Acceptance-Based Psychotherapy in the Treatment of an Adjudicated Exhibitionist: A Case Example

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This paper describes the treatment of a court-referred exhibitionist using principles of Functional Analytic Psychotherapy and Acceptance and Commitment Therapy. The patient’s urges to expose, acts of exposure, and drug use were assessed during 12 months of treatment and at a 6-month follow-up. Results indicated that the patient’s urges to expose and frequency of public masturbation at treatment termination and at the follow-up assessment were significantly reduced from baseline. Further, treatment facilitated social skills development and reduced drug use and symptoms of depression and anxiety. These results suggest that nonaversive treatment methods can be successfully applied to treat exhibitionists. The effectiveness of applying a similar treatment program for other paraphilias should be examined.

Previous efforts to treat exhibitionists have most frequently relied on aversive behavioral techniques such as the pairing of negative consequences to imagined episodes of exposing (i.e., covert sensitization), masturbatory satiation (i.e., prolonged masturbation to deviant thoughts after achieving orgasm), and shame aversion (i.e., requiring the offender to expose to a select audience; for reviews see Blair & Lanyon, 1981; Kilmann, Sabalis, Gearing, Bukstel, & Scovern, 1982; Maletzky, 1997). As reviewed by Maletzky, a number of controlled studies and case reports have demonstrated the efficacy of aversive treatment techniques for treating exhibitionism. However, the use of aversive procedures in the treatment of exhibitionism is ethically questionable, especially if nonaversive techniques can serve as equally effective treatment modalities (Rachman & Teasedale, 1969).

Furthermore, a client’s limited motivation for personal change can impact the effectiveness of aversive techniques. Obtaining consent for techniques like shame aversion or masturbatory satiation can be especially problematic.
in poorly motivated clients (Maletzky, 1997). Even if consent for treatment is obtained, the therapist has no assurance that clients will be motivated to fully engage themselves in the therapeutic process. That is, clients may shift their attentional focus during treatment to avoid fully experiencing aversive stimuli. Clients might also deceive their therapist about treatment efficacy in order to avoid additional therapy. Thus, the use of aversive methods may compromise therapists’ abilities to recruit clients for treatment, apply therapeutic principles, and accurately evaluate treatment effectiveness in clients with limited motivation for treatment. In light of these issues, other treatment approaches for exhibitionism should be examined.

Recently, LoPiccolo (1994) suggested the application of acceptance-based treatments for nonviolent sex offenders. As stated by LoPiccolo, most behavioral treatments are aimed at eliminating deviant thoughts and urges in sex offenders since it is widely believed that deviant thoughts and urges lead to and maintain deviant behaviors. However, obtaining control over deviant thoughts and urges is difficult as evidenced by the fact that many sex offenders struggle to eliminate their urges and thoughts for some time before entering treatment (LoPiccolo). A more appropriate approach, according to LoPiccolo, involves promoting clients’ acceptance of deviant thoughts and urges. This approach provides clients with the opportunity to relinquish the struggle to gain control over their thoughts, which, in turn, allows them to develop and engage in more adaptive, alternative behaviors.

Several treatment methods based on principles of radical behaviorism have been developed that may promote acceptance. One such treatment approach, Acceptance and Commitment Therapy (ACT; Hayes, 1987, 1994, 1995; Kohlenberg, Hayes, & Tsai, 1993), has acceptance as a stated goal. In this treatment paradigm, acceptance refers to the willingness to experience a full range of emotions, thoughts, memories, bodily states, and behavioral predispositions, including those that are “negatively” evaluated, without necessarily having to change them, escape from them, act on them, or avoid them. When private behaviors need not be changed, their controlling effects over overt behavior might be reduced considerably, and concern could shift from emotional or cognitive manipulation to overt action (Kohlenberg et al., 1993).

Another radical behaviorally based treatment is Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991). Briefly, FAP focuses on clients’ in-session target behaviors, reinforcement of goal-oriented behavioral changes during therapy, and generalization of changes outside of therapy. Three types of in-session target behaviors are identified and labeled. First, manifestations of the behaviors for which clients seek treatment are referred to as Client-Related Behaviors-1 (CRB-1). Second, efforts to replace problematic behaviors with goal-directed behaviors are called Client-Related Behaviors-2 (CRB-2). Finally, clients’ recognition of the contingencies involved in their own behavior are labeled Client-Related Behaviors-3 (CRB-3).

