

**Understanding service user and therapists' experiences of incarcerated sex offenders receiving pharmacological treatment for sexual preoccupation and/or hypersexuality**

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## **Understanding service user and therapists' experiences of incarcerated sex offenders receiving pharmacological treatment for sexual preoccupation and/or hypersexuality**

This research comprises two qualitative studies understanding the experiences of 1) convicted sex offenders voluntarily receiving pharmacological treatment to reduce sexual preoccupation and 2) therapists working with these offenders. The studies form part of a research programme evaluating the use of pharmacological treatment with sexual offenders. In study one, semi-structured interviews were conducted with 13 sexual offenders receiving selective serotonin reuptake inhibitors (SSRIs). In study two, interviews were conducted with eight intervention staff with varying levels of experience of working with offenders taking anti-libidinals. Thematic analysis was used and in study one, two main themes emerged: (i) the impact of the pharmacological treatment on prisoners' daily functioning; (ii) barriers to compliance/engagement. In study two, three main themes emerged: (i) offenders' reluctance to engage with pharmacological treatment; (ii) challenges for therapists; (iii) pharmacology: 'just another piece of the puzzle'. Findings are discussed in relation to practice and future research.

Keywords: sex offender; pharmacological treatment; qualitative; anti-libidinal; SSRI; hypersexuality

## **Introduction**

The presence of an excessive sexual appetite is referred to under a number of different labels within the literature. The term sexual preoccupation refers to ‘an abnormally intense interest in sex that dominates psychological functioning’ (Mann, Hanson & Thornton, 2010 p. 198), potentially resulting in engagement in a high frequency of sexual behaviours to relieve sexual urges. High frequency or excessive sexual behaviours is often referred to in the literature as hypersexuality (Kaplan & Krueger, 2010), hypersexual disorder (Krueger & Kaplan, 2002) and sexual addiction (Marshall, Marshall, Moulden & Serran, 2008). Sexual preoccupation is recognised as being a significant predictor for sexual, violent and general recidivism (Hanson & Morton-Bourgon, 2004; Hanson, Harris, Scott & Helmus, 2007). Potential explanations as to the link with sexual offending have been offered: ‘a general lack of self-control (common among young people and general criminals), specific problems controlling sexual impulses, and a tendency to overvalue sex in the pursuit of happiness’ (Hanson & Morton-Bourgon, 2004, p.15).

Psychological therapy exists as the preferred and accepted standard method of treatment for sexual offenders, with Sex Offender Treatment Programmes (SOTP) offered throughout prison and probation services within the UK (Ho & Ross, 2012). However, these programmes do not specifically target deviant sexual arousal and fantasies present in some sexual offenders (Adi et al., 2002) and so treatment needs relating to these may be left unmet. Similarly, for individuals who possess particularly dangerous deviant sexual interests, psychological treatment alone may not be sufficient (Marshall, Marshall & Serran, 2006). Furthermore, if sexual urges or thoughts are particularly intense, this can impact upon individuals’ ability to focus/participate in treatment programmes, and their ability to apply techniques to manage their sexual preoccupation (Marshall et al, 2006; Saleh, Grudzinskas, Malin & Dwyer, 2010).

This treatment ‘gap’ has spawned the use of pharmacological interventions in the treatment of sexual offenders to diminish deviant sexual fantasies, urges and behaviours (Bourget & Bradford, 2008), and facilitate learning within psychological treatment programmes (Saleh et al., 2010). In 2007, protocols were established within the UK to allow the pharmacological treatment of sexual offenders (within the care of the prison or probation service) on a voluntary basis. This pharmacological treatment is viewed as a supplement and

‘needs to happen in combination with psychological treatment to help people understand their sexual thoughts and to challenge deviant thought processes’ (Home Office, 2007 p. 14).

The pharmacological treatment, specifically anti-androgens (Cyproterone Acetate; CPA) and Selective Serotonin Reuptake Inhibitors (SSRIs; Fluoxetine) are the medications referred to in this research. CPA reduces sexual arousal through the reduction of testosterone levels (by approximately 30-40%, Bancroft, 1989) and SSRIs increase serotonin, which has been evidenced to inhibit sexual desire, psychological and physiological arousal and physiological orgasm (Jordan, Fromberger, Stolpmann, & Müller, 2011; Meston & Frohlich, 2000). Research thus far has tentatively indicated positive results of both these treatments with sexual offenders, although the findings are currently considered inconclusive, and with further research needed (Beech & Mitchell, 2005; Grubin, 2007; Guay, 2009).

The studies described here form part of a mixed-method programme of evaluation of the use of pharmacological treatment. Within the literature, there is an apparent lack of qualitative research which provides rich and in-depth understanding of this research topic. The aim of the current research is therefore to use qualitative methods to explore the impact of receiving pharmacological treatment from the perspective of both service users and of psychological intervention staff working with sexually preoccupied offenders. Qualitative methods have become a successful and accepted method of evaluation (McDavid, Huse & Hawthorn, 2005) and utilising qualitative methods within an evaluation is increasingly recognised for its ability to ‘tell the program’s story by capturing and communicating the participants stories’ (Patton, 2003, p. 2). It is hoped that this will add depth and understanding to the quantitative findings of the evaluation (Winder et al., under review).

## **Method**

### *Context*

The current study is part of a mixed-method programme of research that was designed in collaboration with a UK sex offender prison to evaluate the use of pharmacological treatment to reduce sexual preoccupation and/or hypersexuality in sexual offenders. The establishment is the largest treatment centre for sexual offenders in Europe, housing approximately 840 adult males who have been convicted of a sexual offence or who have a sexual element to their offending.

## ***Participants***

### *Study one*

Participants comprised 13 convicted adult male sexual offenders prescribed SSRIs (Fluoxetine) to reduce their sexual preoccupation. Participants were White British (12) or White Other (1), with a mean age of 47 (29-72, s.d. = 13.7) and a mean IQ of 88 (59–108, s.d. = 15.8). See table 1 for further participant information. Participant names were replaced with pseudonyms to maintain anonymity.

