The Behavioral Treatment of Rapists and Child Molesters

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Crimes of sexual aggression, such as child molestation and rape, are common in Western societies. Although exact figures are difficult to obtain because of vagaries in victim-reporting practices and differences in legal definitions over regions, serious acts of sexual aggression are almost exclusively committed by males and constitute a serious social problem. A sizable minority of sexually aggressive men commit sexual crimes at high frequencies over long periods of time (Abel, Becker, & Skinner, 1985; Groth, Longo, & McFadin, 1982). These individuals, who are the primary focus of the present chapter, are infrequently arrested by the police or, if apprehended and incarcerated, often reoffend upon release (Abel et al., 1985).

Clinicians and behavioral scientists have sought to develop methods that will modify the sexually aggressive behaviors of these men. Because of the seriousness and frequency of their crimes, each cessation of offending by a sexually aggressive person is important. Despite the importance of developing effective interventions for these offenders, however, not much evaluative research on interventions has been conducted. Most of the methodologically acceptable literature is recent, and the field is a long way from having definitive evaluations of any treatment methods. This chapter provides an introduction to the behavioral treatment of sex offenders through the description of a particular program.

Traditionally, sex offenders have been treated using psychotherapeutic methods, most frequently group psychotherapy. These psychotherapeutic methods have diverse rationales, but many appear to rest on the assumption that sex offenders have character traits that must be altered. Unfortunately, the search for unique character traits among sex offenders has not yet proved successful (e.g., Quinsey, 1977, 1984, 1986; Quinsey, Arnold, & Pruesse, 1980),

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and no trait theory has been able to explain the different sorts of sexual misbehaviors that offenders consistently exhibit.

More direct measurement of phenomena that are known or thought to be related to the behaviors of interest has proved useful, however. For example, sexual arousal, as measured by penile expansion to slides or stories, has been shown to be under stimulus control (Quinsey, Chaplin, & Upfold, 1984; Quinsey, Steinman, Bergersen, & Holmes, 1975). The stimuli that occasion sexual arousal among sex offenders are related to their offense histories, so that sex offenders can be differentiated both from nonsex offenders and sex offenders with different offense histories by measurements of their sexual arousal to a variety of stimuli.

The findings of individual differences in sexual arousal patterns, together with advances in other areas of the behavioral literature, have led to a new rationale for the treatment of sex offenders and a new treatment methodology. Briefly, sexual behaviors may be conceptualized as behaviors like any others. In this view, undesirable sexual behaviors are assumed to be the result of skill deficits and/or inappropriate behaviors acquired at an earlier time, in particular, the acquisition of inappropriate or "deviant" masturbatory fantasies. The task of treatment, therefore, is to provide the offender with the requisite skills and techniques for the self-management of his future sexual behavior. Broadly speaking, these assumptions are those of the social competence model (Rice & Quinsey, 1980).

In a social competence model, sexual behavior is considered to be learned behavior, involving the acquisition of the specific behaviors involved in sexual activity, the association of particular stimuli and fantasies with sexual arousal, and the acquisition of attitudes toward various sexual activities and sexual partners. In all likelihood, the same processes underlying the acquisition of acceptable sexual behaviors underlie the acquisition of inappropriate or aggressive sexual behaviors. Although the evidence supports the assumption that sexual behaviors are learned, the precise mechanisms are, at present, unclear. In addition, certain associations (such as an association of aggression with sexual arousal or an association of female characteristics or youthful appearance with sexual arousal) may be particularly easy to learn because of the historical influence of evolutionary selection pressures on reproductive behavior (Quinsey, 1984). The belief that sexual behavior is learned encourages the development of behavioral procedures in the treatment of persons who exhibit inappropriate sexual behaviors. As an aside, though, behavioral methods of treatment might be efficacious even if the behaviors were not learned or, conversely, nonbehavioral methods might be appropriate with behaviors that are learned.

The program to be described in this chapter was developed using an explicit logic. First, measures were sought that either had a prima facie theoretical relationship to sexual offending or differentiated identifiable subgroups of sex offenders from other offenders and from persons who had not committed an offense of any kind. After such measures were identified, interventions were designed that would change offenders so that they had post-
treatment scores on these measures similar to those of nonoffenders or that would produce changes expected to be related to lower recidivism. The final task was to determine whether these measures were related to recidivism and whether changes on these measures were related to lower recidivism rates.

The Setting

Traditionally, treatment programs for serious sex offenders have been housed in correctional institutions or mental health facilities for forensic psychiatric patients. These typically all-male, secure institutions are still the most common sites for sex offender treatment programs. Some of these institutions have different kinds of offenders, and others specialize in the housing and treatment of sex offenders alone. These institutions must not only provide custodial care and treatment but also make decisions about whether or when these men should be released. These decisions are related to complex issues of law and social policy. More recently, a number of programs have been implemented in the community; some of these programs treat persons under a variety of legal mandates, whereas others treat only voluntary clients who are under no legal coercion (e.g. Abel et al., 1985).

The setting of any program provides a set of opportunities and constraints that structures the form the program can take (Quinsey, 1981). This section of the chapter describes the institutional environment in which the treatment program highlighted in this chapter—the "Oak Ridge" Sex Offender Program—is housed.

