Chapter

Word count: 6,673 (including references)

Contact details: jayson.ware@justice.nsw.gov.au

The treatment of sexual deviance within a therapeutic setting

Jayson Ware

Meagan Donaldson

&

Danielle Matsuo

Corrective Services New South Wales, Australia

ABSTRACT

This chapter will describe the treatment philosophy used by Australian correctional jurisdiction to treat sexual deviance issues within a therapeutic setting. The basis of the approach is to assist individuals convicted of a sexual offence to learn a small number of skills that can be used for all treatment risk areas. In so doing, there is a focus on healthy sexuality throughout all of the treatment process and a limited need for specific treatment exercises relating solely to sexual deviance. The importance of contextual or process issues to create optimal therapeutic environments within which to target sexual deviance is highlighted. Having described the treatment philosophy, we then illustrate specific treatment strategies used for sexual functioning with reference to specific exercises or concepts organised under physiological arousal, cognitions, and behavioural.

INTRODUCTION

There is no doubt that individuals convicted of a sexual offence require assistance with their sexual functioning. Deviant sexual interests, sexual preoccupation, and sexual entitlement have all been found to robustly relate to risk of recidivism (See Mann, Hanson and Thornton, 2010). It is, therefore, somewhat surprising that sexual interests (including healthy sexuality) is often not adequately addressed in treatment programs (Marshall, Hall, & Woo, 2017) or, if it is addressed, there is often an absence of clarity regarding treatment targets and technique (Marshall, Marshall, Serran, & O'Brien, 2011). Further there seems to be a distinct lack of robust research into the validity and reliability of these techniques, at least within the sex offender-specific literature, in comparison to other psychological areas such as sexual dysfunction.

This chapter will describe treatment targets, concepts, and techniques used with adult individuals convicted of a sexual offence within an Australian jurisdiction (Corrective Services New South Wales). These treatment concepts are used, with small adjustments, interchangeably with those convicted of rapists, child molestation, and individuals convicted of non-contact sexual offences. Similarly these are used with heterosexual as well as homosexual offenders. Importantly, these same treatment concepts are used for healthy sexual functioning, deviant sexual thoughts and behaviours, and sexual preoccupation depending upon our formulation of the individual offender's treatment needs. Whilst individuals within our programs may be referred for pharmacological interventions, we do not describe their use within this chapter (see instead Ware & Allnutt, 2010; Winder et al. in this volume for a description of their use).

We will initially describe our treatment philosophy which reflects a theoretical move away from the specific behavioural techniques used to change deviant sexual interests towards a treatment approach using more generic and simpler techniques derived, in part, from the sexual dysfunctions and relationships areas. Our approach is to use fewer techniques and to keep these consistent with the skills the offender needs to use in all areas of his life. This smaller number of techniques are then learnt and practiced across time and context – both within the prison environment and upon release. This, in effect, sets the scene for our description of what treatment techniques we use. We will also focus on the important *process* issues relating to the delivery of these techniques. Specifically, we describe the therapeutic settings and therapist characteristics that we believe are essential to assisting individuals with their sexual functioning. At this point, we describe a small number of techniques we use specific to sexual deviance organised under physiological arousal, cognitions, and behavioural headings. We conclude by providing a brief case study as an illustration of our approach.

TREATMENT PHILSOPHY

Our general philosophy is that the reduction of deviant sexual thoughts, fantasies, or arousal occurs within a broader focus on healthy sexual functioning. We note that many individuals have offended in very specific circumstances or contexts and therefore we do not assume that an explicit focus on techniques to reduce deviant sexual thoughts or fantasies is always needed. Our view is that if many offenders were to develop the attitudes, skills, and confidence to function effectively in adult prosocial sexual relationships, then deviant sexual interests are no longer required to compensate for these deficiencies (see also Mann & Marshall, 2009; Marshall, 1997). In support of this theoretical position, Marshall and Fernandez (2003) have noted that not all individuals convicted of a sexual offence are assessed as having enduring deviant sexual thoughts or feelings. There are individuals, however, that have high levels of deviant sexual thoughts and arousal such as those with sexual preoccupation and, for these offenders, we espouse the limited use of a number of explicitly focused behavioral approaches despite their limitations.

Broader focus

Any effort to modify an individual's sexual interest should occur within the broader context of treatment. It should not be seen, in our view, as a stand-alone treatment module. We agree with Marshall, O'Brien, and Marshall (2009) who argued that efforts to modify sexual

interests should be embedded within the context of all other relevant issues addressed in the sex offender treatment program. As we will go on to outline, discussions relevant to sexual functioning should occur repeatedly over the course of the treatment program or programs and the environmental context within which treatment takes place needs to be organised in a manner so that participants can openly discuss and, as required, practice and rehearse skills relevant to sexual interests.

