

Fantasy Management in sex offender treatment

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Abstract

Sexual fantasies of sex offenders are a difficult therapeutic issue. First, there is not much we know about sexual fantasies in general. In the second place, the question rises as to what role sexual fantasies play as a risk factor in sexual abuse. And third, there's the difficult task for therapists on how they may affect sexual fantasies of their client (if they choose at all to address the issue). In this article we reflect on how to manage fantasies, which possibly sustain a relapse arousal pattern, therapeutically.

Key words: Sex offenders, fantasies, sexual arousal, risk management

Some forensic reflections on sexual fantasies

If you wish to research literature on sexual fantasies in sex offenders, you will meet some problems. First there is a confusing use of terms. Thus, when discussing risk factors in sex offenders one may find references to deviant sexual arousal, sexual preference or orientation, sexual interest, deviant sexual desire, sexual deviation and deviant sexual fantasies.

We weren't able to find a consensus regarding these definitions and it falls outside the scope of this article to do this here in a scientific way. However, we stress the importance of using these sexological concepts in a systematic way in our forensic practices (see eg. Janssen, Everaerd, Spiering & Janssen, 2000 and Janssen, McBride, Yarber, Hill & Butler, 2008). Here are some proposals. Arousal refers to measurable physiological processes (eg. erection). It is important for this purpose to keep in mind that all these concepts can exist with or without sexual fantasies.

Plaud and Bigwood (1997) define a sexual fantasy as "a private or covert experience in which the imagination of desirable sexual activity with a partner is sexually arousing to the individual" (p. 222). It strikes us that this definition only takes desired activities associated with positive feelings (excitement) into account. "Sexual fantasy" mostly refers to any mental imagery that is sexually arousing or erotic to the individual. The definition of Leitenberg and Henning (1995) refers to sexual fantasies as "almost any mental imagination for someone who is erotic or leads to sexual arousal" (p.470). A sexual fantasy can be an extended story, a fleeting thought, or a jumble of images and memories that flash in a chaotic order. The content may be bizarre or realistic. I may even be non-sexual and yet lead to excitement. The fantasy may occur spontaneously, can be cued deliberately, or can be generated by other thoughts, feelings or sensory information (Wilson, 1978).

Today we do not know so much about sexual fantasies among sex offenders. Do offenders fantasize more and in other ways than the average citizen? How can one really be sure that a specific fantasy of a particular offender increases the risk in relapse? What exactly makes a fantasy deviant and how do these fantasies evolve? Are masturbation and orgasm the only reinforcers? What is the effect of delaying orgasm whilst masturbating in order to become an even bigger "fantasmorgasm" (dixit one client)? And the excuse often heard "I've masturbated to a deviant

fantasy to ensure that I wouldn't do it in real life", is it always and at all times a distortion?

Leitenberg and Henning (1995) found four types of fantasies in a normal population. Whether these occur in the same way in sex offenders, we don't know for sure, but they at least have clinical relevance in working with offenders:

1. "Normal" sexual fantasies of past, current or imagined partners. Although many people also have 'unusual' fantasies, Leitenberg and Henning indicate they were surprised to find that these "normal" fantasies are by far the most common.
2. "Bold" or "forbidden" fantasies: unusual places, questionable partners (eg, total strangers, scary family members, colleagues, ...) or special sexual activities.
3. Fantasies about sexual irresistibility: through sheer sexual charisma seduce unwillingly others to have sex with you.
4. Fantasies of domination and submission: to force or to be forced to have sex.

This last category is not that unusual. Person (1986) found that 44% of surveyed men have sexual dominance fantasies. Malamuth (1986) found that one third of a group of young males indicate to be able to rape, if they can be 100% sure they won't get caught. Heilbrun and Loftus (1986) found that at least 30% of male respondents find images of women in emotional distress sexually more attractive than pictures of women who radiated joy. Studies about the raping of relatives (Warshaw, 1988) and of partners (Finkelhor & Yllo, 1985) show that both of these perpetrators often use sadomasochistic porn prior to the assault. But Donnelly and Fraser (1998) found that men experience more arousal in fantasizing about sadomasochist practices than women do, but when practiced in reality that difference disappears.

