Behavioral Treatment of Sexually Offending Behavior

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Discussion is given to relevant behavioral issues in the treatment of sexual offending, with specific emphasis on issues related to persons with developmental disabilities. Recommendations for quality behavioral programming are made, and a review of the relevant literature illustrates several major approaches in the clinical management of inappropriate sexual arousal and behavior. It is concluded that quality behavioral programming in the area of sexual offending comprises the following domains: (1) implementation of therapeutic behavior change regimens in sexual offending tailored to each individual in all sexual and general curriculum areas; (2) behavioral responses directly measured; (3) behavior patterns charted (e.g., graphed using a standard celeration charting system); (4) functional and descriptive definitions of behavior used in the implementation of behavior change regimens; (5) an emphasis on building new and appropriate sexual behaviors as well as general behavioral skills; and (6) a behavior analytic investigation of the impact of environmental influences on each individual's behavior.
Keywords: developmental disability, intellectual, mental retardation, sexual deviance

Behavior analysis of sexually offending behavior currently comprises the most comprehensive approach in the management of this growing societal problem.[5] The issues are complex in deciding the appropriate techniques used to gather information about potentially deviant sexual interests and overt behavioral repertoires, and in the systematic attempt to manage and change sexually deviant behavior. With regard to persons with developmental disabilities (DD) who also exhibit sexually offending behavior, special concerns arise due to the adaptive skill deficits that may hinder attempts at shaping new, more socially appropriate sexual behavior repertoires.[6] The purpose of this paper is to review behavioral treatment strategies for sexually offending behavior, with special emphasis given to persons with DD.

As specific elements in the behavioral treatment of sexually offending behavior for persons with DD are discussed in this paper, it is important to consider the following issues: (1) implementation of therapeutic behavior change regimens in sexual offending tailored to each individual in all sexual and general curriculum areas; (2) behavioral responses directly measured; (3) behavior patterns charted (e.g., graphed using a standard celeration charting system); (4) functional and descriptive definitions of behavior used in the implementation of behavior change regimens; (5) an emphasis on building new and appropriate sexual behaviors as well as general behavioral skills; and (6) a behavior analytic investigation of the impact of environmental influences on each individual's behavior.

Sexual Offending and DD

Although the research has been sparse concerning special characteristics and demographic data for persons with DD who also have histories of sexually offending behavior, Haven et al., have noted in a survey of 40 treatment providers reporting on 1,567 "intellectually disabled" sex offenders, all but 25 (1.6%) of the offenders were male.[6,7] Further, sex offenders with intellectual disabilities appear to be over represented in prison populations, are usually imprisoned for longer periods of time, and have less access to alternative sentencing arrangements than nondisabled offenders.[14]

Knopp and Lackey found that 95% of female and 68% of male intellectually disabled sexual abusers related being sexually abused prior to emitting their own sexually offending behaviors.[7] Seattle Rape Relief estimates that only 20% of sexual assaults in their catchment area perpetrated against persons with intellectual disabilities are reported to law enforcement because 99% of the offenders were relatives, friends, acquaintances, or caretakers of the victims.[3]

One of the most significant problems in cultural perceptions of DD and sexual offending concerns a continuation of the myths that persons with intellectual disabilities are oversexed, promiscuous, or have no sexual interest and should be regarded as children with regard to issues of sexual consent and behavior. Haaven and colleagues noted that behavioral risk issues are important in the assessment of sexual offending behavior in persons with DD. These authors defined risk behaviors as those involving impulsive decision making, use of physical force or weapons, chronic substance abuse, firesetting, animal torture and enuresis, and failed prior specialized treatment. They conclude:

> "There are more similarities than differences in working with intellectually disabled sex offenders compared to nondisabled sex offenders. Characteristically, both groups have complex cognitive and behavioral deficits. They express various levels of denial; possess immature social and sexual skills...feel intimidated by peers; experience low self-esteem and high criticism; demonstrate inadequate adult heterosexual or homosexual responsivity; engage in obsessively deviant fantasy patterns; lack empathy; display poor impulse control, particularly in response to stress; are unable to process and evaluate information, particularly about sexual roles and sexuality" (p. 25).[6]

Lund emphasizes six relevant points in providing for a multipurpose framework for looking at male sexuality, as presented in Table 1.[10] In approaching the behavioral assessment and treatment of persons with DD who also have histories of sexually inappropriate behavior, it is important to consider each of these points as integrative treatment regimens are considered.