### **Insert Table 1**

### *Study two*

Participants comprised eight members of psychological intervention staff working at a UK sex offender treatment prison. Participants were aware of offenders taking pharmacological treatment and were gained through purposive sampling. All participants worked within the psychology department (see table 2 for job titles, treatment and experience) and no specific training had been delivered to these participants on the pharmacological treatment. To maintain confidentiality, job titles are not assigned to individual participants, and names are replaced with non-gender specific pseudonyms.

### **Insert Table 2**

## ***Data Collection***

Ethical approval for both studies was received from HMPS and a UK University. Potential participants were identified by a prison-based gatekeeper for both studies (study one: the prescribing prison psychiatrist; study two: senior prison psychologist). For both studies, information about the research was distributed to all potential participants. Further information was presented at a face-to-face interview, in which written consent was obtained. British Psychological Society ethical guidelines were followed with regard to consent, opportunity for withdrawal of data, stated boundaries of confidentiality and debriefing of participants. All interviews took place in a dedicated private room within the prison. The interviews were digitally recorded, and transcribed verbatim.

*Study one: Service users (convicted sexual offenders)*

Data was collected through semi-structured interviews (n = 22) with the lead author; interviews lasted between 25-135 minutes (mean = 75 minutes), with 1-3 interviews per participant. Where individuals were particularly high risk, interviews were conducted with two researchers present (n = 3).

The interview schedule was developed through consultation with colleagues and structured into three broad sections; personal information and offending history; development of sexual preoccupation and use of the medication (SSRIs); other treatments (e.g. psychological) and future plans.

*Study two: Intervention staff*

Data was collected through semi-structured interviews with the second researcher; interviews lasted between 33-66 minutes (mean = 45 minutes), with one interview per participant. The interview schedule was developed as above and comprised five broad sections: referrals; consent; impact of medication; offenders' views on medication; and offender rehabilitation.

***Analytic approach***

This research utilised thematic analysis as a method for 'identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79). The aim is to provide a complex, detailed and rich account of the data (Braun & Clarke, 2006). The researchers adopted techniques outlined by Miles and Huberman (1994) and Braun and Clarke (2006) entailing transcription, thorough reading to increase familiarisation and initial data reduction (coding). The data was organised systematically and themes were identified and reviewed. A type of inter-rater reliability was undertaken, with the analysis being 'audited' (Lincoln & Guba, 1985) by the co-authors to assess the validity of the interpretations.

**Study one: Results and discussion**

Two main themes were identified from the narratives provided by the service users. Each is discussed in depth (see table 3 for delineation of themes).

### INSERT TABLE 3

#### *Superordinate theme 1: Impact of the pharmacological treatment on prisoners' daily functioning*

Participants discussed a range of ways in which the medication had impacted upon their daily functioning; these included a reduction in sexual preoccupation, sexual arousal, and improvements in their abilities to manage negative emotions.

##### *Sub-theme 1.1: A clearer way of thinking: from sexually preoccupied to 'human'*

Within the narratives, participants portrayed their situation prior to taking the medication:

I think the best way of describing it is if a person has got a problem with their mind and it's and it's there constantly, 24 hours a day, 7 days ... (Mohammed)<sup>1</sup>

It's just getting the frustration out [masturbation], it's not that I want to have sex all the time it's just release. It's a relief, it just gets rid of that urge, know what I mean, out of your system and you feel alright and you can just get on with your daily routine (John)

These accounts accentuate the difficulty and distress the participants are experiencing, with Mohammed's extract highlighting the psychological aspects, the constant and intense sexual thoughts and fantasies. John describes a later stage where the thoughts have now become sexual urges and there is a compulsion to engage in sexual activity to relieve this urge. John suggests that a 'daily routine' or normality cannot commence until this urge has been relieved.

When discussing the impact of the medication, all participants reported a reduction in sexual thoughts and fantasies in reports that it had 'lessened them to almost nothing most of the time' (Joshua). However, participants acknowledge still having some sexual thoughts, as

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<sup>1</sup> All names provided in relation to the data are pseudonyms and are not related to actual participant names.



with Evan; he is aware that while the medication has repressed his sexual thoughts, fantasies and urges, they are still there and would return should the medication stop: ‘...it’s still there in a sense I’d say clawing at the cage wanting to be let out (Evan)’.

Participants discussed the reduction in sexual thoughts and fantasies in relation to deviant content, which is reassuring considering the aim of pharmacological treatment is to reduce deviant sexual interests and behaviours while maintaining those that are appropriate (Bradford & Kaye, 1999; Bradford 2001). The Good Lives Model (GLM; Ward & Marshall, 2004) of offender rehabilitation introduces the notion of primary human goods; actions, characteristics, experiences or states of mind that are intrinsically beneficial and are likely to increase psychological well-being if achieved. The central premise is that everybody (offenders and non-offenders) shares the same basic needs and are naturally predisposed to seek these goals or primary human goods. As such, offenders commit crime because as they are seeking these via inappropriate methods thus, rehabilitation is focussed on re-evaluating the goals and how these may be achieved. Considering this, reducing deviance sexual interest in individuals who have no appropriate alternative would be concerning, since according to the GLM, sexual satisfaction is a ‘primary human good’, thus eliminating capacity for sexual arousal and sexual outlets would be detrimental, reducing the individual’s level of well-being (Ward & Marshall, 2004). Circumstances such as this support the argument that psychological treatment is important alongside pharmacological treatment (Guay, 2009) to aid the development of healthy sexuality.