Unusual sexual and abuse related fantasies are present in the broad population. Offenders tell us that these fantasies have different functions to them such as: assistance to push up masturbation excitement; assistance to be able to flee and drift away from an unpleasant situation; provide consolation and relief; soothing; experience a perfect sexual encounter. On the other hand sexual fantasies do not necessarily have to be associated with only positive feelings. Clients report that they are often accompanied with feelings of guilt, loss of control, powerlessness, being handed down, feeling dirty, etc., but that nevertheless the fantasy-arousal-orgasm cycle sustains.

In 1908 Freud stated (1962, p. 146) that only unsatisfied people have sexual fantasies. However, studies on human sexual behavior have proven exactly the opposite. Sexual fantasies have been shown to be associated with high libido as defined by high sex drive and orgasm frequency. Leitenberg and Henning (1995) found that those who fantasize a lot, have more (varied) sex, more partners and also masturbate more. Sexual fantasies and appetite thus seem to go together. There is nothing wrong with fantasizing in itself. On the contrary, it might be a key element for a healthy psycho-sexual functioning.

Why should we do fantasy work with offenders?

"Sexual deviation" is often indicated as a possible risk factor for recidivism of sexual abuse (see eg Hanson & Buisson, 1996). The Sexual Violence Risk 20 (SVR-20) infers sexual deviation in a paraphilia related way from fantasies, urges, physiological arousal and behaviour (Boer, Hart, Kropp & Webster, 1997). The link between fantasy and behavior is not direct (Donnelly & Fraser, 1998). Those who fantasize about rape, do not necessarily become rapists. And those who fantasize about being raped, do not want this to happen in real life. Similarly, there is no evidence that sexual excitement found in laboratory conditions corresponds with actual sexual behaviour in real life (Barker & Howell, 1992; Hall, Proctor & Nelson, 1988; Simon & Schouten, 1991). Not all sexual

offenders have a sexual arousal pattern that is fully consistent with their offenses (Hall, Proctor & Nelson, 1988; Marshall & Eccles, 1991). Only 22% of child abuse offenders indicate to have fantasized about children prior to their first offense (Leitenberg & Henning, 1995). There are several possible pathways leading to a first offense, and fantasies do not necessarily play a part in this. We can assume that many, if not all perpetrators have memories of their first offense and that fantasies through memories or a consciously created stimulation can play a growing role. But does this mean that all sex offenders fantasize while masturbating?

First, one can question whether all sex offenders masturbate. With witticism it is sometimes said that 95% of men masturbate and the other 5% lie. According to the authoritative studies by Alfred Kinsey and his team (Kinsey, Pomeroy & Martin, 1948, pp. 499) the percentage of adult males that masturbate is 92% (in women that is 62%). Gerressu, Mercer, Graham, Welling and Johnson (2007) showed that 53% of men reported to have masturbated in the past week (18% of female respondents). The witticism is false. But is this also true for sex offenders?

A second question is whether everyone who masturbates also fantasizes? Leitenberg and Henning (1995) report that approximately 86% of masturbating men indicate fantasizing during masturbation (69% of women). 76% of men and 70% of women fantasize during intercourse and in other situations (eg daydreaming) these percentages are 93% and 85%, respectively. Person (1986) found that only 5% never sexually fantasize. Those who worry about their fantasies and feel guilty about them, are less satisfied about their sex life. Moreover, these feelings of guilt - again according to Person - do not refer to the content of deviant fantasies, but rather correspond to ideological and religious beliefs. Whether this is also the case in sex offenders, we don't know.

And thirdly, there is the pertinent question whether sex offenders masturbate with abuse-related fantasies? One of the few studies in this area was carried out by O'Connell (1998). He found that only 26% of the 127 research subjects spontaneously admitted to masturbating to abuse fantasies. After polygraph testing 54% admitted it (69 of 127). A small majority indicated that their offenses were accompanied by some form of indirect sexual rehearsal and reinforcement. Daleiden, Kaufman, Hilliker and O'Neil (1998) even found that adolescent offenders of both sexual and non-sexual violence had less "deviant" sexual fantasies comparable to those of non-criminal youth.

