

**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]

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ASSESSMENT OF SEXUAL DEVIATION IN THE MALE

by Gene G. Abel

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(in press).

## ASSESSMENT OF SEXUAL DEVIATION IN THE MALE

by Gene G. Abel

The behavioral assessment of sexual deviations has reached a fairly sophisticated level within the last ten years. Three factors appear to have contributed significantly to these advancements. First, traditional means of evaluation and treatment have not been particularly successful at treating sexual deviates. In hopes of finding a more successful approach, deviates have been referred for newer treatment modalities, such as behavioral modification. The availability of sexual deviates for assessment has led to concentrated efforts regarding their evaluation and treatment as opposed to other categories of psychological problems. Second, sexual activities such as exposing oneself or voyeurism are specific, easily identifiable acts that lend themselves to behavioral observation. Since accurate identification of the behavior to be changed is the hallmark of the behavior approach, the phenomenology of deviant sexual acts has assisted in their more thorough behavioral assessment. Third, physiologic measurement of sexual arousal patterns has made rapid progress recently, allowing further objectivity to be brought to the assessment techniques for sexual deviates.

The following schema for assessment of sexual deviates assumes that to be relevant, the assessment procedures must be simple enough to be understood and applied by both the therapist and client. To

facilitate understanding of what is basically a complicated issue, deviant sexual behavior, the complete assessment has been broken down into its four major components (Abel, Blanchard and Becker, in press; Barlow, 1974; Barlow and Abel, in press), (1) the extent of deviant arousal, (2) the amount of heterosexual arousal, (3) the adequacy of heterosocial skills, and (4) the appropriateness of gender role behavior.

These four components were arrived at empirically by assessing a variety of sexual deviates from the vantage point of their clinical needs and then identifying what appeared to be the common components of these treatment needs, irrespective of diagnostic categories. The schema makes no pretense at being the "final word" on the areas of behavior needing assessment. Quite the contrary, it is expected that further understanding of the treatment needs of sexual deviates will demand further elaboration and refinement of these and other components. At this time, however, the schema appears to assess the major areas that may or may not need treatment for all varieties of sexual deviates.

Under each of the four components are identified the self report, physiologic and motor responses specific to that component. It is suggested that only by integrating these three measures as they apply to the four major components, that we begin to arrive at a thorough understanding of any client's excesses or deficits of behavior contributing to his overall deviant behavior:

Deviant Sexual Arousal

Abnormal arousal patterns have traditionally been viewed as the

only component of behavior needing correction in sexual deviates. This simplistic view assumed that correction of the abnormal arousal pattern alone would lead to rehabilitation of the client. Subsequent discussion will demonstrate that this treatment alone is usually insufficient.

Deviant sexual arousal patterns include arousal to inappropriate objects (e.g., pedophilia, homosexuality, bestiality and fetishism) or inappropriate behaviors (e.g., sadism, voyeurism, exhibitionism and rape). The pedophile, for example, desires to hold, caress, have genital contact and establish an emotional relationship with another person, but his choice of a young child to carry out this behavior frequently leads to his arrest. The voyeur, by contrast, usually selects an appropriate object (an adult female), but his behavior towards that female is inappropriate. Instead of attempting to develop a relationship, date and possibly become sexually involved with her, he watches her through a window, usually fantasizing sexual behavior with her. Such inappropriate behavior (observing without consent) leads to his arrest.

1. Self Report: Assessment of deviant behavior usually begins with self report data obtained from the client. Obtaining information about deviant sexual behavior is usually hampered by both client and therapist characteristics. Many deviates are ashamed and feel quite guilty about their deviant sexual behavior after its commission. To relay such experiences to the therapist is to lay oneself open to even further possible ridicule and criticism. The therapist may himself harbor severe sanctions against such behaviors as rape, bestiality

or pedophilia. A thorough assessment, however, demands a complete understanding of exactly what deviant behaviors occur and what internal cues are associated with that behavior. The therapist should thus convey in a concerned manner his desire to assist the client as they work together identifying antecedents and concomitants of the deviant acts. If the therapist, due to his belief systems, is unable to maintain objectivity, he should identify this to the client and refer him to a therapist whose personal attitudes will allow a more accurate assessment.

To assess the client's self report of his deviant behavior, the therapist might begin by stating to the exhibitionist, for example, "Tell me in 10 or 15 minutes about what you do that leads to your arrest." If the client glosses over specific details, ask him to slow down and describe things as they occur, step-by-step. Be especially attentive to the client's words and descriptive phrases. Later during treatment, you may have to recreate in imagery the exhibitionistic experience for the client. Using his words and his phrases facilitates his ability to recall and revisualize those experiences. The therapist improves his own comfort and ease with this vocabulary by actually using the client's language in the process of obtaining self report information. As the exhibitionist says "and as I come up to her, I pull my zipper down, pull it out and flash her," the therapist responds, "so then you pull it out and flash her, and then what do you do?" Using this technique, the client and therapist both become more comfortable with the deviant's language being spoken by both.

