

**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

[No. 64]

Printed for the use of the  
Committee on Science and Technology



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**ACQUISITIONS**

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The Behavioral Assessment of Rapists

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Preparation of this chapter was supported in part by the National Institute of Mental Health, Grant No. MH-27724 and the Center for the Studies of Crime and Delinquency, Grant No. MH-38051.

134. Frederiksen LW, Jenkins JO, Foy DW, et al: Social skills training in the modification of abusive verbal outburst in adults. *Journal of Applied Behavior Analysis* 9:117-125, 1976
135. Rimm DC, Keyson M, Hunziker J: Group assertive training in the treatment of antisocial aggression. Unpublished manuscript, Arizona State University, 1971

Assessing the treatment needs of rapists is a relatively new concept. At least two factors have limited the need for such assessment, including (1) in the past rapists have been treated primarily by incarceration and since no specific programs were available for rapist within the prison system, detailed assessment was simply not needed and (2) when treatment was provided, it was dynamic in its orientation. Assessment using the dynamic model was a rather global procedure. Assessing the rapist was no different than the assessment of other sexual deviates or in most cases, other types of incarcerated offenders.

In the last 10 years behavioral approaches have been used with increasing success in the assessment and treatment of various sexual deviates (Abel, in press, Abel and Blanchard, 1976; Barlow, 1974; Barlow and Abel, 1976) and recently, behavioral assessment-treatment has specifically focused down on the treatment needs of rapists and other sexual aggressives (Abel, Blanchard and Becker, 1976; Abel, Blanchard & Becker, in press). Table 1 outlines such an assessment-treatment program for sexual aggressives. Treatment, includes various nonspecifics such as a warm, empathetic relationship with the patient as well as the acceptance by the patient that he has a problem that he wishes corrected. Beyond these nonspecifics however, there are three major areas needing evaluating with sexual aggressives.

All rapists have excessive urges to rape while others may or may not also have arousal to non-rape, sexual stimuli and/or various social skills deficits. Since excessive urges to rape and deficit arousal to non-rape stimuli are discussed in the bulk of this chapter, the various social skills deficits will



Table 1

## THE BEHAVIORAL ASSESSMENT AND TREATMENT OF SEXUAL AGGRESSIVES

Assessed Behavioral Excess or Deficits		Treatment Methods
Excessive arousal to rape stimuli		Aversion-Suppression methods 1. covert sensitization 2. electrical aversion 3. odor aversion 4. chemical aversion 5. biofeedback assisted suppression
Deficit arousal to non-rape, sexual stimuli		Generation of arousal to non-rape cues 1. masturbatory conditioning 2. exposure 3. fading 4. systematic desensitization
Social Skills Deficits	Heterosocial skills	Heterosocial skills training
	Assertive skills	Assertive training
	Sexual performance	Sexual dysfunction treatment
	Gender Role behavior	Gender role, motor behavior training

first be briefly discussed so as to give the reader an appropriate prospective on the rapist's total treatment.

Under the general heading of social skill deficits any one rapist may have deficits of heterosocial skills. Such individuals fail to have appropriate skills with which to interact socially with women. They are unable to talk with, flirt, ask women out on a date, etc., due to the absence of appropriate heterosocial behaviors or incapacitating anxiety or discomfort when attempting to relate socially. Behaviorally, heterosocial skills are assessed by asking the rapist to interact with a female confederate in a role playing scene in which he must demonstrate appropriate heterosocial skills. These role playing scenes are video-taped and rated as to the present or absence of appropriate heterosocial skills, using a heterosocial skill checklist (Barlow, Abel, Blanchard, Bristow and Young, in press). Rapists with heterosocial skills deficits are then offered specific heterosocial skills training to correct them.

Some rapists also fail to have adequate assertive skills. They may be unable to express their own opinions, unable to express feelings of tenderness and caring towards other individuals, or in still other cases, inappropriately assert themselves by explosions of anger and hostility. The assessment of assertive skills is completed by asking the rapist to role play scenes in which he must carry out appropriate assertive behaviors (Eisler, in press; Eisler, Miller and Hersen, 1973; Hersen, Eisler and Miller, 1973). Those without appropriate assertive skills undergo specific assertive skills training to develop same.

Rapist likewise need an evaluation of their sexual skills. Sexual skills deficits may include any number of problems extending along a continuum from inadequate sexual information to the more specific sexual dysfunction problems, i.e. premature ejaculation, retarded ejaculation, etc. At present, specific

behavioral assessment techniques have not been developed in this area and assessment remains at the clinical level.

A final social skills deficit involves gender role behavior. Although an infrequent problem as compared to the three previously described social skills areas, a few rapists do have excessive masculine gender behavior or inappropriate gender motor behaviors. Assessment is completed by the measurement of masculine or feminine gender motor behavior. Rating scales have been developed which specifically identify deficits in this area (Abel, in press) and treatment is directed at developing appropriate gender role behavior through role playing, modeling, social reinforcement and video feedback.

#### The Uses of Physiological Assessment with Rapist

Once the social skills areas are evaluated, the remaining two areas of assessment of the rapist include evaluation of his arousal to rape stimuli and an assessment of potential deficits in his arousal to non-rape, sexual stimuli. All rapists are excessively responsive to stimuli depicting the act of rape. These same rapists may or may not be aroused to normal, mutually enjoyable sexual encounters with an adult partner. For example, many pedophiles and sadists are responsive to either young children or sadistic acts directed towards their partner but are unaroused by adult females.

Zuckerman (1971) has reviewed the literature regarding the assessment of sexual arousal in the male and concluded that the most objective means of measuring male sexual arousal involves direct calibration of penile tumescence (Abel and Blanchard, 1976). To determine penile tumescence a penile transducer is placed around the penis and as tumescence occurs, an electrical output displays the increased penile size on recording paper. Using this transducer it has become possible to examine the various sexual responses of rapists. The

