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A healthy sex programme for individuals with paraphilic interests convicted of sexual offending

Biopsychosocial processes and intervention procedures

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Introduction

In the modern time of intervention science, a new question is upon us: "What core biopsychosocial processes should be targeted with this client given this goal in this situation, and how can they most efficiently and effectively be changed?" (Hayes & Hofmann, 2018a, p. 428). Answering it involves targeting established processes that promote change. The change sought by interventions is to the prosperity of the individual and their ability to live skilfully and non-harmfully, rather than in the mere absence of their risks. The question is undoubtedly more complex than a binary question, such as "does intervention work?" In the field of programmes for sexual offending, differences between interventions and weak standards of scientific rigor have made this question difficult to answer (Schmucker & Lösel, 2017; Walton, 2018). However, this new question requires clinicians to search from a wider spectrum of biological, behavioural, cognitive and emotion science and to specify core processes of change and their links to the intervention procedures used. In doing so, an emphasis on the mediators of change is likely to increase and, with it, an account of what, when, why and how programmes yield particular effects may begin to emerge.

In this chapter, I will describe the Healthy Sex Programme (HSP). The HSP is designed for adult men with convictions for sexual offending who experience

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offence-related paraphilic interests. The HSP is delivered in prisons within Her Majesty's Prison and Probation Service (HMPPS) and is open to those with and without mild learning disability and challenges (LDC). The programme was revised in 2019 and has received accreditation from the Correctional Services Advice and Accreditation Panel (CSAAP). In the first section of this chapter, I will describe the biopsychosocial processes that shape the manifestation of paraphilia. In the second section, I will describe the intervention procedures that are used to achieve intervention goals with HSP participants. These procedures span different competencies from cognitive behavioural therapy (CBT). They include behaviour modification and self-management, modification of beliefs, mindfulness, values clarification, compassion work, urge management and intimacy/interpersonal skills practice. Across mental healthcare, these procedures have been shown to lead to change and manipulate processes that mediate it. As such, they are considered to be evidence-informed (Hayes & Hofmann, 2018b). The change processes include behavioural learning processes, changes in cognition, increased metacognition, psychological acceptance, decentring, reduced rumination, values clarification, physiological soothing, increased compassion and improved interpersonal skills. I will discuss how the procedures are used in the HSP, but firstly and for the benefit of readers less familiar with this area, I provide a brief introduction to paraphilia.

Paraphilia

The term 'paraphilia' can be defined as "any intense and persistent sexual interest other than a sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (American Psychiatric Association [APA], 2013, p. 685). 'Phenotypically normal' in this case refers to the typical characteristics of adults. There are currently eight classifiable paraphilic conditions according to the American Psychological Association (APA) (see Table 6.1, see also Beech, Miner & Thornton, 2016; First, 2014). Four of them, namely voyeurism, exhibitionism, frotteurism and paedophilia, if acted on, result in a criminal act. The others may be legally fulfilled with consenting partners. Some surveys suggest that voyeuristic, masochistic, and fetishistic experiences and fantasies are not unusual (Joyal & Carpentier, 2016). However, for other paraphilia they are much rarer. For example, the rates of fantasising about sexual acts with a prepubescent child has been reported to be about 4% in a male German sample (Dombert et al., 2016), about 1.8% in a male Canadian sample (Joyal, Cossette & Lapierre, 2015) and less than 1% in a sample of male Finnish twins (Santtila et al., 2015). Based on a range of available surveys, an informed guestimate for the prevalence of an actual paedophilic preference in the general male

Table 6.1 Clinically Recognised Paraphilia

Paraphilia	***Ability to derive sexual pleasure, excitement or arousal from:***
Voyeurism	Watching an unsuspecting nonconsenting person(s) nude, disrobing or engaging in sex
Fetishism	Non-living objects or specific body parts
Exhibitionism	Exposing one's own genitals to an unsuspecting non-consenting person(s)
Frotteurism	Touching or rubbing against a non-unsuspecting, non-consenting person(s)
Masochism	Being humiliated, hit, bound or otherwise suffering
Sexual Sadism	Physical or emotional suffering of others
Transvestitism	Cross-dressing that is sexually arousing
Paedophilia	Sexual activity with a child that is prepubescent (<13 years)

population is approximately 1%, and for women this is likely to be lower (see Seto, 2017, 2018 for reviews). The DSM-V (APA, 2013) uses the term 'paraphilic disorder' to classify paraphilia that lead to distress, impairment or harmful non-consenting sexual acts. This makes it possible for paraphilia to occur without a person receiving a mental health diagnosis. This is important because although paraphilia are associated with sexual recidivism (Mann, Hanson & Thornton, 2010), many people who experience them function without offending (Cantor & McPhail, 2016) or experiencing distress or impairment (Wismeijer & Assen, 2013). Therefore, it is 'paraphilic disorder' that distinguishes the dysfunctional manifestations of paraphilia. Paraphilia per se are not necessarily pathological.

There is debate about whether paraphilia are changeable, and some of this is related to a question of whether some are best defined as a sexual orientation. In terms of the first issue, all but one paraphilic disorder can be classified as 'in remission' according to the DSM-V. This is defined as a period of five years or more, where in an uncontrolled environment distress, impairment or harm has been absent. This does not necessarily mean that the paraphilia has disappeared. The specifier relates to the dysfunction, not the sexual interest. The exemption is 'paedophilic disorder', for which there is no remission specifier at all (APA, 2013). This omission would appear deliberate, but there is little evidence to suggest that the features of distress, impairment or risk of perpetrating harmful behaviour are more intractable for paedophilic disorder than they are for other paraphilia disorders. As such, this exemption is quite contentious (Briken, Fedoroff & Bradford, 2014).

Paedophilia itself, however, seems fairly stable. Large-scale surveys suggest that the onset occurs during puberty and then persists (Bailey, Hsu & Bernhard, 2016b; Grundmann, Krupp, Scherner, Amelung & Beier, 2016). Where change has been reported using phallometric testing (Müller et al., 2014), it has been the subject of criticism (Cantor, 2015; Bailey, 2015; Lalumière, 2015). Furthermore, the view that paedophilia and other paraphilia are stable now pervades some clinics, where goals toward self-management are favoured (Berlin Institute of Sexology and Sexual Medicine, 2013). Other clinicians claim that paraphilia are changeable (Marshall, 2008). Fedoroff (2016, 2018a) in particular suggests that clinicians should advise their clients that there is no evidence that paraphilia cannot be changed and that their prognosis is 'excellent'. This type of messaging is divisive (see Cantor, 2018). Clinicians should certainly try to evoke their client's motivation for change, but they should be careful not to engender false hope.