While ACT and FAP may appear to represent different therapeutic modalities, the experiential methods of focusing on the client-therapist relationship
promoted by FAP can powerfully impact the acceptance of previously intolerable affective states (Cordova & Kohlenberg, 1994). For instance, by facilitating clients' understanding of the contingencies involved in their behavior (i.e., CRB-3s) and, thus, teaching them self-observation, FAP allows clients to respond to negative private experiences in ways other than avoidance. Further, the deliberate elicitation of CRBs within session affords the client additional opportunities to experience their emotions and to receive immediate reinforcement for adaptive responses (i.e., CRB-2s).

The current paper presents the treatment of a drug abusing, court-referred exhibitionist using techniques from both ACT and FAP. The primary goals of therapy were to reduce the frequency of exposing and public masturbation. Secondarily, treatment was aimed at decreasing the frequency of the client's drug abuse and promoting his social interaction.

Method

Subject

Darrel, a 20-year-old Caucasian male, was referred to the clinic after being arrested for indecent exposure. According to court documents, Darrel had driven by several females and exposed himself while masturbating. As such, Darrel's behavior fulfilled Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) criteria for exhibitionism. He presented for treatment on the advice of his lawyer, who anticipated that his sentence would be reduced if he made efforts to seek psychological assistance. Shortly after his first contact with the clinic, Darrel was ordered by the court to remain in weekly therapy for 1 year or until he was deemed "healthy."

Prior to his arrest, Darrel had no legal history. However, at the age of 13 he mailed pictures of himself masturbating to several females at his school. As a result, Darrel was suspended from school for several days and required to attend one therapy session with a counselor and his mother.

Darrel lived with his parents and younger brother in a small rural town. He attended a small high school and was the valedictorian of his graduating class. Darrel had few friends and he had never been involved in an intimate relationship or sexual encounter. At the time of his arrest, he was attending college on an academic scholarship, although he was failing several classes. He reported a positive relationship with his mother and a more distant, yet satisfactory, relationship with his father.

During his initial therapy session, Darrel rarely made eye contact and he spoke very softly. He communicated significant embarrassment about the behaviors that brought him into therapy and reported that public exposing was no longer a problem for him. As such, he refused to discuss the specifics of his exhibitionistic behaviors. In fact, before the first session was over Dar-
rel requested a note indicating that he was “healthy” so that he would not need to return to therapy.

In the second month of therapy, Darrel disclosed information related to his exhibitionistic behaviors. He reported that he began exposing himself in public 6 months prior to being caught. Darrel reported significant distress resulting from the frequency and intensity of his urges to expose. He stated that his urges made him feel like a “psycho.” He also recalled numerous unsuccessful attempts to control his urges. Darrel interpreted his failure to control his urges to suggest that he would remain a “psycho” for the rest of his life.

Despite denying significant problems related to exhibitionism at the initial treatment session, Darrel did report that he was experiencing depression and anxiety, related to his pending court dates. He also reported feelings of awkwardness and anxiety in social interactions, particularly with females. Thus, his stated goal in therapy was to develop social skills so that he could “find a companion.”

**Measures**

*Self-ratings (Maletzky, 1997).* In an attempt to circumvent a sex offender’s inaccurate self-reporting and low motivation for change, treatment providers have used more “objective” measures, such as penile plethysmography, to evaluate treatment success. However, the validity of these ratings as measures of deviancy has been questioned since exhibitionists and nonexhibitionists do not consistently demonstrate significantly different patterns of arousal to deviant and nondeviant stimuli (Maletzky, 1980). Furthermore, the suppression of arousal to deviant stimuli is unproven as a useful treatment target for sex offenders (e.g., Blader & Marshall, 1989).

Thus, clinicians are ultimately dependent upon sex offenders’ self-reports for the purpose of evaluating treatment efficacy. Fortunately, several findings suggest that self-monitoring is an appropriate method for collecting such data (Maletzky, 1980, 1997). As such, Darrel was instructed to record the frequency and intensity of his urges to expose, episodes of exposing, masturbation practices, and patterns of drug use. Urges to expose and to use marijuana were rated by Darrel on a 10-point Likert scale (1 representing minimal intensity and 10 reflecting severe intensity). For periods during which Darrel denied the occurrence of a behavior he was monitoring, but then later admitted the behavior, retrospective estimates of frequency and intensity were obtained.