Oak Ridge is a 300-bed, all-male, maximum security hospital in Penetanguishene, Ontario. It is operated by the Provincial Ministry of Health but is built in the style of an old prison. Patients enter Oak Ridge in several distinct legal categories: (a) persons under warrants of remand who are referred by the courts for a pretrial or presentence psychiatric assessment, (b) persons under warrants of the lieutenant governor who are referred by the courts after having been found not guilty by reason of insanity or, more rarely, unfit for trial, and (c) involuntarily certified patients who are referred from federal or provincial correctional institutions as mentally ill or from regional psychiatric or mental retardation facilities as severe management problems.

Oak Ridge is a second-stage institution that accepts and refers patients primarily to and from other institutions, and very seldom to or from the community. The patient population is very heterogeneous in its characteristics, including length of stay. Adequate staffing has always been a problem, and there are few professional staff, as is characteristic of such institutions. Although the program characteristics of Oak Ridge are complex, the programs themselves tend to be designed for all patients on a given ward, and include work placement, patient-run milieu therapy, or token economy programs. Phenothiazines and other medications are commonly used. A more detailed description of various aspects of Oak Ridge has been presented elsewhere (Quinsey, 1981).
HISTORICAL DEVELOPMENT

Although current behavioral programs for sex offenders are usually conceptualized in terms of social learning theory (e.g., Bandura, 1969), they are the historical result of early treatment efforts in the behavior therapy tradition (e.g., Wolpe, 1958), most particularly assertion training and studies on aversion therapy with homosexuals (e.g., Feldman, 1966). To a large extent, current behavioral programs for sex offenders represent the behavior therapy approach, together with Freund’s (1981) psychophysiological method of measuring male sexual preference. An overview of the history of behavior therapy and early work with sex offenders has been provided by Yates (1970).

At the time the Oak Ridge sex offender program was started, in 1972, the literature on the assessment and treatment of rapists and child molesters was very limited. As time went on, however, more information became available from the literature and from our own studies that encouraged the modification of our treatment procedures. Reviews of the literature can be found in Abel, Blanchard, and Becker (1978), Kelly (1982), Langevin (1983), Laws and Osborn (1983), Quinsey (1973, 1977, 1983, 1984, 1986), and Quinsey and Marshall (1983).

We started measuring child molesters’ sexual-age preferences using a technique pioneered by Freund (for a review, see Freund, 1981) and attempted to modify these preferences with classical conditioning techniques (Quinsey, Bergersen, & Steinman, 1976). We subsequently added sex education, hetero-social skill training (Whitman & Quinsey, 1981), and training in self-management techniques (Pithers, Marques, Gibat, & Marlatt, 1983). In addition, Abel and his colleagues (Abel, Blanchard, Barlow, & Guild, 1977) developed a technique to assess sexual arousal to sexual themes (e.g., force, bondage, etc.) that allowed us to include rapists in our treatment and assessment efforts. Finally, we have added treatment techniques such as signaled punishment (Quinsey, Chaplin, & Carrigan, 1980), satiation (Marshall, 1979), and olfactory aversion (Maletzky, 1980) in a continuing attempt to improve our ability to modify inappropriate sexual arousal. These procedures are described in more detail later.

This program, then, has evolved from the simple use of classical conditioning to modify child molesters’ inappropriate sexual-age preferences to a multifaceted program of skill acquisition and self-control. Similar changes have occurred in other behavioral sex offender programs. These changes, we believe, have led to a much stronger treatment intervention. At the same time, however, the changes have made the overall program difficult to evaluate. Fortunately, the recent literature does contain some evidence that behavioral treatment packages of the kind described in this chapter are efficacious. Davidson (in preparation), for instance, has followed up sex offender inmates who had received behavioral treatment (sex education, social skills, and aversion therapy) and compared them with a cohort of similar inmates who were released before the availability of the behavioral program. Child molester inmates who had received treatment were convicted significantly less fre-
sequently for new sex offenses than child molesters who had not received the program; unfortunately, no differences were found between treated and untreated rapists. Kelly (1982) has reviewed 32 behavioral studies that used a variety of treatment techniques in the treatment of child molesters and concluded that behavioral techniques do lower sexual recidivism rates; fewer data, however, are available on the behavioral treatment of rapists (Quinsey, 1984).

At present, the sex offender program at Oak Ridge has five components: (1) laboratory assessment of sexual arousal, (2) problem identification, (3) heterosocial skill training, (4) sex education, and (5) modification of inappropriate sexual preferences. These components are described individually next.

**THE PROGRAM**

**Laboratory Assessment of Sexual Arousal**

The assessment of sexual arousal, although not yet entirely standardized, is performed in a similar manner by a variety of laboratories. Laws and Osborn (1983) have presented a very detailed outline of how such laboratories operate.