Since receiving medication, participants report the current thoughts to be less intense and ‘a lot more manageable’ (Mohammed). Additionally, participants report an increased ability to recognise inappropriate sexual thoughts and distract from them:

I suppose it’s, it’s given me the opportunity and the and the space in mind to address inappropriate fantasies and and slowly bring them into the, bring to something more acceptable ...I mean it is just, it’s made me more able for me to ignore the inappropriate fantasies...yeah and then slowly given time and maybe because I’m ignoring them or because I’m not act acting on them they they’re not returning (Peter)

This allows individuals to ‘choose’ the stimuli that they become aroused by and masturbate to. As Peter articulates, this process of ‘ignoring’ inappropriate fantasies has stopped them from returning, while masturbating to appropriate fantasies has reinforced these, thus altering

the nature of their fantasies:

Erm it given me, erm it's allowed me should I say to (3) develop my what are more appropriate sexual boundaries (Peter)

Participants often attribute these changes in their arousal to the general reduction in sexual preoccupation and having more 'head space' to process thoughts and make conscious pro-social decisions.

*Sub-theme 1.2: Reduced sexual arousal: a cost or benefit?*

The reduction in sexual thoughts and fantasies resulted in a reduction in sexual arousal and frequency of masturbation. The majority of participants also reported physical effects on arousal, including: an inability to achieve or maintain an erection: 'I can get a bit of an erection but I can't get a full erection' (Tom); an inability to ejaculate or difficulty reaching ejaculation: '...it just goes on and on and on and I won't ejaculate and I'll just give up on it' (Mohammed); and/or a reduction in the amount of semen if ejaculation occurred: 'There was hardly anything there at all and sometimes there was nothing there at all...although I ejaculated er it was, I suppose you could call it a dry ejaculation' (Neil). Previous research has also reported similar adverse effects of SSRIs (Strohm & Berner, 2001 as cited in Hill, Briken, Kraus, Strohm & Berner, 2003 p. 410). Participant reactions to these effects varied across the sample:

What you don't have you don't miss (Joshua)

And at first, it was rather annoying erm, I also found that the fantasies that I had used previously, were no good any longer...Erm, they weren't strong enough to tip me over the edge erm...and that became very difficult in trying to come up with a fantasy that was strong enough to enable me to ejaculate (Neil)

Some participants appeared to accept such effects without compunction; others perceived these as problematic and attempted to counteract these by becoming non-compliant as a deliberate method of being able to achieve an erection, or by altering the nature of their fantasies. Similar findings are documented that individuals may seek more sexually deviant fantasies in order to maintain sexual arousal or reach ejaculation and it is suggested that if

this occurs the dosage should be altered (Hill et al., 2003) and there should also be psychological intervention to dissuade individuals from adopting this strategy.

### *Sub-theme 1.3: Managing negative emotions*

Participants reported an increased ability to manage their emotions in situations when previously they would become angry or frustrated. This is reiterated in descriptions of themselves as ‘more patient’ (Joshua), ‘more mellowed’ (Nathan) and ‘calm’ (Tom). One participant, Evan, attempts to offer an explanation:

I think it’s, in a way, because my mind’s not so occupied with wrong thoughts that I’m able to recognise other thoughts coming in and feelings as well. So the fact that I know when I feel angry or I feel annoyed, I can think ‘yep, I am feeling that’ and then it’s kind of like ‘why?’ and then I think why I’m feeling like that. (Evan)

Having more headspace appeared to allow participants to process thoughts and emotions that they previously could not, allowing them to respond differently. Participants who reported difficulties with depression also reported improvements from the medication, acknowledging its use for such conditions: ‘Cos it’s like an anti-depressant anyway’ (Nathan). This was something they spoke about very positively, with the reduction in depressive symptoms allowing them to be more sociable and feel less isolated.

For some participants, these effects appear linked to those previously discussed, with masturbation providing an outlet to overcome depressive symptoms and ‘make me feel better’ (Nathan). This is supported within the sex offender literature (e.g. Cortoni & Marshall, 2001; Mann, Hanson & Thornton, 2010; Seghorn & Ball, 2000) in which sexual outlets are recognised as ‘self medication’ or a coping strategy to overcome depression, anxiety or negative emotional states. Whether these effects of reduced depressive symptomology, and those of reduced arousal and preoccupation, are direct or indirect effects of the medication is currently unknown as there is difficulty in determining which is reduced first, but nevertheless a reduction in all was apparent.

### *Superordinate theme 2: Barriers to compliance and engagement*

Generally the level of compliance appeared high, with individuals presenting as engaged and

motivated to take the (voluntary) medication. Nevertheless, some non-compliance was apparent and this theme considers the challenges that may impact upon compliance.

*Sub-theme 2.1: Participant concerns*

Participants experienced a number of concerns whilst taking the medication. Initially, these anxieties centred on the side effects of the medication:

Erm I always do, I, any treatment we are doing or any medication I always, I suppose get worried about you know, side effects, you know, is it going to work? Is it going to make things worse? (Scott)

Moreover, it was apparent that concerns arose from rumours circulating within the prison: ‘they said you could get like 'man boobs' and things like that’ (Nathan). Although this is not necessarily wrong (gynecomastia or breast growth is a known side effect of anti-androgen treatment such as CPA – see Thibaut et al., 2010 - which is also prescribed within the prison), this was not applicable to participants in this study as they were taking SSRIs.

Other concerns related to the impact the medication may have on future sexual relationships, particularly for individuals experiencing physical effects on arousal (discussed previously). Worries about becoming dependent on the medication, as well concerns that it may stop working as they are ‘getting used to it’ (Nathan) were also expressed.

Although these apprehensions did not appear to have a deleterious effect on current compliance, some participants displayed uncertainty regarding their intentions to continue taking the medication after release, an uncertainty that can be attributed to some of these concerns:

I'm not really sure. If it's going to help me most probably yeah, but I don't want to be independent on it, know what I mean? I try not to be independent on tablets but if it's going to help me in the long run, then I er, I don't know. I can't see no problem. As long as I still have a healthy sexual relationship with a woman (John)

This extract highlights the cost/benefit analysis that individuals may conduct, with a tension between the advantages of reducing inappropriate sexual thoughts/fantasies, contrasted against the possibility of impairing individuals’ ability to have a sexual relationship. While this may not be problematic in prison, it may create difficulties in trying to achieve a

meaningful intimate relationship when released.