*Behavior log.* In order to obtain information regarding the conditions under which Darrel’s exhibitionistic urges occurred, Darrel was also asked to monitor the antecedents and consequences of his exhibitionistic urges using an A-B-C log (Sarafino, 1996).

*Questionnaires.* To assess his symptoms of anxiety and depression, Darrel was administered the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) and the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) at the intake session (baseline), after completing 12 months of therapy, and at a 6-month follow-up.
Therapeutic Interventions

Darrel’s behavior log revealed a general pattern for exposure urges that occurred in the following sequence: Darrel typically smoked marijuana in his car before he drove home from work. On his way home, he purposely sought out attractive women. After locating them, he would experience a strong urge to expose. Prior to his arrest, it was at this point that he would expose himself while masturbating. Later in the evening at home, Darrel would smoke marijuana again while masturbating to memories of past exposures.

Based on this information, we hypothesized that several factors were involved in the activation and maintenance of Darrel’s exhibitionistic behaviors (see Figure 1). First, the powerful intensity of Darrel’s urges to expose was directly related to his acts of exposure. Darrel was more likely to expose in response to urges that he experienced as intense. Further, Darrel found his urges highly distressing and engaged in numerous futile attempts to control them. Paradoxically, these unsuccessful efforts at control may have maintained his urges and produced feelings of worthlessness.

A second element in the cycle of his sexually deviant behavior was Darrel’s negative self-evaluation. As mentioned, this view was due, in part, to his failure to control his deviant urges. Another source of Darrel’s low self-esteem was his limited social life. Like many exhibitionists, Darrel had few reinforcing social outlets. Moreover, despite significant interest in being involved in an intimate relationship, he had never been on a date. Darrel’s negative view of himself was also influenced by his substantial drug use. Although Darrel enjoyed the acute, intoxicating effects of drugs, he recog-
nized that his drug use had long-term negative consequences, such as his poor performance in college. His drug use also maintained his social isolation because he avoided sober people when he was intoxicated, which was the majority of the time.

Third, Darrel's drug use was directly related to his exposure behavior. Marijuana use probably compromised his ability and desire to refrain from exposing. Moreover, his drug use after exposing likely reduced the intensity of the guilt and embarrassment that typically followed his exhibitionistic behavior, minimizing the intensity of these "natural punishers."

After exposing in public, Darrel would feel disappointed in himself. These aversive feelings added to the chronic distress that Darrel experienced related to his poor performance in college and his limited social reinforcers. In an effort to escape these aversive feelings, Darrel would use drugs, and the cycle would repeat.

Taken collectively, it appeared that Darrel's self-perceived social incompetence, his unsuccessful efforts to control his deviant thoughts, and his drug use interacted in a complex manner to activate and maintain his exhibitionistic behaviors. Since Darrel had already been making unsuccessful attempts to curtail his urges, it was decided that treatment should not be aimed at these already unattainable goals. Thus, a counterintuitive approach emphasizing tolerance of cognitive, emotional, and bodily states was taken. As such, Darrel's treatment focused on (1) accepting deviant thoughts and emotions, (2) reducing the frequency of exhibitionistic behavior, (3) reducing the frequency of drug use, and (4) increasing social contacts. The therapeutic approaches described below were employed to achieve these goals.

ACT (Hayes, 1987, 1995; Kohlenberg, Hayes, & Tsai, 1993). The main goals of ACT are to give the client a counterintuitive method of accepting, rather than eliminating, troublesome internal events and to focus on long-term adaptive behavior. Five therapeutic stages are implemented to accomplish these goals. In the first stage, clients are helped to understand that previous struggles to control their inner experiences have been unsuccessful. In the second stage, clients are helped to see that not only have their previous struggles to control their thoughts and feelings been unsuccessful, but also the struggles may have made matters worse. The third stage of ACT emphasizes attempts to help clients delineate between their personal self and their cognitive, emotional, and physiological experiences. In the fourth stage, clients are asked to willingly experience the aversive private behaviors that they have previously avoided to accomplish their previously unreachable goals. Finally, the fifth stage of ACT involves securing a commitment from the client to change.

