

**Exploring the relationships between personality disorder, sexual preoccupation,
and adverse childhood experiences among individuals who have previously
sexually offended**

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of the requirements of Nottingham Trent University
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Abstract

Sexual offending creates a significant public health issue (Mann, Hanson & Thornton, 2010), whereby having a better understanding of the underlying factors related to sexual offending will result in more effective prevention, assessment, and intervention (Seto, 2019). Various factors are identified as aetiological factors for sexual offending, or risk factors for recidivism, including adverse childhood experiences (ACEs), problematic personality traits, intimacy deficits, deviant sexual preferences, and sexual preoccupation (Hanson & Morton-Bourgon, 2005; Mann et al., 2010).

Personality disorders (PDs) are highly prevalent among Individuals Who Have Previously Sexually Offended (IPSO; Chen, Chen & Hung, 2016; Craissati & Blundell, 2013), with this relationship being recognised in the UK by the development of the Offender Personality Disorder (OPD) pathway in 2011. However, there are issues regarding the current screening procedure in that it predominantly screens for antisocial and borderline PDs, meaning that a proportion of IPSO with a range of other PDs may be being missed. Furthermore, the prevalence of PDs among IPSO housed in UK prison establishments has not yet been explored.

Another factor which is thought to contribute to the aetiology of sexual offending is Sexual Preoccupation (SP; Seto, 2019; Ward & Beech, 2017), which is one of the most strongly present treatment needs among IPSO in the UK (Hocken, 2014). Nonetheless, it is the only risk factor that is not currently addressed by psychological treatment programs for IPSO in the UK (Lievesley, 2019). A tentative link has been reported between PD and SP among IPSO, with sexually preoccupied IPSO presenting with a different personality profile compared to those without SP (Berman-Roberts, 2015). Given that these individuals have acted upon their sexual thoughts and engaged in illegal sexual behaviour, it is imperative to learn more about the underlying mechanisms of SP in order to inform and enhance assessment and treatment (Jardin et al., 2017), which is the main aim of this thesis.

Additionally, ACEs are an integral part of understanding sexual offending (Hanson & Morton-Bourgon, 2005; Levenson, 2014), and are also implicated in the aetiology of PD and SP (Courtois & Weiss, 2018; Zanarini, 2000), whereby PD symptomology and SP may be better understood as functional responses deployed as ways of coping with these experiences. ACEs are now considered to be a public health 'crisis' (Anda, Butchart, Felitti & Brown, 2010), and studies have recently explored the prevalence of ACEs among prisoners in Scotland and Wales (Carnie, Broderick, Cameron, Downie & Williams, 2017; Ford et al., 2019). Yet, the prevalence of ACEs among IPSO housed in UK prison establishments has not yet been explored, nor the relationships between PD and ACEs, and SP and ACEs among this population. Therefore, ACEs were also included for exploration within this thesis in order to fully understand the relationship between PD and SP among IPSO.

Through utilising a mixed-methods approach, this thesis offers the first in-depth exploration of the relationships between PD, SP, and ACEs among a sample of IPSO housed in two UK prison

establishments. Study one ($n = 203$) explores the psychometric properties of two PD scales in a UK general population sample, before they were employed for use with a prison population. The second ($n = 155$) and third ($n = 45$) studies explore the prevalence of PD, SP, and ACEs among IPSO, as well as the relationships between PD and SP, PD and ACEs, and SP and ACEs. Finally, the fourth study ($n = 5$) explores the life trajectories and narrative identities of IPSO that experienced adverse environments during childhood and developed a preoccupation with sex and problematic personality traits.

The findings reveal that attempting to understand the underlying mechanisms of SP is a complicated process, as SP manifests differently for each individual. SP may be used as a way to regulate emotions and manage stress, and/or as a way of managing identity and self-worth. Although this thesis provides support for the impulsivity and compulsivity models of SP, as well as it being used as a coping mechanism for anxiety and depression, it also highlights the relationships between SP and emotion dysregulation, and SP and impaired identity. Furthermore, the results bolster Montaldi's (2002) claim that some presentations of SP may be better understood through the use of PDs, whereby this thesis highlights the possibility of two pathways for IPSO with SP (in relation to borderline and narcissistic PDs). Multiple kinds of SP presentation suggest the need for multiple treatment approaches, and it is important for clinicians to tailor treatment according to the individual's motivation for SP.

In regard to the prevalence of PD among IPSO in the UK, a range of PDs (predominantly dependent, depressive, borderline, and avoidant PDs) were reported among IPSO housed in UK category C prison establishments. This has important implications for the current OPD pathway screening procedures, in that these may need amending to be more inclusive of the range of PDs present among IPSO, or specific services for IPSO with PD may need to be developed and implemented. Moreover, a large proportion of IPSO met the criteria for PD, and among these individuals, all of them experienced at least one ACE, with over half reporting four or more ACEs. Thus, this demonstrates the need for all services to adopt a trauma-informed and relational approach, whilst also highlighting how preventative measures are crucial in order to try and prevent the cyclical nature of ACEs, and to prevent individuals from coming into contact with the criminal justice system in the first place.

This thesis concludes that PD and SP symptomology may be better understood as effective survival strategies to abnormal circumstances, and it is important that clinicians address this aspect of an individual's sense-making during treatment. Furthermore, a common thread throughout all studies is regarding impairments in identity. Therefore, a useful treatment target among IPSO is in relation to incoherence in the self-narrative, as having a coherent, pro-social identity is thought to be crucial to rehabilitation and desistance (Maruna, 2001). Clinicians should work from a Good Lives Model (GLM; Ward, Mann & Gannon, 2007) perspective in order to help individuals identify appropriate values and goals, and work towards a more appropriate narrative identity (Ward & Marshall, 2007). An individual's protective factors should also be taken into account, in which peer-support roles and religiosity may play an important part in protecting individuals from future offending. Implications and limitations of all studies are discussed extensively throughout, as are opportunities for further research.

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A Note on Terminology

It is necessary to consider the language used to describe the population of interest, especially in relation to labels. Language is thought to play a crucial role in shaping perceptions (Scheufele & Tweksbury, 2007), and labels can impact how people respond to individuals who have offended (Lowe & Willis, 2019). People that have committed crimes are referred to as 'offenders' in the literature, which carries a lot of stigma with it. This can impact the way a person feels about themselves (Inzlicht, Tullett, & Gutsell, 2012), and people are more likely to desist from crime if they do not define themselves in this way, rather viewing themselves as a good person who made a mistake (Chiricos, Barrick & Bales, 2007; Maruna, 2001). Mann (2013) acknowledges that the term 'offender' exists throughout a person's life, as even after they leave prison, they may be referred to as an 'ex-offender'. A person first term, such as 'people with convictions' is encouraged (Discovering Desistance, 2013).

When focusing specifically on people who have committed sexual offences, the label 'sex offender' is typically used in the literature. This label is laden with negative consequences and elicits a negative response unlike that of public reactions to other crimes (Lowe & Willis, 2019). Among the general public it evokes emotional reactions of fear, disgust and outrage (Olver & Barlow, 2010), which are exemplified by terms used in the media, such as 'beast', 'predator', 'monster' or 'psychopath' (Harper & Hogue, 2015; Zilney & Zilney, 2009). Hocken (2014) suggests that this label is endured throughout the whole lifetime, as the term 'ex-sex offender' is rarely used. This may reflect society's attitude, in which they believe this group of people cannot change, resulting in exclusion. However, inclusion is thought to be crucial for rehabilitation (Wilson, Cortoni & McWhinnie, 2009).

Willis, Levenson and Ward (2010) recommend that researchers should discontinue the use of these negative labels, as it could result in a negative Pygmalion effect, whereby individuals begin to see themselves in this way (Ward & Maruna, 2007). It has also been suggested that researchers should be aware of how using such terms may impact the reader's interpretation of research (Harris & Socia, 2014). Walton (2019b) suggests it may be beneficial to refer to people as 'people with convictions for sexual offending', as this description recognises the crime, but does not purely define the person based on this. Furthermore, Lowe and Willis (2019) suggest that using neutral language (such as a 'person who has sexually offended') may prime individuals to think of a person, as opposed to stereotypes they have encountered in the media, whereby separating an individual from their behaviour recognises their humanity and ability to change. This thesis aims to embrace this philosophy of inclusion by adopting a person first term, therefore, the term 'Individuals who have Previously Sexually Offended' (IPSO) will be used for sexual offences, and 'Individuals who have Previously Violently Offended' (IPVO) when referring to violent offences.

Abbreviations

ACEs	Adverse Childhood Experiences
ACORN	Adapt, Change, Opportunity, Reflect, Navigate
AMPD	Alternative Model to Personality Disorders
APA	American Psychological Society
CBT	Cognitive Behavioural Therapy
CDC	Centers for Disease Control and Prevention
CFA	Confirmatory Factor Analysis
CFI	Comparative Fit Index
CFT	Compassion Focused Therapy
CSBD	Compulsive Sexual Behaviour Disorder
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSPD	Dangerous and Severe Personality Disorder
EMDR	Eye Movement Desensitization and Reprocessing
FFM	Five Factor Model
GLM	Good Lives Model
HMPPS	Her Majesty's Prison and Probation Service
HSP	Healthy Sex Program
ICD	International Classification of Diseases
IPP	Imprisonment for Public Protection
IPSO	Individuals who have Previously Sexually Offended
IPVO	Individuals who have Previously Violently Offended
LPFS	Levels of Personality Functioning Scale
LSI	Life Story Interview
MFM	Motivation-Facilitation Model
MII	Mean Inter Item
MIT	Mean Item Total
MMPSA	Medication to Manage Problematic Sexual Arousal
MOJ	Ministry of Justice
MPI	My Private Interest
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health For England
NOMS	National Offender Management Service
OASys	Offender Assessment System
OCD	Obsessive Compulsive Disorder

OM	Offender Manager
OPD	Offender Personality Disorder
PAI	Personality Assessment Inventory
PD	Personality Disorder
PD-NOS	Personality Disorder – Not Otherwise Specified
PDQ-4	Personality Diagnostic Questionnaire – 4
PDTs	Personality Disorder Trait Specified
PID-5	Personality Inventory for DSM-5
PID-5-BF	Personality Inventory for DSM-5 – Brief Form
PID-5-SF	Personality Inventory for DSM-5 – Short Form
PSY-5	Personality Psychopathology Five
PTM	Power Threat Meaning
RMSEA	Root Mean Square Error of Approximation
SCS	Sexual Compulsivity Scale
SIPP – 118	Severity Indices of Personality Problems 118
SIPP-SF	Severity Indices of Personality Problems – Short Form
SOCAMRU	Sexual Offences, Crime and Misconduct Research Unit
SP	Sexual Preoccupation
TIC	Trauma Informed Care
TLI	Tucker Lewis Index
TSO	Total Sexual Outlet
WASREP	Whatton And SOCAMRU Research and Evaluation Panel
WHO	World Health Organisation

Chapter One: Introduction

1.1 Background

Sexual offending creates a significant public health issue, whereby crimes of a sexual nature are thought to summon the most public concern and are of interest to both members of the public and professionals (Hocken & Gredecki, 2018; Mann et al., 2010). Not only do sexual offences impact the victim, but the victim's family, the perpetrator's family, and communities and society as a whole (Brown & Saied-Tessier, 2015; Elliott & Beech, 2012). Within the UK, sexual abuse is conceived as a public protection and risk management issue (McCartan, Hoggett & Kemshall, 2018), in which having a better understanding of the underlying factors related to sexual offending will result in more effective prevention, assessment, and intervention (Seto, 2019). Various factors are identified as aetiological factors for sexual offending, or risk factors for sexual recidivism, including Adverse Childhood Experiences (ACEs), problematic personality traits (antisocial orientation and impulsivity), intimacy deficits, self-regulation problems, deviant sexual preferences, and Sexual Preoccupation (SP; Hanson & Morton-Bourgon, 2005; Levenson, 2014; Mann et al., 2010).

Of these factors, problematic personality traits have consistently been linked to sexual offending (Gillespie & Beech, 2016; Hanson & Morton-Bourgon, 2005; Mann et al., 2010). Personality Disorders (PDs) are highly prevalent among Individuals who have Previously Sexually Offended ([IPSO]; Chen et al., 2016; Craissati & Blundell, 2013; Dunsieath et al., 2004), and are predictive of general, violent, and sexual recidivism (Kingston, Olver, Harris, Wong & Bradford, 2015). PD is a serious mental health condition and is thought to be a useful treatment target (Garofalo, Bogaerts & Denissen, 2018). The National Health Service (NHS) and Her Majesty's Prison and Probation Service (HMPPS) have recognised this relationship between PD and sexual offending, whereby they jointly commissioned a new initiative in 2011, referred to as the Offender Personality Disorder (OPD) pathway (Joseph & Benfield, 2012). The pathway was designed for high risk individuals that have committed sexual or violent offences who are likely to have PD, in order to improve public protection (Skett & Lewis, 2019). However, there are issues with the current screening procedure, in that it predominantly screens for antisocial and borderline PDs. This means that a large proportion of IPSO that demonstrate a range of other PDs (such as avoidant, dependent, and schizoid) may be being missed due to the current screening tool. Additionally, the prevalence of PD specifically among IPSO has not yet been explored among IPSO residing in UK prison establishments.

Another factor which is thought to contribute to the aetiology of sexual offending is Sexual Preoccupation (SP; Seto, 2019; Ward & Beech, 2017), whereby high sex drive (and consequently excessive SP) is one of the primary motivations for sexual offending (Seto, 2019). SP has also been identified as a major predictor of general, violent, and sexual recidivism (Hanson & Morton-Bourgon,

2005; Knight & Thornton, 2007; Mann et al., 2010), and is recognised as one of the most strongly present treatment needs among IPSO in the UK (Hocken, 2014). Despite this, it is the only risk factor that is not currently addressed by psychological treatment programs for IPSO in the UK (Lievesley, 2019; Winder et al., 2017; Winder et al., 2018). It is thought that this may be due to a lack of knowledge regarding the underlying mechanisms of SP, or how to effectively treat it (Berman-Roberts, 2015; Seto, 2019), as SP is largely understudied in comparison to other dynamic risk factors. The relationship between SP and sexual offending has been recognised in the UK, with a voluntary medication program for IPSO being developed, referred to as Medication to Manage Problematic Sexual Arousal (MMPSA; Winder et al., 2014). Pharmacological treatments are used as a useful adjunct to psychological treatment (Guay 2009; Turner, Basdekis-Jozsa & Briken, 2012), and evaluative research indicates that pharmacological medication has been able to successfully reduce sexual thoughts, feelings and behaviours (Winder et al., 2014; Winder et al., 2017).

Both PD and SP have been found to impede an individual's ability to engage in treatment programs (Howells et al., 2011; Marshall, Marshall & Serran, 2006; Saleh, Grudzinskas, Malin & Dwyer, 2010), and research suggests that problematic personality traits are key predictors of sexual recidivism, especially when paired with a deviant sexual interest (Hanson & Morton-Bourgon, 2005). Although research has focused on the influence of personality traits on sexual offending, the personality traits of sexually preoccupied IPSO has not yet been explored in detail (Payne, 2014). A tentative link has been reported between PD and SP, with sexually preoccupied IPSO presenting with a different personality profile compared to those who were not sexually preoccupied (Berman-Roberts, 2015). However, further research is required to explore this relationship between PD and SP among a broader sample of IPSO, in order to establish the underlying mechanisms of SP. Given that these individuals (IPSO) have acted upon their intrusive sexual thoughts and engaged in illegal sexual behaviour, it is imperative to learn more about the underpinnings of SP and the links with personality within this population, in order to inform and enhance assessment and treatment (Costa & McCrae, 1992; Jardin et al., 2017).

Therefore, the main aim of this thesis is to explore the relationship between PD and SP among IPSO. However, given that ACEs are implicated in the aetiology of sexual offending, PD, and SP, they were also included for exploration within this thesis in order to fully understand the relationship between these factors. ACEs are a public health 'crisis' (Anda, Butchart, Felitti & Brown, 2010), and the notion of ACEs has begun to gain momentum in the UK in recent times (Bellis, Hughes, Leckenby, Perkins & Lowey, 2014a; Bellis, Lowey, Leckenby, Hughes & Harrison, 2014b; Couper & Mackie, 2016). The prevalence of ACEs has recently been explored among prisoners in Scotland and Wales (Carnie, Broderick, Cameron, Downie & Williams, 2017; Ford et al., 2019), however, the prevalence of ACEs specifically among IPSO in the UK has not yet been explored. Although ACEs have been found to be related to PD and SP, the relationships between ACEs and PD, and ACEs and SP specifically among IPSO has not yet been investigated in the UK.

The majority of research conducted in prison settings is of a quantitative nature, however, these studies fail to provide rich in-depth data about an individual's lived experiences, whereby there is a need to focus on service user perspectives (Nee, 2004). Additionally, McAdams' (1994) triarchic model of personality suggests that there are three levels of personality: (i) broad dispositional traits, (ii) characteristic adaptations (an individual's goals, stresses, motives, interests, values, etc.), and (iii) the internalised life story (narrative identity), in which the life story represents a distinct level of personality that offers a unique contribution to the understanding of personality (McAdams & Pals, 2006). Therefore, this thesis aims to explore the relationships between PD, SP and ACEs among IPSO utilizing a mixed methods research design, incorporating both quantitative and qualitative methods, in order to get a more comprehensive understanding of these relationships. The first study explores the psychometric properties of two PD scales in a UK general population sample (as it became evident that the chosen scales had not previously been validated or used within the UK). The second and third studies explore the prevalence rates of PD, SP, and ACEs among IPSO housed in two UK prison establishments, as well as quantitatively exploring the relationships between PD and SP, PD and ACEs, and SP and ACEs. Finally, the fourth study explores the life stories of IPSO that experienced adverse environments during childhood and developed a preoccupation with sex and problematic personality traits. This enables the deepest level of personality (the narrative identity) to be explored among IPSO, as well as affording a usually marginalised group (Tewksbury, 2012) the opportunity to have their voices heard, to tell their stories, and be listened to in a non-judgemental, non-threatening environment.

1.2 Research context

At the commencement of this thesis (2015), the Diagnostic and Statistical Manual of Mental Disorders (5th Edition; DSM-5) had not long been released (American Psychiatric Association [APA], 2013a). Section II of the DSM-5 contained the traditional categorical criteria for PD, however, an Alternative Model for PDs (AMPD) was included in section III (emerging measures and models). This alternative model integrated a continuous approach to PD, whereby dimensional personality traits and levels of functional impairment are explored. Within the literature, the PD categorical versus continuum debate was topical, and the DSM-5 incorporating the AMPD prompted research into this area. This thesis utilises the DSM-5 dimensional approach to PD as a way of gaining insight above and beyond that of a categorical diagnosis (discussed further in section 2.2.1). However, this thesis is also influenced by McAdams' (1994) triarchic model of personality, which postulates that there are two additional levels of personality beyond dispositional traits (character adaptations and narrative identity), thus, this thesis attempts to explore all three levels of personality among IPSO.

Individuals with a diagnosis of PD have received more public attention in the UK since the National Institute for Mental Health for England (NIMHE) published the 'Personality Disorder: No Longer a Diagnosis of Exclusion' guidance (NIMHE, 2003), with the aim of encouraging the development of

services for individuals with PD (Craissati & Blundell, 2013). As previously mentioned, the presence of PD among prisoners has been recognised within the UK, with the NHS and HMPPS developing the OPD pathway (Joseph & Benfield, 2012). The pathway was born out of the dangerous and severe personality disorder (DSPD) program after evaluations highlighted various concerns and limitations (Skett & Lewis, 2019). These limitations were in regard to the service only being available in high secure settings, as well as issues around identification and prevention. The OPD pathway was initiated in 2011, in order to meet the joint strategic aims of the Ministry of Justice, the Department of Health, and their respective agencies (Joseph & Benfield, 2012; for a summary of evidence underpinning the OPD pathway please see Skett & Lewis, 2019). Within the pathway, there is a mutual understanding that these individuals cannot be managed by either agency alone and that it is a shared responsibility of all agencies working together. The OPD pathway does not rely on diagnosis, but instead views offending and complex psychological problems as being underpinned by adverse experiences (Skett & Lewis, 2019); it takes a developmental and trauma focus, whereby they value the question 'what has happened to you?' as opposed to 'what is wrong with you?' (Kezelman & Stavropoulos, 2012).

Although the OPD pathway adopts a psychologically informed approach using formulations, it does however use a screening procedure, which predominantly focuses on antisocial and borderline PDs, and has yet to be empirically validated (Craissati, 2019). Research has highlighted discrepancies among the prevalence of PDs found among Individuals who have Previously Violently Offended (IPVO) compared to IPSO (discussed further in section 2.1.1; Ahlmeyer, Kleinsasser, Stoner & Retzlaff, 2003; Schroeder, Iffland, Hill, Berner & Briken, 2013), suggesting that a proportion of IPSO whom require help with their personality difficulties may be being missed due to the current screening procedure. This is also highlighted in the most recent guidance for the OPD pathway, Therefore, amendments may be required to the current screening tool in order to be inclusive of the range of PDs present among IPSO, or services designed specifically for IPSO. In 2018, the Adapt, Change, Opportunity, Reflect, and Navigate (ACORN) service was implemented in a prison that houses IPSO, providing the first PD service developed specifically for IPSO.

The context of this thesis also relates to the MMPSA service, which was originally piloted at a local prison establishment for IPSO in the Midlands, before being rolled out as a national treatment pathway across several prison establishments. An extensive evaluation of the MMPSA service is being conducted by the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) based in the Department of Psychology at Nottingham Trent University, in which some of the data used for comparative purposes within this thesis comes from this evaluative data. Given that SP is not targeted by psychological treatment programs for IPSO (Lievesley, 2019; Winder et al., 2017; Winder et al., 2018), pharmacological medication was introduced as a supplement to psychological treatment (Home Office, 2007). Results from evaluative research indicate that pharmacological medication has been able to successfully reduce sexual thoughts, feelings, and behaviours (Winder et al., 2014; Winder et al., 2017),

giving IPSO more ‘headspace’ so that they could focus on treatment programs (Lievesley et al., 2014, p. 269).

The MMPSA service was initially placed in conjunction with the OPD pathway, which is where it still currently resides. Although it does not quite fit under the umbrella term of OPD services, and there is currently no established link between PD and SP among IPSO, pragmatically it was deemed the most appropriate place for the service to sit. Not all individuals with PD will have difficulties with SP, and not all individuals with SP will have personality difficulties, however, the service evaluation demonstrates a tentative link between PD and SP among IPSO (Berman-Roberts, 2015; Hocken et al., 2016). Additional research is required to further explore this relationship in order to understand the psychological underpinnings of SP among this population.

Finally, although the exploration of ACEs was not originally included within the research plan for this thesis, it soon became evident that ACEs were an integral part of understanding sexual offending, PD, and SP. Despite the first ACE study being conducted in 1998 in the US (Felitti et al., 1998), it has taken almost two decades for the notion of ACEs to gain momentum in the UK (Bellis et al., 2014a; Bellis et al., 2014b; Bellis et al., 2015; Couper & Mackie, 2016). Therefore, when this research commenced in 2015, the notion of ACEs was very topical, and has grown extensively over the following years, with recent ACE studies being conducted with prisoners in Scotland and Wales (Carnie et al., 2017; Ford et al., 2019). ACEs are considered to be a public health issue (Anda et al., 2010; Larkin, Felitti & Anda, 2014), and are one of the strongest predictors of poor health and social outcomes (Ford, Butler, Hughes, Quigg & Bellis, 2016). The ACEs movement has inspired a strong focus on the prevention of ACEs, and the implementation of services to help vulnerable individuals and families as early as possible (Donovan, 2018; Larkin, 2018; Leitch, 2017). However, the prevalence of ACEs has not yet been explored specifically among IPSO residing in UK prison establishments (discussed further in section 2.1.3).

[1.3 Pictorial representation of research studies and structure of thesis](#)

Figure 1 highlights the four separate studies that were conducted as part of the research, showing how these studies link together and follow on from each other. Figure 2 reveals the outline and structure of the thesis, including how individual studies fit into relevant chapters.

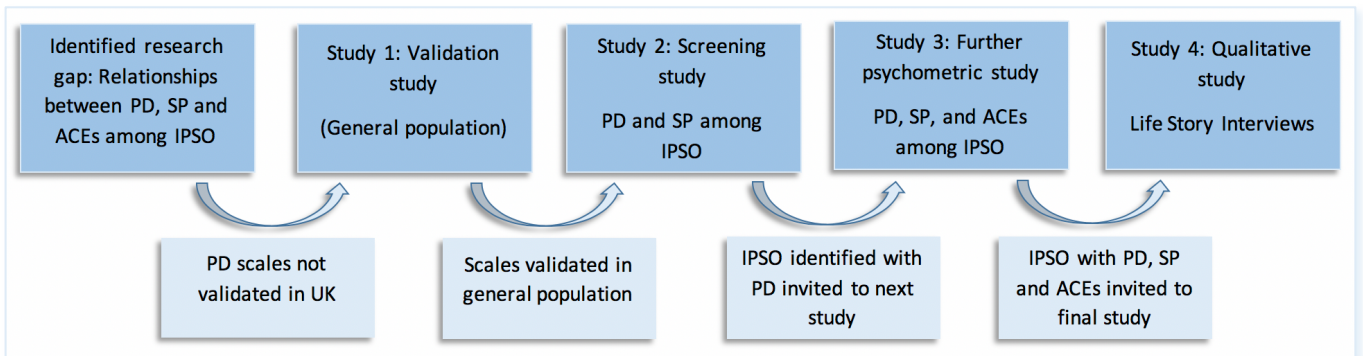


Figure 1. Links between the four research studies and the process of data collection

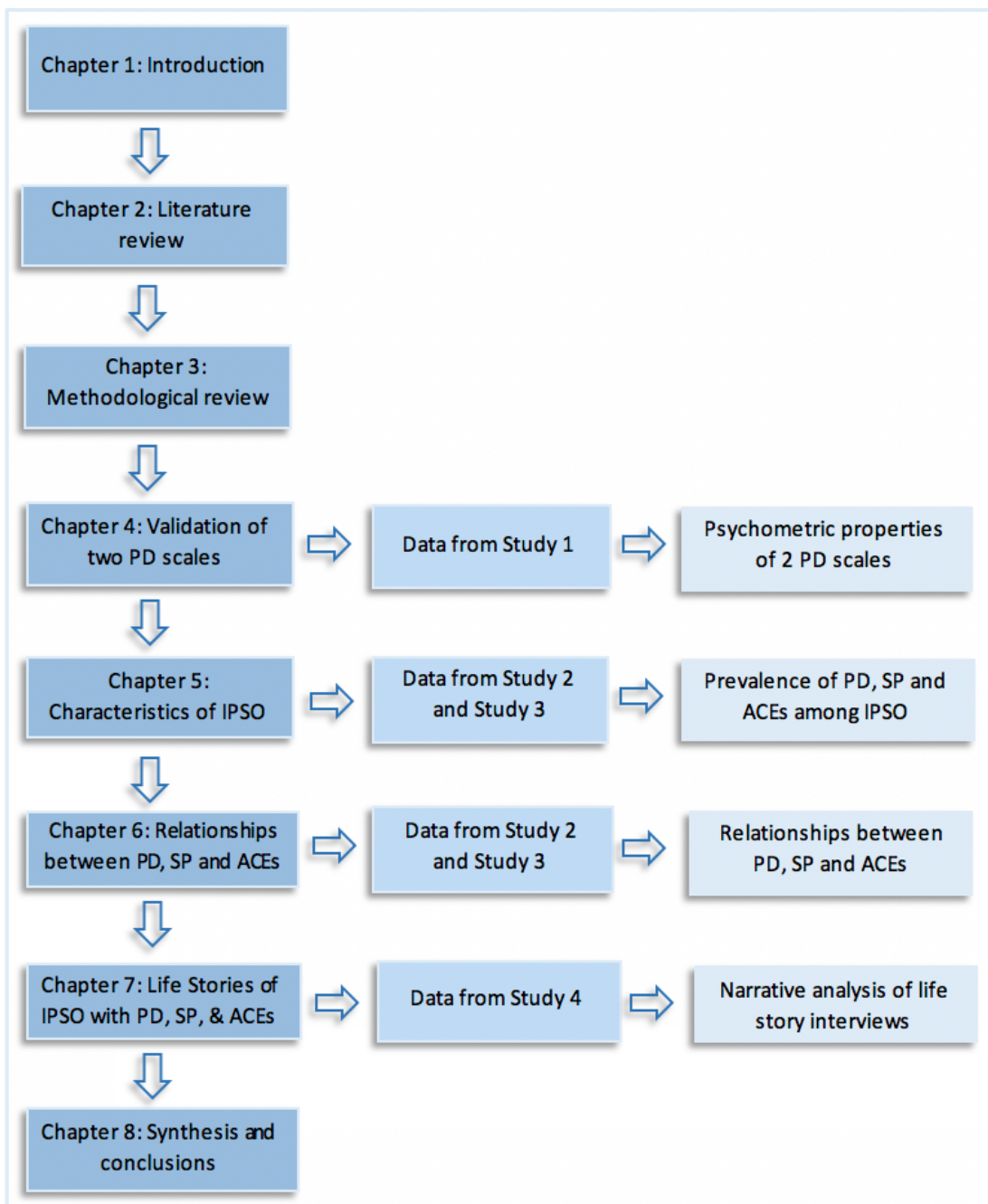


Figure 2. Outline and structure of thesis

1.4 Thesis structure and outline of chapters

This thesis utilises a mixed methods approach and draws on data from the general population in the UK, and from the UK custodial population of IPSO. The following is an overview of the thesis chapters:

Chapter One: Introduction. This chapter provides an introduction and background to the thesis, as well as providing an outline of the structure of the thesis, and the overarching research questions and aims.

Chapter Two: A literature review of personality disorder, sexual preoccupation, adverse childhood experiences, and their associations with sexual offending. This chapter introduces the phenomena of interest and offers a critical review of the relevant literature to the thesis, whilst also providing a clear rationale for the research.

Chapter Three: Methodological review. This chapter outlines the methods utilised in the empirical studies, providing a rationale for each chosen method. It introduces the participants for each study, describes the recruitment and consent processes, as well as ethical considerations. This chapter covers general methodological aspects, however, the specific methodology used in each empirical study will be included in relevant chapters.

Chapter Four: Reliability and validity of the Severity Indices of Personality Problems – Short Form (SIPP-SF) and the Personality Inventory for DSM-5 Brief Form (PID-5-BF) in a sample of UK males. The aim of this study was to assess the psychometric properties of two PD scales in a UK male sample. The SIPP-SF was used to assess personality functioning, and the PID-5-BF was used to assess pathological personality traits. The two scales were compared to the Personality Diagnostic Questionnaire 4 (PDQ-4), a scale that has previously been validated and utilised within the UK.

Chapter Five: An exploration of the characteristics of individuals who have previously sexually offended. This chapter details the characteristics of IPSO, including the offence type, and prevalence of PD, SP and ACEs. It also compares impairments in personality functioning, pathological personality traits, SP, and ACEs to available normative data, general population data, and a sample of IPSO taking MMPSA. It combines data from study 2 and study 3, with a main focus on the characteristics of IPSO. This chapter is divided into four sections: offence characteristics (part A), personality disorder (part B), sexual preoccupation (part C), and adverse childhood experiences (part D).

Chapter Six: An investigation into the relationships between personality disorder, sexual preoccupation, and adverse childhood experiences among individuals who have previously sexually offended. The aim of this chapter was to explore the relationships between PD, SP and ACEs, also incorporating data from study 2 and study 3 (with a focus on the relationships between phenomena, as opposed to prevalence rates as in chapter five). This chapter consists of three separate parts: the

relationship between PD and SP (part A), the relationship between PD and ACEs (part B), the relationship between SP and ACEs among IPSO (part C).

Chapter Seven: An exploration of the life trajectories and narrative identity of individuals who have previously sexually offended that have experienced adverse childhood environments, personality disorder, and sexual preoccupation. The aim of this study was to investigate the life trajectories and narrative identity of IPSO with PD, SP, and ACEs, using a narrative psychological approach. The narratives were initially analysed individually, and then cross-case analysis was performed to identify any similar themes or patterns across narratives.

Chapter Eight: Synthesis and conclusions. This chapter provides a synthesis of the four empirical studies and concludes the thesis. It integrates the results and suggests recommendations for practice and further research. In addition, it outlines the implications and practical applications of the thesis on current practice and research, whilst also reflecting on the process of conducting this research.

1.5 Research question and aims

The overarching research question relating to this thesis is:

- What is the relationship between PD and SP among individuals who have previously sexually offended?

The main aim of this thesis is:

- To explore the relationship between PD and SP among a sample of IPSO housed in UK prison establishments

Additional aims of the thesis include:

- To assess the prevalence rates of PD, SP, and ACEs among IPSO.
- To examine the relationship between PD and ACEs among IPSO.
- To explore the relationship between SP and ACEs among IPSO.
- To examine the life trajectories and narrative identity of IPSO who have experienced ACEs, PD, and SP.

1.6 Summary

This introductory chapter provides a brief summary of research relevant to this thesis, as well as contextualising the research, and indicating why there is a need for further exploration of the relationship between PD and SP among IPSO. It then discusses the structure of the thesis, as well as providing a pictorial representation. Finally, this chapter details the overarching research questions and aims relevant to this thesis, whereby individual aims and objectives of each study will be provided within the relevant chapters.

Chapter Two: A literature review of personality disorder, sexual preoccupation, adverse childhood experiences, and their associations with sexual offending

Overview

This chapter examines the relevant literature to the thesis. First of all, it offers an overview of sexual offending as a way of postulating the wider context of the thesis, as well as describing how each of the main phenomena (personality disorder [PD], sexual preoccupation [SP], and adverse childhood experiences [ACEs]) are related to sexual offending. It then goes on to explore PD, SP, and ACEs in more depth, specifically focusing on the definition, relevant theories, and impact of each phenomena. Finally, this chapter explores the relationships between PD, SP, and ACEs, as well as describing the overarching aims of the thesis.

2.1 Sexual offending

The topic of sexual offending is of interest to both the public and professionals, due to the significant impact it has on the victim, and the public health issue that it creates (Brown & Saied-Tessier, 2015; Elliott & Beech, 2012; Hocken & Gredecki, 2018). The Crime Survey for England and Wales (Office for National Statistics, 2019) estimates that approximately 700,000 individuals between the ages of 16 to 59 years were victims of a sexual assault between December 2017 and December 2018. However, the majority of these instances will not enter the criminal justice system, as it is thought that fewer than one in five victims report their assault to the police (Office for National Statistics, 2018). The number of reported sexual offences between January 2018 and December 2018 was 159,740 (Office for National Statistics, 2019), with 13,359 prisoners serving sentences in England and Wales for sexual offences as of March 2019 (around 18% of the prison population; Ministry of Justice, 2019), and 58,637 individuals being registered on the sexual offender register as of March 2018 (Ministry of Justice, 2018).

In comparison to other crimes, sexual crimes summon the most public concern (Mann et al., 2010). Sexual abuse in the UK is conceived as a public protection and risk management issue, which focuses on the management of IPSO and the prevention of re-offending (McCartan et al., 2018). Seto (2019) argues that having a better understanding of the underlying factors related to sexual offending will result in more effective prevention, assessment, and intervention, as well as helping to tackle the 'taboo' nature of sexual offending (Kemshall & Wood, 2008). There is a consensus in the field that a credible explanation of sexual abuse is multifactorial, encompassing several aetiological pathways which lead to the onset and maintenance of sexual offending (Ward & Beech, 2016). Integrated theories of sexual offending suggest that abuse occurs as a consequence of an interaction between biological, psychological, and social factors (Smallbone, Marshall & Wortley, 2008; Ward & Beech, 2006;

Ward & Beech, 2016; Ward & Siegert, 2002), which is also the current perspective used within HMPPS treatment programs.

Over the past twenty years, research has predominately focused on factors associated with the persistence of sexual offending (sexual recidivism), whereas, the understanding of factors associated with the onset of sexual offending is less established (Seto, 2019). The gap between the two is thought to be partly due to the fact that it is easier to follow and conduct research with IPSO assessed in clinical or forensic settings than it is identifying and following large community samples to see who might commit a sexual offence in the first place (Seto, 2019). Although onset and persistence factors may be similar, they are not necessarily the same, for example, research suggests that being sexually abused as a child is related to the onset of sexual offending, however, it is not a significant predictor of sexual reoffending (Jespersen, Lalumière & Seto, 2009; Widom & Massey, 2015).

Nevertheless, focusing on risk factors (such as the 'central eight' risk factors associated with the risk-need-responsivity (RNR) model; Andrews & Bonta, 2006) associated with sexual recidivism has enabled clinicians to make decisions based on recidivism risk and has guided treatment and supervision planning (Seto, 2019). According to Thornton (2013) and Walton, Ramsay, Cunningham and Henfrey (2017), it is commonly agreed that there are four risk domains: sexual (sexual deviancy), cognitive (antisocial attitudes), relationships (interpersonal skills and intimacy deficits), and self-management (emotional dysregulation or poor self-control). A meta-analysis in 2005 revealed that deviant sexual preferences and antisocial orientation were major predictors of sexual recidivism, with SP, impulsivity, pro-offending attitudes and intimacy deficits being identified as useful treatment targets (Hanson & Morton-Bourgon, 2005). Furthermore, a meta-analysis in 2010 reported similar risk factors for sexual recidivism, including: SP, sexual deviance, offence-supportive attitudes, emotional congruence with children, lack of emotionally intimate relationships with adults, lifestyle instability, general self-regulation problems, poor cognitive problem solving, resistance to rules and supervision, grievance/hostility, negative social influences, hostility towards women, Machiavellianism, callousness, and dysfunctional coping (Mann et al., 2010).

2.1.1 Sexual offending and personality disorder

It is widely documented that IPSO typically experience difficulties with intimacy (Marshall, 1989), emotional loneliness (Marshall, 1993), empathy (Marshall, Anderson & Champagne, 1997), social skills (Marshall, Barbaree & Fernandez, 1995; Segal & Marshall, 1985), emotional skills (Gillespie & Beech, 2016), self-confidence (Marshall et al., 1997), and cognitive distortions (Mann & Beech, 2003; Ward, 2000). The aforementioned meta-analyses also suggest a strong association between problematic personality traits and recidivism (Hanson & Morton-Bourgon, 2005; Mann et al., 2010). These difficulties are related to personality impairments which lead to difficulties in developing and

maintaining relationships with others (Laulik, Allam & Sheridan, 2007), whereby the majority of these deficits are also hallmark symptoms for psychopathology and PDs (Ahlmeyer et al., 2003).

There are several similarities between theories of PD and theories of sexual offending, in that several of the symptoms associated with PDs are also relevant to the understanding of sexual offending (Prince, 2008). Marshall and Marshall (2000) argue that poor-attachment styles may result in cognitive, social, and affective deficits, which in turn, leads to a greater probability of a child being sexually abused, being conditioned with sexual responses, developing coping strategies based around sex, lacking the inability to inhibit deviant sexual fantasy, experiencing general psychopathology, and social isolation. Additionally, impairments in identity and relational capacities are in accordance with self-regulation theories of sexual offending (Stinson, Becker & Sales, 2008; Ward & Beech, 2006). Schemas are focused on when working with individuals with PD, which contain beliefs, attitudes, assumptions, and rules about the world (Young, Klosko & Weishaar, 2003). Schemas are analogous to the notion of 'implicit theories' (Ward & Keenan, 1999), whereby an IPSO with PD may present with offence-related schemas, as well as more general maladaptive schemas found in non-offending patients with PD (Prince, 2008). Various theories have been developed to explain the relationship between PD and sexual offending, such as Proulx, Blais and Beaugard's (2006) model of personality disorder and rape, and Bushman and van Beek's (2003) model of IPSO with PD, however, it is beyond the scope of this thesis to describe these theories in detail (please see Tennant & Howells [2010] for a more detailed description).

2.1.1.1 Prevalence of personality disorder among IPSO

In the general population, prevalence rates of PD are fairly low: 2-3% (Snowden & Kane, 2003), 4.4% (Coid, Yang, Tyrer, Roberts & Ullrich, 2006) and 4-11% (National Offender Management Service [NOMS] and NHS England, 2015). Whereas, in prison populations, the prevalence rates are considerably higher in comparison, ranging from 61% – 70% (Fazel & Danesh, 2002; NOMS & NHS England, 2015; Stewart, 2008). In regard to prevalence rates among IPSO, studies have found differing prevalence results, ranging from 33% - 94% (Chen et al., 2016; Craissati & Blundell, 2013; Dunsieith et al., 2004; Fazel, Hope, O'Donnell & Jacoby, 2002; Kingston, Olver, Harris, Wong & Bradford, 2015; McElroy et al., 1999). Furthermore, research has found that PDs are often comorbid with other PDs (Zimmerman, Rothschild & Chelminski, 2005). Dunsieith et al. (2004) reported that 28% of IPSO met criteria for three or more PDs, and among a sample of UK IPSO in the community, 25% reported multiple PDs (Craissati & Blundell, 2013).

Ahlmeyer et al. (2003) suggest that IPSO show greater levels of pathology in affective and social domains in comparison to general prisoners. General prisoners are thought to demonstrate more criminal personality characteristics (such as antisocial and narcissistic traits), whereas, IPSO are more likely to have PDs that related to emotional and social distress (such as depressive, avoidant and

schizoid PDs; Francia, Coolidge, White, Segal, Cahill & Estey, 2010). Several studies have assessed the prevalence of PDs among IPSO, however, the research is inconclusive regarding what PDs are most prevalent. Some studies posit that antisocial PD is the most dominant PD among IPSO (Chen et al., 2016; Dunsieith et al., 2004; Hanson & Morton-Bourgon, 2005; Kingston et al., 2015; Leue, Borchard & Hoyer, 2004; McElroy et al., 1999; Sigler, 2017), whereas, other research suggests that a range of other PDs are prevalent among IPSO, including schizoid, avoidant, dependent, passive-aggressive, borderline, narcissistic, obsessive-compulsive and paranoid PDs (Chantry & Craig, 1994; Craissati & Blundell, 2013; Dudeck, Spitzer, Stopsach, Frehberger, Barnow, 2007; Francia et al., 2010; Langevin et al., 1988).

The majority of this research has been conducted in the US, Canada, or Europe. Some of these studies have purely examined the prevalence of PDs among IPSO, whereas, others have included control groups for comparative purposes. In terms of studies conducted in Europe (without a control group), Curtin and Niveau (1998) explored the prevalence of PD among 67 IPSO in Switzerland, reporting that half of the sample was diagnosed with PD, whereby borderline PD was the most prominent. Borchard, Gnoth and Schulz (2003) found that antisocial, paranoid, borderline, and avoidant PDs were the most prevalent among a sample of 47 IPSO in Germany. Leue, Borchard and Hoyer (2004) also looked at IPSO in Germany ($n = 55$), finding that antisocial PD was the most common, followed by avoidant, borderline, narcissistic, obsessive-compulsive and dependent PDs. More recently, in 2013, Craissati and Blundell (2013) assessed PD among IPSO residing in the community in the UK ($n = 137$), in which avoidant and schizotypal traits were the most prevalent.