We can cautiously conclude that probably not all sex offenders use masturbation fantasies. From sexological practice it is known that masturbation without fantasizing is possible. Clients report that they can concentrate on the good feelings, the sensory stimulation. There are also "sexual thoughts or cognitions", but they are not accompanied by visual images or memories. We must be careful with generalizations when we talk about the role of fantasies in recidivism risk. Through group therapy discussions about "the role of fantasies" we distinguish four features which may play a role in the abuse cycle:

1. maintain the arousal pattern, and often even spark it
2. sustain cognitive distortions about themselves, the world and about victims
3. try out scenarios and elaborate them ("covert rehearsal", see Laws, 2003)
4. keep the road to recidivism open

Emotional bond

Deciding to give up abuse is one step, preparing oneself to tackle longtime cherished fantasies is quite a different one. They can have become a trusted partner in life, so that a black hole is waiting when thinking about giving them up. What strikes me is the commitment of some clients to their fantasies. Years, sometimes decades, they have been the lifeline, the ally, the refuge, the soul

mate, the source of comfort. The client could always rely on them. It's important to realize this before starting fantasy management. Is the client prepared to say goodbye to them or does he want to continue using them like before? Is he ready? Is he ready to "mourn"? There is no fantasy management without the motivation and consent of the client.

According to results reported by McAnulty and Adams (1991), men are more successful at suppressing cognitive arousals than physiological ones. The authors proposed that this was the result of "emotional distancing" (p. 574) and that participants processed the stimuli as cognitively arousing. However, once an erection had occurred, they were not able to control it anymore. On the other hand, subjects in a study conducted by Adams, Motsinger, McAnulty and Moore (1992) claimed that they were unable to control their cognitive arousal (interest), but managed to suppress an erection. During the debriefing of a study by Mahoney and Strassberg (1991) participants were asked to describe the technique they used to suppress an erection. Most indicated that they had tried to observe the stimuli in a detached way. It would therefore appear that the most effective technique for minimizing physiological sexual arousal is "emotional detachment" (Mahoney & Strassberg, 1991).

This is not surprising. Emotional distancing is a well-known basic skill in emotion regulation (Gross, 2002; Ochsner & Gross, 2005). Several researchers and theorists have argued that sexual arousal is best understood as "emotional functioning" (Everaerd, Laan, Both & Spiering, 2001; Janssen, Everaerd, Spiering & Janssen, 2000; Lambie & Marcel, 2002). Through emotion regulation individuals are able to monitor which emotions they have and how they experience and express them. Emotion regulation may be automatic or controlled, conscious or unconscious. Emotions can be regulated whilst processing the emotional stimuli or after the response has been activated. Gross (2002) suggested that two different strategies can be used in order to down-regulate emotion. The first, reappraisal, comes early in the emotion-generative process. It consists of changing the way a situation is construed in order to decrease its emotional impact. The second, suppression, comes later and consists of inhibiting the outward signs of inner feelings. Gross cites studies that find reappraisal often to be more effective than suppression. Reappraisal can be achieved by distancing oneself from the situation or the emotional significance of the stimulus to review (see "urge surfing"). Lambie and Marcel (2002) described a similar process whereby an individual can regulate an emotional reaction by taking an objective perspective.

An ethical framework for Fantasy Management

Through a series of guidelines we want to mount a framework that can help to guide our attitude as a therapist in fantasy management.

1. Sexual fantasies are free and belong to everyone's intimate privacy.
2. The deviancy of a sexual fantasy is not its content, but the possible link to criminal sexual conduct.
3. Deviant fantasies may be managed, when the client thinks they are undesirable.
4. The emergence of a fantasy can not be controlled. Fantasy management is about how you deal with them.