Throughout each stage, metaphors and paradoxical language are used to prevent the client from using language in a literal sense and thoughts and feelings as reasons for behaviors. For example, to facilitate the client's understanding that their past struggles to avoid aversive emotional states have not worked and, therefore, a new approach should be considered, the therapist draws similarities between the client's past attempts and struggling in quick-
sand. The therapist might say, "Struggling to avoid uncomfortable experiences is like being in quicksand: The more you struggle, the worse things get. Sometimes, the best approach is to do something that you haven't already tried. In quicksand, you need to lie flat and get as much of your body in contact with the elements. Similarly, in life, sometimes it is best to experience as much as possible" (Hayes, 1995, p.17).

FAP (Kohlenberg & Tsai, 1991) FAP focuses on clients' problematic behaviors that occur during the therapy session, reinforcement of goal-oriented behavioral changes during therapy, and generalization of positive behavioral changes outside of the therapy session. To accomplish this, therapists utilize five techniques. First, they are vigilant for the occurrence of in-session CRBs. Second, therapists work to elicit CRBs and foster the expression of CRB-2s in the therapy session. Third, therapists acknowledge the expression of CRB-2s in therapy with "natural" reinforcers rather than the "contrived" reinforcers, or consequences that clients would not experience outside of therapy (e.g., giving a token reinforcer to a client who has difficulties with anger management for demonstrating restraint). Fourth, therapists assess whether or not reinforcement of clients' expressions of CRB-2s has influenced their behavior. Finally, therapists explain, when appropriate, a client's problematic behavior in terms of their learning history and the functional properties of their behavior. In summary, the main goals of FAP are to establish a strong therapeutic relationship and to use the relationship as a vehicle to elicit CRB-1s and reinforce CRB-2s and CRB-3s, within session.

Procedure

During the first 2 months of therapy, Darrel repeatedly denied experiencing any urges to expose or episodes of exposure. In accordance with ACT, we administered a "values assignment" in order to ascertain the issues, if any, on which Darrel was willing to work. This assignment required Darrel to describe what he wanted in life regarding issues such as education, family, and career. Darrel acknowledged that he truly desired to be involved in an intimate relationship. As such, the initial goals of therapy were adjusted to focus on Darrel's social anxiety, which he viewed as the major obstacle to his developing new relationships.

In the first stage, the therapist fostered a sense of "creative hopelessness" in Darrel. Creative hopelessness refers to a client's recognizing the futility of his past struggles to control his internal experiences and appreciating that his agenda for change may be flawed. To elicit this state, all of Darrel's previous efforts at internal control were explored in detail and the utility of these attempts were evaluated. When Darrel's list was exhausted, the therapist emphasized the great exertion and minimal benefit of the previous efforts to solve his problems. In addition, the therapist elicited and affirmed the sense that Darrel felt stuck in his situation.

In the second stage, the goal of therapy was to show Darrel that, despite his extensive attempts, control of private events is not possible. In fact, the more
one struggles to control his/her emotions or thoughts, the more frequently and intensely they occur. A particularly powerful metaphor used in this stage of ACT to illustrate the paradox between attempts to control and proliferation of unwanted inner experiences involves a polygraph. In this metaphor, the therapist asked Darrel to imagine that:

... you are hooked up to the best, most sensitive polygraph machine that ever existed. When you are all wired up to it there is no way you can be aroused or anxious without the machine knowing it. Now, also imagine that, while you are hooked up to this machine, your task is to try to stay relaxed. If you get the least bit anxious, however, the machine will pick it up. To give you an incentive to do well in this task, I have a .44 Magnum which I'll hold to your head. If you stay relaxed, I will not blow your brains out, but if you get nervous (and I'll know it because you are wired up to this perfect machine), I will have to pull the trigger and kill you. Your brains will be all over the walls. So, just relax. What do you think would happen? Guess what you'd get? How could it work otherwise? The tiniest bit of anxiety would be terrifying (Hayes, 1995, p. 27).

By the end of this stage, Darrel recognized that future attempts at control would likely be similarly disappointing.