The second issue is whether certain paraphilia should be defined as a sexual orientation (e.g., paedophilia, Seto, 2012). Seto (2017) has argued that sexual orientation is a broad concept, defined as a tendency to orient people preferentially in terms of their attention, interest, attraction and arousal to classes of stimuli along different dimensions. These dimensions are not limited to gender, but could also include age and species. Seto (2017) suggests that sexual interests in different stages of maturation can be defined along a dimension of sexual orientation for age. Some have welcomed this idea and applied it to other paraphilia (e.g., zoophilia; Miletski, 2017) and others have rejected it entirely (Fedoroff, 2018b).

These issues are beyond the scope of this chapter. In short, the majority consensus is that paraphilia are stable. However, this should not be conflated with a view that people do not or cannot change. Some paraphilia are related to other presentations, for example, an emotional identification with children (Hermann, McPhail, Helmus & Hanson, 2017) and hypersexuality (Kafka, 2010). Paraphilic exclusivity also varies, with few people reporting exclusive sexual interests, particularly in children (McPhail, Olver, Brouillette-Alarie & Looman, 2018). This is important because an exclusive interest is associated with higher sexual recidivism and sexual compulsivity (McPhail et al., 2018; McPhail, 2018), as well as self-reported offending in non-forensic samples (Bailey, Bernhard & Hsu, 2016a). In the HSP, the agenda is orientated toward expanding functional repertoires for the thriving of the *whole person* toward a constructive crime-free life. Within this it is expected that change will look, feel and function differently for different people. This will depend on the biopsychosocial processes underlying how their paraphilia manifests and their capacities for change in other domains. The next section discusses several biopsychosocial processes that influence paraphilia.

Part 1: biopsychosocial processes underlying paraphilia

Biopsychosocial models of sexual offending and characteristics associated with recidivism have been proposed before (Marshall & Barbaree, 1990; Carter & Mann, 2016). However, in this chapter, I provide more of a focus on paraphilia. Typically, in a biopsychosocial model, 'biological processes' refers to genetics, hormones, physiology and neurobiology; 'psychological processes' refers to motivational and cognitive systems (e.g., perception, beliefs, memory) and learning processes, including observation and classical and operant conditioning; whereas 'social processes' are concerned with peer and societal influences, as well as the wider cultural context. Although these processes are presented separately, they should be thought of as bidirectional and reciprocally influential.

Biological processes

Starting broadly, sexual offending clusters in families (Långström, Babchishin, Fazel, Lichtenstein & Frisell, 2015). This is mostly explained by genetic and non-shared environmental factors. Some paraphilia, particularly paedophilia, may be heritable (Alanko, Gunst, Mokros & Santtila, 2016; Alanko, Salo, Mokros & Santtilla, 2013), but this does not mean that they are genetically predetermined. Genetic variations may play a role, but as with all complex behaviour, this will likely be about potential, not certainty. Genetic influences will be contextually dependent on other biological factors, learning and the social environment.

A neurohormonal model of paraphilia has been proposed by Kafka (2003). Paraphilias often co-occur with hypersexual behaviour, as well as mood disorders (Kafka, 2010). Kafka (2010) has suggested that these co-occurrences indicate a general biological vulnerability. He proposes disturbances in the processes of neurotransmitters such as dopamine and serotonin as the cause. These interact with the male sex hormone testosterone, providing a biological substrate for sexual drive. Sexual drive is certainly relevant. For example, in a survey of paraphilia, Dawson, Bannerman and Lalumière (2016) found that measures of sex drive and hypersexuality were related to paraphilia and accounted for the gender difference found in prevalence rates. These authors suggest a high sex drive motivates interests in rare sex acts and contributes to their development. However, in terms of Kafka's model, it remains unclear why disrupted neurotransmitter levels would affect the specificity of sexual interests.

Neuroscientific studies have so far offered the most extensive evidence of a biological mechanism for paraphilia. There have been two main lines of enquiry.

The first is the measurement of neurodevelopmental correlates. The second is neuroimaging of structural brain differences. The neurodevelopmental studies have revealed that men with paedophilia often have mild features associated with abnormal neurodevelopment. Examples include lower intellectual quotient (IQ) (Cantor et al., 2004), elevated rates of left-handedness (Fazio, Lykins & Cantor, 2014), shorter height and leg length (Fazio, Dyshniku, Lykins & Cantor, 2015; McPhail & Cantor, 2015) and minor physical abnormalities (Dyshniku, Murray, Fazio, Lykins & Cantor, 2015). These features are thought to be neurodevelopmental markers because they begin in utero, are affected by prenatal stress (e.g., maternal malnutrition, drug use) and solidify during childhood (Fazio, 2018). The neuroimaging studies have shown neural white and grey matter differences between individuals with and without paedophilia. Some authors suggest a pattern of *dys*connectivity in white matter circuitry associated with the sexual response processing in the brain (Cantor et al., 2015; Cantor et al., 2016).

One problem with the neuroscience so far is the reliance on forensic samples. This risks conflating factors associated with offence status (criminality) with sexual interest (paraphilia). For example, a lower IQ has since been found to relate to offence status, not paedophilia (Gerwinna et al., 2018). Some grey matter differences have also been attributed to offence status, rather than paedophilia (Schiffer et al., 2017). Therefore, it is possible that sexual offending rather than sexual preference better explains many of the differences observed in neuroscientific studies (Joyal et al., 2019). At present, although the possibility remains that neurodevelopmental anomalies are involved, the science suggests some caution should be applied. Most likely is that some paraphilia start prenatally, but that the course and manifestation are also shaped by learning processes and specific social niches.

Psychological processes

The learning processes set out by behaviourists such as Ivan Pavlov and B.F. Skinner were heralded as a cause of paraphilia for decades (e.g., McGuire, Carlisle & Young, 1965). The basic model suggests that when the natural response of arousal (unconditioned response) elicited by genital stimulation (unconditional stimulus) is paired with a neutral stimulus, for example, an inanimate object such as long leather boots, the neutral stimulus obtains the function of eliciting arousal (Figure 6.1a). It in turn serves as an antecedent for the contingency of positive reinforcement; that is, where the rewarding consequence of sexual pleasure increases the intensity and frequency of sexual response in its presence (Figure 6.1b). Generalisation can then allow the learning contingency to include other stimuli (e.g., other leatherwear). Long leather boots are a normalised and accepted fetishism, but other neutral stimuli could include children or violence.