Each sex offender who is referred to the Oak Ridge Sex Offender Program for treatment is first assessed in the sexual behavior laboratory. The laboratory is equipped with a sound attenuating and electrically shielded patient’s chamber, a rearview projection screen, and apparatus for automatically scheduling slides and audiotaped material and for monitoring penile circumference and skin conductance. Penile circumference is monitored on a Beckman Dynograph at two levels of magnification and on a digital voltmeter.

Depending on the nature of the patient’s offense history, he receives a slide test of sexual-age preference or an audiotaped test designed to measure his arousal to rape stimuli. Because the two methods of assessment are similar, the visual assessment method is described here in detail, and the methods for the auditory stimulus assessment are described more briefly later.

During assessment sessions, patients are seated in a reclining chair. Penile circumference is measured by means of a mercury-in-rubber strain gauge placed around the shaft of the patient’s penis. The gauge is connected to a Parks Electronic Model 270 Plethysmograph. A desk top is placed across the arms of the chair to prevent the patient from seeing or manipulating his penis.

The patient is instructed to relax, remain as still as possible, keep his eyes on the translucent screen, and try to imagine the person represented in each slide as a potential sex partner. A standard array of slides is then presented to the patient. This array consists of two slides of each of the following categories: adult females, adult males, pubescent females, pubescent males, child females between the ages of 6 and 11, child males between 6 and 11 years of age, child females under the age of 5, male children under the age of 5, explicit
heterosexual activity, and landscapes. Each slide is presented for a period of 30 seconds. Penile circumference is recorded from 2 seconds following slide presentation until 30 seconds after the slide offset. The interslide interval is 30 seconds, although this is extended if the response does not return to baseline (the starting position). The patient's sexual arousal pattern is determined by the relative levels of response to each of the 10 slide categories.

In the auditory assessment, stimuli are presented via an intercom. On our standard tape, these stimuli consist of 18 audiotaped scenarios describing various interactions with an adult female, read in a male voice in the first person. Five of these scenarios describe consenting heterosexual interaction, five describe nonconsenting heterosexual interaction (rape), five describe nonsexual violence, and three describe sexually neutral interactions. The patient is instructed to try to imagine that he is the person speaking on the tape. Maximum penile circumference within the interval from 2 to 180 seconds after stimulus onset is recorded. A 30-second interval precedes the next stimulus, during which responses are not scored.

We have conducted a lengthy series of studies designed to validate various aspects of our measurement of sexual arousal. In our first study (Quinsey et al., 1975), we found that penile responses to slides of persons varying in age and gender discriminate child molesters from normals (community volunteers and nonsex offender patients), whereas verbal reports do not. Penile responses also relate closely to the child molesters' histories of victim choice. Child molesters showed more sexual arousal to slides of children who were the same ages and genders as their victims than did others. Incest offenders exhibit less inappropriate age preference than other child molesters (Quinsey, Chaplin, & Carrigan, 1979).

Rapists exhibit relatively more sexual arousal to audiotaped descriptions of brutal rapes than to consenting sex stories in comparison to normal subjects (Quinsey, Chaplin, & Varney, 1981). Some rapists show sexual arousal to descriptions of nonsexual violence as well, and the amount of this arousal is related to whether they have in the past physically injured their victims (Quinsey & Chaplin, 1982). Normal subjects show less arousal when the victim does not consent and very little when the victim is described as suffering. Rapists' arousal, however, is not affected by victim consent or suffering (Quinsey & Chaplin, 1984). Rapists are best differentiated from nonsex offenders on the basis of their sexual arousal when the rape stories are cruel and short.

Although penile response measurement is far superior to verbal report, sexual arousal measures can be faked by some persons and must always be interpreted with caution (Quinsey & Bergersen, 1976; Quinsey & Carrigan, 1978). Although faking is frequently not a problem in initial testing (Quinsey et al., 1975), it becomes more of a difficulty in treatment. In treatment, this problem can be addressed, if not solved, by attempting to ensure that the results of psychophysiological assessment do not determine whether the offender is kept within the institution, which is sometimes difficult, and in presenting the treatment issue to the patient as not involving a "cure" but as
learning to control inappropriate arousal. From a research or evaluative perspective, the issue of faking is bypassed by relating sexual arousal measures directly to recidivism.

**Problem Identification**

Within many institutions for the treatment of offenders, serious problems exist in the rational selection of suitable targets for intervention and in the assignment of offenders to various treatment programs. The emphasis in assessment is often on diagnosis and various legal issues rather than on the identification of offender problems that might be amenable to modification and much less on collaboration with the offender in the design of an individualized program that can address these problems. Quinsey and Maguire (1983) have found that, although experienced forensic clinicians agreed on psychiatric diagnosis and on whether an offender would benefit from phenothiazines, they exhibited little agreement as to the appropriateness of other behavioral and nonbehavioral methods of intervention. In addition, there was little agreement as to how much these various treatments (or any treatment) might benefit a given offender. Given this lack of consensus, it is not surprising that the offenders themselves are often skeptical and frequently resistive when offered the opportunity to participate in treatment programs of various kinds.

The purpose of the problem identification program is for therapists and patients to reach the same view of what treatment is appropriate and relevant before treatment proceeds. Therapeutic compliance and active patient commitment are seen to follow from a “theory” of sexual offending that is shared by the offender and the therapist.