Quantifying the client's deviant behavior is also helpful since it allows the therapist to identify high frequency behaviors that will probably need greater treatment than other less frequent deviant behavior. "How many times per day do you think about exposing yourself, how many times per week will you cruise areas to expose yourself, how many times per week do you actually expose yourself?", will all help clarify high frequency behaviors.

A more systematic means of collecting self report data is by a frequency count. In the early stages of evaluation, the client is asked to record three times per day (lunch, supper and bedtime) how often he has fantasies of exposing himself and how often he actually exposes himself. The client carries a pocket size notebook and at the appropriate mealtime, tabulates the frequency of these experiences since the last reporting. Although still only as valid as self report data, frequency counts are a somewhat systematic collection of information and by the time assessment has been completed, considerable data will have accumulated to identify the high frequency behaviors to be reduced. Such quantification is of some prognostic value as well, since Evans (1970) has reported that a high frequency of deviant behavior and a high frequency of deviant fantasies both identify those individuals who will need more extensive treatment.

Individually tailored card sorts offer another means of collecting self report information. Brief phrases are developed from the deviate's descriptions of highly erotic, deviant experiences he has had or would like to have. For example, two phrases developed for an exhibitionist, included, (a) I have an erection; I'm masturbating

in front of an attractive 12 year old girl; she's fascinated by my penis and (b) It's in the afternoon; the two girls on the motor scooter are looking at my penis; they are really excited.

The client rates each phrase daily on a seven point scale where -3 indicates the phrase was sexually repulsive, 0 sexually neutral, +3 highly sexually erotic and -2, -1, +1 and +2 falling between. By daily tabulating the total arousal value of such deviant scenes, the client provides the therapist with an ongoing confirmation of his arousal pattern. Card sorts and frequency counts can also provide ongoing assessment of treatment, with gradual reduction of sexual arousal to such scenes and a lower frequency of deviant acts and fantasies to be expected as treatment becomes effective.

It is also important to understand not only the terminal behavior that the deviate executes (exposing his genitals to the female, for the exhibitionist) but also the entire chain of behaviors that precede or follow that event. Therapy will probably be directed at all the behaviors along that chain, not just the terminal one (Mandel, 1970) and the therapist needs an understanding of all elements in the chain. For example,

Therapist: "Well, what exactly occurred the day you were arrested?"

Exhibitionist: "Not much, I just found a girl and exposed myself."

Therapist: "Tell me how you got to that final point of exposing yourself. What happened each step of the way?"

Exhibitionist: "Well, it started when I blew up at my wife. I got in the car and just planned to drive around a little. Then, I started looking for college girls, you know, short dresses.

I really wasn't thinking about exposing myself. Then, I saw this real sharp one and young, so I slowed down to look. Then, I started thinking about exposing myself and I circled the block and parked the car in front of her, like I usually do, and leaned over towards the sidewalk side of the car - - -."

Here, we are beginning to see not just the final cues active at the time the client exposed himself, but those early behaviors that although not immediately active at the time of the exposure, still played a role in the chain of events that culminated in exposure. Improving the client's marital relationship, disrupting his avoidance of his wife after fights, blocking his solitary rides in the car, stopping his looking at attractive college girls (even though he perceives no urges to expose himself), etc., are all elements of the chain that will probably need disruption.

Finally, self report measures should include information about covert events occurring near or during the deviant behavior. Such internal cues play a vital part in the arousal patterns of deviates (Abel and Blanchard, 1974; McGuire, Carlisle and Young, 1965). Example: A 27 year old rapist describes having raped over 50 women. By his report and available information from his defense lawyer, he has never injured his victims. When questioned about his fantasies during the rapes, he reports imagining beating and cutting-up his victim with a knife. Relying on only what he reports as his overt behavior would have ignored those internal cues that are also reported as

occurring at the time of the rape. Treatment will probably be directed at these reported fantasies in addition to the actual behaviors involved in the rapes.

Self report provides considerable rapid, specific information regarding the client's deviant arousal pattern at minimal expense. Relying exclusively on such client controlled information, however, has its limitations, since such information may be misperceived, not recalled or at times, concealed by some clients.

2. Physiologic Measures: Major advancements have occurred in assessing sexual arousal and the development of physiological devices that accurately record sexual arousal in males (Barlow, Becker, Leitenberg and Agras, 1970; Zuckerman, 1971) and females (Sintchak and Geer, in press). The details of how such instrumentation is applied to the physiological assessment of sexual deviates has recently been reviewed by Bancroft (1971) and Abel and Blanchard (in press).

The most valid measure of sexual arousal in male deviates is direct calibration of penile erection as recorded by the penile transducer (Zuckerman, 1971). This apparatus encircles the penis and generates an electrical signal as erection occurs. This signal is in turn displayed by a pen recording polygraph. By comparing partial erection measures to those recordings obtained during full erection, the client's physiologic erection during sexual stimulus presentation can be quantified as percent of a full erection. Such

transducers are currently, commercially available and have brought a new objectivity to the assessment of deviant arousal.