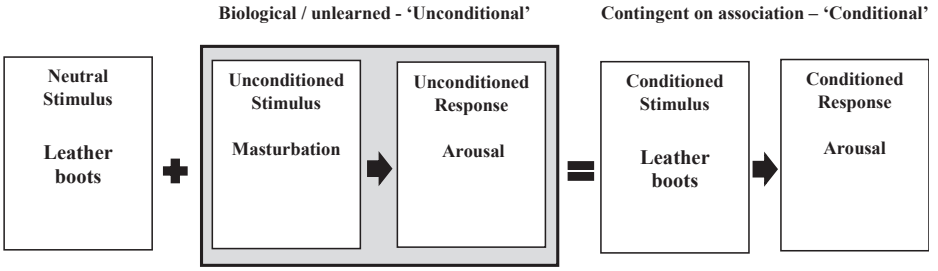

Figure 6.1a Stimulus-Response contingency: transfer of stimulus function of leather boots

Source: Images drawn by author.

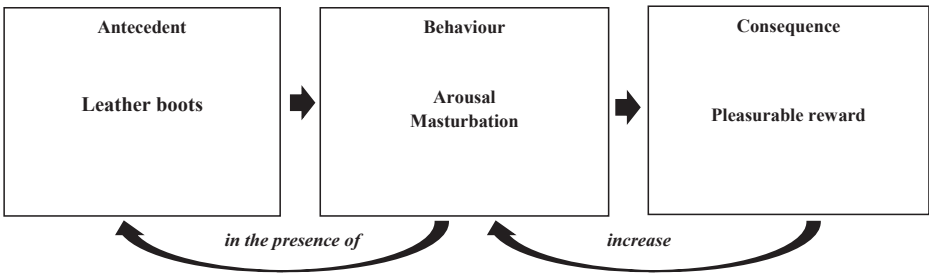

Figure 6.1b Positive reinforcement contingency: increase frequency and intensity of sexual response

Source: Images drawn by author.

Behaviour learning processes are unequivocal. However, as an explanation for paraphilia, researchers have reported parsimonious support because the evidence that paraphilia develop through contingency learning is weak (Camilleri & Quinsey, 2008; Seto, 2018). Contemporary behavioural learning accounts have been provided (Roche & Quayle, 2007). However, it remains the case that learning processes alone are insufficient as a causal explanation and that they probably influence paraphilia to the extent that an individual is already predisposed. This might include a biological predisposition as discussed earlier. Another potential predisposition is childhood adversity and the associated early learning experiences which affect life-course development.

Broadly, there is emergent evidence of significantly high (but by no means universal) levels of adverse childhood experiences (ACEs) in people convicted of sexual offending (Jespersen, Lalumière & Seto, 2009; Levenson, Willis & Prescott, 2016; Seto & Lalumière, 2010). Furthermore, individuals convicted of sexual offending report more ACEs consisting of sexual abuse than do individuals convicted of non-sexual offending (Jespersen et al., 2009; Reavis, Looman, Franco & Rojas, 2013; Seto & Lalumière, 2010). This is also found at the offence-type level, with those convicted of sexual offending against children

reporting higher rates of childhood sexual abuse than those convicted of sexual offending against adults (Jespersen et al., 2009; Seto & Lalumière, 2010). High ACEs are also associated with higher sexual deviancy scores (Levenson et al., 2016; Levenson & Grady, 2016).

How could ACEs increase vulnerability for sexual offending and paraphilia? The first point to note is that childhood adversity impacts the attachment system. Attachment is a biological process as much as anything else, but it also encapsulates learning, memory and emotion responding, as well as the development of cognitive representations of self, others and the world. Growing up in a stressful, unpredictable, unsafe or otherwise emotionally impoverished environment can have drastic effects in these domains. Humans are born built to form a secure attachment bond, inclusive of validating biofeedback. When it is not provided, a cascade of neurodevelopmental changes can occur that impede abilities for self-regulation, intimacy, cognitive flexibility and social affiliation. It is of no surprise that the changes can manifest characteristics associated with recidivism in later life such as impulsivity, emotional dysregulation, hostility, intimacy difficulties, poor coping and an emotional identification with children. In many cases, a confused and frightened child has become a fragmented and insecure adult whose attempts to alleviate their own emotional pain increase injury to themselves and others. The absence of a childrearing environment that is in every sense of the word 'growth-facilitating', providing safe experiences for cooperation and prosocial learning, changes a person from how genes are expressed and brains grow to the internal psychological models that form and how social life unfolds. Quite literally, "the body keeps the score" (see van der Kolk, 2014 for a book-length review).

As for the way childhood adversity and abuse could increase a person's vulnerability for developing paraphilia, the causal processes are less clear. MacCulloch, Gray and Watt (2000), for example, suggest a process of 'sensory preconditioning' for sadism that results from sexual abuse. MacCulloch et al. outline how sexual abuse can evoke anger and aggression in a child and sometimes abuse-related arousal. If there are sufficient pairings of these experiences, it is proposed that anger and aggression could become antecedents for eliciting arousal. Observational learning is another process that has been considered (Burton, 2003). Individuals could simply copy abusive acts that were once perpetrated against them. Whilst these processes are plausible, they rely on little more than copying and associative learning. Because ACEs can have such disruptive effects on global neurodevelopment, it is more likely that other vulnerabilities develop which influence how paraphilia manifest. Examples might include an emotional identification with children, problems with sexual self-regulation and beliefs that endorse sexual abuse. These can co-vary with some paraphilia, for example, paedophilia (Hermann et al., 2017; McPhail, Hermann & Fernandez, 2014), and those who report a history of childhood sexual abuse as compared to those who

do not can exhibit higher rates of them (Blank, Nunes, Maimone, Hermann & McPhail, 2018).

Social processes

Society and culture matter. From peer groups, to social norms, to cultural attitudes and media-technology, all are influential. Two social processes that are studied for their influence on paraphilia are internet pornography (Fisher, Kohut, Di Gioacchino & Fedoroff, 2013) and social stigmatisation (Jahnke, 2018a). These processes cannot be said to cause paraphilia, though they are researched for how they influence sexual behaviour and personal distress.

In terms of internet pornography, one issue is clear. Rapid technological growth has created seismic shifts in pornography accessibility and culture. Pornography has changed unrecognisably from the 1990s, when watching sexually explicit material often involved the acquisition of a VHS cassette or DVD. In recent years free-access licensed platforms such as 'RedTube' and 'PornHub' offer viewing of clips that people have upload to share with an online community. Clips are listed by category (e.g., 'Anal', 'Bondage', 'Gangbang'), and some are headed toward paraphilic themes (e.g., 'Teen'). PornHub publishes its annual usership data. Global use is colossal. In 2019 PornHub hosted 42 billion visits, averaging 115 million visits per day. PornHub's amateurs, models and content partners uploaded 6.83 million new videos.[1] To put this in perspective, PornHub.com in their 2019 Year in Review, state that if you merged all the content uploaded to PornHub in 2019 and started watching it way back in 1850, you would still be watching it in 2020. This level of unlimited novelty is what can be called a 'supernormal stimulus'. It is an artificially exaggerated imitation of sex. It recruits the reward system, but activates it on a level never faced by our ancestors. Some scientists have implicated the inexhaustible novelty and chronic dopamine activation in the conditioning of arousal, as well as increases in sexual dysfunction (Park et al., 2016). Others suggest we should not under- or over-credit it as a clinical issue (Fisher & Kohut, 2017).