In Stage 3, Darrel was helped to distinguish himself from his thoughts and feelings through the use of various metaphors. He was led to understand that he is the context in which they are played out. By demarcating their personal selves from experiences, clients establish a solid basis for the acceptance of aversive experiences. For example, Darrel was instructed to describe his thoughts and feelings related to social situations by stating, "I'm having a feeling of anxiousness when I think about talking to a girl," rather than "I'm an anxious person." At the end of this stage, Darrel acknowledged the difference between himself and his experiences.

Stage 4 focused on Darrel's emotional willingness. In ACT, willingness is defined as the opposite of control. It is stressed to the client that willingness is a process, not an outcome, and is an all-or-nothing action. One exercise to illustrate this point involves the client trying to pick up a pen, rather than picking it up. From this exercise clients quickly realize that, just like picking up a pen, willingness is an all-or-nothing process.

At this point, the client was asked if he was willing to fully experience his thoughts and emotions and focus on behavioral action to achieve his goals. Following an affirmative answer, the client's emotional discomfort related to social situations was broken down into smaller components in order to facilitate their experience. Thus, private events typically avoided by Darrel were
brought into therapy (via imagery or other willingness exercises) and dissem-
bled into component pieces: bodily sensations, thoughts, behavioral predis-
positions, and memories. In all cases, the goal here was not to gain control
over these private events but to experience them without any attempt to mod-
ify or escape them. Darrel began to initiate conversations with females in his
classes and his anxiety began to decrease.

In the third month of therapy, before the fifth stage of ACT (commitment to
change) had begun, Darrel finally revealed to the therapist that he was experi-
encing strong urges to expose that he had been unsuccessfully attempting to
control. Darrel believed that an increase in urges would lead him to expose
and he feared the legal ramifications of his behavior. As such, Darrel became
willing to address these issues and we implemented the ACT approach to
treat Darrel’s exhibitionistic behavior. For the next 3 months, therapy ses-
sions were aimed at treating Darrel’s exhibitionistic behaviors by using the
same techniques and stages of ACT described for addressing Darrel’s
social anxiety.

Eventually, Darrel acknowledged that his past attempts to control his urges
had not worked, and future attempts to eliminate his urges would probably
not be successful. In addition, he reported differentiating himself and his urges.
Interestingly, in Stage 3, one particular metaphor from ACT used by the thera-
pist seemed to resonate very strongly with Darrel. The therapist stated:

It’s as if you were a house filled with furniture. The furni-
ture is not, and can never be, the house. Furniture is the
content of the house, or what’s inside it. The house merely
holds or contains the furniture and is the context in which
furniture can be furniture. Whether furniture is thought to
be good or bad, says nothing about the value of the house.
You are the house but not the furniture. Your thoughts and
feelings are the furniture. Just as the furniture is not the
house, your thoughts and feelings are not you. They are
experiences you have, like the pieces of furniture. There is
a limit to the kind of control that the house has. The house
can hold the furniture but it cannot tell the furniture what
to do or where to go. It doesn’t matter. Like the furniture,
your thoughts and emotions cannot be told what to do or
where to go (Hayes, 1995, p. 49).

However, Darrel remained unwilling to experience his private behaviors
related to exhibitionism. Instead, he avoided addressing them and thus the
frequency of his urges to expose remained stable during the first 9 months of
therapy (see Figure 2). Further, Darrel reported that he was masturbating
while driving his car, although he denied exposing his genitals.

Since Darrel had become unwilling to proceed with the ACT approach, we
decided that there might be other ways to facilitate Darrel’s acceptance of
previously intolerable affective states (Cordova & Kohlenberg, 1994). As such, we decided in the 6th month of therapy to alter the treatment program by incorporating principles of FAP.

The primary goal was to address Darrel’s difficulty disclosing thoughts, feelings, and urges related to public exposure during therapy sessions (CRB-1). The therapist was vigilant for the occurrence of avoidance of self-disclosure during sessions. Correct identification of this CRB-1 provided the therapist with an opportunity to respond to the client. The therapist also fostered the expression of any exhibitionistic thoughts, feelings, and urges (CRB-2) during session. Next, the therapist responded to CRB-2s with “natural” reinforcers and assessed whether or not these reinforcers influenced Darrel’s behavior. Also, whenever possible, the therapist described Darrel’s CRB-1s in terms of his learning history and the functional properties of his behavior.