In addition to choosing from a variety of transducers (Abel and Blanchard, in press), the therapist must also determine, (1) the modality of stimulus presentation during physiologic recording of erection, (2) the content displayed by that modality and (3) the instructional set given the client during such recording. The deviant stimuli presented during erection measurement can be displayed by video tape clips; movies, slides, audio descriptions, written descriptions or by simply having the client fantasize his deviant experiences. A comparison of the effectiveness of different modalities at generating erections in homosexuals, voyeurs, pedophiliacs, exhibitionists, sadists and rapists (Abel, Barlow, Blanchard and Mavissakalian, in press; Abel and Blanchard, in press) indicates that video tapes, slides, audio descriptions and client's fantasies are most successful at producing erection responses in a decreasing order of effectiveness. Since the therapist is attempting to evaluate the client's physiological arousal to deviant cues and video clips produce the largest of such responses, the video modality should be selected if available. Usually, two minute selections are sufficient for measurement, since longer selections fail to produce erections of significantly greater magnitude.

The therapist next selects the content displayed by the chosen modality. The deviant content should capture as closely as possible

<sup>1</sup>Farrall Instrument Company, P. O. Box 1037, Grand Island, Nebraska 68801

those environmental conditions, people and acts that the client's self report identified as most erotic. Sometimes video clips for common deviant arousal patterns are commercially available, i.e. male homosexuality. Less common arousal patterns are not always as available in the video modality and slides<sup>1</sup>, audio descriptions or free fantasy must be used. Audio descriptions appears to be especially effective at presenting idiosyncratic, bizarre sexual scenes (Abel, Blanchard, Barlow and Mavissakalian, 1975) or scenes that are technically or ethically impossible to present by other methods, such as incest or rape (Abel and Blanchard, in press). Evaluation results using such accurate measures of physiologic arousal and precise control of stimulus content have demonstrated that although verbal report sometimes correlates with physiologic measures of deviant erotic preferences, sometimes there is marked disparity between these two assessment techniques.

Abel, et al. (1975), for example, explored the physiologic arousal response of a client who reported a fetish for women's sandals. Using audiotaped descriptions, the authors isolated sandal cues only. When such stimuli were presented, however, the client developed minimal physiologic arousal. Assuming that the client's arousal must be in some way related to sandals, another audio description was developed to isolate cues specific to a woman's foot, devoid of sandal references. Contrary to the client's verbal report, foot stimuli generated marked erections. Using a single case experimental

design, repeated measures confirmed those findings. This and other examples described by the authors substantiate that frequently self report alone is insufficient to identify deviant arousal patterns. A thorough assessment of deviant arousal patterns requires the integration of information from all three sources, i.e. self report, physiologic and motor responses.

A final issue to be determined by the therapist during erection measures is the instructional set given the client. Deviates (Abel, Barlow, Blanchard and Mavissakalian, in press) like normal males (Henson and Rubin, 1971; Laws and Rubin, 1969) have a certain degree of control over their erections during such measures. Evidence suggests that the client's control of attention to the deviant stimuli is probably the technique by which such control is possible (Geer, 1974). This means that physiologic measures of deviant arousal should be conducted with cooperative clients who are not attempting to conceal their true arousal patterns. Since suppression of erections to sexual cues is far easier than generating false responses (Henson and Rubin, 1971; Laws and Rubin, 1969), when possible the therapist should give greater weight to positive erection measures as opposed to drawing conclusions about arousal pattern based on the client's failure to develop erections to deviant stimuli. For example, erection responses to exhibitionistic cues should be accepted as a more valid finding indicating a client's deviant arousal, than assuming that no erections to exhibitionistic cues indicates he is no longer aroused to such cues.

Abel and Blanchard (in press) also suggest that measurement of both the client's ability to be aroused by deviant cues and his

ability to suppress that arousal be evaluated. Erection measures under both instructional sets allow the therapist to judge the client's ability to voluntarily influence the objectivity of such measures, and thus the therapist has a better understanding of the validity of the erection measures he is relying on. As data accumulates regarding the use of the penile transducer as an assessment instrument, the influence that instructional sets have on the validity of these physiologic measures should become more apparent.

3. Motor Responses: A client's motor behavior is not particularly helpful at identifying his deviant sexual preferences, although it is extremely helpful at identifying that component of over all deviant sexual arousal called gender role behavior (see below). Actual deviant motor behavior is sometimes role played by the client during treatments such as electrical aversion or shame aversion (Serber, 1970), but visualizing deviant behaviors for assessment is usually not indicated.

#### Heterosexual Arousal

The second and frequently overlooked area of assessment is the client's arousal to adult heterosexual cues (sexual arousal to a mutually consenting adult homosexual would be equally as appropriate if selected by the client). Adequate arousal to appropriate sexual objects has been a frequently neglected area of assessment. It was assumed that clients who have suppressed their deviant arousal and have good social skills would "naturally" develop arousal to adult females. When such arousal was not forthcoming, the need for assessing

heterosexual arousal became apparent (Abel and Blanchard, in press; Barlow, 1973; Barlow and Abel, in press).