Even authors with such differing views would surely agree that intervention is desirable when an individual is harmed by pornography. They will disagree on the extent to which evidence is sufficiently robust to draw causal inferences about general social harms. Pornography use is not a sufficient cause of paraphilia or sexual offending (Fisher et al., 2013). It does seem reasonable, though, that a person would seek pornography that reflects their sexual interests, paraphilic or not. This means that some people who search for child sexual exploitation material (CSEM), teen or sadomasochistic content on mainstream sites could already be

engaged in harmful behaviour. For example, in a sample of 110 men, McCarthy (2010) found that 84% had engaged in child abuse before they possessed CSEM. Individuals such as these convicted of both contact sexual offending and downloading CSEM are most likely to have a sexual interest in children (Babchishin, Hanson & Van Zuylen, 2015). At the very least it seems that pornography in the context of previous contact sexual offending could influence paraphilia or otherwise obstruct offence-free living.

The stigmatisation of paraphilia is not universal. For some paraphilia, however, it is particularly harsh. Typecasts about paedophilia, for example, are that individuals are dangerous, amoral and in control of what they are attracted to (Imhoff, 2015; Imhoff & Jahnke, 2018; Jahnke, Imhoff & Hoyer, 2015; Jahnke, 2018b). Hate for individuals with paedophilia is found at all levels of Western society, including the young, educated and liberal-minded (Imhoff, 2015; Imhoff & Jahnke, 2018). The effects are bleak. They include marginalisation, stress (of disguise), anger, fear and shame, all of which are threatened states toxic to health. Recently, researchers have turned their attention to the harmful effects of stigmatisation on characteristics associated with sexual recidivism (Jahnke & Hoyer, 2013; Jahnke, Schmidt, Geradt & Hoyer, 2015) and how responses to such an internalising and suppressing stigma impact the wellbeing of people with paedophilia and their ability to seek help (Grady, Levenson, Mesias, Kavanagh & Charles, 2019; Lievesley, Harper & Elliott, 2020).

Biopsychosocial summary

Susceptibility to paraphilia likely emerges early, sometimes prenatally, but the manifestation is also shaped by the environmental niche provided. ACEs feature in the history of many people with paraphilia, and something corrosive has often happened. Many paraphilia are a puzzle (Seto, 2017). However, one thing is clear: no one chooses them. No one chooses their genetics or prenatal influences, the childhood experiences and learning processes that shape their beliefs or the cultural context in which they are born and whether society accepts or marginalises them. That said, everyone is responsible for safe sexual expression, and no one has the right to sexually abuse others. A programme can support a person to build capacities to realise this responsibility but not by merely removing their risks. It must promote a non-harmful life trajectory in which prosocial behaviour is appealing. To do this the programme needs to be responsive to the neurodevelopmental consequences of adversity and trauma. It would also benefit from attending to shame and teaching techniques that regulate threatened states of social rejection. Beyond this, the procedures would need to target

emotion regulation, intimacy and cognition, as well as behavioural and arousal management. The HSP was recently revised with these aims in mind.

Part 2: the Healthy Sex Programme

The HSP is accessed via one of four programme pathways in HMPPS. People assessed as high risk without LDC who present with strong criminogenic needs across attitudinal, relationship and self-regulation domains access *Kaizen*, whilst those with LDC access *Becoming New Me Plus* (BNM+). Individuals who have less need and more pro-social skills access less intensive intervention, called *Horizon*, and those with LDC access *New Me Strengths* (NMS). Walton, Ramsay, Cunningham and Henfrey (2017), Ramsay, Carter and Walton (2020), and Ramsay (2020) have provided an overview of these programmes. The HSP is delivered in prisons to graduates of these programmes who exhibit paraphilia **and** are either experiencing distress **and/or** are assessed as requiring support to build skills for a leading law-abiding life.

The HSP offers 12 to 30 hours of one-to-one intervention divided across five modules which focus on engagement, formulation and planning, building skills for safe sexual self-regulation, sex and intimacy psychoeducation and relapse prevention. Each module contains a number of exercises, which are structured around different intervention procedures that make up the bulk of evidence-based CBT procedures. It is not possible to review all the exercises here, but the procedures will be described. Most exercises are optional, and they can be flexibly sequenced. This offers a tailorable programme that provides therapists with the scope to craft a bespoke intervention plan, which can be adjusted according to the emerging needs, strengths and responsivity requirements of their participants. Therapists are mostly psychologists, though some qualified probation officers are also trained. All therapists must be experienced in working with the people convicted of sexual offending. They must meet standards of competency on HSP training and receive supervision for each case from the HSP treatment manager or an HSP supervisor. Before discussing the intervention procedures, it is important to talk about how the programme aims to be responsive.

Responsivity to the neurodevelopmental effects of adverse childhood experiences

As already mentioned, childhood adversity can lead to corrosive neurodevelopmental injuries with implications for adult life. These can manifest in many domains, including verbal, attention and memory functions, as well as

emotional dysregulation and cognitive inflexibility. To work with this, the HSP uses a brain-friendly approach that appeals more widely to neurodiversity, as described by Williams and Carter (2018). It is essentially a multimodal approach, whereby methods for sensory learning such as visual, auditory and kinaesthetic are used as much as possible. The aim is to minimise an excessive focus on traditional sedentary routines that are literacy-centred: sitting, verbalising, reading, writing and so forth. Alternative learning methods might include in-action 'body-movement' techniques, symbolising, drawing, gesturing, skills practice and brain-breaks. The idea is to blend such methods to achieve a rich variety of ways for learning.

Beyond the impact on neurocognitive functioning and learning, ACEs can also make it difficult for people to regulate threat. Without a predictable, reciprocal, caring and safe environment, the attachment system becomes specialised in processing threat. This can present differently for different individuals, depending on other risk vulnerabilities that may manifest such as emotional dysregulation or seeking emotional closeness and intimacy with children. For some individuals, resistance to perceived authority may present in observable ways, with aggression and antagonism, whilst a fear of adults could be observed in others. Much of this is understandable in the context of brains that have specialised in abandonment, threat and fear with little experience of a safe haven. Pressuring individuals who experience these challenges to engage in the HSP is unlikely to foster alliance and a basis for change. As such, like Kaizen, BNM+, Horizon and NMS, as a basis for engagement, HSP merely asks that a participant invests in learning new pro-social skills – building on personal strengths, trying new tactics and exploring what works. A lot of what risk management professionals view as 'needing' to change (e.g., hostility, rigidity, impulsivity, sexualised coping, etc.), although restrictive and/or harmful, often developed out of conditions that fall short of what is required for humans to pro-socially flourish. They frequently function for self-protection, and change or merely exploring different ways of doing things can be daunting.