Sexual fantasies are free and belong to everyone's intimate privacy (1). This is an ethical principle. The therapist must ethically justify himself before he can insist that the content of fantasies should be discussed in therapy. Embarrassment and shyness in talking about sexual fantasies is normal and healthy. We should rather worry about those clients who wish to share all the details of their sexual fantasies without being invited to do so. An ethical check can be done using the criteria of Carroll (1991). He formulated, based on the perspective of human rights, five principles on which

the client-offender may rely:

The right to informed consent: which options does he have and What are the sanctions? The right to a precise the therapeutic goal to which the therapist adheres. For Carroll, this can only be relapse prevention. Health or welfare can not be imposed onto a client. The right to choose for the least intrusive method, if two equivalent methods are available. The right not to let one's intimate life be intruded without explicit justification in the light of the relapse prevention goal. The right to a therapy duration proportionate to the crime committed. We will use these principles further on.

The deviancy of a sexual fantasy is not it's content, but the possible link with criminal sexual conduct (2). Not the deviant arousal is the root of the problem, but the damage caused by the behavior. This is the starting point from which to address fantasies (see Carroll, 1991). Williams, Cooper, Howell, Yuille and Paulhus (2009) found, based on laboratory research, no direct effect of pornography or sexual fantasies on deviant behavior. The effect which was found, could be explained by a mediating personality factor, especially psychopathy. We must be careful to point towards sexual fantasies as a single risk factor. It can be assumed that deviant sexual fantasies can be maintained through masturbation and the consumption of pornography. Therefore, it can be an hypothetical rule for therapy that fantasies are free, unless a link can be established with criminal behavior (keeping in mind that consuming child pornography is a criminal offense in itself).

Deviant fantasies may be managed, when the client thinks they're undesirable (3). For many types of mental health the effectiveness of treatment "is proportional to the degree of cooperation" (American Psychiatric Association 1967, p.1459). The choice of a goal that seems desirable and achievable leads to expectancies of success and therefore help to bring about favorable treatment outcomes (Deci, 1980). Predictions and expectations of goal achievement stimulate feelings of self-efficacy in the patient, which in turn spark action and effort in furtherance of the goal (Bandura 1997; Bandura 1986). With Carroll's view in mind it seems fair to discuss, with the client, how he relates to his fantasies. What about fantasies that differ only a little from his offenses? How far should the difference go to be "safe" again? Should he handle the strictest criterion ("above suspicion and out of danger", see Vanhoeck & Van Daele, 2011)? Undesirable fantasies offer an interesting therapeutical approach since it allows consideration. It refers directly to desired fantasies. Can any of them be considered "socially acceptable"? It also seems interesting to take a 'health' perspective. Given the history of the client, which fantasies does he perceive as being "healthy" for himself? Such an approach can not be imposed or enforced. The therapist should make the effort to discuss this with the client.

The emergence of a fantasy can not be controlled (4); fantasy management is about how to deal with them. A client can be held accountable for his handling of a fantasy once it has popped up. But we do not know what the mechanism is exactly which brings a fantasy to pop up. Also, we do know that thought suppression is not a good strategy to make cognitions disappear (Shingler, 2009). If we do not know how the emergence of a fantasy can be influenced or avoided, we should not expect clients to try this and feel guilty about failing. The moment a fantasy pops up in someone's mind doesn't seem to be preceded by "rational choice". Afterwards however, there are choices: what do I do now that this fantasy has come into my mind? Maybe the client doesn't have the feeling he has a choice. Some feel handed over to their fantasies. But this can often be explained by learned helplessness. It seems reasonable to expect our clients to deal with their fantasies in a responsible way. This does not mean to maintain, promote or reinforce them, but to decide not to give in. This may be an interesting subject for therapy: what can the client do in order not to get carried away by his fantasies?

Fantasy management in practice: a gradual approach

We propose, here below, a number of methods and techniques. Our arguments are based on the previously stated background and guidelines. We hope to inspire the reader to take 'sexual fantasy management' seriously. Simultaneously, we urge caution, because much in this area is uncertain. We advocate an ethical and economical use of resources based on a thorough and gradual preparation.