Assessing the presence of heterosexual arousal is also of prognostic value. Feldman and MacCulloch (1971) identified the absence of prior heterosexual arousal as a means of identifying those clients who would not respond to their anticipatory avoidance treatment for male homosexuals. Barlow (1973) also stresses how the presence of heterosexual arousal has also been viewed in the psychoanalytic literature as a good prognostic sign in treating deviates.

Assessment of this area follows closely the procedures outlined under deviant sexual arousal, since the only major difference is the quality of the chosen sexual object or behavior.

1. Self Report: Self report is usually rapid and fairly accurate at identifying heterosexual arousal. The client should indicate how old he was when heterosexual arousal began, his early and later dating patterns, the characteristics of the female or heterosexual behaviors he preferred. If the client denies heterosexual arousal, be sure to determine if at anytime in the past the client did have some heterosexual arousal. Frequently that arousal pattern was present but subsequent deviant arousal has been so strong that heterosexual arousal patterns have been almost forgotten. If such heterosexual arousal was present, identify the exact cues that were most erotic at the time, since their incorporation into treatment to redevelop heterosexual arousal may be critical.

It is especially helpful to explore fantasies occurring during apparent heterosexual involvements or masturbation to supposed heterosexual cues.

Example: A 27 year old male reports sexual arousal to homosexual themes, but also says he has had sexual intercourse with women on three occasions. His description of his heterosexual encounter suggests that he may have adequate heterosexual arousal. When questioned about his sexual fantasies during heterosexual intercourse, his true arousal pattern becomes more apparent. In all three circumstances, he took great pains to fantasize that the women he was having intercourse with were actually men. Rather than having penile-vaginal intercourse, in his "mind's eye" he saw himself having anal intercourse with the fantasized male. In real life as he put his arms around the woman and embraced her, in imagination he visualized himself holding, embracing a man. In this case, relying exclusively on the overt behavior reported would have ignored significant internal cues.

The frequency reports and card sort techniques described under deviant sexual arousal can also be easily adapted to the evaluation of heterosexual arousal. The client self reports three times per day either heterosexual fantasies or actual heterosexual behaviors in the same small notebook used for deviant reporting. The card sort method is also adapted so that -3 (sexually repulsive) through +3 (highly sexually erotic) scores are given to heterosexual phrases such as, (a) I'm in a room with Alice; I have my arms around her; I feel her breasts rubbing up against my chest and (b) I'm naked, in bed with Jean; she's feeling my penis with her hand as she tells me how

much she loves me. As with deviant arousal, frequency reports and card sort techniques allow a systematic means of collecting information about sexual preference for assessment value, but these identical measures can become dependent measures during treatment as well.

2. Physiologic Measures: The issues involved in physiologic techniques for the assessment of heterosexual arousal are almost identical to that of assessing deviant arousal. Use of the penile transducer, the modality used during the presentation and instructional sets remain the same. The major change is the selection of content to be presented during such measurement.

Although recent work has identified the specific heterosexual movie content most erotic to non-deviates (Sandford, 1974), the therapist should be careful in selecting content that superficially might appear to be non-deviant. Mavissakalian, Blanchard, Abel and Barlow (1975) presented strictly heterosexual and strictly homosexual males, video clips of a seductive, single girl, two lesbians, a heterosexual couple and a male homosexual couple engaged in genital activity. Only the male homosexual couple (responded to by the homosexual group) and the lesbian couple clips (responded to by the heterosexual group) discriminated between the groups. The homosexual group reported responding to the heterosexual couple scenes by imagining sexual activity with the male participant. These findings demonstrate the importance of content selection during erection measures. Here, a scene depicting heterosexual intercourse was responded to as a homosexual cue by the homosexual group, stressing the need for careful content selection.

Similar care must be taken while evaluating other arousal patterns. Transvestites may interpret a slide of a female as actually a deviant cue, e.g., seeing himself really dressed well in women's clothes. A male to female transsexual may interpret a slide of a naked woman as deviant, allowing the women to represent the kind of body he would want to have. Similar issues regarding stimuli selection are discussed by Abel and Blanchard (in press) and Abel, et al. (1975).

Finally, the choice of heterosexual stimuli should consider who might be an appropriate object for the client to have arousal to. Pictures frequently chosen for presentation depict women from Playboy type magazines. In the client's world, however, the woman he is likely to meet and have the opportunity to become aroused to is not usually a Playboy type, but a girl from the office or down the block. Erection measures should thus determine arousal to women more commonly seen in real life, rather than the atypical, infrequently encountered woman displayed in popular magazines.

Discrepancies between physiologic measures and self report are seen during the assessment of heterosexual arousal, as in assessing deviant arousal. Example: A 27 year old male reported that although married for three years, he had no arousal to women, but extensive arousal to males. When questioned about ever having had minimal arousal to women, he denied same. When further questioned about the women he was leashed repulsed by, he described the pleasing personality of a female social worker he had been seeing weekly for almost two years. He was then asked to describe her in detail and

appeared to enjoy describing the texture and color of her skin.