In regard to research conducted in the US and Canada, McElroy et al. (1999) reveals that antisocial, borderline, paranoid, obsessive-compulsive, avoidant, narcissistic, dependent, and histrionic PDs were prevalent among 36 IPSO in Cincinnati. Dunsieith et al (2004) looked at a slightly larger sample, 113 male IPSO from Ohio, reporting that all DSM-IV PDs were prevalent among the sample, with antisocial, borderline, paranoid, narcissistic and avoidant being the most common. More current research in New Jersey shows that antisocial, borderline, schizotypal, schizoid, and narcissistic PDs were common among the sample of 3061 IPSO (Sigler, 2017), however, the prevalence rates were particularly low in comparison to previous research. Sigler (2017) proposes that this may be due to the PD diagnoses being coded from mental health records, as opposed to any form of assessment or interview. Although these studies report a high prevalence of PD among IPSO, it is important to highlight that some of these samples are relatively small, and no comparisons have been made with other groups (such as the general population, or non-IPSO prisoners).

Conversely, other studies have included control groups for comparative purposes, for example, Dudeck et al. (2007) utilised a modest sample of 19 IPSO and 32 non-IPSO (prisoners convicted of non-sexual offences) from Germany, determining that narcissistic PD was significantly more frequent in IPSO compared to non-IPSO, however, only narcissistic, borderline and antisocial PD prevalence rates were

provided. Again, in Germany, Schroeder, Iffland, Hill, Berner and Briken (2013) report that IPSO ($n = 61$) reported significantly lower levels of antisocial and borderline PD in comparison to IPVO ($n = 99$) and sexual and violent ($n = 60$) prisoners. In France, Perrot, Benony, Chahraoui and Juif (2014) studied personality trends among IPSO ($n = 28$) and a control group of men with no psychiatric disorders ($n = 28$), discovering that IPSO presented with higher rates of avoidant PD in comparison to the control group. Furthermore, Fazel et al. (2002) looked at PDs among IPSO ($n = 101$) and non-IPSO ($n = 102$) within prisons in the UK, although the focus was on elderly IPSO (59+), revealing that IPSO had more avoidant, schizoid, and obsessive-compulsive traits, and less antisocial traits in comparison to non-IPSO.

Regarding studies conducted in the US and Canada, Langevin et al. (1988) compared 247 IPSO in Canada to a control group (consisting of police trainees [$n = 100$], general prisoners [$n = 33$], and general community volunteers [$n = 39$]). The results highlight that IPSO were significantly more schizoid, avoidant, dependent and passive-aggressive, and less narcissistic than the control group. In Chicago, Chantry and Craig (1994) compared 397 IPSO with 206 IPVO, whereby IPSO demonstrated higher rates of avoidant PD than IPVO. Similarly, Ahlmeyer et al. (2003) found that IPSO ($n = 695$) were more likely to be diagnosed with avoidant, depressive, dependent, schizoid, and schizotypal PDs in comparison to non-IPSO (prisoners convicted of non-sexual offences), who demonstrated more antisocial and narcissistic PDs. Comparable results were also found in 2010 among 562 IPSO from Colorado (Francia et al.), whereby IPSO were more likely to have depressive, avoidant and schizoid PDs compared to non-IPSO.

Overall, there is a lot of diversity within the literature regarding what PDs are most prevalent among IPSO, which may be two-fold. Firstly, all of the studies have used various methods of categorising PD diagnoses (including scoring patient files, psychometrics measures, and diagnostic interviews), which may be one explanation as to why there are differences in prevalence rates. Secondly, it may also be impacted by some studies treating IPSO as a homogenous group (irrelevant of their offence type), whereas, other research suggests that the prevalence of PDs may differ between groups of IPSO, such as IPSO against adults and IPSO against children (e.g. Ahlmeyer et al., 2003; Eher, Rettenberger & Schilling, 2010; Shea, 1996; Sigler, 2017). Research argues that IPSO against children are more likely to present with avoidant, passive-aggressive, dependent, depressive, schizoid, and obsessive-compulsive PDs (Ahlmeyer et al., 2003; Craissati, Webb & Keen, 2008; Eher et al., 2010; Francia et al., 2010), whereas, IPSO against adults display higher rates of narcissistic, antisocial, borderline, and paranoid PDs (Craissati et al., 2008; Eher et al., 2010; Francia et al., 2010; Sigler, 2017).

Jones (2007; as cited in Jones, 2009) suggests that although there is no consistent link between individual PDs and specific offences, IPSO against adults and IPSO against both adults and children tend to have PDs that would be classed as being in the dominant section of the interpersonal circle (narcissistic, antisocial and histrionic; Blackburn, 1998), and IPSO against children are more likely to experience PDs within the submissive section (schizoid, dependent and avoidant). This corroborates

with Jones' (1997) suggestion that IPSO may be more likely to offend against others whom are considered to be equal or lower than themselves according to their own perceived dominance. NOMS and NHS England (2015) propose that IPSO against children may show higher rates of avoidant PD because they have difficulties establishing and maintaining intimate relationships with adults, and higher rates of schizoid PD may be due to difficulties experiencing intimate attachments with adults.

As well as categorical PDs, research has identified that IPSO demonstrate impairments in general personality functioning, particularly in relation to identity integration and relational capacities (Bumby & Hansen, 1997; Garofalo et al., 2018), in which intimacy has also been linked to sexual recidivism (Hanson & Morton-Bourgon, 2005). Additionally, Garofalo et al. (2018) demonstrate that IPSO show impairments in the domains of responsibility and self-control too. Elevated levels of negative affect have been found among IPSO (Smallbone & Dadds, 2000; Ward & Hudson, 2000), with IPSO reporting worse mood management and feeling more threatened by stressful situations than non-sexual prisoners (Ross & Fontao, 2006). Impulsivity and a lack of empathy are also common traits found among IPSO (Giotakos, Vaidakis, Markianos & Christodoulou, 2003), whereby increased levels of hostility and impulsivity are associated with sexual recidivism (Hanson & Morton-Bourgon, 2005, Mann et al., 2010). Of note, psychopathic traits are some of the most popular traits found among prisoners, and although psychopathy is discussed extensively in the literature regarding individuals who have violently or sexually offended, the concept of psychopathy is not covered throughout this thesis.

Overall, it is evident that the literature on PD among IPSO is varied, with several studies suggesting different relationships between PD and sexual offending. It appears that IPVO and general prisoners appear to be more narcissistic and antisocial compared to IPSO, who present with more varied PDs, mainly borderline, avoidant, dependent and schizoid. When comparing different types of sexual offences, IPSO against children tend to display more avoidant, dependent, depressive, schizoid and passive-aggressive PDs, whereas, IPSO against adults show more narcissistic, antisocial, paranoid and borderline PDs. There is minimal research focusing on PD among IPSO in the UK, and of the two studies discussed here, one focused on IPSO residing in the community (Craissati & Blundell, 2013), and the other focused on elderly IPSO (Fazel et al., 2002), highlighting a paucity within the literature relating to PD among IPSO residing in UK prison establishments. Therefore, one of the aims of this thesis is to explore the prevalence of PD among IPSO housed in two UK prisons.

2.1.2 Sexual offending and sexual preoccupation

Sexual preoccupation (SP) is thought to be implicated in the aetiology of sexual offending, and according to the motivation-facilitation model (MFM; Seto, 2019), high sex drive is one of the primary motivations for sexual offending, whereby individuals with a high sex drive may experience excessive SP. SP has also been identified as one of the major predictors of general, violent and sexual recidivism, and as a useful treatment target (Hanson & Morton-Bourgon, 2005; Knight & Thornton, 2007; Mann et al., 2010). Cognitive-behavioural therapy (CBT) has been the primary psychotherapeutic treatment for IPSO in the UK for many years (Lievesley et al., 2013), however, despite SP being identified as one of the most strongly present treatment needs among IPSO in the UK (Hocken, 2014), it is the only risk factor which is not addressed by current UK IPSO programs (Lievesley, 2019; Winder et al., 2017; Winder et al., 2018).

There are numerous similarities between theories of SP and theories of sexual offending, in that several aetiological factors are implicated in the development of both phenomena, including poor attachment styles, adverse childhood experiences, emotional dysregulation, impulsivity, self-control, and many more. Traumatic experiences are thought to lay the groundwork for a range of interpersonal problems and maladaptive coping skills (Elliot et al., 2005; Teyber & McClure, 2011), including difficulties with emotion regulation. It is thought that SP and resultant sexual behaviour may be used as ways of coping with these emotions (Cortoni & Marshall, 2001; Jerome, Woods, Mozkowitz & Carrico, 2016; Whitfield, 1998). IPSO who are driven by emotional dysregulation may continue to use these coping strategies during adulthood, whereby they may turn to pornography or sexual offending when they experience stress, anger, loneliness, or powerlessness (Yule, Brotto & Gorzalka, 2017). Additionally, Ward and Siegert (2002) propose that sexual offending involves four components: sexual arousal, emotional dysregulation, intimacy and social skills deficits, and antisocial personality traits or distorted cognition, whereby a dysfunctional mechanism is one that fails to work in the way that it was intended. These four mechanisms have also been implicated in the regulation of normal sexual arousal (Bancroft, Janssen, Strong & Vukadinovic, 2003; Giraldi, Kirstensen & Sand, 2015; Whiteside, Lynam, Miller & Reynolds, 2005; Zapolski, Cyders & Smith, 2009), in which sexual offending may occur due to a dysfunctional mechanism associated with normative sexual arousal. Ward and Siegert (2002) propose that all IPSO will have deficits across all four mechanisms which interact in order to cause their sexual offending behaviour, but one mechanism will be prominently deficient for each IPSO.

2.1.2.1 Prevalence of sexual preoccupation among IPSO

Discrepancies within the literature regarding the different ways of describing, conceptualising, and assessing SP (described further in section 2.3.1) results in a wide variation in the estimated prevalence rates of SP (Moser, 2011). There are minimal studies which focus specifically on the prevalence of the

cognitive aspect (SP), with many researchers measuring the resulting physical behaviours (such as hypersexuality, compulsive sexual behaviours, and total sexual outlet [TSO]), therefore, the prevalence of these will also be discussed below.

In the general population, prevalence rates of between 1.2% and 18% have been reported (Carnes, 1989; Coleman, 1990; Kuzma & Black, 2008; Marshall, Marshall, Moulden & Serran, 2008; Odlaug et al., 2013; Skegg, Nada-Raja, Dickson & Paul, 2010), whereas, the rates are thought to be higher among certain populations, including IPSO and homosexual men (Carnes, 1991; Hanson & Morton-Bourgon, 2005; Kingston & Bradford, 2013; Kuzma & Black, 2008; Reid, 2013). In relation to IPSO populations, findings suggest prevalence rates between 9% and 55% (Blanchard, 1990; Briken, 2012; Carnes, 1989; Hanson, Harris, Scott & Helmus, 2007; Kingston & Bradford, 2013; Marshall & Marshall, 2006; Marshall et al., 2008). In 1989, Carnes suggested that around 50% of IPSO would meet the criteria for sexual addiction, however, Carnes failed to provide any empirical data to support this estimation. Nevertheless, subsequent studies have provided evidence for Carnes' claims. In 1990, Blanchard used self-report measures with 109 IPSO from America and found that 55% of the sample met the criteria for sexual addiction. Of this 55% that met the criteria, 71% offended against children and 39% offended against adults, showing higher rates of sexual addiction among IPSO against children.

Later studies conducted by Marshall and Marshall (2006) and Marshall et al. (2008) were consistent with previous results. Marshall and Marshall (2006) looked at the prevalence of sexual addiction in Canada, comparing IPSO ($n = 40$) and community ($n = 40$) samples, finding that 35% of IPSO reported experiencing sexual addiction compared to 12.5% of the matched community controls. Marshall et al. (2008) conducted research with a larger sample of IPSO ($n = 114$) and a community sample ($n = 117$). Similar results were found, with 44% of the IPSO population demonstrating sexual addiction, and 18% of the community sample meeting criteria. However, unlike Blanchard (1990), they found that IPSO against adults had higher rates (51%) compared to IPSO against children (39%), but no significant differences were found between the two.

Conversely, other research has found lower prevalence rates. Hanson et al. (2007) looked at 805 IPSO in the community in Canada, discovering that 11.3% met the criteria for sexual preoccupation, and Briken (2012) found that 9% of IPSO against children from Germany ($n = 244$) met the criteria for hypersexual disorder. Furthermore, Kingston and Bradford (2013) looked at TSO as a measure of hypersexuality and reported that 12% of IPSO ($n = 586$) met the criteria (≥ 7) for hypersexuality. The discrepancies among the prevalence rates of SP among IPSO may be due to the various ways of conceptualising and measuring the phenomenon, as well as the way in which questions are asked, under what circumstances they are asked in, and the perceived positioning of the person asking the questions. Kingston and Bradford (2013) argue that the lower rates evident in the latter studies may be due to these studies using more objective criteria.

As is evident from the literature, the prevalence of SP among IPSO is unclear, and to the best of the author's knowledge the prevalence of SP has not previously been assessed among UK prison establishments that house IPSO, which is consequently one of the aims of this thesis. Reid (2013) argues that we know very little about the prevalence of this phenomenon and how it manifests across various populations. Although the prevalence rates have not been explored across UK prison establishments, SP was found to be one of the most strongly present risk factors for reoffending (regardless of IQ or offence type) in a study of 1,462 male IPSO housed in 30 prison sites across England and Wales (Hocken, 2014), as well as being identified as a risk factor for recidivism (Hanson & Morton-Bourgon, 2005; Mann et al., 2010). This highlights the crucial need to further explore the prevalence and underlying mechanisms of this phenomenon among IPSO housed in UK prison establishments.

2.1.3 Sexual offending and adverse childhood experiences

Contemporary theories of sexual offending argue that adverse family environments provide the perfect 'breeding grounds' for sexual offending (Hanson & Morton-Bourgon, 2005; Levenson, 2014, p. 14), whereby it is well-recognised within the literature that traumatic experiences in childhood may contribute to the development of later sexual offending, particularly experiences which impact the development of secure attachments (Beauregard, Lussier & Proulx, 2004; Houston, 2008; Jespersen et al., 2009). It is thought that a lack of nurturance and appropriate guidance may result in individuals developing social functioning problems (such as emotional dysregulation, mistrust, hostility and insecure attachment), which, in turn, are related to social rejection, loneliness, negative peer associations and delinquent behavior (Hanson & Morton-Bourgon, 2005). Adverse Childhood Experiences (ACEs) are thought to impact brain development (particularly affective regulation, planning abilities, and the way in which an individual interprets events), which, according to Ward and Beech (2016), are risk factors for sexual behaviour. Family dysfunction, childhood sexual abuse, and emotional abuse have been reported as developmental risk factors for sexual offending (Lee, Jackson, Pattison & Ward, 2002), and the sexual abuse hypothesis posits that the experience of childhood sexual abuse may link to sexual offending in later life (Lindsay, 2002), stemming from the idea of a circle of abuse (Dhawan & Marshall, 1996; Levenson, 2014). However, it is important to recognise that not all children who experience abuse go on to abuse others (Stinson et al., 2008), which suggests that abuse alone is not a sufficient explanation of sexual offending, but it is the interaction between a variety of factors which may result in an individual engaging in harmful sexual behaviour (Ward & Beech, 2016).

Although adverse family environments are not predictive of sexual recidivism, they are thought to be crucial to the onset of sexual offending, and various theories suggest that ACEs are an important aetiological factor which should be taken into consideration in the development of sexual offending (Grady, Levenson & Bolder, 2017; Levenson, 2014; Ward & Beech, 2016). However, previous research has focused on the presence of just one (predominantly child sexual abuse), or a few types of trauma

(Lasford et al., 2007). More recently, the notion of ACEs has gained momentum within the literature, whereby the concept of ACEs provides a framework to explore a range of traumatic experiences (including child maltreatment and household adversity), as well as the cumulative and enduring impact of these ACEs (Ford et al., 2019). ACEs are now viewed as a public health 'crisis' (Anda et al., 2010; Felitti, 2002; Larkin et al., 2014), whereby this recognition that ACEs are an increasing international concern (Bellis et al., 2015) has led to an increase in ACE studies within the UK, including England (Bellis et al., 2014a), Wales (Bellis et al., 2015), and Scotland (Couper & Mackie, 2016). The most recent advancement within this field includes an exploration of ACEs among a general sample of male prisoners in Scotland (Carnie et al., 2017) and Wales (Ford et al., 2019). Studies among IPSO indicate that IPSO are more likely to experience ACEs in comparison to the general population (Levenson, Willis & Prescott, 2014).

Not only are ACEs important in the aetiology of sexual offending, they are also implicated in the development of PD and SP. Research has identified a link between early childhood trauma and PD, whereby victims of childhood trauma are more likely to experience PD and elevated PD symptoms (Johnson, Cohen, Brown, Smailes & Bernstein, 1999; Zanarini, 2000; Laporte, Paris, Guttman and Russell, 2011). Furthermore, a relationship between childhood trauma and SP has also been noted (Carnes, 2000; Courtois & Weiss, 2018; Engel et al., 2019; Marshall, 2016a), whereby men with SP report higher rates of ACEs, especially emotional abuse/neglect and sexual abuse (Engel et al., 2019), which have been shown to be associated with emotional regulation difficulties (Carvalho Fernando et al., 2014). 20

2.1.3.1 Prevalence of adverse childhood experiences among IPSO

The ACE scale was developed in the 1990s to measure childhood adversity, but, despite the first ACE study being conducted in 1998 (Felitti et al.), it has taken almost two decades for the notion of ACEs to gain momentum in the UK (Bellis et al., 2014a; Bellis et al., 2014b; Bellis et al., 2015; Couper & Mackie, 2016; Ford et al., 2016). ACE studies in UK general population samples demonstrate that individuals with 4 or more ACEs were 8 to 20 times more likely to have ever been incarcerated (Bellis et al., 2014a; Bellis et al., 2015; Ford et al., 2016), with the most recent ACE studies exploring the prevalence of ACEs among prisoners in Scotland (Carnie et al., 2017) and Wales (Ford et al., 2019). Ford et al. (2019) revealed that 85% of prison residents experienced at least one ACE, with 46% reporting four or more ACEs. High prevalence rates of child maltreatment and household dysfunction were common among both samples (Carnie et al., 2017; Ford et al., 2019), whereby prisoners with four or more ACEs were 3.5 times more likely to prolifically commit crime (Ford et al., 2019).

However, to the best of the author's knowledge, the prevalence of ACEs specifically among IPSO (using the ACEs framework) has not yet been explored within the UK, particularly among IPSO housed in UK

prison establishments. In terms of IPSO in the UK, Craisatti and Blundell (2013) identified that 52% of IPSO in the community reported verbal abuse, 38% had been sexually abused, and 31% reported physical abuse, however, this study did not take into account wider aspects of adversity, such as household dysfunction. Studies outside of the UK demonstrate that in comparison to general population and non-IPSO samples, IPSO were more likely to experience higher rates of early childhood trauma (Jespersen et al., 2009; Levenson et al., 2016; Reavis et al., 2013), whereby IPSO were 3.4 times more likely to report child sexual abuse in comparison to non-IPSO (Jespersen et al., 2009).

Although previous meta-analyses have reported that childhood abuse was not related to sexual recidivism (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2005), other research indicates an association between child sexual abuse and sexual recidivism among high-risk IPSO (Nunes, Hermann, Malcom & Lavoie, 2013), and a relationship between ACE scores and risk scores (Levenson et al., 2016). ACE studies have been conducted with IPSO in the US, whereby Marshall (2016a) reports that 76% of IPSO experienced at least one ACE, and Levenson et al. (2016) report that 84% of IPSO reported at least one ACE. Furthermore, these studies highlight that around half of IPSO experienced four or more ACEs (Levenson et al., 2016; Marshall, 2016a; Reavis, Looman, Franco & Rojas, 2013), suggesting that IPSO may have been raised in disordered social environments by caregivers who were unable to appropriately protect them from emotional, physical, and sexual abuse (Levenson et al., 2016).

Considering individual ACEs, Reavis et al. (2013) explored the prevalence of ACEs among a sample of IPSO ($n = 61$) that were receiving outpatient psychological treatment in the US. The results reveal that IPSO reported high rates of psychological abuse (66%), physical abuse (46%) and sexual abuse (40%), as well as household dysfunction: parental divorce (61%), substance abuse (56%), domestic violence (36%), mental illness (30%) and incarceration (26%). Similarly, Marshall (2016a) reports that child maltreatment was common among a sample of IPSO from the US: physical abuse (49%), verbal abuse (46%), sexual abuse (17.1%), as well as a high prevalence of household dysfunction: parental separation (56%), substance abuse (42%), mental illness (37%), domestic violence (20%) and incarceration (10%). Moreover, Levenson et al. (2016) explored the prevalence of ACEs among a larger sample of IPSO ($n = 679$) from civil commitment (28%) and outpatient (72%) IPSO treatment programs across the US, and compared them to males in the general population. Their results illustrate that IPSO demonstrate high rates of child maltreatment: verbal abuse (53%), physical abuse (42%), sexual abuse (38%), emotional neglect (38%), physical neglect (16%), with household dysfunction also being common among the sample: parental separation (54%), alcohol abuse (47%), drug use (47%), mental illness (26%), domestic violence (24%) and incarceration (23%). In comparison to the general population, IPSO were thirteen times more likely to experience verbal abuse, four times more likely to suffer emotional neglect, three times more likely to have been sexually abused, and twice as likely to report physical abuse.

The prevalence of child sexual abuse is discussed extensively in the sexual offending literature, with IPSO demonstrating higher rates of sexual abuse in comparison to general population and non-IPSO samples (Craissati, McClurg, & Browne, 2002; Dudeck et al., 2007; Weeks & Widom, 1998). Dudeck et al. (2007) revealed that IPSO were 11 times more likely to experience child sexual abuse compared to non-IPSO, in which it is thought to increase the likelihood of later committing a sexual offence (Burton, Miller & Schill, 2002; Glasser, Kolvin, Campbell, Glasser, Leitch & Farrelly, 2001; Haapasalo & Kankkonen, 1997). Additional research has highlighted a link between the intensity and repetition of the abuse and the likelihood of the victim becoming an IPSO later (Burton et al., 2002; Glasser et al., 2001). Regarding emotions, sexual abuse is linked with the development of anger and hostility, which are important aspects in relation to sexual offending (Lee et al., 2002; Malamuth, Sockloskies, Koss & Tanaka, 1991; Marshall & Barbaree, 1999). Furthermore, previous research illustrates that individuals who experience sexual abuse are twice as likely to experience other forms of maltreatment or family dysfunction (Dong, Anda, Dube, Giles & Felitti, 2003), meaning that sexual abuse rarely occurs in isolation and overlaps with other adverse experiences.

Overall, the literature indicates that ACEs are common among IPSO, who report experiencing more ACEs than general population and non-IPSO samples. Although the prevalence of ACEs among IPSO has been explored in American samples, and research in the UK has explored the prevalence of traumatic events (i.e. sexual abuse, emotional abuse, and physical abuse), to the best of the author's knowledge the prevalence of ACEs (using the ACEs framework) among IPSO in the UK has not yet been explored. Ford et al. (2016) argue that the extent of ACEs and the resulting impact may vary across different populations, and therefore studies may not be generalizable. It is essential that this is explored specifically among IPSO in the UK in order to gain a better understanding of the prevalence and impact of ACEs, as Anda and colleagues (Anda et al., 2006; Anda et al., 2010) argue that having a clear understanding of the impact of early adversity among specific populations is crucial for the development of social policy and treatment interventions.

2.2 Personality disorder

PD is a serious mental health condition, which is present among 52% of psychiatric out-patients and 70% of in-patients and forensic patients (Banerjee, Gibbon & Huband, 2009; NOMS & NHS England, 2015). Given that the presence of personality pathology has been shown to be evident among IPSO (Gillespie & Beech, 2016; Marshall et al., 1997, Mann & Beech, 2003), and increases the risk of reoffending (Hanson & Morton-Bourgon, 2005; Kingston et al., 2015; Mann et al., 2010), it is thought that it may serve as a crucial treatment target (Garofalo et al., 2018). Effective treatment for PD is a priority given the health complications associated with the disorder, such as: extensive use of healthcare resources, a reduced life expectancy, and high rates of suicide (Chiesa, Fonagy, Holmes,

Drahoard & Harrison-Hall; 2002; Fok et al., 2012; Stone, 1993). The following section will explore the definition, relevant theories, and impact of PD.

2.2.1 Defining personality disorder

Everybody has a personality, which consists of a combined and consistent pattern of thinking, feeling, behaving, and ways of relating to other people (Matthews, Deary & Whiteman, 2009). However, if this pattern interferes and impacts on an individual's day to day functioning, then it is referred to as PD (Hales, Yudofsky & Gabbard, 2008). Personality disorder is a recognised mental disorder, defined in the Diagnostic and Statistical Manual of Mental Disorders (5th Edition; DSM-5) as 'an enduring pattern of inner experience and behaviour that deviates markedly from expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment' (American Psychiatric Association [APA], 2013a, p. 645).

There are two main classification systems for PDs; the DSM-5 (APA, 2013a) and the International Classification of Diseases (11th Revision; ICD-11; World Health Organization [WHO], 2018). At the commencement of this thesis (2015), the 11th revision of the ICD had not yet been released, however, the DSM-5 had not long been released, which contained both a categorical system and a new dimensional approach to PDs. Therefore, the DSM-5 classification system is the main focus of this thesis (as opposed to the ICD-11). As well as the formal classification systems, PDs are commonly understood in relation to the three Ps; whereby they are persistent, problematic, and pervasive (West, 2014).

2.2.1.1 Categorical approaches to personality disorder

For several years, PDs have been defined as categorical diagnoses, with the DSM-5 main section providing criteria for ten PDs, which are grouped into three clusters: A, B and C. Cluster A PDs are known as odd or eccentric disorders, consisting of paranoid, schizoid and schizotypal PDs. Cluster B PDs are referred to as the dramatic, emotional or erratic disorders, including antisocial, borderline, histrionic and narcissistic PDs. Lastly, cluster C encompasses anxious or fearful disorders, consisting of avoidant, dependent and obsessive-compulsive PDs (please see table 1 for a breakdown of the different PDs throughout all editions of the DSMs, and appendix 1 for a brief description of each PD according to the DSM-5). The DSM-5 is split into three sections: (i) basics, (ii) diagnostic criteria and codes, and (iii) emerging measures and models, whereby the DSM-5 contains the traditional PD symptom criteria in section II (retaining the PD categorical structure from the DSM-IV-TR; 4th ed., text rev.; APA, 2000).

Table 1. Personality disorder diagnoses in all editions of the Diagnostic and Statistical Manual of Mental Disorders (Modified from Widiger, 2012)

DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV	DSM-IV-TR	DSM-5	
Personality pattern disturbance:						Section II:	Section III:
Inadequate	Inadequate						
Schizoid	Schizoid	Schizoid	Schizoid	Schizoid	Schizoid	Schizoid	
Cyclothymic	Cyclothymic						
Paranoid	Paranoid	Paranoid	Paranoid	Paranoid	Paranoid	Paranoid	
		Schizotypal	Schizotypal	Schizotypal	Schizotypal	Schizotypal	Schizotypal
Personality trait disturbance:							
Emotionally unstable	Hysterical	Histrionic	Histrionic	Histrionic	Histrionic	Histrionic	
		Borderline	Borderline	Borderline	Borderline	Borderline	Borderline
Compulsive	Obsessive-compulsive	Compulsive	Obsessive-compulsive	Obsessive-compulsive	Obsessive-compulsive	Obsessive-compulsive	Obsessive-compulsive
Passive-aggressive;							
Passive-aggressive type	Passive-aggressive	Passive-aggressive	Passive-aggressive				
Passive-dependent type		Dependent	Dependent	Dependent	Dependent	Dependent	
Aggressive type							
	Explosive						
	Aesthetic						
		Avoidant	Avoidant	Avoidant	Avoidant	Avoidant	Avoidant
		Narcissistic	Narcissistic	Narcissistic	Narcissistic	Narcissistic	Narcissistic
Sociopathic personality disturbance:							
Antisocial reaction	Antisocial	Antisocial	Antisocial	Antisocial	Antisocial	Antisocial	Antisocial
Dyssocial reaction							
Sexual deviation							
Addiction							

Appendices: DSM-III-R; self-defeating and sadistic PDs, DSM-IV and IV-TR; passive-aggressive and depressive PD

However, the categorical approach has several limitations, whereby it is thought that only half of patients meet specific criteria for categorical diagnoses (Zimmerman et al., 2005), with PD not otherwise specified (PD-NOS) being the most common diagnosis in practice (Coccaro, Nayyer & McCloskey, 2012). Of the patients that do meet criteria for a specific PD, they often meet the criteria for more than one (Nurnberg et al., 1991), whereby excessive diagnostic comorbidity has been reported (Clark, 2007; Skodol et al., 2011). Although clinicians can recognise PDs when they are typical and pragmatic, Paris (2015) argues that ‘many if not most patients fall between the cracks of the system’ (p. 19) because of these issues.

Furthermore, issues around heterogeneity within diagnoses (i.e. two individuals that meet the minimum threshold for a PD may present with very different traits), lack of external validity, less than desirable reliability, and lack of empirically validated cut-offs are also discussed within the literature (Clark, 2007; Hyman, 2010; Skodol et al., 2011; Trull & Durrett, 2005; Widiger & Trull, 2007). Although in the main section of the DSM-5 personality disorders are defined as ten categorical entities, there is limited evidence supporting the latent structure of personality pathology as ten dichotomous variables (Widiger, Simonsen, Krueger, Livesley & Verheul, 2005).

2.2.1.2 Dimensional approaches to personality disorder

As a way of addressing the existing issues with the categorical approach, the DSM-5 Personality and Personality Disorder Workgroup proposed an alternative dimensional system for the diagnosis of PD (Anderson, Snider, Sellbom, Krueger & Hopwood, 2014), given that various research has evidenced the advantages of understanding PD from a trait-dimensional perspective (e.g., Clark, 2007; Livesley, 2007; Widiger & Trull, 2007). The new model was rejected as the primary model for diagnosing PD and was subsequently placed in section III of the DSM-5 (emerging measures and models) as a way of preserving ‘continuity with current clinical practice’ (APA, 2013a, p. 811).

This Alternative Model for PDs (AMPD) is a hybrid dimensional and categorical system, in which PDs are aligned with dimensional personality traits and levels of functional impairment, which map onto one of six categorical PDs (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs; PDs were retained on the basis of empirical support and clinical relevance; Waugh et al., 2017), with a seventh diagnosis of personality disorder-trait specified (PDTs). A diagnosis using this model requires clinicians to assess the level of impairment in personality functioning (criterion A), as well as evaluating pathological personality traits (criterion B). According to the DSM-5 AMPD (APA, 2013a), both functioning and trait expression must be relatively inflexible and pervasive across a broad

range of personal and social situations (criterion C); relatively stable across time, with origins traced back to adolescence or early adulthood (criterion D); not better explained by a different mental disorder (criterion E), not due to substance use or another medical condition (criterion F); and not considered normal for an individual's developmental stage or sociocultural environment (criterion G).

The defining features of PD according to this model are impairments in personality functioning (criterion A) and the presence of pathological personality traits (criterion B; Wakefield, 2013). Criterion A focuses on impairments in the domains of self (identity or self-direction) and interpersonal (empathy or intimacy) functioning, with a moderate or greater impairment being required for a diagnosis of PD. Criterion B is an empirically based model of maladaptive personality traits (Krueger & Markon, 2014), which describes 25 pathological traits organised into five domains (see appendices 2 and 3 for detailed descriptions of the domains and facets).

Bender, Morey and Skodol (2011) identified that impairments in self and interpersonal functioning make up the core dimensions of personality pathology, however, this is not formally represented in the categorical approach to PDs (Bastiaansen, Fruyt, Rossi, Schotte & Hofmans, 2013). Descriptors of self and interpersonal problems are instead spread throughout the PD categories (Parker et al., 2002), which is thought to contribute to the extensive diagnostic overlap between PDs (Morey et al., 2011). In the DSM-5 AMPD, impairments in self and interpersonal functioning are recognised as a core diagnostic criterion (A).

The second criterion (B) focuses on pathological personality traits (organised into five domains: negative affectivity, detachment, antagonism, disinhibition, and psychoticism), which are grounded in literature that supports the empirical validity of dimensional models of maladaptive personality (Krueger et al., 2011; Samuel & Widiger, 2008;). The personality trait model can be better understood as maladaptive and extreme variants of the domains of the five-factor model (FFM; agreeableness, conscientiousness, neuroticism, extraversion, and openness to experience; Costa & Widiger, 2001) of personality (Trull & Widiger, 2013). Impairments in self and interpersonal functioning (criterion A) are common among all PDs, whereas, personality traits (criterion B) account for the stylistic differences between the different types of PD (Morey et al., 2011). Biologically based 'traits' are thought to be different from socially learned 'adaptations' (Bastiaansen et al., 2013), whereby personality traits that are rooted in the biological makeup of an individual are thought to be less likely to change over time, in comparison to adaptive capacities (McGlashen et al., 2005). Therefore, interventions may have more success at attempting to change adaptive capacities (McCrae et al., 2000), with Clark (2009) suggesting that initial treatment efforts should address these more changeable aspects first.

Bastiaansen et al. (2013) argue that traits and personality functioning should be distinguished within practice, as the severity of functioning may indicate the level of care required, whereas, trait style may reveal the most useful treatment for the individual. In which case, independent assessment tools for both functioning and traits are required. The Levels of Personality Functioning Scale (LPFS; Morey et al., 2011) is provided by the DSM-5 to measure criterion A, and the Personality Inventory for DSM-5 (PID-5; Krueger, Derringer, Markon, Watson & Skodol, 2012) is provided in order to assess criterion B. However, to date, neither of these assessment tools have been validated or utilised in the UK.

There is a substantial body of literature supporting the reliability, validity and factor structure of the DSM-5 AMPD personality trait model (Bastiaens et al., 2016; Krueger & Markon, 2014; Morey, Benson, Busch, & Skodol, 2015), as well as showing expected relations with Section II PDs (Anderson et al., 2014; Sellbom, Sansone, Songer, & Anderson, 2014). When this thesis first commenced, the DSM-5 AMPD was relatively new and was gaining popularity within the literature, with the dimensional approach to PDs being preferred over the categorical approach. Although in clinical practice neither categorical nor dimensional approaches to PDs are used much (as formulations are preferred as a way of attempting to explain why an individual is presenting in a specific way; Jones, 2011), some services still utilise categorical approaches as inclusion/exclusion criteria, and the DSM-5 AMPD is thought to provide clinicians with information above and beyond that of a categorical diagnosis (Bastiaansen et al., 2013).

2.2.1.3 Alternative approaches to personality disorder

It is important to note that the problems with categorical PDs, such as comorbidity, heterogeneity, and assumptions that are not in accordance with evidence, are apparent throughout the whole DSM, not just regarding PD diagnoses (Hyman, 2010). As a result of these issues, other approaches have begun to emerge as alternatives to traditional models based on psychiatric diagnosis, such as the Power Threat Meaning Framework (PTM; Johnstone et al., 2018). The PTM framework is the result of an earlier position statement from the BPS' Division of Clinical Psychology which called for a paradigm shift towards a system which is no longer based on a disease model of psychological distress (Division of Clinical Psychology, 2013; Grant, 2015). The PTM framework looks at the role of several types of power present in an individual's life, the threat that this may pose to an individual, what meaning this has for the person, and the learned and evolved threat responses that have developed as a reaction. The framework argues that threat responses are not symptoms but are effective survival strategies that deserve to be understood and honoured, whereby individuals are thought to be experiencing a normal reaction to an abnormal circumstance (Johnstone, 2018).

2.2.2 An overview of theories relating to personality disorder

There are numerous theories of personality disorder, including: psychodynamic theories (Freud, 1923; Kernberg, 1975), cognitive-behavioural (or social learning) theories (Bandura, 1986; Beck, Freeman & Davis, 2003; Mischel, 1979; Young, Klosko & Weishaar, 2003), trait theories (Allport, 1937; Costa & Widiger, 2001; McCrae & Costa, 1997; Widiger, 2000), biological perspectives (Cloninger, 1998; Depue & Collins, 1999; Siever & Davis, 1991), attachment theory (Bowlby, 1973; Ainsworth, Blehar, Waters & Wall, 1978), integrative theories (Benjamin, 1993; Millon, 1969; Western, 1995), and many more.

The biopsychosocial model of PD is one of the most common approaches used among clinicians (Department of Health, 2014; NOMS & NHS England, 2015), whilst also taking into account the impact of attachment (NOMS & NHS England, 2015). Given that the dimensional approach to PDs discussed previously relies heavily on trait psychology, and the current OPD pathway focuses on the biopsychosocial model of PD, these theories/models will be covered in more detail in this chapter. McAdams' (1994) triarchic model of personality will also be discussed here, as although it describes 'normal' personality rather than PD, it has previously been applied to the treatment of PD (Day & Bryan, 2007) and has a large influence on this thesis. It is beyond the scope of this thesis to describe all theories of PD in detail, therefore, please see Oldham, Skodol and Bender (2005) for a more comprehensive discussion of the major theories of PD.

2.2.2.1 Biopsychosocial model

The biopsychosocial model (see figure 3) posits that only interactions among biological based vulnerabilities ('bio'), early childhood experiences with significant others ('psycho'), and the role of social factors ('soc') are sufficient conditions for the development of PD (NOMS & NHS England, 2015; Paris, 2015). Biological vulnerabilities refer to the genetic and biological elements to personality development, whereby half the variation in personality characteristics is thought to be due to genetic differences (Paris, 1998), with personality traits developing from a mixture of temperament and life experiences (Rutter, 1987). The psychological factor relates to the need for a biological human attachment with another person (a child's caretaker, usually mother or father), whereby attachment theory is thought to be at the core of understanding PD. Research indicates that negative childhood experiences may be a risk factor for PD (Johnson et al., 1999; Zanarini, 2000; Laporte et al., 2011) and are incorporated into this model. The risk of developing PD is also thought to be influenced by the social environment, as one of the main factors linked to resilience to adversity is the availability of social support and attachments outside of the family (Rutter, 2012), whereby social factors can either aggravate or buffer against problematic characteristics. PD is thought to be the outcome of complex interactions between all three of these factors (Paris, 2015).

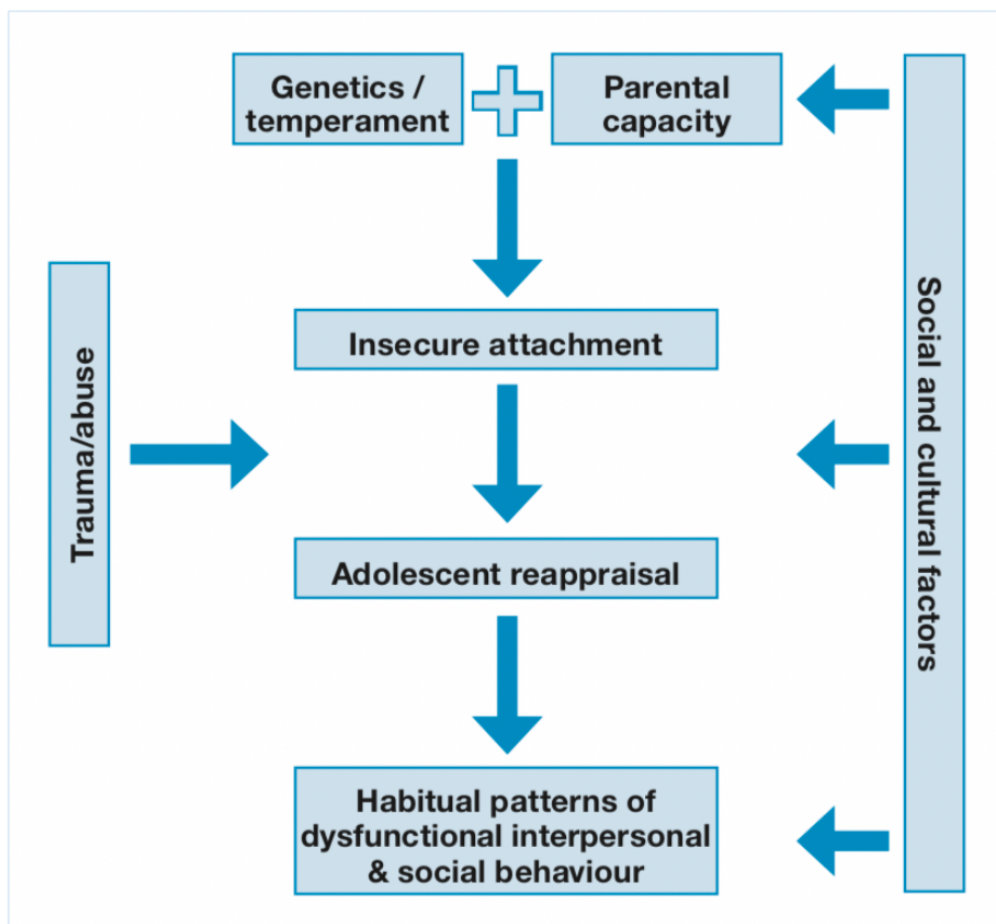


Figure 3. The biopsychosocial model of personality disorder (Crassati et al., 2015; Contains public sector information licensed under the Open Government Licence v3.0)

2.2.2.2 Trait theories

One of the most widely used and accepted models in trait psychology is the five-factor model (FFM; Costa & Widiger, 2001), suggesting that an individual can be described according to the following five dimensions: agreeableness, conscientiousness, neuroticism, extraversion, and openness to experience. As previously mentioned, the DSM-5 personality trait model (criterion B) is thought to be maladaptive and extreme variants of the FFM domains, whereas, the FFM is generally conceived as a model of normal personality (Anderson et al., 2014). Krueger and Eaton (2010) argue that the similarities between the two models far outweigh the differences, with the personality trait model focusing on pathological/abnormal personality, as opposed to normal personality. In terms of the domains, negative affectivity aligns with the FFM domain of neuroticism, detachment is the opposite of extraversion, antagonism is the opposite of agreeableness, and disinhibition is the opposite of conscientiousness (Krueger & Eaton, 2010). Regarding the FFM domain openness to experience, Paris (2015) suggests that it was excluded from the hybrid model as it had little significance for psychopathology, whereas, the fifth domain (psychoticism) is not included in normal personality models as it is less common among community populations, however, is relevant for individuals experiencing PD.

2.2.2.3 McAdams' triarchic model of personality

Similar to how PD can be studied by looking at 'normal' personality traits (such as the FFM), the triarchic model of 'normal' personality (McAdams, 1994) can also be applied to the conceptualisation and treatment of PD (Day & Bryan, 2017). According to McAdams' (1994), personality is best conceived across three structural levels: (i) the first level consists of broad dispositional traits which provide a 'signature for personality' (p. 300), (ii) the second level, characteristic adaptations, refers to an individual's goals, plans, strivings, interests, etc., and (iii) the third level involves the life narrative, which is an 'internalised and evolving story that integrates a reconstructed past, perceived present, and anticipated future into a coherent and vitalising life myth' (p. 306). This internalised life story has been termed 'narrative identity', whereby people are thought to construct stories to account for what they did, why they did it, and to make sense of their lives (McAdams, 1985). These narratives are thought to shape and guide future behaviour, as people act in accordance with the stories that they present about themselves (McAdams, 1985). This life story represents a distinct level of personality that is not captured when only focusing on personality traits and is thought to make a unique contribution to the understanding of personality (McAdams & Pals, 2006). For example, Maruna (2001) found distinct differences in the life narratives of a group of individuals that were either persisting with or desisting from crime, however, the dispositional traits of each group were not able to account for any differences between the two. This illustrates how life narratives can provide critical information above and beyond that of dispositional traits. Constructing a coherent personal narrative on disorderly lives is sometimes a struggle for certain individuals (Sampson & Laub, 1995), particularly those with mental health difficulties including anxiety, depression, and personality disorder (Adler et al., 2012; Maruna, 2001). Therefore, it may be important to explore the life narratives of individuals in order to understand how they make sense of their lives (McAdams, 1995).