By ensuring that sexual functioning discussions occur throughout treatment, we are actively attempting to assist the offender to 'normalise' these discussions and to prevent the defensiveness that can occur when an offender is only asked about his sexual thoughts and behaviours during particular treatment components. We are also intending to minimise the risk of offenders simply telling therapists what they think the therapist wants to hear when they need to hear it. We have noted that, when sexual functioning is segmented into its own treatment module, offenders who were progressing well in treatment can quickly resort to discussing sexual interests in a manner designed to appease the therapist, as opposed to a genuine attempt to greater psychological insight into his sexual functioning. Waldram (2007, 2008) refers to the telling of the life story as "a performance", where the narrator frequently "surrenders" to the dominating expectations of how he should tell his story. In support of our treatment philosophy we note that long term retention of learning, and subsequent behaviour change, best occurs when learning is spaced out over time (see Marshall et al., 2011 for a brief summary of the evidence). For this reason, we emphasize the continued discussion of sexual issues throughout our preparatory, treatment, and maintenance programs.

Whilst we ensure that sexual functioning discussions occur frequently, we also ascribe to the philosophy that detailed discussions of *past* sexual thoughts, fantasies, or arousal is not always necessary. Indeed, a focus on this can lead to defensiveness and non-engagement (Ware & Blagden, 2017). Instead, we focus on assisting the offender to prepare for the future. In doing so, we are replicating Ware and Mann's (2012) approach to acceptance of responsibility. Ware and Mann built upon earlier work by Maruna and Mann (2006) and attempted to clarify what acceptance of responsibility should look like within sex offender treatment. Their argument is that *passive* responsibility, or seeing oneself as responsible for past actions (e.g., "I did it") is not a necessary condition for change and should be de-prioritised as a treatment goal. Instead they argued that there should be an increased focus on *active* responsibility, whereby the therapist focuses the offender toward seeing

themselves as responsible for changing their future behaviour for the better ("What do I need to do to make sure it is not done again?").

We also focus on the use of approach strategies and plans specific to sexual functioning rather than having offenders generate lists of situations, persons, and thoughts that they must avoid. Our experience is consistent with that described by Mann, Webster Schofield, and Marshall (2004) who found that sex offenders in programs that focused on individualised approach goals were more likely to be fully engaged in treatment and to complete within-sessions practice. In our view, if we are taking something rewarding away from individuals convicted of a sexual offence (e.g., their sexual fantasies) we must then replace this with something as, or as close to, rewarding. This forms the basis of their approach goals and is particularly important for offenders who are sexually preoccupied. Importantly, we note that significantly higher proportions of individuals convicted of a sexual offence have been assessed as sexually preoccupied when compared to matched community controls (43% *cf* 15%; Marshall & O'Brien, 2009) and that sexual preoccupation is an important predictor of recidivism (Hanson & Morton-Bourgon, 2005).

Specific to sexual functioning, we use the model of human sexual responding outlined by Kaplan (1979) to help structure our interventions in a way that is meaningful for offenders. As we will outline in a following section, we utilise a consistent and well-practiced range of generalized techniques and strategies to assist offenders to manage their sexual desire, excitement, orgasm, and resolution. Anecdotally, we have found that individuals are able to easily identify which treatment techniques could be used in each or all of these phases of sexual functioning.

Finally, within our broader treatment focus, our philosophy is that individuals convicted of a sexual offence should be assisted to recognize, monitor, understand, and appropriately manage situations, thoughts, physiological arousal, feelings, and behaviours *in general* and that these skills are taught to be generalizable across risk factors and situations and context including sexual functioning. In practice this means that an offender will use the same technique, for example employing various distraction techniques, to cope with issues relating to a range of dynamic risk factors rather than having discrete techniques for different risk factors or issues. We also expect that offenders will be able to demonstrate attitudinal and behavioural change across time and across context. For this reason, we are particularly interested in assessment tools such as the Violence Risk Scale: Sexual Offending (VRS: SO) where an offender can only move through stages of action and maintenance when changes in behaviour that are relevant to the risk behaviour are documented over time and over different

contexts.. The evidence shows that change scores on the VRS: SO were associated with reductions in sexual recidivism after controlling for static risk (Beggs & Grace, 2011; Olver, Wong, Nicholaichuk, & Gordon, 2007). Within treatment, offenders are encouraged to practice skills regularly in everyday situations that occur in the therapeutic unit, when experiencing less intense emotions or when they feel they are generally in control. The aim is for offenders to rehearse and master the skills so they become better equipped to deal when stressors arise, when they experience strong emotions and when they experience situations in which they perceive they have limited control. These skills are then applied to deficits in sexual regulation, using sex as a coping strategy, sexual preoccupation and deviant sexual interests. Campitelli and Gobet (2011), in their review of expertise acquisition, note that repetition of a new skill alone is not enough and that deliberate practice is necessary for this to occur. Deliberate practice requires attention to, and rehearsal of, new skills across time and context