The program is run in a group format with four to seven patients and two staff members. Patients are selected who have one or more offenses involving child molestation or rape, have sufficient verbal ability to participate in the group, and are at least potentially interested in treatment. The goal of the program is to produce a written theoretical account of each patient’s sexual offense pattern to which all group members subscribe.

The first meeting begins with an elementary exposition by one of the therapists on the scientific method. Specificity of explanation is stressed with a variety of examples. Consistency between the evidence and the phenomena to be explained is advanced as the criterion for acceptance of a theory. An illustration of this issue is provided later. The accepted theories are, of course, acknowledged not to be absolutely true but are the best that can be developed given the state of our knowledge.

The second group meeting is concerned with a general discussion of why a man might rape a woman and later why a man might molest a child. Typically, group members advance explanations couched in dynamic terms that they have learned in group psychotherapy or idiosyncratic justifications for their behavior.

At the third meeting, a therapist hands out a sheet containing a “person-
ality profile" of each patient that is asserted to be a provisional explanation of the patient's offense history. Each profile is typed with the patient's name at the top and the therapist's signature at the bottom. Actually, the profiles are identical and are taken from Ulrich, Stachnik, and Stainton (1963). The profiles contain assertions that are true of everyone or so vague as to be meaningless. The therapist asks for written feedback on the accuracy and adequacy of his preliminary effort. The purpose of this procedure is to vividly demonstrate the type of explanations that are not desirable and to indicate how one can check on the validity of explanations of behavior. Patients are typically enthusiastic in their acceptance of the profile's validity. After a very careful description of how the profiles were obtained, however, patients often see the nature of their task more clearly, particularly the need for specificity, and they become more skeptical of glib and vague explanations.

In the remaining sessions, each patient in turn presents an oral autobiography. Each autobiography takes from 2 to 6 hours. Notes are maintained and checked informally against the patient's history (e.g., relatives' accounts, police reports, etc.). At the conclusion of the history, a brainstorming session is held. The hypotheses that emerge from this session are systematically checked against the autobiography and eliminated where inconsistent with the autobiographical material. Sometimes, other information such as laboratory tests of sexual preferences are included as data. The therapist, working backward from the offenses, produces a theory of proximal factors (circumstances immediately surrounding the offenses) and distal or predisposing factors, which are more remote in time. This theory is presented to the group and the final revision (as amended by group discussion) accepted by the group. A copy of the theory is given to the patient, and one is put on his clinical file.

Theory construction is a difficult task. Where possible, the scheme put forward by Pithers et al. (1983) is used to organize the material. An example may clarify these points. A patient in one of the groups had committed a series of rape murders. During the time in which the murders were committed, the patient was very depressed about his wife openly having an affair with another man. The patient naturally enough attributed these murders to his depression. Through the autobiographical material, however, we could demonstrate that the "depression," perhaps more properly labeled as anger, was only one of the proximal causes and that the explanation was much more complex and involved factors that had occurred much earlier in time. The patient, had in fact, attempted to rape a woman many years before his marriage. This occurrence led to questions about sadistic sexual fantasies that the patient acknowledged and that were confirmed by psychophysiological assessment. The final list of relevant problems included assertion deficits, sadistic fantasies, and a number of other difficulties.

The procedures described here appear to resemble those used in any treatment program and, in particular, those used in psychodynamic programs. There is an important difference, however. Specifically, the explanations themselves are pitched at a low level of inference and are very data-oriented. The amount of objective detail used to support the explanations is sufficient to
convince most of the patients of the explanations' validity without difficulty, particularly because the data and often the theories are supplied primarily by the patients themselves.

Patients are usually pleased with the results of the program initially but later begin asking what the theory means with respect to their treatment. At that point, the therapist is in a position to inform the patient what can and cannot be addressed with existing programs. On occasion, an individual program has to be developed, or the patient may have to be referred elsewhere within the institution for programs (such as those for alcohol abuse) in addition to, or instead of, the sex offender programs. Because of the detailed knowledge of the sex offense pattern that the therapist has acquired, a program of self-management can often be advanced and elaborated upon in subsequent treatment.

The problem identification program is the newest module in our treatment program, and, as yet, no evaluative data are available.

**Heterosocial Skills Training**

It is widely believed that many sex offenders are socially incompetent in a variety of areas (Marshall & Barbaree, 1984). Thus, in addition to attempting to suppress inappropriate behavior, both behavioral and nonbehavioral treatment programs frequently incorporate methods to improve various aspects of sex offenders' social abilities. At Oak Ridge, the heterosocial skills program is designed to improve the social skills of rapists and child molesters and to reduce their heterosocial anxiety. The rationale for this approach is that offenders must be able to obtain sexual gratification in an appropriate manner in order for appropriate behaviors to be reinforced. The naturally occurring rewards in appropriate sexual interactions are probably critical in reducing recidivism. Heterosocial skill deficits, however, need not have played an etiological role, although they may have, particularly in combination with other factors. This point is important because of Stemac and Quinsey's (1986) finding that rapists show the same level of social skills in interacting with females as with males and are not differentiable from other patients who are not sex offenders. Both groups of patients were, however, less skilled than nonpatient, low socioeconomic status controls.

