RESEARCH INTO VIOLENT BEHAVIOR: OVERVIEW AND SEXUAL ASSAULTS

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
DOMESTIC AND INTERNATIONAL SCIENTIFIC
PLANNING, ANALYSIS AND COOPERATION
OF THE
COMMITTEE ON
SCIENCE AND TECHNOLOGY
U.S. HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION

JANUARY 10, 11, 12, 1978

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Evaluating and Treating Rapists and Child Molesters: Current Status

by

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Presented January 12, 1978 to the Domestic and International Scientific Planning, Analysis and Cooperation (DISPAC), Subcommittee of the Committee on Science and Technology, U.S. House of Representatives.

This report and its accompanying appendices attempts to identify the major advances in the treatment of rapists and child molesters as well as those impediments that interfere with implementing treatment for these offenders. It begins by identifying the subgroups of sexual aggressives whose treatment would most significantly reduce the rape rate, then outlines the extent to which we can evaluate the sexual aggressives treatment needs and characteristics and finally, categorizes and describes the major components of treatment for this subgroup of sexual aggressives.

Where Should Treatment Be Directed? Fifty-five thousand rapes are reported yearly in the United States by conservative estimates, 2.2 rapes are committed for each one reported. When charges have been brought, the conviction rate has been exceedingly low (13%) for those charged with sexual assaults. When incarceration does follow conviction, recidivism rates remain quite high, i.e. 22-36% five years after release. The conclusions we have reached from these data are (a) most rapists needing treatment are "on the street", this is, not incarcerated and (b) our current system of dealing with rapists is not particularly effective.

Rapes are committed by a heterogenous group of offenders. Some rapes are the result of socio-cultural influences but at present, our society lacks the necessary understanding to reverse these factors and prevent this category of rapes (gang rapes, rapes committed in the course of a burglary, etc.) One subgroup of rapists, however, are appropriate candidates for some of our current treatment methods. Members of this subgroup prefer to rape, not as a result of social pressures, but due to specific psychological conflicts. This subgroup is unique because its members rape

multiple victims and as a result, their predilection to rape does damage to a significant number of our societal members. Since a finite number of resources exist to combat rape, we need to look at the most efficient method of reducing the total number of rapes. Treating the rapist motivated by psychological factors appears to be the most practical means of accomplishing this task.

Rapists' Characteristics and Their Treatment Needs: Treatment agents in the past have usually relied on the rapist's self report of his global functioning to evaluate his treatment needs and characteristics. In recent years, however, it has become apparent that we must not only rely on the rapist's self report, but also information from other sources to understand the rapist. Although some sexual aggressives accurately report their sexual behaviors and sexual arousal patterns, many either cannot or will not identify their sexual arousal patterns or their need for control over their sexual behavior.

The following summarizes some major findings using physiologic means to evaluate the erotic preferences of rapists (for more details, see Abel, Barlow, Blanchard and Guild, 1977 and Abel, 1977).

1) Rapists and non-rapists show similar erection responses to explicit descriptions of mutually enjoyable, consenting intercourse. Rapists and non-rapists differ however in their erections to descriptions of rape scenes. Only rapists respond to such stimuli while non-rapists fail to respond to rape cues.
2) Non-rapists' subjective reports of the extent of their sexual arousal to various sexual cues closely parallels the physiologic measurement of that arousal. Rapists by contrast, down-

grade their subjective report of sexual arousal to rape and non-rape cues by reporting less arousal than that physiologically recorded. This finding further substantiates the limitation of relying on rapists' self reports regarding the extent of their sexual arousal and preference.

3) When the extent of a rapist's erection response to rape stimuli is compared with the number of rapes he has committed, there appears to be a definite relationship. This is seen when comparing the rapist's arousal to stimuli depicting rape to those sexual stimuli depicting non-rape. The resultant "rape index" correlates positively with the number of rapes any individual subject has committed. Non-rapists have low rape indices. Rapists who have raped on one or two occasions also have low indices, but rapists with higher numbers of rapes have a much higher rape index. This is especially obvious when the rapist has committed greater than 20 rapes. Such individuals also routinely have rape indices of 1.5 or greater.

4) There is a strong correlation between rape indices and the rapist's likelihood of having injured his victims during the act of rape. Those rapists with rape indices of 2.0 or greater are those rapists who have a history of having severely injured their victim.