Quality Behavioral Programming Considerations

There are many important issues to consider in the assessment and treatment of sexual offenders, with and without intellectual deficits. Generally, the goal of providing quality behavioral support services in this area is to guide a program into utilizing appropriate, data-based, behavioral programs. In order to meet the challenges of this goal, a program should offer multiple phases of behavioral programming for its individuals. Behavioral residential services should employ contingency management of daily living skills (through the utilization of behavioral contracts, appropriate staffing, and adequate security precautions), individual education (individualized using precision teaching methods), and specialized behavioral programming for sexual offending (through individual and group behavioral skills training and sexual arousal reconditioning approaches).

The three tiers of quality behavioral programming; daily living skills, education, and specialized sexual offender behavioral services, should be interlocked. The ultimate goal of a behavioral treatment program is to achieve behavioral competency skills in all three areas simultaneously, and fade advances in each area to the other areas. For example, an individual's achievement in sex education through precision teaching in a classroom setting should be integrated with attaining appropriate sexual behavior skills through specialized behavioral programming and opportunities to practice appropriate expression of sexuality in an interpersonal situation. Another example is that an individual will follow a daily living contract regarding interpersonal interactions with another individual or staff member combined with specialized behavioral programming that addresses social or communication skills training. In other words, it is a major function of a quality program to integrate ongoing daily living behavior skills with daily educational and specialized behavioral programming skills for sexual offending. Furthermore, three major ancillary services of quality behavioral programs should be provided: ongoing behavioral and psychophysiological assessment of patterns of sexual arousal, staffing issues, and transition/after care planning.

Staffing Issues

A quality behavioral program recruits and retains qualified staff responsible for the monitoring, educational experiences, and behavioral intervention strategies employed in the

TABLE 1. A MULTIPURPOSE FRAMEWORK FOR LOOKING AT SEXUALITY[10]
1. Sexually relevant behavior and experiences are present across virtually all ages and developmental levels.
2. Adults experience great diversity in forms of sexual expression and preferences regardless of whether intellectual functioning is within or below "normal" limits.
3. These diverse forms of sexual expression reflect genetic, constitutional, physiological, developmental, and environmental influences, or may also reflect "accidents" of conditioning history, based on actual life experiences.
4. Sexual arousal and orgasm constitute a potent reinforcer; the pairing of heightened sexual arousal and orgasm with some object, event, fantasy, activity, or person produces powerful conditioned associations, attachments, and emotions.
5. Once this association occurs, it may promote the development of strong and unusual preferences.
6. Because sexual reinforcement is so powerful, it is difficult to alter preferences for certain types of sexual behavior except under the following conditions: (1) there is some acceptable alternative which is more reinforcing; (2) the specific sexual behavior produces negative consequences for the individual.

program. Ongoing staff education and training programs should be in effect at all times. As the first step to successful transition planning, an inpatient or residential program should address the community reintegration of each individual. Once an individual makes satisfactory progress in a program (measured through objective, reliable, and valid behavioral indices) that person should be placed in a transition program that will serve as the first step to community reintegration and after care of the individual. Research has shown that for sexual offenders, the first two years after release from an inpatient treatment program or correctional facility are the most critical in terms of recidivism.[5] Active criteria should also be developed to initiate this transition process, and a sample set of criteria is shown in Table 2.

Sexual behavior should always be functionally assessed and defined for each individual through referral source information, thorough record review, direct behavioral assessment, psychometrically validated behavioral self-report measures, and when possible, psychophysiological measurement such as penile plethysmography.