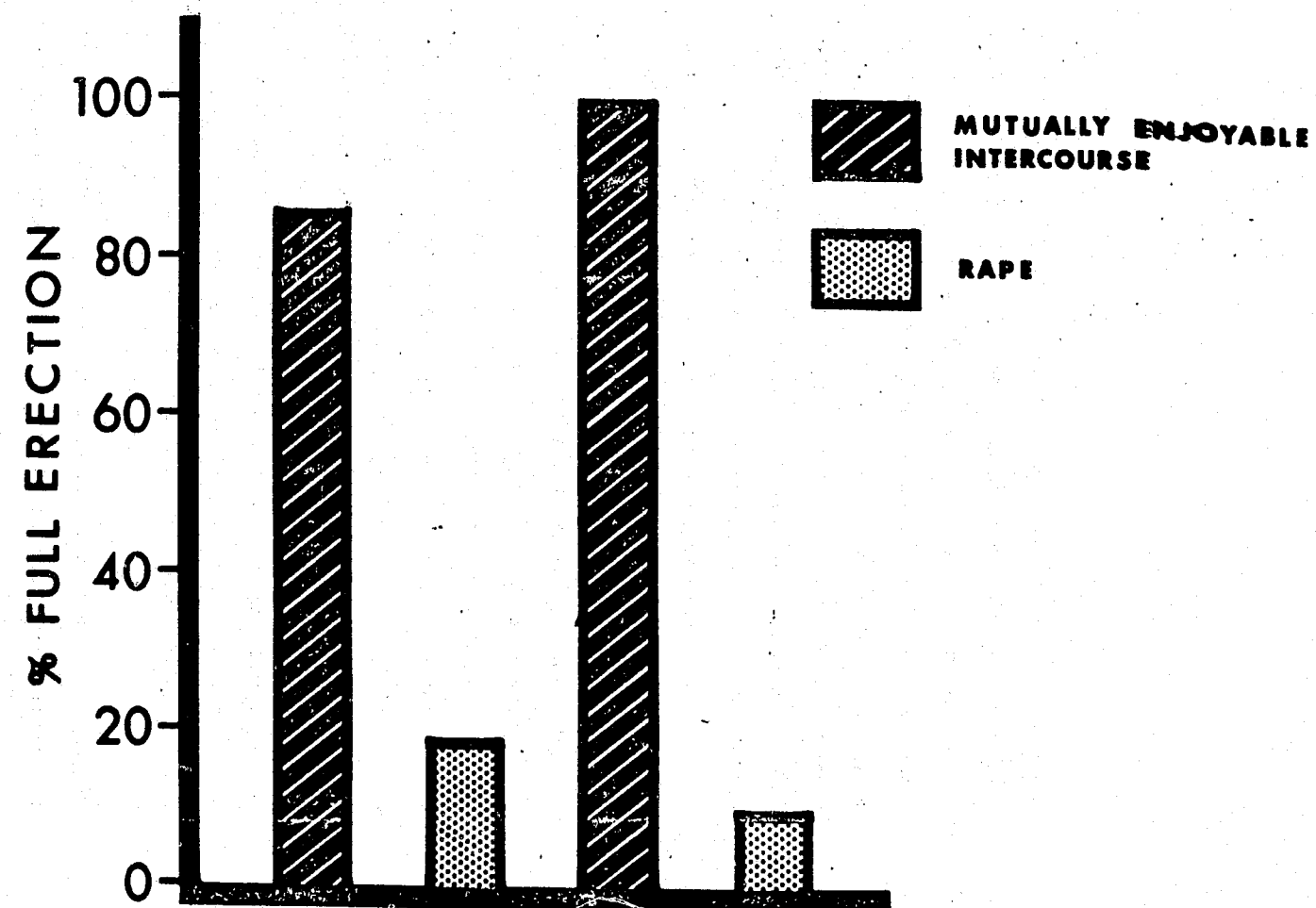
remainder of this chapter will elaborate on recent findings resulting from such physiologic recordings of rapists as compared to non-rapists. These findings can be categorized into six major areas including,

#### 1. The comparison of the erection responses of rapists and non-rapists:

Comparing the erection responses of rapists and non-rapists has required measuring both group's erections while presenting them specific stimuli depicting either rape or non-rape experiences (Abel, Barlow, Blanchard & Guild, in press). The patient wears the penile transducer while seated in the laboratory, listening to two minute audio taped descriptions depicting scenes of a specific content. The patient's greatest erection response during this two minute interval is then calculated and converted into percent of full erection. In this fashion, various types of sexual descriptions can be compared objectively on the basis of their ability to elicit sexual responsiveness. (Abel, Blanchard, Barlow and Mavissakalian, 1975).

Figure 1 indicates the typical sexual responses of a non-rapist to scenes depicting mutual enjoyable intercourse and rape. This particular subject had never forced himself on a female, denied having urges to rape in general, had warm empathetic relationships with women. His erections to separate scenes depicting mutually enjoyable intercourse, rape, mutually enjoyable intercourse (a repeat of the prior scene) and rape (a repeat of the prior scene) indicate that the patient has greater than 80% of a full erection to mutual enjoyable intercourse cues while his arousal to rape cues is less than 20% full erection.

These results are in marked contrast to those of a typical rapist. The case history of the rapist's data which follow, indicates he was a 19 year old



male with an extensive history of sexual aggressive acts since age 13. At that time he would approach females in parking lots or shopping centers, would enter their car and grab them in the vaginal area. This behavior continued intermittently until the patient was 19 years of age. He began raping at age 17. Seeing women in a parking lot, he would follow them home, enter the home on a false pretext and rape them. Of note in his history was a very strong religious background with the patient and his family very prominent in their church.

This rapist's erection measures appear in Figure 2. Examining for the present only those four bars on the far right, it is apparent that this rapist responds to mutual intercourse descriptions similar to the non-rapist, with 93 and 54% erections respectively. Where the non-rapist failed to respond to rape stimuli however, this rapist obtained 68 and 100% full erections to the rape cues.

To confirm that the responses of these two subjects reflect the responses of non-rapists and rapists in general, erections of seven non-rapist, sexual deviates were compared to the erections of seven rapist, using descriptions of mutually enjoyable intercourse and rape similar to those described above. These results in Figure 3 confirm that rapist and non-rapist both respond equally to mutually enjoyable intercourse scenes. When examining their arousal to descriptions of rape scenes however, obvious differences occur. Rapists' erections to rape descriptions are identical in quantify to their erections to non-rape descriptions. By contrast, non-rapists respond to non-rape, mutually enjoyable