To work with this the HSP therapist is encouraged to act as a supportive coach. What this means in practice is that they aim to inspire, motivate and affirm internal strength and evoke curiosity in the change process. It also means they compassionately support coping with the suffering linked to childhood adversity or stigmatisation as it surfaces, perhaps as anger, anxiety, fear or shame. In short, there is a sensitivity in the HSP toward the fact that even in the simple request to learn skills for change, participants will encounter uncomfortable territory and necessarily work with it in the service of increasing their behavioural repertoire for leading a crime-free life. This is partly the basis of developing a compassionate mind (Gilbert, 2010), and compassion training is an optional intervention procedure featured in the programme.

Building compassion

Compassion can be defined as a sensitivity to suffering in self and others, with a commitment to try to prevent and alleviate it (Gilbert & Choden, 2013). This is courageous because it requires a turn towards painful states that are often displaced, for example, anger, fear or disgust. It is also a strengthening act because it involves stimulating emotions and competencies that foster helpful rather than harmful living. Compassion is felt precisely when emotional pain shows up. It draws on a care-based motivational system that evolved first in mammals and a set of evolutionary newer competencies that are cognitive and unique to humans (Gilbert, 2019). Compassion training was designed for dealing with the exact type of painful state that is often experienced in people with certain paraphilia; namely, *shame*. There is evidence of positive outcomes for compassion intervention in healthcare (Kirby, Tellegen & Steindl, 2017). Compassion training is also adaptable for participants with LDC (Clapton, Williams, Griffiths & Jones, 2018; Cowles, Randle-Phillips & Medley, 2020). The HSP aims to develop two qualities of compassion, namely (1) to empathically engage with the suffering of self and others and (2) to build skills for taking helpful action in dealing with it. The work toward building these qualities is simply called 'Compassionate Me'.

Rather than convincing a participant that they should be compassionate, the idea is to introduce a model that helps them realise the inherent difficulties of being human such that compassion makes sense. The model is called 'Three Circles' (Figure 6.2), and it is developed from the work of Professor Paul Gilbert (Gilbert, 2010). It is grounded in the neuroscience of evolved emotion regulation systems that we share with our mammalian ancestors. In short, as mammals, humans have a threat system (red system). This system governs us, exhibiting emotions like anger, fear, disgust and anxiety. We also have states that activate us, for example, excitement and lust. These ensure we pursue resources and are reward driven (blue system). We also have abilities for bonding and feeling safe and soothed (green system). These safeness functions are central to our attachment system – a vital adaptation in all mammals. Unlike many mammals, though, and at the core of why being human is *so* difficult, we have new competencies such as language, reasoning, imagination and self-awareness. They are both our defining advantage and our greatest challenge. They produce unmatched intelligence, but also arbitrarily activate ancient motivations and emotions that for hundreds of millions of years have organised species to pursue, avoid and attack. This leads to profound sources of pain for us, for example, humiliation, vengeance and shame.

The HSP therapist works with the model to depathologise negative affect. Simply put, human emotion is not a human's fault. Our brains evolved through

natural selection. We arbitrarily inherit them, and they are choreographed by the environment we coincidently inhabit. Little is chosen. Where ACEs have occurred, a therapist can sensitively suggest how it makes sense for *any* human to develop a robust threat system when threat has featured in life. However, in the case of paraphilia and sexual offending, because of how socially despised they are, the source of threat is often to the most crucial biological need for humans – the ability to belong (Walton, 2019). In turn, the threat system activates as it is meant to, but because of our cognitive competencies, the experience is imaginary and it is constructed cognitively and verbally. It may be oneself as 'bad', 'sick' and valueless to others. This experience is 'internal shame', and it can be agonising. Escaping the agony can include projecting one's shameful features onto others and attacking them (Gilbert, 2018) or constantly self-monitoring for one's inevitable faults (Gilbert, 2010). Both are survival strategies in response to threat, and this threat-based state can prioritise many such strategies,

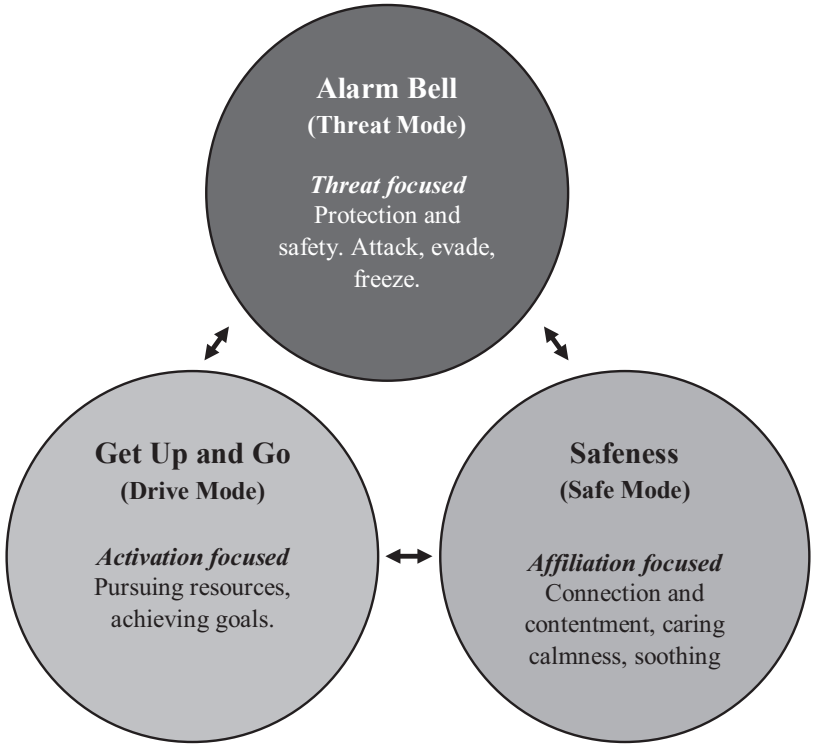

Figure 6.2 Three functionally evolved emotion regulation systems adapted from work by Paul Gilbert.

Source: Image drawn by author

including denial, blaming and hostility. In short, internal shame is unlikely to contribute toward a crime-free life because it shuts people off to caring for others, including the harms they have caused them. For a person to take responsibility for leading a crime-free life, they must experience a sensitivity to the suffering that they can cause to others. To do this, they need also to be able to engage with their own suffering and have the capacities to take helpful action in dealing with it.