2.2.3 The impact of personality disorder and comorbidities

An individual with PD uses healthcare resources extensively, whereby they are frequent visitors to emergency departments at hospitals as a result of relationship breakups, violence, self-injurious behaviour, impulsivity, suicide, and sudden violent death (Warren et al., 2002; Watzke, Ullrich & Marneros, 2006). Individuals with PD have an impaired quality of life, high amounts of stress, a reduced life expectancy, and high rates of suicide (Black et al., 2007; Chiesa et al. 2002; Fok et al., 2012; Stone, 1993). Comorbidity of other psychiatric disorders is also common among individuals with PD, including mood disorder, anxiety disorder, panic disorder, alcohol disorder, substance abuse disorder, and eating disorders (Friborg et al., 2014; Mcglashan et al., 2000; Tomko, Trull, Wood & Sher, 2014; Zimmerman & Mattia, 1999). Additionally, research indicates that individuals with PD are at a higher risk of getting into conflict with the law (Dunsieth et al., 2004; Watzke et al., 2006; Black et al., 2007).

Not only are individuals with PD at a higher risk of coming into contact with the law, but PDs in general have been linked to an increased risk of recidivism among offending populations (Howard, McCarthy, Huband, & Duggan, 2013; Walter, Wiesback, Dittman & Graf, 2011), with some research indicating that prisoners with PD are at least two times more likely to reoffend in comparison to prisoners without PD (Fridell, Hesse, Jaeger & Kulhorn, 2008; Hiscoke, Langstrom, Ottosson & Grann, 2003). The link between PD and recidivism has also been established among IPSO (Hanson & Morton-Bourgon, 2005; Kingston et al., 2015; Mann et al., 2010). Furthermore, difficulties with engagement and treatment drop out are common among individuals with PD (Howells et al., 2011; McMurrin, Huband & Overton, 2010), which makes it difficult to treat these individuals using traditional treatment programs developed for IPSO. Jones (2009) suggests that it would be unethical to address offending or trauma-related issues before ensuring that difficulties around emotional regulation and coping skills are addressed, whereby services should utilize the treatment pathways model (Hogue, Jones, Talkes & Tennant, 2007; Jones, 1997) which targets therapy-interfering behaviour and develops the capacity to tolerate emotional distress first, before moving on to offence-focused interventions.

2.3 Sexual preoccupation

SP has been identified as one of the most strongly present treatment needs among IPSO in the UK (Hocken, 2014), however, in comparison to other risk factors, the research on SP is minimal and less is known about the mechanisms that underpin it (Berman-Roberts, 2015; Seto, 2019). Given that the presence of SP has been shown to be evident among IPSO (Hanson et al., 2007; Kingston & Bradford, 2013; Marshall & Marshall, 2006), and the established links to recidivism (Hanson & Morton-Bourgon, 2005; Mann et al., 2010), it is thought that it may serve as a useful treatment target (Knight & Thornton, 2007). Effective treatment for SP is a priority given some of the health complications that are associated with it, including: higher levels of anxiety and depression, substance use disorders, suicide attempts and self-harm, and the breakdown of relationships and loss of employment (Abracen, Looman & Anderson, 2000; Costa & McCrae, 1992; Paunović & Hallberg, 2014; Reid, Bramen, Anderson & Cohen, 2014; Walton, Cantor & Lykins, 2017). Having a better understanding of the personality traits and domains which are associated with SP will inform and enhance assessment and treatment techniques for these individuals (Costa & McCrae, 1992). The subsequent section will explore the definition, relevant theories, and impact of SP.

2.3.1 Defining sexual preoccupation

Sexual preoccupation has been described in various ways within the literature, in which attempting to deduce the range of terms used proves difficult. A variety of terms are utilised by researchers and clinicians, including: sexual preoccupation, high sex drive, sexual compulsivity, hypersexuality, hypersexual disorder, hypersexual cognition, compulsive sexual behaviour disorder, sexual addiction,

and an obsession with sex (Briken, 2012; Carnes, 1989; Marshall et al., 2008; Seto, 2019; Winder et al., 2014; World Health Organisation [WHO], 2018), with these terms constantly being refined in the literature (Winder et al., 2014). Lloyd, Raymond, Miner and Coleman (2007) argue that all of the definitions appear to describe the same basic syndrome, whereby individuals spend significant amounts of time fantasising about, resisting urges, or engaging in sexual activity, and experience distress from this intense SP. Marshall and Marshall (2006) argue that the lack of agreement over this is partly due to the lack of understanding of the aetiology and factors related to this sexual behaviour, as well as the difficulty in identifying at which point these thoughts and behaviours become excessive for an individual (Kingston & Bradford, 2013).

Sexual compulsivity refers to both the thoughts and behaviours associated with excessive sexual behaviours (Lee & Forbey, 2010), whereby it is thought that sexual compulsivity can be broken down into two: sexual preoccupation and hypersexuality. SP refers to the cognitive aspect (Coleman, 1987), whereas hypersexuality describes the sexual behaviours (Kaplan & Krueger, 2010). A common feature among all of the delineations is the presence of intense sexual thoughts, with SP being recognised as a significant concomitant with hypersexuality/hypersexual disorder/sexual addiction (Kafka, 2003; Kalichman & Rompa, 1995; Kalichman & Cain, 2004), and compulsive sexual behaviours being characterised by a preoccupation with sex (Derbyshire & Grant, 2015; WHO, 2018). It is thought that individuals with high levels of sexual preoccupation often need to engage in high levels of sexual activity (known as hypersexuality) in order to satisfy their intrusive sexual thoughts (Kafka, 1997; Lievesley et al., 2014), which may result in them engaging in socially deviant behaviours in order to meet their sexual needs (Saleh & Berlin, 2003). This high engagement in sexual activity which becomes problematic for an individual is then referred to as sexual compulsivity (Kalichman et al., 1994), compulsive sexual behaviour disorder (Miner, Raymond, Mueller, Lloyd & Lim, 2009; WHO, 2018), sexual addiction (Carnes, 1989), or hypersexuality (Kaplan & Krueger, 2010), which can be measured by the total number of sexual outlets (Kafka, 1997; Kinsey, Pomeroy & Martin, 1948).

Sexual preoccupation is defined as 'the tendency to think about sex to an excessive degree' (Snell & Papini, 1989, p. 256), and 'an abnormally intense interest in sex that dominates psychological functioning' (Mann et al., 2010, p. 198). Kafka (2003) suggests that SP is when an individual spends more than an hour a day thinking about sex or engaging in fantasies, whereby they 'become so absorbed in, obsessed with, and engrossed in sexual cognitions and behaviours, that one virtually excludes thoughts of other matters' (Snell & Papini, 1989, p. 257). Furthermore, among a sample of IPSO, SP is described as sexual thoughts which 'fill one's headspace, leaving little room for anything else' (Lievesley et al., 2014, p.269). Lee and Forbey (2010) suggest that it is beneficial to conceptualise this cognitive component as sexual preoccupation, as the concept accurately portrays the level of intrusive thoughts. Furthermore, they also identify that the majority of research on sexual

preoccupation and compulsivity focuses mainly on the compulsive behaviours, rather than the cognitive aspect.

Although there is a debate within the literature about the definition of SP and the term that should be used to describe this behaviour, Marshall et al. (2008) note that sexual preoccupation is the term used within the literature that focuses on IPSO (Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2005; Mann et al., 2010), however, it is difficult to find a concise, consistent definition of the term. Although there have been numerous attempts to provide a uniform definition, the various terms are still used interchangeably throughout the literature. This thesis adopts the definition of SP offered by Mann et al. (2010), which describes SP as ‘an abnormally intense interest in sex that dominates psychological functioning’ (p. 198), focusing more on the cognition aspect as opposed to the physical sexual behaviour (such as TSO). However, given that the majority of research in this area focuses on compulsive behaviours (Lee & Forbey, 2010), and various terms are used interchangeably throughout the literature, alternative terms may be used when discussing theories/prevalence due to there being minimal research specifically addressing SP (though intense sexual thoughts are a common feature of all other terms that are used synonymously). However, the term sexual preoccupation will be predominantly used throughout the rest of the thesis.

2.3.2 An overview of theories relating to sexual preoccupation

The aetiology of SP is largely unknown, and according to Bancroft and Vukadinovic (2004), the literature has predominantly focused on the issues around defining this problematic behaviour, paying little attention to the aetiology and possible causal explanations for why sexual behaviour becomes problematic. Kingston, Graham and Knight (2017) argue that there are surprisingly few studies which examine the aetiology and course of SP, however, some aetiological theories do exist (Bancroft & Vukadinovic, 2004; Kafka, 2003), with generic speculations that SP results from complex interactions between biological, psychological, and social factors (Bancroft, 2008; Kaplan & Kreuger, 2010; Samenow, 2010).

Several attempts have been made to explain SP, whereby various factors are thought to be involved in the aetiology of SP, such as: neurobiology (Berlin, 2008; Kafka, 2008), excess testosterone (Grubin, 2018), childhood trauma (Courtois & Weiss, 2018; Noll, Trickett & Putnam, 2003), emotional dysregulation (Bancroft & Vukadinovic, 2004; Miner et al., 2009), self-control (Berman-Roberts, 2015; Hocken et al., 2016), a manifestation of an impulse control disorder (Barth & Kinder, 1987; Grant, Levine, Kim & Potenza, 2005), a facet of OCD (Garcia & Thibaut, 2010; Kalichman et al., 1994), and a coping mechanism for anxiety and depression (Bancroft & Vukadinovic, 2004). Walton et al. (2017) suggest that predispositions towards SP are complex and diverse, involving a range of risk factors that may differ across individual presentations.

Some theories suggest SP is a long-term effect of childhood sexual abuse (Noll et al., 2003), whereby SP may be used as a coping strategy; as a way of escaping the emotional and psychological pain created by unresolved childhood trauma (Courtois & Weiss, 2018; Gartner, 2018). Additionally, it has been theorised that SP may be used as a way of coping with negative affect or negative emotional states (such as depression, stress, and anxiety; Bancroft & Vukadinovic, 2004; Cortoni & Marshall, 2001; Parsons et al., 2008), with various research identifying links with poor emotional regulation skills (Bancroft, 2008; Bancroft et al., 2003; Miner et al., 2009). Bancroft and Vukadinovic (2004) propose a model with three distinct pathways whereby sexual behaviours are thought to be due to negative emotions: (1) as a way of gaining emotional support and/or validation, (2) as a way of distracting from negative affect, or (3) due to the co-occurrence of sexual and emotional arousal.

Furthermore, various other theoretical approaches have been put forward, which describe SP (and resulting sexual behaviours) in terms of compulsivity, impulsivity, addiction, and sexual excitation/inhibition. The sexual compulsivity model conceptualises SP as falling within the broader spectrum of obsessive-compulsive disorder (OCD; Bradford, 1999; Coleman, 1990; Kalichman et al., 1994; Krueger & Kaplan, 2001), whereby SP relates to the obsessions, and the physical sexual behaviours (or hypersexuality) are analogous to compulsions. Theoretically, SP may be related to the concept of obsession, in which sexualised thoughts include a pattern of persistent thoughts, impulses, or images that are perceived as intrusive (Lee & Forbey, 2010). Excessive sexual behaviours (compulsions) may be motivated by relief from anxiety or distress which are caused by these obsessive thoughts, impulses, or fantasies (Bancroft et al., 2003; Black et al., 1997; Reid, Carpenter & Lloyd, 2009). In contrast to this, some theorists argue that hypersexuality may be viewed as a manifestation of an impulse disorder (rather than an inflated sexual desire; Barth & Kinder, 1987), with Compulsive Sexual Behaviour Disorder (CSBD) being included in the ICD-11 under the impulse control disorders category (WHO, 2018). The impulsivity model proposes that individuals may experience difficulty resisting an impulse, drive, or temptation (Coleman, 1990; Raymond et al., 2003), whereby these urges and behaviours may be positively reinforced due to the experience of pleasure (Montaldi, 2002).

The addiction model is one of the most widely discussed models in relation to hypersexuality (Hall, 2013), whereby addiction relates to a strong tendency to participate in some form of pleasure-producing behaviour in order to relieve painful affects, or as a way of regulating oneself, or both of these (Goodman, 2001). Addiction is thought to begin with early childhood trauma, in which addictive behaviour may be employed as a coping mechanism (Carnes, 1992). The dual control model postulates that sexual response (and associated arousal) is determined by the balance of two systems in an individual's brain: the sexual excitation system (e.g. arousal in the presence of an attractive person) and the sexual inhibition system (e.g. a reduced response when sexual activity is perceived as potentially dangerous; Bancroft, Graham, Janssen & Sanders, 2009). It is hypothesised that individuals

with a high propensity for excitation and/or a low propensity for inhibition would be more likely to participate in problematic sexual behaviour (Bancroft et al., 2009).

Moreover, current advances suggest that SP and resultant sexual behaviours may be explained by neurological processes (such as imbalances in brain chemistry, reward and motivation systems, neurocognitive disorders etc., Cipriani, Ulivi, Danti, Lucettu & Nuti, 2016; Robinson & Berridge, 2008; Walton et al., 2017), however, neurobiological research is in the early developmental stages, and further research is required to fully understand the associated brain activity and common neurotransmitter systems (Walton et al., 2017). Although several theories have been briefly mentioned, it is beyond the scope of this chapter to cover all of these in detail, therefore, please see Kaplan and Krueger (2010) or Walton et al. (2017) for more detailed descriptions of the salient theories. The majority of the literature and theoretical models focus mainly on compulsive behaviours, as opposed to the cognitive aspect. SP as a phenomenon in its own right is still understudied, and less is known about the underpinnings of SP (Berman-Roberts, 2015), therefore, further research is required to gain a better understanding of the underlying mechanisms of SP.

2.3.3 The impact of sexual preoccupation and comorbidities

The presence of SP is linked to a number of adverse outcomes regarding the wellbeing of individuals, including effects on psychological and emotional wellbeing, whereby SP has been found to have substantial psychiatric comorbidity with other disorders (Kaplan & Krueger, 2010; Khan et al., 2015). An individual with SP may experience a decline in physical and/or emotional health (Gartner, 2018), impairment in daily functioning (Dhuffar, Pontes & Griffiths, 2015), a dissatisfaction with life (Långström & Hanson, 2006), and high rates of suicidal ideation (Black et al., 1997). They report higher rates of mood disorders (including stress, anxiety, and depression; Raymond et al., 2003; Walton et al., 2017), substance use disorders (Abracen et al., 2000; Raymond et al., 2003), paraphilias (Kafka & Hennen, 1999; Krueger, Wechsler & Kaplan, 2009), ADHD (Blankenship & Laaser, 2004; Reid, Carpenter, Gilliland & Karim, 2011), personality disorders (Carpenter, Reid, Garos & Najavits, 2013; Raymond et al., 2003), impulse control disorders (Kafka & Hennen, 2002; Kafka & Prentky, 1998), and eating disorders (Briken, Habermann, Berner & Hill, 2007; Carnes, 2000). SP is also associated with difficulties with self-esteem and social isolation (Reid et al., 2009), maladaptive coping and emotions, feelings of hopelessness, loneliness and shame (Reid, 2007; Reid et al., 2014), and interpersonal problems (Winder et al., 2014).

Furthermore, SP may impact on the wider aspects of an individual's life, whereby it has detrimental consequences, contributing to relationship difficulties and subsequent breakdown (Paunović & Hallberg, 2014; Spenhoff, Kruger, Hartmann & Kobs, 2013), financial problems (Reid, Garos & Fong, 2012), and loss of employment (Paunović & Hallberg, 2014), all of which have an effect on an individual's wellbeing. Regarding the physical behaviours which may result from excessive sexual preoccupation, the consequences may be personally injurious (Walton et al., 2017), including genital

soreness and physical injury (McBride, Reece & Sanders, 2008), greater rates of unprotected sex (Benotsch, Kalichman & Kelly, 1999), sexually transmitted infections (Långström & Hanson, 2006; Walton et al., 2017; Yoon, Houang, Hirshfield & Downing, 2016), and unplanned pregnancies (McBride et al., 2008).

For some individuals, being unable to manage their persistent and intrusive sexual thoughts may result in them engaging in inappropriate or illegal behaviours (Reid et al., 2009; Walton et al., 2017). It has been acknowledged that SP interferes with an individual's ability to function appropriately within the prison environment, as well as their ability to focus during treatment programs (Marshall & Marshall, 2006), which makes it difficult to treat these individuals using traditional treatment programs developed for IPSO. SP is thought to be a key factor in treatment ineffectiveness (Grubin, 2018), whereby Winder et al. (2019) propose that the high prevalence of SP among IPSO may have contributed to the former cognitive-behavioural psychological treatment programs for IPSO not being associated with changes in sexual offending recidivism (Mews, Di, Bella & Purver, 2017), as people may have experienced difficulties focusing on psychological treatment due to the intrusive and intense sexual thoughts (Lievesley et al., 2014).

2.4 Adverse childhood experiences

ACEs are an increasing international concern (Bellis et al., 2015), a public health crisis (Anda et al., 2010; Larkin et al., 2014), and are one of the strongest predictors of poor health and social outcomes during adulthood (Ford et al., 2016). Although it took almost two decades for the notion of ACEs to gain momentum in the UK, these studies have now gained the attention of several governments in the UK, whereby an ACEs support hub has been implemented by the Welsh Government (Hopkins, n.d.), the Scottish Government have stated that they will be focusing on preventing ACEs and tackling their impact (Sturgeon, 2018), and the English Government are developing a work plan between policing and public health in order to prevent ACEs (Hindle & Christmas, 2018). Furthermore, research has begun to explore the prevalence of ACEs among prisoners in Scotland (Carnie et al., 2017) and Wales (Ford et al., 2019). However, it is important to note that there are several limitations and critiques of the ACEs framework (see Kelly-Irving & Delpierre [2019] for a detailed description of these limitations).

ACEs are thought to be implicated in the aetiology of sexual offending (Hanson & Morton-Bourgon, 2005), whereby they are thought to be even more pernicious as they contribute to offending pathways containing serious sexual crime (Drury et al., 2016). Research indicates that IPSO are more likely to experience ACEs in comparison to the general population (Levenson et al., 2016), and treatment interventions for IPSO are beginning to take a trauma informed approach (Henfrey, 2018). Not only are ACEs implicated in the aetiology of sexual offending, but, are also important in the aetiology of PD and SP (Engel et al., 2019; Laporte et al., 2011; Noll et al., 2003). It is fundamental that the impact and treatment of ACEs among IPSO is taken into consideration given the health complications which are

associated with them, such as an increased risk of premature ill health, early mortality, anxiety, depression, personality disorder, self-harm, suicidal thoughts, and many more (Bellis et al., 2014; Bellis et al., 2015; Cutajar et al., 2010; Fergusson, Boden & Horwood, 2008; Kingston et al., 2017). Having a clear understanding of how ACEs impact IPSO is imperative in the development of treatment interventions and policy (Anda et al., 2006; Anda et al., 2010). The subsequent section will explore the definition, relevant theories, and impact of ACEs.

2.4.1 Defining adverse childhood experiences

The term adverse childhood experiences (ACEs) was developed in the US (Felitti et al., 1998), and has been accepted to mean ‘intra-familial events or conditions causing stress responses in the child’s immediate environment’ (Kelly-Irving et al., 2013, p. 722). According to Corcoran and McNulty (2018), ACEs are described as ‘traumatic events (e.g., sexual abuse, physical abuse, emotional abuse) or chronic stressors (e.g., neglect, parental separation) that are uncontrollable to the child’ (p. 297), that occur within the first 18 years of an individual’s life. Previous research has focused on the presence of just one (e.g. sexual abuse) or a few types of traumatic experiences (Lasford et al., 2007; Teague, Mazerolle, Legosz & Sanderson, 2008) among IPSO, however, the concept of ACEs provides a framework to explore a range of traumatic experiences, including child maltreatment as well as household dysfunction, and their cumulative impact (Ford et al., 2019). ACEs include a range of stressful events that an individual may be exposed to before the age of 18 years, including experiences that may directly harm them (e.g. maltreatment), or impact them via the environment they are brought up in (e.g. growing up in a house with substance misuse; Bellis et al., 2015). See figure 4 for the various types of ACEs.

The ACE scale was developed in the 1990s in order to measure childhood adversity, and has become a well-known, valuable research tool for measuring the number of traumatic events (neglect was not included in the original ACE study, but was later incorporated into the scale; Anda et al., 2010; Felitti et al., 1998). The total ACE score mirrors the number of items endorsed, whereby higher scores demonstrate a more pervasive and diverse range of adversities (Levenson & Grady, 2016a). Researchers over the past few decades have begun to recognise that early traumatic experiences are more prevalent than initially thought (Centers for Disease Control and Prevention [CDC], 2013), and ACE research documents the pervasive and long-term impact of these traumatic events (CDC, 2013). According to the DSM-5, trauma is defined as any extraordinary event (which may be experienced or witnessed by an individual) that threatens their psychological or physical well-being, as well as challenging their coping skills (APA, 2013a).

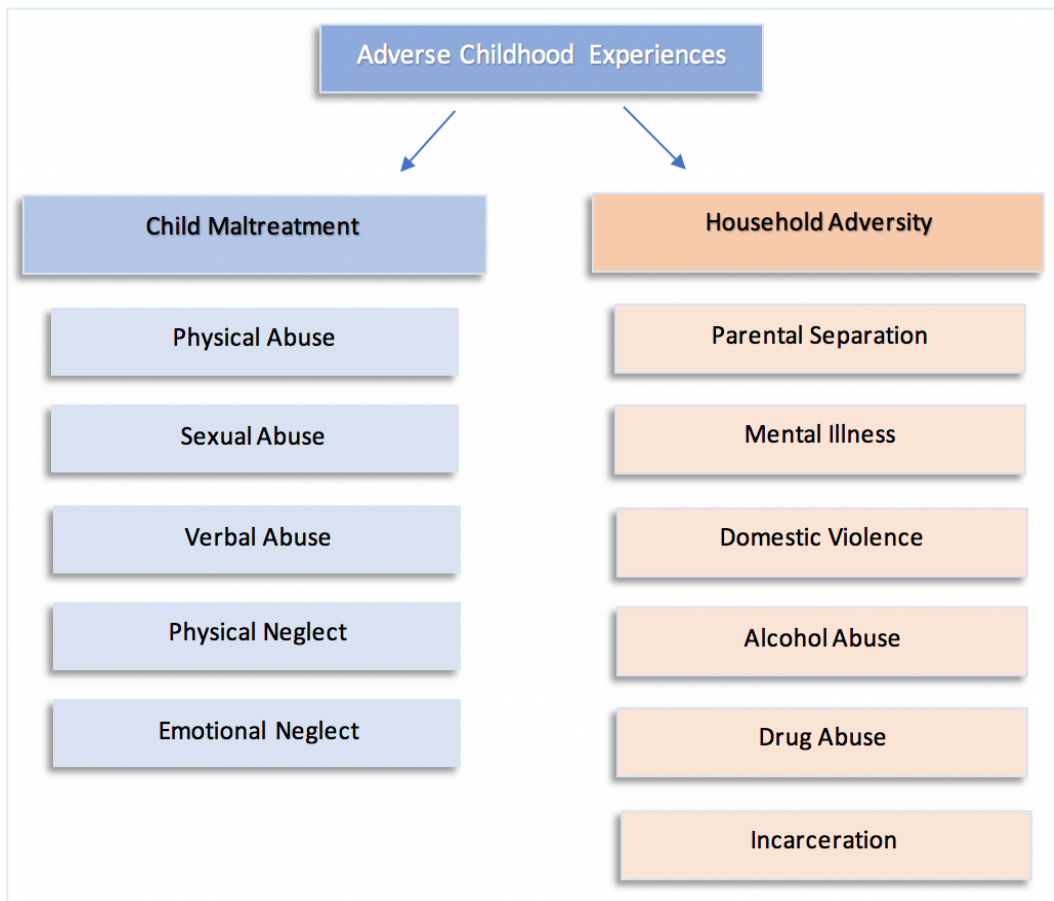


Figure 4. Categories of adverse childhood experiences

2.4.2 Theories of adverse childhood experiences

There are several theoretical frameworks which can be used to explore trauma/ACEs, including: cognitive-behavioural theory (Gonzalez-Prendes & Resko, 2012), psychoanalytic theory (Brandell, 2012), attachment theory (Ringel, 2012), and Maslow’s hierarchy of needs (Maslow, 1943). Contemporary trauma theory provides a theoretical framework for understanding the ways in which trauma impacts an individual’s functioning, whilst also representing a paradigm shift in how clinicians perceive survivors of trauma (Goodman, 2017). According to Goodman (2017), contemporary trauma theory is based on the following properties: dissociation, attachment, re-enactment, long-term effect on later adulthood, and impairment in emotional capacities. It is beyond the scope of this chapter to describe all of these theories in detail, therefore, the conceptual framework relating to ACEs will be discussed, as well as briefly touching on evolutionary theory. In recent years, compassion focused therapy (CFT: Gilbert, 2010) has been incorporated into treatment interventions for IPSO in UK prisons (particularly HSP; Walton, 2019a), which has roots in evolutionary theory and contextual behavioural science (Walton & Hocken, 2017), therefore, this will also be briefly mentioned below.

2.4.2.1 Adverse childhood experiences conceptual framework

The findings of the original ACE study resulted in the development of the ACE pyramid, which embodies the conceptual framework for the ACE study, and highlights links between adverse experiences and health and wellbeing outcomes in adulthood (see figure 5). Trauma is thought to be the result of an individual's adaptability to their experience of traumatic events (Williams, 2006). Some individuals may have developed resilience so that they are able to continue living, whereas, for other people, these events may impact their social, psychological, and biological equilibrium (Van der Kolk, McFarlane & Weisaeth, 1996; Williams, 2006). Ringel and Brandell (2012) propose that early childhood trauma can affect the neurological development of a child, resulting in them having difficulties processing information, regulating emotions, and categorising experiences, which may then lead to poor impulse control, aggression, difficulty in interpersonal relationships, and other negative outcomes. Levenson et al. (2016) suggest that this neurodevelopmental pathway from ACEs to problematic adult behaviour is a complicated biopsychosocial process. The central theme of many theoretical approaches is the exploration of the emotional processing of traumatic memories (Rose, 2002), whereby individuals may have distressing symptoms as a result of their mind struggling to process these traumatic memories, which may include: arousal difficulties, anxiety, depression, dissociation, and numbing (Greenberg,

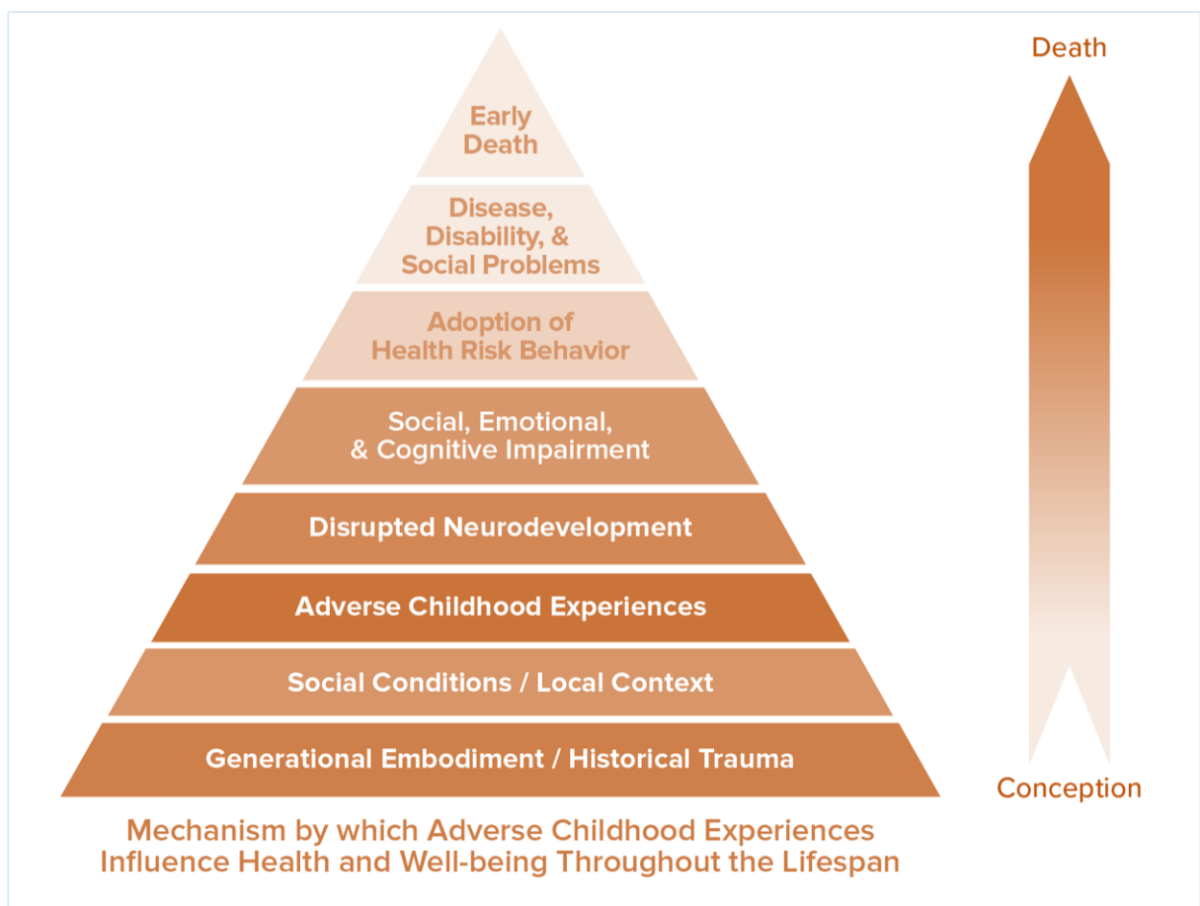


Figure 5. The ACE pyramid (CDC, 2019)

1998; Herman, 1992). These negative consequences continue to reverberate throughout childhood, adolescence, and adulthood (Van der Kolk, 2005), whereby emotional, cognitive, and social impairments result in high-risk behaviours being used as coping strategies to relieve distress, which results in the development of psychosocial problems, illnesses, disabilities, and premature mortality (as demonstrated in the ACE pyramid; Felitti et al., 1998).

2.4.2.2 Evolutionary perspective

It is thought that adverse experiences have a profound impact on the brain, resulting in individuals being in a constant state of fight or flight (McCartan, 2019). Bloom (1999) argues that it is not possible to understand human responses to trauma without having an insight into the role of evolution, whereby the fight or flight response is thought to be part of our mammalian heritage which has a significant impact (physiologically) on how we respond to stressors. Gilbert (2010) also comes from an evolutionary perspective, whereby he views emotions (as well as corresponding thoughts, motives and behaviours) as survival functions that have evolved from the interaction of three emotional regulation systems (Gilbert, 2014).

Gilbert (2014) acknowledges how the more highly evolved brain can help to understand post-trauma symptomology (McLean, Steindl & Bambling, 2018), whereby he recognises that our brains are a mixture of both old brain and new brain capabilities, which he terms the 'tricky brain' (p. 17). Our old brain consists of the basic motives in order to reproduce and get necessary resources (such as food), as well as enabling us to care for our children, and be motivated by our basic emotions (e.g. anger and disgust) and behaviours (e.g. fight, flight, freeze and submission). However, over the years our ancestors have evolved, and our complex cognitive abilities have increased, enabling us to make plans, imagine, ruminate, and self-monitor. These cognitive abilities allow individuals to be creative and flourish, yet, on the other hand, they also create problems for us. Our new brain enables us to worry, self-reflect, and ruminate, which, in the case of somebody that has been abused or neglected, may keep the threat going for them (Irons & Lad, 2017), resulting in them being in a constant state of fight or flight (McCartan, 2019).

Gilbert (2010) suggests that there are three major emotional regulation systems (see figure 6), and the balance of these systems is important for positive mental health (McLean et al., 2018). However, this process is thought to be impacted by the overactivation and dominance of the threat system in response to trauma, meaning that various posttraumatic symptoms (such as avoidance and hypervigilance) can be explained by this imbalance (Lee, 2012). It is thought that, for an individual who has been abused or neglected, their drive-seeking and threat systems may be activated, and their self-soothing and affiliation system may be inhibited (Johnstone et al., 2018), which may result in individuals reexperiencing their trauma through flashbacks, nightmares and intrusive thoughts (Hackmann, Ehlers, Speckens & Clark, 2004). It is beyond the scope of this chapter to describe this approach in rich detail, therefore, please see Gilbert (2014) for further details.

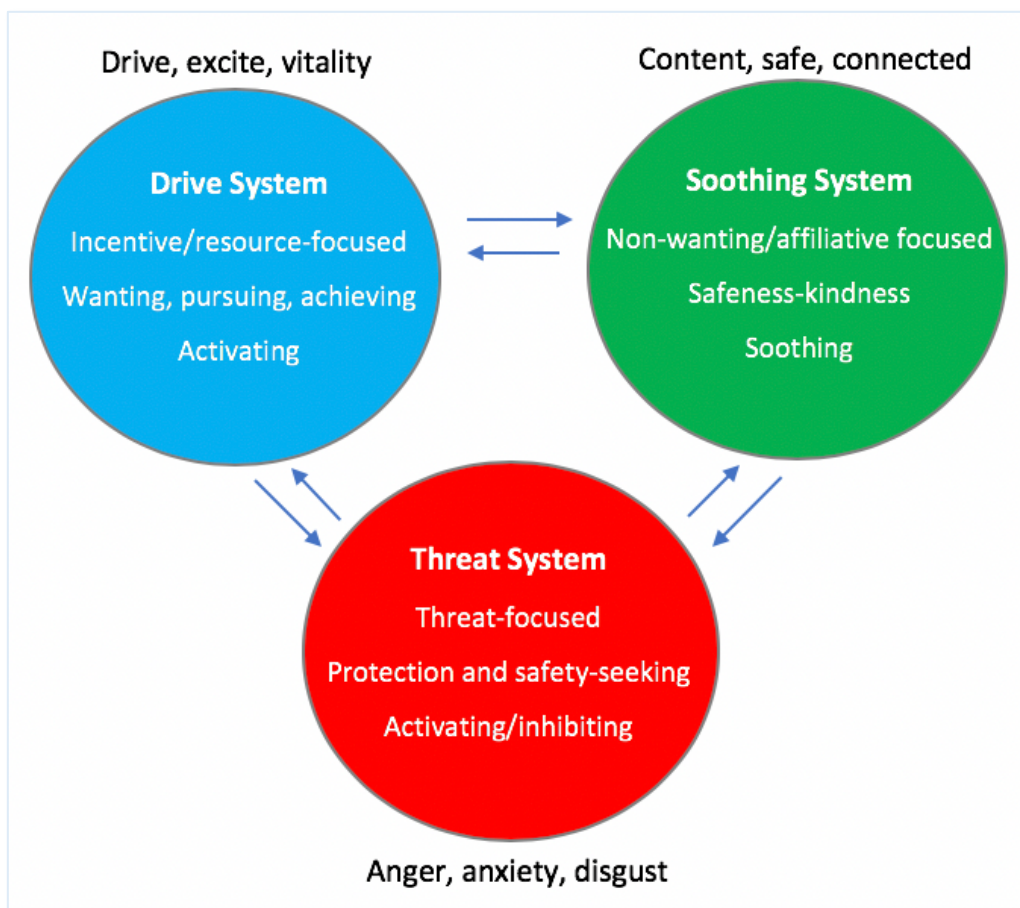


Figure 6. The three-circle model of emotion (adapted from Gilbert, 2009)

2.4.3 The impact of adverse childhood experiences and comorbidities

Bloom (1999) suggests that traumatic experiences impact the entire person; the way they think, learn, remember things, feel about themselves, feel about other people, and the way in which they make sense of the world. ACEs affect individuals throughout their entire life course, whereby children from stressful environments are more likely to adopt health-harming behaviours which may lead to physical and mental health problems later on in life (Felitti, 1998). These individuals then raise children in households where ACEs may be present, resulting in a cycle of adversity across generations (Bellis et al., 2015). A dose-response relationship has been found between ACEs and leading causes of poor health and adult mortality (Felitti et al., 1998; Flaherty et al., 2013), whereby experiencing four or more ACEs increases the chances of these negative sequelae.

Being exposed to chronic stress during childhood impacts a child's cognitive, behavioural and physical development due to disturbing the development of the brain (National Scientific Council on the Developing Child, 2007). Chronic stress alters the way in which a child's brain develops, as well as altering the development of nervous, hormonal, and immunological systems (Anda et al., 2010; Danese & McEwen, 2012; Broyles et al., 2012). McCartan (2019) argues that ACEs rewire the brain, whereby individuals may be in a constant state of fight or flight, or their systems may be 'locked' into a higher

state of alertness (Bellis et al., 2015, p. 6). These physiological changes increase the allostatic load (the wear and tear on the body), resulting in individuals being at an increased risk of premature ill health (Felitti et al., 1998; Anda et al., 2006). This impact on the brain also affects a range of other functions, including: regulating the stress response, emotional regulation, emotional numbing, learning new skills, planning, attention, memory, and how an individual perceives and interprets events (Ford et al., 2019; Shonkoff & Garner, 2012; van der Kolk, 2014). Additionally, prolonged exposure to trauma results in individuals experiencing hyper-arousal symptoms, such as hypervigilance, agitation, anxiety and night terrors (Herman, 1992; van der Kolk, 2014; Williams, 2006).

Levenson et al. (2016) demonstrate how trauma can result in issues relating to attachment, self-regulation, and emotional competence, whereby enduring trauma often lays the groundwork for a range of interpersonal difficulties and maladaptive coping skills (Elliott et al., 2005; Teyber & McClure, 2011). As noted by Levenson et al. (2016) if a child's world appears to be a dangerous place with minimal nurturing caregivers, their ability to trust becomes impaired and they may become wary and skeptical of others. This impact on trust and safety, which can lead to intimacy problems, distrust of people, and emotional discomfort, makes it difficult for individuals to build healthy, lasting relationships (Kendall-Tackett, Williams & Finkelhor, 2001). In terms of the psychological impact, exposure to ACEs contributes to an increased risk of anxiety, depression, personality disorder, low self-esteem, low self-worth, self-harm, suicidal thoughts, sexual dysfunction, and hypersexuality (Chapman et al., 2004; Cutajar et al., 2010; Edwards, Holden, Felitti & Anda, 2003; Fergusson et al., 2008; Kingston et al., 2017; Laporte et al., 2011).

Furthermore, this exposure to toxic stress (particularly from experiencing four or more ACEs) during childhood increases the likelihood of adopting health-harming behaviours and lifestyles, such as smoking, alcoholism, drug abuse, poor diet, low levels of exercise, aggression and violence, intimate partner violence, sexual addiction, and risky sexual behaviours (Anda et al., 2006; Chapman et al., 2004; DeLisi & Beauregard, 2018; Edwards et al., 2003; Felitti et al., 1998; Gartner, 2018; Maniglio, 2011). In turn, some of these behaviours may lead to poor health by increasing the risk of various health outcomes such as heart disease, diabetes, cancer, respiratory disease, liver disease, and hypertension, as well as premature mortality (Bellis et al., 2014; Bellis et al., 2015; Felitti et al., 1998; Ford et al., 2016). Furthermore, the prevalence of four or more ACEs increases the likelihood of individuals experiencing low mental wellbeing, low life satisfaction, problems with being overweight, and sexually transmitted infections (Bellis et al., 2014; Bellis et al., 2015; Ford et al., 2016).

Similarly, ACEs have also been found to affect a child's engagement and performance at school, their ability to gain qualifications, their employment status and earnings, their socioeconomic status, and their contribution to the economy (Bellis et al., 2014, Bellis et al., 2015; Currie & Widom, 2010; Sansone, Leung & Wiederman, 2012). The prevalence of ACEs also results in individuals developing anti-social

behaviours, including a susceptibility for aggressive and violent behaviour, resulting in contact with the criminal justice service (Dregan & Guildford, 2012). Individuals with four or more ACEs are more likely to be involved in crime, with Bellis et al. (2015) highlighting that these individuals were 15 times more likely to have committed violence against another person within the last 12 months (compared to individuals with zero ACEs), and were 20 times more likely to have been incarcerated in their lives.

ACEs are intergenerational in that children who suffer ACEs are more likely to develop behaviours and conditions that later become ACEs for their own offspring (Ford et al., 2019). Through intergenerational cycles of crime, it has been estimated that 65% of males who had a parent incarcerated during childhood are likely to later offend (Williams, Papadopoulou & Booth, 2012). Of this criminal behaviour is the increased risk of sexual offending (Duncan & Williams, 1998; Marshall, 2010; Mersky, Topitzes & Reynolds, 2012), whereby it is thought that childhood trauma may lead to sexualised coping, early onset and compulsive masturbation, and sexually coercive or offending behaviour (Duncan & Williams, 1998; Maniglio, 2011; Smallbone & McCabe, 2003). Furthermore, as well as increasing the likelihood of sexual offending, the lasting impact of trauma and ACEs also creates barriers for treatment success (Janssen, 2018), as unresolved childhood trauma and attachment style impacts how an individual progresses through treatment, as well as increasing the risk of recidivism (Levenson & Grady, 2016b; Miller & Najavits, 2012; Nunes et al., 2013). Reavis et al. (2013) propose that treatment programs for IPSO should have a stronger emphasis on the role of early trauma in self-regulation and attachment, and other researchers argue that IPSO need to be able to come to terms with their own traumatic experiences before moving on to offence-focused or empathy-focused work (Allam, Middleton & Brown, 1997; Cluley, 2019).

[2.5 The relationships between personality disorder, sexual preoccupation, and adverse childhood experiences](#)

This section is split into three sections, whereby it explores the relationships between (i) personality disorder and sexual preoccupation, (ii) personality disorder and adverse childhood experiences, and (iii) sexual preoccupation and adverse childhood experiences.

2.5.1 The relationship between personality disorder and sexual preoccupation

In regard to sexual offending, Seto's (2019) MFM suggests that sexual arousal issues (including sexual preoccupation) are key motivators for sexual offending, whereby trait factors (such as antisocial personality traits) may facilitate the acting upon these motivations if the opportunity arises, showing that both personality and SP may be implicated in the aetiology of sexual offending. Additionally, there are similarities between theoretical explanations of both PD and SP as both phenomena share difficulties with factors relating to self-management, including impulse control and urge management,

which are problematic mechanisms for both (Hocken et al., 2016). Montaldi (2002) takes this a step further, proposing that many features of hypersexual behaviour 'resemble the wider patterns of personality disorder' (p. 3), whereby hypersexual behaviour may be a way of acting out interpersonal themes in order to validate the self, with regulating mood being a secondary outcome. Montaldi (2002) states that a large proportion of hypersexual cases can be explained by an Axis I model (addiction, obsessive-compulsive disorder, impulsive-control disorders, mood-related disorders), however, some cases may be better explained using an Axis II model (personality disorders). Within this Axis II model of hypersexuality, individuals may not recognise negative consequences of their behaviour, may have maladaptive and inflexible patterns of behaviour, views their sexual behaviours as ego-syntonic and as a way of gaining validation. He also proposes several parallels between hypersexuality and PDs, including borderline, histrionic, narcissistic and sadistic PD. Reid et al. (2009) state that although some ideas regarding PD and SP have been advanced, PDs among this this population of SP individuals is 'virtually untapped' (p. 59) and should be explored in future studies, particularly among IPSO (Hocken et al., 2016).