# RAPIST'S ERECTIONS TO NON-SEXUAL AGGRESSIVE, RAPE AND INTERCOURSE DESCRIPTIONS

Figure 2

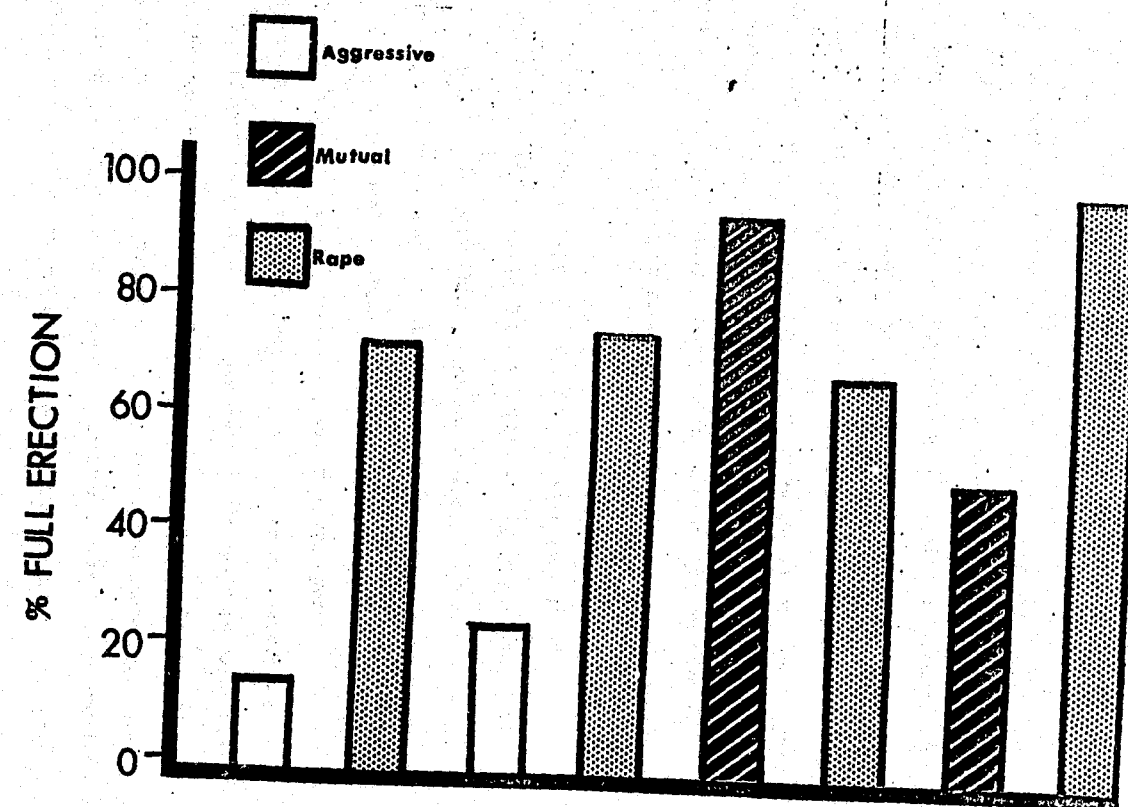
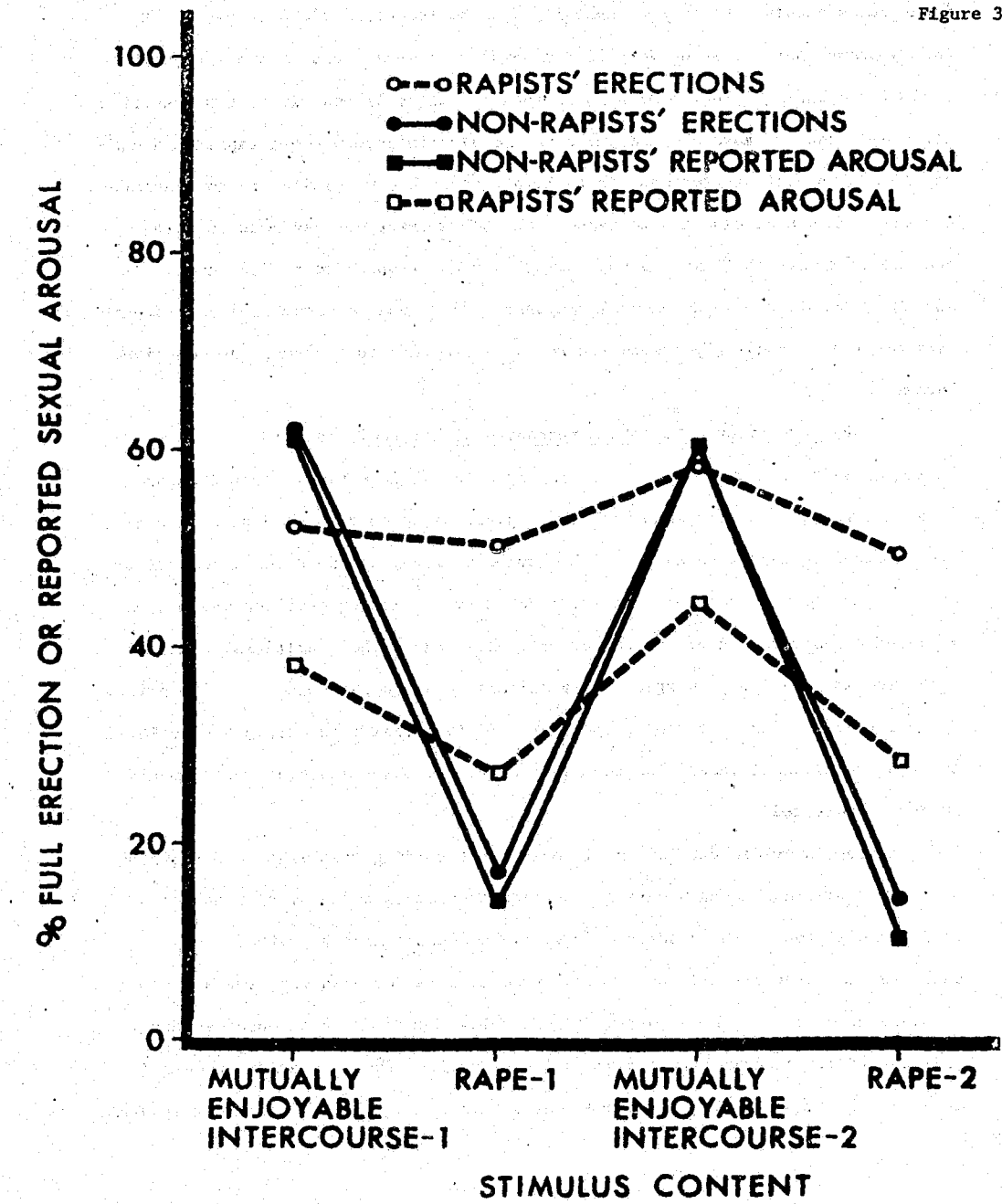


Figure 3





intercourse scenes, but fail to sexually respond to descriptions of rape. It thus appears that rapist do vary from non-rapist on the basis of their physiological responding. The importance of such a finding is that it is now possible, using an objective physiological measure, to discriminate between rapist and non-rapist. If a goal of treatment is to help rapists become similar to non-rapist, treatment should be expected to reduce the rapist's erection responses to rape cues so that they to (like the non-rapist) are not responsive to rape cues. It is thus possible to use the rapist's response to rape and non-rape cues as a dependent measure to ongoingly assess the rapist's progress in treatment as described latter.

## 2. The comparison of erection responses with verbal report:

Rapists have traditionally been assessed by clinical interviews. After establishing a working relationship with the rapist, he is questioned regarding his true arousal pattern, the extent of his urges to rape, his need for a control of these urges, etc. Since the equipment necessary for making erection measures is an added expense to the evaluation process and because the traditional clinical interview is relatively inexpensive, a serious question is, "What is to be gained by measuring rapists' erection responses?" If identical information is available through the clinical interview, the added expense of erection measurement would be contraindicated.

Figure 3 provides preliminary information regarding this issue. The group of seven rapist and seven non-rapist were questioned regarding the extent of their sexual arousal (on a scale of 0 equals no sexual arousal, 100 equals marked sexual arousal) and these verbal reports were compared with the actual recorded erection responses to rape and mutually enjoyable intercourse scenes. The results depicted in Figure 3 are quite dramatic. The non-rapist group had an extremely high correlation between their reported arousal and recorded arousal,

indicating that non-rapist by-and-large accurately verbalize the extent of their sexual arousal. Rapists by contrast consistently reported less sexual arousal than was actually recorded by the transducer method. These results suggest that rapists' verbal reports fail to reflect the extent of their recordable arousal and therefore verbal reports are a poor means of assessing progress in treatment. This is certainly the case if one of the goals of treatment includes reduction of the rapist's arousal to rape cues and maintenance of arousal to non-rape, sexual scenes.

Figure 4 further highlights this same issue. These results are the erection responses of an 18 year old single male, referred for pretrial evaluation. History reveals that reportedly while intoxicated, he and a friend had kidnapped an 18 year old female, driven her to a deserted area and raped her. The patient repeatedly indicated that although he was seeking a psychiatric evaluation, he was not a rapist and that the incident was entirely a product of his drinking. Throughout the evaluation process, he consistently reported no sexual arousal to any scenes presented to him. Erection measures by contrast show greater than 30% full erection to all the sexual scenes presented to him. His erections to rape scenes showed erection of 84, 100, 50 and 94% during the four presentations of rape stimuli. The patient denied not only a lack of sexual arousal to all scenes but reported sensing only minimal erections to any cues except for 5% of an erection to the first rape scene and 3% of an erection to the third rape stimulus. During the fourth presentation of rape stimuli, the patient volunteered that he was unable to even visualize any portion of the scene described. Concomitant measurement however revealed 94% full erection.