Patients are assessed before and after treatment using the same measures. Because not all sex offenders have social skills problems, the assessment is used to determine which sex offenders should be offered this treatment. The treatment itself is behavioral in nature and involves modeling, coaching, videotape feedback, and extensive rehearsal in a group context; more detail is provided later.

**Assessment**

Likely candidates are interviewed at some length regarding their dating history before formal assessment. The nature of the assessment and treatment
program is explained in detail at this initial interview. The formal assessment begins with a 10-minute conversation with a female who is unknown to the patient. This conversation is videotaped. The patient is instructed to converse on any topic except the assessment itself. He is asked to behave as if the woman were a potential date but is not required to ask her for a date. The female is instructed to converse in a friendly but passive manner and not to initiate conversation. She is instructed to interrupt silences of 5 to 10 seconds with an innocuous comment (e.g., “Nice weather we are having”). The patient and female confederate subsequently fill out questionnaires that measure their perceptions of the conversation.

Two trained females later independently rate a videotape of the conversation according to patient anxiety, social skill level, and a variety of other measures. We have obtained good interrater reliabilities on these measures (Stermac & Quinsey, 1986; Whitman & Quinsey, 1981).

The second phase of the assessment involves the Heterosocial Adequacy Test (Perri, Richards, & Goodrich, 1978). This measure has been shown to have high internal consistency, interrater reliability, ability to discriminate known groups, and sensible correlations with other measures (e.g., high correlations with subjects’ self-ratings of heterosocial skill and low correlations with the Taylor Manifest Anxiety Scale). Our version of the Heterosocial Adequacy Test has been adapted for our population and consists of 20 audiotaped heterosocial situations. The situations involve interactions that are highly likely to occur, are of moderate difficulty, and prompt a wide range of responses. The patient is asked to respond as he would if the situations were actually occurring. The patient’s verbal response (or indication of a nonverbal response) is recorded on a second tape recorder. These responses are evaluated on dimensions of social skillfulness by two independent raters following the methods of Perri et al (1978).

Finally, the patient completes four questionnaires: the Social Avoidance and Distress Scale, the Fear of Negative Evaluation Scale (both developed by Watson & Friend, 1969), the Assertiveness Questionnaire (Callner & Ross, 1976), and a dating history questionnaire that provides information on the frequency, duration, and perceived success of past relationships. The psychometric characteristics of these questionnaires are acceptable and are given in the original references.

The assessment determines the extent to which the patient has difficulty in heterosexual interactions. For patients who exhibit substantial heterosocial skill deficits, the assessment data provide a pretreatment baseline with which to compare subsequent performance, together with a specification of which areas require improvement.

**Treatment**

A male and a female therapist together with four to six patients constitute a group. The first session is devoted to introductions and establishing rapport. Group members state their objectives. The confidentiality of material dis-
cussed in the group is stressed. The remaining sessions focus on learning specific skills, following a curriculum that has been adapted from McGovern et al. (1975).

The first topic concerns asking a female for directions in an appropriate manner. This skill is intentionally simple and nonthreatening and is used to habituate patients to videotaping and receiving videotaped and verbal feedback on their performance. It provides an experience of initial success. Each of the skills is introduced and taught in the same manner. The therapists first describe the technique and model the appropriate behaviors. Then each of the patients, in turn, role-plays the situation with the female. A videotape of the performance is then discussed. Feedback always starts with praise and ends with constructive criticism. Specific behaviors, such as posture, eye contact, spacing, clarity of speech, voice volume, and speech content are addressed.

The next few sessions are spent teaching the importance of listening in becoming a good conversationalist. A listening game is employed to demonstrate listening skills. Listening is a major focus of all the sessions that follow and is, therefore, discussed in great detail. Concentrating on listening also serves as a distraction from becoming anxious or concerned with how to respond when the other person is finished speaking. Patients are encouraged to use open (e.g., “What do you think about X?”) as opposed to closed questions (e.g., “Do you like X?”). The emphasis is on asking questions that allow the partner to give an extended rather than a “yes” or “no” response. The patient is then expected to listen to the response so that he can ask another related open question. Other techniques that are taught include: (a) paraphrasing (a technique used to rephrase the statement the other person has just made in order to demonstrate that one is listening), (b) perception checking (a technique used for clarifying the other person’s feelings on the topic being discussed), (c) elaboration (a technique used to express an opinion or experience similar to the one being discussed by the other person), (d) association (a technique used to switch topics in a conversation to a related topic), and (e) answer-ask (a technique used to encourage the other person to express feelings by offering one’s own first). Everyone is expected to learn each new technique before progressing to the next technique. Each practice conversation in which the patient engages is expected to include the newest technique learned and, as applicable, any techniques learned earlier. By using this style of teaching, the length of each conversation increases in preparation for the topic of informal dating.