1st step: general psycho-education on sexual fantasies for all clients

2nd step: screening and careful 'need and requirement' assessment

3rd step: motivation enhancement and informed consent

4th step: mapping the current fantasies

5th step: questioning what is desirable and healthy

6th step: specific management techniques embedded in a psychotherapeutic approach

1st step: general psycho-education for all clients

Fantasies are an important theme in most sex offender treatments. Information about fantasies, how they can play a role in the offense chain, what is known and not known about them, how they can be handled responsibly. Group therapy lends itself to a psycho-educational approach in which information is given and a first cautious discussion is possible about urges, problem awareness and responsibility.

Marshall, Marshall and Ware (2009) warn that group therapy is not the right platform to reveal sexual fantasies associated with the crime. It might indeed increase, rather than decrease, sexual excitement in the other group members. This may distract them from focusing on the important issues in treatment and may provide them with additional deviant fantasy details.

2nd step: screening and careful need assessment

Marshall (1998) summarizes the literature and concludes that one must be cautious to focus treatment directly on sexual fantasies. On the one hand it is not proven that this will contribute to reducing recidivism rates. On the other hand several other techniques, which focus on other aspects of the functioning of the sex offender, might also indirectly influence his fantasies. Clients should be carefully screened in order to determine whether they might benefit from fantasy management: clients who suffer from their fantasies and/or are aware that they constitute a problem, as well as and clients whose fantasies may play a major role in the offense cycle and possibly in their relapse risk.

We can divide clients into four groups:

- Not everyone has fantasies and not all fantasies that play a role in sexual abuse are sexual in nature (eg, revenge fantasies). These clients don't need specific sexual fantasy management.

- Fantasies can have a coping function and be part of a strategy of short-term solace, comfort and satisfaction. Self-analysis, promoting coping skills and emotion regulation are important tools for these clients. Possibly, but perhaps not always, some fantasy management may be useful (cf. the problem drinker who does not drink daily).
- In case of major abuse fantasies which play an important role in masturbation practice, there is a serious problem and fantasy management makes sense (cf. the alcoholic addict).
- Finally, there are offenders who have intrusive and uncontrollable fantasies to which they feel surrendered. This group needs previous psychiatric screening (eg, PTSD, hypersexuality) and medical or psychiatric intervention should be considered before fantasy management is discussed.

When screening sex offenders, the question arises whether one believes what they say about their sexual fantasies? Since the consequences of telling the truth (i.e. a declaration of guilt and acceptance of responsibility) might be a big threat for one's self-esteem (Bok, 1978), most sex offenders will be expected to lie or at least to minimize their deviant fantasies (Dean, Mann, Milner & Maruna, 2007; Maruna & Mann, 2006). Marshall, Marshall and Ware (2009) call dissimulation "a common human tendency." For Nietzsche (1844-1900) the truth itself is simply a lie, and according to the lawyer and political philosopher Bentham (1748-1832) it is allowed to lie in order to minimize damage. Books such as *Lying and Deception in Everyday Life* (Lewis & Saarni, 1993) offer interesting lecture for therapists and clients. Why should sex offenders not lie about their fantasies? Many are hooked on them. They bring comfort, etc ... Therefore, it is not reasonable to bring this theme up early in therapy. A strong therapeutic alliance is needed before it is appropriate to tackle such a private and shameful topic like personal fantasies. Even then offenders will probably continue to lie. Using the polygraph in this situation is a possibility (see above O'Connell, 1998), but that - on the other hand - raises a lot of ethical and other questions (see Kokish, 2004). As therapists we should ask ourselves whether private cognitions such as fantasies can be discussed sincerely and openly, or even be changed, if the road to access it is based on coercion and mistrust (polygraph procedure). Fantasy management in a psychotherapeutic perspective will probably not reach all clients with problematic fantasies. 'Liars' and 'deniers' need a separate approach (see Vanhoeck & Van Daele, 2011). But it is worthwhile raising questions throughout therapy and give clients the opportunity to come over the bridge with their fantasies.