These results confirm the frequent findings that rapists cannot or will not verbalize the extent of their sexual arousal to scenes depicting rape and other sexual content. This was especially conspicuous in the case mentioned above where the rapist made every effort to identify his absence of sexual responsiveness to the rape cues and even an inability to see such scenes in his mind's eye. In conclusion, these results from the laboratory confirm what has been suspected for some time. Evaluative techniques that rely exclusively on the rapist's verbal report run a high risk of obtaining invalid data. If our intent as treatment agents is to conduct assessment and therapy on the basis of valid data, erection measurement appears to be of vital importance in assisting us in this goal.

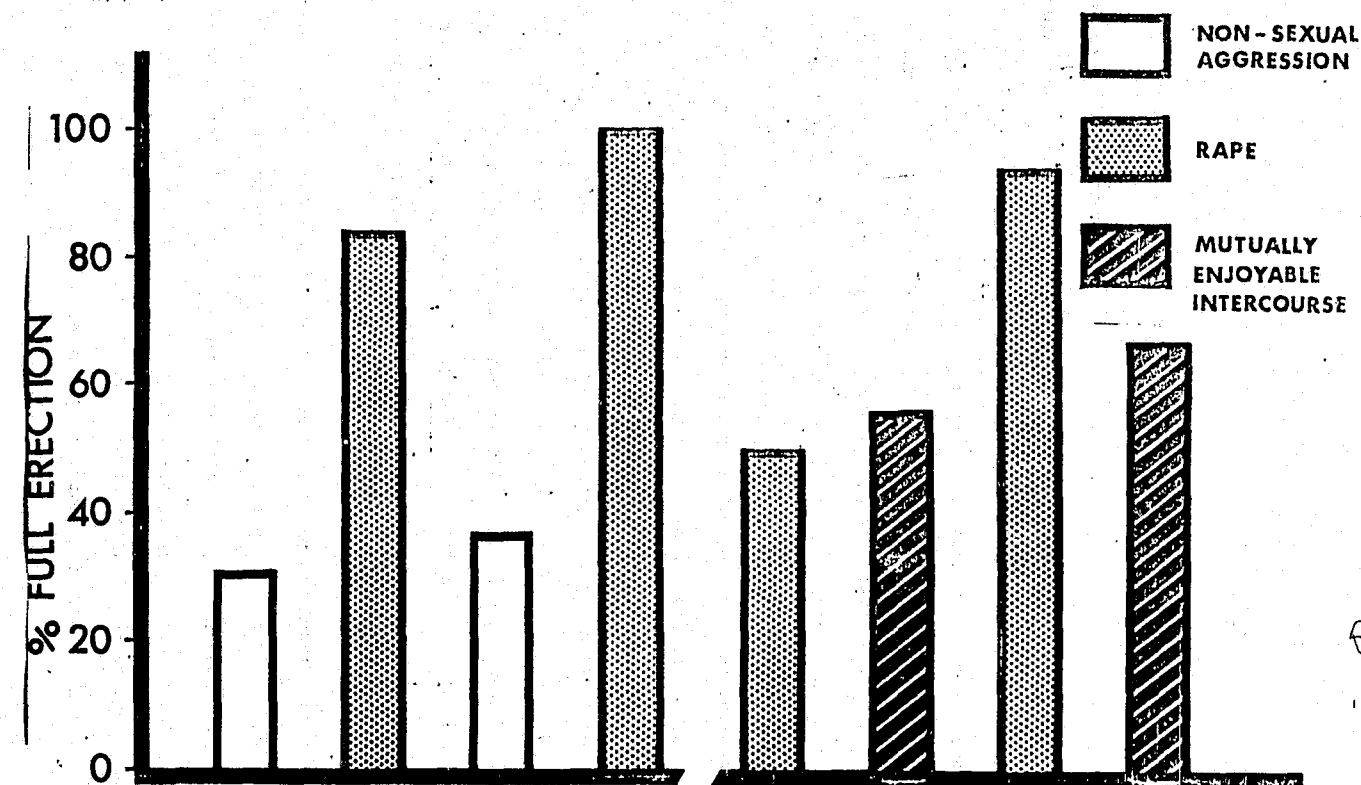
3. The contribution of erection measurement to further understanding of the rapist and his treatment:

Audio descriptions are highly flexible and can be altered to present any variety of unique stimuli to the patient (Abel, Blanchard, Barlow and Mavissakalian, 1975). It thus becomes possible to examine various issues related to the rapist's arousal patterns. For example, one treatment reported to be effective at reducing deviant sexual arousal is covert sensitization. This treatment involves the pairing of aversive images, images that are anxiety provoking or distasteful to the patient, with images or thoughts of carrying out inappropriate sexual behaviors, such as rape. Covert sensitization usually involves obtaining a clinical history from the rapist and relying upon his self-report as to the effectiveness of the treatment, whether the cues are indeed aversive, whether they reduce his arousal to rape themes, etc. This issue can be more objectively evaluated by a "trial of therapy" in the laboratory using the erection measurement techniques.

Figure 5 depicts the erection responses of the 19 year old rapist whose

Figure 4

**RAPIST'S ERECTIONS TO NON-SEXUAL AGGRESSION,  
RAPE AND INTERCOURSE DESCRIPTIONS**



history was reported early. In light of the rapist's extensive religious training and background, it was questioned whether religious references would be more powerful at reducing the patient's erection responses to rape as compared to other references, such as the legal consequences of rape. Two scenes were subsequently developed. The first included religious consequences of rape, i.e. how God would feel on seeing the patient rape, the deacons' of the church reactions to his raping, etc. A second description elaborated on the legal consequences of rape, i.e. going to jail, etc., and ignored any references to religious consequences. Both scenes depicted rape, with the addition of the respective consequences. Results indicated that the rapist obtained 89 and 82% full erection to rape scenes with concomitant references to legal consequences. By contrast, rape scenes concomitantly depicting religious consequences produced only 24 and 49% full erection. If covert scenes were to be used to reduce the patient's arousal to rape cues, references to religious themes could be expected to more significantly reduce arousal to rape cues than references to legal consequences. Using the erection measurement method, the therapist can preview the expected response to covert sensitization scenes before actually applying the treatment or relying exclusively on the rapist's verbal report as to the effectiveness of such covert scenes.