Importance of process issues

When considering the treatment of sexual issues, the environmental context is particularly important. We have described elsewhere (Frost & Ware, 2018; Ware & Galouzis, 2019; Ware, Galouzis, Hart, & Allen, 2012) that positive prison climate will provide individuals convicted of a sexual offence with the opportunity to practice and rehearse their new learning (*content*), acquired within treatment sessions, within a therapeutic context where they are exposed to a myriad of supportive relationships and therefore receive consistent feedback and challenge (*process*). In the all-day–everyday context of the prison, this means not just "talking the talk" in the therapy group specific to modifying sexual interests but "walking the walk" by practicing and rehearsing in the prison unit during and after treatment. This is particularly relevant to sexual deviance. Our challenge, as we have seen it, is how to provide each offender with the opportunities to practice and rehearse, not just talk about, their sexual thinking and arousal.

Although the evidence remains under-developed, it appears that the characteristics of the therapist, therapeutic relationship or alliance, and group climate positively influence sex offender treatment engagement and pre to post-treatment changes (Kozar & Day, 2012; Marshall & Burton, 2010). We believe a number of these characteristics are particularly important to modifying sexual interests. It is our experience that therapists who approach sexual deviance discussions in a manner perceived as confrontational, judgemental, or rigid had less effective outcomes with offenders. In these instances, offenders typically responded

by withholding information relating to sexual discussions or engaging in positive impression management (acquiescing, or lying for self-preservation or through fear of judgement) or were even openly hostile. Conversely, therapists who were confident in discussing sexual issues, who demonstrated genuineness, empathy, directed discussions, and who explored issues through open ended questions generally experienced offenders as engaged in group discussions, less judgemental of each other's sexual issues, and appeared more focused on promoting and supporting change in themselves and others.

In practice we have adopted two approaches to introducing the treatment of sexual issues to offenders. Firstly, we aim to introduce the offender as early as possible to the expectation of talking about sex and sexual issues. This is commonly started in the pre-treatment assessment interviews or preparatory programs where, specific to sexual functioning, we explicitly provide treatment-related information including examples of treatment assignments. Secondly, we ensure that that sexual functioning is explored throughout every stage of treatment. Whilst it is tempting for each therapist to ignore discussion of sexual issues, for example, when exploring an offender's life history, offence pathways, or when developing plans for their future, we will expect the offender to relate each treatment area to sexual functioning.

To assist our therapists to develop and enhance their therapeutic relationship with offenders, we focus the majority of these sexual discussions around establishing a healthy and fulfilling sex life. It is our experience that process-focused group sessions, rather than manualised or scripted session plans promote open discussions which allow offenders to direct the discussions. Our treatment groups are facilitated using a rolling format model which we believe has significant advantages specific to the discussion of sexual issues (see Ware, Mann, & Wakeling, 2009). Rolling groups greatly enhance the opportunity for new group members to learn vicariously from other group members who have been in treatment for longer who can model trust and openness. Our preference is to address sexual topics in the moment and as they arise (*process*); however throughout the duration of the program, we facilitate psycho-education and process sessions focused specifically on sex and sexual issues, with the aim being to promote healthy sexuality.

We also recognise that attempting to change sexual preferences for some offenders is futile. There needs to be an acceptance from both offender and therapist that their sexual interests (e.g., in children) may never dissipate (Blagden et al., 2017). Accepting this, may assist the offender (and therapist) to focus on their efforts on managing their sexual thoughts, feelings and behaviours and to develop enhanced risk management strategies.

DESCRIPTON OF STRATEGIES AND EXERCISES

Having described our treatment philosophy and the importance of context and process issues to our efforts to modify sexual interests, we now illustrate treatment strategies used for sexual functioning with reference to specific exercises or concepts organised under physiological arousal, cognitions, and behavioural. Within treatment sessions we do not use these terms but instead use simple concepts to describe what type of skill or exercise is being used (e.g., thoughts, being sexually aroused, and making good decisions) and remind offenders repeatedly of the availability of each of these exercises for use with other psychological issues. We hope to demonstrate the effective use of general techniques for sexual deviance. We have also borrowed from the sexual dysfunction literature as we see these treatment strategies as interchangeable with sexual deviance treatment.