Physiologic assessment included the development of audio descriptions of a few of the women he had described. The description of his social worker, describing in detail her skin, was immediately associated with marked increase in his erection to greater than 50% erection. When questioned at the time, he denied any sexual arousal. Repeated presentation of cues depicting the same social worker with further elaboration of her physical characteristics continued to produce marked erections. Here the client's physiologic measures conflicted sharply with his self report, suggesting that the client had significant physiologic arousal beyond what he reported. Further assessment of this client confirmed the validity of the erection measures.

3. Motor Responses: Motoric responses do not contribute significantly to the identification of the extent of heterosexual arousal and will not be elaborated on further.

#### Heterosocial Skills

As treatment of clients assisted them in the development of adequate heterosexual arousal and the suppression of deviant arousal, a third treatment need became apparent, the adequacy of heterosocial skills. Such clients were no longer preoccupied with excessive deviant arousal, were sexually aroused by adult females, but reported they did not know how to socially interact with women.

These problems of interacting with females appear to exist along a continuum extending from social, to heterosexual, to explicit sexual interactions. On one end of the spectrum is the inability to

carry out even rudimentary social skills with either males or females, i.e. not maintaining eye contact; appropriate body position or flow of conversation with another individual. This general area is reviewed in Chapter 13, Assessment of Social Skills.

At the opposite end of this spectrum are specific sexual skills, the client lacking the specific behaviors needed to carry out explicit sexual activity with his partner. This general area is reviewed in Chapter 15, Assessment of Sexual Dysfunction. Midway between these two extremes are deficits in heterosocial skills, i.e. those social behaviors antecedent to explicit sexual activity. These latter complex behaviors normally develop on a trial and error basis in the course of early dating. By learning from our own successes and failures and modeling after others, most males learn to date, flirt and communicate a desire for further intimacy with a female partner. When inadequate opportunity, practice and modeling or the client's deviant arousal pattern removes him from the opportunity to relate socially to females (e.g., exclusive male homosexuals and pedophiliacs), it is not too surprising that clients have significant heterosocial deficits. Earlier, more simplistic treatments assumed that such skills would have to appear due to the socialization process, but experience strongly suggests that this is not always the case. Heterosocial skills must, therefore, be assessed from the usual self report, physiologic and motoric elements.

1. Self Report: The male deviate should be questioned about his past history of dating; age of onset, frequency, and information reflecting his adeptness. The therapist should identify what are

the usual environments, people and situations in which he excels or fails heterosocially. Are his heterosocial deficits occurring on approaching and first meeting a female (or preferred partner), initiating conversation with her, asking her for a social date, flirting or during the more intimate exchanges just antecedent to sexual contact.

A common error in such assessment is to not be sensitive to the client's real world of heterosexual interaction. If you and he come from different social environments, the situations, opportunities and style of heterosocial interacting may be entirely different. To ask him about how he approaches or interacts with women on coke dates and fraternity parties may have little relevance when his culture leads to heterosocial interactions at bars and bowling alleys.

2. Physiologic Measures: Eisler, Miller, Hersen and Alford (in press); Hersen (1973); Hersen, Eisler and Miller (1973) and Hersen and Miller (1974) have stressed the value of appraising the client's physiologic responses during his heterosocial performance. You must not only be aware of his actual skills, but also the extent of anxiety, nervousness, tachycardia, diaphoresis and tremor, etc., associated with these skills. If the client's heterosocial performance is flawless and yet he displays and describes excessive physiological responses, assessment must identify these factors for inclusion in the client's total treatment.

Directly monitoring such physiological responses with instruments, although possible, is usually not needed. Most therapist directly observe the client for such physiologic responses during the client's

role playing of his heterosocial skills as described below. In addition to your own observation, the client should self report his own anxiety during role playing by using the subjective unit of disturbance scale (SUDs) described by Wolpe and Lazarus (1966). The most severe anxiety experienced by the client is rated as 100, absolute calm is zero. After each role playing scene, the client reports the greatest degree of anxiety or discomfort he experienced during the scene on the scale of zero to 100. You also need to know exactly which segment of his performance was that peak anxiety associated with.

3. Motor Responses: Some clients can accurately recall and assess their heterosocial skills and concomitant physiologic responses, but most of us fail miserably at such a task. Therefore, the best means of evaluation is by actually observing the client's motor skills during heterosocial interactions. In this fashion the therapist observes and can confirm the client's self report. Although many authors use social skills training and report it as extremely helpful and effective with clients lacking skills (Clark and Arkowitz, 1975; Goldsmith, 1973; MacDonald, Lindquist, Kramer, McGrath, Rhyme, 1973; McGovern, Arkowitz, Gilmore, 1975); developing a means of quantifying heterosexual performance has been quite difficult.