A similar issue is examined in Figure 6, once again previewing an anticipated response to using a specific covert sensitization image to reduce arousal to rape cues in the 19 year old rapist mentioned earlier. After questioning the patient regarding potential aversive covert images, it was suspected that images of the rape victim having open bleeding sores about her

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### RAPIST'S ERECTIONS AS A FUNCTION OF RAPE'S CONSEQUENCES

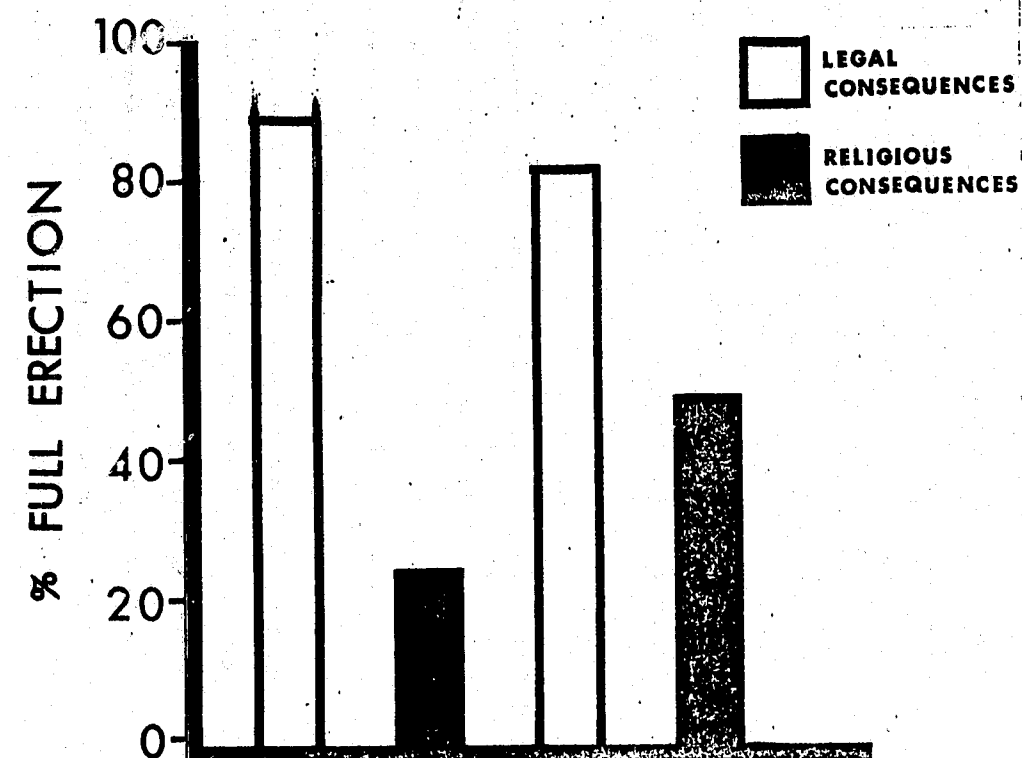


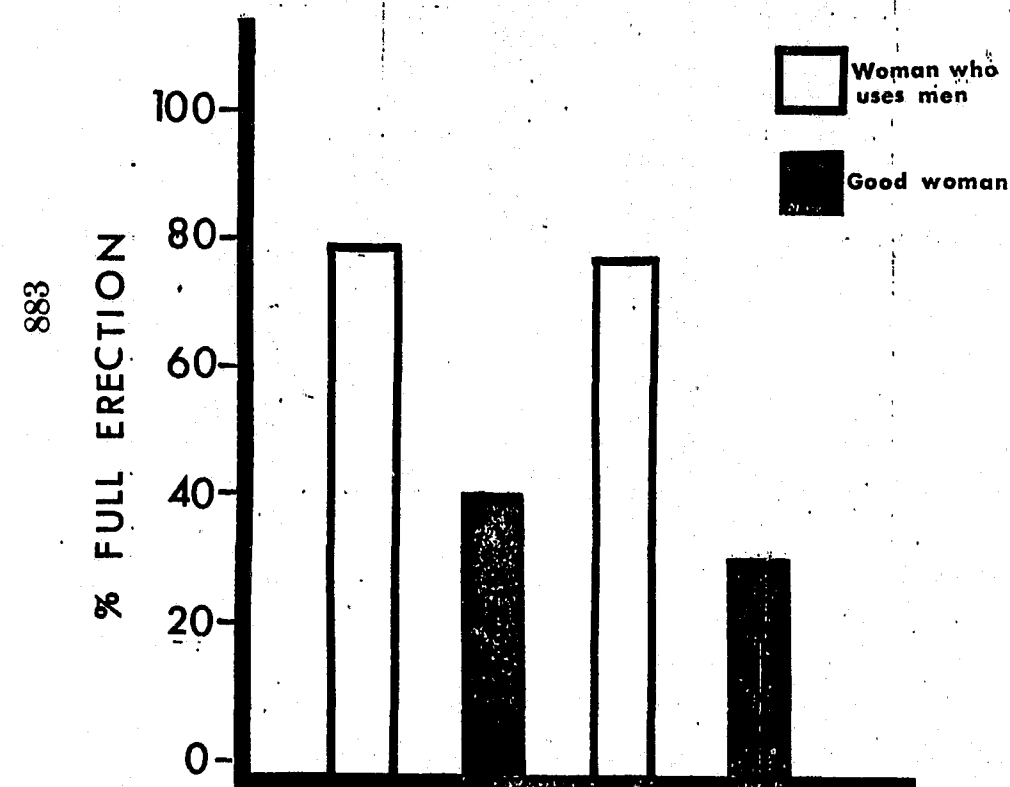
Figure 5

body would significantly reduce the patient's arousal to urges to rape. Two scenes were developed, one describing rape, the other describing a similar rape but including references to the rape victim having vulgar, bleeding sores. The patient's erections to the rape scenes were 90 and 100%, while his erections to the rape of the victim with bleeding sores was 53 and 46%. These erection findings confirmed the therapist's clinical suspicions regarding the effectiveness of these particular covert cues.

A final example of the additional information that can be obtained by erection measurement appears in Figure 7. History from the 19 year old rapist revealed his tendency to dichotomize women into one of two groups. Women were either good (non-manipulative, not self-centered) or bad (women who used men for their own selfish purposes). In real life, he reported that he raped the "bad" women but would not assault "good" women. To investigate this concept further, scenes were described depicting women known to the patient who in his opinion came from the two different groups. Care was taken that they were equally attractive to the patient and varied only on the parameter of "good" versus "bad" character. The rapist's erections to these descriptions indicate that the patient's erection is markedly influenced by the victim's character. When the scene described the rape of a woman who uses men, he obtained 79 and 77% full erection. When the scene described the patient raping the "good" woman, his erections were limited to 40 and 31% respectively. These results confirm with laboratory measures a clinical impression described in the literature, that

### RAPIST'S ERECTIONS AS A FUNCTION OF VICTIM'S CHARACTER

Figure 7 .



rapists frequently divide or dichotomize the world into good women (non-victims) or bad women (potential rape victims).

In summary, it appears that by altering the specific content of audio tape descriptions the therapist can evaluate the various parameters that contribute to the rapist's sexual arousal or reduce that sexual arousal. Using such physiological measurement will allow an exploration of possible motives behind rape. The therapist can also assess specific treatments that may be effective with a particular rapist.

4. The prediction of dangerousness on the basis of erection measures:

The rising crime rate and ethical dilemmas related to offender incarceration both beg the issue of predicting the dangerousness of the rapist. To examine this issue using erection measures, 13 rapists were ranked ordered from R1 to R13 on the basis of the greater number of rapes they had committed. R1 had committed one rape, R7 two rapes or more, R8 ten or more, R10 twenty, R11 thirty, R12 about one hundred and R13 clearly over one hundred. The rapists' erections to rape stimuli were plotted against their rank order number and number of rapes committed. No significant trend could be identified. An examination of the data revealed that there was considerable variability regarding each rapist's responsiveness to the sexual cues. To nullify the individual variability of erection responses, the rapists' mean percent erection to rape stimuli was divided by their mean percent erection to mutually enjoyable, non-aggressive scenes of sexual intercourse. The resultant value was termed the rape index.

