate arousal, but he was able to increase appropriate responses. These gains were achieved gradually over the course of the second phase.

As Marshall, Eccles, and Barbaree (1991) demonstrated, strict behav-

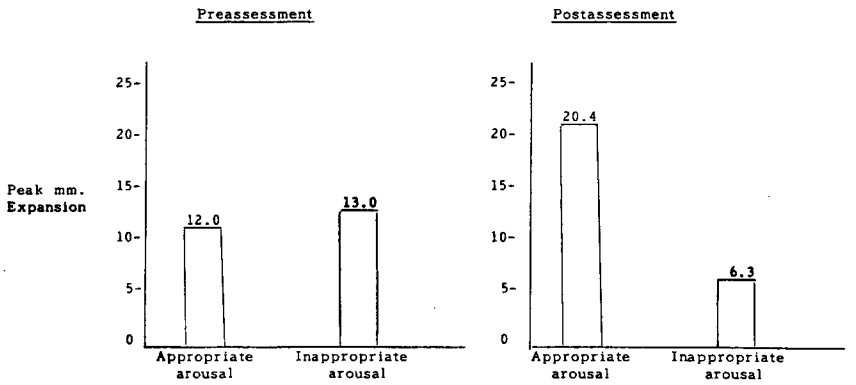

Figure 1 Phallometric test results before and after therapy

ioral approaches to treating exhibitionism such as aversion therapy and orgasmic reconditioning fare poorly compared to more "cognitive" techniques such as covert sensitization. These investigators also noted that "interpersonal problems are paramount in exhibitionists" (p. 134). The case of T.C. would indicate that such a view may indeed be correct. His exhibitionistic fantasy and behavior usually followed an argument or conflict of some nature with a girlfriend or family member. He felt helpless to deal with the demands that his friends and family placed on him and, lacking the problem solving and communication skills to resolve conflicts quickly and effectively, he would seek resolution in the tension reduction of a sexual encounter in the streets with a strange woman. The obvious deviancy of his actions also was a direct message to friends and family to "back off," stop making demands or disagreeing with him, or the "family dishonor" of his behavior would continue. He did not appear to use his deviant acts for sympathy or support, but rather a means of revenge on those close to him who "crossed" him. An understanding of his own thinking and his family dynamic, and discussion of how to deal more directly and effectively with them, may well have contributed to his increased control of his deviant arousal.

The individual involved in the present treatment study is likely an atypical exhibitionist. His frequency of deviant fantasy and masturbation, as well as related inappropriate arousal, appears to violate the norm for exhibitionism (Marshall, Payne, Barbaree, & Eccles, 1991). Even his approach strategy towards his victims appears unique, although his use of "prior consent" is an interesting and perhaps common approach employed by experienced exhibitionists. He is, nonetheless, one kind of client encountered by clinicians who deal with paraphilias, and he appears to have benefitted from the individually tailored treatment program. Clearly more systematic research into cognitive-behavioral approaches is demanded but,

together with data from other investigations (e.g., Marshall, Eccles, & Barbaree, 1991), there is reason for optimism. Understanding and attempting to alter an individual's personal beliefs and values that are supportive of offensive sexual behavior is not an easy task. It is the task, however, that clinicians must undertake if paraphilias like exhibitionism are to be understood and treated effectively.

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