3rd step: motivation enhancement and informed consent

Because of the emotional dependency issue it is important to devote extra attention to motivation. Fantasy management is an intrusive method which requires careful assessment, a thorough preparation and an informed-consent procedure (see Carroll, rule 1).

Three motivational aspects are worth mentioning:

1) The personal motivation of the client. Change will only occur when the client acknowledges the importance of change and he sufficiently recognises the difference between current behavior and his own values and goals. It is not about the "measurable" difference but the "perception", the realization of the disadvantages of current behavior and the benefits of change. Prescott (2009) explicitly works with 'ambivalence' as the basis for his motivation model. He explores the following questions with the client: Do I want to break new ground? Do I need to develop new skills? Do I mourn for what I leave behind (eg unwanted fantasies)? The conscious, voluntary agreement, to accept a treatment and intervention, constitutes the setting of a clear goal which in itself is a significant factor in its achievement (Huber, 1985; Kirschenbaum & Flanery, 1984; Locke, Shaw, Saari, Latham, 1981). Indeed, imposed treatment may produce feelings of resentment which in turn diminishes compliance and the likelihood of a successful treatment (Brehm 1966; Brehm and Brehm

1981).

2) The client must have the capacity to change. This means that the client must be confident that he can bring the change to a successful end. Sexual offenders as a group are precisely characterized by deficits such as low self-esteem, external locus of control, intimacy problems and emotional loneliness (Beech, Fisher & Thornton, 2003). Before they can acquire effective management techniques (see step 6), it might be necessary to meet their self-confidence and self-image needs. In modern motivational theory and research 'autonomy support' has become a key element in influencing behavioral change (Ryan, Lynch, Vansteenkiste & Deci, 2010).

3) Finally, the client has to be "ready" for change. He must have the willingness (readiness) to work NOW, to make it a topic in his life now and invest time and energy in change. 'Willingness to change' is not a personality trait, it is a constant process and it is the result of interaction (see Ward, Day, Howells & Birgden, 2004). Resistance to addressing unwanted fantasies can be seen as a signal that the therapist was mistaken in the clients' willingness to change. His motivational strategies need to be adapted to the clients' situation and his environment.

4th step: mapping the current fantasies

Mapping fantasies and masturbation practices is an important therapeutic step. First the client should complete a "fantasy logbook". Clients often have little insight into their practices. If they start with their registration duties, they are often surprised to discover their own patterns and schedules. It can be interesting to list the trigger categories: external direct (porn, ...) - external postponed (street scenes, memories, ...) - internal (no obvious external reason). A combination of triggers is also possible. The intention is to let the client fill out a logbook during two to three weeks and then discuss the results with the therapist. What are the benefits? How does it feel to register everything? What patterns emerge?

5th step: questioning what is desirable and healthy

As the client gets a better view of his fantasies and masturbation practices, the question arises what fantasies are undesirable. What fantasies are clearly related to abuse? Which sustain a relapse risk? Which are undesirable because they are intrusive and as such disturbing everyday life? It is important to discuss this with the client. He is responsible for his life and for his fantasies. But he is also responsible for his actions and for relapse prevention strategies. This conversation is best held after the analysis phase (fourth step). There is already some distance and the concrete results of the registration can be discussed.

Specific management techniques embedded in a psychotherapeutic approach (6th step)

All the previous steps above are an integral part of fantasy management and should not be seen as preparation. We give, here below, an non-exhaustive overview of techniques. Some fit in a therapeutic tradition and cannot be used as a single technique without appropriate training. It is the responsibility of each therapist to evaluate his ability to use these techniques in a professional way and to adapt them to the needs of the client.

Cognitive techniques

As discussed above Gross (2002) found that when emotional impact must be decreased reappraisal is a better strategy than suppression. This is confirmed in the cognitive literature on thought suppression. Wegner, Shortt, Blake and Page (1990) come to the tentative conclusion that the suppression of sexually exciting thoughts may well have the reverse effect, namely that suppression might make these thoughts more appealing. Shingler (2009) discusses a lot of thought suppression studies in other domains (anger, mood, depression) and concludes similarly that results are usually paradoxical. On this basis, she recommends not to use thought suppression as a long-term fantasy management strategy. The more active one tries to suppress the cognitions, the more resilient they will resurface. And when someone is under high cognitive pressure, thought suppression will be even less successful. Finally, if the failure to suppress is internally attributed ("I'm really doing bad"), this results in further negative effects. Acceptance, distraction and monitoring give much better results.