Figure 8 demonstrates this rape index for the 13 rapists as well as 7 non-rapists, sexual deviates. These data indicate that a rape index of 0.5 or

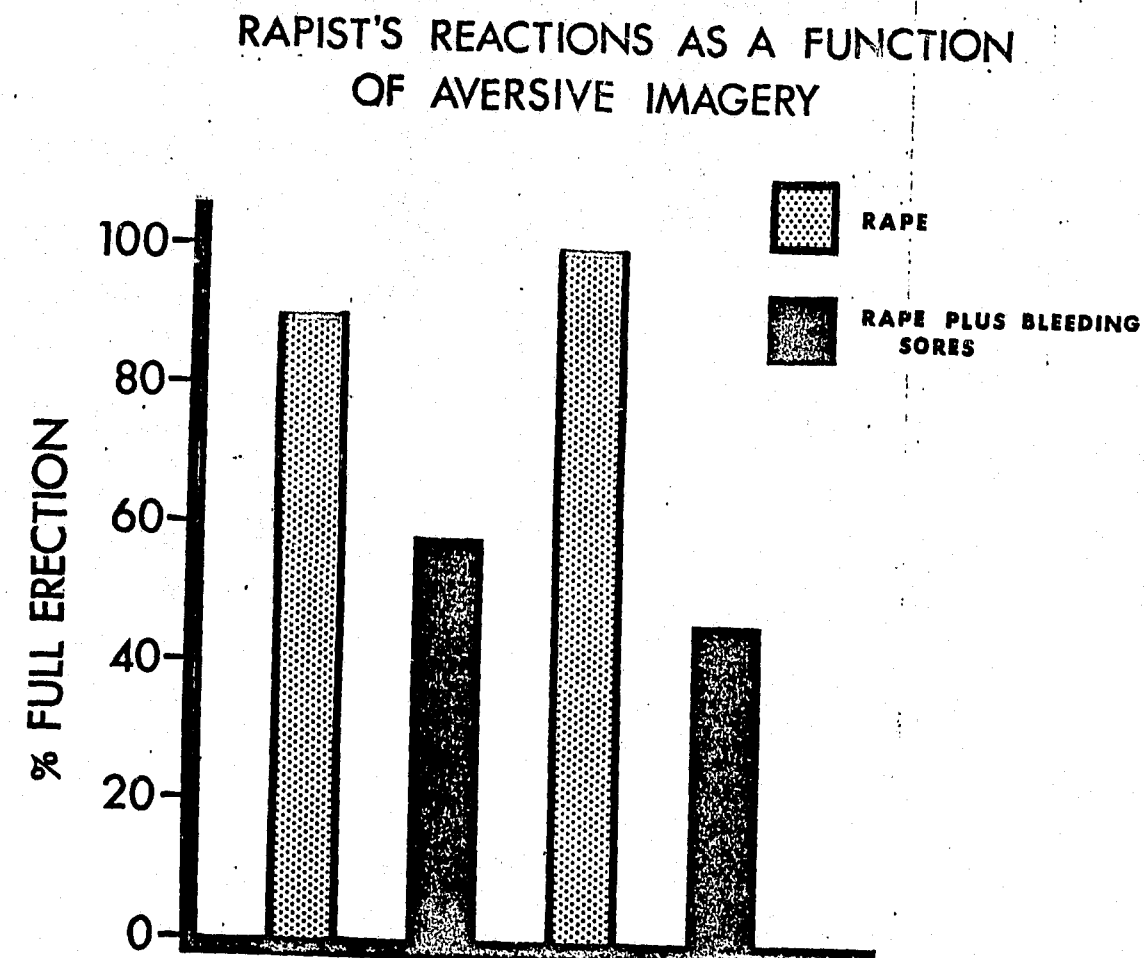
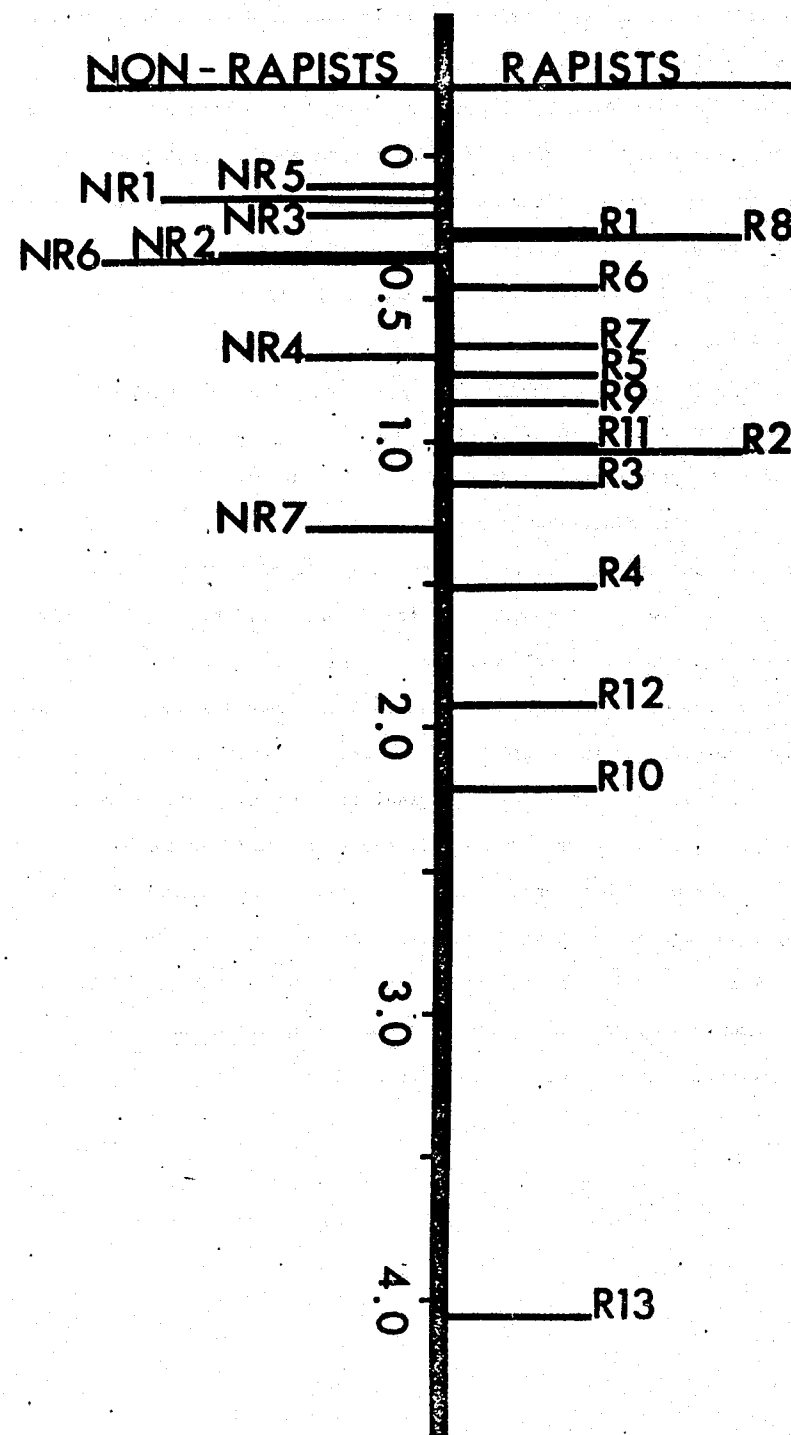


Figure 6





greater is quite suggestive of the patient being a rapist. Especially conspicuous are the rape index of R10, R12, and R13. These three rapists out of the 13 had raped at a very high frequency and also had the highest rape index, indicating that it may be possible to identify those rapists who have raped at the highest frequency by determining their rape index. If one defines a rapist as dangerous if he has raped at a high frequency in the past, then the rape index appears to be able to identify the few individuals at the far end of the spectrum who have raped at that high frequency. It should also be pointed out that non-rapist NR4 with a high rape index was a sadomasochist. His rape index is very likely greater than 0.5 because although not a rapist, he was aroused to sadomasochistic activity similar to rape. Non-rapist NR7 was a voyeur. His high rape index cannot be accounted for on the bases of his reported past behavior.