For all participants, gaining knowledge and information about the medication eased these concerns. Further, a good therapeutic relationship with the consulting psychiatrist appeared to be critical in providing participants with a safe environment to voice and discuss their concerns.

### *Sub-theme 2.2: Not fully engaged*

Despite generally good levels of compliance, throughout the narratives there were instances in which participants exhibited a nonchalant attitude towards the medication:

...because its not the really serious medication, it's not cos I've got a heart defect or anything  
(Barry)

when I remember to take them. I'm never very good at remembering tablets (Peter)

Most participants reported occasionally forgetting to take their medication, and taking it as soon as they remembered; participants did not seem concerned about such lapses, believing the medication was 'still in my system anyway' (Joshua). However, periods of more sustained non-compliance (ranging from several days to over a week) were also self-reported by individuals.

Individuals' motivation apropos complying with pharmacological treatment is vital, when, as Harrison (2008 p. 2) points out, 'treatment is in the pill form and administered by the offender', emphasising the need for individuals to want to change and take medication to achieve this. Considering the uncertainty regarding compliance post-release voiced by some of our participants (see sub-theme 2.1), the importance of motivation and engagement becomes particularly vital when individuals are being released into the community; a less controlled environment, where the level of support for the medication is reduced and, as such, their motivation may wane.

### *Sub-theme 2.3: Side effects of the medication*

The majority of participants (11/13) reported at least one side effect they associated with the medication, including: constipation, sweating, headaches, tiredness and/or nausea. In only a small number of cases did individuals find these unmanageable, with most participants

acknowledging that ‘they’ve gone within a couple a day or two so’ (Peter) or reporting they were ‘adjusting to the medication’ (Evan). This supports the literature regarding the transient nature of most side effects experienced with SSRIs (Bourget & Bradford, 2008).

Additionally, some individuals reported developing techniques to manage these effects: ‘but err I take two at the moment err at night because if I take them during the daytime it tends to make me drowsy’ (Joshua).

### ***Study one: Conclusions***

Participants reported reduced levels of sexual preoccupation and/or hypersexuality, and it appears that the SSRIs were acting effectively as an anti-libidinal agent. There were some issues with offenders’ compliance and engagement on the medication, either as a result of side effects and/or the difficulties in achieving physical arousal. The latter is interesting in that individuals reported feeling happy about the reduction in sexual preoccupation (thinking about sex all the time), but less happy with the reduced capacity to perform the act of masturbation and ejaculation. Despite such issues, participants appear able to manage and overcome these challenges and compliance and engagement within this group seemed generally high. This may be a consequence of the medication being voluntary, ensuring that the individual is choosing to engage with the treatment and is motivated to reduce their sexual preoccupations and hypersexual behaviours. However, this level of compliance may not be demonstrated in circumstances in which the treatment is mandatory or motivation for the treatment may be different (to secure release). As such, developing our understanding of the factors that impact upon compliance will be important as decisions are made about these individuals regarding their level of risk, and subsequently movement through the prison system or release into the community.

This treatment is by no means viewed as a cure and despite the improvements, participants demonstrate an understanding that if they stop taking the medication, without additional treatment, they would revert back to their situation prior to the medication. As such, all participants accentuated that the medication should not be seen as a replacement to psychological treatment and instead felt that they worked well together. Combining psychological treatment and SSRIs appears most effective, with the former offering insight and techniques to manage inappropriate sexual interests and the latter improving overall well-being through the reduction of a range of symptoms, which in turn enhances the

implementation of psychological techniques. The increased effectiveness of this combination in comparison to mono-therapy, is supported in the literature (e.g. Saleh et al., 2010; Guay, 2009).

A number of limitations with this study are worth noting. First, as these findings are based purely on the self-report of offenders during interviews, the possibility that they were providing socially desirable responses must be considered. However, the voluntary nature of the treatment allows us to assume that participants would have little to gain from providing false effects of the medication to researchers. Further, lengthy interviews were conducted with all participants, typically with 1-2 follow-up interviews. This extended engagement provided the opportunity to build rapport and ‘improve the interviewer’s chances of overcoming potential social desirability biases and getting at the truth’ (Rubin 2000, p. 175). As with all qualitative research, this study presents a relatively small sample size and so the ability to generalise to wider populations is limited. However, despite the limitations, the authors consider that these findings inform our knowledge surrounding the use of effective medical treatment for sexual offenders and support the wider programme of evaluation.

Finally, it should also be noted that a small number of our participants chose to stop taking the medication at some point in their treatment journey; however, without exception, all drop-outs subsequently asked to return to the medication. The complex treatment journeys of individuals referred for pharmacological treatment may inform our understanding of the role that sexual preoccupation plays in these individuals’ lives (see Winder, Lievesley, Elliott, Norman & Kaul, 2014, in press).

## **Study two: Results and discussion**

Three main themes emerged from the analysis of therapist-participants’ narratives (see table 4 for delineation of themes); each theme is discussed below.

### **INSERT TABLE 4**

#### ***Superordinate theme 1: Offenders’ reluctance to engage with pharmacological treatment***

Participants reported offenders’ reluctance to taking the medication, highlighting concerns

about the impact and side effects, or a lack of awareness by offenders of their sexual preoccupation as a problem.