2.5.1.1 Personality disorder and sexual preoccupation among IPSO

The majority of the research in this area explores the relationship between SP and personality among general population samples, college students, and clinical samples, however, there are minimal empirical investigations which focus on this relationship among IPSO. Given that these individuals (IPSO) have acted upon their intrusive sexual thoughts and engaged in illegal sexual behaviour, as well as SP being identified as an important treatment need and predictor of recidivism (Hocken, 2014; Mann et al., 2010), it is imperative to learn more about the underpinnings of SP and the links with personality within this population in order to inform and enhance assessment and treatment (Costa & McCrae, 1992).

In relation to general population and clinical samples, there are three main studies which explore this relationship (Black et al., 1997; Carpenter et al., 2013; Raymond et al., 2003). Black et al. (1997) reported that 44% of individuals with SP also met the criteria for PD ($n = 36$), with histrionic, paranoid, obsessive-compulsive, and passive-aggressive PDs being the most prevalent. Raymond et al., (2003) found that 46% met the criteria for both PD and SP ($n = 24$), whereby paranoid, narcissistic, avoidant, obsessive-compulsive and passive-aggressive PDs were the most common. Carpenter et al. (2013) explored a larger sample of males with hypersexual disorder ($n = 132$), finding that the screening tool indicated that 92% of the sample showed the possibility of at least one PD, particularly among borderline, narcissistic, paranoid, and passive-aggressive PD symptoms. However, when using the clinician administered interview, only 17% of the sample met the actual criteria for PD, indicating that high rates of PD comorbidity are not common among SP individuals. Carpenter et al. (2013) propose that the lower prevalence rates may be due to the differences in recruitment and ways of measuring

PD and SP. Conversely, the results may indicate that individuals with SP show borderline, narcissistic, paranoid and passive-aggressive personality styles, but may not meet criteria for a fully-fledged diagnosis of PD, which aligns with Montaldi's (2002) theory that individuals can 'exhibit an 'Axis II' hypersexual pattern without necessarily meeting sufficient criteria for a wider Axis II personality diagnosis' (p. 1).

Borderline PD is one of the most researched disorders within the wider PD literature (National Collaborating Centre for Mental Health, 2009), and given the known links between borderline PD, impulsivity, and risk-taking behaviours (APA, 2000; Lloyd et al., 2007; Williams, 2006), there is no surprise that strong links have been reported between borderline PD and SP (Jardin et al., 2017; Northey, Dunkley, Klonsky & Gorzalka, 2016; Rickards & Laaser, 1999). Interestingly, borderline PD has been found to be highly prevalent among male IPSO (Borchard et al., 2003; Curtin & Niveau, 1998; Leue et al., 2004), therefore, further research is required to assess this relationship specifically among IPSO.

Regarding IPSO, Payne (2014) argues that the personality profiles of sexually preoccupied IPSO have not been explored in detail, and to the best of the author's knowledge there are only three studies which explore this relationship among IPSO from the MMPSA service, located at a local prison that specifically houses IPSO (as part of the service evaluation). Payne (2014) explored the personality characteristics (using the Personality Assessment Inventory; PAI) of 25 IPSO that were part of the MMPSA service, discovering that they displayed higher rates of paranoia, borderline, and antisocial features in comparison to community and clinical populations. Furthermore, in 2015, Berman-Roberts explored the personality functioning of IPSO involved in the MMPSA service ($n = 46$), focusing on the self-management and relationship domains of the severity indices of personality problems (SIPP-118). The results highlight that in comparison to the general population, IPSO were significantly more impaired on all facets (emotional regulation, effortful control, frustration tolerance, responsible industry, aggression regulation, intimacy, enduring relationships and self-respect), whereas, in comparison to a clinical sample (mental health admissions), IPSO showed more dysfunction in the facets of effortful control, aggression regulation, intimacy and self-respect. This demonstrates that sexually preoccupied IPSO present with a different personality profile compared to the general population and clinical samples, whereby after six months of taking MMPSA a large proportion of IPSO made a clinically significant change (in which their personality functioning moved from the maladaptive range to the clinically normal range).

Similar results were also reported by Hocken et al. (2016) who further explored this relationship among 69 IPSO from the same MMPSA service. Results highlight that the facets most problematic for IPSO were effortful control, emotional regulation, self-reflexive functioning, frustration tolerance, and stable self-image. Additionally, both statistical and clinically significant change was also demonstrated for all scales (relating to self-management and relationships) after six months of taking MMPSA, whereby the

largest change was revealed in emotional regulation. Both Berman-Roberts (2015) and Hocken et al. (2016) argue that these results suggest that personality (particularly self-control; consisting of emotional regulation and effortful control) may be key underlying mechanisms of SP, in which SP may be a psychological and behavioural manifestation of maladaptive self-control, which present as difficulties managing sexual thoughts and urges. They also propose that these results may provide support for the theory that SP is driven by an impulse control disorder, and that having an improved understanding and management of these underlying mechanisms (self-control) may help to improve the management of intrusive sexual thoughts (SP).

Berman-Roberts (2015) and Hocken et al. (2016) both acknowledge that these results demonstrate only a tentative link between personality and SP and are from the same sample of IPSO taking MMPSA, therefore, further research is required to confirm or dispute this association. Previous investigations only used the relationships and self-management domains of the SIPP-118, however, as demonstrated above (section 2.2) identity integration and relational capacities are linked to personality functioning (criterion A of the DSM-5 AMPD), and pathological personality traits are also pertinent (criterion B). Additionally, these studies only recruited IPSO that were taking MMPSA, whom consequently demonstrated high levels of SP, therefore, further research is required to explore the relationship between PD and SP among a broader sample of IPSO in order to establish the psychological underpinnings behind SP and how best to treat it. Thus, the main aim of this thesis is to explore in detail the relationship between PD and SP among a more general sample of IPSO (by exploring personality functioning, pathological personality traits, and categorical PD diagnoses). Learning more about the underlying mechanisms of SP and how it manifests among IPSO will enable more targeted treatment for this specific population, which may also help to broaden the availability of treatment options for individuals that are unable to or choose not to take MMPSA.

2.5.2 The relationship between personality disorder and adverse childhood experiences

The main aim of this thesis is to explore the relationship between PD and SP among IPSO, however, given that ACEs are an integral part of understanding sexual offending, PD, and SP, they were also included for exploration within this thesis. Regarding the relationship between PD and ACEs, there is an abundance of research which demonstrates a strong link between early adverse experiences and the later development of PD (Johnson et al., 1999; Laporte et al., 2011; Tyrka, Wychea, Kelly, Lawrence & Carpenter, 2009; Zanarini, 2000). Levenson et al. (2016) posit that the impact of ACEs results in difficulties with attachment, self-regulation, and emotional regulation, whereby chronic trauma is thought to lay the groundwork for a range of interpersonal difficulties and coping skills (Elliot et al., 2005; Teyber & McClure, 2011), which are hallmark symptoms for PD (Ahlmeyer et al., 2003). However, few studies have explored this relationship between PD and ACEs among male prisoners (Roberts, Yang, Zhang & Coid, 2008), particularly IPSO, as the majority of research has focused on traumatic

experiences in women, or have restricted the measures of negative experiences to that of abuse and neglect (Fondacaro, Holt & Powell, 1999; Keaveny & Zwaszniewski, 1999). Therefore, further research is required to explore the relationship between a range of ACEs and PDs among IPSO within UK prison establishments.

It is important to acknowledge that most individuals who experience ACEs do not develop PD (Afifi et al., 2011), and not all individuals with PD have a history of childhood adversity (Paris, 2000). The presence of a risk-factor is not necessary or sufficient to explain the development of PD, and does not explain why some survivors of traumatic experiences develop PD whereas others do not (Lewis & Grenyer, 2009). However, it is likely to be biologically-determined differences in stress sensitivity and vulnerability that interact with chronic stress and trauma that increase the likelihood of developing problems (Goodman, New & Siever, 2004; Skett & Lewis, 2019), as well as the cumulative effect of ACEs.

2.5.2.1 Personality disorders and adverse childhood experiences among IPSO

Within the wider literature, particularly among clinical populations, several studies demonstrate associations between PD and childhood trauma (Cohen et al., 2014; Douglas et al., 2011; Hengartner, Aidacic-Gross, Rodgers, Müller & Rössler, 2013; Kalkamis & Chandler, 2015; Laporte et al., 2011; Lobbestael, Arntz & Bernstein, 2010; Waxman, Fenton, Skodol, Grant & Hasin, 2014), however, there are minimal empirical investigations which focus on this relationship among male prisoners (Roberts et al., 2008), particularly among male IPSO. Johnson et al. (1999) found that individuals who experienced abuse and neglect were more than four times more likely to have PD in early adulthood (compared to those who did not experience trauma). Interestingly, this impact of trauma is not confined specifically to clinical populations, as research also shows links in community studies with sub-clinical PD symptoms (Johnson et al., 1999; Johnson, Cohen, Chen, Kasen & Brook, 2006; Grover et al., 2007), suggesting there is a wide array of personality outcomes following traumatic experiences. Various associations have been found between individual ACEs and individual PDs; however, it is beyond the scope of this chapter to describe these in detail, rather, the literature relevant to IPSO only will be discussed further.

In regard to IPSO, although research demonstrates a high prevalence of PD and ACEs among IPSO (Gillespie & Beech, 2016; Jespersen et al., 2009; Levenson et al., 2016; Marshall et al., 1997, Mann & Beech, 2003; Reavis et al., 2013), there are minimal studies which have examined this relationship among specific samples of IPSO, particularly in the UK. Craissati and Beech (2005; 2006) explored the relationship between developmental variables and risk among IPSO in the UK, discovering that childhood experiences of emotional, physical and sexual abuse were related to increased risk and the likelihood of failing in the community. They propose that these childhood experiences may result in extensive psychological difficulties during adulthood and/or PD, however, they did not test this

hypothesis within their research. Craissati et al. (2008) took this a step further by exploring the relationship between PD and childhood difficulties (emotional neglect, physical abuse, and sexual abuse) among 241 IPSO from England. The results revealed that experiencing two or more childhood difficulties was significantly related to PD, whereby IPSO were almost three times more likely to report PD if they had two or more traumatic experiences. However, Craissati et al. (2008) failed to explore the impact of household adversity within childhood, or the relationship of trauma with individual PDs (as they focused on PD as 'a definite PD diagnosis', 'Cluster A PD', and 'Cluster B PD').

However, one study that has explored the relationship between PD and a range of ACEs among a sample of male prisoners in the UK ($n = 1936$) was conducted by Roberts et al. (2008). Data were used from the Prisoner Cohort Study, which was part of the dangerous and severe personality disorder (DSPD) service development program in England and Wales. The sample consisted of high-risk individuals that were incarcerated for sexual or violent offences, so although the sample is not exclusively IPSO, it does contain a sample of IPSO. The results revealed that among high risk prisoners, paranoid PD was associated with a lack of affection from parents, schizoid PD was linked with emotional abuse, borderline PD had strong associations with sexual abuse, bullying, and being placed in care, antisocial PD was associated with a lack of affection from parents, substance abuse and incarceration within the family home, and being placed in care, histrionic PD with sexual abuse, bullying, and mental illness within the family home, individuals with narcissistic PD were less likely to report incarceration or being placed in care, avoidant PD was associated with neglect, bullying, and incarceration, obsessive-compulsive PD was linked with neglect and emotional abuse, and no associations were found between ACEs and schizotypal and dependent PDs.

Overall, this study confirms a strong relationship between PD and ACEs among high risk prisoners in the UK, however, this study only accounts for high risk prisoners, and is not an exclusive sample of IPSO. To the best of the author's knowledge, the relationship between PD and a range of ACEs among a specific sample of IPSO has not yet been explored within the UK. Therefore, further research is required to explore this relationship among a broader sample of IPSO in the UK, which is consequently one of the aims of this thesis.

2.5.3 The relationship between sexual preoccupation and adverse childhood experiences

As previously mentioned, ACEs are thought to be involved in the aetiology of SP (Courtois & Weiss, 2018; Kuzma & Black, 2008; Noll et al., 2003), with theorists suggesting SP may be a long-term effect of abuse (Noll et al., 2003), or a maladaptive coping strategy employed as a way of escaping the emotional and psychological pain created by trauma (Courtois & Weiss, 2018; Gartner, 2018; McKeague, 2014). Various research has explored the relationship between childhood trauma and SP (Chatzittofis et al., 2017; Courtois & Weiss, 2018; Efrati & Gola, 2019; Engel et al., 2019; McPherson, Clayton, Wood, Hiskey

& Andrews, 2013), even among IPSO (Davis & Knight, 2019; Kingston et al., 2017; Marshall, 2016a; Marshall & Marshall, 2006), however, the impact of wider adversity (such as household dysfunction, as well as childhood maltreatment) has yet to be explored among IPSO within the UK. Given that ACEs are highly prevalent among IPSO (Drury et al., 2016; Jespersen et al., 2009; Levenson et al., 2016; Reavis et al., 2013), SP is one of the most prominent risk factors among IPSO (Hocken, 2014), and IPSO have acted upon their intrusive sexual thoughts and engaged in illegal sexual behaviour, it is crucial to learn more about the underpinnings of SP and the links with ACEs within this population in order to inform and enhance treatment.

2.5.3.1 Sexual preoccupation and adverse childhood experiences among IPSO

Research among general population and clinical samples reveals that early traumatic experiences are prevalent among individuals with SP (Chatzittofis et al., 2017; Courtois & Weiss, 2018; Efrati & Gola, 2019; Griffee et al., 2012; Opitz, Tsytsarev & Froh; Perera, Reece, Monahan, Billingham, & Finn, 2009; Smith, Potenza, Mazure, Mckee, Park & Hoff, 2014), whereby an increased amount of traumatic experiences and the severity of trauma is thought to be linked to greater SP (Efrati & Gola, 2019). Sexual abuse has been found to be strongly associated with the development of SP (Chatzittofis et al., 2017; Engel et al., 2019; Meyer, Cohn, Robinson, Muse & Hughes, 2017; Perera et al., 2009; Skegg et al., 2010), and Noll et al. (2003) argue that due to the explicit nature of sexual abuse in comparison to other forms of child maltreatment, there is an increased possibility of developing SP as sexuality and intimacy issues may become more salient. However, other research argues that higher rates of emotional and physical abuse are present among those with SP (Davis & Knight, 2019; Engel et al., 2019; Kingston et al., 2017), as well as parental mental illness and a dysfunctional family environment (Augustine Fellowship, 1986; Engel et al., 2019). On the other hand, a history of trauma is not prevalent in all individuals with SP (Gold & Heffner, 1998), and some research has found no significant relationship between ACEs and SP (Chaney & Burns-Wortham, 2014; Parsons, Grov & Golub, 2012).

In regard to IPSO, there are several studies which have also explored this relationship (Davis & Knight, 2019; Kingston et al., 2017; Marshall, 2016a; Marshall & Marshall, 2006). Research indicates that SP is significantly correlated with the total ACE score (Marshall, 2016a), whereby the accumulation of traumatic experiences is associated with an increase in SP (Kingston et al., 2017). In 2006, Marshall and Marshall explored the relationship between childhood sexual abuse and SP among 40 IPSO from the US, discovering that IPSO with SP were significantly more likely to report sexual abuse than IPSO without SP. Later, in 2016, Marshall reported that SP was associated with the total ACE score among 41 IPSO in the US, however, the relationships between SP and individual ACEs were not discussed (Marshall, 2016a). Green and Marshall (2016; as cited by Marshall, 2016b) also revealed that IPSO with SP in the US had higher rates of ACEs (in comparison to IPSO without SP), particularly emotional and

physical abuse, and emotional neglect. Interestingly, sexual abuse was not found to be significantly related to IPSO with SP.

More recently, Kingston et al., (2017) and Davis and Knight (2019) have explored the relationship between child maltreatment and SP among adult and juvenile IPSO. Kingston and colleagues (2017) explored the relationship between child maltreatment (physical, psychological/emotional, and sexual abuse) among 529 adult IPSO from the US. The results highlight that emotional/psychological abuse (perpetrated by a male caregiver) was the most prominent correlate of SP, above and beyond the other types of maltreatment. Furthermore, Davis and Knight (2019) report similar results among 329 juvenile IPSO from the US, whereby emotional/psychological abuse from a male caregiver remained a potent correlate of SP, however, sexual abuse was also found to be significantly related to SP.

The majority of the research which examines the relationship between adverse experiences and SP has mainly been conducted in non-offending samples, with a strong emphasis on childhood sexual abuse (Kingston et al., 2017). More recent studies have begun to include other types of child maltreatment, however, there appears to be a paucity within the literature regarding the relationship with wider adversity such as household dysfunction among IPSO. As well as this, the author is not aware of any other research conducted in the UK which has explored this relationship among IPSO, therefore, one of the aims of this thesis is to explore the relationship between a range of ACEs and SP among IPSO housed in UK prison establishments.

It is important to acknowledge that although the term SP has been used throughout this section for consistency purposes, as pointed out in section 2.3.1, there are discrepancies within the literature regarding the definition and terms used to describe this phenomenon. The above studies used the terms sexual addiction and hypersexuality, which may involve different ways of operationalizing and measuring this behaviour. Additionally, there are also inconsistencies in how people define ACEs (Noll et al., 2003), for example, Noll et al. (2003) highlight that there are inconsistencies in the operational definitions of child sexual abuse (varying from non-contact abuse to contact abuse), and a lack of details about the characteristics of abuse (i.e. perpetrator identity, age at onset, the amount of physical coercion used), which may account for some of the differences found within the literature.

[2.6 Overall summary](#)

A thorough review of the literature highlights the importance of personality disorder and sexual preoccupation among IPSO, as well as how ACEs are implicated in the aetiology of sexual offending, PD and SP. The review also indicates that the prevalence of PD, SP and ACEs has not yet been explored among IPSO housed in UK prison establishments. Although a tentative link has been found between PD and SP among IPSO, the underlying mechanisms of SP are relatively unexplored among IPSO, and

further research is required to help enhance assessment and treatment techniques. In order to fully understand this relationship between PD and SP, it is important to consider the impact of ACEs among this population, and how they relate to PD and SP among IPSO as well. Furthermore, it is not possible to fully understand how an individual makes sense of their life or interprets the world around them without exploring their narrative identity, which is the internalised life story that an individual has created about themselves (McAdams, 1994). It is important to explore all aspects of personality (including traits, characteristics, and narrative identity) in order to get a comprehensive understanding of what it is like for individuals that have experienced adversity during their childhood, as well as personality difficulties and sexual preoccupation throughout their lives.

2.7 Research question and aims

The overarching research question relating to this thesis is:

- What is the relationship between personality disorder (PD) and sexual preoccupation (SP) among individuals who have previously sexually offended (IPSO)?

The main aim of this thesis is:

- To explore the relationship between PD and SP among a sample of IPSO housed in UK prison establishments

Additional aims of the thesis include:

- To examine the relationship between PD and ACEs among IPSO.
- To explore the relationship between SP and ACEs among IPSO.
- To assess the prevalence rates of PD, SP, and ACEs among IPSO.
- To examine the life trajectories and narrative identity of IPSO who have experienced ACEs, PD, and SP.

Individual aims and objectives of each study will be provided within the relevant chapters.

Chapter Three: Methodological review

Overview

This chapter outlines the methodological approach employed within this thesis. It starts by providing an overview of the methodological approach and research plan, before discussing each of the four empirical studies individually (regarding the rationale, participant recruitment, data collection, and methods of analysis of each study). Finally, this chapter will detail some of the ethical challenges and considerations faced whilst conducting this research. The general methodological aspects will be covered in this section, however, the specific methodology and intricacies relevant to each study will be detailed within relevant chapters.

3.1 Methodological approach and research plan

A research paradigm (also referred to as 'research methodologies' [Neuman, 2014], 'philosophical worldview' [Cresswell, 2014], and 'philosophical stance' [Boucher, 2014]) refers to a theoretically informed approach to research, stemming from the underlying epistemological stance (Lincoln, Lynham & Guba, 2011; Ryan, 2006). A worldview is thought to consist of stances on each of the following elements: ontology, epistemology, axiology and methodology (Cresswell & Plano Clark, 2007; Teddlie & Tashakkori, 2009). It is commonly agreed that there are four research paradigms: positivism (and postpositivism), constructivism (or interpretivism), transformative, and pragmatism (Cresswell, 2014; Cresswell & Plano Clark, 2007). Positivism and its successor postpositivism assume that there is an objective reality that can be scientifically measured, and are closely aligned with quantitative research, whereas, constructivism encompasses a subjective approach which acknowledges the possibility of multiple interpretations of reality, and is commonly identified with qualitative research (Hall, 2013; van Griensven, Moore & Hall, 2014). Traditionally, psychological research utilises a single research paradigm (Alasuutari, Bickman & Brannen, 2008), usually that of positivism (utilising quantitative methods) or constructivism (utilising qualitative methods). However, mixed methods research has evolved as a third research approach over the past thirty years (Teddlie & Tashakkori, 2009), which integrates both quantitative and qualitative data (Cresswell & Plano Clark, 2007; Greene, 2007), and aligns with the transformative and pragmatism paradigms (Cresswell, 2014; Hall, 2013).

A positivist approach views reality as static (Bryman, 2004), believing that there is only one reality or truth that can be examined objectively, through cause and effect, providing generalisable results (Howitt & Cramer, 2005). It builds on deductive theory and is considered to be a reductionist approach in that it reduces ideas into a small, discrete set to test, such as the variables included in specific hypotheses (Cresswell, 2014). The greatest strength with this approach, and ultimately quantitative research, is that the methods used generate reliable data that can potentially be generalised to a wider

population (Howitt & Cramer, 2005; Marshall, 1996). In contrast to this, a constructivist approach is idiographic in nature, builds on inductive theory, and recognises that there may be multiple interpretations of reality and truth (Henn, Weinstein & Foard, 2005; van Griensven et al., 2014). Constructivism, and ultimately qualitative research, acknowledges that reality is a socially constructed phenomenon (Yilmaz, 2008), whereby individuals develop subjective meanings of their experiences, and these meanings may be varied and multiple. Therefore, it is the role of the researcher to reveal the subjective meanings that individuals use to interpret their world (Walliman, 2015), as well as seeking out the complexity of these, rather than narrowing meanings into a limited number of categories or ideas (Cresswell, 2014). Furthermore, Cresswell (2014) argues that under this approach, researchers recognise how their own backgrounds impact their interpretation of the data, and they position themselves within the research in order to acknowledge this.

Both quantitative (positivist) and qualitative (constructivist) approaches have received criticism, whereby quantitative research fails to recognise the subjectivity of the participants or the role of the researcher, and qualitative research is thought to lack theory and be overly subjective, meaning that it lacks validity and reliability (Easton, McCornish & Greenberg, 2000; Hall, 2013). As a way of overcoming the weaknesses of these approaches, some researchers suggest that the combination of quantitative and qualitative data (referred to as mixed methods research) provides a greater depth, understanding, and breadth of information which is not possible when using a singular approach (Almalki, 2016; Cresswell, 2014; Morse & Niehaus, 2009). For example, researchers may want to both generalise findings to a wider population, whilst also developing a detailed understanding of the meanings of a specific phenomenon for individuals (Cresswell, 2014). Some researchers argue that it is not possible to combine research approaches given their opposing epistemological stances (Guba & Lincoln, 1994), whereas, others suggest that research paradigms should be viewed as lying on a continuum, whereby emphasis should be placed on the similarities between the approaches, rather than the differences (Onwuegbuzie & Leech, 2005). Mixed methods research draws from the strength of individual approaches, whilst also compensating for the weaknesses of each (Kelle, 2006; Onwuegbuzie & Leech, 2005). It has been suggested that, for complex research questions, it is important to integrate methods in order to provide a comprehensive understanding (Lund, 2012), with both idiographic and nomothetic perspectives being considered vital for research relating to human experience (Hindle & Franco, 2009). Furthermore, one of the strengths of a mixed methods approach is that it enables data triangulation (Langdrige & Hagger-Johnson, 2013), whereby the aim is to 'map out, or explain fully, the richness and complexity of human behaviour by studying it from more than one standpoint' (Cohen, Manion & Marrison, 2007, page 254). Under the model of triangulation, equal value is placed on both the quantitative and qualitative components, with both being required to answer the research question (Langdrige & Hagger-Johnson, 2013).

In terms of research paradigms, the argument that mixed methods may not be possible due to the incompatibility of the underlying paradigms (Guba & Lincoln, 1994) has resulted in a range of alternative approaches (Tashakkori & Teddlie, 2003; Cresswell & Plano Clark, 2007). According to Cresswell (2014), the first approach (a-paradigmatic stance) ignores these paradigmatic issues altogether, the second approach (multiple paradigm approach) suggests that multiple paradigms are compatible and can be used in one research project, and the third (single paradigm approach) asserts that both quantitative and qualitative research can be conducted under one paradigm. Two paradigms are thought to be contenders for the single paradigm approach, namely transformative and pragmatism (Cresswell, 2014). Pragmatism is advocated by a number of mixed methods researchers, has gained considerable support, and is the most frequently used paradigm within mixed methods research (Feilzer, 2010; Johnson, Onwuegbuzie, & Turner, 2007; Maxcy, 2003; Morgan, 2007; Tashakkori & Teddlie 2003). Pragmatism involves 'solving practical problems in the 'real world'' (Feilzer, 2010, p. 8), and is concerned with 'what works' and finding solutions to problems (Patton, 1990). Rather than focusing on methods, the pragmatist approach emphasizes the research problem, encouraging the researcher to use all available approaches in order to better understand the problem (Rossman & Wilson, 1985; Tashakkori & Teddlie, 2003). Biesta (2010) argues that pragmatism disrupts the hierarchies between positivism and constructivism, providing a way of looking at what is meaningful from both paradigms, preventing the researcher from being limited to one worldview (Tebes, 2012).

The majority of research conducted with prisoners is of a quantitative nature, however, these studies fail to provide rich in-depth data about an individual's life experiences. Therefore, among prisoners, there is still a need to focus on service user perspectives (Nee, 2004), whereby Liebling (1999, p. 8) argues that a mixed methods approach can enable the researcher to access both the 'experience and emotion' of the individual, as well as 'structure and measurement', resulting in a credible understanding of the individual. Given the relative lack of research exploring the relationship between PD and SP among IPSO, this research adopts a mixed methods approach, which is well aligned with the overarching aims of the thesis. Each empirical study has individual aims, therefore, it was important for the researcher to select the most appropriate method to achieve these aims, as opposed to being confined to a predetermined design that may not have been able to meet all of the aims of the research. It was decided that utilising both quantitative and qualitative research would offer the best contribution to the literature regarding this understudied area, whilst also affording the thesis an opportunity to triangulate the data. The overarching paradigm adopted within this thesis is therefore pragmatism, as it offers a flexible approach which accounts for both positivist and constructivist perspectives (Feilzer, 2010; Tebes, 2012), enabling the researcher to value the importance of both quantitative and qualitative research. This thesis acknowledges the usefulness of quantitative research methods throughout the first three empirical studies (enabling the prevalence of PD, SP, and ACEs to be assessed, as well as the relationships between these three phenomena), whilst also recognising the value of a qualitative element which enables us to learn subjectively about an individual's lived experiences, whilst

also being able to explore the deepest level of personality (McAdams, 1994). The qualitative element of this thesis draws largely on constructionism and phenomenology (discussed further in section 3.5), and the combination of both quantitative and qualitative data provides a more holistic and comprehensive understanding of the relationship between PD, SP, and ACEs among IPSO.

Regarding the research plan, the first empirical study assesses the psychometric properties of two PD scales in a UK male sample (prior to using these tools to screen for PD among IPSO), and the second study screens for PD and SP among a sample of IPSO housed in two UK prison establishments. The third study follows by inviting IPSO that demonstrated signs of PD to complete further psychometric scales focusing on PD, SP, and ACEs. Finally, the fourth study explores the life stories of IPSO that experienced ACEs, personality difficulties, and a preoccupation with sex throughout their lives, using a narrative psychological approach.

3.2 Study one: Validation study

3.2.1 Rationale

The literature review in chapter two highlighted a paucity in the literature regarding the relationship between PD and SP among IPSO in the UK, therefore, given the need to screen for PD among a wide sample of IPSO (discussed in more detail in section 3.3), the focus subsequently turned to identifying suitable measures to screen for PD. With the DSM-5 retaining the old categorical system, whilst also incorporating the new hybrid model (AMPD), it resulted in a variety of PD psychometric scales being available. This thesis aligns with current research which shows support for the dimensional approach, therefore, finding reliable and valid screening tools (that were freely available due to funding restraints) which could be used with prisoners in the UK became a challenge. The DSM-5 developed the Levels of Personality Functioning Scale (LPFS; Morey et al., 2011) to measure criterion A (personality functioning), and the Personality Inventory for DSM-5 Brief-Form (PID-5-BF; Krueger et al., 2012) to assess criterion B (pathological personality traits). However, the LPFS is a clinician rated report, rather than self-report, making it less than ideal for screening purposes. The Severity Indices of Personality Problems – Short Form (SIPP-SF; Verheul et al., 2008) has been identified as a useful measure of personality functioning, however, has not yet been validated within the UK. Similarly, the PID-5-BF has not been validated in the UK, therefore, it was decided to include an additional study into the research project. The purpose of this study was to assess the reliability and validity of the SIPP-SF and PID-5-BF among a sample of UK males that may be representative of a prisoner sample, with the intention of later using these scales to screen for PD among IPSO in the UK.

3.2.2 Participant recruitment and sampling

Purposive sampling was employed as participants were selected according to pre-determined criteria (Guest, Bunce & Johnson, 2006). Participants comprise a specific sample of 203 adult males from the UK, recruited from factories, warehouses, garages, call centres, and trade jobs. Given that future studies intended to conduct research with male IPSO, it was important to validate these scales in a sample which may be representative of male prisoners, therefore, rather than using general population or student samples, a purposive sample of males was chosen (for further details see section 4.3.2).

3.2.3 Data collection

A survey research design was utilised, whereby the researcher distributed questionnaire packs to various factories, warehouses, garages, call centres, and trade jobs in and around the East Midlands. The researcher was present to answer any questions or offer support if necessary, alternatively, participants could take the questionnaires home to complete in their own time, returning to the university via a pre-paid envelope.

3.2.4 Method of analysis

In order to assess the psychometric properties of the SIPP-SF and PID-5-BF, Cronbach's alpha coefficients and mean item-total correlations were used to assess the internal consistency of the scales, bivariate correlations were conducted to demonstrate discriminant validity between the SIPP-SF and PID-5-BF, and criterion validity was evaluated by means of bivariate correlations with PD criterion counts. Finally, the factor structure of the PID-5-BF was assessed using confirmatory factor analysis.

3.3 Study two: Screening study

3.3.1 Rationale

The main purpose of this thesis is to enhance the understanding of the relationship between PD and SP among IPSO using a mixed methods approach, whereby one of the aims is to explore the prevalence of PD and SP among IPSO. The main researcher considered various ways of identifying IPSO with PD, including the use of gatekeepers in psychology or healthcare services (see below; section 3.3.2), however, in order to also gather prevalence rates of PD and SP among a general sample of IPSO (as this has not yet been explored among IPSO residing in UK prison establishments), it was decided to use screening tools to recruit across the whole prison environment. Therefore, the purpose of this study is three-fold; firstly, it aims to assess the prevalence of PD and SP among a sample of IPSO housed in two UK prison establishments, secondly, it enables the exploration of the relationship between PD and SP

among IPSO, and finally, it aimed to identify individuals with potential PD who could then choose to participate (or not) in subsequent studies.

3.3.2 Participant recruitment and sampling

Similar to above, purposive sampling was employed given that it was a specific sample of prisoners (IPSO) which were of interest in this study (Guest et al., 2006). IPSO with PD and SP were required for the fourth (qualitative) study, and the researcher contemplated recruiting IPSO that had been identified with PD through healthcare and/or psychology services. However, discussions with healthcare clinicians revealed that official diagnoses of PDs were not common, and IPSO that did access healthcare/mental health services often demonstrated borderline or antisocial traits (due to the associated behaviours, whereas, individuals with paranoid/avoidant PD were less likely to come to the attention of healthcare/mental health services). Furthermore, the screening tool for the OPD pathway was considered as a way of identifying individuals using the Offender Assessment System (OASys), however, this only screened for antisocial and borderline PDs. Given that one of the aims of this study was to assess the prevalence of a range of PDs and SP among a general sample of IPSO, it was decided that screening tools administered to all IPSO in the prison establishments would be the most appropriate way of gathering this data. This also enabled the researcher to identify IPSO that may be suitable for the subsequent studies. For this study, participants consisted of 155 adult male IPSO who were serving a custodial sentence at two category C prison establishments.

3.3.3 Data collection

A survey research design was utilised, whereby the main researcher distributed questionnaire packs under 1,600 cell doors at two category C prison establishments that house IPSO. The researcher contemplated various ways of assessing PD, such as structured clinical interviews versus self-report scales, however, given that the research design involved 1,600 potential participants, it was not feasible to conduct in-depth interviews at this stage. Short screening tools were required to easily assess problematic personality among a large quantity of IPSO, which also meant that scales that were freely available to use were preferred due to limited funding. As previously mentioned, the DSM-5 AMPD was gaining popularity within the literature when this thesis first commenced and was chosen due to its ability to gather both categorical and dimensional data relating to PDs. The SIPP-SF and PID-5-SF were used within the AMPD framework as a way of exploring categorical PD diagnoses, as well as providing insight above and beyond that of a categorical diagnosis (i.e. gaining information regarding an individual's specific impairments in personality functioning and their pattern of pathological traits).

Service users that form part of the Whatton and SOCAMRU Research and Evaluation Panel (WASREP) were included in the design of the research project and advised on various aspects such as the content

of information sheets and consent forms, as well as appropriate ways of advertising the research and distributing questionnaires. Service user involvement in the development of research is considered important and has been recognised in the UK (Department of Health, 2006; National Institute for Health Research, 2012). Insight from the WASREP group enabled the researcher to advertise the research in various forms, as well as minimising any potential barriers (such as placing labelled boxes on each wing for IPSO to place their completed questionnaires in, as the group identified that some IPSO may be wary of handing personal data to wing staff).

3.3.4 Method of analysis

Data from this study is analysed in both chapter five (characteristics of IPSO) and chapter six (relationships between PD, SP and ACEs). See figures 1 and 2 (in section 1.4) for more information regarding this. Cronbach's alpha coefficients were used to assess the internal consistency of the scales. In order to explore the characteristics of IPSO in chapter five, descriptive statistics were used to describe the sample regarding the prevalence of PD and SP. A series of independent samples *t*-tests and one sample *t*-tests were used to compare the research sample to general population norms, general population data (from study 1: validation study), and a sample of IPSO taking MMPSA. Finally, categorical PDs were compared to other research samples using binomial analyses and odds ratios. Furthermore, in chapter six, in order to explore the relationship between PD and SP, independent sample *t*-tests were conducted, as well as correlational and multiple regression analyses.

3.4 Study three: Further psychometric study

3.4.1 Rationale

The literature review demonstrated that the relationship between PD and SP was underexplored among IPSO, as well as highlighting that ACEs were implicated in the aetiology of sexual offending, PD and SP. It also came to light that there was minimal research focusing on the relationships between PD and ACEs, and SP and ACEs among IPSO, therefore, this study intended to address these gaps within the literature. Study two identified IPSO with personality difficulties, whereas, this study aimed to explore personality functioning in more depth (as opposed to using a screening tool), further explore sexual preoccupation, and to incorporate the concept of ACEs into the research. ACEs were only included at this stage due to various ethical concerns (see section 3.6 for more information). Moreover, this study identified suitable participants for the fourth (qualitative) study, which required IPSO with a history of ACEs, personality difficulties, and a preoccupation with sex.

3.4.2 Participant recruitment and sampling

Given that a specific sample of IPSO were the target of this study (IPSO demonstrating personality difficulties), purposive sampling was employed according to pre-determined criteria in relation to the research aims (Guest et al., 2006). Participants from study two that showed PD (according to the AMPD definition; impairments in personality functioning and at least one pathological personality trait) were invited to take part in this further psychometric study (if they consented to being contacted for future research purposes; discussed further in section 3.6.1). For this study, participants consisted of 45 adult male IPSO from two category C prison establishments.

3.4.3 Data collection

This study utilised a survey research design, whereby questionnaires were completed with the researcher in a one-to-one appointment (dependent upon risk level of IPSO; discussed further in section 3.6.3). Full length scales were utilised in this study, and a face-to-face appointment enabled the researcher to assess participants levels of understanding and fatigue, as well as being able to monitor any distress caused by the exploration of ACEs.

3.4.4 Method of analysis

As with study two, data from this study is also analysed in both chapter five and six, whereby the information detailed above in section 3.3.4 is applicable to the analysis of this data. In addition to the above analytical information, data from this study enabled the prevalence of ACEs among IPSO to be explored, as well as the relationships between PD and ACEs, and SP and ACEs using descriptive statistics, independent samples *t*-tests, correlational, and regression analyses.

3.5 Study four: Qualitative study

3.5.1 Rationale

Although this thesis acknowledges the usefulness of quantitative research (as demonstrated by the previous studies), it also recognises the value of qualitative research, and how this can enable us to better understand what it is like to experience childhood adversity, personality difficulties, and sexual preoccupation from individuals that have experienced it first-hand. This thesis also aligns with McAdams' (1994) triarchic model of personality, and therefore, a mixed-methods approach enables all three levels of personality to be explored among IPSO, with the qualitative study exploring an individual's narrative identity. It was always the intention of this thesis to be a mixed-methods project in order to provide a holistic and comprehensive understanding of the relationships between PD, SP,

and ACEs, however, the need for a qualitative study was reinforced during data collection for study three. Whilst conducting the ACE scale with participants it became evident that some participants sought to discuss their childhood experiences and adversity (rather than answering just yes or no), and according to Law and Ward (2010) IPSO typically want to tell their story, however, in the past this may have been to disbelieving audiences. Therefore, this study intended to provide individuals with the opportunity to tell their story in a non-judgemental, non-threatening environment. The previous quantitative studies explored dispositional traits, but failed to explore an individual's narrative, or the subjective meanings of experiences and how they interpret the world (Walliman, 2015). This study gives IPSO a voice and enables them to tell their story, whereby a focus on idiosyncratic meaning making enables the exploration of how past experiences can impact an individual's present (Riessman, 2008).

3.5.2 Participant recruitment and sampling

Purposive sampling was also employed for this study due to participants being selected according to pre-determined criteria in relation to the research aims (Guest et al., 2006). Participants from study three that demonstrated signs of personality disorder, sexual preoccupation, and adverse childhood experiences were invited to take part in the qualitative study (if they consented to being contacted for future research purposes; see section 3.6.1). Purposive sampling enabled the selection of 'experts' in this particular area (Henn et al., 2005), and participants consisted of five adult male IPSO recruited from across both prison establishments.

3.5.3 Sample size

Sample size in qualitative research is a debated topic within the literature, however, the overall consensus is that quality is far better than quantity (Smith, Flowers & Larkin, 2009; Terry, Hayfield, Clarke & Braun, 2017). Rich data enables researchers to gain detailed and nuanced insights (Terry et al., 2017), whereby the level of depth required for analysis means that small sample sizes are often accepted and considered the norm (Smith & Osborn, 2003). The aims of these studies are not to produce generalisable results, but, to provide an in-depth exploration and understanding of an understudied topic (Blagden, Winder, Gregson & Thorne, 2014; Howitt, 2016). Maruna and Matravers (2007) argue that even single participant samples hold psychological truth as they can provide meaning to an individual's experiences. With regard to life stories, Reichenbach (1983) states that there are two ways of studying life narratives: the context of discovery and the context of justification. In the context of discovery, researchers examine life stories for patterns, themes, images, and qualitative characterisations in order to understand a single life in full, or to generate new theories. Whereas, in the context of justification, researchers aim to see how hypotheses play out in multiple lives, utilising well-validated coding systems and statistical analysis. It has been suggested that narrative interviews result in rich, detailed stories, and therefore, life experiences of an individual or a few individuals is

adequate, rather than large sample sizes (Muylaert, Sarubbi Jr, Gallo, Neto & Reis, 2014). Given that this thesis aims to explore an understudied area it falls under the context of discovery, and the sample size ($n = 5$) can be considered appropriate for such thorough and detailed life story interviews (discussed further in section 3.5.5).

3.5.4 Data collection

In order to explore the internalised and evolving life stories of IPSO that experienced ACEs, PD, and SP, a narrative psychological approach was taken, which involved conducting life story interviews with participants. This aligns with McAdams' (1994) triarchic model of personality as this approach enables the second and third levels of personality to be explored (character adaptations and narrative identity). In-depth life story interviews were conducted with participants over several sessions in private assessment rooms. Interviews were recorded using a password protected dictaphone, and the researcher was able to monitor participant fatigue throughout the interview, as well as watching out for any signs of distress.

3.5.5 Methodological approach

A narrative psychological approach was a logical choice for the qualitative study given that the aim was to explore the life stories of IPSO, in order to delve deeper into their personality and understand how they make sense of their experiences. This approach offers an alternative way of exploring personality compared to the quantitative approach used throughout the earlier studies, which only focuses on personality functioning and dispositional traits. Narrative research (sometimes referred to as life story research or autobiographical research) attempts to understand the lives of people as told through their own narratives (Langdrige & Hagger-Johnson, 2013), which allows for the exploration of character adaptations and narrative identity (levels two and three of McAdams' [1994] personality model). McAdams (2003) argues that personality and identity are constructed narratively, and states that narratives are more than simple stories, as 'life stories speak directly to how people come to terms with their interpersonal worlds, with society, and with history and culture' (McAdams, 2008, p. 257). The self-narrative is often understood as a crucial part of an individual's personality and inner self (Maruna, 2001), and these narratives that people have about their lives impose an order on their actions, and explain their behaviour using a sequence of events which relate to goals, motivations, and feelings (McAdams, 1985). These self-narratives then shape and guide an individual's future behaviour, as they act in accordance with the stories they have created about themselves (McAdams, 1985). Furthermore, McAdams (1993) argues that an individual's narrative identity (unlike personality traits, which tend to be largely stable over time) can change throughout their life course, whereby individuals continuously restructure their identity in light of new experiences.