“Informal dating” is introduced next because it is very similar to the longer conversations the patient has been practicing. An informal date is described as a date that occurs on the spur of the moment. For example, the patient encounters a woman he knows and with whom he has had a conversation in the past and asks her to join him for lunch or a beer. Such a date does not involve preparation and, therefore, prevents unnecessary preparatory anxiety. In a role-playing format, the patient is expected to engage in a short conversation with the woman and then ask her to join him for a beer. He constructs the scene for this encounter in accordance with his life-style. For
example, if he often shops in a mall, then this is where the scene is set. The conversation they engage in while having a beer is exactly as it would be in the longer conversations that have been practiced. It is stressed at this point that beginning a heterosexual relationship is very similar to starting any friendship and can, therefore, be expected to develop slowly. The second and third dates are very similar to the first but can involve a more formal meeting (e.g., going out for dinner).

The other topics in the social skills program include phoning to ask for a date, introducing a woman to friends or family, complimenting a woman, and dealing with annoyance and rejection. At the completion of this 60-hour program, the patient completes the assessment procedure described earlier for a second time in order to measure his improvement.

**Evaluation**

Whitman and Quinsey (1981) have shown that blind ratings of sex offenders' heterosocial skills increase significantly from pre- to posttreatment. A sex education control condition that involved a similar amount of group time and interaction with a female therapist did not affect social skills ratings.

**Sex Education Program**

The rationale for sex education is much the same as for heterosocial skill training. In order for sex offenders to develop appropriate sexual relationships, they must have an understanding of appropriate sexual behavior and community values. Many sex offenders lack sexual knowledge and maintain beliefs that appear likely to encourage further sex offending (Abel et al., 1985; Quinsey, 1977, 1984; 1986).

**Assessment**

Patients are assessed at the beginning and end of treatment on a variety of paper-and-pencil measures. The Sex Education Quiz examines the objective knowledge covered by the course curriculum. The quiz is divided into a section that requires patients to match biological labels with corresponding anatomical structures in diagrams of male and female reproductive systems, a section that contains multiple-choice items, and a section that requires patients to supply appropriate terms in paragraphs describing ovulation, sperm production, and pregnancy. A brief version of this quiz has been developed for patients with more limited academic skills.

The Cognition Survey (Chaplin & Quinsey, 1984) was taken from various sources in the literature; some of it was adapted from work done by Abel and Marshall and their colleagues. The survey consists of a set of statements relating to specific sexual beliefs and is organized into three categories of 36 items each. Patients indicate the extent of their agreement with each item. The child molestation category items involve beliefs that may serve to main-
tain sexual behaviors with children (e.g., "A child who doesn’t physically resist an adult’s sexual advances wants to have sex with the adult"). The rape category is similar (e.g., "Many women fantasize about rape and privately hope it happens to them"). The general category relates to commonly held beliefs about sexuality (e.g., "Athletes make better lovers than nonathletic people").

Further questionnaires measure attitudes toward rape (Feild, 1978), attitudes toward women (Spence, Helmreich, & Stapp, 1973), social self-esteem (Lawson, Marshall, & McGrath, 1979), social anxiety (Record, 1977), and sex roles (Bem, 1974).

**Treatment**

The sex education program is divided into an objective knowledge section and a subjective or value-related section. The order of presentation, depth, and relative focus of the sections are tailored to the needs of each particular group of patients. Instruction is done in a group format with a male and a female therapist and a group of four to six patients.

Each therapist takes responsibility for presenting specific lecture material. Lecture topics for the objective portion include history of sexuality, male sexuality, male sexual response, female sexuality, female sexual response, sexual intercourse, masturbation, conception, pregnancy, childbirth, birth control, sex-related diseases, sexual dysfunctions, and sexual variations and deviations. Value-related topics include relationships and marriage, sexual behavior, norms and parameters, sexual attitudes, sex and the law, sex and morals, and stages of moral development.

After each lecture, a question period is followed by a discussion of related issues. Whenever possible, audiovisual aids are used to present or clarify the material. Periodic quizzes are given to help assess progress.

An effort is made to relate the material to the offenders’ own lives. Often, discussions deal with aspects of institutional life, such as lack of privacy, lack of access to females, and the stigma attached to “being a sex offender.” A sense of group cohesion is developed, particularly in the early sessions, by the use of awareness exercises. For example, dilemmas involving competing values are presented to the group in a concrete situation. Members are then asked to choose how they would respond to the situation and present a justification for their choice.

Although the intent of the course is essentially instructional, some time is spent addressing group process issues and dealing with interpersonal issues among group members and, occasionally, helping with current problems the patients may be having on the wards.

**Evaluation**

Large increases in factual knowledge, as reflected by paper-and-pencil tests, are associated with participation in this program (Whitman & Quinsey, 1981). Evaluations of any shifts in attitudes that may be produced by the course have yet to be conducted.
Modification of Inappropriate Arousal

Because of the relationship of inappropriate sexual arousal patterns to sexual offending (Marshall & Barbaree, 1984; Quinsey, 1984, 1986), nearly all behavioral programs contain an element that is directed to the modification of deviant arousal. At Oak Ridge, several forms of behaviorally oriented laboratory treatment procedures are offered in order to modify sexual arousal patterns, as manifested by changes in penile circumference to various stimuli. Basically, the aim is to lower patients' penile arousal to inappropriate stimuli. This section outlines the criteria patients must meet in order to be accepted into a treatment program, briefly describes several of the treatment procedures, and outlines the evaluation of progress throughout treatment.