*Sub-theme 1.1: Offenders' concerns about pharmacological treatment*

Therapist-participants provided consonant explanations for why offenders were reluctant to the medication:

He seemed to think that once he started the medication that would be it for life but that would also then effectively chemically castrate him and he thought that that was permanent...because I think unfortunately it was a lot of rumours start flying around about the different medications. (Tony)

When I did a referral a while ago, he really didn't want to take the anti-libidinal<sup>2</sup> medication in compared to the SSRI because of the side effects of it. And he'd heard there were quite strong side effects and it had been bandied around about getting boobs and things and so he was really quite anxious about that. (Chris)

They're a bit dodgy about going on to the other one [anti-androgen] because they think they're gunna lose their manlihood. (Charlie)

These accounts highlight the challenges faced by treatment providers in encouraging suitable offenders to consider pharmacological treatment. Rumours circulate within any prison environment, and in this instance they serve to increase trepidation about taking the medication. Therapist-participants describe the concern around the side effects of the medication and also highlight offenders' fear of an inability to engage in sexual relationships indefinitely and 'thinking that they'll never be able to be aroused again' (Ashley).

Rumours arise in ambiguous situations and are used to restore a sense of control and reduce anxiety (Bordia & DiFonzo, 2004). Thus, there is a need for increased availability of information on the medication to reduce anxiety and the spreading and acceptance of false or exaggerated rumours. Nevertheless, it should be noted these rumours are not all false, as research indicates potential side effects of anti-androgen medication (including CPA) such as

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<sup>2</sup> Anti-libidinals is the term used by participants to describe anti-androgens (CPA).



gynecomastia (Bradford, 2001; Giltay & Gooren, 2009; Rainey & Harrison, 2008). However, this information should be readily available in appropriate format to educate offenders. In addition, offenders should be made aware of the long-term goal of the medication which is not to suppress all sexual drive and create an asexual individual, but to selectively suppress deviant sexual urges and fantasies (Thibaut et al., 2010). Informing offenders of all the possible implications and side effects should help instil confidence in the treatment and reduce the reluctance currently apparent in some offenders who may benefit from it.

*Sub-theme 1.2: Poor insight into the need for medication*

Therapists perceived that offenders' lack of insight into the problematic link between their level of sexual preoccupation and risk was another barrier to individuals taking the medication:

He very much saw himself as actually being ok and not being a risk...Urm, so, as much as I tried to work with him to get him to see the benefits [of medication] he was quite reluctant. (Sam)

In my opinion it would be maybe guys that are at later, through their sentence and have maybe done some group work because they'll be more aware of what sexual preoccupation is and whether it's a problem for them urm and I think until maybe they're aware of that treatment need, they might not know, right this is a problem for me there's something [medication] that can help me. (Alex)

These accounts describe offenders who demonstrated a risk attributable to high levels of sexual preoccupation, but who may not consider taking medication, as they do not accept, or are unaware, that this is a risk factor for them. Alex explained that poor problem recognition and lack of awareness of the risks associated with sexually deviant thoughts are only likely to be addressed in group treatment. Consequently, until this point offenders may not consider medication as beneficial. As well as issues with problem recognition, many participants explained that offenders believe disclosing a need for pharmacological treatment increases their perceived risk level, increasing reluctance to do so:

A lot of them see that if they disclose high levels of preoccupation that actually that's gonna actually make them feel more risky. (Jo)

...those guys who aren't really aware of the bigger picture, they might see that the parole board believes it to increase their risk by going on medication, because then they're admitting to being riskier. (Tony)

These extracts reflect the majority of participants' views that offenders believe admitting a need increases risk. Tony in particular referred to offenders who are not 'aware of the bigger picture', indicating their lack of insight is a causal factor here.

It is widely accepted that poor problem recognition inhibits offenders' engagement and progress in therapy (Levenson, Macgowan, Morin & Cotter, 2009) and it is reasonable to apply this to pharmacological treatment. Perhaps more worrying is the indication that offenders are reluctant to disclose their sexual preoccupation due to fear of increasing their perceived riskiness. Burrowes and Needs' (2009) Barriers to Change model describes the 'perceived cost benefit analysis of change' (p. 45) as a potential barrier to treatment. This model would help to elucidate why some offenders may believe the costs of change outweigh the benefits, leading to low treatment readiness. Finally, participants revealed that many offenders were not even aware of the pharmacological treatment available:

The amount of people that I've actually met and gone 'do you know this [medication]' and their like 'no I've never heard of that before' (Jo)

So if you've got a prisoner here that's got a high level of sexual preoccupation but he hasn't done any group work and hasn't really had any kind of time with urm psychology department then I'm doubtful they even are aware that it's [medication] available. (Alex)

But if they're not open at that stage [induction interview], you know they might miss the opportunity you know through not knowing that it's [pharmacology] available. (Billy)

Jo highlighted experiences of meeting offenders who have never heard of the medication. Alex and Billy explained this lack of awareness may be due to information on the medication only being available at certain stages in a prison sentence.

This theme accentuates the importance of working with individuals to help them to recognise sexual preoccupation and take responsibility of their risk. Education with respect to both offenders and staff is required, so that sexual preoccupation and hypersexuality is recognised and acknowledged and treated as a positive step towards an individual taking responsibility for their risk.

### ***Superordinate theme 2: Challenges for therapists***

Participants expressed concern about lack of awareness regarding aspects of the pharmacological treatment process among themselves and those outside psychology and/or healthcare.

#### *Sub-theme 2.1: Lack of feedback about referrals*

Participants perceived the referral process as a one-way system, claiming that once they submitted a referral, they did not find out whether the offender started taking medication or not:

So you really just feel like you're just the messenger, and then you're giving it [referral form] to them and they'll do whatever they will with it. So, when you say 'what do you hope to gain from it', you don't have the power to hope. (Charlie)

...whilst the referrals come through psychology it almost feels like an outside process and not that much to do with us in some respects. (Ashley)

These extracts represent the narrative of all participants; that referrals are an 'outside process'. Charlie's extract portrays a sense of feeling unjustly uninvolved in the referral process, indicated by the statement of being powerless. Ashley explains that the divide between departments in the prison hindered the process of gaining feedback on offenders' referrals.