In 2000, Crossley developed a narrative psychological approach when addressing traumatic experiences, which is concerned with subjectivity and experience, assuming a chain of connection between what a person says and how they think, feel, and reflect about themselves, others, and the world (Crossley, 2007). Furthermore, a life story approach is a valuable method for including marginalised voices in the research process, as the main focus enables participants to 'tell their story', and participants are able to give an account of how and why their life took the form it did. As Maruna (2001) points out, narrative researchers are not concerned with the facts contained within these narratives (whether they are true or false), but rather the meanings that individuals attach to these facts, and how they choose to frame these specific events. Although narrative analysis is concerned with the function of linguistic practices, this is not its only interest, as it also has a strong focus on the content of the narrative (Crossley, 2000). The narratives that participants tell about their lives are thought to represent their meaning making, whereby how they connect and integrate these experiences, and select which information to tell or omit, are all aspects of how they understand their lives (Josselson, 2011). Researchers conducting narrative research pay interest to both the content of the story ('the told'), and the structure of the story ('the telling'; Josselson, 2011), as well as what is unsaid or unsayable (Rogers et al., 1999).

This narrative approach was deemed appropriate for this study for several reasons. Firstly, it enables IPSO to tell their stories, and for us as researchers to explore the deepest levels of their personality and sense-making without directly asking them about PD, SP, or traumatic childhood experiences. This allowed IPSO to describe what events and moments in their lives were meaningful for them, rather than being influenced by any predetermined thoughts or preconceptions from the researcher. For example, if the researcher developed an interview schedule they may ask questions around child sexual abuse, which may place a focus on these events and assumes that they were meaningful, whereas, a narrative approach allows participants to include moments in their life that they find important and pivotal in their own life history. This was similar to research by Gibson and Morgan (2013) who chose not to directly ask about child sexual abuse but allowed participants to decide whether or not to include the abuse in their accounts, and to represent these experiences in any way they chose.

Secondly, IPSO are a marginalised group (Tewksbury, 2012) and their voices are rarely heard, whereby there is minimal research which explores the life stories of IPSO. Previously, Maruna (2001) explored the life stories of individuals who have committed crime, Cowburn (2005) explored the life histories of IPSO, and Farmer, McAlinden and Maruna (2016) considered the life stories of IPSO with a focus on desistance. However, to the best of the author's knowledge, no previous research has explored the life stories of IPSO with PD, SP, and ACEs. The researcher thought it was important for these individuals to be given an opportunity to tell their story and allow their voice to be heard in a non-judgemental, non-threatening environment. Furthermore, by focusing on idiosyncratic meaning making, narrative research is able to explore how past experiences can be understood to impact on a participant's present

(Riessman, 2008), which in relation to this study means that it is possible to explore how earlier stages of life (and potentially childhood adversity) may impact an individual's life, as well as how personality difficulties and an obsession with sex play out throughout their lives. Therefore, the decision to take a narrative approach for the qualitative element of this thesis was also based on a pragmatic decision as it was considered the most appropriate method for exploring the deepest layers of personality and sense-making among IPSO, whilst also allowing individuals to have a voice and tell their story.

3.5.6 Philosophical stance in relation to study four

Social constructionist approaches (such as postmodernism, discourse analysis, and feminist psychological approaches) view the self as dependent on language and linguistic practices that we use every day in order to make sense of ourselves (Crossley, 2007). One of the main problems with these approaches is that they omit the ability of participants to be reflexive, whereas, Parker (1991) argues that the capacity to be reflexive (to think about oneself) is central to human agency and understanding. IPA differs from these approaches as it is based on 'realist' assumptions, whereby it assumes that there is a domain of facts regarding human experience which can be discovered (Augustinus & Walker, 1995), as well as believing there is a 'chain of connection' between what somebody says, and how they think and feel (Crossley, 2000). Crossley (2007) suggests that there is a need for an approach which appreciates the linguistic practices, as well as maintaining a sense of the personal, coherent, and 'real' nature of subjectivity, which is where narrative psychology fits in. However, within narrative psychology, there is not only one approach (Langdridge & Hagger-Johnson, 2013). Some researchers focus on understanding the content of narratives, whereas, others emphasise the practice and form (linguistic practices) of narratives (Bamberg, 2006). Furthermore, there are researchers attempting to bring together both content and form (Crossley, 2000; Langdridge, 2007), which is the approach that this study aligns with.

According to Hiles and Cermak (2008), narrative analysis has its roots in both social constructionism and phenomenology, whereas Josselson (2011) argues that it is grounded in hermeneutics, phenomenology, ethnography, and literacy analysis. Narrative analysis is an interpretive method, which shares with discourse analysis an appreciation for the importance of and function of language (Crossley, 2007). However, narrative analysis differs from discourse analysis regarding the status they both afford to subjectivity and experience. Discourse analysis is dubious of mapping people's narratives onto underlying subjective experiences, whereas, narrative analysis (like IPA) is interested in retrieving the subjectivity of participants by focusing on lived experiences. Therefore, narrative psychology also operates within a 'realist' epistemology which affords sufficient respect to individuals' experiences (Crossley, 2000). These 'realist' assumptions are typically associated with more traditional psychological approaches. These approaches are commonly limited by their over-reliance on quantitative methods, and it has been argued that qualitative methods and analysis are required to

achieve greater depth (Crossley, 2000). Furthermore, Josselson (2011) proposes that narrative analysis 'eschews methodological orthodoxy in favor of doing what is necessary to capture the lived experience of people in terms of their own meaning making' (p. 225). This philosophical stance of narrative analysis aligns with the overarching research paradigm adopted in this thesis (pragmatism) in that it encourages a 'what works' approach, which enables the most efficient data to be gathered in order to understand the phenomena under investigation, as well as the 'realist' perspective aligning with the previous quantitative studies.

As mentioned previously, narrative analysis is grounded in phenomenology (Josselson, 2011) which is a philosophical stance usually related to an interpretivist research paradigm, and concerns the subjective meanings that participants assign to their lived experiences (Aresti, Eatough & Brooks-Gordon, 2010). Participants are viewed as 'experts' with regard to the phenomenon under investigation, and the researcher aims to gain an insight into their understanding and perspectives (Larkin, Watts & Clifton, 2006). Furthermore, narrative analysis acknowledges that meaning is co-constructed, in that it is an active process which the storyteller (participant) and audience (researcher) are part of, therefore, story tellers may shape their narratives with the intended audience in mind (Griffin & May, 2017). Not only are researchers implicated during the interview process, but they also have an active participation in the analysis and interpretation of the narratives. A double hermeneutic process is used whereby participants attempt to make sense of their world, and the researcher attempts to make sense of participants' sense making (Aresti et al., 2010), in which there is always an act of re-construction when a researcher writes about a participants' experience (Griffin & May, 2017). Therefore, this study will attempt to re-construct the reality of participants, whilst also bearing in mind that their narratives may not offer a direct representation of reality.

3.5.7 Life story interviews

When it comes to narrative research, there are various sources of data that can be utilised, including pre-existing documentation or self-documentation (i.e. diary entries), unstructured interviews, semi-structured interviews, and observation (Langdrige & Hagger-Johnson, 2013). The main focus of this study was to explore the self-narrative of participants, and although a variety of methods have been proposed in order to access these internalised stories (Denzin, 1989; Singer & Salovey, 1993), semi-structured interviews are the most common (Maruna, 2001). The transcribed life stories are not the self-narratives directly, however, the stories which participants tell social scientists are assumed to entail the outlines of their internalised narrative, in a similar way that answers on a personality test are thought to represent an individual's personality (McAdams, 1993).

Life story interviews encourage interviewees to talk about their life, whereby Murray (2018) suggests that researchers should provide some guidelines for participants in order to provide some structure to

the interview process, whilst also allowing the narrator to have control over their story. Several life story guides or interview protocols have been developed, with McAdams' (1995) life story protocol being the most popular (Murray, 2018). These protocols start by asking the participant to describe their life as if it were a book, and includes additional guiding questions relating to key experiences, getting participants to structure their account as if it consisted of several chapters. A modified version of McAdams (2008) life story interview (LSI) was utilised in this study, which is described in further detail in chapter seven, section 7.3.2 (also see appendix 4). This specific interview protocol was chosen as it has previously been used with prisoners (Maruna, 2001), has been advocated for use with IPSO (Law & Ward, 2010), is one of the most common interview protocols used in narrative psychology (Murray, 2018), and enables character adaptations and narrative identity to be explored in depth (McAdams, 1994).

3.5.8 Quality control

The traditional concepts of reliability (the stability of a measure) and validity (the extent to which it measures what it is intended to measure) are easily applied to positivist research which is based on the notion that there is a single objective truth, which can be measured through quantitative methods (Bryman, 2016; Howitt, 2016; Sandberg, 2005). However, this is often neglected in qualitative research as there is no universal criteria for how to assess the reliability and validity of qualitative data (Bryman, 2016; Howitt, 2016; Kornbluh, 2015), given that an interpretivist approach believes that there are many different subjective truths. However, some researchers argue that reliability and validity can be assessed in qualitative research by using a criterion of 'trustworthiness', which consists of four criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These four criteria (discussed below) were considered throughout this study in order to ensure the trustworthiness of the research.

3.5.8.1 Credibility

Credibility is thought to be the parallel of internal validity in quantitative research (Bryman, 2016). Within qualitative research the results should reflect one of many possible interpretations, whereby credibility is the extent to which this holds true (Brocki & Wearden, 2006; Reid, Flowers & Larkin, 2005). One way of ensuring credibility is by conducting research in line with principles and guidance of good practice (Bryman, 2016), which this study attempted to do by adhering to all ethical procedures, ensuring that the most appropriate methods of data collection were utilised, and analysing in line with relevant procedures. Data triangulation is another way of ensuring credibility, which involves collecting multiple sources of data exploring the same phenomenon, which has been achieved within this thesis through the collection of both quantitative (psychometric scales) and qualitative (life story accounts) data. Having an analysis that is viewed as interpretative (the results are not facts but transparent,

grounded examples from the data, which are reasonable to other readers) is considered to be a successful analysis (Houston & Mullan-Jensen, 2012). Finally, respondent validation (providing participants with a copy of the findings and assessing their reactions of accuracy) is another way of confirming credibility (Lincoln & Guba, 1985). However, although there are several advantages of doing this, there are also multiple disadvantages, such as: participants not understanding the findings, participants not feeling able to express their disagreement due to participant-researcher power dynamics, and the researcher having to restrain their results to a more descriptive level so that they are understood by participants (Kornbluh, 2015; Lincoln & Guba, 1985; Morse, Barrett, Mayan, Olsen & Spiers, 2002). Therefore, this process was not formally implemented within the current study, on the other hand, two of the participants did request a copy of the findings, therefore credibility was informally achieved on these two occasions as both participants agreed with the findings.

3.5.8.2 Transferability

In quantitative research, generalisation (or external validity) is examined, whereby the results are used to make predictions regarding other samples. However, due to the nature of qualitative research (developing an in-depth understanding of small, targeted groups of participants) it is not possible to generalise to the whole population (Bryman, 2016; Pietkiewicz & Smith, 2014). Instead, the concept of transferability is used within qualitative research, which refers to the extent that findings can be applied to similar contexts from which the results originated (Henwood & Pidgeon, 1992). It has been proposed that this can be achieved by providing description rich accounts regarding the context of the research and ensuring that this is sufficiently explained during any dissemination of the findings. This research was conducted within prisons that house IPSO, and the qualitative element was conducted specifically with IPSO that demonstrated signs of PD, SP, and ACEs, therefore, the transferability of these findings can only be applied to other IPSO with PD, SP, and ACEs. The climate of the prison settings may also require due consideration, as one of the prison establishments has been described as able to generate feelings of acceptance and safety (Blagden, Winder & Hames, 2016), whereas other prison contexts may not have a similar effect on prisoners.

3.5.8.3 Dependability

Dependability is thought to be the parallel of reliability in quantitative research, which is achieved through a process of auditing (Bryman, 2016). Lincoln and Guba (1985) propose that researchers should create an audit trail which clearly documents each phase of the research. Regarding this current study, the main researcher kept detailed records throughout the research process (developing research questions, ethical considerations, participant selection, fieldwork notes, observations, interview transcripts, data analysis, and write up decisions), which were then audited by the supervisory team. This ensured that dependability was achieved, as well as confirming that the findings and

interpretations were valid, coherent, and grounded in the data (Bryman, 2016), as well as enabling any problems to be captured as early as possible (Morse et al., 2002).

3.5.8.4 Confirmability

Bryman (2016) suggests that confirmability is the parallel of objectivity, and although it is not possible to achieve complete objectivity, the researcher must be aware of and not overtly allow their personal values or theoretical inclinations to sway the conduct of the research, or the subsequent findings (Bryman, 2004; 2016). Auditing (as mentioned above) is thought to be important in the process of establishing confirmability (Lincoln & Guba, 1985), as well as reflexivity, which is thought to bolster reliability and validity (Winter, 1989), and help to achieve confirmability (Howitt, 2016). Reflexivity involves the researcher taking into consideration the influence that their prior assumptions and lived experiences may have on the research. Although it is acknowledged that researchers cannot detach themselves from these, it is important for them to be aware of these influences so that they can be managed throughout the research, limiting any potential researcher bias and enabling the results to be considered trustworthy (Willig, 2013). Within this reflexivity, the researcher should state their own experiences and values as a way of minimising any potential researcher bias (McCoy, 2017), and the researcher kept a reflective diary throughout the process which enabled the trustworthiness of the results to be maintained.

3.6 Ethical considerations

This research is concerned with individuals who may have experienced adverse environments during their childhood, as well as reporting personality difficulties and a preoccupation with sex throughout their lives, and have been convicted of a sexual offence. Therefore, given the specific population of interest, and because the research employs both quantitative and qualitative methodology, it presents an ethically complex body of research. All of the studies within this thesis sought and received ethical clearance from both the Nottingham Trent University Business, Law and Social Sciences College Research Ethics Committee, and from the HMPPS ethics board (excluding study one, which did not require HMPPS ethical approval). Additionally, the research adhered to the British Psychological Society's (BPS) guidelines regarding ethical considerations of collecting data for research purposes (BPS, 2018). The process of seeking ethical approval enabled the researcher to consider and reflect on the research process and any potential ethical challenges that may arise, including informed consent, confidentiality, disclosure of information, security and retention of data, and risk of harm to participants and researchers. It is argued that ethical practice is a dynamic, ongoing process which should be monitored throughout all stages of data collection and analysis, as opposed to just during the design stage (Smith et al., 2000; Winder & Blagden, 2008). Given that this research is of a particularly sensitive nature, and the population of interest may be considered vulnerable, it was

imperative to ensure that the research process was ethically sound. The subsequent section outlines the key ethical challenges faced when conducting this research.

3.6.1 Informed consent

Fully informed consent is an essential requirement of participation in any research (BPS, 2018), as such, in line with the BPS guidance, fully informed consent was obtained from all participants. This process involved providing participants with the necessary information in order for them to make an informed decision about their involvement in the research (Bryman, 2016). All information sheets, consent forms, and debrief forms were written in line with guidance for how to write for individuals with intellectually disability, ensuring that they could be understood by all participants (i.e. using simple language and dividing sections into small relevant chunks of information; Craig and Hutchinson, 2005). Also, a specific font (Tw Cen MT) was used in order to make them accessible for individuals with dyslexia (as the 'a' is more rounded to look like a written 'a' rather than a typed 'a', and there is good kerning [space between the letters] to enable individuals to distinguish between the letters).

During study one and two, participants were provided with information sheets which detailed the relevant information, and a separate consent form which required a signature to confirm their consent. Throughout these studies the researcher was not present due to large quantities of questionnaires being distributed to individuals for them to complete in their own time. Therefore, only written consent was obtained from individuals that decided to participate in these two stages of the research. For study two, whereby questionnaires were distributed under cell doors at two prison establishments, a support request form was provided within the questionnaire packs for individuals that required assistance in completing the questionnaires. Four IPSO completed this form, therefore, the main researcher met with these participants to support them and was able to verbally explain the research to them, ensuring both written and verbal consent was obtained.

With regard to study three and four, although consent had previously been sought from these individuals, and they had previously consented to being contacted for future research purposes, separate informed consent was obtained for each individual study. Ethical practice is a dynamic, ongoing process (Smith et al., 2000; Winder & Blagden, 2008), and it cannot be assumed that initial consent is valid at different time points. Study three and four involved face to face appointments with the main researcher, meaning that the information sheet and consent form could be verbally explained by the researcher. This enabled the researcher to ascertain the participants level of comprehension and capacity to provide fully informed consent, as well as obtaining both written and verbal consent. The researcher checked the participants comprehension by asking questions that would determine their understanding, for example, asking participants to reiterate what the research was about, or what was required of them. In accordance with the Mental Capacity Act (2005), if the researcher had concerns

regarding a participant's capacity to consent, she would consult with the supervisory team, and participants would be sensitively withdrawn from the research (although this situation did not arise in any of the research studies).

The information sheet and consent form provided detailed information about the purpose of the research, the voluntary nature of the research, what is expected of participants, how data are used and stored, confidentiality and anonymity, and their right to withdraw or stop the research at any time. It was made clear to participants that no rewards (monetary or otherwise) were given for their participation, and that they could choose to stop the interview at any time or withdraw their data (within four weeks) without giving an explanation. The debrief form reiterated the purpose of the research, the individual's right to withdraw, contact details for the main researcher and supervisory team, and contact details for necessary support services.

3.6.2 Confidentiality and anonymity

As well as informed consent, confidentiality is also an essential ethical consideration when conducting psychological research (BPS, 2018), which involves maintaining the confidentiality of participants' identity and personal data. For study one (general population) the identity of participants was not required as they remained anonymous (creating a unique identifier for withdrawal purposes). However, with regard to the prison studies, the notion of confidentiality and anonymity is something which the researcher deliberated over for some time and discussed extensively with the supervisory team, as well as senior psychologists at the prison establishments. Study two aimed to assess the prevalence of PD and SP among IPSO, whilst also identifying IPSO that may be suitable for later stages of the research, meaning that identifying information (name or prison number) was required in order to contact IPSO for future research purposes. However, requiring IPSO to give their details may have prevented some individuals from participating in the research. In regard to study two, whereby questionnaires were distributed under cell doors, individuals were given the option to remain anonymous and not provide any identifying information, or, if they were happy to be contacted for future research purposes, they could leave their details on a separate section of the consent form. The main researcher was able to detach this section from the main consent form and store in a separate folder to ensure confidentiality. Participants were assigned a unique identifier, which the researcher then used for the purposes of referring to and storing of data.

For studies three and four, anonymity was not maintained as the researcher required identifying information in order to arrange appointments with IPSO (although confidentiality was maintained by storing consent forms with identifying information on in a separate folder to the data, using unique identifiers only to refer to the data). The notion of confidentiality is especially pertinent when considering qualitative research, given that it is sometimes difficult to eliminate identification during

in-depth interviews (Bryman, 2004). Given that the sample size was small, and the interviews provided such rich detailed data, there was a concern that individuals may be identifiable. This risk was minimised by removing any identifiable information (such as names and locations) when transcribing the interviews and referring to individuals using a pseudonym. Furthermore, the researcher remained alert to the possible ways that participants may be identified, for example, one participant discussed a specific health concern which would have easily distinguished him from other prisoners. In order to protect his anonymity, such descriptions of this health condition were omitted from extracts, and discretion was used when choosing extracts that are included within the thesis.

It is argued that making an assurance of confidentiality may encourage individuals to provide a wealth of detailed information (Cowburn, 2005), however, when working with prisoners this creates some ethical dilemmas. The researcher aims to protect individuals' anonymity and confidentiality, whilst also trying to balance the consideration for public protection and responsibilities within the prison establishment, whereby the researcher has a moral, professional, and legal duty to pass on relevant information to authorities (Cowburn, 2005). The approach used within these studies is what Cowburn (2005) refers to as 'limited confidentiality', where clear boundaries are defined at the beginning as to what is deemed confidential or not. For the three prison studies, participants were made aware of the limits of confidentiality within the information sheets and consent forms, and this was also verbally explained to participants during studies three and four. Participants were informed that, if they were to disclose certain information (regarding any risk of harm to themselves or other people, plans to escape prison or break prison rules, details of any offence(s) they have not been convicted for, or details of being a victim of an offence that has not yet been reported), this information would be passed on to relevant authorities, such as prison staff, prison security, and the police. Although individuals may have disclosed information whilst completing the psychometric scales, this was particularly important during the qualitative study, whereby individuals were asked to talk in-depth about their life story (which includes aspects of their childhood [i.e. abuse] and their offending behaviour). Therefore, extra care was taken when conducting these interviews to ensure participants were fully aware of the limited confidentiality agreement, and when and how the researcher would have to break confidentiality.

Confidentiality concerns surrounding the storage, removal, and transportation of research data from the prison were also acknowledged by the researcher, and all prison policies and ethical procedures were adhered to at all times. Participants were informed that the physical data would be stored in a locked NTU filing cabinet at the prison establishment, that only the supervisory team had access to. Anonymised research data were removed from the prison establishment via a password protected memory stick or a password protected Dictaphone (using a locked briefcase) and transferred onto a password protected file on the researcher's personal computer.

3.6.3 Vulnerability and risk

The sensitive nature of this research is also an ethical concern, as it can present a number of threats to both participant and researcher (Cowburn, 2005), which will be highlighted briefly in the following sections.

3.6.3.1 To the participant

Given the sensitive nature of this research (i.e. ACEs, SP, personality difficulties) it was essential that the researcher considered the well-being of participants, and the potential risk of harm to participants. Asking sensitive and personal questions can induce negative emotions and distress among individuals, which is why the topic of ACEs was not explored until study three. Due to ethical considerations it was decided not to include the ACE scale in study two (under cell doors) as the researcher would be unable to monitor the impact of such sensitive questions on individual participants. Whereas, in face to face appointments, the main researcher was able to monitor the participants' responses and identify any distress among participants, whilst also discussing with them the support services available if required, which is one of the benefits of collecting data face to face with participants (Bosworth, Campbell, Demby, Ferranti & Santos, 2005).

This ethical consideration was especially pertinent when conducting the life story interviews with participants, as allowing IPSO to discuss their stories and narrate their past can cause unexpected emotions and distress to arise during the interview (Cowburn, 2010; Draucker, Martsof & Poole, 2009). Although the life story interview does not directly ask individuals about traumatic events, there was an expectation that some participants may discuss such events as important aspects of their life. The researcher was aware of the potential risks of re-experiencing or re-traumatisation for participants when talking about difficult experiences (Varvin & Rosenbaum, 2003), and aimed to provide a non-judgemental, empathic and secure space for participants to explore their life story (Gibson & Morgan, 2013). Therefore, a primary part of this research was building rapport with participants and developing a safe space where they felt able to explore intricate details of their lives (Waldram, 2007). The life story methodology was chosen partly because of its potential to deal with such sensitive topics, as it enabled participants to decide whether or not to include traumatic aspects of their childhood, as well as allowing them to present these experiences in any way they chose. The researcher felt that it was critical that the researchers did not make any prior assumptions about the significance of ACEs for participants and allowed them to express what events had meaning to them (Gibson & Morgan, 2013). In order to minimise the potential risk of harm, participants were informed about the nature of the research before conducting the interview, they were advised that it was entirely their choice regarding what events they discussed, they did not have to answer any questions they did not feel comfortable

with, and could stop the interview at any time. Their right to withdraw was also explained in detail so that participants were aware of their options, even after the interview had terminated.

After the interview the researcher checked in with participants to see how they were feeling, and also provided them with a debrief form which detailed several avenues of support, in case individuals became distressed afterwards. Smith et al. (2009) argue that it is important to provide support to participants following the interview, especially when it is of a sensitive nature, and this was another attempt at minimising the potential risk of harm to participants. During the interviews two participants became visibly upset and distressed when talking about certain life events, and it was important for the researcher to take prompts from the participant and let them guide what happened next (Pietkiewicz & Smith, 2014; Winder & Blagden, 2008). The participants were offered tissues during this time of distress and were given the time and space they needed to express their emotions and compose themselves. They were then given the options to continue with the research, take a break, or stop the interview. After taking time to recuperate, both participants decided to continue with the interview, however, the researcher reflected with them at the end about the process and how they were feeling. As encouraged by Blagden and Pemberton (2010), it was important for the researcher to end the interview positively by focusing on the participants hopes and plans for the future. Furthermore, the researcher explained to both participants that she would be contacting relevant wing staff to inform them that the participants had been involved in a difficult interview which may have brought up some unexpected negative emotions, enabling participants to receive further support if required once they returned to their wing. The debrief form was also explained and given to participants which detailed various support services that individuals could use.

Another way in which the researcher attempted to minimise any undue distress was in relation to the terminology used. The term 'personality disorder' was not used when discussing the research with participants, rather the term 'personality characteristics' was used. This was decided after speaking to clinicians at the prison establishment and the supervisory team, whereby it was discussed that explicitly stating PD may cause upset or distress for some prisoners, especially if they are invited back to participate in the following studies as they may interpret this as them having a PD. There is a lot of stigma associated with PDs (Aviram, Brodsky & Stanley, 2006), which may have caused undue distress to participants, especially as the aim of this research was not to diagnose PD, and the scales used do not provide a diagnosis of PD. The researcher acknowledges that the scales used within this thesis are only screening tools that demonstrate where individuals may have impairments in personality functioning, and pathological personality traits (as opposed to a formal diagnosis of PD), therefore, it was decided to explain the research to participants in terms of personality characteristics that may impact an individual's life (for example, making it more difficult for them to get along with people or have lasting relationships).

3.6.3.2 To the researcher

Although it is imperative to minimise the risk of harm to participants, it is also important to consider the impact of conducting challenging, sensitive, and emotionally demanding research on the researcher (Dickson-Swift, James, Kippen & Liamputtong, 2008). Conducting research within a prison environment can sometimes be complex, stressful, and isolating (Liebling, 1999), especially when the research covers sensitive topics. Not only does the sensitive nature of this research potentially cause distress among participants, but also among the researcher (Cowburn, 2010), as they may be bearing witness to traumatic events (Cluley & Marston, 2018; Mulcahy, 2018). Cowburn (2005) recognises that life story interviews (due to their intensity, focus, and length), may result in individuals recounting private and painful events, which can be extremely stressful for the participant to recount, and to the listener (researcher) of the story. Therefore, the psychological and emotional well-being of both participants and researchers should be considered. In addition to this, the researcher may find it difficult to respond to a participant that is in distress and want to reassure the participant. Cowburn (2010) argues that it is not the researcher's role to change the participant or make them feel better (as a clinician or therapist would), but the role of the researcher is to elicit information and gain knowledge from the participant. Therefore, whilst conducting interviews the researcher acknowledged this principle, and tried to mediate between the want to reassure participants and being aware of these ethical boundaries. When participants did become visibly distressed during interviews, the researcher offered them tissues, time, and space to express their emotions, as well as time to compose themselves.

Another ethical challenge for the researcher is regarding their own viewpoints and morals, which may be challenged by participants' views, for example, an IPSO may express child abuse supportive views such as 'the child enjoyed it' (Blagden & Pemberton, 2010, p. 277). This creates an ethical dilemma for the researcher, whereby should they challenge this participant (to make it clear they do not agree with this belief) or allow the participant to continue (gaining rich data and potentially a greater insight). Blagden and Pemberton (2010) highlight that it is not the role of the researcher to challenge the participant (this is more of a clinician's role), however, the researcher must ensure they do not unintentionally agree with the participants viewpoint.

As a way of overcoming any distress or ethical dilemmas, it was essential that the researcher had an appropriate support network available throughout the course of the research. This involved regular supervisions and debriefing sessions with the supervisory team, as well as debriefing sessions with clinicians at the prison establishments. This practice is considered to be essential (Dickson-Swift et al., 2008), reducing levels of distress among those working with IPSO (Ennis & Home, 2003). The supervisors were available to offer support and guidance at any time, and ad-hoc meetings were arranged when faced with difficult dilemmas. This enabled the researcher to identify and discuss the

impact of the research, and how this could be managed effectively. Counselling sessions were also available to the researcher at the prison or university, however, these were not required.

The researcher also had to be aware of and monitor any risks to safety whilst conducting this research. After spending two days a week at the prison throughout the first year of studying, the researcher was familiar with the environment, staff members, prison regime, and security procedures. She ensured that she followed these procedures at all times, always carried a personal alarm, and informed colleagues of her whereabouts. Given that the research sample consisted of highly sexually preoccupied individuals that had previously sexually offended, and demonstrated personality difficulties, there was a potential risk to the researcher. In order to minimise this risk, the researcher had access to prison databases so she could assess participants' risk level before meeting them one-to-one. Three of the IPSO were identified as high risk (study three), therefore, another member of the SOCAMRU was present during these assessments to ensure the safety of the researcher.

[3.7 Summary](#)

This chapter has outlined the methodological approach employed within this thesis, including the benefits of a mixed methods research design, before introducing each of the four empirical studies alongside the rationale, recruitment process, and methods of analysis for each study. Finally, the ethical challenges and considerations of conducting sensitive research with a vulnerable population were discussed.

Chapter Four: Reliability and validity of the Severity Indices of Personality Problems – Short Form (SIPP-SF) and the Personality Inventory for DSM-5 Brief Form (PID-5-BF) in a sample of UK males

Overview

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013a) includes an alternative dimensional model for PDs in Section III, in which personality functioning (criterion A) and pathological personality traits (criterion B) are two of the main criteria. The Severity Indices of Personality Problems - Short Form (SIPP-SF) has been identified as a suitable screener for personality functioning (Rossi, Debast & van Alphen, 2016), and the Personality Inventory for DSM-5 Brief Form (PID-5-BF) was developed to measure pathological personality traits (APA, 2013b). However, neither of these scales have been validated or used in the United Kingdom. The convenience of having short, reliable instruments that have been validated in different countries will help to ease the transition of PD diagnoses from a categorical framework to a dimensional one (Fossati, Somma, Borroni, Markon & Krueger, 2017), as well as providing short screening tools for assessment and research purposes. This empirical chapter will assess the psychometric properties of the SIPP-SF and PID-5-BF in a specific sample of UK males, with the intention of later using these scales to screen for PD among male prisoners in the UK. The results section is split into four sections: reliability and descriptive statistics (part A), factorial structure (part B), internal validity measures (part C), and external validity measures (part D).

4.1 Introduction

As discussed in the literature review (section 2.2.1), several problems have been identified with the categorical PD diagnoses (Clark, 2007; Skodol et al., 2011; Trull & Durrett, 2005; Widiger & Trull, 2007), whereby the DSM-5 incorporates an alternative model for PDs (AMPD) which is a hybrid dimensional and categorical system containing two main criteria: personality functioning (criterion A) and pathological personality traits (criterion B; APA, 2000). An innovative component of the model is the Levels of Personality Functioning Scale (LPFS; Morey et al., 2011), which is a scale provided by the DSM-5 to evaluate criterion A. The scale assesses both the presence and severity of personality pathology, in which the clinician is required to select the level of functioning that represents the patient's level of impairment (Morey et al., 2011). This is the first step towards the diagnosis of a PD (Skodol, Morey, Bender, & Oldham, 2015), next, the clinician would need to assess pathological personality traits (criterion B). The LPFS was derived from two existing measures: the General Assessment of Personality Disorder (GAPD; Livesley, 2006), and the Severity Indices of Personality Problems (SIPP-118, Verheul et al., 2008).

The alternative model has been criticised for being too complicated for clinical and research use (Skodol et al., 2015), and a major limitation of the LPFS is that self and interpersonal functioning are assessed together, rather than separately. This makes it difficult to distinguish between problems that relate to the self, as opposed to those manifested in interpersonal situations (Rossi et al., 2016). As pointed out by Rossi et al. (2016), these areas may be intertwined; however, treatment programs often target these areas separately, so combining the two together may result in clinicians having difficulty making treatment recommendations. Another criticism of the LPFS is that a clinician/researcher is required to rate the individual's personality functioning, which may not be suitable for all types of research (e.g. screening purposes). At the time of developing and conducting this study (2015 - 2016), there was no self-report version of the LPFS available; however, the SIPP-118 was identified as a promising instrument to measure criterion A (Rossi et al., 2016). Although, in subsequent years, a self-report version of the LPFS has been developed (Morey, 2017).

The SIPP-118 demonstrates good reliability, validity and a robust factor structure (Verheul et al., 2008), and has been used in various studies of personality functioning (Bastiaansen et al., 2013; Clark et al., 2015). An important consideration for some research is the length of the scale (e.g. for screening purposes), in which psychometrically sound, short-form versions are preferred. The SIPP-118 contains 118 items, which, combined with a scale measuring criterion B, may be considered too long for screening purposes. However, there is a SIPP-Short Form (SIPP-SF) available for use, which contains 60 items (Verhaul et al., 2008). The SIPP-SF includes summary scales for all five domains of functioning as found in the parent measure: Self-Control, Identity Integration, Responsibility, Relational Functioning, and Social Concordance. However, there is a lack of information regarding the reliability and validity of the SIPP-SF, preventing the widespread use of this scale (Rossi et al., 2016). To the researcher's knowledge, only one main study has assessed the reliability and validity of the SIPP-SF among younger and older adults in Belgium (Rossi et al., 2016), indicating good internal reliability and good construct validity, demonstrated by a five-factor structure, similar to the parent measure. The SIPP-SF has been used in the context of personality functioning in a student and community sample in America, indicating good internal reliability (Ro & Clark, 2009). However, the SIPP-SF has not yet been validated or used in the United Kingdom, despite it being identified as a useful screening instrument for personality pathology (Rossi et al., 2016).

Similar complications have been found with the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012), the measure created to assess criterion B. The PID-5 is a 220 item self-report questionnaire which focuses on maladaptive personality traits, rather than normative personality traits (Fossati et al., 2017). The DSM-5 work group developed the pathological personality trait model by reviewing existing instruments and models, resulting in 25 personality traits, organised into five higher order domains: Negative Affectivity, Detachment, Antagonism, Disinhibition and Psychoticism (Krueger et al., 2012; for definitions of the domains and personality traits please see appendices 2 and 3). There is a substantial

body of literature supporting the reliability, validity and factor structure of the PID-5 (Bastiaens et al., 2016; Krueger & Markon, 2014; Morey et al., 2015; Quilty, Ayearst, Chmielewski, Pollock, & Bagby, 2013), as well as showing expected relations with Section II PDs (Anderson et al., 2014; Hopwood, Thomas, Markon, Wright, & Krueger, 2012; Sellbom et al., 2014). However, completing 220 items is time consuming, potentially resulting in participant fatigue, random responses, or dropout (Bach, Maples-Keller, Bo, & Simonsen, 2015), and may not be suitable for screening purposes. For research and clinical purposes, it would be useful to have a shorter version of the PID-5, for example, to use as a screening instrument prior to initiating full assessments (Bach et al., 2015; Zachar & First, 2015).

As a way of dealing with this issue, Maples et al. (2015) created a short version of the PID-5 through item response theory, containing 100 items. The Short PID-5 showed strong reliability and validity, assessing the same 25 traits and five domains as the PID-5. Furthermore, there is also a brief 25-item version of the PID-5 (PID-5-BF; APA, 2013b) available, which measures the five higher order domains, but does not assess individual facets. For the purpose of this current study, the PID-5-BF was utilised for brevity's sake, as it was necessary to include additional inventories; the SIPP-SF to measure criterion A, and the Personality Diagnostic Questionnaire-4+ (PDQ-4+; Hyler, 1994) as a measure of convergent validity. Therefore, shorter versions of the scales were preferred in order to help reduce participant fatigue and dropout.

The PID-5-BF is available online (see APA, 2013b); however, there is no published report available that describes the psychometric properties of the scale (it was developed alongside the original PID-5 form). The brief form is not designed to assess pathological personality traits in depth like the PID-5, but to screen for possible personality disorder by looking at elevated scores across domains (Fossati et al., 2017). In addition, it yields a score for the overall measure, indicating overall personality disturbance (APA, 2013b).

One main study has assessed the reliability and validity of the PID-5-BF, demonstrating good internal consistency, test-retest reliability, and factor structure in an Italian sample (Fossati et al., 2017). However, this study used an adolescent/college sample, so, it is unclear how these results would generalise to an adult population (Anderson, Sellbom, & Salekin, 2018). Bach et al. (2015) compared the PID-5, Short PID-5, and PID-5-BF in Danish psychiatric and community populations. They found satisfactory reliability and factorial validity for the PID-5-BF, including the brief form demonstrating a similar pattern of relations with external PD criteria as did the full PID-5 form. Nonetheless, neither the Fossati et al. (2017) nor Bach et al. (2015) studies used the official English language version of the measure. Whereas, Anderson et al. (2018) used the English language version among a college/community sample in America. The results demonstrate adequate internal consistency, provide support for the factor structure, and show expected associations with Section II PDs. However, the PID-

5-BF has not yet been validated or used in the United Kingdom, despite it being identified as a useful screening measure of pathological personality traits (Anderson et al., 2018; Fossati et al., 2017).

4.2 Research aims, objectives, and hypotheses

The main aim of this study was to evaluate the psychometric properties of the PID-5-BF and SIPP-SF in a UK male sample (with the intention of later using these scales with male prisoners in the UK). This will be achieved by meeting the following objectives:

- Explore the internal consistency of the PID-5-BF and SIPP-SF
- Assess the factor structure of the PID-5-BF
- Examine the discriminant validity of the SIPP-SF domains (criterion A) and the PID-5-BF domains (criterion B)
- Explore the convergent validity of the PID-5-BF and SIPP-SF with section II PDs.

Based on previous research (Anderson et al., 2014; Anderson et al., 2018; Bach et al., 2015; Hopwood et al., 2012; Sellbom et al., 2014) and the proposed PD traits-profiles in the DSM-5 Section III (APA; 2013a), it was hypothesized that the PID-5-BF **Negative Affectivity (NA)** domain would be significantly related to: Avoidant, Borderline, Obsessive-Compulsive, Schizotypal, Paranoid, Histrionic, Passive-Aggressive, Dependent and Depressive PDs; **Detachment (DE)** would be significantly related to: Avoidant, Borderline, Obsessive-Compulsive, Schizotypal, Paranoid, Schizoid and Depressive PDs; **Antagonism (AN)** would be significantly related to: Antisocial, Narcissistic and Depressive PDs; **Disinhibition (DI)** would be significantly related to: Antisocial and Borderline PDs; and **Psychoticism (PS)** would be significantly related to: Borderline, Schizotypal, Narcissistic and Paranoid PDs. It was expected that the Identity Integration and Relational Capacities domains of the SIPP-SF would correlate with all DSM-IV PDs, as they relate specifically to self and interpersonal functioning (Criterion A; Berghuis, Kamphuis, & Verheul, 2014).

4.3 Method

4.3.1 Design

This study utilised a survey research design, which involved a purposive sample of males recruited from factories, warehouses, garages, call centres and trade jobs in the Midlands. Purposive sampling was employed as participants were selected according to pre-determined criteria in relation to the research aims (as described below; Guest et al., 2006).

4.3.2 Participants

A purposive sample of males were recruited in order to validate the scales, with the intention of later using them as screening tools with male prisoners in the UK. According to the Ministry of Justice (MOJ; 2012a), 47% of prisoners had no qualifications, and of the 53% that had qualifications: 65% were educated to GCSE level or equivalent, with 8% being educated to higher than A levels. In terms of employment: 68% of prisoners were unemployed in the four weeks before custody, and 13% of prisoners had never had a job. When taking into account the last 12 months before custody, 52% were in paid employment, in which 49% of these prisoners were classed as working in routine and semi-routine occupations (i.e. postal worker, machine operative, van driver, packer, labourer etc.; MOJ, 2012a). Among prisoners, over 9,000 work in industrial workshops across the prison estate (MOJ, 2012b); therefore, a specific sample of males (with a broad age range; working in factories, warehouses, garages, call centres, and trade jobs) were chosen in order to try and gain a sample that may be representative of a male prisoner population.

Participants consisted of 203 males, with an age range of 18 – 81 years old (age $M = 36.83$, $SD = 14.68$), from Nottinghamshire and Derbyshire. According to the International Standard Classification of Occupations (ISCO-08; International Labour Office, 2012): 36.9% were Craft and Related Trade Workers (builders, electricians, mechanics), 24.6% were Plant and Machine Operators (machine/labelling/picking operator), 20.7% had Elementary Occupations (factory picker/stacker, waste collector), and 17.7% were Service and Sale Workers (call centre and customer contact centre staff). Concerning education attainment: 17.7% reported no qualifications, 37.9% reported GCSEs or NVQ equivalent, 34% reported A-levels or NVQ equivalent, and 10.4% reported degree level (BA/BSC) or NVQ equivalent. A large majority of participants were married/cohabiting (56.6%), with 36.5% being single, and 6.9% being divorced/separated/widowed.

4.3.3 Measures

4.3.3.1 Severity indices of personality problems – short form (SIPP-SF)

The SIPP-SF (Verhulst et al., 2008) is a 60-item self-report questionnaire which was designed to assess five core domains of (mal)adaptive personality functioning: *self-control*, *identity integration*, *relational capacities*, *responsibility*, and *social concordance*. Within this study, the SIPP-SF was used to measure personality functioning (criterion A of the DSM-5 AMPD). Each domain scale consists of 12 items. The SIPP-SF was derived from the SIPP-118, measuring the same domains with a reduced number of items. As in the SIPP-118, each SIPP-SF item is scored on a 4-point Likert scale (1 = fully disagree; 2 = partly disagree; 3 = partly agree; 4 = fully agree).

Items are scored in both a positively and negatively keyed direction. The scales time frame is the 'past 3 months', with higher scores showing more adaptive (and thus less pathological) capacities, whereas, lower scores indicate more maladaptive personality functioning. Scores are converted to a Z-score and then a T-score in order to compare to normative data (general population and PD population; Verheul et al, 2008), whereby scores less than 40 indicate impaired adaptive functioning, and less than 30 indicate severely impaired adaptive functioning. Regarding internal consistency, excellent Cronbach's alpha (α) values have been found in America (0.83-0.89; Ro & Clark, 2009) and Belgium (0.81-0.88; Rossi et al., 2016). The reliability of the SIPP-SF in the current sample will be discussed in the subsequent results section.

4.3.3.2 Personality inventory for DSM-5 brief form (PID-5-BF)

The PID-5-BF (APA, 2013b) is a 25-item self-report questionnaire which was designed to assess the five domains of the DSM-5 personality trait model: *negative affectivity*, *detachment*, *antagonism*, *disinhibition*, and *psychoticism*. The PID-5-BF items come from the 220-item self-report PID-5 (Krueger et al., 2012), which was developed to assess pathological personality traits as part of the DSM-5 AMPD. Each domain scale consists of five items, however, not all 25 pathological personality traits are represented by the 25 items in the scale. The scale consists of 21 of the most pure-loading facets, which means that *restricted affectivity*, *rigid perfectionism*, *submissiveness* and *suspiciousness* are not included in the brief form (however, these are not included when calculating the domain scores for the full version or short version either). Instead, the facets of *withdrawal*, *impulsivity*, *eccentricity*, and *cognitive and perceptual dysregulation* are measured by two items each.

As in the PID-5, each PID-5-BF item is scored on a 4-point Likert scale (0 = very false or often false; 1 = sometimes or somewhat false; 2 = sometimes or somewhat true; 3 = very true or often true). All items are scored in a positively keyed direction, which is different to the full PID-5 version, which contains negatively keyed items. Higher scores on the domains of the PID-5-BF indicate greater dysfunction. The PID-5-BF differs from other versions of the PID-5 as it yields a score for the overall measure, providing a score for the overall personality disturbance (APA, 2013b). In terms of internal consistency, there is no published report available that describes the psychometric properties of the scale, however, acceptable α values have been found in America (ranging from 0.68 - 0.78 across three samples: Anderson et al., 2018), Denmark (0.74 - 0.81; Bach et al., 2015), and Italy (0.64 - 0.77; Fossati et al., 2017). The reliability of the PID-5-BF in the current sample will be discussed in the subsequent results section.