One of the key philosophies underpinning our approach to sexual deviance is that offenders have often told us that they were not "thinking" at the time leading up to their offending and instead were focused on their feelings of sexual arousal. Rather than attempting to refute this, we have considered this issue important and have used the theoretical construct of cognitive deconstruction (Baumeister, 1990; Ward, Hudson & Marshall, 1995) to structure our treatment response. Essentially, we assist offenders to recognise that, at those times, they are choosing to focus on the immediate short term, focusing on movements and sensations (physiological arousal), and thinking only of proximal, immediate tasks and goals. In effect, we assist them to understand that they are using a problematic form of mindfulness (see next section and structured touching as an example) and need to focus, at those times, on raising their level of cognitive awareness (cognitions). For these reasons, we aim to assist individuals convicted of a sexual offence master their management of physiological arousal before cognitions.

Physiological Arousal

Throughout treatment offenders are introduced to a range of de-arousal techniques aimed at decreasing and regulating physiological arousal, including relaxation strategies (deep breathing techniques, use of imagery, progressive muscle relaxation), mindfulness techniques, and 'urge surfing' (Marlatt & Gordon, 1985). These techniques, once learnt and rehearsed by offenders, can assist with general emotional regulation such as managing anger or anxiety. However, these techniques can also assist when sex is used as a coping strategy to ameliorate emotions or tension or to reduce sexual preoccupation.

Offenders are taught a range of mindfulness strategies and are encouraged to identify the strategy that is most effective for them. Mindfulness skill building typically commences with present-moment experiences such as breathing and mindful observation of thoughts and builds to more sensory-focused mindfulness strategies such as mindful eating or drinking, or using all five senses. Some offenders experience difficulty with the abstract aspects of imagery (such as 'leaves on a stream') and benefit from the more sensory or tactile strategies. The underlying skill in all of the mindfulness techniques is for the offender to learn to stay present (in the here and now) and manage intrusive thoughts or strong emotional experiences through developing the skills to observe and describe without judgement and without acting on thoughts or emotions. These techniques are then generalised to sexual thoughts and managing sexual arousal.

Principles of mindfulness can be found in early sexual therapy techniques such as Sensate Focus (Masters & Johnson, 1970). Sensate focus is a set of structured touching suggestions aimed to reduce the pressures associated with sex and to assist the individual to learn about their physical responses by tuning into sensations and refocusing away from evaluation of the experience (Weiner & Avery-Clarke, 2014). This is achieved through non-demand touching where the focus is on one's own tactile experience or sensations, for their own interest, rather than trying to make themselves (or their partners) aroused. When an individual diverts focus from his own body to either his partner or environmental features, he subsequently diminishes his control over his sexual arousal (Metz & Pryor, 2000). Applying techniques from the sexual dysfunction research, the ability to shift the focus from external stimuli, to one's own experiences is important in the management of sexual deviance. Sensate focus is mindful, silent and non-evaluative touching. Traditionally, sensate focus techniques focus on couples; however, these techniques increase body awareness and self-control in individuals. Within a custodial therapeutic program, these techniques can be applied by those who are hypersexual, learning to touch and focus on sensations without becoming sexually aroused or for the need to engage in sexual intercourse or orgasm; and can also be applied by those who experience anxiety and unhelpful cognitions around sexual underperformance. Consistent with early behavioural strategies from the sexual dysfunction literature (i.e., stop-start technique, Semans 1956; or squeeze technique, Masters & Johnson 1970), as well as de-arousal techniques prominent in the current self-regulation literature, the current behavioural trends focus on the sensations experienced by self, re-direction of attention and non-judgemental evaluations. Mindful masturbation may be another effective technique for offenders who experience negative appraisals or anxiety regarding their sexual interests. The

aim of mindful masturbation is for an offender to focus on the sensations he experiences without using sexual stimuli, thoughts or fantasies. Focusing on senses, an offender may notice the water temperature whilst showering, or the rhythm and pressure of his movements whilst masturbating.