Re-balancing the three systems is important. However, this is not a cognitive task, at least not initially. These systems are ancient, and much of their phenomena exist biophysically in the body's viscera. "The body keeps the score" (Van de Kolk, 2014), and so the work often needs to begin with the body to initiate the physiological functions of the safeness system, specifically those of the parasympathetic nervous system (PSNS), which acts as a counteracting force to the body's stress response. Similar to most compassion and emotion regulation work (Gilbert, 2010; McKay, 2018), the HSP uses a breathing technique that focuses on a slow rhythmic breath, deep from the diaphragm, extending the exhale to activate parasympathetic arousal. This technique can improve emotion regulation and self-control, and the main neurobiological process mediating these benefits appears to be respiratory stimulation of the vagus nerve (Gerritsen & Band, 2018). The vagus nerve is part of the PSNS and has connections to the voice, heart, lungs and visceral organs (Figure 6.3).

Slow rhythmic breathing can increase vagal activity, lowering heart rate and blood pressure and inhibiting stress response activity. As this happens, the body's slowing and soothing sensations can also influence cognitive perception of stressors through biofeedback channels facilitating further self-regulation (Gerritsen & Band, 2018). The aim with the technique in the HSP is to soften threat physiologically and shift to sensations of soothing facilitated by the PSNS. Of course, brains that have specialised in detecting threat can be triggered by these sensations. Therefore, it is vital that this work occurs slowly, anchored in Gilbert's three circles and explored from the secure base that the HSP therapist tries to provide.

With the soothing breathwork continuing on, the therapist and participant can begin to strengthen Compassionate Me – a wise, courageous and skilful version of self that is invested in being helpful, not harmful. Qualities and skills for compassion are developed by practising a set of self-regulation skills that feature across programmes, called the 'Great Eight' (Williams & Carter, 2018). Relevant skills include, *Here and Now* (mindful awareness), *Praise and Reward* (self-kindness), *Sticking at It* (resilience), *Their Shoes* (sensitivity to others), *Asking for Help* (supporting and receiving support) and *Better Life* (imagery of a healthier, more fulfilling life). Beyond this, the work focuses on compassionate imagery, thinking and behaviour. The emphasis is on developing courage and wisdom to work *with* the aspects of oneself that suffer and to deal helpfully with suffering.

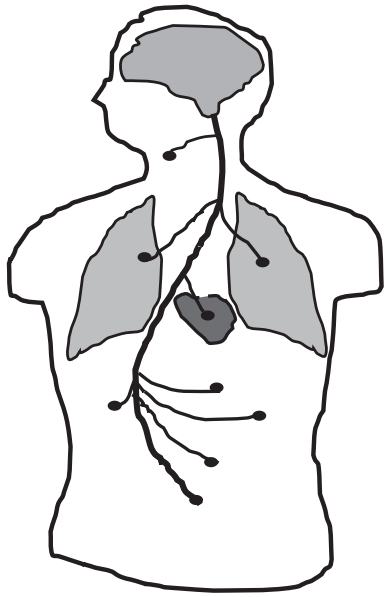

Figure 6.3 Vagus connects to voice chords, lungs, heart and organs below the diaphragm.

Source: Image traced and drawn by author

Anchored in the breathwork, a participant will imagine, try out or draw caring tones, expressions, postures and actions. These qualities, when strengthened, are then used to bravely contact the self that suffers – the critical, fearful, angry or shamed self. Again, this is not about rationalising self-talk. It is compassionate self-correction, designed to evoke the safeness system to work soothingly with distress. This means that by practising embodying a compassionate version of self, the participant practises wisely, appreciating that their shame, anger or fear is self-protective and understandably human, but in the way the threat system is narrowly focused and oversensitive, the efforts are not always actually helpful to leading a non-harmful, law-abiding life.

Mindfulness: *Here and Now*

Here and Now is used in all programmes. It is a mindfulness skill. The positive effects of mindfulness in forensic mental health have been reported (Yoon, Slade & Fazel, 2017). The processes that mediate the effects of mindfulness have been reviewed by Baer (2018) and include reduced cognitive and emotional reactivity and rumination, increased self-compassion and changes in metacognition – a

process of being consciously aware of one's thinking. Neurobiological changes are also noted to occur in prefrontal regions of the brain associated with attention and regulating emotion (Hölzel et al., 2011; Siegle & Coan, 2018).

Here and Now as used in the HSP focuses on the interrelating processes of present-moment awareness, acceptance and defusion. Together these aim to change the way a participant relates to their experiences. Defusion techniques aim to reduce the automatic control of thoughts on emotions and behaviour. Thoughts have automatic control because humans often experience thoughts as literal truths. This is called *cognitive fusion*. It refers to the way the literal meaning of a thought and the process of thinking are experienced as one and the same, as if they are 'fused' together. Defusion reveals that the process of thinking is separate from the literal meaning of a thought. Experiencing thoughts less literally has been shown to have positive effects on the believability of difficult thoughts and related distress (Levin, Hildebrandt, Lillis & Hayes, 2012). A range of defusion techniques are used in the HSP from labelling 'the mind' or feelings and noticing thoughts to meditation practices.

Acceptance is the process of willingly opening up to present-moment experiences. A precursor to this is helping a participant recognise the internal experiences that they cannot eliminate and will intensify if they try. Avoidance of painful experiences through the use of sex and CSEM to cope are common in people who sexually offend, and acceptance techniques have recently been discussed as a means to support change (Quayle, Vaughan & Taylor, 2006; Walton & Hocken, 2020). Try as people might to get rid of unwanted experiences, there is no unlearning of what went before. Our nervous system is additive, not subtractive, and memories, thoughts and feelings cannot be selectively removed. Similar to putting too much salt in a soup, once incorporated, the excess salt cannot be extracted. The solution is to change the impact of the salt. To do this, you need to add more soup. Likewise, acceptance is about letting go of the struggle to remove discomforting internal experiences as if unlearning was possible. Defined in this way, acceptance is not about accepting thoughts about sexual abuse, and it should not be mistaken for this. Similar to defusion, it is about a person practising a functional change in how they relate to their thoughts and feelings, such that the unhelpful influences on their behaviour diminish. Said another way, it is about expanding their repertoire of functional responses (i.e., adding more soup). In the HSP, acceptance is taught using well-known metaphors and techniques (see Harris, 2019).

Values clarification

Clarifying personal values has been important in programmes for many years, but it has been secondary to an emphasis on goals. Values, unlike goals, are ongoing.

They represent what truly matters and gives life meaning, for example, love, security, connection and peace. Values work is now of increasing interest in this field (Quayle et al., 2006; Walton & Hocken, 2020). It deeply links skills for change to meaning and purpose. This is important because the reality of change for an HSP participant is a challenging one. It may entail forgoing the dependable gratification of arousal to thoughts about abusive sex and/or opening up to painful experiences associated with adversity and stigma. Why would they do these things? They may do them if it is in service of taking action that is consistent with what they deeply care about – perhaps their safety, health, wellbeing, family or autonomy. In short, the HSP focuses participants to clarify their values. This is because when skills for change are linked to values, the personal energy required to learn and use them is well spent. It is spent in the service of what truly matters in life.