4.3.3.3 Personality diagnostic questionnaire – 4

The PDQ-4 (Hyler, 1994) is a 99-item self-report questionnaire which was designed to assess DSM-IV PDs. It is a true-false instrument, consisting of items that correspond directly to criteria for the DSM-IV PDs. The measure produces 12 scales, which index the 10 PDs included in Section II of the DSM-IV (*Paranoid, Schizoid, Schizotypal, Histrionic, Narcissistic, Antisocial, Borderline, Avoidant, Dependent, and Obsessive Compulsive*) and the two PDs in the appendix of the DSM-IV (*Passive-aggressive and Depressive*). The PDQ-4 can be used to create individual PD diagnoses according to the number of DSM-IV criteria endorsed, or, it can generate a total score of the number of pathological traits endorsed. Similar to Hopwood et al. (2012) and Anderson et al. (2018) this study used continuous symptom counts rather than categorical PDs, as continuous psychopathology scales are generally more reliable and valid than categorical markers (Markon, Chmielewski, & Miller, 2011). The PDQ-4 has been widely used and demonstrates reasonable convergence with other PD measures (Bagby & Farvolden, 2004). It has been found to be valid and reliable in various countries (Ling, Qian, & Yang, 2010; Calvo et al., 2012), including the UK (Davison, Leese, & Taylor, 2001; Whyte, Fox, & Coxell, 2006).

In the current sample, the overall Cronbach's alpha coefficient (α) for the whole scale was excellent, with a value of 0.94. Cronbach's alpha coefficients for the subscales ranged from 0.53 (*Obsessive-Compulsive*) to 0.78 (*Avoidant*), with a mean of 0.65. Some of these values indicate poor internal consistency ($< .60$; Streiner, 2003), however, they are similar to α values found in comparable studies (Anderson et al., 2018; Hopwood et al., 2012; Samuel, Hopwood, Krueger, Thomas, & Ruggero, 2013), which is thought to be due to the heterogeneous compositions of symptoms that comprise Section II PDs. Despite this, the PDQ-4 has been used in previous research to compare Section II and Section III models (Anderson et al., 2018; Hopwood et al., 2012).

Due to the PDQ-4 having a dichotomous scoring system, it may be argued that the Ordinal alpha should be calculated, rather than Cronbach's alpha. Conceptually, the two are the same; however, the Ordinal alpha performs well for dichotomous data (Zumbo, Gadermann & Zeisser, 2007). Therefore, the Ordinal alpha was also calculated for the overall scale (.97), and individual subscales (ranging from 0.59 [*Obsessive-Compulsive*] to .90 [*Avoidant*]), with a mean of .80), demonstrating good internal consistency.

4.3.4 Procedure

The purpose of this study was to validate the SIPP-SF and PID-5-BF in a sample of UK males in the community, in order to later use these scales to screen for PD among prisoners (as demonstrated in the subsequent chapters of the thesis), therefore, as described above in section 4.3.2, a specific sample of males were recruited to participate in this study. The main researcher contacted and distributed questionnaires to several factories, warehouses, garages, call centres and trade jobs in and around Nottinghamshire and Derbyshire. Participants were provided with an information sheet, consent form, battery of tests and debrief form, which were placed within a sealable envelope (please see appendices 5 - 7 for examples of the information sheet, consent form and debrief form). Participants were able to complete the questionnaires on their lunch break at work or could take it home to complete in their own time, returning it to the researcher via a pre-paid envelope. The debrief form contained contact details for the researcher, as well as contact details for any support services if required.

4.3.5 Analysis

4.3.5.1 Analytical procedures

Throughout the whole thesis, all analyses were conducted using SPSS Version 23, *Mplus* version 7.2 (Muthen & Muthen, 2015) or R (R Core Team, 2017). The psychometric properties of the PID-5-BF and SIPP-SF were investigated by examining the factor structure, internal consistency, discriminant validity and convergent validity of the scales. All variables were examined for normality by assessing skewness and kurtosis, whereby a value between -2 and +2 indicates normality of distributions (George & Mallery, 2010). Additionally, variables were assessed for extreme outliers using boxplots, as extreme outliers may introduce bias into statistical estimates (Kwak & Kim, 2017). In the current study, no variables exceeded the range for skewness and kurtosis, and no extreme outliers were identified, therefore, all cases were used for analytical purposes. All assumptions were met before any of the further analytical techniques were conducted.

Cronbach's alpha coefficient (α) and mean item-total correlations (MIT) were used to assess the internal consistency of the scales. Internal reliability coefficients should be above 0.6 (Streiner, 2003), and MIT values should be above 0.3 (Nunnally & Bernstein, 1994). Due to the brevity of the PID-5-BF (25 items), mean inter-item (MII) correlations were also conducted to assess internal consistency (optimal range between 0.2-0.4; Briggs & Cheek, 1986). Descriptive statistics were examined, and one sample t-tests were conducted to compare the means of the current sample to previous population means. Discriminant validity among trait domains was assessed by means of divergent intercorrelations. Correlations were interpreted according to Cohen's guidelines (Cohen, 1988; .10 - .29 = small, .30 - .49 = medium, and .50 - 1.0 = large).

To explore the factor structure of the questionnaires, a ratio of participants-to-variables of 4:1 or larger is advised (MacCallum, Widaman, Preacher, & Hong, 2001), meaning 100 participants would be required for 25 PID-5-BF items, and 240 participants for 60 SIPP-SF items. Therefore, confirmatory factor analysis (CFA) was only conducted on the PID-5-BF, using robust weighted least squares estimation. In order to assess model fit, the comparative fit index (CFI; Bentler, 1990), Tucker-Lewis Index (TLI; Tucker & Lewis, 1973), and root mean square error of approximation (RMSEA; Browne & Cudeck, 1993) were calculated, in addition to the goodness-of-fit chi-square (χ^2) test.

A CFI/TLI value of $\geq .90$ is indicative of adequate fit, and a value of $\geq .95$ is considered a good fit (Hu & Bentler, 1999). Consistent with Hu and Bentler's (1999) suggestions, an RMSEA value $\leq .08$ is interpreted as adequate fit, with values $\leq .05$ being considered good fit. Confidence intervals (CI) were calculated for the RMSEA to provide more information than a point estimate, in which the upper bound of the CI should be $\leq .10$ (Chen, Curran, Bollen, Kirby, & Paxton, 2008) for acceptable model fit. A non-significant χ^2 value indicates that the model has excellent fit, however, there are various issues with the χ^2 , including: the assumption of multivariate normality (McIntosh, 2007), and its sensitivity to sample size (Jöreskog & Sörbom, 1993). When considering factor loadings, items with a factor loading of 0.32 and above were considered to significantly load on a factor (Tabachnick & Fidell, 2013).

Discriminant validity was also assessed between the PID-5-BF and SIPP-SF by conducting bivariate correlations, in order to differentiate between personality functioning and personality traits. Finally, convergent validity of the PID-5-BF and SIPP-SF was evaluated by means of bivariate correlations with DSM-IV PD criterion counts (as measured by the PDQ-4).

4.3.5.2 Missing data

No missing data were reported for this study, therefore, all data points were used in the analysis. Although this study involved completing self-report questionnaires, for the majority of participants the main researcher was present at their workplace so was able to offer any help or advice if required.

4.4 Results

4.4.1 Part A: Reliability and descriptive statistics

4.4.1.1 SIPP-SF

Reliability analyses were conducted to inspect the internal consistencies of the five domain scales of the SIPP-SF. Results, as shown in table 2, reveal that the Cronbach's alpha coefficients of the domains ranged from .82 (*Responsibility*) to .91 (*Self-control*), indicating excellent internal consistency. The overall Cronbach's alpha coefficient was excellent with a value of .95. For all five domains, the MIT correlation score was considerably higher than .30, ranging from .48 (*Responsibility*) to .65 (*Self-Control*), with three items (6, 7, 44) having an item-total correlation below .30.

Descriptive statistics show that responses per domain were within the healthy range of personality functioning, ranging from 3.22 - 3.47, with an average of 3.32. There is no published report of the SIPP-SF, meaning that there is difficulty comparing the mean level of domains to population norms. However, a validation study has been conducted on younger (17 - 31 years) and older (61 - 99 years) adults from Belgium (Rossi et al., 2016). The mean scores from this UK population were comparable both to mean scores among younger adults (ranging from 3.20 – 3.39, with an average of 3.26), $t(4) = 1.43$, $p = .225$, and those demonstrated among older adults (ranging from 3.21 - 3.49, with an average of 3.37), $t(4) = -1.11$, $p = .330$.

4.4.1.2 PID-5-BF

Reliability analyses were conducted to inspect the internal consistencies of the five domain scales of the PID-5-BF. Results, as shown in table 2, reveal that the Cronbach's alpha coefficients (α) of the domains ranged from .70 (*Detachment*) to .77 (*Psychoticism*), indicating good internal consistency. The overall α for the whole scale was excellent with a value of .89. For all five domains, the MIT correlation score was well above .30, ranging from .46 (*Detachment*) to .56 (*Psychoticism*). Inspection of item-total correlations for the overall personality pathology was from .31 (Item 6) to .63 (Item 21), with a mean value of .47. Due to scale brevity (25 items), the mean inter-item correlation (MII) for each domain was also evaluated. The MII correlations ranged from .32 (*Detachment*) to .40 (*Psychoticism*), falling within the optimal range of .2 - .4.

Table 2. Descriptive statistics, Cronbach's α values, mean inter-item correlations and mean item-total correlations for the PID-5-BF and SIPP-SF

Domain	<i>M</i>	<i>SD</i>	α	<i>MIT</i>	<i>MII</i>
SIPP-SF					
Self-control	3.29	.63	.91	.65	-
Identity Integration	3.47	.58	.90	.62	-
Responsibility	3.36	.52	.82	.48	-
Relational Capacities	3.22	.55	.83	.49	-
Social Concordance	3.27	.55	.85	.51	-
PID-5-BF					
Negative Affectivity	.85	.65	.73	.49	.35
Detachment	.72	.61	.70	.46	.32
Antagonism	.50	.57	.72	.49	.35
Disinhibition	.85	.63	.74	.51	.37
Psychoticism	.74	.64	.77	.55	.40

Note. MII not calculated for SIPP-SF; α = Cronbach's alpha coefficient; *MII* = mean inter-item correlation; *MIT* = mean item-total correlation; SIPP-SF = Severity Indices of Personality Problems – Short Form; PID-5-BF = Personality Inventory for DSM-5 Brief Form

Descriptive statistics show that responses per domain were between the range of .50 - .85 ($M = .73$), suggesting that all PID-5-BF domains were usually *very/often false* or *sometimes/somewhat false*. There is no published report on the PID-5-BF, meaning that there is difficulty comparing the mean level of domains to population norms. However, a validation study has been conducted on the PID-5-BF in Italy, so it is possible to use their mean scores as a comparison. The mean scores from this UK population are significantly lower in comparison to mean scores found among adolescents in Italy (ranging from 0.58 – 1.31, with an average of 0.93; Fossati et al., 2017); $t(4) = -3.01, p < .05$.

4.4.2 Part B: Factorial structure of the PID-5-BF

4.4.2.1 Confirmatory factor analysis

CFA using robust weighted least squares estimation (specifically, WLSMV) was conducted to evaluate the five-factor structure of the PID-5-BF. Adequate model fit was observed in the current sample (CFI = .91, TLI = .90, RMSEA = .06, 90% CI for RMSEA [.06, .07], WLSMV $\chi^2(265) = 485.21, p < .001$), thus providing support for the factor structure of the PID-5-BF. Intercorrelations among the factors ranged from .46 (*Negative Affect* and *Disinhibition*) to .85 (*Detachment* and *Psychoticism*). In addition, all items loaded to an acceptable degree on their respective factors, whereby standardized item-level factor loadings are shown in table 3.

Table 3. Factor loadings of the PID-5-BF (n = 203)

Domain	Item	Scale	λ_{SD}	<i>p</i>
Negative Affectivity	Item 8	Anxiousness	.58	<.001
	Item 9	Emotional lability	.71	<.001
	Item 10	Separation insecurity	.63	<.001
	Item 11	Perseveration	.64	<.001
	Item 15	Hostility	.79	<.001
Detachment	Item 4	Depressivity	.68	<.001
	Item 13	Intimacy avoidance	.47	<.001
	Item 14	Withdrawal	.60	<.001
	Item 16	Withdrawal	.75	<.001
	Item 18	Anhedonia	.69	<.001
Antagonism	Item 17	Callousness	.74	<.001
	Item 19	Attention-seeking	.51	<.001
	Item 20	Grandiosity	.57	<.001
	Item 22	Deceitfulness	.73	<.001
	Item 25	Manipulativeness	.93	<.001
Disinhibition	Item 1	Risk taking	.67	<.001
	Item 2	Impulsivity	.61	<.001
	Item 3	Impulsivity	.84	<.001
	Item 5	Irresponsibility	.81	<.001
	Item 6	Distractibility	.48	<.001
Psychoticism	Item 7	Eccentricity	.73	<.001
	Item 12	Unusual beliefs	.62	<.001
	Item 21	Eccentricity	.77	<.001
	Item 23	Perceptual dysregulation	.74	<.001
	Item 24	Perceptual dysregulation	.83	<.001

Note. NA = Negative Affectivity, DE = Detachment, AN = Antagonism, DI = Disinhibition, PS = Psychoticism, λ_{SD} = standardized factor loadings.

4.4.3 Part C: Internal validity measures

4.4.3.1 Discriminant validity of the SIPP-SF domains

Discriminant validity correlations are presented in table 4. These correlations were conducted within form, where each SIPP-SF domain was correlated with the remaining four domains. As can be seen from the table, each domain displays either a moderate or large correlation with each other domain, generally showing poor discriminant validity.

4.4.3.2 Discriminant validity of the PID-5-BF domains

Discriminant validity correlations are presented in table 5. These correlations were conducted within form, wherein each PID-5-BF domain was correlated with the remaining four domains. As can be seen from table 5, there were four large correlations (*Negative Affectivity x Detachment*, *Negative Affectivity x Psychoticism*, *Detachment x Psychoticism*), and the remaining correlations were either small or moderate. Correlations of the five domains with the overall personality pathology score ranged from .63 (*Antagonism x Overall Personality Pathology*) to .84 (*Psychoticism x Overall Personality Pathology*), with a mean correlation of .74.

4.4.3.3 Discriminant validity between the PID-5-BF and SIPP-SF

Discriminant validity correlations are shown in table 6. Correlations were conducted between the PID-5-BF domains and the SIPP-SF domains. Regarding the PID-5-BF, large correlations were found between the *Negative Affectivity* domain and the SIPP-SF *Self-Control*, *Identity Integration* and *Social Concordance* domains, between *Detachment* and SIPP-SF *Self-Control*, *Identity Integration*, *Relational Capacities* and *Social Concordance* domains, between *Disinhibition* and SIPP-SF *Self-Control* and *Responsibility* domains, and between *Psychoticism* and SIPP-SF *Self-Control*, *Identity Integration*, *Responsibility* and *Social Concordance* domains. All other correlations were either small or moderate in size.

4.4.4 Part D: External validity measures

4.4.4.1 Convergent validity: relations between SIPP-SF domains and DSM-IV PDs

Table 7 presents the correlations between the SIPP-SF domains and DSM-IV PDs, as measured by the PDQ-4+. Overall, each of the PDs were associated with the theoretically expected SIPP-SF domains (*identity integration* and *relational capacities*). The *identity integration* domain correlated with all twelve PDs either moderately or largely, as expected. The *relational capacities* domain also correlated with all twelve PDs, however, two coefficients were lower than expected (for *antisocial* and *histrionic* PD).

Table 4. Discriminant validity correlations among domains of the SIPP-SF (N=203)

	Self-Control	Identity Integration	Responsibility	Relational Capacities	Social Concordance
Self-Control	-	.67	.60	.49	.78
Identity Integration	.67	-	.62	.64	.52
Responsibility	.60	.62	-	.44	.49
Relational Capacities	.49	.64	.44	-	.47
Social Concordance	.78	.52	.49	.47	-

Note. All correlations significant at $p < .001$ level. Large correlations are indicated in bold.

Table 5. Discriminant validity correlations among domains of the PID-5-BF (n = 203)

	Negative Affectivity	Detachment	Antagonism	Disinhibition	Psychoticism
Negative Affectivity	-	.57	.36	.34	.61
Detachment	.57	-	.46	.40	.62
Antagonism	.36	.46	-	.28	.48
Disinhibition	.34	.40	.28	-	.53
Psychoticism	.61	.62	.48	.53	-

Note. All correlations significant at $p < .001$ level. Large correlations are indicated in bold.

Table 6. Correlations among domains of the PID-5-BF and SIPP-SF (n = 203)

	PID-5-BF	Negative Affectivity	Detachment	Antagonism	Disinhibition	Psychoticism
SIPP-SF						
Self-Control		-.61	-.51	-.31	-.50	-.59
Identity Integration		-.61	-.61	-.36	-.36	-.58
Responsibility		-.39	-.44	-.31	-.61	-.59
Relational Capacities		-.46	-.71	-.38	-.29	-.43
Social Concordance		-.51	-.50	-.46	-.47	-.52

Note. All correlations significant at $p < .001$ level. Large correlations are indicated in bold. PID-5-BF = Personality Inventory for DSM-5 Brief Form. SIPP-SF = Severity Indices of Personality Problems – Short Form. Correlations are in a negative direction due to lower scores on the SIPP-SF indicating more impaired functioning.

4.4.4.2 Convergent validity: Relations between PID-5-BF trait domains and DSM-IV PDs

Table 7 presents the correlations between the PID-5-BF domains and DSM-IV PDs, as measured by the PDQ-4+. Overall, each of the PDs were associated with the theoretically expected PID-5-BF domains, with the majority correlating either moderately or largely with expected domains. However, the correlation between *antagonism* and *depressive PD* was lower than expected (.25), whereas, the correlation between *psychoticism* and *passive-aggressive PD* was higher than expected (.53). Of note, the *psychoticism* domain was found to be moderately or largely correlated with all PDs, which was not expected.

Table 7. Correlations between the PID-5-BF and SIPP-SF domains and DSM-IV Personality Disorders (N=203)

Personality disorders	PID-5-BF					SIPP-SF				
	NA	DE	AN	DI	PS	SC	II	RE	RC	SCO
PDs retained in <i>DSM-5</i>										
Antisocial PD	.20	.28	.46	.52	.48	.57	.32	.46	.26	.57
Avoidant PD	.57	.57	.18	.35	.44	.48	.68	.46	.52	.34
Borderline PD	.59	.48	.32	.41	.52	.71	.70	.49	.47	.60
Narcissistic PD	.44	.46	.50	.30	.47	.52	.38	.37	.41	.51
Obsessive-Compulsive PD	.39	.41	.37	.18	.40	.36	.40	.30	.40	.32
Schizotypal PD	.53	.54	.36	.30	.49	.56	.59	.41	.60	.50
PDs not retained in <i>DSM-5</i>										
Paranoid PD	.43	.44	.28	.30	.48	.62	.45	.33	.41	.53
Histrionic PD	.44	.30	.35	.29	.38	.47	.38	.39	.24	.38
Schizoid PD	.37	.56	.27	.21	.37	.43	.53	.39	.64	.38
Passive-Aggressive PD	.53	.47	.33	.46	.53	.68	.57	.56	.47	.60
Dependent PD	.55	.37	.32	.28	.44	.43	.59	.40	.36	.30
Depressive PD	.55	.44	.25	.19	.39	.42	.55	.31	.40	.31

Note. Domains that are expected to be related to each PD are in bold. PID-5-BF = Personality Inventory for *DSM-5* Brief Form; SIPP-SF = Severity Indices of Personality Problems – Short form; NA = Negative Affectivity; DE = Detachment; AN = Antagonism; DI = Disinhibition; PS = Psychoticism; SC = Self-Control; II = Identity Integration; RE = Responsibility; RC = Relational Capacities; SCO = Social Concordance; PD = Personality Disorder; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders 5th Edition*. All correlations >.18 are all significant at p<.001 level.

[4.5 Discussion](#)

The *DSM-5* section III alternative model is a step in the right direction for the adoption of a dimensional model of PDs (Bach et al., 2015). The model requires both personality dysfunction (criterion A) and pathological personality traits (criterion B) for a diagnosis of PD, in which efficient inventories measuring both criteria are required, in order to help ease the transition of PD diagnoses from a categorical framework to a dimensional one. To the best of the author's knowledge, this study represents the first investigation of the SIPP-SF and PID-5-BF psychometric qualities in a UK male population. The results support the use of the SIPP-SF as a screening instrument for personality functioning, and the use of the PID-5-BF as a brief screener for pathological personality traits, as measured by the *DSM-5* Section III model. The results indicate that both scales demonstrated adequate internal reliability, factor structure (PID-5-BF only), discriminant validity, and expected relationships with *DSM-5* categorical PDs.

[4.5.1 Internal consistency](#)

The SIPP-SF demonstrates excellent internal consistency in a sample of UK males, for both the individual domains and overall scale. These results are comparable to α coefficients reported in community samples in Belgium (Rossi et al., 2016) and America (Ro & Clark, 2009). Internal consistency was also acceptable for the item-total correlations. Three items were below the expected value (.3) for item-total correlations, however, only a minor improvement in Cronbach's alpha value was found if items were deleted. Overall, the scale demonstrates good reliability in the present sample.

The PID-5-BF demonstrates good internal consistency in a sample of UK males, for both the individual domains and overall scale. These results are comparable to α coefficients found in community and student samples in America (Anderson et al., 2018), Denmark (Bach et al., 2015), and an adolescent sample in Italy (Fossati et al., 2017). Additionally, they are consistent with results from the development study of the short PID-5 (Maples et al., 2015). This provides convincing support for the brief version, as it was able to demonstrate adequate reliability regardless of having a considerable decrease in item numbers. Internal consistency was also acceptable for the item-total correlations and inter-item correlations.

In regard to the PID-5-BF, the mean for the current population is lower than that reported in previous research (Fossati et al., 2017), however, this may be due to the variation in samples. The previous study consisted of adolescent/college student samples, whereas, this study focused on general population males with a mean age of 37. Therefore, the difference could be explained by age, as personality characteristics are liable to change over a person's lifetime, and research shows age-related changes in adaptive and maladaptive personality traits (Debast et al., 2014).

4.5.2 Factor structure

In terms of the PID-5-BF, the results demonstrate support for the five-factor structure through CFA, in a general population community sample of males. These results are similar to those shown in previous research with the full PID-5 (Krueger et al., 2012), and the PID-5-BF (Anderson et al., 2018; Bach et al., 2015; Fossati et al, 2017). As noted by Anderson et al. (2018), the previous studies used exploratory analyses (including exploratory factor analysis and exploratory structural equation modelling), which are less stringent than CFA. Similar to Anderson et al. (2018), these results offer strong support for the factor structure of the PID-5-BF using CFA, particularly when poor model fit is usually common for personality inventories when using CFA (Hopwood & Donnellan, 2010).

4.5.3 Discriminant validity

In terms of the SIPP-SF, there is no published report that assesses the discriminant validity of the SIPP-SF domains, however, there is research looking at the full SIPP-118 version. Previous research has identified that discriminant validity correlations across the SIPP-118 domains ranged from .27 to .60 (Feenstra, Hutsebaut, Verheul & Busschbach, 2011), and from .24 to .59, with an average of .45 (Arnevik, Wilberg, Monsen, Andrea & Karterud, 2009). It was expected that discriminant validity correlations for the SIPP-SF would fall within this range also. The average discriminant validity correlations for the SIPP-SF was .57 (ranging from .44 to .78), which is slightly higher than expected. There were several large correlations among the SIPP-SF domains, however, none of the correlations were above .8, which would indicate multicollinearity (Berry & Feldman, 1985). Arnevik et al (2009) argue that theoretically, the domains should be intercorrelated, as the underlying constructs are not distinct entities. Additional research exploring the discriminant validity of the SIPP-SF would be beneficial in order to fully understand the relationships between domains.

Previous research has identified that average discriminant validity correlations across the full-length PID-5 domains were .46 (Quilty et al., 2013) and across the short PID-5 domains were .57 (Maples et al., 2015). PID-5-BF domains were .59 (undergraduate sample), .34 (community sample; Anderson et al, 2018), and .49 (combined community and psychiatric sample; Bach et al, 2015). Therefore, it was expected that discriminant validity correlations for the PID-5-BF would be in this range also. The average discriminant validity correlation for the PID-5-BF for this study was .46, consistent with the previous hypothesis. These discriminant validity correlations are higher than what is usually found, with Crego et al. (2015) suggesting this may be due to the development process of the PID-5, the natural complexity of personality structure (Hopwood & Donnellan, 2010), or that cross-domain correlations are inherent reflections of a general factor of maladaptivity (Krueger et al., 2012; Quilty et al., 2013).

Within this study, there were three large correlations among the domains, similar to those reported in previous research (Anderson et al., 2018; Bach et al., 2015). However, none of these correlations were above .8, which would indicate multicollinearity (Berry & Feldman, 1985). Notably, the PID-5-BF demonstrates adequate discriminant validity to yield a five-factor structure in the current sample of UK males, as well as in previous studies.

Discriminant validity between the SIPP-SF and PID-5-BF was also assessed, in order to support the notion that personality functioning and pathological personality traits are separate entities. Most of the correlations were similar to those reported by Rossi et al. (2016), whereby the average discriminant validity correlation for Rossi et al.'s (2016) older adult sample was .52, and younger adult sample was .33. The average discriminant validity correlation for this current sample was .48, similar to Rossi et al.'s (2016) older adult sample. It is important to note that Rossi et al (2016) used the full PID-5, and also conducted partial correlations (controlling for gender), therefore, this is not a direct comparison.

Similar to previous research, there were several large correlations between the domains, indicating that personality functioning and personality traits are intertwined (Rossi et al., 2016), supporting Zimmerman et al.'s (2015) proposal that the distinction between criteria A and B is somewhat blurry. None of these correlations indicate multicollinearity, as they were all below .8 (Berry & Feldman, 1985). In the present study, the *psychoticism* and *detachment* domains from the PID-5-BF were intertwined with personality functioning: both PID-5-BF domains showed large correlations with four of the five SIPP-SF domains. The results indicate that personality functioning and personality traits have unique variance, however, they are also associated due to them both being measures of personality pathology (Rossi et al., 2016). It is important to note that due to both measures being self-report, the inflation in correlations may be due to common method variance, which may have resulted in an overestimation of overlap between personality functioning (criterion A) and personality traits (criterion B; Rossi et al., 2016).

4.5.4 Convergent validity

Transitioning to a dimensional trait model of personality pathology brings about various issues, particularly losing the existing categorical diagnoses that have long been used for clinical purposes. Therefore, coverage of the existing diagnoses is important for the clinical utility of the trait model (Bach et al., 2015). As previously hypothesised, the two domains (*identity integration* and *relational capacities*) were associated with all PDs, indicating good convergent validity. As proposed by Berghuis, et al. (2014), all five domains of the SIPP-SF were significantly correlated with all twelve PDs, indicating that general personality dysfunction is associated with all PDs. Correlations between the *relational capacities* domain and *antisocial* and *histrionic* PD were weaker than expected. As far as the author is aware, this is the first study to explore the relationship between SIPP-SF domains and categorical PDs,

however, Berghuis et al. (2014) have explored this relationship using the full-length SIPP-118. Due to a number of PDs being minimally represented in their sample, analyses were only carried out on Paranoid, Borderline, Avoidant and Obsessive-Compulsive PDs, in which similar results to this present study were reported.

In relation to the PID-5-BF, as hypothesised, all five of the PID-5-BF domains were associated with theoretically expected PDs, indicating good convergent validity. Similar to what was demonstrated in Hopwood et al.'s. (2012) study, the relationship between *antagonism* and *depressive PD* was lower than expected, and the correlation between *psychoticism* and *passive-aggressive PD* was higher than expected. However, of note, the *psychoticism* domain was found to be moderately or largely correlated with all categorical PDs, which has also been reported in previous research (Anderson et al., 2018; Hopwood et al., 2012). Additionally, all five domains showed significant relations with multiple other PDs (excluding *antagonism* and *avoidant PD*, and *disinhibition* and *obsessive-compulsive PD*). This is similar to what has been reported in previous research (Bach et al., 2016; Hopwood et al., 2016), suggesting that PID-5 traits may relate to a general factor of maladaptivity (Bo, Bach, Mortensen & Simonsen, 2015; Wright et al., 2012).

4.5.5 Limitations

The generalizability of this study is limited by an exclusively male sample (with specific employment backgrounds), and therefore, can only be generalized to a similar population. The study is also limited by a modest sample size, and further research should be conducted to assess the factor structure of the SIPP-SF in a UK population. It is important to note that this study uses general population males to validate the measures; however, the DSM-5 is a diagnostic manual, in which direct evidence from clinical samples is required regarding the validity and reliability of the two measures (Hopwood et al., 2012). The PID-5-BF's use as a clinical screening tool needs further evaluation, and when norms become available, the utility of elevated PID-5-BF scores with clinician rated PD diagnoses should be evaluated (Anderson et al., 2018).

Another limitation of this study is the use of questionnaires to collect data, which, as noted by Hopwood et al. (2012), may potentially lead to a disadvantage in understanding the validity of the measures and constructs. All of the variables in this study were assessed using self-report, meaning that associations may be inflated due to shared method variance (Anderson et al., 2018), which could potentially lead to overlap between criteria A and B (Rossi et al., 2016). Self-report data also provides only one point of view, and may be more appropriate for internalizing problems, rather than externalizing problems, which may be better represented by informant reports (Rossi et al., 2014). Future research should consider using non self-report data (i.e. observation or historical data) or structured clinical interviews (i.e. SCID-II interview, similar to Bach et al., 2015), in order to reduce the inflation, and to gain a better

understanding of the PID-5-BF and SIPP-SF's associations with clinical judgement (Anderson et al., 2018).

Furthermore, for the purpose of this study, it was beneficial to use a measure (PDQ-4) that linked directly to DSM-IV PDs. However, some of the scales were found to have low internal consistencies, similar to those reported by Anderson et al. (2018) and Hopwood et al. (2012). As previously suggested, it may be beneficial to use other ways of assessing PD (i.e. clinical judgement, observation, structured interview) in order to further evaluate the link between the DSM-5 alternative model and DSM-IV PDs. However, as discussed earlier, the PDQ-4's low internal consistencies may be due to the dichotomous scoring system, meaning that the ordinal alpha should be calculated, which demonstrates good internal consistency in this sample.

[4.6 Summary](#)

Despite these limitations, the current study provides a useful evaluation of the SIPP-SF and PID-5-BF as screening tools for personality functioning and pathological personality traits. As far as the author is aware, this is the first validation study of the SIPP-SF and PID-5-BF in a UK population. Although these measures cannot be used to diagnose PDs using the DSM-5 alternative model, the results support the reliability and validity of the SIPP-SF and PID-5-BF as screening tools of personality functioning and pathological traits, which may warrant further assessment. The findings from the present study suggest that the PID-5-BF and SIPP-SF, which were developed in America and the Netherlands respectively, can be generalised to the UK population (males), supporting the use of the measures as screening tools for PD among male prisoners in the UK.

The DSM-5 including the alternative trait model is an important step in the right direction to adopting a dimensional model of personality pathology. However, this adoption will require a body of research supporting its validity. Additional research, particularly in clinical and/or forensic settings is required to evaluate the use of the SIPP-SF as a screening tool for criterion A, and the use of the PID-5-BF as a screening tool for criterion B. This current study provides support for the PID-5-BF and SIPP-SF cross-culturally, and will hopefully facilitate research and clinical use of the model by providing valid and reliable screening measures for criteria A and B. This study aimed to validate the scales in a UK male population, with the intention of later using them with male prisoners in the UK. Therefore, this study concludes that the scales are suitable screening tools for personality functioning and pathological traits among a UK male population.

Chapter Five: An exploration of the characteristics of individuals who have previously sexually offended

Overview

Following on from chapter four which validated two personality disorder (PD) scales in a sample of UK males, the scales were used to assess PD among a sample of individuals who have previously sexually offended (IPSO) in the UK. This empirical chapter will provide an overview of the characteristics of IPSO, including (i) offence characteristics (offence type, victim type, victim sex, and sexual attraction), (ii) personality disorder (personality functioning, pathological personality traits, and categorical PD diagnoses), (iii) sexual preoccupation (SP), and (iv) adverse childhood experiences (ACEs). Data presented in this chapter are a combination of data from study 2 (screening study; main sample of IPSO) and study 3 (further psychometric study; sample of IPSO with PD). The research samples are compared to available normative data, UK general population data (from study 1; validation study), and a sample of IPSO taking medication to manage problematic sexual arousal (MMPSA). The results are split into four separate segments: offence characteristics (part A), personality disorder (part B), sexual preoccupation (part C), and adverse childhood experiences (part D), whereby the prevalence rates of PD, SP and ACEs will be explored. Implications and limitations of both studies are also discussed.

5.1 Introduction

5.1.1 Personality disorder among IPSO

As discussed in chapter two, section 2.1.1, PDs are highly prevalent among IPSO, with research finding prevalence rates of 33% – 94% (Chen et al., 2016; Craissati & Blundell, 2013; Kingston et al., 2015). However, the literature differs in terms of what PDs are most prevalent among IPSO, with some research arguing that antisocial is the most prevalent (Chen et al., 2016; Kingston et al., 2015; Sigler, 2017), and others suggesting a range of other PDs are more common, including schizoid, avoidant, dependent, passive-aggressive, borderline, narcissistic, obsessive-compulsive and paranoid PDs (Chantry & Craig, 1994; Craissati & Blundell, 2013; Francia et al., 2010).

Overall, in comparison to non-IPSO (prisoners that did not commit a sexual offence), IPSO were more likely to present with schizoid, avoidant, dependent, passive-aggressive, depressive and obsessive-compulsive, whereas, non-IPSO showed more antisocial and narcissistic PDs (Ahlmeyer et al. 2003; Chantry & Craig, 1994; Fazel et al 2002; Langevin et al., 1988). Furthermore, IPSO against children were typically more likely to experience avoidant, dependent, depressive, schizoid and passive-aggressive PDS in comparison to IPSO against adults, who were characterised by more antisocial, narcissistic,

borderline, obsessive-compulsive and paranoid PDs (Ahlmeyer et al., 2003; Chantry & Craig, 1994; Craissati et al., 2008; Eher et al., 2010; Francia et al., 2010; Sigler, 2017). Although the literature demonstrates various links between PD and sexual offending, and the UK have developed specific pathways (such as the OPD Pathway) to help target this, there is a paucity within the literature regarding the prevalence of PDs specifically among IPSO residing in UK prison establishments. Although two studies (discussed in further detail in chapter two, section 2.1.1) were conducted in the UK, one focused on IPSO residing in the community (Craissati & Blundell, 2013), and the other focused on elderly IPSO (Fazel et al., 2002). Therefore, one of the aims of this thesis is to explore the prevalence of PD among IPSO in two UK prisons establishments.

5.1.2 Sexual preoccupation among IPSO

Although SP has been identified as a significant predictor of general, violent, and sexual recidivism (Hanson & Morton-Bourgon, 2005; Mann et al., 2010), there are relatively few studies which have assessed the prevalence of SP among IPSO. To the best of the author's knowledge, the prevalence rates of SP among IPSO housed in UK prisons has not yet been established, although, it has been found to be one of the most prominent treatment needs among IPSO in the UK (Hocken, 2014). Among the general population, prevalence rates are thought to range from 1.2% - 18% (Carnes, 1989; Klein, Schmidt, Turner & Briken, 2015; Marshall et al., 2008; Odlaug et al., 2013), with a higher prevalence being reported among IPSO, ranging from 9% - 55% (Blanchard, 1990; Briken, 2012; Carnes, 1989; Hanson et al., 2007; Kingston & Bradford, 2013; Marshall & Marshall, 2006; Marshall et al., 2008). However, due to a variety of terms used interchangeably within the literature, and the diverse ways of assessing SP (as discussed within chapter two, section 2.3.1), there are discrepancies regarding the prevalence rates of SP among IPSO.

As is evident from the literature review (see chapter two, section 2.1.2), the prevalence of SP among IPSO is unclear, and although the UK have developed specific pathways to help target SP, there is a paucity within the literature regarding the prevalence of SP specifically among IPSO residing in UK prison establishments. Given that this thesis focuses more on the cognition side (SP) rather than the physical behaviour (i.e. total sexual outlets), self-report data that assesses intrusive and uncontrollable sexual thoughts and behaviours (Kalichman, 2010) will be used, which is also the same scale used for the initial screening/inclusion criteria for the MMPSA pathway.

5.1.3 Adverse childhood experiences among IPSO

Higher rates of ACEs are found among individuals that are incarcerated, with 84% reporting at least one ACE, and 46% reporting four or more (Ford et al., 2019). Evidenced within the literature is the relationship between early traumatic experiences and sexual offending (see chapter two, section 2.1.3

for more information; Abbiati et al., 2014; DeCou et al., 2015; DeLisi & Beauregard, 2018), whereby IPSO report higher rates of early childhood trauma in comparison to general population and non-IPSO samples (Jespersen et al., 2009; Levenson et al., 2016; Reavis et al., 2013). Among IPSO in the US, 76 - 84% demonstrated at least one ACE, with half experiencing four or more (Levenson et al., 2016; Marshall, 2016a). Within the UK (community sample), Craissati and Blundell (2013) found that 52% of IPSO reported verbal abuse, 38% had been sexually abused, and 31% reported physical abuse.

Although ACEs have been found to be common among IPSO, the majority of this research has been conducted in America. Craissati and Blundell (2013) looked at child maltreatment among IPSO in the community in the UK, however, they did not explore the full range of ACEs. To the best of the author's knowledge, the prevalence of ACEs among IPSO housed in UK prison establishments has not yet been established, especially among IPSO with personality disturbance. Given the strong link between PD and early childhood trauma (Johnson et al., 1999; Laporte et al., 2011; Tyrka, et al., 2009), whereby PDs may be considered a response to child maltreatment and neglectful environments (Battle et al., 2004), the prevalence of ACEs among IPSO that demonstrate personality disturbance is of particular interest within this current study.

5.2 Research aims

The main aim of this chapter is to explore the prevalence rates of PD, SP, and ACEs among IPSO that are housed in two UK prisons. This will be achieved by meeting the following objectives:

- Explore the offence characteristics of IPSO
- Establish the prevalence rates of PD and SP across two UK prisons that house IPSO
- Examine impairments in personality functioning (criterion A) and pathological personality traits (criterion B) among IPSO
- Establish the prevalence rates of ACEs among IPSO with PD housed in two UK prisons
- Compare PD, SP and ACEs among IPSO to available normative data, a non-offending general population sample (study 1: validation study), and a sample of IPSO taking MMPSA

5.3 Method

5.3.1 Design

The screening study and further psychometric study both utilised a survey research design, which involved a purposive sample of males recruited from two UK prisons that house IPSO. Purposive sampling was employed as participants were selected according to pre-determined criteria in relation to the research aims (as described below; Guest et al., 2006).

This chapter utilises data from both study two and three, therefore, the methods relating to both studies will be discussed throughout the subsequent section.

5.3.2 Participants

5.3.2.1 Study 2: Screening study

Participants consisted of 155 male IPSO who were serving a custodial sentence at two category C prisons. Both prison establishments specifically house IPSO, however, one is a treatment focused prison that includes a MMPSA pathway, whereas, the other encourages active citizenship. There are eight prisons in the UK that specifically house IPSO (two category B and six category C prisons), and these are two of the category C establishments based in the Midlands region. Throughout this thesis, the prison containing the MMPSA treatment pathway will be referred to as Prison 1, and the other prison will be referred to as Prison 2. Questionnaires were distributed to 1,590 IPSO (Prison 1; $n = 840$, Prison 2; $n = 750$), with a 9.75% ($n = 155$) response rate for the initial screening study. Participants ages ranged from 21 – 79 years ($M = 45.52$, $SD = 14.78$).

5.3.2.2 Study 3: Further psychometric study

Participants from the screening study that showed PD were invited to take part in this further psychometric study. Eighty-four participants met the criteria for PD (demonstrating impairments in personality functioning [identity integration and/or relational capacities], and at least one pathological personality trait). Of these 84 participants, 54 provided consent to be contacted for future research purposes. Due to the time lapse between study 2 and study 3, nine of these participants were released/transferred before data collection began. Therefore, for this study, participants consisted of 45 IPSO from Prison 1 and Prison 2. Participants ages ranged from 22 – 79 ($M = 41.36$, $SD = 14.80$). Please see figure 7 for the sample attrition for study two and three.

5.3.2.3 Non-offending sample (general population)

Please see Chapter Four, section 4.3.2 (participants) for further details.

5.3.2.4 IPSO taking MMPSA sample

Participants consisted of 89 male IPSO that were taking MMPSA at Prison 1 as part of research being conducted by the Sexual Offences Crime and Misconduct Research Unit (SOCAMRU) into the evaluation of MMPSA. Participants ages ranged from 24 – 73 ($M = 43.74$, $SD = 14.32$). The author was granted ethical permission from HMPPS and NTU ethics boards to access this data for comparative purposes.

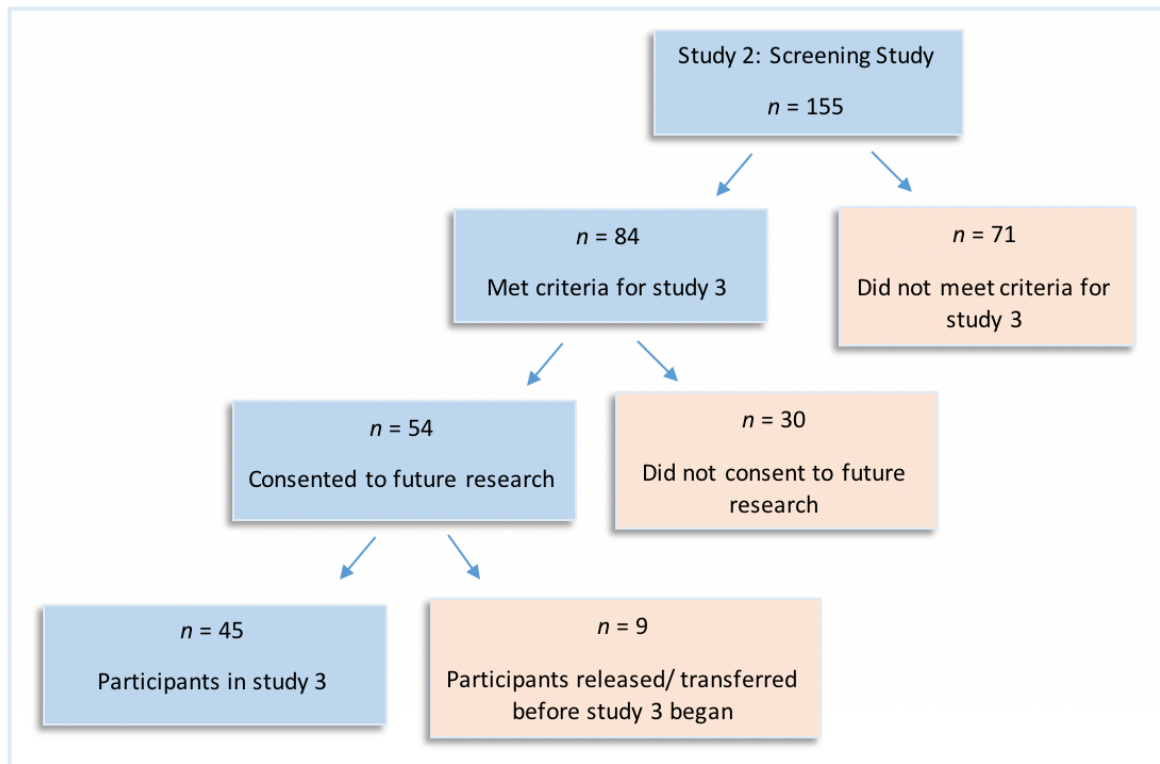


Figure 7. Sample attrition for study two and three

5.3.3 Measures

5.3.3.1 Study 2: Screening study

Participants received the following battery of psychometric tests under their cell door:

Severity Indices of Personality Problems – Short Form (SIPP-SF)

Please see chapter four, section 4.3.3 (measures) for further details regarding the SIPP-SF. The SIPP-SF was used to measure personality functioning (criterion A of the DSM-5 Alternative Model to PDs [AMPD]). In order to keep the size of the test battery to a minimum, with the aim of encouraging responses from IPSO, only items relevant to the *self-control*, *identity integration* and *relational capacities* domains were included in the screening study. These specific domains were chosen as *identity integration* and *relational capacities* are directly related to criterion A of the AMPD (self and interpersonal functioning: APA, 2013a), and *self-control* is linked to sexual recidivism (Hanson & Morton-Bourgon, 2005). In the current IPSO sample, acceptable/good Cronbach's alpha (α) values were found for the domains: *self-control* = .89, *identity integration* = .72, *relational capacities* = .77.