Drawing on mindfulness techniques and relapse prevention research (Marlatt & Gordon, 1985) offenders are typically taught 'urge surfing' skills to manage strong emotions and cravings associated with substances use. Urge surfing skills can also be applied to manage sexual arousal and sexual urges. The main learning point for offenders is they do not have to act on an urge when they experience it. Education is provided to offenders to increase their understanding that (sexual) urges pass by themselves. Often the person focuses on the urge growing stronger and feels the need to act; alternatively, they attempt to distract themselves from the urge but later giving in. Urges are described like ocean waves that build and then eventually dissipate. It is important offenders understand that the urge will grow in size until it peaks and then dissipates. The discomfort they are likely to experience is normalised as a natural experience and offenders are encouraged to know what their triggers are for experiencing urges. These may be external factors, such as stimuli they experience as sexually arousing or internal factors such as an emotion, thought or sexual fantasy. By naming the experience as an urge, the offender can view the urge as a natural occurrence, something that they can maintain control over and something that is temporary. The outcome for the offender is to learn to wait out the urge, endure the moment in time when the urge and discomfort is peaking, and to look forward to the downside.

Online or internet sex offenders have typically paired sexual arousal with internet access/use (see de Almeida Neto, Galouzis, Ware, Eyland, & Kevin, 2013). Our approach to assist online or Internet sex offenders, in practice, is to manage their physiological and sexual arousal, practicing the techniques identified above, with behaviours such as sitting in front of the computer, clicking through programs, and using the intranet available to offenders. Once the use of the computer or internet is no longer paired with sex or heightened arousal, computer stimuli are less likely to trigger sexual arousal, making it easier for the online offender to resist sexual impulses and urges.

Cognitions

We use a sexual urges log for offenders to better identify and understand their sexually deviant thoughts and urges, when they occur and in what situations. Thought stopping and 'changing the channel' exercises, used in managing their thoughts and emotions more

generally, are specifically used to assist offenders to gain some control over their sexual thoughts and to replace the problematic thinking with alternative more appropriate thoughts.

However, we note that attempting to simply suppress or replace intrusive or risky thoughts can be ineffective and that changing the meaning of the thoughts, so the intrusive thoughts no longer have any personal significance, is often more useful (Jennings & Deming, 2013; Shingler, 2009). Therefore, one of the skills we assist with is replacing the higher-level meanings to the offender's awareness using cognitive restructuring techniques. One strategy we use, based on Marshall et al. (2011), is to ask offenders to identify as many sexual behaviours as they can; ask the group to identify which behaviours are appropriate, alternative/unusual or deviant/illegal; and provide a rationale for their decisions. From here, we explore attitudes and beliefs about the sexual behaviours identified and how to establish a healthy sex life now and in the future.

A simpler strategy which is particularly useful for Aboriginal individuals convicted of a sexual offence, is a 'camp fire' discussion centred on the letters 'SEX'. The therapist prompts for their immediate thoughts, attitudes, or emotional experience when the letters are placed on the ground or when talking about sex, and what experience they may have had which contributed to this response. Common responses include fear around forming new sexual relationships in the future, particularly disclosing their offence history or being accused of further sexual offences because of their offence histories; and the occasional comment regarding the forced abstinence of sex in custody (e.g., "Sex, what's that?"). Discussions frequently emerge around what healthy/unhealthy sex is, the message the media sends about sex, and how social norms have changed over time. This is an opportunity to identify and then constructively challenge myths or exaggerated stories from other males, about masturbation, the use and role of pornography, and consent.

To promote healthy sexual functioning, we ask offenders to write down an appropriate sexual fantasy that they can attribute new meaning to and feels sexually exciting. We outline the elements of an appropriate fantasy in that it must involve a consenting adult able to provide consent and a willing participant in the fantasy; no power imbalance; and no unhealthy or deviant aspects to the fantasy.

Behavioural

In what is perhaps a distinct shift away from the norm we use specific behavioural approaches to address sexual deviance sparingly due to their limitations which we now outline. Initial behavioural strategies were used primarily, although not exclusively, with

child molesters (see Marshall, O'Brien, & Marshall, 2009 for a review of these techniques). Treatment was based on aversive procedures pairing deviant sexual interest with aversive stimuli (e.g., olfactory aversion) and/or masturbatory strategies to enhance normality and reduce sexual interest. The aversive procedure still recently used in over half of the sex offender treatment programs within the United States, and also by our program, is covert sensitization (also called minimal arousal conditioning; McGrath et al., 2010). Within this technique, an individual pairs an aversive thought within a behavioural chain of events leading to an offence with a negative consequence (Cautela, 1967). Apart from case studies there remains limited evidence of its effectiveness. Masturbatory techniques appear to be used more frequently, at least in part, due to the fact that masturbation is a common and non-invasive behaviour. It has been considered an initial cause of deviant sexual interests (McGuire, Carlisle, & Young, 1965) and therefore a key treatment target. Masturbatory techniques generally involve individuals either simply pairing appropriate sexual fantasies with masturbation and orgasm (Maletsky, 1991), or masturbating to deviant sexual fantasies before switching to appropriate sexual fantasies prior to orgasm (e.g., directed masturbation; Laws & Marshall, 1991). This is usually followed immediately by satiation techniques where the offender then verbalises deviant sexual fantasies during the refractory period when he is sexually unresponsive (Laws, 1995).