5) Physiological measures can accurately identify the sadist or sadistic rapists. The sadistic rapists have an extremely high rape index, greater than 4.0. The same sadists or sadistic

rapists can also be identified by their sexual arousal to scenes depicting a non-sexual, physical assault on the victim (Abel, Blanchard and Becker, in press).

6) Finally, it is possible to identify those rapists who select out a victim least likely to be able to defend herself during the assault, the very young or the very old victim. This is accomplished by measuring the rapist's erotic arousal to descriptions of the rape of victims of various ages. Child molesters show a definite trend with higher sexual arousal to victims of lower ages. Rapists who have selected older victims likewise show greater arousal to scenes describing the rape of older women.

These physiologic measurements of rapists are capable of providing significant information regarding the rapist's characteristics that was not available in the past. Assisted by such information, it is now possible to more precisely assist the rapist in identifying his treatment needs. These physiologic means, aided by other observational sources (Abel, in press), have pinpointed five possible treatment needs of rapists and child molesters, including, (A) all rapists and child molesters have excessive sexual arousal to deviant themes, i.e. rape or child molestation, (b) some sexual aggressives fail to have adequate sexual arousal to adult partners, (c) some aggressives fail to have adequate heterosocial skills, i.e. the ability to talk and interact socially with an appropriate adult partner, (d) some rapists have inappropriate assertive skills, that is they can not ask others to change their behavior, express how they feel,

etc. and (e) a portion of rapists fail to be able to empathize with others.

Fortunately, the means by which each of these five areas needing assessment are evaluated are not easily distorted by the rapist, and once each of the five components are assessed, treatment proceeds easily.

Treating Rapists and Child Molesters: A frequent assumption is made that sexual aggressives are not seeking treatment for their aggressive acts. Although true for some rapists, others feel guilty about their deviant behavior and wish to change. Unfortunately, our current system tends to prevent rapists from coming into contact with treatment facilities. For example, sexual aggressives are often treated through legal channels that minimize their contact with therapists. Indeterminate sentences make it unlikely that the offender will discuss his sexual problem, since doing so will be interpreted as a definite need for further incarceration and release becomes less likely.

To develop new treatments is a difficult task and especially problematic when working with clients whose behavior is dangerous to society. Fortunately, treatments have already been developed for various types of sexual deviates and these same methods can and have been applied directly to rapists and child molesters (Abel, Blanchard and Becker, in press). These treatments include;

1. Decreasing excessive arousal to rape or molesting children. It is unfortunate that so little attention is payed to this treatment need, since it is the reason sexual aggressives assault their victims. To ignore these components of treatment however, is to prevent the sexual aggressive from gaining control over his urges to rape.

Various treatments have successfully demonstrated themselves as effective means of reducing urges to rape or molest. Most involve the association of deviant sexual urges with thoughts or feelings of an aversive nature so that the deviant urges take on a negative valence. Such treatments include covert sensitization, odor aversion, etc.

2. Increasing sexual arousal to appropriate partners. Minimal attention has been payed to this treatment need in the past, but a number of methods (exposure, fading and orgasmic reconditioning) have the ability to teach males to respond to adult partners when that arousal has been absent in the past. These treatment methods have been developed over the last 5-10 years, but have not been brought to bear on this problem because sufficiently trained treatment staffs have not been available within the prison setting.

3. Developing heterosocial, assertive or empathetic skills. Skills training with each of these behaviors involves asking the sex offender to role play various situations requiring any of the three skills. The therapist then models appropriate skills for the sexual aggressive. The client's attempts to demonstrate the skills are then videotaped and played back to him, and the therapist points out the rapists successes or failures. The entire process is then repeated and further practice and refinement of appropriate skills follow.

In summary, treatment methods although only having been developed in the last 5-10 years, are readily available for sexual aggressives, having been developed on less dangerous sex offenders. What is needed now is the treatment vehicle by which to apply these techniques to incarcerated and non-incarcerated aggressives. A major hurdle will be the ethical

problems involved in providing services to an offender who may be under coercion to participate in any treatment offered. The guidelines provided by HEW for obtaining informed consent provide appropriate steps to follow in this difficult task. Hopefully, society's increased awareness that treatments do exist for sexual aggressives and our increased attention to sexual aggressive's requests for treatment will lead to reduction in the rate of rape and child molestation.

END