Modifying beliefs

Beliefs that support sexual abuse are associated with sexual recidivism (Mann et al., 2010; Helmus, Hanson, Babchishin & Mann, 2013). Reappraising them is a goal of programmes such as Kaizen and BNM+. Those beliefs important to identify are the ones that a participant holds resolutely and which are rigid and narrow their behavioural repertoire. They can be identified using a self-guided formulation such as a life map and using Socratic questions which evoke reflection on learning from life events. The HSP provides an opportunity to continue with this work, but with a focus on beliefs about intimacy and sex and male and female roles. Identifying the relevant beliefs often shows how people's minds are shaped by the environments they inhabit. For HSP participants, with regular harsh, hurtful and abusive experiences in their life map, it is usually clear to see that many restrictive beliefs fulfil a safety function. Their short, rigid, antisocial and overgeneralised nature (e.g., "all women are liars") offers protection because it can be applied in a blanket fashion, making the world seem predictable with easy-to-follow rules to avoid feeling vulnerable or exposed (e.g., "don't trust women", "don't show weakness"). The goal is to work with the participant to distance them from these unhelpful beliefs enough to consider alternative ways of seeing things that are more flexible, pro-social and balanced. To do this safely and compassionately, therapists must appreciate their developmental origin and their function as contextualised working models.

HSP therapists may use cognitive reappraisal techniques such as evidence testing, self-talk and constructing alternative beliefs. These techniques may exert their effects through changing cognition, for example, altering beliefs and their meaning. However, ultimately the work aims to encourage participants to recognise

their thought processes and change their relationship with them, seeing them not as absolute truths but as mere mental events. In this way, it is possible that changes in meta-cognition are also involved, and this has been reported in the general cognitive therapy literature (Hayes-Skelton & Graham, 2013). For this reason, cognitive reappraisal and Here and Now techniques are sometimes used together in the HSP in an integrated way towards a similar intervention goal.

Self-management

Self-management is a form of behaviour therapy. Behaviour therapy is based on behavioural learning processes, such as stimulus control and positive reinforcement. These are often used to understand and change behaviour using the well-known three-term behaviourist learning contingency, called *Antecedent-Behaviour-Consequence* (ABC). In the HSP, self-management involves functionally analysing and managing the antecedent stimuli that trigger paraphilic arousal and associated behaviour and increasing the antecedent stimuli that trigger thoughts about healthy sex. It also includes practising alternative behaviours that achieve the consequences of paraphilic arousal. To clarify some of these terms:

- An antecedent stimulus is a cue that comes before a behaviour. It is a trigger.
- Reinforcement is a process whereby the consequence of the behaviour increases the likelihood of the response recurring in the presence of the antecedent stimulus.
- A stimulus exerts control when the behaviour is more likely to occur in its presence.

Antecedent stimuli that tend to exert control over paraphilic arousal and behaviour can include uncomfortable (and so aversive) feelings like shame or loneliness, certain visual stimuli such as children, fetish items or violence, situational opportunities and specific states, for example, boredom. Behaviours such as accessing CSEM or fantasising and masturbating to abusive sex typically follow and are reinforced precisely because their consequence is the removal of the aversive stimulus and/or gaining of pleasurable reward. Self-management in the HSP focuses on shaping new contingencies that deal with the antecedent stimuli that exert control. In short, this procedure amounts to devising a self-management schedule using a functional analysis. In the HSP, the ABC contingency is simply called *What Happens, What I Do, What I Get* (Figure 6.4).

In an HSP exercise called *Getting the Good Things from Not OK Sexy Thoughts*, a participant can identify how fantasising about abusive sex provides reinforcing consequences, for example, feelings of mastery or intimate connection, or the

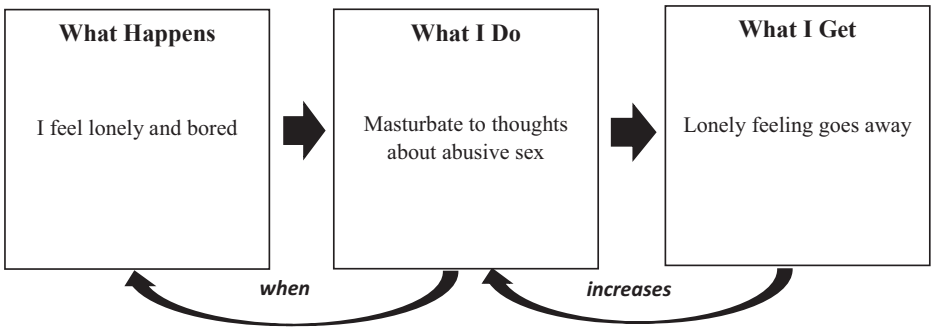

Figure 6.4 Accessible format: functional analysis of negatively reinforced stimulus control.

Source: Images drawn by author

removal of feelings of boredom or loneliness. The therapist and participant can then focus on equipping safer behaviours that can be similarly reinforced to obtain these consequences, for example, practising skills to develop self-efficacy, intimacy with adults or coping with discomforting feelings. Similarly, in an exercise called *Skills for Managing Triggers*, the participant can focus on practising skills to manage the antecedent stimuli that have gained control over paraphilic arousal (i.e., strong triggers). In both cases, for skills to be integrated into the participant's behavioural repertoire, the experience of using them must be reinforcing. The therapist must therefore help create rich schedules of reinforcement. One way to do this is to link the use of skills to values as outlined earlier. When this occurs, self-management skills are reinforced by virtue of them being linked to what the participant genuinely cares about.

Behaviour modification

Behavioural modification (BM) is also a form of behaviour therapy. BM uses behaviour learning processes such as reinforcement, punishment and extinction to shape sexual arousal (Marshall, O'Brien & Marshall, 2009). BM is associated with the contingency learning account of paraphilia described earlier (see Figure 6.1a and 6.1b), and has been a dominant intervention procedure for over 60 years. A recent meta-analysis found that BM reduced paraphilic arousal ('paedohebephilia' specifically), especially for those who show high levels of such arousal (McPhail & Olver, 2020). Whether these effects lead to decreases in long-term sexual recidivism or not is still unclear. Lösel and Schmucker (2005) found a significant effect on sexual recidivism for interventions that included BM. Gannon, Olver, Mallion and James (2019) have more recently reported that

interventions that included BM produced larger reductions in recidivism than those that did not. However, both these sets of findings should be interpreted carefully. This is because the evaluations of interventions incorporating BM originally included by Lösel and Schmucker (2005) were heavily confounded. In an update of their meta-analysis using far stricter scientific rigor, Schmucker and Lösel (2017) excluded most of these evaluations because they were too methodologically weak. However, Gannon et al. (2019) included many evaluations that fall below the rigorous standards Schmucker and Lösel set. As such, it is perhaps expectable that Gannon et al. would report a similar optimistic effect to Lösel and Schmucker in their original meta-analysis.