Motor assessment should involve the client role playing scenes depicting those very situations he must deal with in real life. To insure that you are evaluating an adequate sampling of such situations, have him select at least three different scenes to role play. It is most helpful if a female assistant of a similar age and unknown

to the client, can role play the part of the female to increase the validity of the situation. Three scenes might include (1) the client enters a bar where a woman is sitting alone; he tries to introduce himself and strike up a conversation; (2) the client is at a small restaurant where he has eaten before; he tries to ask a familiar waitress for a date while she is serving him and (3) he has been asked up to his date's apartment; he tries to flirt, discussing her personality, appearance, clothes and his attraction to her.

Since mental health workers are usually heterosocially adept, the female assistant may have a tendency to lead the conversation in such scenes and inadvertently assist the client in his performance. Since the goal of this assessment is to evaluate his heterosocial performance, his performance is best taxed by cautioning the female confederate to not initiate conversation, to limit her verbal response to five words or less and to avoid excessive reinforcement during the scene, either verbal or non-verbal.

Once the scene is established, heterosexual performance can be quantified by the use of an appropriate scale. Although a scale for assessing all categories of heterosocial behavior is not available, Barlow, Abel, Blanchard, Bristow and Young (1975) have recently developed a check list of three heterosocial behaviors that discriminates males with successful heterosocial skills from sexual deviates without same. Appropriate heterosocial motor skills in these three areas of performance include,

- voice:
  - sufficiently loud, without breathy overtones
  - lower in pitch than female role player
  - no excessive inflection
  - no dramatic effect
- form of conversation:
  - introduces, initiates conversation
  - responds at least once to female's vocalizations
  - allows no pauses - 5 seconds or longer in conversation
  - comments reflect interest in the female
- affect:
  - facial expression appropriate to conversation's content
  - eye contact occurs five seconds per 30 seconds of conversation
  - laughter is without giggling or high-pitch

Usually two and one-half minutes of social interaction in each of three role playing situations is observed. The client's performance is rated in 30 second blocks for the presence or absence of each sub-category under voice, form of conversation and affect. The percent of appropriate behavior is calculated and compared with the client's self report of his heterosocial skills. This information is then combined with self report and evaluations of the client's physiologic responses during such role play, to pinpoint exactly what heterosocial deficits exist and, therefore, need appropriate intervention. This same assessment technique, like the previously mentioned erection measures, can provide the therapist with a continuous assessment of treatment interventions in the heterosocial skills area.

Example: A male seeking treatment to reduce the occurrence of homosexual fantasies, reports he also has marked difficulty trying to date women. Up to the present, he has avoided dating. When simply near women, he feels nervous, anxious and uncomfortable. The three role playing situations mentioned above are described to him and he is instructed to be as socially adept as possible during the scenes. Although he displayed fair social skills during his interview with a male therapist, his performance is quite different in the heterosocial role playing scenes with a female. His voice assessment is extremely good; i.e. 90% appropriate. His form of conversation, however, is extremely poor, e.g., he initiates conversation only twice in three minutes, he doesn't respond to the woman's replies, he allows some 50 second pauses to occur in conversation and makes no comments reflecting interest in the woman. His affect performance is equally as poor. His subjective units of disturbance is 75 to 100 during the three scenes.

This case highlights the value of the motor assessment of heterosocial skills and its relationship to self report and physiological assessment. Although the client displayed some deficits in the clinical interview, when faced with an actual woman in the role playing situation, his heterosocial skills deficits became very obvious. His self report of heterosocial deficits, however, was only partially correct. Actual assessment of his voice performance indicate no significant deficits. His form of conversation and affect, however, were extremely poor and consistent with his self report.

These findings point out the added value of breaking down evaluation processes into subparts. Heterosocial skills are usually evaluated by global, unquantified assessment methods that fail to identify specific areas of competency or deficits. When complex behaviors are broken down into subparts, some areas (such as this individual's voice assessment) turn out to be very appropriate, not needing treatment. Such discrimination of treatment needs allows the therapist to concentrate treatment on the precise deficits needing treatment with a more efficient use of client-therapist time.

The reliability of this heterosocial motor scale is relatively high when rating video taped recordings of role playing scenes, but reliability is also a function of the specific behavior being observed. The reliability coefficient for the affect scale is 86-91, the form of conversation scale 94-96 and the voice scale 94-97 when calculated by comparing agreement and disagreement of independent raters rating 30 second blocks of behavior.

The major relevance of such motor assessment is its validity. On the basis of self report, the therapist might assume that the client's heterosocial skills are adequate or deficit. However, we no longer have to make such speculations, since role playing heterosocial scenes allow us to actually observe and quantitate performance. If physiologic concomitants of such skills occur, we can actually view the tremor or hear the client's inappropriate voice inflections. If the client's discomfort is not observable, such as feeling anxious or upset during such scenes, his self report of that disturbance (SUDs)

can be more closely associated with the specific tasks that make such discomfort higher or lower, rather than relying on his recall of distant events, that are frequently distorted.