A sex offender treatment program should always be pledged (for societal safety and the protection of the rights of sexual offenders relative to effective, objective, and empirically validated assessment and treatment), to providing the necessary resources to assess sexual arousal and behavior. Programs should utilize a complete assessment and treatment clinic that uses the penile plethysmograph, as well as the future possibility of a photo-plethysmograph for the assessment of patterns of sexual arousal in females.

Behavioral Contingency Management and Specialized Services

As stated above, contingency management of daily living skills is achieved through the utilization of behavioral contracts, with appropriate staffing, and adequate security precautions. Individual education also is a appropriate staffing, and adequate security primary consideration, and is usually accomplished through behavioral precision teaching methods. Furthermore, specialized

behavioral programming for sexual offending can be achieved through individual and group behavioral skills training and sexual arousal reconditioning approaches. Specialized behavioral programming skills should be offered on an ongoing basis for each individual, based upon individual behavioral assessment results and upon behavioral research to date. A brief review of this literature will facilitate the implementation of empirically-based conditioning-based procedures.

TABLE 2. SAMPLE BEHAVIORAL CRITERIA FOR TRANSITIONAL PROGRAMMING

1. Successful and documented participation in the behavioral treatment regimens in the treatment program, with a three month minimum absence of any major target or major disruptive behaviors.
2. Psychophysiological plethysmographic evaluation indicating a relative absence of disordered patterns of sexual arousal. Other forms of psychological/behavioral assessment will also be integrated into a transition risk management assessment protocol.
3. An absence of verbalizations of denial (covert/verbal) with corroborating overt behavior to support and document acknowledgment and acceptance of the sexually offending behavior patterns in question.
4. Identification of the chain of behaviors that put the individual at risk for re-offending (sometimes referred to as the "cycle").
5. Demonstration of relapse prevention/safety plan skills while an individual is in the program (behavioral rehearsal plans will be integrated into behavioral training).
6. Documentation of successful supervised visits with family/social networks while an individual is in the program.

Aversion Therapy Techniques

This set of techniques was among the first to be applied to sexual deviations.[5] These techniques have in common the goal of reducing sexual arousal to deviant stimuli through the introduction of aversive events. Methods include: covert sensitization, olfactory aversion, and faradic or electrical aversion therapy.

Covert sensitization is a form of conditioning in which a behavior and its antecedent events are paired with some aversive stimulus in order to promote avoidance of the precipitative events and thereby to decrease the undesirable behaviors. Cautela and Kearney discussed covert conditioning and defined it as the following:

> "Covert conditioning refers to a family of behavioral therapy procedures which combine the use of imagery with the principles of operant conditioning. Covert conditioning is a process through which private events such as thoughts, images, and feelings are manipulated in accordance with principles of learning, usually operant conditioning, to bring about changes in overt behavior, covert psychological behavior (i.e., thoughts, images, feelings) and/or physiological behavior (e.g., glandular secretions)" (p. 86).[2]

In covert sensitization, the aversive stimulus usually consists of an anxiety-inducing or nausea-inducing image that is presented verbally by the therapist and imagined by the individual. The aversive scene is individually created, and is specific to each individual's problem behavior. Covert sensitization has frequently been successfully employed alone and in combination with other techniques.[8]

An underlying theory of this treatment approach is probably best thought of as a combination of classical and operant conditioning processes. The therapist works with an individual

to develop an aversive image that will be paired with the precipitative events, and with the image of the deviant behavior itself, according to a classical conditioning paradigm. The aversive image serves as the unconditioned stimulus (UCS). The images of the precipitative events, being continually paired with the UCS, become the conditioned stimulus (CS). Both the conditioned response (CR) and the unconditioned response (UCR) consist of a negative reaction, which may be emotional (e.g. fear), physiological (e.g. nausea), or in some other way repulsive. Once the individual's deviant behavior has been classically conditioned, then that person should begin to actively avoid or escape the situations associated with the deviant behavior. The precipitative events, as well as the behavior itself, should elicit a negative reaction, and thus be aversive.