Dallaire (2006) proposes, in the tradition of Acceptance and Commitment Therapy (ACT), a procedure that aims to stop thoughts, without actually trying to stop them. He refers to Wegner's work (see Wegner & Schneider, 2003) who, inspired by Tolstoy, asked subjects to make sure not to think of a "white bear". The only way, Dallaire decides, to stop negative thoughts and images is to shift them towards their positive and productive counterparts.

As opposed to suppression 'reappraisal' can be achieved by distancing oneself from the situation or from the emotional significance of the stimulus in order to be able to review it (Gross, 2002). Urge surfing is a cognitive technique with already some tradition in fantasy management. Alan Marlatt is one of the founders of the relapse-prevention approach towards sex offenders (see eg Laws, 1989; Larimer, Palmer & Marlatt, 1999). He also coined the term "urge surfing" in working with clients with a dependency problem (Ostafin & Marlatt, 2008). Clients had to visually imagine the urge to give in to their fantasy as a wave, a wave that goes up and down and finally throws itself on the beach and dies out. The client is explicitly instructed not to fight against the tide, nor to let himself be dragged away or go under. He actively needs to imagine "riding" the wave, to surf on it. Urge surfing has become a technique in which distance is created, not by fighting but by observing. This attitude is closely related to Mindfulness. Therefore it is not surprising that surfing the urge has found its place in mindfulness-based interventions (see e.g. Bowen & Marlatt, 2009).

A final cognitive technique is journaling (see Ullrich & Lutgendorf, 2002). We could have ranked it amongst the sexological techniques, when the focus is put primarily on journalling masturbation practices. Some clients don't feel capable (yet) to challenge undesirable fantasies directly. Through journaling (more detailed mapping as in step 4) they can target the triggers and through stimulus reduction limit masturbation reinforcement. But journaling can also be used as a stress reduction technique and may have an indirect influence on sexualized coping.

Classic behavioral techniques

Maletzky, who's 1991 book can still be considered the bible of behavioristic techniques, recently published a rather optimistic 25-year follow-up on treatment success (Maletzky & Steinhäuser, 2002). Schmucker and Lösel (2008) report in a recent update of their big meta-analysis study (Lösel & Schmucker, 2005) that only behavioral and cognitive behavioral programs among the psychosocial approaches give positive results. "The odds ratios, of the other psychosocial approaches, center around 1 and indicate no difference in recidivism rates between treated and untreated offenders."

Behavior therapy techniques

Covert sensitisation uses imagined, but highly detailed, aversive consequences interrupting the arousal coming from an imagined sexually arousing scenario (Cautela 1967). Despite its common use in treatment programs, however, this technique has not produced robust treatment effects (Maletzky, 1996).

Olfactory aversion is designed to reduce deviant sexual arousal by pairing a powerful aversive odor repetitively with conditioned sexually arousing fantasies, utilizing foul odors such as ammonia (Colson, 1972) or rotting animal or human tissue (Maletzky 1991).

Nonaversive or "positive" conditioning techniques are not as widely established. Reconditioning behavioral techniques aim to "fade" the intensity of a conditioned deviant stimulus and strengthen the arousal produced by "accepted" sexual fantasies during masturbation (Marquis, 1970). A variant of this technique is called "masturbatory satiation" (Laws & Marshall, 1991; Marshall, 1979) where the subject is instructed first to masturbate to orgasm using socially acceptable sexual fantasies, and then, for 30-60 minutes during the post-ejaculatory latency period, to continue to masturbate to his deviant fantasies. The theory supporting this technique is that prolonged masturbation following ejaculation is aversive. Although some clients report strong effects in the short term, they experience the technique as "dirty and degrading". Moreover there is little evidence that these behavioral reconditioning techniques are useful for a large group of clients (Laws & Marshall, 1991).