A second definition of dangerousness might be that the individual has severely injured his victims in the past, such as sadistic rapist. The two most dangerous rapists in the group of 13 as defined by their injury or harm to their victim, R12, and R13, also have two of the three highest rape indices. This suggests that if dangerousness is defined on the basis of a higher likelihood of having injured ones victim in the process of rape, a high rape index, especially one greater than 1.5 is suggestive of such individuals.

Another means of identifying rapist's who are likely to harm their victim is to identify sadomasochists, i.e. those who respond to physical violence with sexual arousal. We subsequently presented rapists with aggression descriptions devoid of sex. These aggression scenes, two minutes in duration, described the same victim as the rape or mutual enjoyable scenes, but instead of a sexual experience the scene depicts the rapist beating up the female, injuring her, slap-

ping her about the face, beating her with his fists, etc., (see Figures 2 and 4). In calculating our 13 rapists' response to these aggression cues versus their response to rape cues, a correlation was identified at the .98 level. Individual's arousal to assault scenes was almost exactly 40% of their arousal to rape cues, suggesting that arousal to aggression and arousal to rape are directly related in some manner. The only exception to this relationship was R13. This individual developed excessive arousal to the assault cues, relative to the rape cues. This same individual was the only clear sadist in our group. Thus, it appears that erection responses to aggression cues can be used to identify sadomasochists or individuals who have a high probability of injuring their victim during the course of their rape, as was the case with R13.

Finally, if dangerousness is defined as the rapist selection of an extremely young or extremely old victim less able to defend themselves against the rape, erection responses will assist in identifying such individuals. This is accomplished by developing a generalization gradient. Rape scenes are described in which the rape behavior is held constant but scenes are varied by altering the victim's age. Figure 9 represents the generalization gradient from the 19 year old rapist described earlier. These data show that the rapist's peak arousal varied from victims 20 to 50 years of age. Similar measures from R7, R9 and R12, the only pedophiles in our group, showed a clear skewing to the left with the patient's erection responses progressively increasing to descriptions of the rape of progressively younger victims. It thus appears possible using erection criteria to identify rapist whose victims are likely to be very young or very old on the basis of the generalization gradient finding.

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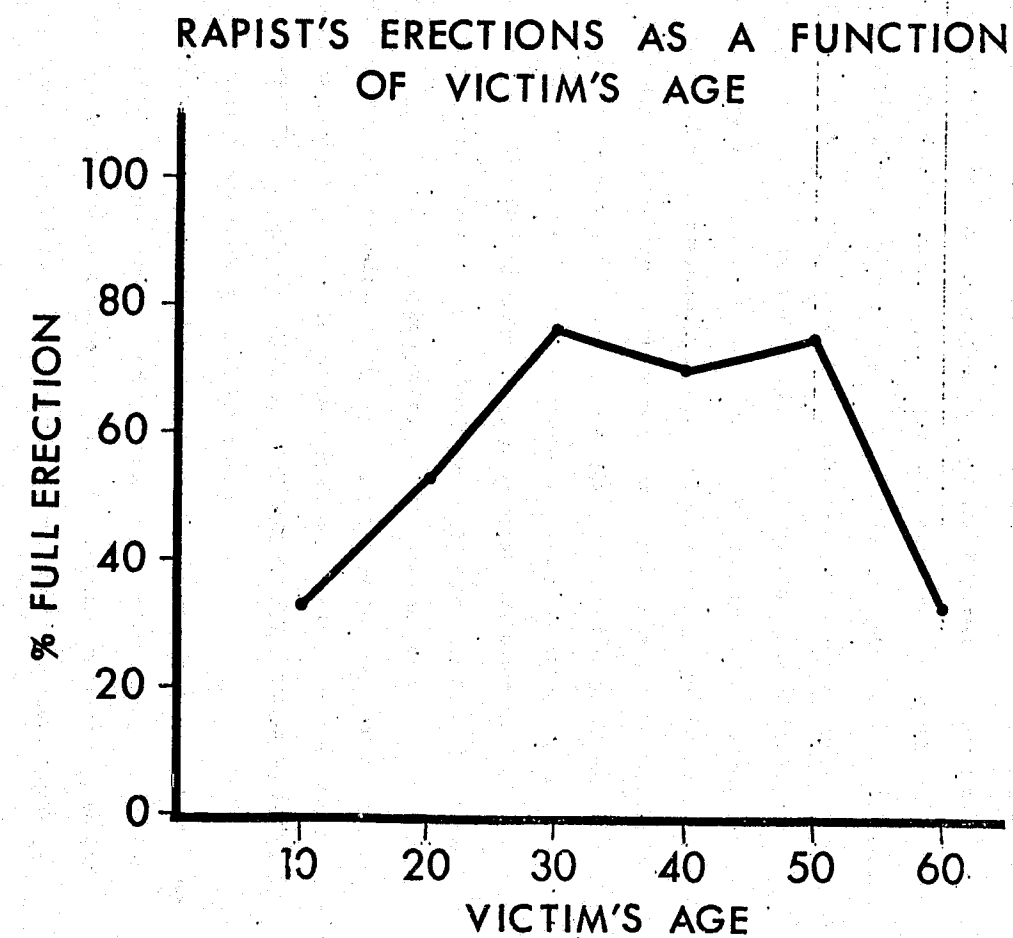