In spite of the initial success with this scale, numerous problems suggest it should only be considered a rudimentary first start at quantifying assets and deficits. It is already apparent (Barlow, et. al., 1975) that the scale's validity does not hold up when used with age groups, races and socioeconomic groups other than those it was validated with. Clinical experience also strongly suggests that the three heterosocial behaviors are but a small fraction of the total repertoire of behaviors needed for good heterosocial functioning and thus the scale needs to be expanded. We will also need to integrate heterosocial skills assessment with the evaluation of the general, social and specific sexual skills mentioned earlier to arrive at a more total assessment of any one deviate's entire skills repertoire. A final issue to explore is how does in-office role playing relate to heterosocial skills performance in the real world. It might be expected that a client's performance with our female confederate in the office would be considerably easier than a heterosocial encounter in a bowling alley with an unknown woman. Only further research in this area can answer these rather complicated problems.

#### Gender Role Behavior

The final component of assessing sexual deviations is gender role behavior, the most recently investigated and probably least understood of the four components. Our confusion regarding gender

role behavior has probably evolved from our assumption that sexual identity and gender role are always positively correlated. As each of us develop, we acquire a sense of sexual identity, e.g., I am a male or I am a female. Assessment of this belief is described under deviant sexual or heterosexual arousal.

Separate from one's sexual identity is how we represent ourselves to the environment, our gender role. If we represent the characteristics traditionally associated with males, for example, our gender role would be viewed as masculine. Confusion has developed when it was assumed that sexual identity and gender role behaviors had to be similar. The effeminate homosexual, however, exemplifies how this is not always the case. The effeminate homosexual may sit, stand, walk and dress in a fashion traditionally ascribed to females. When asked whether he considers himself a man or a woman, he replies (rather affronted), "Well, I'm a man, of course." We may be confused by his reply because although he reports he is a male (male sexual identity), we have interpreted that he represents himself as a female (female gender role behavior).

Furthermore, our diagnostic classification systems have also viewed sexual identity or gender role behavior as either masculine or feminine rather than such characteristics residing on a continuum. To spot light this issue, let us examine the gender role continuum and the associated clinical conditions seen along same. To the far right might be the masculine homosexual and masculine heterosexual diagnostic categories. Their sexual identity is male, gender role behavior masculine. Further to the left is the effeminate

homosexual, effeminate heterosexual and transvestite diagnostic categories. In all three cases the gender role is becoming more feminine but elements of masculine gender role are still present. Sexual identity is predominately male, but in some cases sexual identity is blending into a female identity. Further to the left of the continuum would be the transsexual whose sexual identity and gender role is female and feminine respectively.

The important thing to note is that our current nomenclature (DMS II) simply does not fit the clinical conditions seen because (a) gender role exist on a continuum, (b) sexual identity exist on a continuum and (c) gender role and sexual identity are not consistently correlated across clients. At present, it is best to analyze gender role behavior as a completely separate component of a sexual deviation.

1. Self Report: The client is asked how he comes across to others, as masculine or feminine. Be especially sensitive to exactly what he is seeking. If he is a male homosexual who desires to be more feminine and believes he comes across quite feminine, but motor evaluation (see below) confirms strong masculine role behaviors, treatment is indicated in this particular area. A further check on the success of his gender role behavior is how others have responded to his role behavior performance.

Example: A 26 year old biologic female, presurgical female to male transsexual recently moved to a new town and began living completely as a male. The client reports that <sup>a</sup>female fellow worker is trying to arrange a date for the client / <sup>with a</sup> girlfriend (assuming that the client was a man) and the client was recently propositioned by

a female prostitute. In both circumstances, the female to male transsexual was related to as if she-he was a male. Since this is the gender role behavior the client has chosen to display, verbal report confirms adequate male gender role behavior.

Systematic self report measures are also possible with gender role behavior. Bem (1974) has recently developed an attitudinal measure that attempts to quantify characteristics usually identified with masculine or feminine roles. Bem's masculine and feminine scales have been developed to be independent of each other and thus allows measurement of masculine and feminine characteristics without being exclusive of one another. A final refinement of the scale is that it quantifies the extent to which the client reports being able to diverge from typical sex-typed standards, e.g., reflecting the rigidity of the client's sex typing. Such a scale may offer considerable assistance in the evaluation of gender role behaviors if adequate standardization can be established for the culture from which the client comes from.

Frequency reports and card sorts are also possible when adapted to gender role behaviors. For example, masculine gender role cards might include, (a) I want my sexual partner to see me as a real "take charge person," (b) I want my sexual partner to feel that I really protect them and (c) I want people to see me as truly masculine. Tabulation of such frequency reports or card sorts is identical to that described earlier and can likewise be used for evaluative purposes or as a measure of treatment progress.

2. Physiologic Measures: The client's assessment of internal states such as anxiety and discomfort should be assessed using the SUDs method as described under heterosocial skills and visible physiologic responses monitored by the therapist during the client's actual performance of gender role behaviors described below.