Notwithstanding the limited evidence regarding their effectiveness, we will use these techniques in an individualised manner if we believe it to be warranted. A small number of individuals, particularly those who are sexually preoccupied and who are seeking our assistance, report these techniques to be beneficial, at least in the immediate short term. We note that, in the absence of compelling evidence, there are published case studies (e.g., Marshall, 2007) that are very useful for therapists. When using these techniques, in keeping with an overarching philosophy of our program where offenders need to take active responsibility for their treatment (see Ware & Mann, 2012), we will provide each individual with an overview of each of these techniques and will assist the offender to choose. For the most part, these techniques and their use are discussed within individual treatment sessions.

Case Study

John was a 50-year-old male who reported a sexual attraction to pre- and post-pubescent children since his late teens. His sexual offending history consisted of contact offences against pubescent males when he was in his twenties and a contact offence against a pre-pubescent female when he was in his forties. John had otherwise lived a prosocial lifestyle

with stable supports and employment. He had previously engaged in long-term psychotherapy with a psychiatrist. John reported establishing intimate relationships with adult women throughout his life; however, during sexual interactions with his partners, he described visualising sexual behaviours with children to assist him to maintain an erection and achieve an orgasm. He believed masturbating to the fantasies he experienced would minimise his chances of his acting out the behaviour. In our view this resulted in his sexual interests in children strengthening over time.

Whilst John reported an adequate intellectual understanding of his sexual interests and ability to manage his fantasies (he was proactive in his own research into the treatment of deviant sexual interests towards children), it was still considered important to assist John to appreciate in greater detail the context, triggers, and processes involved and to identify how his coping strategies were poorly conceived. Early in treatment, whilst the focus was on the development of better coping strategies, John was assisted to complete sexual urges logs. John reported becoming more aware of his arousal to images of children on television or in newspapers. Of note, he also reflected that his monitoring for his deviant sexual thoughts actually inadvertently increased his sexual preoccupation.

Within initial group treatment sessions, John stated that he was hopeful there was a 'cure' to his sexual interests whilst at the same time acknowledging how entrenched his sexual interests indeed were. He accepted that these interests may not be amenable to intervention but instead needed to be managed appropriately. For these reasons, it was considered appropriate to use directed masturbation techniques. John struggled to use these successfully. He searched television programs for adult nudity and fiction literature for sexual content as a means to develop and pair appropriate sexual fantasy with masturbation and orgasm. John was ultimately unable to achieve an erection or orgasm using these procedures and their continued use was considered to be problematic.

By this stage in treatment, John was demonstrating significantly enhanced emotional coping strategies. He reported getting considerable benefits from distraction and mindfulness techniques. At this point, John's therapist focused John towards the use of these techniques for managing his sexual fantasies and arousal. John had been implementing mindfulness techniques into his everyday living, particularly through his art, and he was therefore encouraged to practice mindful masturbation as a strategy. John continued to explore this technique throughout treatment as a means to develop arousal without needing to resort to thoughts about children. John was also assisted to use a series of distraction techniques that

he had found helpful for managing his emotions at times when he needed to reduce his sexual thoughts or arousal.

Simultaneously in treatment, John had identified a lack of emotional awareness and expression as a treatment need. Through other treatment modules (such as emotional regulation) John learnt skills in distress tolerance, radical acceptance and urge surfing and had rehearsed theses skills in the context of frustration tolerance. John applied urge surfing techniques at times he woke aroused after a sexual dream, increasingly noticing that his erection abated, and reported a preference for this technique in managing his sexual urges and deviant sexual arousal.

Together with his other treatment goals of improving the quality of his relationships, his ability to communication with others, and his view of himself, whilst John did not change his sexual interests in children, he gained confidence in his ability to manage his sexual arousal and implement strategies to assist with risk management in the future.