In line with the principles of operant conditioning, and specifically of negative reinforcement, the individual should behave in ways that would minimize contact with the aversive stimulus (in this case the antecedent events and the deviant behavior). If the individual does pursue the deviant behavior further, hopefully the treatments will have at least reduced the effectiveness of the reinforcement for the deviant behavior, which should lead to lower frequency of the behavior. It would also be possible for classical conditioning to work alone, if the CR was so powerful that it rendered the person unable engage in the deviant behavior, or consisted of a response that was incompatible with the deviant behavior. For example, if the CR was extreme anxiety or fear and the deviant behavior required an erect penis, it may be the case that the CR would preclude the possibility of erection, and thereby negate the deviant behavior.

Olfactory aversion, or olfactory aversive therapy, is frequently used in the treatment of sexual deviance, to reduce deviant sexual behaviors, arousal, and fantasies.[13] The aversive stimulus used in treatment may be a presentation of ammonia, valeric acid, or just about any noxious odor. Frequently in this type of therapy, the subject self-administers the aversive stimulus by inhaling from an ampule containing the noxious substance. Another way to administer the aversive odor, which is usually under the therapist's direct control, consists of a device much like a small atomizer, which sprays a small amount of a noxious vapor into the individual's nostrils. Several studies have shown the usefulness of olfactory aversive therapy.[13]

Faradic aversion, also known as electrical aversive therapy, or simply as aversion therapy, is a technique in which aversive electrical shocks are used to reduce the occurrence of a deviant behavior and its antecedent events.[13] Faradic aversion has often been used in the treatment of sexual deviance as well as other problem behaviors. Faradic aversion is conceptualized to operate in an almost identical manner as olfactory aversive therapy; it is merely a difference in the form of aversive stimulus used. Of course, in the case of faradic aversion therapy, the aversive stimulus consists of a mildly painful electrical stimulation. The theory underlying faradic aversion may be either operant or classical conditioning acting independently, or a combination of classical and operant conditioning, depending on the specific procedures used and the results. In the cases discussed above,[4] it would seem that heterosexually-oriented behaviors were being directly positively reinforced, and thus operantly conditioned through masturbation and orgasm. Alternately, the pairing of electrical shocks with the homosexually-oriented slides would result in classical conditioning, and an aversive conditioned response to homosexually-oriented behaviors. However, the aversive CR associated with homosexually-oriented behaviors may operantly result in avoidance or escape of those situations. Finally, the CR may be such that it renders the person incapable of engaging in the deviant behavior altogether, which would be an instance of classical conditioning acting alone.

The issue of using aversive procedures with persons with DD is both complex and controversial. Informed consent from the individual receiving sexual offender treatment or his/her guardian, clear assent from the person receiving treatment, adequate demonstration that the person understands the main components of the treatment regimen, and agreement that the person receiving an aversive protocol may voluntarily withdraw consent at any time during therapy should be clearly established prior to employing any aversive procedure discussed in this paper. Furthermore, aversive procedures should never be used in isolation, but as one component of a package which also focuses on shaping and maintaining positive behavioral repertoires, such as communication and social skills training.

Masturbatory Retraining Techniques

Techniques based upon masturbatory retraining, including masturbatory satiation, masturbatory extinction, and orgasmic reconditioning, did not appear generally until the early 1970's. Although the primary goal of these techniques, much like the aversion techniques described above, is the reduction of sexual arousal to deviant stimuli, the process by which this is achieved is much different.[12]

Masturbatory satiation is a technique in which the erotic value attached to deviant stimuli is systematically decreased. This procedure entails having a individual masturbate while engaging in deviant fantasies for a much longer time than is pleasurable, usually one to two hours at a time. If the individual ejaculates during the time period, which very often happens in the initial sessions, he is instructed to continue masturbating until the time period has ended. Thus, through this process, the deviant stimuli lose their erotic value as they become associated with boredom.[12]