Participants were keen to communicate the benefits of getting feedback on the referrals they made:

If I was doing risk assessment or continuing to work with that person like in offender management or a probation officer I would suspect that they would want to know kind of, a regular kind of update, in terms of how the guy's doing on the medication. (Chris)

...if we know that they're still getting them from healthcare, then that's something. And that combined with their self-reports should give us more evidence to see, if they are taking them and it is working. (Alex)

Chris's extract captures the views of most participants, that awareness of who is on medication is important for all parties involved in an offender's sentence plan. Alex also commented that feedback could increase the reliability of self-reports. Other benefits of feedback were identified as being a consequence of: (i) informing staff if a referral was 'the right referral to make or did they not go on to have medication?' (Chris); (ii) preventing therapists from a 'false sense of security that this guy's actually, somehow, maybe cognitively challenging his fantasies and his level of masturbation when actually it's, it may be the medication that's doing that' (Jo); and (iii) 'keeping them [prisoner] updated as to the stage they were at with the whole consent process and who's looking at it, what it means, when the next time frame will be' (Tony). Ashley provides a succinct summary of the benefits of improved communication and providing feedback to therapists stating it will promote 'more of a, I suppose end-to-end offender management in a way because it's more holistic.'

This theme demonstrates participants desire to have more involvement in the pharmacology process, consistent with the aim of the National Offender Management Service (NOMS) Offender Management Model (OMM) (Grapes, 2006), to promote 'a single, universal, core, end-to-end process which transcends the separate contributions of the main providers' (p.12).

### *Sub-theme 2.2: Being on the outside*

Participants discussed the lack of awareness and involvement in the pharmacology process among those outside of psychology:

I think possibly it [referral form] could be promoted a bit more to staff. Because I think that people outside of psychology don't have a lot of confidence in filling in that type of

stuff or feel that it's just psychology's job, when everyone's involved in terms of risk and management. (Ashley)

You might have a prisoner that comes to their personal officer, because they feel comfortable talking to that person and they [personal officer] might not really know a lot about it [medication]. And they might not have the confidence to put an application into psychology or go and speak to healthcare. (Alex)

Ashley and Alex emphasised those outside psychology may lack confidence to complete referral forms and discussed a potential lack of awareness of responsibility to do so. This was supported by Chris who stated 'officers on the wing particularly would just kind of think oh it's [pharmacology] not my area and just dismiss it'. Most participants expressed that staff who do not have 'that experience of dealing with guys who have intrusive thoughts', 'some more guidance would be useful' (Jo). Furthermore, Alex highlights that it may be those outside psychology who offenders confide in. Thus, increased awareness in what sexual preoccupation is and how medication can help is important for all prison staff and is likely to increase staff taking responsibility for making referrals.

Finally, an important extract from Jo's data set indicates that 'outsiders' sometimes have unhelpful views about the pharmacology:

...he said the last time he raised the medication in another jail that his probation officer told him that that would go against him at a parole board hearing. (Jo)

Jo also stated that some prisoner officers feel medication is 'just a way of cheating, you know, anyone can take medication' but that 'negative attitudes come from just lack of awareness' (Jo). Although this view was only expressed by Jo, it is important to note, as it is another example of why increased knowledge about pharmacological treatment is important.

This sub-theme has illustrated that staff outside of psychology may be unaware of the pharmacological referral process or the putative benefits of pharmacological treatment. However, it may be members of staff, such as wing officers, to whom offenders confide their sexual preoccupation. In addition, increased knowledge of the pharmacological methods available may help to reduce the rumours that circulate and cause concern among prisoners (see staff sub-theme 1.1). As the first point of call to a prison's services and given their daily

contact with offenders, prison officers may play a crucial role in the pharmacological referral process (Crewe, 2011).

This theme suggests a programme of education and training is needed with those outside psychology in the types of behaviours that may indicate a need for medication. The referral loop should also be examined and moved to a two-way system where each referral, irrespective of the outcome, results in feedback being provided to the original referrer, as well as those involved in the offender's treatment and supervision.

### ***Superordinate theme 3: Pharmacology: 'just another piece of the puzzle'***

All therapist-participants expressed positive attitudes towards pharmacological treatment; they emphasised the fact that the medication should not be viewed as a 'cure' or something that can work alone, but rather it was 'just another piece of the puzzle really to kind of help the guys make some of the changes that they need to' (Tony).

#### *Sub-theme 3.1: Psychology and pharmacology working together*

All therapist-participants promulgated pharmacological treatment in conjunction with psychological treatment:

But it [medication] needs to be ran alongside something else. In the same way that I'm running a really good programme with the guy but without the medication it's not going to be beneficial. (Charlie)

I don't think it [medication] should ever be used as a standalone because I don't think that it is the cure as I've said. And I don't think that should ever be the intention behind the medication because ultimately they can stop taking it at any point and so therefore they're kind of left with nothing. (Chris)

These extracts reflect the consistent view among participants that psychological work alongside pharmacology is extremely important because, without psychological treatment, offenders could stop taking the medication at any time and be left with no other strategies to stop their offence related thoughts and desires. Sam reported the experience of an offender who 'was still having a lot of sexual thoughts every day' but 'found it harder to ejaculate'. Sam went on to explain that 'he hadn't done much treatment so he wasn't very

knowledgeable so he basically expanded his sexual thoughts to become more graphic, to allow him to ejaculate'. Sam's extract as well as findings from study one highlight how delayed ejaculation can lead to offenders resorting to changing unhealthy fantasies in order to reach orgasm.

The increased effectiveness of combining psychological work and pharmacology in the treatment of sexual offenders is widely accepted (Guay, 2009; Hall & Hall, 2007; Krauss et al., 2006; Mann & Marshall, 2009). Gordon and Grubin (2004) assert that there are high dropout rates with pharmacological treatment, and therefore medication should almost always be combined with psychological interventions.