3. Motor Responses: Barlow (1973) measured the motor performance of a group of males and females, identifying those modes of sitting, standing and walking specific to traditional male or female gender role behaviors as follows:

Gender Role Behavior	Masculine	Feminine
<u>sitting</u>		
buttocks position from back of chair	distant	close
legs uncrossed, knees	apart	close
legs crossed	foot on knee	knee on knee
arm movement from	shoulder	elbow
fingers	together and straight	relaxed
wrist action	firm	limp
<u>standing</u>		
feet apart	greater than three inches	less than three inches
arm movements from	shoulder	elbow
hand motion	minimal or in pocket	greater than 4 movements per minute
wrist action	firm	limp

Gender Role Behavior	Masculine	Feminine
<u>walking</u>		
strides	long	short
hip "swish"	absent	present
arm movement from	shoulder	elbow
wrist action	firm	limp
arm to trunk relationship	free and swinging	close and non-swinging

Although the validity and reliability of these measures have not been reported, its use in single case experiments (Barlow, Agras and Mills, 1973) adds support to its effectiveness at defining those behaviors that discriminate masculine from feminine role behavior.

Assessment begins by asking the client to behave as masculine as possible (or feminine, depending on his goal of preferred gender role behavior), while he sits, stands and walks. His performance is video taped and rated as to the presence or absence of the gender role behaviors described above per unit of time. The percent appropriate (to gender role goal) behavior is then calculated in each of three motor behavior areas. These results are then integrated with self report and physiologic observations and compared with the client's treatment goals. If he is directly seeking gender role behavior change (an infrequent request) or his gender role behavior is inconsistent with his sexual preference choice, specific treatments can be offered (Barlow, et. al., 1973).

The assessment of gender role behaviors will not routinely apply to all clients, but should be applied in those cases where sexual identity and gender role behaviors may be at issue, such as homosexuality, transsexualism and transvestitism. Assessment should also occur in those situations where the therapist sees disagreement between the client's reported sexual identity and his observed sex role behaviors. Examples of the latter might include a heterosexual male whose gross gender role behavior appears quite feminine or a masculine homosexual seeking more feminine gender role behaviors. As with the other major components of treatment, self report, physiologic and motoric responses frequently correlate, but not absolutely. This is especially the case when the client is in the process of change, e.g., a transsexual begins to act the gender role behaviors he feels consistent with his sexual identity.

#### Summary and Conclusions

Psychiatry and psychology have traditionally viewed sexual deviates as a heterogeneous group of individuals who can be subgrouped on the basis of similar deviant arousal patterns. Clinicians have been taught to identify these subgroups and to seek out the similarities between those with similar diagnostic labels. As greater numbers of deviates have been examined, other behavior excesses or deficits have been noted in addition to excessive deviant arousal. It has finally become apparent that relying on the single criterion of deviant arousal is insufficient in evaluating any one client, since other components of the client's sexual being need to be evaluated. It

now appears time to discard the older diagnostic system, relying instead on the more detailed and more specific evaluation of deviant arousal, heterosexual arousal, heterosocial skills and gender role behaviors.

This newer four component assessment makes no presupposition that any one client must have difficulties in one, two, three or even all four component areas. Whether such excesses or deficits exist are conclusions arrived at only after an appropriate assessment of each of the four areas, rather than being based on what most homosexuals, for example, "usually" show.

Within the assessment of any one of the four components, the self report, physiologic or motoric element may be especially valid for that component of sexual assessment. It should be pointed out that which of the three elements is most valid usually depends on which most accurately generates an observable response closely associated to the component being measured. For example, physiologic responses (erections) are especially effective at measuring deviant sexual arousal since erections can be closely associated with the sexual cues presented. Heterosexual skills are most validly measured by the motoric response element since these behaviors are immediately associated with adequate or inadequate heterosexual role playing.

This is not to say that the other elements can be excluded from the assessment. On the contrary, proper evaluation demands the inclusion of the most valid element with the integration of the other two elements. The examples mentioned above demonstrate the

pitfalls of relying exclusively on either the self report, physiologic or motoric element to the exclusion of the other two.

Probably the greatest advantage of this assessment schema is that it remains fluid. The system documents where any one client stands along a continuum in each of the four component areas. Whether the client moves from that position, in which direction and how far, remains a decision for the client to make. He may wish to increase or decrease his deviant or heterosexual arousal, increase or decrease his heterosocial skills or he may wish to develop more masculine or feminine gender role behaviors. Although it is the therapist's responsibility to identify to the client where he stands on each of these continuums, where he goes from there is a decision that must remain with the client. In any event, these assessment techniques will provide tracking of that movement during treatment, irrespective of the client's final choice.

Finally, the fluidity of such an assessment schema appears to fit quite well with the delicate ethical issues related to working with sexual deviates (Davison, 1974), such as who really speaks for the client's best interests and is it the client or society that needs change. Since assessment and treatment fit on continuums in each of the four areas, the client can have the opportunity to identify exactly what he wants. Rather than the male homosexual, for example, having to make a decision as to whether he wants to be homosexual or heterosexual, he can now identify that he wishes to maintain his arousal to males and his current moderately feminine gender role behavior, but to develop greater heterosexual arousal

and better heterosocial skills. Such percision of assessment when supported by concomitant, percise treatment provides a more humane approach to the treatment of sexual deviation, an attitude long overdue in our society.

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