Self-disclosure regarding thoughts and urges to expose was targeted as a CRB-2 and appropriately reinforced with the natural consequences for the behavior (reciprocated expressions of intimacy) by the therapist each time the behavior was emitted. For example, after Darrel disclosed any intimate information about himself, the therapist would reciprocate by stating that he appreciated being able to get to know Darrel better and that he felt closer to Darrel when he self-disclosed.

While self-disclosure of exhibitionistic urges and thoughts were the primary target behavior, the therapist also reinforced emotional disclosure in general, since it was hypothesized that Darrel’s social competence would benefit. Additionally, it was hypothesized that reinforcing any emotional disclosure would help to generalize his self-disclosure behaviors to outside the therapy session.

This approach was extremely successful in promoting Darrel’s experience

Fig. 2. Average frequency of urges to expose (per month) and use of marijuana (per week).
and disclosure of information that was related and unrelated to exhibitionism. One positive outcome of reinforcing Darrel’s self-disclosure was that within 1 month of incorporating FAP into treatment, Darrel revealed that he had been smoking a large amount of marijuana on a daily basis, and he immediately committed to decreasing this behavior.

In the remaining 3 months of therapy, principles of ACT and FAP were combined in order to address Darrel’s social anxiety, exhibitionism, and use of marijuana. Darrel continued to work on the ACT stages that had been addressed in previous therapy sessions related to his social anxiety and his urges to expose (i.e., ACT stages 1 to 4). In addition, Darrel and the therapist discussed, openly and honestly (CRB-2), the role that smoking marijuana might have in the activation and maintenance of his exhibitionistic behavior (CRB-3; see Figure 1). In light of these discussions, Darrel committed to reducing his use of marijuana (ACT; Stage 5). For the remaining 3 months of therapy Darrel continued to openly disclose personal issues with the therapist. He reported reduced social anxiety as a result of being sober more often (since he no longer had to worry about people discovering that he was “high”), and he adopted the belief that his drug use might be related to his exhibitionism. Moreover, after reducing his marijuana intake he reported getting better grades in school.

Results

At the intake session, Darrel scored a 22 on the BDI and a 22 on the BAI, which was indicative of his elevated levels of anxiety and depression. After completing 12 months of therapy, his score of 8 on both the BDI and BAI were in the normal range. At the 6-month follow-up assessment, Darrel’s scores of 2 and 1 on the BDI and BAI, respectively, indicated that he was not experiencing any mood or anxiety disturbances.

In the 6 months prior to his arrest, Darrel reported an average of 4 to 5 urges to expose each week. The average intensity of these urges was reported to be 8.5 on a 10-point Likert scale. Darrel exposed approximately 25 times in the 6 months prior to his arrest. During the 6 months preceding treatment, Darrel reported masturbating at least once per day, with thought content consisting mostly of past exposures. Finally, during the same time period, Darrel smoked marijuana about 6 separate times per day, 7 days per week (i.e., approximately 42 discrete times per week); he continued this pattern of drug use during the first 5 months of treatment.

In general, this pattern remained stable until elements of FAP were integrated into therapy (see Figure 2). At this point, Darrel reported an immediate decrease in drug use and a slight increase in frequency of urges. As FAP and ACT were used simultaneously, both marijuana usage and urges to expose continually decreased. At termination, Darrel reported an average of 2 urges per week, each with an average intensity of 5. He recorded masturbating an average of 3 times per week, though the content consisted of fantasies of het-
erosexual intercourse. In addition, his marijuana consumption reportedly reduced to an average of 4 times per week. Socially, Darrel also made significant gains. Before the end of his treatment, he dated a female that he met at school and he developed strong relationships with several other females that he met through social groups.

At the 6-month follow-up assessment, Darrel reported experiencing urges to expose an average of only 2 times per month, with an average intensity of 4. He continued to masturbate an average of 3 times per week, with thoughts of heterosexual intercourse. He had reduced his marijuana smoking to an average of 1 time per week. Finally, he continued to engage in social relationships with male and female classmates. Darrel reported that he was continuing to have success with meeting and talking to females.