SUMMARY

The specific treatment of sexually deviant thoughts, feelings, and arousal remains an important objective for treatment programs. We have argued for a treatment philosophy that moves away from the sole use of behavioural techniques towards an approach using more generic and simpler techniques derived, in part, from the sexual dysfunctions and relationships areas. In our view, the treatment of sexual deviance within a therapeutic setting also requires careful consideration of a number of important contextual or process issues in order to create optimal therapeutic environments. Specifically, we described the therapeutic settings and therapist characteristics that we believe are essential to assisting individuals convicted of a sexual offence with their sexual functioning. We also articulated a small number of techniques we use specific to sexual deviance, organised under physiological arousal, cognitions, and behavioural headings. We are not able demonstrate the effectiveness of this broader approach to the treatment of sexual deviance but note that, due to the absence of any strong evidence about the effectiveness of specific behavioural techniques used, much is still to be learnt about how best to approach sexual deviance within therapeutic settings. We therefore encourage treatment providers and researchers to give greater attention to this area. To this end we hope that our descriptions of our treatment approach may inspire greater empirical and conceptual consideration of these issues in the future.

REFERENCES

Andrews, D. A., & Bonta, J. (2010). *The Psychology of Criminal Conduct (*4th ed.). Cincinnati, OH: Anderson Publishing.

Baumeister, R.F. (1990). Suicide as escape from self. *Psychological Review, 97*, 90-113.

Beggs, S.M. & Grace, R.C. (2011). Treatment gain for sexual offenders against children predicts reduced recidivism: A comparative validity study. *Journal of Consulting and Clinical Psychology* 79 (2): 182-192.

Blagden, N.J., Mann, R., Webster, S., Lee, R., and Williams, F. (2017). It's not something I chose you know: Making sense of pedophiles' sexual interest in children and the impact on their psychosexual identity. *Sexual Abuse: A Journal of Research and Treatment,* 1-27.

Campitelli, G. & Gobet, F. (2011) Deliberate Practice: Necessary But Not Sufficient. *Current Directions in Psychological Science, 20,* 280-285.

Cautela, J. R. (1967). Covert sensitization. *Psychological Reports, 20,* 459-468.

de Almeida Neto, A. C., Eyland, S., Ware, J., Galouzis, J., & Kevin, M. (2013). Brief Interventions: Solving the 'Internet Sex Offender Paradox'. *Psychiatry, Psychology, and Law, 20 (2),* 182-188.

Frost, A., & Ware, J. (2018). The heart and soul of the transforming environment: how values driven ethos sustains a therapeutic community for sexual offenders' in G. Akerman, A. Needs & C. Bainbridge (Eds.), *Transforming Environments and Rehabilitation: A Guide for Practitioners in Forensic Settings and Criminal Justice (pp. 289-305).* Routledge New York.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73,* 1154-1163.

Jennings, J. L., & Deming, A. (2013). Effectively utilizing the "behavioral" in cognitive-behavioral group therapy of sex offenders. *International Journal of Behavioral Consultation and Therapy, 8* (2), 7-13.

Kaplan, H. S. (1979). *Disorders of sexual desire*. New York, NY: Brunner Mazel.

Kozar, C. J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17,* 482-487. doi: 10.1016/j.avb.2012.07.004

Laws, D. R. (1995). Verbal satiation: Notes on procedure with speculations on its mechanism of effect. *Sexual Abuse: A Journal of Research and Treatment, 7,* 155-166.

Laws, D. R., & Marshall, W. L. (1991). Masturbatory reconditioning with sexual deviates: An evaluative review. *Advances in Behaviour Research and Therapy, 13*, 13-25.

Maletsky, B. M. (1991). *Treating the sexual offender*. Newbury Park, CA: Sage.

Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22*, 191–217.

Mann, R. E., & Marshall, W. L. (2009). Advances in eth treatment of incarcerated sex offenders. In A. R. Beech, L. A. Craig, & K. D. Browne (Eds.), *Assessment and treatment of sex offenders: A handbook* (pp 329-347). Chichester, England: Wiley.

Mann, R. E., Webster, S. D., Schofield, C., & Marshall, W. L. (2004). Approach versus avoidance goals in relapse prevention with sexual offenders. *Sexual Abuse, 16*, 65-75.

Marlatt, G.A. & Gordon, J.R. (1985). *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors*. New York, NY: Guilford press.

Marshall, L. E., & O'Brien, M. D. (2009). Assessment of sexual addiction. In A. R. Beech, L. A. Craig, & K. D. Browne (Eds.), *Assessment and treatment of sex offenders: A handbook* (pp 163-177). Chichester, England: Wiley.

Marshall, W. L. (1997). The relationship between self-esteem and deviant sexual arousal in nonfamilial child molesters. *Behavior Modifications, 21*, 86-96.