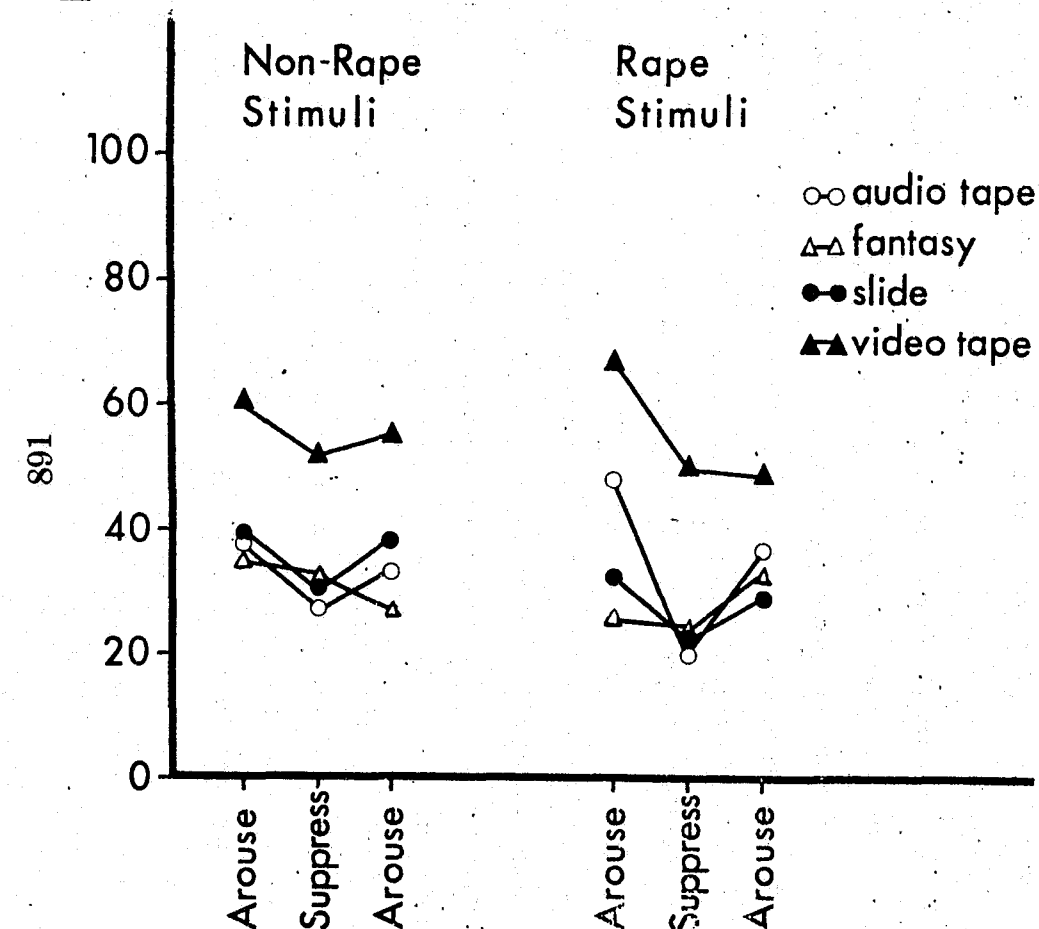
Figure 9

In summary, it is possible to identify the more dangerous rapist, depending on one's definition of dangerous. Currently, erection measures will assist in identifying (1) those who have raped at the highest frequency, (2) those who are likely to have injured their victim in the process of rape and (3) those whose victim is more likely to be the very young or very old.

5. Erection measures as a mean of evaluating rapists' response to treatment:

Although various treatment programs are available for rapists, delineating their effectiveness has posed definite problems. One difficulty has been the lack of specification as to exactly what changes in the rapist are to occur when treatment has been effective. In this regard, identification of various objective behaviors to be altered, as listed in Table 1, allows the evaluation of the rapist's progress in treatment to be a more objectively assessed. A second difficulty with evaluation is that it has relied almost exclusively on the rapist's report of improvement. The data reported in Figures 3 and 4 attempt to point out the dangers involved in relying on just such self-report information.

The assessment of rapists' response to treatment should include not only the standard clinical interview, attitudinal measures and the report of the frequency of rape and non-rape sexual thoughts and behaviors, but also necessitates repeated measurement of the rapist's arousal to rape and non-rape sexual stimuli. Previous studies (Abel and Blanchard, 1976; Abel, Blanchard and Becker, in press) have examined which modalities of stimulus presentations are most effective at generating deviant and non-deviant arousal in rapists. These results reflected in Figure 10 confirm in a rapist population that video tapes or movies are far more erotic than similar content presented by the vehicles of audio-tape descriptions, the rapist's free fantasy or slides depicting the



sexual activities. These results are similar to those obtained with a homosexual population (Abel, Barlow and Blanchard, 1975) as well.

In addition to the modality chosen, the patient's instructional set is also critical in recording ongoing erection responses. Sexual arousal as measured by the penile transducer is not simply an automatic response, completely outside of the control of rapists. Rapists are able to suppress portions of their erections as reflected in Figure 10. If ongoing erection measures are to accurately reflect the patient's progress in treatment, the patient's ability to voluntarily control portions of that erection response must be controlled for. One approach is to measure the rapist's erections under instructions to become aroused to the cues and also under the instructions to suppress that arousal. These data provide the therapist with information regarding the rapist's ability to voluntarily control his erection before treatment begins. Any reductions in arousal to rape cues can thus be evaluated in light of the known degree to which the patient can voluntarily control his measures.

Finally, it is critical to ongoingly plot or graph the rapist's arousal to rape or non-rape sexual cues as treatment progresses. Plotting of such values insures the therapist that appropriate measurements have been obtained and also allows the therapist a constant check on incidents occurring during treatment that may have marked influence on the rapist responses. Ideally, as treatment progresses, one is looking for a gradual but progressive reduction of deviant arousal concomitant with the implementation of treatment to reduce same, and a paralleling maintenance or increase in the patient's arousal to non-rape, mutually enjoyable sexual cues in addition to improvement in social skills as mentioned earlier.

#### 6. The potential for ethical abuse of erection measurement:

As newer evaluative techniques develop that are capable of determining a patient's progress beyond his awareness, the potential for ethical abuse becomes more serious. As our appreciation of the relevance of these erection measures increase, the potential for ethical abuse becomes more serious since decisions regarding continuation or discontinuation of therapy may rely on them more and more. A number of steps need to be taken to prevent such ethical abuses. The first would be to not exclusively rely on such erection responses but to incorporate these measures with the clinical interview and attitudinal measures that contribute to the total assessment. As with any other therapeutic intervention, erection measurement requires the patient's informed consent. In our own program a written informed consent procedure is used, describing in considerable detail the potential dangers to the patient of the data obtained from such physiological measurement.

Treatment for the rapist poses especially difficult problems when compared to other psychological problems. The principle of using the least intrusive therapeutic intervention for example becomes more complicated to judge when one considers the consequences of the rapist raping again. In an idealized system, it is best to generate heterosexual arousal (if absent) and teach social skills (if deficit) before proceeding with aversive methods to reduce arousal to rape stimuli since these treatments alone sometime result in loss of arousal to rape cues. If the patient is incarcerated and runs a high likelihood of raping fellow prisoners or in an outpatient treatment program such as our own at the University of Tennessee, control of the patient's urges to rape become more critical and aversive procedures have to be implemented earlier to protect the potential rape victims. Finally, treatment programs require both

internal and external auditing systems to confirm that the potential for ethical abuse is known to the therapist and appropriate steps have been taken to prevent same.

#### Conclusion:

Therapy for the rapist has made tremendous strides in the last few years. A number of factors have contributed to these advancements, including (1) rapist have been more accessible to the psychological community so that newer assessment-treatment techniques could be developed, (2) behavioral approaches developed for the treatment of sexual deviates in general, appear to have direct applicability to many rapist; this fact has greatly accelerated the development of treatment programs for rapist and (3) recent advancement in the means of assessing rapist's arousal have provided us new means of exploring etiological factors contributing to that arousal as well as a means of ongoingly assessing the patient's response to treatment. The remaining major hurdle is to acquaint the public with these advancements so that society might be more willing to allow these various factors to be brought to bare on the problem of treating the rapist. In the past, the public has rightfully been cautious regarding the handling of rapist. With the recent developments mentioned above, the treatment of rapist (as opposed to incarceration) appears to be much more tenable.

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