A patient must meet several criteria in order to be considered for the laboratory treatment procedures. First, the patient must display an inappropriate sexual arousal pattern on one of our standard assessments; that is, the patient must show relatively high sexual arousal to sexually inappropriate stimuli as compared with appropriate stimuli. The two basic assessments (visual assessment for age preference and auditory assessment for activity preference) were described earlier. An assessment must have occurred within the 6 months immediately preceding treatment, or the patient is reassessed. Second, the patient must understand and admit that he has a problem with his sexual arousal. Third, he must understand the nature of the therapy. Finally, the patient must be cooperative and consent to the treatment procedures. Patients are informed that treatment is voluntary and that they are free to withdraw from the program at any time, for whatever reason, without penalty.

Methods

Four basic treatment procedures are used: biofeedback, signaled punishment, olfactory aversion, and masturbatory satiation. All treatment occurs in the sexual behavior laboratory described previously.

Biofeedback is used with either auditory or visual stimuli (Quinsey, Chaplin, & Carrigan, 1980). It involves the illumination of lights inside the chamber that informs the patient of the state of his arousal. In this procedure, a patient either views slides or listens to audiotapes while his penile circumference is monitored. Plethysmograph output is sent to a Schmitt Trigger (an analog-to-digital converter) that illuminates lights when a certain preselected criterion is surpassed. The criterion is set by the therapist and is approximately half of the maximum response exhibited during the preceding session. Stimuli are constructed individually for each patient.

In the case of visual stimuli, several sets of slides are generated from our pool. Each set consists of 10 slides of adult females, and 10 slides representing each of the patient's deviant categories as determined by the assessment. Audiotrimuli consist of six scenarios describing consenting heterosexual activity and six scenarios describing nonconsenting heterosexual activity (rape). Scenarios are either chosen from the pool of previously recorded tapes or are generated by the therapist with the aid of the patient to reflect the relevant inappropriate fantasies.
In a treatment session, a patient views slides and/or listens to tapes while his penile circumference is being monitored. If penile circumference surpasses the preset criterion during presentation of an appropriate stimulus, a blue light is illuminated. Alternatively, if the criterion is exceeded during presentation of a deviant stimulus, a red light is presented. A patient would normally participate in a series of biofeedback sessions involving a different set of stimuli, presented in a different random order each day.

Signaled punishment uses the same stimuli and the red and blue lights as described above (Quinsey & Marshall, 1983; Quinsey, Chaplin, & Carrigan, 1980). A mildly painful (but harmless) electric shock, however, is associated with arousal to inappropriate stimuli. During the recording interval for a deviant stimulus, a brief shock is delivered via a probability generator at the end of 40% of the 5-second intervals in which the patient was above criterion (i.e., the red light was on). These shocks are delivered via an arm band that is attached to the upper part of the patient's left arm. Shock intensity is determined by the patient before each session.

Olfactory aversion is similar to signaled punishment but, rather than using a shock, an aversive odor is associated with arousal to deviant stimuli (Laws, Meyer, & Holmen, 1978; Maletzky, 1980). We have experimented with several noxious odors including those obtained from rotting meat, valeric acid, and ammonia. During a session, the patient is instructed that when the red light is illuminated, indicating that his penile circumference has surpassed the preset criterion during the presentation of an inappropriate stimulus, he is to inhale deeply from a squeeze bottle containing the odoriferous substance. The therapist can monitor the patient's behavior via a one-way mirror to ensure compliance with the instructions.

Masturbatory satiation is the final method of modifying sexual arousal that is used in our laboratory (Marshall, 1979). Unlike the preceding treatments, penile circumference is not monitored throughout this procedure. A patient is taken into the assessment chamber and is seated on the reclining chair. The therapist sits outside the chamber where he can see the patient through the one-way mirror and hear him via the intercom. The patient is instructed to masturbate while verbalizing a consenting (and age-appropriate) heterosexual fantasy until ejaculation. At this point the patient continues to masturbate but now verbalizes his deviant fantasies. The patient masturbates and fantasizes throughout a long series of hour-long sessions. The goal of treatment is to satiate the patient with his inappropriate fantasies through their extensive rehearsal in a state of low sexual arousal (Marshall, 1979).

Evaluation of Progress

Each patient participates in a pretreatment assessment. In the case of an auditory session, the standard tape described before is used in the pretreatment assessment. In the case of visual sessions, a pretreatment set of slides (known as the individual diagnostic sequence) is constructed for a patient's particular deviant interest group. This set consists of 5 slides of adult females,
5 of sexually neutral scenes, and 10 slides selected from the patient's deviant category(ies).