High scores demonstrate better adaptive functioning, whereas lower scores indicate more maladaptive personality functioning. Scores are converted to a Z-score and then a T-score in order to compare to normative data (general population and PD population; Verheul et al., 2008), whereby scores less than

40 indicate impaired adaptive functioning, and less than 30 indicate severely impaired adaptive functioning. For the purpose of analysis, the scores will be analysed dimensionally, other than when to ascertain the prevalence of impairment for the assessment of criterion A.

Personality Inventory for DSM-5 – Short Form (PID-5-SF)

The PID-5-SF was used to measure the pathological personality traits that form criterion B of the DSM-5 AMPD. The brief version (PID-5-BF) was used in the validation study (study 1) for brevity's sake, due to the length of the other scales, and the additional scale (PDQ-4) required to validate against. However, the brief form was deemed inadequate for this study, as it only provides domain level scores and not facet level assessment (Bach, Maples-Keller, Bo & Simonsen, 2015).

As reported in the previous study, the full PID-5 version is a 220-item self-report questionnaire that was developed to assess pathological personality traits as part of the DSM-5 AMPD, and is thought to be a reliable instrument which is able to recover DSM-IV PDs, whilst also providing additional rich information in relation to personality traits (Fossati, Krueger, Markon, Borroni & Maffei, 2013; Hopwood et al., 2012). In 2015, Maples et al. used item response theory to test whether the trait model could be measured with a reduced set of items, and developed the PID-5-SF. The PID-5-SF consists of 100 items and is similar to the full PID-5 in terms of factorial structure and relations with external criteria (Bach et al., 2016; Maples et al., 2015; Thimm, Jordan & Bach, 2016). Bach et al. (2016) compared all three forms together and revealed that all forms were able to reliably and validly assess PD traits, providing support for the use of the forms in a European population. Therefore, to minimize participant burden and increase the likelihood of responses, the short version (PID-5-SF) was chosen over the full version for this study. The combination of the PID-5-SF (pathological personality traits) and SIPP-SF (impaired personality functioning) enables the DSM-5 AMPD to be explored within this study (Veenstra et al, 2019).

Similar to the full form and brief form, the PID-5-SF is scored on a 4-point Likert scale, ranging from 0 (very false or often false) to 3 (very true or often true). It includes 25 first-order facets which are grouped into five second-order domains. The five domains include *Negative Affectivity*, *Detachment*, *Antagonism*, *Disinhibition*, and *Psychoticism*. The 25 facets contain four items each, and include *Anhedonia*, *Anxiousness*, *Attention Seeking*, *Callousness*, *Deceitfulness*, *Depressivity*, *Distractibility*, *Eccentricity*, *Emotional Lability*, *Grandiosity*, *Hostility*, *Impulsivity*, *Intimacy Avoidance*, *Irresponsibility*, *Manipulativeness*, *Perceptual Dysregulation*, *Perseveration*, *Restricted Affectivity (lack of)*, *Rigid Perfectionism (lack of)*, *Risk Taking*, *Separation Insecurity*, *Submissiveness*, *Suspiciousness*, *Unusual Beliefs and Experiences*, and *Withdrawal* (please see appendix 8 for a breakdown of PID-5-SF domains, appendix 2 for a description of the domains, and appendix 3 for a description of the PID-5-SF traits).

Higher scores on either the facets or domains of the PID-5-SF indicate greater dysfunction. To establish whether a given trait or domain is elevated, the rational cut off point (a mean score of 2.0 or higher) will be used (Samuel et al., 2013). In order to retain the advantage of using a dimensional model, Samuel et al. (2013) explored the effectiveness of methods in calculating continuous scores for each PD, finding that the sum method was the most effective at reproducing PD diagnoses. The sum method involves summing an individual's mean score for traits that characterize each PD, producing an overall score that captures the degree to which an individual has traits relevant to a specific PD. Samuel et al. (2013) also identify a simpler method called the count method, which consists of counting the number of traits assigned to each PD that are elevated (using the rational cut off point, a mean score of 2.0 or higher indicates elevation on any given trait), which would act as an individual's dimensional score for the PD. However, this method sacrifices valuable information by turning continuous scores into categorical indicators. Therefore, for the purpose of this research, the sum method is used for analytical purposes, except for when assessing prevalence rates (whether a particular PD is present or absent). In this instance, the count method will be used, which involves aggregating all elevated traits (mean score of 2.0 or higher) corresponding to each PD and using the diagnostic criteria relevant to each PD (described in more detail below).

For the six retained PDs in the DSM-5 AMPD, diagnostic criteria were used in relation to elevated traits. However, for the excluded PDs, Samuel et al.'s (2013) half method was used, which requires half (or half + 1 if an odd number) of the traits associated with each PD to be elevated in order to classify them into the diagnostic PD category (associated traits were taken from the trait cross-walk proposed for the DSM-5, also used in studies by Hopwood et al. [2012], and Samuel et al. [2013]). PDs were identified if participants demonstrated impairments in *identity integration* or *relational capacities* (criterion A) and displayed personality traits relevant to each PD (please see appendix 9 for a breakdown of which pathological personality traits are associated with each PD). Additionally, as stated in the DSM-5 AMPD, if a person demonstrates significant impairments in personality functioning, but the combination of impairments and pathological personality traits does not meet the criteria for any of the six retained PDs, then a diagnosis of PD Trait Specified (PDS) can be given instead.

In terms of internal consistency, the PID-5-SF shows α values between .90 and .93 for the domains, and .83 and .86 for the facets (Maples et al., 2015). The psychometric properties of the scale have been confirmed cross culturally, including: Spain, Denmark, America, Italy, and Norway (Aluja, Gracia, Cuevas & Lucas, 2019; Bach et al., 2016; Maples et al., 2015; Somma, Krueger, Markon, Borroni, & Fossati, 2018; Thimm et al., 2016). In the current IPSO sample, excellent α values were demonstrated between .87 (*detachment*) and .92 (*negative affectivity*) for the domains ($M = .90$), and .70 (*irresponsibility*) and .92 (*impulsivity*) for the facets ($M = .83$; see appendix 10 for individual α values of domains and facets).

Sexual Compulsivity Scale (SCS)

The SCS was developed in 1994 by Kalichman et al., and assesses insistent, intrusive, and uncontrolled sexual thoughts and behaviours, the impact of these on daily functioning, and the inability to control these thoughts or behaviours (Kalichman, 2010). The scale consists of 10 items that are rated on a four-point Likert scale from 1 (not at all like me) to 4 (very much like me). Indicative items include 'my sexual thoughts and behaviours are causing problems in my life' and 'I think about sex more than I would like to'. The SCS demonstrates α values of .89 with a male sample and .92 with a female sample (Kalichman & Rompa, 2001), .79 among young adults (McBride et al., 2008), and .83 for a sample of IPSO taking medication to manage their sexual arousal (Winder et al, 2014). An excellent α value (.92) was found for the current population.

The cumulative scores can range from 10 to 40, with higher values demonstrating greater likelihood of sexual compulsivity. Grov, Parsons and Bimbi (2010) state there is no established cut-off for the SCS, however, respondents are considered sexually compulsive if their average score (total score divided by number of items) exceeds 2.1 (Kalichman & Rompa, 1995; Kalichman & Rompa, 2001; Öberg, Hallberg, Kaldo, Dheine & Arver, 2017), or 2.4 (Parsons, Bimbi & Halkitis, 2001). A different cut-off score is used within the prison service, whereby a score of 1.5 or higher is used for a referral to the MMPSA service for individuals with a sexual conviction (Her Majesty's Prison Service, 2016). This cut off is slightly lower than what is suggested for the general population due to individuals being convicted of a sexual offence, and clinical judgement of the consulting psychiatrist and research team being used to decipher what is clinically relevant for the service. This is in accordance with the ongoing evaluation of individuals referred for MMPSA in HMPPS (see Winder et al., 2014; Winder et al., 2018). Although the SCS measures both sexual thoughts and behaviours, it was utilised in this study as it is the measure currently used within HMPPS, and enables comparisons to be made between the general population of IPSO and those who take MMPSA. The SCS will be used both dimensionally and categorically for the purposes of analysis, and when used as a cut off to delineate between participants that show SP and those that do not, the 1.5 service cut off will be used, in accordance with HMPPS criteria.

Additional Offence Related Questions

Participants were also asked several questions relating to their offence, including: 'Who have you offended against?' (child, adult, both), 'Were your offence(s) committed against a male or female?' (male, female, both), 'Were your offence(s) contact or non-contact offence(s)?' (contact, non-contact [not internet], internet), and 'Please indicate which age group(s) you find sexually attractive' (Infant [0-3 years old], Prepubescent [6-10 years old], Adolescent [11-15 years old], Adolescent [16-19 years old], Adult [20-54], Elderly [55+], Same age as me). In terms of the last question, for analytical purposes, responses were categorised into 'Child', 'Adult' and 'Both'. Additionally, responses were also categorised into 'paedophilia' (under 11 years; prepubescent), 'hebephilia' (11-15 years; early pubescent children), 'paedohebephilia' (0-15 years; both prepubescent and early pubescent children;

Blanchard, 2010), 'teleiophilia' (16+, sexual interest in adults; Blanchard, Barbaree, Bogaert, Dickey, Klassen, Kuban & Zucker, 2000), and 'both child and adult'. Any responses to 'Elderly' (55+) were individually assessed, and all responses were combined with the 'same age as me' response, therefore were considered to be within normal/healthy sexual development and categorised under teleiophilia.

5.3.3.2 Study 3: Further psychometric study

Participants received the following battery of psychometric tests during one-to-one assessments with the researcher:

Severity Indices of Personality Problems – 118 (SIPP-118)

In the previous study (validation study, chapter four) the SIPP-SF was used to assess personality functioning (criterion A), however, it only provides domain level scores and not facet level assessment, and only three of the domains were assessed for brevity's sake. Therefore, in this study, the SIPP-118 was used to assess criterion A, which involves assessing all domains and facets (see appendix 11 for a breakdown of the domains). The SIPP-118 is a dimensional measure for the severity of personality pathology, which contains 118 items that measure 16 facets (Verheul et al., 2008). The 16 facets are clustered into five domains, which are weighted sums using primary and secondary loadings in line with factor analytic and qualitative considerations (Feenstra et al., 2011). The domains were interpreted by scale authors as: *Self-control* (including *emotion regulation* and *effortful control* facets), *Identity integration* (including *self-respect*, *stable self-image*, *self-reflexive functioning*, *enjoyment* and *purposefulness* facets), *Relational capacities* (including *intimacy*, *enduring relationships* and *feeling recognised* facets), *Responsibility* (including *trustworthiness* and *responsible industry* facets), and *Social concordance* (including *aggression regulation*, *frustration tolerance*, *respect* and *cooperation* facets).

The SIPP-118 measures the core components of mal(adaptive) personality functioning and is scored on a 4-point Likert scale ranging from fully disagree to fully agree. Scoring of the SIPP-118 is similar to the SIPP-SF, whereby higher scores demonstrate better adaptive functioning and lower scores indicate more maladaptive personality functioning. For the purpose of analysis, the scores were analysed dimensionally, other than when to ascertain the prevalence of impairment for the assessment of criterion A. In terms of internal consistency, the SIPP-118 shows α values between .69 (*respect*) and .84 (*aggression regulation*) for the facets ($M = .77$; Verheul et al., 2008). The psychometric properties of the scale have been confirmed in several populations including adolescents (distinguishing between personality disordered and non-personality disordered samples), and adults with PD, including cross-national validation (Norway and Netherlands; Arnevik et al., 2009; Feenstra et al., 2011; Verheul et al., 2008). In the current IPSO sample acceptable α values were found between .72 (*responsibility*) and .90 (*self-control*) for the domains ($M = .81$), and .64 (*self-reflexive functioning* and *respect*) and .89 (*aggression regulation*) for the facets ($M = .74$; see appendix 12 for individual α values of domains and

facets). Twelve of the 16 facets had α values above .70, with the remaining four (*self-reflexive functioning, trustworthiness, feeling recognised* and *respect*) having values above .60. Although the typical cut off for acceptable reliability is .70 (Kline, 1999), research also suggests that other factors need to be considered when assessing reliability as psychometric assessments are expected to have more variance than other forms of testing (Lance, Butts & Michels, 2006; Schmitt, 1966; Taber, 2018), and among scales that have fewer than ten items it is common to find low α values (the subscales of the SIPP-118 consisted of 7/8 items; Pallant, 2016). Streiner (2003) argues that values greater than .6 reflect an acceptable level of reliability, therefore, these facets will still be interpreted in the analysis, with some caveats.

Sexual Compulsivity Scale (SCS)

Please see the above screening study for details of the SCS. The SCS demonstrated excellent internal consistency within this study (α value = .88). Test-retest reliability, as explored from the screening study to the further psychometric study was good, with a Pearson's correlation coefficient of .80, showing the SCS to be reliable over time.

My Private Interests (MPI)

The MPI is a 54-item scale which measures sexual interests (Williams, 2005), consisting of four subscales: sexual preference for children, obsessed with sex, preferring sex to include violence or humiliation, and other offence-related sexual interests. It was developed to form part of the assessment battery for IPSO undertaking the HMPPS Sex Offender Treatment Program (SOTP). The MPI tests risk factors known to be strongly associated with sexual offending, including sexual preoccupation. For the purpose of this study, only the *obsessed with sex* scale was used to assess sexual preoccupation, as a way of triangulating the data with SCS scores. Previously, the SCS was used to screen for IPSO that may demonstrate difficulties with their sexual thoughts and behaviour, and the MPI was used to further examine sexual preoccupation. The full version of the MPI asks very personal, intrusive questions such as 'I feel turned on (sexually excited) when I think about having sex with a child' and 'I would like to have sex with a dead body'. Therefore, only the *obsessed with sex* subscale (which Williams [2005] claims is the 'sexual preoccupation' component) was used in order to minimize undue distress or harm to participants, as the other scales were not deemed necessary for the aims of this research.

The MPI is scored on a dichotomous true/false scale (true = 2, false = 0). The *obsessed with sex* scale consists of 11 items, and items are summed to give a total score with higher scores relating to higher SP (range 0 – 22). In terms of internal consistency, the MPI shows a Cronbach α value of .82 for the *obsessed with sex* subscale (Williams, 2005), and it has been shown to have good validity and excellent internal reliability when used with IPSO in the United Kingdom (Farren & Barnett, 2014). Acceptable internal consistency was found in the current study (α value = .78). The data were triangulated with the SCS scores and cross verification of the data was conducted. Pearson's correlation demonstrated that

SCS scores were significantly correlated with MPI scores ($r = .72, p < .001$), demonstrating that, as SCS scores increased, so did scores on the MPI.

Adverse Childhood Experiences (ACE) Module

The Behavioural Risk Factor Surveillance System (BRFSS) ACE module was used in order to assess child maltreatment and household challenges (Centers for Disease Control and Prevention [CDC], 2010). The module consists of 11 items that assess exposure to nine types of ACEs: *verbal abuse, physical abuse, sexual abuse, household mental illness, household alcohol abuse, household drug abuse, domestic violence, parental separation/divorce, and incarcerated family members.*

Response options differed according to each item, For example, for the *domestic violence* item 'How often did you parents or adults in your home ever slap, hit, kick, punch, or beat each other up', the response options include 'Never', 'Once' or 'More than once'. Therefore, for questions with varying options were collapsed into 'Never' or 'One or more times', which conveys exposure to a given type of experience (Ford et al., 2014). Several questions already provided dichotomous (yes/no) answers, for example 'Did you live with anyone who was a problem drinker or alcoholic?'. Scoring involves summing the number of items endorsed in order to provide an overall total of exposure to ACEs. Ford et al. (2014) evidenced support for this scoring algorithm, however, through exploratory and confirmatory factor analysis also identified a 3-factor solution (*household dysfunction, emotional/physical abuse, and sexual abuse*). They suggest that creating three separate composite scores may be beneficial to estimate the specific effects of exposure to *household dysfunction, emotional/physical abuse, and sexual abuse.*

In terms of internal consistency, the ACE questionnaire has previously been found to have acceptable Cronbach's α values of .78 for the overall score, .61 for *household dysfunction*, .70 for *emotional/physical abuse*, and .80 for *sexual abuse* (Ford et al., 2014). The ACE module has been shown to have good validity and reliability in American samples (CDC, 2010; Ford et al., 2014), and has been used in England and Wales (Bellis et al., 2015; Bellis et al., 2014a; Bellis et al., 2015). Acceptable α values have been found in the current sample of IPSO: .78 for the overall score, .63 for *household dysfunction*, .65 for *physical/emotional abuse*, and .67 for *sexual abuse.*

5.3.4 Procedure

5.3.4.1 Study 2: Screening study

The purpose of the screening study was to assess the prevalence of PD and SP among IPSO, and to identify individuals demonstrating signs of PD who were suitable for the next two stages of the research. Questionnaires were distributed under 1,600 cell doors at both prisons by the researcher (with special thanks to wing staff and wing orderlies for their assistance). Prior to this, as a way of encouraging responses from IPSO, the researcher advertised the research and explained that questionnaires would be posted under cell doors in a weeks time. This was done by placing posters on each wing and around

the prison, speaking to wing representatives, providing leaflets for prisoner information desks (PIDs), having posters displayed on the TV channel, and having notices to staff and notices to IPSO sent out by the Governor at each prison.

An information sheet, consent form, battery of tests, debrief form, and support request form were placed within a sealable envelope, and posted under cell doors (please refer to appendices 13 - 16 for information sheet, consent form, debrief form and support request form). The researcher placed a box on each wing (situated either on the prisoner information desk or in the wing office) whereby IPSO could place their sealed envelopes, rather than passing on to wing staff (as the WASREP identified this as a potential barrier, as IPSO may be wary of handing sensitive and personal information to prison staff). Participants could choose to remain anonymous and not provide any identifying information, or, if they were interested in taking part in future research, were asked to leave their name and prison number. Support request forms were included for people that required assistance in completing the questionnaire, and four participants completed this form. The researcher met with these participants in assessment rooms at the prison establishments in order to complete the battery of tests with them. Questionnaires were collected from each wing over the following two weeks, and a further notice to staff and a notice to IPSO were sent out informing them of the final deadline for return of any completed questionnaires. After this deadline, a few IPSO handed their completed questionnaires directly to the psychology department at Prison 1, which were passed onto the researcher and included in the research.

5.3.4.2 Study 3: Further psychometric study

Participants that showed signs of PD from the screening study (impairments in personality functioning and at least one pathological personality trait) and left their name/prison number were invited to take part in this study. Rather than simply using screening tools, this study aimed to explore personality functioning and sexual preoccupation in more depth, whilst also exploring the topic of ACEs.

Participants were invited to an assessment room (at either Prison 1 or Prison 2) with the researcher, where they were provided with a new information sheet and consent form (see appendix 17 and 18). During the information/consent stage of this study, the researcher was transparent with IPSO by explaining that she intended to conduct in-depth interviews in the future. If participants were happy to be contacted in the future, they were asked to sign a separate consent form to confirm this. The researcher read aloud the questions of the psychometric tests, providing participants with a printed copy of the responses. This enabled the researcher to assess participants' understanding and monitor fatigue throughout the assessment. Some participants completed all questionnaires within a one-hour appointment, whereas, others required two sessions to complete the test battery. Due to ethical

considerations, it was decided to include the ACE scale in this study only, rather than posting it under cell doors, due to the sensitive nature of the questions. This way, the researcher could monitor the participants' responses and identify any distress among participants, whilst also discussing with them the support services available if required (further details provided on the debrief form, see appendix 19). The researcher had access to prison databases in order to assess participants' risk level before meeting on a one-to-one basis, for safety purposes. Three of the IPSO were considered high risk; therefore, another member of the SOCAMRU was present during these assessments.

5.3.5 Analysis

5.3.5.1 Analytical procedures

In order to explore the characteristics of IPSO, offence characteristics and prevalence rates of PD, ACEs and SP among IPSO were explored. Descriptive statistics (e.g. mean, standard deviation, percentages) were used to describe the sample in relation to the prevalence of PD, SP and ACEs (PD was split into personality functioning [criterion A], pathological personality traits [criterion B], and categorical personality disorder diagnoses). As per the criteria defined in chapter four (section 4.3.5), no variables exceeded the range for skewness and kurtosis, and no extreme outliers were identified, therefore, all cases were used for analytical purposes. All assumptions were met before further analysis was conducted.

The means of the research sample were compared to normative data (or available comparative data), a sample of non-offending UK males (data from chapter four: study 1), and a sample of IPSO taking MMPSA. How these groups differ in terms of personality functioning, pathological personality traits and sexual preoccupation was examined using descriptive and inferential statistics. A series of independent samples *t*-tests and one sample *t*-tests were used to compare the group of IPSO to general population norms or general population data (from study 1), and a sample of IPSO taking MMPSA. In terms of categorical personality disorders and adverse childhood experiences (dichotomous variables), prevalence rates were compared to general population data, a sample of IPSO, and/or a psychiatric sample using binomial analyses and odds ratios (OR).

Odds ratios (OR) were used to compare the relative odds of an event occurring (e.g. having borderline PD) in one group, with the odds of it occurring in another group (Szumilas, 2010), as well as 95% confidence intervals (CI). Similar to Levenson, Willis and Prescott (2016), the ORs in the current analysis were calculated as described in the subsequent example:

'... If 25 out of 100 sex offenders have a history of sexual abuse, their odds of having a sexual abuse history are 25/75, or 0.33; if 10 of 100 non-sex offenders have a similar

history, their odds are 10/90, or .11. The OR for this comparison is therefore 0.33/0.11, or 3.0. An odds ratio of 1.0 represents the absence of a group difference whereas an odds ratio greater than 1.0 means a greater prevalence of abuse in the first group; an odds ratio smaller than 1.0 means a lower prevalence of abuse in the first group' (Jespersen et al., 2009, p.182).

5.3.5.2 Missing data

In relation to the question asking about victim type (child, adult or both), three participants elected not to answer this question, meaning that any analysis using this variable is conducted with $n = 152$. Regarding the psychometric scales, missing value analysis was conducted on the data, revealing that data were missing completely at random (MCAR), whereby 0.093% of the data were missing (study 2; $n = 155$). Tabachnick and Fidell (2007) advise that less than 5% of missing data would be inconsequential and removing these cases would lead to a loss of statistical power. They also highlight that with less than 5% missing data, any procedure for handling missing data would yield similar results. Furthermore, Rubin, Witkiewitz, St. Andre, and Reilly (2007) suggests that, in this instance, single imputation using Expectation Maximisation algorithm (EM) is the recommended procedure in order to maintain the structure of the data. Therefore, as a way of retaining all cases due to a limited sample size, and an attempt to maintain the structure of the data, the EM algorithm was utilized. In terms of study 3, due to it being a one-to-one assessment where the main researcher completed psychometric measures with participants, there was no missing data.

5.3.5.3 Multiple comparisons and type 1 error

Throughout this thesis, multiple comparisons are made using several statistical tests, which therefore increases the chance of reporting false positives (type 1 error). Controlling the familywise error rate using the Bonferroni correction is one way of dealing with this, however, this has been criticised for various reasons, including being too conservative when there are a large number of multiple comparisons (Glickman, Rao & Schultz, 2014; Perneger, 1998). The Benjamini-Hochberg procedure (Benjamini & Hochberg, 1995) has been suggested as a suitable alternative (Glickman et al., 2014), therefore, this procedure will be used throughout in order to correct for this issue. The Benjamini-Hochberg procedure involves controlling for the false discovery rate (FDR), whereby the individual p values are ranked in size order (smallest to largest), and compared to their relevant Benjamini-Hochberg critical value, $(i/m)Q$, where i is rank, m is the total amount of tests, and Q is the false discovery rate (which has been set at .05 for the purposes of this research). The largest p value that is smaller than the critical value is significant, and all p values ranked prior to that are also significant.

5.3.5.4 Research samples

This chapter presents results from both study 2 ($n = 155$) and study 3 ($n = 45$), with some data (i.e. personality functioning facets) only being available for the latter, due to the psychometrics used within each study. Study 3 was only conducted with IPSO that demonstrated signs of PD (who will be referred to as IPSO with PD moving forward), however, it is important to bear in mind that this sample represents IPSO with signs of PD, rather than IPSO in general. Throughout the results sections within this chapter and chapter six, it will be made clear which sample is being analysed, referred to as either the main IPSO research sample ($n = 155$), or IPSO with PD ($n = 45$). For brevity's sake, where results are available for both samples, only the tables/figures relating to the main IPSO sample will be presented, and additional tables for IPSO with PD will be included in the appendices.

5.4 Results

5.4.1 Part A: Offence characteristics of IPSO

For the following characteristics, descriptive statistics were similar across both studies, therefore, data will only be presented for the larger study (study 2: $n = 155$).

5.4.1.1 Offence type

The offence type of IPSO was explored, and results are presented in table 8. Due to prison 1 being a treatment prison, residents tend to stay longer for treatment purposes, therefore, may be more likely to have longer sentences, which may explain the larger proportion of contact offences shown among this sample.

Table 8. Offence type of IPSO from both prison establishments

		IPSO sample		
		Overall	Prison 1	Prison 2
Offence Type	Contact	74%	79%	65%
	Non-contact (non-internet)	9%	6%	13%
	Internet	16%	13%	22%

5.4.1.2 Victim type

In terms of victim type, 67.7% of IPSO offended against a child, 21.3% offended against an adult, 9% offended against both adult and child, and 2% were unknown.

5.4.1.3 Victim sex

In relation to the sex of victims, the results indicate the following: 64.5% female, 20% male, 14.2% both male and female, and 1.3% unknown. Considering both victim type and victim sex, of the offences against children, 56% of victims were female, 26% were male, and 18% were both male and female. Of the offences against adults, 91% of offences were committed against females, and 9% against males. Offences against both children and adults are accounted for by 72% female victims, 7% male victims, and 21% both male and female victims.

5.4.1.4 Sexual attraction

Self-reported sexual attraction of IPSO was as follows: 24.5% reported a sexual attraction to children, 57.4% reported a sexual attraction to adults, and 17.4% were attracted to both children and adults.

Of the 24.5% of IPSO attracted to children, 6.5% reported paedophilic interests (prepubescent), 7.7% reported hebephilic interests (early pubescent), 10.3% demonstrated paedophephilia (both prepubescent and early pubescent), 57.4% reported teleiophilia (adults), and 17.4% were attracted to both children and adults.

Of note, when considering victim type, 67.7% of IPSO offended against a child, whereas, only 24.5% report a sexual attraction to children. Table 9 depicts IPSO self-reported sexual attraction compared to who they offended against.

Table 9. Descriptive statistics of IPSO self-reported attraction type x victim type

		Attraction Type			Total
		Child	Adult	Both	
Victim Type	Child	37 (35.2%)	52 (49.5%)	16 (15.2%)	105
	Adult	0 (0.0%)	31 (93.9%)	2 (6.1%)	33
	Both	1 (7.1%)	4 (28.6%)	9 (64.3%)	14
	Total	38	87	27	152

5.4.1.5 Summary

Overall, the IPSO sample used throughout this thesis predominantly committed a contact offence, mainly consisting of offences against children, with victims being mostly female. Although, over half of the sample self-reported being sexually attracted to adults rather than children.

5.4.2 Part B: Personality disorder among IPSO

This section will consider (i) the impairments in personality functioning (criterion A) present among IPSO, (ii) the prevalence of pathological personality traits (criterion B), and (iii) the prevalence rates of categorical PD diagnoses shown among IPSO.

5.4.2.1 Criterion A: Personality functioning

5.4.2.1.1 Impairments in personality functioning domains among IPSO

In the screening study ($n = 155$), personality functioning was assessed using three domains from the SIPP-SF (*self-control*, *identity integration* and *relational capacities*). Raw scores were converted to Z-scores and then T-scores, whereby scores less than 40 indicate impaired adaptive functioning, and less than 30 indicate severely impaired adaptive functioning (lower scores indicate worse functioning). Figure 8 depicts the percentage of IPSO that showed impairments in each domain.

As can be seen from figure 8, 44.5% of IPSO had impairments in both *identity integration* and *relational capacities*, and 32.3% showed impairments in *self-control*. Eighty-four IPSO (84.3%) showed impairments in either *identity integration* or *relational capacities* (criteria for study 3).

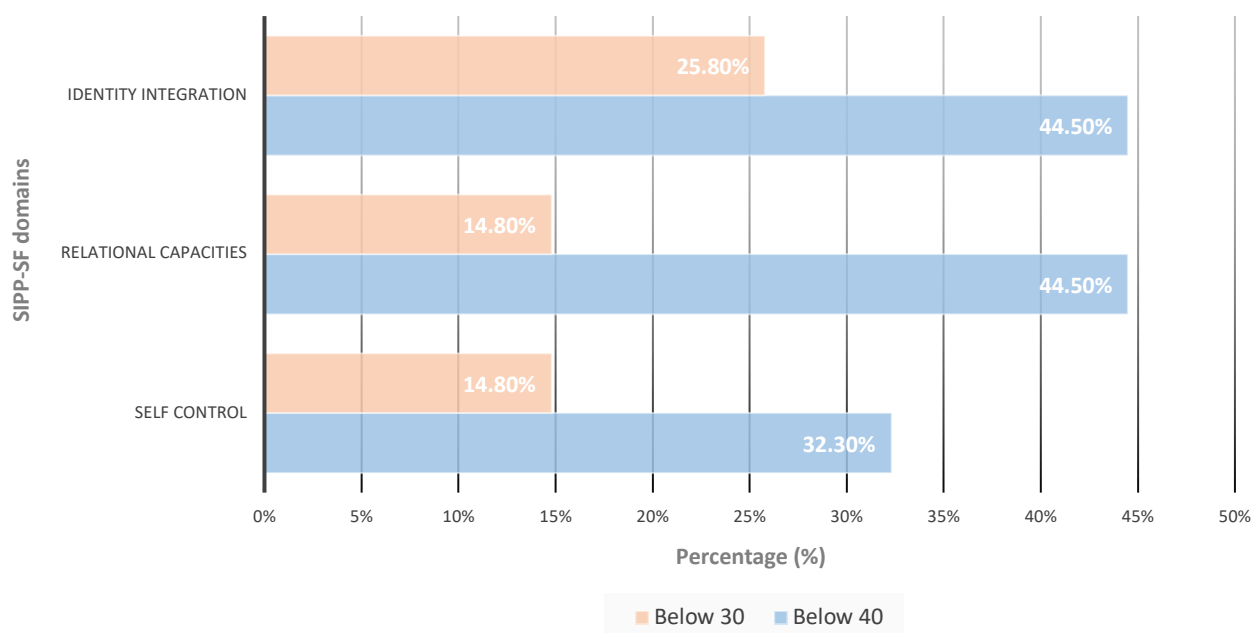


Figure 8. The percentage of IPSO that demonstrated impaired functioning on SIPP-SF domains

Table 10. One sample t-tests comparing the adaptive personality functioning (SIPP-SF domains) of IPSO to (i) a general population sample and (ii) MMPSA sample

SIPP-SF Domains	Research Population (n = 155)	Male General Population (n = 203)			MMPSA Population (n = 89)		
	M (SD)	M (SD)	t (df)	p	M (SD)	t (df)	p
Self-control	3.17 (.75)	3.32 (.61)	-2.14 (356)	.033*	2.54 (.66)	6.91 (232)	.001***
Identity integration	2.90 (.80)	3.47 (.58)	-7.80 (356)	.001***	2.74 (.50)	2.02 (232)	.045*
Relational capacities	2.71 (.69)	3.22 (.55)	-7.74 (356)	.001***	2.75 (.48)	-0.38 (232)	.466

Note. Significant at *.05 level, **.01 level, ***.001 level. SIPP-SF = Severity Indices of Personality Problems Short Form; IPSO = individual who has previously sexually offended; MMPSA = medication to manage problematic sexual arousal; PD = personality disorder. Lower scores equate to more impaired functioning.

5.4.2.1.2 SIPP-SF domains compared to the general population and IPSO taking MMPSA

A series of independent t-tests enabled comparisons of IPSO against non-offending males from the general population (data from study 1: validation study) and IPSO taking MMPSA, in terms of their adaptive personality functioning. Table 10 demonstrates that the research sample had significantly lower (worse) adaptive personality functioning than the general population sample on all three domains. In comparison to a sample of IPSO taking MMPSA, the research sample demonstrated no difference in terms of *relational capacities*, and significantly higher (better) functioning in the domains of *self-control* and *identity integration*. However, *identity integration* became non-significant after using the Benjamini-Hochberg procedure (please see appendix 20.1) indicating that the research sample more closely resembles that of IPSO taking MMPSA in terms of their personality functioning.

5.4.2.1.3 Impairments in personality functioning domains among IPSO with PD

In the further psychometric study (n = 45), personality functioning was measured using the SIPP-118, meaning that all 16 facets (subscales) were also explored. It is important to note here that study 3 was conducted with IPSO that demonstrated signs of PD (impairments in personality functioning and at least one pathological personality trait), therefore, this section on personality functioning is relevant to IPSO that demonstrate PD, rather than IPSO in general.

In terms of the five domains, 67% of IPSO with PD demonstrated impairments in *relational capacities*, 62% in *identity integration*, 60% in *self-control*, 56% in *responsibility* and 38% in *social concordance* (scores <40 indicate impaired functioning; figure 9). Comparing IPSO with PD to normative data consisting of a PD population (n = 55; Andrea et al., 2007), no significant differences were demonstrated

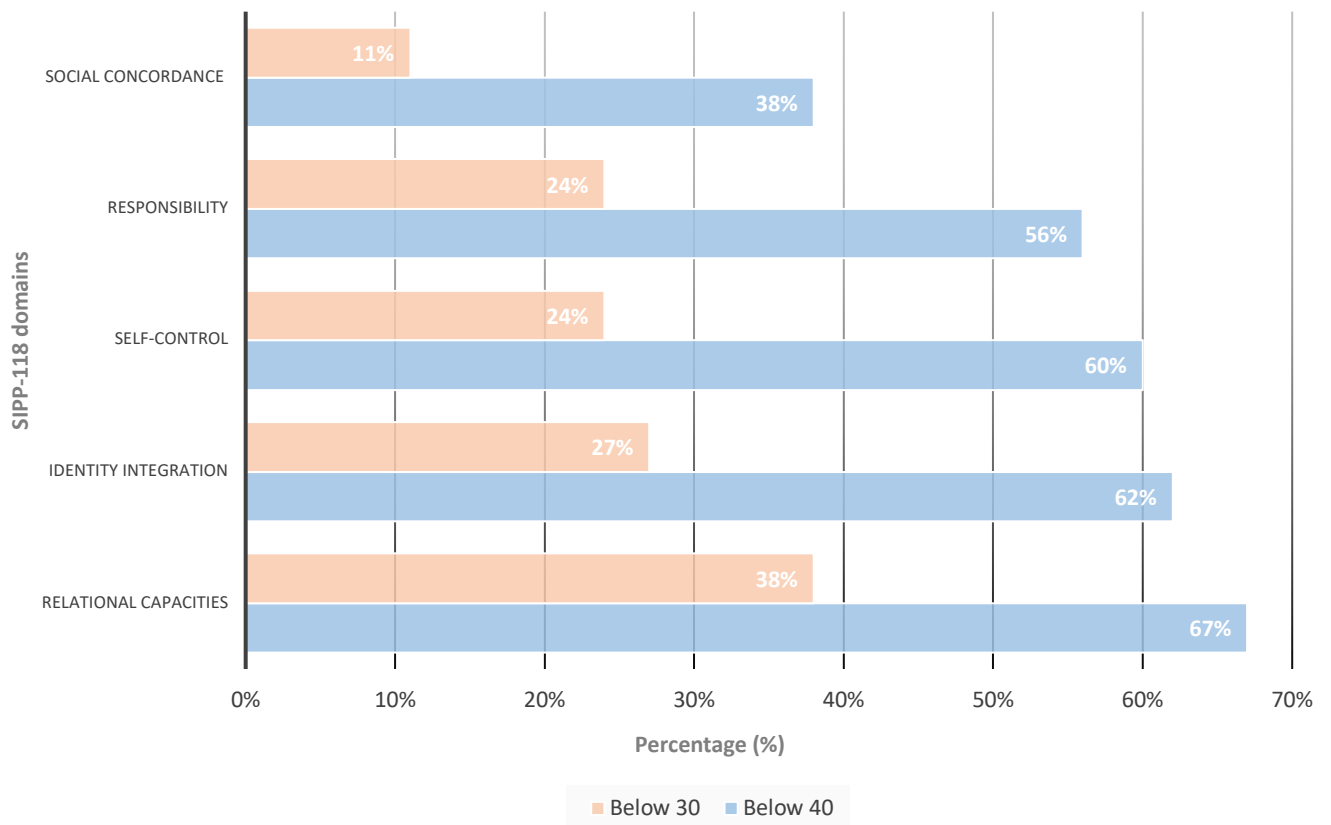


Figure 9. The percentage of IPSO with PD that demonstrated impaired functioning on SIPP-118 domains

among all five domains; *self-control* ($t(44) = -.18, p = .856$), *identity integration* ($t(44) = 1.61, p = .114$), *responsibility* ($t(44) = -.19, p = .854$), *relational capacities* ($t(44) = -1.86, p = .069$) and *social concordance* ($t(44) = -.27, p = .789$), indicating that the adaptive personality functioning of IPSO with PD closely resembles that of patients diagnosed with PD.

5.4.2.1.4 Impairments in personality functioning facets among IPSO with PD

The five domains of the SIPP-118 are broken down into 16 facets. The percentage of IPSO with PD that had impairments in each of these facets can be seen in figure 10. As can be seen, IPSO with PD were impaired the most in *self-reflexive functioning* (60%), *effortful control* (58%), *feeling recognised* (56%), *intimacy* (53%) and *self-respect* (49%).