Marshall, W. L. (2007). Covert association: A case demonstration with a child molester. *Clinical Case Studies, 6*, 218 – 231.

Marshall, W.L, & Burton, D. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior, 15*, 141-149.

Marshall, W. L., & Fernandez, Y. M. (2003). *Phallometric testing with sexual offender: Theory, Research, and practice*. Brandon, VT: Safer Society Press

Marshall, W. L., Hall, K. S., & Woo, C. (2017). Sexual functioning in the treatment of sex offenders. In W. L. Marshall and L. E. Marshall (Eds.), *Handbook on the Assessment, Treatment and Theories of Sexual Offending* (Vol. 3). *(pp. 1369-1384).* Wiley-Blackwell. West Sussex, United Kingdom

Marshall, W. L., O'Brien, M. D., & Marshall, L. E. (2009). Modifying sexual preferences. In A. R. Beech, L. A. Craig, & K. D. Browne (Eds.), *Assessment and treatment of sex offenders: A handbook* (pp 311-327). Chichester, England: Wiley.

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien (2011). *Rehabilitating sexual offenders: A strength-based approach.* Washington, DC: American Psychological Association.

Maruna, S., & Mann, R. E. (2006). A fundamental attribution error? Rethinking cognitive distortions. *Legal and Criminological Psychology, 11*, 155–177.

Masters, W.H. & Johnson, V.E. (1970). *Human sexual inadequacy.* Churchill, London.

McGrath, R., J. Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American Survey.* Brandon, VT: Safer Society Press.

McGuire, R. J., Carlisle, J. M., & Young, B. G. (1965). Sexual deviations as aconditioned behaviour: A hypothesis. *Behaviour Research and Therapy, 2,* 185-190.

Metz, M.E. & Pryor, J.L. (2000). Premature ejaculation: A psychophysiological approach for assessment and management. *Journal of Sex & Marital Therapy, 26,* 293-320.

Olver, M. E., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale – Sexual Offender Version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19,* 318-329.

Semans, J.H. (1956). Premature ejaculation: a new approach. *Behavior Therapy, 2, 307-20.*

Shingler, J. (2009). Managing intrusive risky thoughts: What works? *Journal of Sexual Aggression, 15* (1), 39-53.

Waldram, J. B. (2007). Narrative and the construction of "truth" in a prison-based treatment program for sexual offenders. Ethnography, 8, 145–169.

Waldram, J. B. (2008). The narrative challenge to cognitive-behavioral treatment of sexual offenders. Culture, Medicine and Psychiatry, 32, 421–439.

Ward, T., Hudson, S.M., & Marshall, W.L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist interpretation. *Sexual Abuse: A Journal of Research and Treatment, 7,* 67-83.

Ware, J., & Allnutt, S. (2010). The use of antilibidinal medications in the treatment of sexual offenders. *Australian Journal of Correctional Staff Development.7,* 1-12.

Ware, J., & Blagden, N. (2017). Responding to denial, treatment refusers, and drop outs. *In W. L. Marshall and L. E. Marshall (Eds.), Handbook on the Assessment, Treatment and Theories of Sexual Offending* (Vol. 3) (pp. 1559-1574). Wiley-Blackwell. West Sussex, United Kingdom.

Ware, J., & Bright, D. A. (2008). Evolution of a treatment program for sex offenders: Changes to the NSW Custody Based Intensive Treatment (CUBIT). *Psychiatry, Psychology, and Law, 15,* 340-349.

Ware, J., & Galouzis, J. (2019). Impact of prison climate on sexual offenders: desistance

and rehabilitation. . In N. Blagden, B. Winder, K. Hocken, R. Lievesley, P. Banyard, & H. Elliot (Eds.), *Sexual Crime and the Experience of Imprisonment. (pp. 35-60).* Palgrave Macmillan. Springer: Switzerland.

Ware, J., Galouzis, J., Hart, R., & Allen, R. (2012). Training correctional staff in the management of sexual offenders: Increasing knowledge and positive attitudes, *Sexual Abuse in Australia and New Zealand, 4,* 23 – 30.

Ware, J., & Mann, R. E. (2012). How should "acceptance of responsibility" be addressed in sexual offending treatment programs? *Aggression and Violent Behavior, 17,* 279–288.

Ware, J., Mann, R. E., & Wakeling, H. (2009). What is the best modality for treating sexual offenders. *Sexual Abuse in Australia and New Zealand, 2,* 2-13.

Weiner, L. & Avery-Clarke, C. (2014). Sensate focus: clarifying the Masters and Johnson's model. *Sexual and Relationships Therapy, 29,* 307-319.