### *Sub-theme 3.2: Importance of throughcare*

The notion of throughcare, to provide continuous care or treatment post-release, was also highlighted by the majority (6/8) of participants as being important, claiming that pharmacology is 'a really good idea but the throughcare is also really important too' (Ashley) because 'it [medication] needs to be followed up in the community as well' (Billy):

It's about not just communicating with us, but making that link with the offender manager, and ensuring that he's got a doctor that continues to prescribe it out there and all of that will need to be in place. I think it's really important because that's where his de-stabilizers are gunna be, that's where his triggers are gunna be, more so. (Charlie)

Charlie explained that ensuring support is available to promote the continuation of medication on release is vital due to the change in environment increasing offenders' risk. Others emphasised the importance of offenders taking responsibility, to ensure continuation into the community:

Managing their sexual thoughts is their responsibility. I'm only giving them tools to do that and once I've gone, its gunna be up to them or once their released its gunna be up to them so really, I try and get across the responsibility is pretty much all them. (Sam)

It's gunna be their responsibility to manage it [medication] in the community. It's their responsibility to manage all of their risk, not just around sexual preoccupation. (Alex)

The above narratives place emphasis on 'them managing themselves' (Alex), highlighting the

importance of offenders taking responsibility for their medication as ‘there is no control, particularly in the out like in the community’ and ‘so there is no point in forcing somebody into doing it because it’s not gunna have a long lasting effect’ (Chris). However, Charlie explained that often motivation to continue medication declines on release:

Sometimes they are less inclined to take it when they are released because they think they are ok and oh parole board have said I’m fine to go out, I don’t need anything.  
(Charlie)

Charlie described a classic misconception of patients taking medications; when it works patients often stop taking the medication (O’Donhue & Levensky, 2006). Reduced motivation on release is a recognised concept and accentuates the importance in ensuring those involved in care in the community are aware of the potential need to re-engage offenders in treatment, even when motivation in prison was high (Barrett, Wilson & Long, 2003). This is particularly the case as the association between motivation and increased responsibility to change is an established phenomenon within sexual offender treatment (Garland & Dougher, 1991; Tierney & McCabe, 2002).

Participants also commented on other difficulties faced with the medication during throughcare:

...he was released to an area where there wasn’t a psychiatrist that was sort of on board with the process...I think he went out with a week’s worth of medication. (Sam)

When it’s difficult to chase that information [regarding who is on medication] we’re not then able to share it with the people who are going to be managing them in the community...and they are the people who need to know really when they’re getting released. (Ashley)

These extracts demonstrate gaps in the current throughcare process. In particular, Sam’s narrative raises the concern that continuing medication in the community can be subject to the attitudes of GPs and this may cause additional challenges for individuals. This highlights the need for more support and collaboration to promote the throughcare of medication, particularly as stimuli associated with risk and re-offending are intensified in the community (Lussier, Dahabieh, Deslauriers-Varin & Thomson, 2011). To provide this support, staff



involved must be informed who is on medication, reinforcing the data within the sub-theme 2.1.

*Sub-theme 3.3: Therapists' recognising where medication will help*

Staff reported relying heavily on offenders' self-reports to identify who needed medication. Ashley provided a range of reasons for referral which reflected the views of all participants: (i) 'if they were reporting a level of sexual thoughts that was unhelpful for them'; (ii) 'if they are reporting what appears to be a high level of sexual preoccupation in custody like masturbating several times a day'; (iii) if 'they're reporting offence related thoughts'; and (iv) 'if they're saying things like they can't focus on education because of the level of these thoughts'. Other participants explained offenders may disclose that their sexual arousal is 'uncontrollable', for example, reporting they are 'becoming aroused when they don't want to' (Sam).

Participants also discussed why they would not refer individuals for medication: (i) if an offender has 'got a number of strategies they can use', (ii) 'if they've used distraction as a technique, if that's been successful for them' (Ashley), (iii) 'if they are telling me that they are managing whatever it is that might be happening whatever the sexual thoughts about... with techniques of some description' (Sam). Ashley also highlighted that deciding not to refer 'relies on self-report largely'. However, there was an agreement among most therapist-participants that they would rather refer than not:

But I would never just diss...if I thought that somebody would benefit from it I wouldn't just dismiss that and not refer them. (Chris)

This sub-theme illustrates how heavily staff rely on offenders' self-reports to recognise a need for medication. This simply reinforces the conclusions thus far; that all staff must be involved in the referral of medication to ensure that any offender who discloses a need is followed up and addressed. This sub-theme also illustrates participants' reasons for referral, all of which are in line with Guay's (2009) recommendations for characteristics and behaviours which indicate pharmacological treatment would be suitable. Moreover, participants' preference to refer rather than not demonstrates an inclusive approach for all offenders who may need medication.

### *Study two: Conclusions*

This research highlights areas for improvement as well as of good practice with the pharmacological treatment in this study. An increased knowledge of the medication, both for offenders and staff outside of psychology and healthcare is essential, in order to reduce uninformed decisions by offenders and increase awareness and confidence to refer among staff. As a general rule, institutions provide inductions to groups of staff when new programmes are introduced, however this research indicates that this alone is not sufficient. Specific training is necessary to educate those staff who are not initially involved in the development of a treatment. This should focus on: the pharmacological procedures (including referrals and long terms goals of the treatment); the effects and side effects of medication; behaviours/self-reports indicative of a need for medication; and emphasising the importance of all staffs' responsibility to refer. Participants (who work within psychology) displayed good ability in the referral process. However, if the need for medication can be established earlier in an offender's sentence, this will encourage the individual to address their risk and possibly improve the effectiveness of psychological programmes by reducing sexual preoccupation and increasing the offender's ability to focus on treatment.

One of the most consistent concepts within the data set was the emphasis on the medication not being used alone. Participants felt strongly about this, reflected in their frequent discussion of the need for psychological work alongside. In addition, the importance of support into the community was accentuated by most, highlighting the need for the throughcare process to be carefully and appropriately tailored for offenders taking medication. The desire for feedback about referrals was also a prevailing topic across participants, with many benefits cited, and is therefore highlighted as an essential area for improvement (although confidentiality must be considered).