A patient's course of treatment is determined by his progress throughout sessions. Normally, a patient would begin with a preintervention assessment followed by five sessions of biofeedback. A postintervention readministration of the original assessment would then follow. The assessments, though, do not use the slides or audiotaped scenarios used in treatment, thus making the tests a conservative estimate of the generality of treatment effects. If significant improvement has been made from the biofeedback sessions, treatment could end here. Otherwise, the patient would enter the signaled punishment phase of treatment. Normally, this would consist of 10 sessions, followed by another assessment. If progress were slow but there appeared to be some trend and the patient were willing, another 10 sessions and assessments would follow. The criterion for considering preferences to be changed is a statistically significant shift. Considering the number of test stimuli and the single-subject design, this is a very conservative criterion.

If significant changes were not achieved or if for some reason the patient were unwilling to receive the shocks, olfactory aversion would be employed. This would occur in blocks of 5 or 10 sessions, depending on the patient's apparent progress, with each block being followed by an assessment. Masturbatory satiation would be used only in those instances where significant changes could not be brought about with the previously mentioned programs and would be employed only in cases where the patient was sufficiently verbal and had well-formed deviant fantasies.

**Evaluation**

Quinsey, Chaplin, and Carrigan (1980) found that signaled punishment significantly decreased sexual arousal to children in 10 out of 14 child molesters treated with this technique. Signaled punishment was more effective than a biofeedback alone or a classical conditioning aversion technique. Physiological posttreatment measures of sexual preference for child as opposed to adult stimuli have been found to be significantly (although weakly) related to sexual recidivism over a follow-up period averaging 29 months (Quinsey, Chaplin, & Carrigan, 1980). Over longer periods (averaging 34 months), however, only pretreatment measures of relative sexual age preference were related to recidivism. These results suggest that treatment effects do not last indefinitely and, therefore, support Maletzky's (1980) strategy of employing quarterly "booster" sessions; child molesters treated in Maletzky's program have been found to have very low recidivism rates.

**Problems**

One of the difficulties in treating institutionalized men in any setting is that the results of treatment and/or assessment occasionally have a bearing on
release decisions. Because of this, some patients decide on their own or, more frequently, are advised by their lawyers not to participate. This situation arises because patients or their lawyers sometimes believe that laboratory evidence of inappropriate sexual arousal would result in longer confinements for their clients. This is particularly true of patients who have previously asserted that they are “cured.” Another difficulty relates to the length of time some patients are kept in the institution. Some patients, for example, sex murderers, are kept for many years. Although we attempt to treat sex offenders at the time when they have some chance for release, the indeterminate nature of their commitments makes this a difficult issue. One must avoid the situation where a patient is not considered for release because he has not been treated and is not treated because he is not considered releasable.

A number of problems in program implementation are associated with the types of patients whom we see. Most are very low in socioeconomic status and, although we attempt not to impose our values, this leads to concerns about the content of the material taught in the heterosocial skills and sex education programs, as the therapists (and literature) are middle class. A large minority of our patients are retarded, and some are low-functioning psychotics. These patients have difficulties in attending to the material and in retaining it. In our group programs, we form homogeneous groups based on verbal ability in order to be able to perform the repetition that is necessary for those who need it.

All of the difficulties associated with treatment in a maximum security institution affect the sex offender program; these problems include conflicts between security and treatment, difficulties in attracting and keeping treatment staff, few female staff, and the like. A more important problem, however, is the lack of aftercare. Patients released from Oak Ridge are scattered among institutions of disparate kinds located across all of Ontario. Developing a systematic and consistent program of clinical follow-through under these circumstances is simply impossible at present.

Turning to the issue of program evaluation, the sort of evaluations that are and are not feasible should be clear, given the nature of the present program. Pre- and posttreatment change studies are relatively easy to do, as are assessment validation studies that depend on the differentiation of known groups. Follow-up studies are difficult but can be done so that changes in theoretically relevant variables associated with treatment can be related to subsequent recidivism. What is even more difficult is a follow-up comparison of randomly selected treated and untreated sex offenders. Although we assess more persons than we treat, the treated and untreated groups are not comparable. Persons who are treated by us must first be accepted by the institution, which means that they are “sicker,” have more offenses, and are often less intelligent than the majority who are refused admission. They then must be accepted by us for treatment, which means that they have the types of problems we treat—inappropriate sexual arousal, poor social skills, and inadequate sexual knowledge. Most of the offenders who are accepted by the institution exhibit the sorts of difficulties that we treat. Our treatment cases, unlike
our assessment cases, are a highly selected and unusual group of sex offenders.

Conclusions

Our experience, as well as others' (e.g., Kelly, 1982; Laws & Osborne, 1983; Marshall & Barbaree, 1984), has shown that a behaviorally oriented treatment program for sex offenders can be maintained within a maximum security institution. The Oak Ridge program results in improvement among theoretically relevant measures, such as sexual knowledge, heterosocial skills, and sexual arousal patterns. The program appears to lead to lessened recidivism in the short term.

In the future, more sophisticated follow-up studies are required. Although we and others have shown that short-term change in various target behaviors can be produced with behavioral programs, the relative contributions of the various treatment modalities to long-term outcome are unknown. Several research strategies are required to provide the answers to this and related questions: the comparison of comparable treated and untreated cases; the multivariate prediction of outcome from multiple measures of therapeutic change; and between-groups comparisons of different treatment interventions.

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