Discussion

This paper describes the successful treatment of an adjudicated exhibitionist. Prior to treatment, Darrel reported frequent urges to expose and he typically acted on these urges. In addition, Darrel smoked marijuana daily, had few social contacts, and was performing poorly in college. He initially spoke very little during therapy and was reluctant to disclose personal information. With the application of ACT and FAP, Darrel began to openly communicate with his therapist. His exhibitionistic urges decreased significantly, he denied exposing, he decreased his substance use, his school performance improved, and he successfully developed several relationships. Furthermore, the intensity of his depressive and anxiety symptoms was cut substantially. These improvements were maintained at 6-month follow-up.

Darrel's overall improvement can probably be attributed to several factors. First, the use of ACT principles clearly had a positive impact. Initially, therapy improved Darrel's social incompetence, the discussions related to creative hopelessness and the struggle for emotional control in the initial sessions of therapy may have been applied by Darrel to his sexual deviance, and may have helped him finally to effect work on this problem area. Second, the application of FAP principles, in a positive feedback fashion, played a significant role in Darrel's willingness to disclose personal information. The more that Darrel was reinforced for communicating personal issues, the more frequently his disclosures occurred. In turn, each subsequent disclosure strengthened the therapeutic relationship, which facilitated even more self-disclosure. Increases in self-disclosure were hypothesized as being critical for making changes in social competence as well as exhibitionistic behaviors.

Darrel's drug use probably had a significant role in the activation and maintenance of his exposure behavior by compromising his normal regulatory resources. Also, marijuana use likely maintained his deviant sexual behaviors by allowing the client to avoid intrapersonal punishers (e.g., embarrassment, guilt) associated with exposing. Support for this position is evident in Figure 2.
The authors hypothesize that Darrel's marijuana use was related directly to his unwillingness to change. When his use decreased, Darrel was able to experience the voids (social and otherwise) in his life and appreciate the discrepancy between his life goals and his current situation. Experiencing this discrepancy increased Darrel's desire to change.

The results of this case underscore the complimentary relationship between ACT and FAP. As previously stated, both approaches facilitated Darrel's acceptance of previously intolerable experiences. However, the data suggest that attending to Darrel's CRB-1s and reinforcing his CRB-2s was critical to his willingness to experience private events related to his sexual deviance. The reinforcement he received allowed him to continue to tolerate, disclose, and ultimately respond to aversive stimuli in a supportive environment.

Previous to therapy, Darrel had rarely experienced a relationship in which he was the recipient of frequent positive feedback for prosocial behavior. This feedback caused Darrel to feel closer to his therapist and likely increased his desire to seek social contact beyond therapy. The relationship also likely contributed to his commitment to change.

The importance of the therapeutic relationship in facilitating treatment in this case should not be underemphasized. Initially, Darrel felt embarrassed and "weird" in response to his urges. Although he was required by the court to remain in therapy for 1 year, the content of the therapy was not mandated and thus he could have completed treatment without disclosing any information related to exhibitionism. Since "objective" assessment techniques like penile plethysmography have proven unreliable as measures of treatment success with this population (Maletzky, 1997), we were dependent on the client to self-disclose about his urges. Without a strong therapeutic relationship, it would have been difficult to obtain reasonably accurate information about problem behaviors and treatment efficacy.

As shown in this case, the principles and methods suggested by the approaches of FAP and ACT were powerful clinical tools for promoting a strong therapeutic relationship, a client's self-disclosure, willingness to change, and successful overt behavioral change in an adjudicated exhibitionist. One could argue that a potential limitation of this case study is that the client was a court-adjudicated offender and, as such, he may have had external motivation to provide inaccurate data about the efficacy of the treatment. However, as mentioned earlier, the court only mandated that the client be in treatment for 1 year; there was no requirement about the nature of the therapy. Initially, Darrel withheld information about his urges, exposure, and drug use. He could have continued in this vein and spent his year in therapy focused on social concerns. As mentioned earlier, we believe that the combination of ACT and FAP created a therapeutic environment in which Darrel felt comfortable disclosing information that was personally embarrassing and potentially harmful to his case. Nonetheless, future applications of this therapy should be utilized with voluntary treatment seekers to compare those results with those from adjudicated offenders.
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