Regardless of its empirical support, BM is unlikely to lead to permanent change. This is because it relies on creating new contingencies that govern changed arousal. An example is applying covert punishment such as aversive personal consequences to fantasise about abusive sex, the function being to reduce arousal to the fantasies. This is a BM technique called *modified covert sensitisation*. If the punishment is removed, (i.e., if a participant stops rehearsing the costs of abusive sex), the conditioned response of reduced arousal will diminish and a return of previous arousal levels may follow. Therefore, the use of BM on the HSP is introduced as a procedure that moderates arousal, with the conditioned effects being reliant on continuing practice. The HSP also uses a technique that capitalises on a person's natural desire to satisfy sexual appetite called *directed masturbation*. It works by rewarding progressively healthier fantasies with masturbatory-induced pleasure, thereby steadily shaping arousal to pro-social themes. Its use is important. Intervention cannot merely concern itself with removing risks as if a life of aversion and restriction could ever be fulfilling. Intervention has to offer viable new alternatives that can serve a pro-social life.

Urge management

HSP offers *Surfing the Urge* training to help with sexual urge management. Urge surfing is a Here and Now skill that aims to change one's functional relationship with an urge in order to increase behavioural control. It is supported as a coping skill for substance addiction and appears to work by moderating autonomic responses such as urges and cravings (Ostafin & Marlatt, 2008). However, there are currently no robust trials that test urge surfing with sexual urges.

Another urge management procedure is the use of certain drug therapies. These target serotonin and dopamine systems and testosterone production, all of which are important to sexual functioning. Such drugs are not able to change sexual

interest. However, the features of sexual interest that are to do with sexual libido, impulsivity, emotion and urges are certainly amenable to manipulation using pharmacological treatments (Grubin, 2018). HSP participants can voluntarily undergo assessment for medication to manage sexual arousal at a number of funded prison clinics. Where a participant is dominated by an insatiable sex drive and strong sexual urges, the rapid decrease in arousability can serve as an adjunct therapy to the HSP in helping participants develop sexual self-regulation skills.

Interpersonal skills intimacy and relationships

Poor social skills are not related to sexual recidivism, but the lack of emotionally intimate relationships is (Mann et al., 2010). In short, negotiating general social situations is not usually a difficulty for people with convictions for sexual offending, but close intimacy tends to be, and for many reasons, they can find themselves emotionally out of sync with adults, fearful and struggling to connect. The HSP builds on intimacy skills work from Kaizen, BNM+, Horizon and NMS. The relationship exercises explore compatibility with partners, the concept of a healthy relationship, how to be sexual safely without a relationship and practising skills for intimacy. Commonly introduced interpersonal skills include negotiating, listening and expressing feelings appropriately. People are taught using a systematic method which involves introducing skill steps, modelling, coaching and giving reinforcing feedback. The focal process is improving skills for intimacy.

In an exercise called *Avoiding Relationships: Using My Values to Guide My Actions*, the therapist and participant can explore how as humans we desire connection with others, but by opening our hearts and being vulnerable to form this connection, we also inevitably expose ourselves to the risk of being hurt. When a loved one leaves us or betrays us, or if our childhood has told us that everything about an adult relationship will harm us, the threat system will do its job, and the mind can summon up many reasons as to why intimacy is unsafe or unfeasible. Unfortunately, people suffer by doing the 'safe thing' and avoiding relationships, because without intimacy, they rarely experience connection, acceptance and love – many of our primitive human needs and the things that usually matter most. The therapist carefully creates space for the participant to find this human irony – that what matters to us the most is often found inside what deeply pains us. This is explored safely with prepared fictional cards, with a worry statement on one side and a value on the other. The example of 'James' is presented in Figure 6.5.

Looking at the hurt and worry, the therapist can ask: "What does James really care about?", "What is on the other side of his worry?" and "What was it he

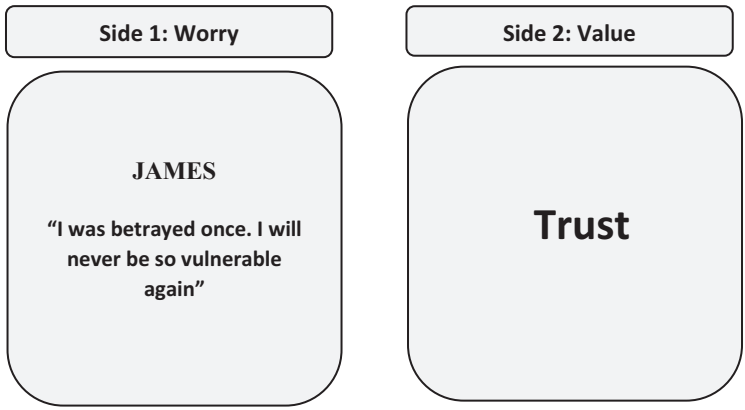

Figure 6.5 Accessible format: fear and value card.

Source: Image drawn by author

had that was so valuable?" In James's case, he can protect himself from being betrayed. By not letting people in, he will never be 'so vulnerable' again. But whilst he is not vulnerable, he is unable to (re)experience what he values – *trust*. The participant would then explore how James's response is a human response. By protecting ourselves so heavily to avoid being hurt, we risk limiting ourselves and experiencing what makes life meaningful. This can hurt in a different way, for example, in our loneliness or the harm we cause. The therapist might then explore with a participant if they are willing to make room for their worries if this is what it would take to live a fulfilling life. From here, skills for intimacy can be practised in the service of taking values-based action towards achieving an intimate relationship.

Conclusion

The HSP is a tailorable programme for individuals convicted of sexual offending whose paraphilic interests pose a risk to the public. It is grounded in a biopsychosocial model of paraphilia, offering a range of intervention procedures that are well known to clinical science. The HSP is part of the wider rehabilitative offering in HMPPS. It is a recently revised programme and will be subject to implementation monitoring and evaluation. Participants who access the HSP are graduates of other programmes that aim to build strengths in criminogenic areas more generally. Invariably, for those assessed as suitable for the HSP, they require more support than those without paraphilic interests. The HSP offers the chance for them to learn skills intended to change their functional relationship

with their paraphilia and their associated distress and risks to others. The best evidence suggests that people do not consciously choose to be sexually interested in abusive behaviour. Despite this, such interests often endure for life. If people are to lead crime-free lives, many public protection efforts will be needed. Effective intervention is just one.

Note

1 www.pornhub.com/insights/2019-year-in-review

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