Masturbatory extinction very closely resembles masturbatory satiation in that a primary goal of the technique is to reduce sexual arousal to deviant fantasies. However, unlike masturbatory satiation, masturbatory extinction is further concerned with increasing sexual arousal to non-deviant fantasies.[1] This procedure involves having an individual masturbate while engaging in non-deviant fantasies until he ejaculates. Next, the individual is instructed to masturbate while engaging in nonsexual fantasies until he ejaculates a second time. Finally, the individual is instructed to masturbate for an extended period of time while engaging in deviant fantasies without ejaculating. The reason for these procedures is to reduce the possibility that he will experience orgasm while engaging in deviant fantasies as well as to ensure that non-deviant fantasies are not associated with a less powerful orgasmic experience which may reduce the erotic value of the non-deviant fantasies.[1]

Orgasmic reconditioning, much like masturbatory satiation and masturbatory extinction, "attaches sexual arousal and rehearses sexual behavior in response to socially acceptable stimuli."[11] Through the use of orgasmic reconditioning, sexual arousal to nondeviant stimuli is increased while, at the same time, sexual arousal to the deviant stimulus is decreased or extinguished. This procedure differs from masturbatory extinction in the sense that the patient need not necessarily be sexually aroused by nondeviant fantasies at the onset of treatment. Techniques that incorporate masturbatory retraining may have limitations for persons with DD due to limiting physical or cognitive factors. It is critical that the person receiving treatment show that he understands the basic elements of the procedure, and assents to following the methodology of masturbatory retraining.

These treatment techniques are only a sample of all of the techniques which have been used to eliminate sexual arousal to deviant stimuli. Other behavioral techniques which have been employed, but which are no longer practiced regularly include anticipatory avoidance, aversion relief, and fading. It is important to note also that the behavioral treatment studies reported here which are supportive of behavioral treatment of inappropriate sexual arousal and behavior **were not** conducted with persons with DD. Although there is good reason to believe that these behavioral techniques would have broad applicability to persons with DD, clearly more research specific to this population is currently needed to validate the behavioral techniques described in this paper.

Individual and Group Based Behavioral Skills Training

Although the treatment techniques which have been discussed above focus solely on changing sexual arousal patterns, many researchers have realized that other behavioral excesses and deficits may either cause, or at least maintain, sexual deviations. For instance, a lack of social skills in dealing with appropriate sexual partners may lead a person to seek out individuals with whom these skills are not required (e.g., children). Thus, other techniques such as social skills training, assertiveness training, relaxation training, and systematic desensitization have been included in more comprehensive treatment approaches.

Conclusion

This brief review of behavioral assessment and treatment issues in the area of sexual offending points to the conclusion that quality behavioral treatment programs should employ multiple approaches to teach sexual skills individually, as well as group based skills training with clearly defined behavioral goals, role-playing, and in vivo experiences to complement conditioning-based approaches to intervention. A complete set of

skills training protocols should be developed, including the following guidelines: (1) the individual knows best and instruction will be tailored to each individual in all sexual and general curriculum areas; (2) behavioral responses will be directly measured; (3) behavior patterns will be charted (e.g., graphed using a standard celeration charting system); (4) functional and descriptive definitions of behavior will be employed; (5) there will be an emphasis on building new and appropriate sexual behaviors as well as general behavioral skills; and (6) there will be an analytic investigation of the impact of environmental influences on each individual's behavior.[8]

Although not usually discussed in context of sexual offending, a quality behavioral treatment program should employ a PRICE model (pinpoint, record, intervene, chart, and evaluate)of sexual behavior intervention programming.[9] Individuals should participate in a comprehensive behavioral program, employing the following intervention strategies: precision teaching in areas of sexual knowledge, "cognitive distortions," and behavioral skills training (e.g., social skills, communication skills, assertiveness skills), direct social reinforcement intervention strategies (individual and group) directly linking appropriate sexual behavior in social contexts (employing role playing and in vivo behavioral strategies), and conditioning-based intervention programs. It is hoped that widespread and consistent implementation of such an approach will lead to significantly improved support services for persons with DD who also have histories of sexually offending behaviors, as well as all persons who can profit from the acquisition of new behavioral skills, and the minimization of inappropriate sexual arousal and behavior.

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