The effectiveness of behavioral techniques that modify the sexual orientation is still under discussion for methodological and ethical reasons (Serovich, Craft, Gangamma, McDowell & Graftsky, 2008). This is why Maletzky (1996) deplored, in 1996 already, the decline of behavioral therapy in the field of the sex offender treatment.

Sexological techniques

Replacing deviant and non-desired fantasies while masturbating by desired ones is not a reliable technique. A sexological approach where clients begin masturbating with 'desired images' in mind, sounds straightforward, but as the climax approaches, the old "trusted" fantasies often intrude again in a powerful way. It is certainly safer to use material from external exposure (erotic pictures or video images) in order to increase the likelihood that the focus remains in the wanted direction.

Research reveals that men can suppress physiological and self-reported sexual arousal to preferred stimuli but are unable to enhance arousal to non-preferred stimuli. Average suppression rates range from 26% to 38% maximum erection, with some men able to suppress their sexual arousal entirely and others not at all (Adams et al., 1992; Golde, Strassberg & Turner, 2000; Mahoney & Strassberg, 1991; McAnulty & Adams, 1991).

Some clients insist that they have no acceptable fantasies which are exciting to them and therefore have no alternative than to be a teetotaler or continue to fantasize as before. It may help to propose masturbation exercises that do not focus on fantasy but on the sensory sensations of the arousal (Zilbergeld, 1978). The goal consists in reducing the pressure to orgasm and to teach the client to concentrate on incentives to increase his excitement. Masturbating in the mirror might help (McCarthy, 1984). The client looks a few times a week in the mirror, first dressed and then naked. He must make himself look good, is encouraged to say something positive about himself. In this way the client is made familiar with his own body and is learning to focus on his body. Finally he can masturbate in the mirror but he has to stay focused on his physical actions and sensations.

Eye Movement Desensitisation Reprocessing (EMDR)

There is some evidence that EMDR can help reduce deviant fantasies when they are linked to the clients' victimization memories. Ricci, Clayton and Shapiro (2006) describe a study involving 10 perpetrators with an own abuse history who were treated with EMDR for their childhood traumas. They reported a decrease in deviant sexual arousal (associated with an assumed accompanying decrease in deviant sexual fantasies) and attributed this to the EMDR model of "adaptive information". Cox and Howard (2007) report on a case study in which EMDR was used in the treatment of trauma-related sex addiction.

EMDR is a highly specialized procedure only to be used for trained therapists. However, an important methodology used in EMDR is to create a "safe place" to which the client can escape when unwanted fantasies overwhelm him. This method is also known in other therapies, such as the schema therapy (Young, Klosko & Weishaar, 2003) and may also be used as a separate management technique. Once clients understand the circle that exists between fantasies, masturbation, arousal and orgasm reinforcement, they can create an imaginary safe place where they can flee to in order to escape this circle. According to the technique it should be an internal safe place, but sometimes one has to start with the physical consultation room where the client can feel safe and to which he can flee in his thoughts when needed.

Drug treatment

The aforementioned study by Schmucker and Lösel (2008) reported good results for hormonal treatments. Fran van Hunsel and Paul Cosyns (2002) describe several studies that report a significant reduction in the impact of sexual fantasies due to medication. These authors propose a protocol with "milder" forms of paraphile fantasy to be treated with SSRIs (selective serotonin reuptake inhibitors) and fantasies with a particular risk on acting out with LHRH (luteinizing hormone releasing hormone) agonists. The authors emphasize, however, that drug treatment should always be accompanied by psychotherapy.

Conclusion

Finally, we cannot emphasize enough that fantasy management should always be embedded in ongoing psychotherapeutical support. Let us not underestimate what it means to say goodbye to that "buddy" which has provided you orgasm and consolation for so many years (Marshall, 1998). "Compassion" is the right word for a therapeutic approach to this difficult and courageous path which the client sets in to.

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