A limitation of this study worth noting is that participants did not always have detailed insight into all the areas probed by the interview schedule, due to their differing roles and experiences. However, the data provided a rich overall perspective of the pharmacological procedures, allowing recommendations to be made for the institution, some of which are already being applied. For example, training days for staff both in and out of psychology (e.g. wing staff, Offender Management Unit staff) have already been completed following this research. There is also the potential limitation of respondent bias due to social desirability (Rubin, 2000), particularly as the participants were staff. However, during

interviews, participants appeared open in their responses and discussed freely their lack of knowledge in certain areas of enquiry. Moreover, where applicable, findings were consistent with offenders' perspectives (see study one).

To conclude, the findings of this research depict that adopting a multidisciplinary approach to the pharmacological intervention, where information sharing and collaboration are frequent, will encourage end-to-end offender management. This will contribute to a more successful delivery of the pharmacological treatment, which adheres to NOMS business objectives of crime reduction, public protection and offender reform (Turley, Ludford, Callanan & Barnard, 2011).

### **General conclusions**

The studies presented here are part of a comprehensive mixed-method programme of research to evaluate pharmacological treatment with sexually preoccupied sexual offenders in custody. The qualitative studies presented in this paper add an additional dimension to the quantitative research evaluating the effectiveness of the pharmacological treatment in that it allows for an exploration of personal experiences, both from the perspective of offenders taking the medication, and (in study two), a better understanding of the views of therapists working with sexually preoccupied sex offenders.

Findings from study one demonstrate that offenders did not view medication as a 'cure' and understood that if they stopped taking the medication, they would revert back to their previous states of sexual preoccupation. This corroborates with therapist-participants' views in study two. Both sets of participants asserted their beliefs that pharmacological treatment would not work as a replacement for psychological treatment, with the latter giving individuals skills and tools to manage their risk generally. This finding is also supported by literature (Guay 2009; Thibaut et al., 2010.). Importantly, findings from both study one and two supported each other in terms of effects of the medication in reducing sexual preoccupation (Lievesley et al., 2012).

Whilst it is fair to claim that qualitative research can make only a limited contribution to studies evaluating the effectiveness of interventions per se, the authors consider that such methods can have a substantive role in contributing to understanding the effectiveness of interventions more generally. The rich data derived from this type of research can help us to understand the context and individuals that comprise an important part of the evaluation,

revealing, in this instance: the need for further education of prison staff and offenders apropos the medication; a change in the referrals process such that a feedback loop is set up for all referrals; and further research exploring factors affecting compliance and engagement. These studies have contributed to our knowledge around the use of pharmacological treatment for sexually preoccupied sexual offenders in custody, offering a more holistic understanding of the effectiveness of this medication, and the diverse factors that might facilitate or impede its utility.

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**Tables**

Table 1: Participant Information (Study 1)

<b>Participant</b>	<b>Marital Status</b>	<b>Index offence(s)</b>	<b>Previous non-contact sexual offences?</b>	<b>Previous contact sexual offences?</b>	<b>Fluoxetine dose</b>	<b>Length of time on medication</b>
1	Single	Rape (child) x 3 Attempted buggery x 2 Rape (adult) x 2 Indecent assault (child) x 3	Yes	Yes	20mg	4 months
2	Divorced	Rape (adult) x 2	No	Yes	20mg	7 months
3	Single	Sexual assault (child)	No	Yes	20mg	3 months
4	Single	Sexual activity with a child	No	Yes	20mg	11 months
5	Single	Possessing indecent images	Yes	Yes	40mg	9 months
6	Single	Murder Indecent exposure x 5	Yes	No	20mg	7 months
7	Divorced	Indecent assault (child)	Yes	Yes	40mg	19 months
8	Single	Sexual assault (child)	No	Yes	20mg	9 months
9	Divorced	Sexual assault (child) x 2 Rape (child) x 12 Sexual activity with a child	No	No	20mg	6 months
10	Single	Murder	No	No	20mg	5 months
11	Single	Sexual activity with a child	No	Yes	40mg	11 months
12	Single	Indecent assault (child) x 5 Buggery	No	Yes	40mg	18 months
13	Divorced	Rape (child)	No	Yes	20mg	3 weeks

Table 2: Participant Information (Study 2)

<b>Key:</b>				
HSF = Healthy Sexual Functioning				
SOTP = Sexual Offender Treatment Programme				
<b>Job titles of participants:</b> Chartered forensic psychologist; Group work facilitator; Psychology assistant; and Forensic psychologist in training				
<b>Participant</b>	<b>Style of Treatment Delivered</b>	<b>Type of Treatment Delivered</b>	<b>No. of Referrals</b>	<b>No. of offenders worked with on anti-libidinals</b>
Charlie	One-to-One	HSF	3+	3+
Tony	Group	Living Skills Programme	1-3	1-3
Ashley	Neither	N/A	0	1-3
Chris	Both	SOTP & HSF	3+	1-3
Sam	Both	SOTP & HSF	1-3	1-3
Billy	Group	SOTP	1-3	1-3
Alex	Group	SOTP	0	1-3
Jo	Group	SOTP	3+	3+

Table 3: Superordinate and sub-themes (Study 1)

<b>Superordinate Themes</b>	<b>Sub-themes</b>
Impact of the pharmacological treatment on prisoners' daily functioning	A clearer way of thinking: from sexually preoccupied to 'human'
	Reduced sexual arousal: a cost or benefit?
	Managing negative emotions
Barriers to compliance and engagement	Participant concerns
	Not fully engaged
	Side effects of the medication

Table 4: Superordinate and sub-themes (Study 2)

<b>Superordinate Themes</b>	<b>Sub-themes</b>
Offenders' reluctance to engage with pharmacological treatment	Offenders' concerns about pharmacological treatment
	Poor insight into the need for medication
Challenges for therapists	Lack of feedback about referrals
	Being on the outside
Pharmacology: 'just another piece of the puzzle'	Psychology and pharmacology working together
	Importance of throughcare
	Therapists' recognising where medication will help