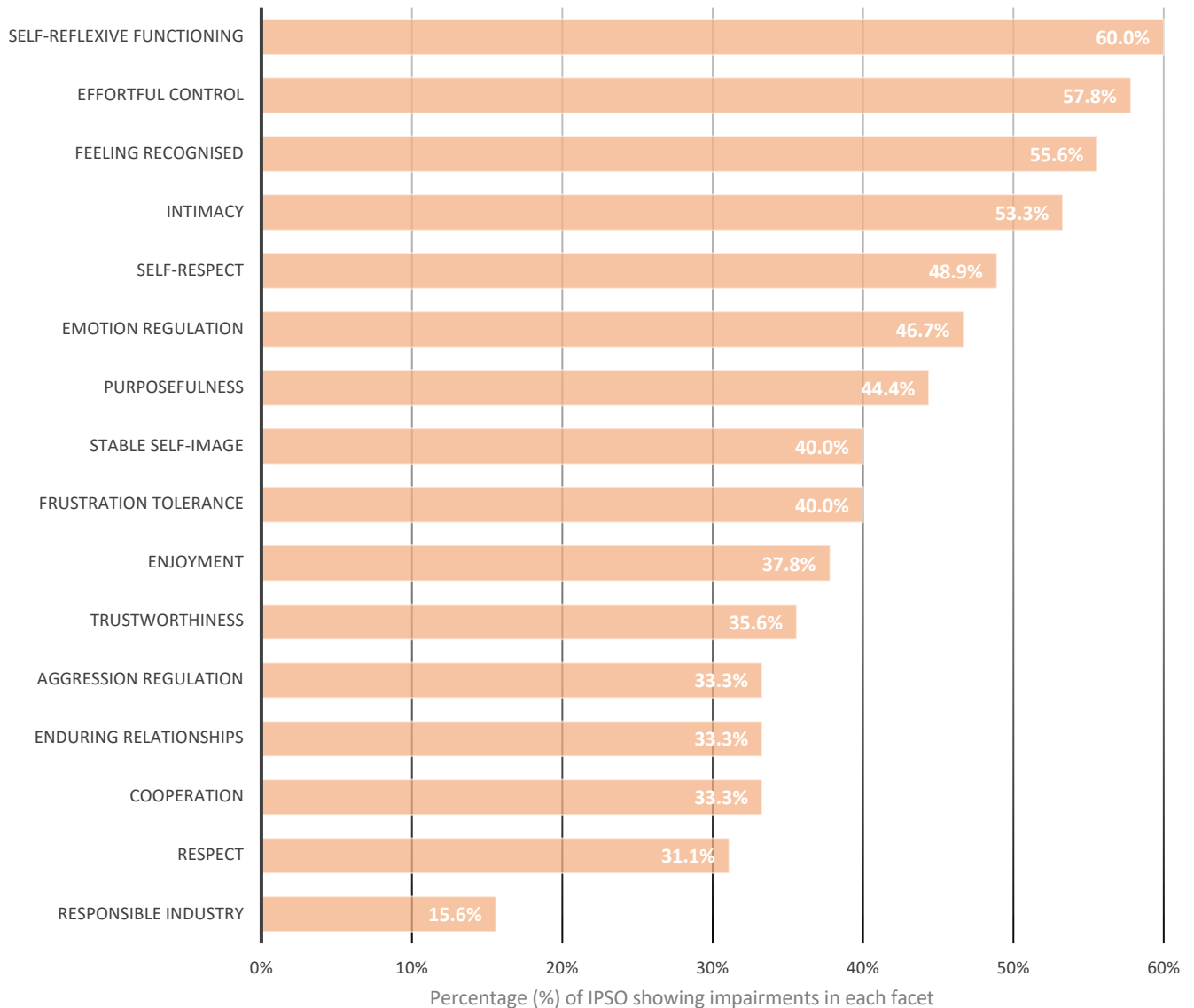


Figure 10. The percentage of IPSO with PD that demonstrated impairments in SIPP-118 facets

5.4.2.1.5 SIPP-118 facets compared to general, PD, and IPSO taking MMPSA populations

A series of one sample *t*-tests were conducted to compare IPSO with PD to SIPP-118 normative data, consisting of (i) a general population sample and (ii) a PD population sample (Andrea et al., 2007). The results demonstrate that IPSO with signs of PD had significantly lower (worse) adaptive personality functioning than the general population on all facets of the SIPP-118, excluding *respect*, where no significant difference was indicated (see table 11). In comparison to a PD population (non-offending), the research sample indicated significantly worse impairments in terms of *intimacy*, however, on over half of the facets, the research sample were not statistically different in comparison to the PD population. Therefore, this indicates that IPSO with PD (as identified using the AMPD screening tools and criteria) were similar to that of a general population PD sample on several characteristics. Nonetheless, IPSO with PD also demonstrated significantly higher (better) adaptive functioning than

Table 11. One sample t-tests and independent samples t-tests (MMPSA) comparing the adaptive personality functioning (SIPP-118 facets) of IPSO with PD to (i) a general population sample (ii) PD sample and (iii) MMPSA sample

SIPP-118 Facets	Research Population	General Population			PD Population			MMPSA population		
	(n = 45)	(n = 478)			(n = 555)			(n = 89)		
	M (SD)	M (SD)	t (df)	p	M (SD)	t (df)	p	M (SD)	t (df)	p
Emotion regulation	2.70 (.67)	3.30 (.61)	-6.05 (44)	.001***	2.44 (.69)	2.55 (44)	.014*	2.47 (.68)	-1.79 (132)	.075
Effortful control	2.43 (.75)	3.16 (.56)	-6.36 (44)	.001***	2.53 (.70)	-.88 (44)	.382	2.23 (.68)	-1.54 (132)	.127
Stable self-image	2.62 (.63)	3.24 (.67)	-6.67 (44)	.001***	2.21 (.66)	4.34 (44)	.001***	2.45 (.68)	-1.40 (132)	.163
Self-reflexive functioning	2.58 (.56)	3.20 (.45)	-7.36 (44)	.001***	2.51 (.57)	.89 (44)	.381	2.40 (.66)	-1.58 (132)	.118
Aggression regulation	3.18 (.82)	3.66 (.45)	-3.92 (44)	.001***	3.30 (.73)	-.96 (44)	.343	3.06 (.80)	-.84 (132)	.401
Frustration tolerance	2.52 (.55)	2.96 (.56)	-5.28 (44)	.001***	2.24 (.56)	3.46 (44)	.001***	2.39 (.58)	-1.29 (132)	.200
Self-respect	2.58 (.61)	3.30 (.59)	-8.01 (44)	.001***	2.36 (.67)	2.38 (44)	.022*	2.55 (.73)	-.17 (132)	.869
Purposefulness	2.75 (.64)	3.34 (.49)	-6.18 (44)	.001***	2.42 (.64)	3.44 (44)	.001***	2.75 (.65)	-.03 (132)	.978
Enjoyment	2.75 (.68)	3.34 (.62)	-5.86 (44)	.001***	2.32 (.64)	4.21 (44)	.001***	2.66 (.56)	-.80 (132)	.427
Feeling recognised	2.55 (.50)	3.23 (.56)	-9.18 (44)	.001***	2.63 (.62)	-1.11 (44)	.272	2.59 (.50)	.51 (132)	.611
Intimacy	2.42 (.67)	3.17 (.60)	-7.54 (44)	.001***	2.68 (.69)	-2.62 (44)	.012*	2.46 (.62)	.33 (132)	.743
Enduring relationships	2.45 (.76)	3.31 (.58)	-7.56 (44)	.001***	2.47 (.67)	-.14 (44)	.888	2.48 (.61)	.22 (132)	.828
Responsible industry	2.93 (.56)	3.44 (.50)	-6.15 (44)	.001***	2.87 (.67)	.73 (44)	.472	2.73 (.67)	-1.77 (132)	.079
Trustworthiness	3.13 (.51)	3.49 (.42)	-4.69 (44)	.001***	3.04 (.61)	1.23 (44)	.226	2.89 (.62)	-2.28 (132)	.024*
Respect	3.25 (.46)	3.34 (.45)	-1.25 (44)	.219	3.14 (.53)	1.65 (44)	.106	3.15 (.56)	-1.04 (132)	.302
Cooperation	3.02 (.61)	3.28 (.51)	-2.85 (44)	.007**	2.84 (.58)	1.96 (44)	.056	2.85 (.61)	-1.52 (132)	.130

Note. Significant at *.05 level, **.01 level, ***.001 level. SIPP-118 = Severity Indices of Personality Problems 118; IPSO = Individual who has previously sexually offended; PD = Personality disorder; MMPSA = medication to manage problematic sexual arousal. Lower scores equate to more impaired functioning.

the PD population on six facets (*emotion regulation, stable self-image, frustration tolerance, self-respect, purposefulness and enjoyment*).

A series of independent samples *t*-tests examined the differences in adaptive personality functioning between IPSO with PD and IPSO taking MMPSA. As can be seen in table 11, no significant differences were reported between the two samples on all SIPP-118 facets, except for *trustworthiness*, whereby IPSO with signs of PD demonstrated significantly higher (better) functioning than IPSO taking MMPSA. This suggests that the two samples demonstrate similar characteristics in terms of personality functioning, indicating that the sample of IPSO taking MMPSA may also demonstrate PD tendencies. After conducting the Benjamini-Hochberg procedure all significant results remained significant (see appendix 20.2).

5.4.2.2 Criterion B: Pathological personality traits

5.4.2.2.1 Pathological personality traits and trait domains among IPSO

Pathological personality traits were assessed by the PID-5-SF, which consists of 25 traits organised into five domains. The traits were often comorbid among IPSO, with 32% of the sample showing no elevated traits, 15% reporting one elevated trait, and 53% having two or more pathological personality traits (including two IPSO who demonstrated elevated scores in all 25 traits). The prevalence of elevated personality traits and domains among IPSO are presented in figure 11. As demonstrated, the main elevated trait domain among IPSO was *negative affect*, with 18.7% of IPSO showing dysfunction in this area (which consists of *anxiousness, emotional lability and separation insecurity*). In relation to pathological personality traits, *anxiousness* was the most common trait, with 31.6% of IPSO demonstrating dysfunction. *Anxiousness* (31.6%), *separation insecurity* (23.9%), *depressivity* (22.6%), *impulsivity* (21.9%) and *intimacy avoidance* (21.3%) were the five most prevalent pathological traits among IPSO.

5.4.2.2.2 Pathological personality traits and trait domains among IPSO with PD

In terms of the 45 IPSO who participated in study 3 (demonstrating signs of PD), over half of the sample demonstrated *anxiousness* (53%), and nearly half reported *depressivity* (49%). The top five most prevalent traits include *anxiousness* (53.3%), *depressivity* (48.9%), *suspiciousness* (37.8%), *impulsivity* (37.8%) and *separation insecurity* (37.8%). Similar to the main IPSO population, *negative affect* was the most prevalent domain, with 33.3% of IPSO with PD endorsing this domain. Furthermore, comorbidity of traits was extensive among IPSO with PD, whereby all participants showed at least one pathological personality trait, and 84% of the sample demonstrated three or more pathological personality traits (see appendix 21 for more details).

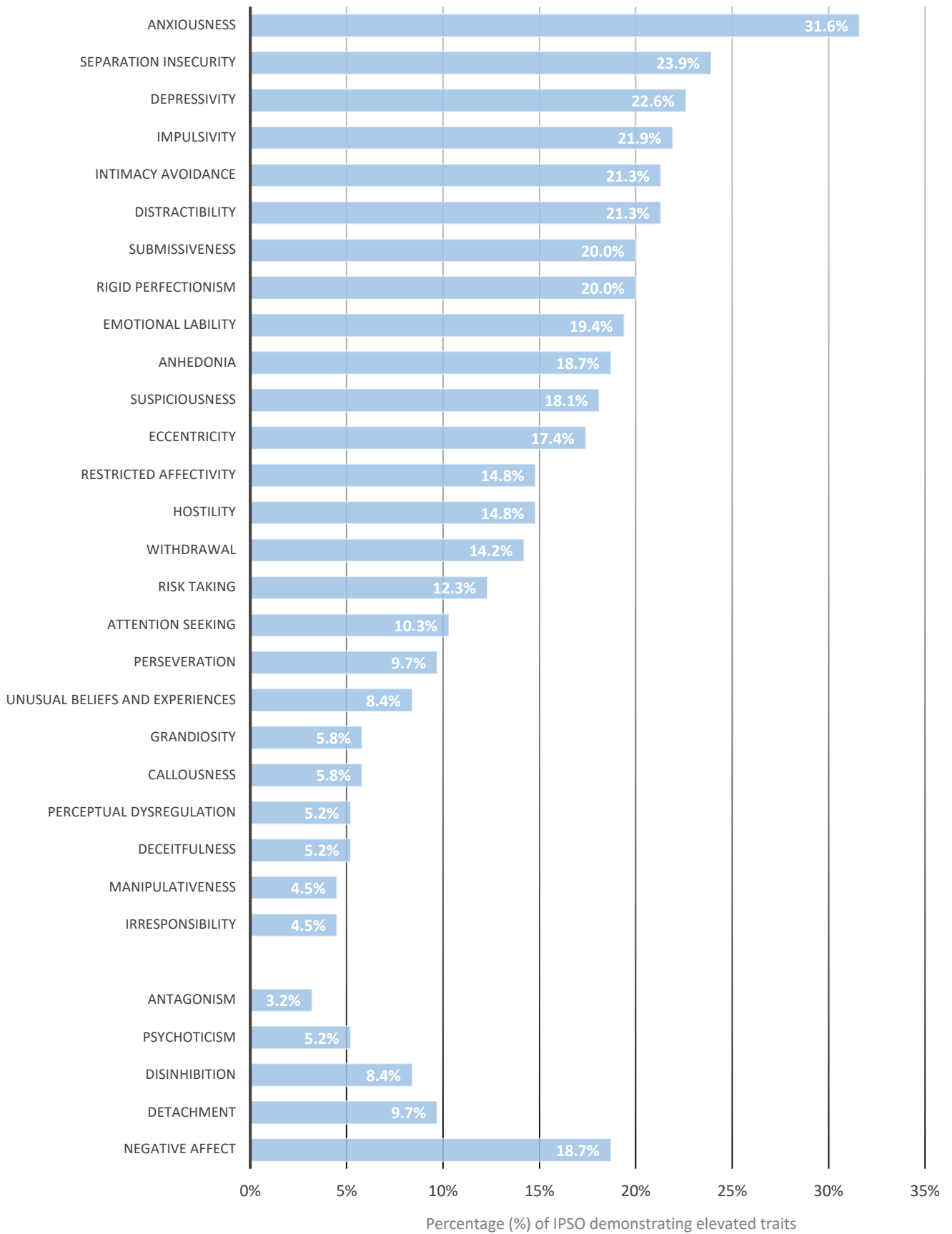


Figure 11. The percentage of IPSO that demonstrate elevated pathological personality traits and domains

5.4.2.2.3 PID-5-SF domains for IPSO compared to general and PD populations

The mean PID-5-SF domain scores were contrasted with a sample of non-offending males from the general population (data from Study 1: Validation study), and a sample of patients diagnosed with PD (mainly avoidant, obsessive-compulsive, dependent, paranoid PDs, and not otherwise specified [excluding borderline]; Bach, Sellbom, Bo & Simonsen, 2016). A series of one sample *t*-tests and independent samples *t*-tests (see table 12) revealed that the main IPSO sample demonstrated significantly more dysfunction in the domains of *negative affect* and *detachment* compared to the general population, however, revealed significantly less pathology than the PD population in these domains. In terms of *antagonism*, *disinhibition* and *psychoticism* no significant differences were reported between IPSO and the general population sample or patients with PD. This suggests that the main IPSO sample demonstrate greater pathology (in terms of *negative affect* and *detachment*) than the general population, but not to the extent of patients with PD.

5.4.2.2.4 PID-5-SF domains for IPSO with PD compared to general and PD populations

The sample of IPSO with PD (that met criteria for study 3) were compared to the general population and PD population samples. As can be seen from table 12, in comparison to the general population, IPSO with PD showed greater dysfunction in all domains except for *antagonism* where no significant difference was revealed. Furthermore, in comparison to the PD population, IPSO with PD demonstrated greater dysfunction in the realms of *disinhibition* and *psychoticism*, and were not significantly different in terms of the three remaining domains. However, the results for *psychoticism* became non-significant after adjusting for multiple tests using the Benjamini-Hochberg procedure (see appendix 20.3). Thus, the pathology of IPSO with PD more closely resembles that of PD patients, with a significant greater dysfunction in *disinhibition* (which consists of the facets *distractibility*, *impulsivity* and *irresponsibility*).

5.4.2.2.5 Pathological personality traits among IPSO compared to general and PD populations

The main sample of IPSO ($n = 155$) were compared to general population and PD population samples. A series of one sample *t*-tests were conducted to compare the personality traits of the main IPSO sample against general population normative data (Krueger et al., 2011) and a sample of patients diagnosed with PD (described above, Bach et al., 2016). In contrast to the general population, IPSO demonstrated significantly less pathology in the traits of *manipulativeness*, *grandiosity* and *risk taking*, however, scored significantly higher (more pathology) in *anxiousness*, *separation insecurity*, *intimacy avoidance*, *depressivity*, *irresponsibility*, *impulsivity* and *distractibility* (see table 13). No significant differences were demonstrated on the remaining fourteen pathological personality traits, suggesting that the main IPSO sample were comparable to the general population, excluding the seven traits where they demonstrated significantly more pathology.

Table 12. One sample t-tests and independent samples t-tests comparing personality trait domains (PID-5-SF) of IPSO and IPSO with PD to (i) a general population sample and (ii) a PD sample

PID-5-SF Domains	Research Population (IPSO) (n = 155)	Male General Population (n = 203)			PD Population (n = 101)		
	M (SD)	M (SD)	t (df)	p	M (SD)	t (df)	p
Negative Affect	1.16 (.79)	.85 (.65)	4.82 (356)	.001***	1.55 (.61)	-6.20 (154)	.001***
Detachment	1.01 (.67)	.72 (.61)	5.41 (356)	.001***	1.32 (.55)	-5.75 (154)	.001***
Antagonism	.48 (.60)	.50 (.55)	-.33 (356)	.741	.52 (.43)	-.74 (154)	.458
Disinhibition	.89 (.70)	.85 (.61)	.68 (356)	.499	.98 (.53)	-1.64 (154)	.102
Psychoticism	.68 (.69)	.73 (.64)	-.87 (356)	.386	.79 (.55)	-1.95 (154)	.053

PID-5-SF Domains	Research Population (IPSO with PD) (n = 45)	Male General Population (n = 203)			PD Population (n = 101)		
	M (SD)	M (SD)	t (df)	p	M (SD)	t (df)	p
Negative Affect	1.63 (.57)	.85 (.65)	9.24 (246)	.001***	1.55 (.61)	.97 (44)	.339
Detachment	1.38 (.49)	.72 (.61)	9.01 (246)	.001***	1.32 (.55)	.81 (44)	.420
Antagonism	.58 (.59)	.50 (.55)	.94 (246)	.351	.52 (.43)	.71 (44)	.480
Disinhibition	1.25 (.63)	.85 (.61)	4.24 (246)	.001***	.98 (.53)	2.85 (44)	.007**
Psychoticism	.99 (.66)	.73 (.64)	2.66 (246)	.011*	.79 (.55)	2.05 (44)	.045*

Note. Significant at *.05 level, **.01 level, ***.001 level. PID-5-SF = Personality Inventory for DSM-5 Short Form; IPSO = individual who has previously sexually offended; PD = personality disorder. Higher scores indicate greater pathology.

Table 13. One sample t-tests comparing pathological personality traits (PID-5-SF) of IPSO with (i) a general population sample and (ii) PD sample

PID-5-SF Traits	Personality	Research Population	General Population			PD Population		
		(IPSO) (n = 155)	(n = 264)			(n = 101)		
		M (SD)	M (SD)	t (df)	p	M (SD)	t (df)	p
Emotional lability		1.06 (.90)	.94 (.74)	1.66 (154)	.098	1.55 (.72)	-6.81 (154)	.001***
Anxiousness		1.31 (.94)	1.02 (.73)	3.81 (154)	.001***	1.84 (.66)	-7.04 (154)	.001***
Separation insecurity		1.10 (.90)	.80 (.68)	4.18 (154)	.001***	1.25 (.84)	-2.07 (154)	.040*
Submissiveness		1.11 (.77)	1.17 (.66)	-1.05 (154)	.296	1.67 (.84)	-9.10 (154)	.001***
Hostility		.88 (.82)	.91 (.67)	-.47 (154)	.639	.98 (.60)	-1.53 (154)	.128
Perseveration		.80 (.78)	.82 (.62)	-.35 (154)	.730	1.18 (.54)	-6.10 (154)	.001***
Withdrawal		1.04 (.77)	1.01 (.72)	.46 (154)	.645	1.43 (.67)	-6.29 (154)	.001***
Intimacy avoidance		1.05 (.89)	.61 (.65)	6.03 (154)	.001***	.83 (.76)	2.96 (154)	.004**
Anhedonia		.95 (.85)	.89 (.64)	.90 (154)	.367	1.71 (.63)	-11.15 (154)	.001***
Depressivity		1.03 (.94)	.53 (.62)	6.59 (154)	.001***	1.47 (.74)	-5.85 (154)	.001***
Restricted affectivity		.96 (.76)	.97 (.56)	-.22 (154)	.824	1.09 (.69)	-2.20 (154)	.029*
Suspiciousness		.99 (.81)	.95 (.58)	.57 (154)	.571	1.20 (.66)	-3.26 (154)	.001***
Manipulativeness		.54 (.65)	.80 (.67)	-5.04 (154)	.001***	.70 (.66)	-3.13 (154)	.002**
Deceitfulness		.49 (.69)	.53 (.54)	-.69 (154)	.490	.55 (.49)	-1.05 (154)	.294
Grandiosity		.43 (.67)	.82 (.58)	-7.31 (154)	.001***	.32 (.39)	1.93 (154)	.055
Attention seeking		.66 (.76)	.81 (.65)	-2.45 (154)	.016*	.72 (.58)	-.97 (154)	.332
Callousness		.44 (.70)	.40 (.50)	.78 (154)	.438	.29 (.39)	2.74 (154)	.007**
Irresponsibility		.58 (.66)	.39 (.49)	3.68 (154)	.001***	.73 (.51)	-2.78 (154)	.006**

Impulsivity	.97 (.93)	.77 (.57)	2.65 (154)	.009**	.77 (.66)	2.65 (154)	.009**
Distractibility	1.11 (.89)	.82 (.69)	4.08 (154)	.001***	1.45 (.78)	-4.70 (154)	.001***
Risk taking	.81 (.80)	1.05 (.51)	-3.84 (154)	.001***	.86 (.41)	-.86 (154)	.389
Rigid perfectionism	1.09 (.90)	1.06 (.68)	.40 (154)	.691	1.45 (.71)	-5.02 (154)	.001***
Unusual beliefs and experiences	.68 (.78)	.64 (.63)	-.65 (154)	.519	.54 (.56)	2.24 (154)	.027*
Eccentricity	.92 (.91)	.82 (.76)	1.38 (154)	.169	1.06 (.75)	-1.09 (154)	.059
Perceptual dysregulation	.44 (.69)	.44 (.48)	.06 (154)	.956	.75 (.57)	-5.52 (154)	.001***

Note. Significant at *.05 level, **.01 level, ***.001 level. PID-5-SF = Personality Inventory for DSM-5 Short Form; IPSO = individual who has previously sexually offended; PD = personality disorder. Higher scores indicate greater pathology.

In comparison to the PD population, the main IPSO sample demonstrated no significant differences on traits *hostility, deceitfulness, grandiosity, attention seeking, risk taking* and *eccentricity*, indicating that they show similar pathology to that of PD patients on these traits. Furthermore, IPSO demonstrated significantly greater dysfunction in *intimacy avoidance, callousness, impulsivity* and *unusual beliefs and experiences* compared to patients diagnosed with PD. In regard to the remaining 15 traits, IPSO scored significantly lower pathology than patients with PD. On 10 out of 25 personality traits IPSO demonstrated pathology similar or worse to that of PD patients, but, were not as impaired as PD patients on 15 of the traits. After conducting the Benjamini-Hochberg procedure, separation insecurity become non-significant, but all other results remained significant (see appendix 20.4).

5.4.2.2.6 Pathological personality traits among IPSO with PD compared to general and PD populations

Next, the sample of IPSO that demonstrated PD ($n = 45$) was compared to the general population and PD population samples, to establish which sample they were more comparable with (see appendix 22). Among the sample of IPSO with PD, they demonstrated significantly worse dysfunction on 17 out of 25 personality traits, were similar on seven traits, and revealed significantly less grandiosity than the general population, indicating that IPSO with PD have significantly more pathology than the general population sample. In comparison to patients diagnosed with PD, IPSO with PD displayed less pathology in the traits of *submissiveness* and *anhedonia*, were similar on 16 traits (no significant differences established), but, were significantly more impaired in *intimacy avoidance, depressivity, suspiciousness, callousness, impulsivity, unusual beliefs and experiences* and *eccentricity*. This shows that the personality trait profile

of IPSO with PD closely resembles that of patients diagnosed with PD, demonstrating worse pathology on seven of the personality traits. All results remained significant after the Benjamini-Hochberg procedure, other than the trait *depressivity* when compared to the PD population (see appendix 20.5).

5.4.2.3 Personality disorder diagnostic categories

Individual PDs were identified using the DSM-5 AMPD, whereby individuals must show impairments in personality functioning (criterion A) and pathological personality traits (criterion B). The AMPD describes six PDs that are retained in the model (*borderline, avoidant, schizotypal, narcissistic, obsessive-compulsive* and *antisocial*), however, this thesis also explores the remaining six PDs that were not retained (*paranoid, schizoid, dependent, depressive, histrionic* and *passive-aggressive*), as they have previously been found to be prevalent among IPSO. Therefore, PDs were identified if participants demonstrated impairments in *identity integration* or *relational capacities* (criterion A) and displayed personality traits relevant to each PD (please see appendix 9 for a breakdown of which pathological personality traits are associated with each PD).

5.4.2.3.1 Prevalence of PD among IPSO and IPSO with PD

Among the main sample of IPSO, 63% demonstrated PD or personality disorder trait specified (PDTs; 34% met specific criteria for specific PD categories, and 29% showed PDTs; impairments in personality functioning and at least one pathological personality trait). In relation to the IPSO with PD sample, all participants demonstrated PD (as this was a prerequisite for the study), with 67% meeting specific criteria for PD categories, and 33% showing PDTs).

The prevalence rates of PDs among the main IPSO sample and sample of IPSO with PD are presented in table 14. Among the main IPSO sample, *borderline* and *avoidant* PD were the most dominant retained PDs (14% and 11%, respectively), with *dependent* and *depressive* being the most prevalent PDs among the ones that are not retained in the new hybrid model (21% and 19%, respectively). Similar patterns were also demonstrated for the sample of IPSO with PD, with *borderline* (27%) and *avoidant* (13%) being the prominent retained PDs. In relation to PDs not retained, more wide-spread patterns were shown, with *dependent, depressive, schizoid* and *paranoid* PDs being prevalent in over 20% of the sample.

5.4.2.3.2 Comorbidity of PDs

In relation to the main IPSO sample, there was comorbidity among the PDs. Of the participants that met specific PD categories ($n = 52$), 29% presented with one PD, whereas the remaining 71% had two or more PDs, with two people demonstrating all twelve PDs. For the six retained PDs, 15% of the sample

Table 14. Prevalence rates of personality disorders reported among (i) IPSO and (ii) IPSO with PD samples

	Personality disorder	IPSO (n = 155)	IPSO with PD (n = 45)
PDs retained in DSM-5 AMPD	Borderline PD	14.19%	26.70%
	Avoidant PD	10.97%	13.30%
	Schizotypal PD	4.52%	8.90%
	Narcissistic PD	3.87%	4.40%
	Obsessive-compulsive PD	2.58%	4.40%
	Antisocial PD	1.29%	0.00%
PDs not retained in DSM-5 AMPD	Dependent PD	20.60%	40.00%
	Depressive PD	18.70%	35.60%
	Passive Aggressive PD	8.40%	15.60%
	Schizoid PD	7.70%	22.20%
	Paranoid PD	6.50%	22.20%
	Histrionic PD	5.20%	8.90%
	PDTS	29.00%	28.00%

Note. PD = Personality Disorder; IPSO = Individual who has previously sexually offended; DSM-5 = Diagnostic Statistical Manual of Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders; PDTS = personality disorder trait specified.

demonstrated one PD, and comorbidity among PDs was present in 8% of the sample. Of the six PDs that were not retained in the DSM-5 AMPD, 12% of the sample had one PD, whereas 20% demonstrated comorbidity, which is a common critique of the PD categories, and one of the reasons why these six PDs were not retained in the new hybrid model.

Similar patterns were shown among the IPSO with PD sample in terms of comorbidity. Of the participants that met specific PD categories ($n = 30$), 20% presented with one PD, whereas the remaining 80% had two or more PDs (with three PDs being the most common amount of comorbidity [33%]). For the six retained PDs, 40% of the sample demonstrated one PD, and comorbidity among PDs was present in 20% of the sample. Of the six PDs that were not retained in the DSM-5 AMPD, 27% of the sample had one PD, whereas 73% demonstrated comorbidity.

Among the top four prevalent PDs (*borderline, avoidant, dependent* and *depressive*), similar traits were shown across all four (see table 15). The trait *anxiousness* is present among all four PDs and is also the most prominent trait reported among IPSO. The traits *separation insecurity* and/or *depressivity* are also indicative of three of the most prevalent PDs and are the second and third most prevalent pathological personality traits.

Table 15. Personality traits associated with the four most prevalent PDs reported among IPSO

Borderline	Avoidant	Depressive	Dependent
Anxiousness	Anxiousness	Anxiousness	Anxiousness
Separation insecurity			Separation insecurity
Depressivity		Depressivity	
	Anhedonia	Anhedonia	
Emotional lability			
Impulsivity			
Risk taking			
Hostility			
	Withdrawal		
	Intimacy avoidance		
			Submissiveness

Note. PD = Personality Disorder; IPSO = Individual who has Previously Sexually Offended.

5.4.2.3.3 Prevalence of PD among IPSO compared to general and elderly IPSO populations

The prevalence rates of PD among IPSO ($n = 155$) were compared to the prevalence in a general population sample (using data from the British National Survey of Psychiatric Morbidity; Knudsen, Skogen, Harvey & Stewart, 2012) and a sample of IPSO from the UK (elderly IPSO; Fazel et al., 2002). The frequencies of PDs among IPSO were compared to these samples using binomial nonparametric tests. Odds ratios (OR) were used to compare the relative odds of an event occurring (e.g. having borderline PD) in one group with the odds of it occurring in another group (Szumilas, 2010). The OR were calculated as described above (see 5.3.5 Analysis for further details).

As can be seen from table 16, in comparison to the general population, the research sample (IPSO) had over 21 times the odds of experiencing *dependent* PD, almost 14 times the odds of *borderline* and *histrionic* PDs, just over 10 times the odds of *narcissistic* PD, and over twice the odds of presenting with *avoidant* PD (binomial tests revealed significant differences for these specific PDs; $p < .05$). The research sample also demonstrated significantly less likelihood of *obsessive-compulsive* and *schizoid* PDs in comparison to the general population. Additionally, no significant differences were demonstrated among IPSO and the general population for *schizotypal*, *antisocial* and *paranoid* PD.

Regarding the IPSO population sample (Fazel et al., 2002), they found zero incidences of *dependent*, *schizotypal*, *histrionic*, *narcissistic* or *borderline* PDs (among elderly IPSO), which consequently resulted in infinite ORs for these specific PDs. Therefore, the Haldane-Anscombe correction was used, which involves adding 0.5 to all cases which would usually result in a division by zero error, enabling the OR and CI to be calculated (Haldane, 1940). In relation to the elderly IPSO in the Fazel et al. (2002) study, the sample of general IPSO in this study were 52 times more likely to experience *dependent* PD, and 33 times more likely to have *borderline* PD. Additionally, the research sample were almost ten times more likely to present with *histrionic* (OR = 10.94), *schizotypal* (OR = 9.51) and *narcissistic* (OR = 8.09) PDs.

Contrariwise, the research sample were significantly less likely to have *obsessive-compulsive* and *antisocial* PDs in comparison to elderly IPSO from the UK. No significant differences were established for *avoidant*, *schizoid* and *paranoid* PDs, indicating that the research sample were similar to the IPSO sample in relation to these PDs. Due to multiple testing the Benjamini-Hochberg procedure was used, which revealed that all results remained significant after adjusting for multiple tests (see appendix 5.17.6).

Table 16. Prevalence of categorical personality disorders among IPSO compared to (i) a general population sample and (ii) elderly IPSO sample

Personality disorders	Research	General	Odds ratio (95% CI)	IPSO	Odds ratio (95% CI)
	Sample (IPSO) (n = 155)	population (n = 6,341)		population (n = 101)	
PDs retained in the DSM-5 AMPD	Borderline PD	14.2%	1.2%***	13.64 (8.23, 22.59)	0%*** 33.25 (1.99, 555.06)
	Avoidant PD	11.0%	4.8%***	2.45 (1.46, 4.1)	10.9% 1.01 (0.45, 2.25)
	Schizotypal PD	4.5%	2.3%	2.01 (0.92, 4.36)	0%*** 9.51 (0.53, 169.4)
	Narcissistic PD	3.9%	0.4%***	10.17 (4.11, 25.17)	0%*** 8.09 (0.45, 146.52)
	Obsessive-compulsive PD	2.6%	10.9%***	0.22 (0.08, 0.59)	9.9%*** 0.3 (0.1, 0.91)
	Antisocial PD	1.3%	3.9%	0.32 (0.08, 1.31)	5.0%* 0.25 (0.05, 1.32)
PDs not retained in the DSM-5 AMPD	Dependent PD	20.6%	1.2%***	21.45 (13.68, 33.63)	0%*** 52.29 (3.16, 864.92)
	Depressive PD	18.7%	-	-	-
	Passive Aggressive PD	8.4%	-	-	-
	Schizoid PD	7.7%	13.0%*	0.56 (0.31, 1.02)	9.9% .76 (0.32, 1.84)
	Paranoid PD	6.5%	6.4%	1.01 (0.53, 1.93)	4.0% 1.67 (0.51, 5.48)
	Histrionic PD	5.2%	0.4%***	13.75 (6.1, 30.99)	0%*** 10.94 (0.62, 192.61)

Note. IPSO = individual who has previously sexually offended; PD = personality disorder; DSM-5 = Diagnostic Statistical Manual for Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders; CI = confidence intervals. Significant at *.05 level, **.01 level, ***.001 level (please note SPSS does not produce coefficients for one sample binomial tests). Data not available for depressive and passive-aggressive PDs.

5.4.2.4 Summary

Almost half of IPSO demonstrated impairments in *identity integration* and *relational capacities*, with 84% of the sample having impairments in at least one of these areas (relevant to criterion A of the DSM-5 AMPD). In relation to pathological personality traits (criterion B), IPSO demonstrated the most dysfunction in the domain of *negative affect*, with the traits *anxiousness*, *separation insecurity*, *depressivity*, *impulsivity* and *intimacy avoidance* being the most prevalent. Compared to patients with PD, IPSO demonstrated greater dysfunction in *intimacy avoidance*, *callousness*, *impulsivity* and *unusual beliefs and experiences*.

Over 60% of IPSO met the criteria for PD, with *borderline* and *avoidant* PD being the most prevalent retained PDs, and *dependent* and *depressive* being the most dominant of PDs not retained in the AMPD. In comparison to the general population, IPSO were 21 times more likely to have *dependent* PD, 14 times more likely to have *borderline* and *histrionic* PDs, 10 times more likely to experience *narcissistic* PD and twice as likely to experience *avoidant* PD. Contrasted with another IPSO sample, the research sample were 52 times more likely to experience dependent PD, and 33 times more likely to report borderline PD.

In terms of IPSO that demonstrated PD, over 60% of the sample had impairments in *identity integration*, *relational capacities* and/or *self-control*, whereby the most dominant impairments were in the following five facets: *self-reflexive functioning*, *effortful control*, *feeling recognised*, *intimacy*, and *self-respect*. IPSO with PD demonstrated similar patterns of adaptive functioning compared to normative data of patients with PD. In relation to criterion B, IPSO with PD also demonstrated the greatest dysfunction in the realm of *negative affect*, with *anxiousness*, *depressivity*, *suspiciousness*, *impulsivity* and *separation insecurity* being the most dominant traits. IPSO with PD demonstrated greater dysfunction on seven of the pathological personality traits compared to patients diagnosed with PD.

5.4.3 Part C: Sexual preoccupation among IPSO

5.4.3.1 Sexual compulsivity scores

5.4.3.1.1 SCS scores among IPSO

The mean SCS score among the research sample ($n = 155$) was 1.66 ($SD = .76$), which overall, is higher than the 1.5 cut-off that is used to refer IPSO for MMPSA within HMPPS. In order to explore the sample in more depth, the main sample of IPSO was divided into IPSO that demonstrated SP (SCS scores of 1.5 or higher), and those that did not demonstrate SP, whereby 45% (69 out of 155) of IPSO showed an average score of 1.5 or above on the SCS. When splitting the group into two, the mean for IPSO with SP was 2.3 ($SD = .70$), and 1.14 ($SD = .21$) for those without. Additionally, of the 45 IPSO that demonstrated PD, 67% met the criteria for SP.

Of the 45% of the main IPSO sample that demonstrated SP, 66.2% of these offended against children, 17.7% against adults, and 16.1% against both children and adults, with a chi-square test for independence indicating a significant difference between the three victim groups and the prevalence of SP ($\chi^2(2, n = 152) = 7.57, p = .023, v = .22$). When considering the difference between the two prison establishments, 43% of IPSO residing at the prison that includes the MMPSA pathway demonstrated SP (prison 1), and 47% of IPSO from prison 2 also met the criteria.

5.4.3.1.2 SCS scores compared to general, IPSO, and IPSO taking MMPSA populations

The mean SCS scores were contrasted with the following three samples: (i) general population (male students), (ii) main IPSO population at Prison 1, (iii) IPSO taking MMPSA at Prison 1 (Winder, Hocken, Lievesley, Elliott, Norman & Payne, 2013). As demonstrated in figure 12, the mean of the IPSO total sample for this study was similar to that of male students and the main IPSO population at Prison 1, whereas, when the sample was split in two, IPSO with SP more closely resembled that of IPSO taking MMPSA.

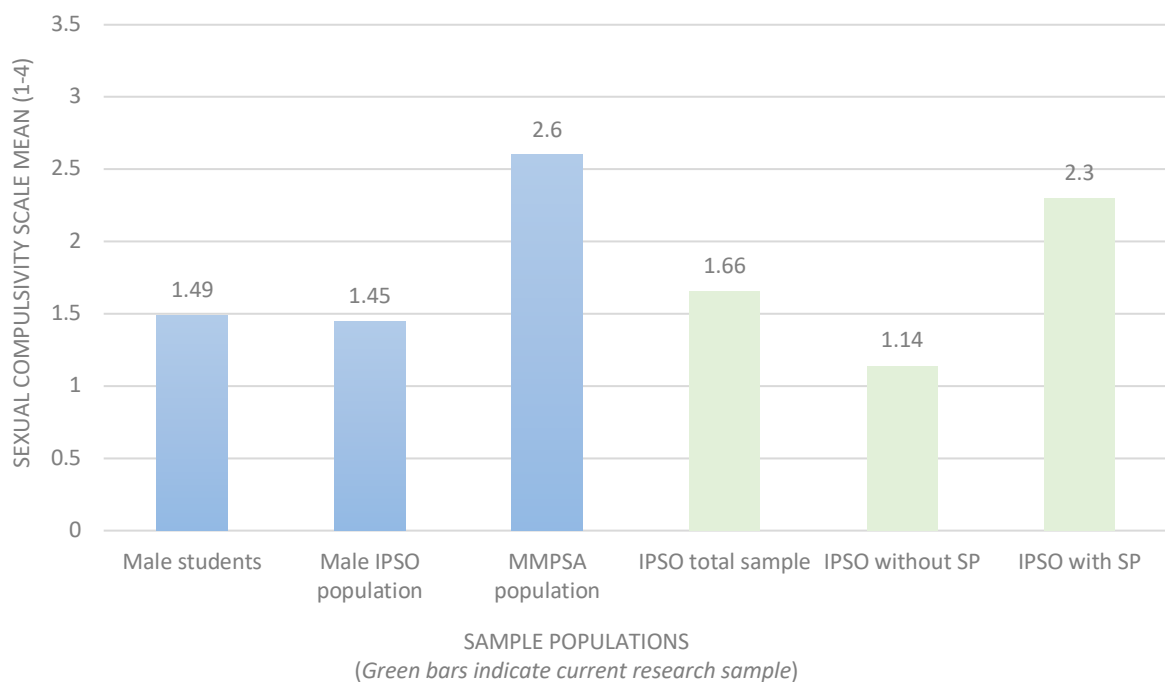


Figure 12. Comparison of SCS mean scores among varying populations of students, IPSOs and IPSOs taking MMPSA

A series of one sample *t*-tests and independent samples *t*-tests (for MMPSA sample) were conducted to compare the research sample to the three samples described above. The results are presented in table 17, which demonstrates that the SCS scores for the main IPSO sample was significantly higher than the male student and IPSO sample, but significantly lower than individuals taking MMPSA. When the research sample was split into IPSO with or without SP, IPSO without SP scored significantly lower than all three samples, whereas, IPSO with SP had significantly higher SCS scores than male students

and the general IPSO population but were significantly lower than IPSO taking MMPSA. After using the Benjamini-Hochberg procedure all results remained significant (see appendix 20.7). Of note, SCS mean scores from the third study ($n = 45$) were similar to the screening study ($n = 155$), resulting in comparable results as reported. Therefore, for the sake of brevity, results are only displayed for the larger sample size.

Table 17. One sample *t*-tests and independent samples *t*-tests comparing sexual compulsivity scores of the research sample to (i) male students, (ii) male IPSO, and (iii) IPSO taking MMPSA

	Research Population		Male Students		Male IPSO population			MMPSA population		
	<i>M</i>	<i>M</i>	<i>t</i> (<i>df</i>)	<i>p</i>	<i>M</i>	<i>t</i> (<i>df</i>)	<i>p</i>	<i>M</i>	<i>t</i> (<i>df</i>)	<i>p</i>
IPSO total	1.66	1.49	2.71 (154)	.008**	1.45	3.36 (154)	.001***	2.6	-9.32 (232)	.001***
IPSO without SP	1.14	1.49	-15.41 (85)	.001***	1.45	-13.67 (85)	.001***	2.6	-18.65 (174)	.001***
IPSO with SP	2.3	1.49	9.72 (68)	.001***	1.45	10.20 (68)	.001***	2.6	-2.24 (155)	.027*

Note. Significant at *.05 level, **.01 level, ***.001 level. IPSO = individual who has previously sexually offended; SP = sexual preoccupation; MMPSA = medication to manage problematic sexual arousal. Student sample, main IPSO sample and MMPSA sample taken from Winder et al. (2013).

5.4.3.2 MPI score

The mean MPI score among the research sample ($n = 45$) was 4.98 ($SD = 5.00$). A series of one sample *t*-tests were used in order to compare the research sample ($n = 45$) to MPI development data, which was conducted with intellectually disabled IPSO (medium risk, high risk, and very high-risk IPSO; Williams, 2005). In terms of the *obsessed with sex* subscale of the MPI (higher scores indicate greater sexual preoccupation), statistically significant differences were reported between the research sample ($M = 4.98$, $SD = 5.00$) and medium risk IPSO ($M = 1.38$, $t(44) = 4.83$, $p < .001$), high risk IPSO ($M = 1.53$, $t(44) = 4.95$, $p < .001$), and very-high risk IPSO ($M = 1.29$, $t(44) = 4.62$, $p < .001$), indicating that the research samples sexual preoccupation scores were significantly higher than intellectually disabled IPSO.

When splitting the sample between IPSO that show SP according to the MMPSA referral criteria ($n = 30$) and those that do not ($n = 15$), the mean *obsessed with sex* subscale score for IPSO with SP was 6.73 and 1.47 for those without SP. IPSO that did not demonstrate SP showed no significant differences compared to medium risk IPSO ($M = 1.38$, $t(14) = .19$, $p = .852$), high risk IPSO ($M = 1.53$, $t(14) = -.14$, $p = .892$), and very-high risk IPSO ($M = 1.29$, $t(14) = .39$, $p = .704$). Whereas, IPSO with SP demonstrated significantly more sexual preoccupation than medium risk IPSO ($M = 1.38$, $t(29) = 5.65$, $p < .001$), high

risk IPSO ($M= 1.53$, $t(30) = 5.50$, $p < .001$), and very-high risk IPSO ($M= 1.29$, $t(30) = 5.75$, $p < .001$). After using Benjamini-Hochberg procedure all results remained significant (see appendix 20.8).

5.4.3.3 Summary

Overall, in comparison to student and general IPSO populations, the current research sample of IPSO demonstrated higher rates of sexual preoccupation, but, significantly lower scores in comparison to the MMPSA sample. When the main sample of IPSO were split into IPSO that demonstrated SP and those that did not (using the service cut-off of 1.5), 45% of the main IPSO sample demonstrated SP. Similarly, those with SP showed significantly more SP than the student and general IPSO samples, but less compared to IPSO taking MMPSA. Further corroboration of SP was evidenced by the scores on the MPI, whereby IPSO that did not meet the criteria for SP showed no differences compared to normative data, but those with SP demonstrated significantly higher scores compared to medium, high, and very-high risk IPSO.

5.4.4 Part D: Adverse childhood experiences among IPSO

5.4.4.1 ACE score

5.4.4.1.1 Prevalence of ACEs among IPSO with PD

The prevalence of ACEs among IPSO with signs of PD was also explored ($n = 45$). It is important to highlight here that study 3 was only conducted with IPSO that demonstrated signs of PD, therefore, the prevalence rates of ACEs are not among IPSO in general, but specifically among IPSO that show PD. In terms of the total ACE score, the mean for IPSO with PD was 4.18 ($SD = 2.10$), which is significantly higher than that of the general population ($M = 1.61$, $SD = 2.07$; $t(44) = 8.19$, $p < .001$; Ford et al., 2014), and a general IPSO sample ($M = 3.50$, $SD = 2.74$; $t(44) = 2.16$, $p < .05$; Levenson et al., 2016).

Figure 13 depicts the proportion of IPSO with PD that endorsed each ACE item. Childhood maltreatment was particularly prominent among this population, with over three quarters of IPSO with PD endorsing *physical* and *verbal abuse*, and over half reporting *sexual abuse* (76%, 76% and 58%, respectively). Household dysfunction was also common, whereby nearly half reported *parental separation* and *domestic violence* (47% and 44%, respectively), and greater than one third of participants endorsing *mental illness* (42%) and *alcohol abuse* (38%). In terms of the distribution of ACE scores, all of the IPSO with PD experienced at least one ACE before the age of 18 years, with over half experiencing four or more ACEs (58%), suggesting that the research sample experienced several maltreatments and co-occurring household dysfunction.

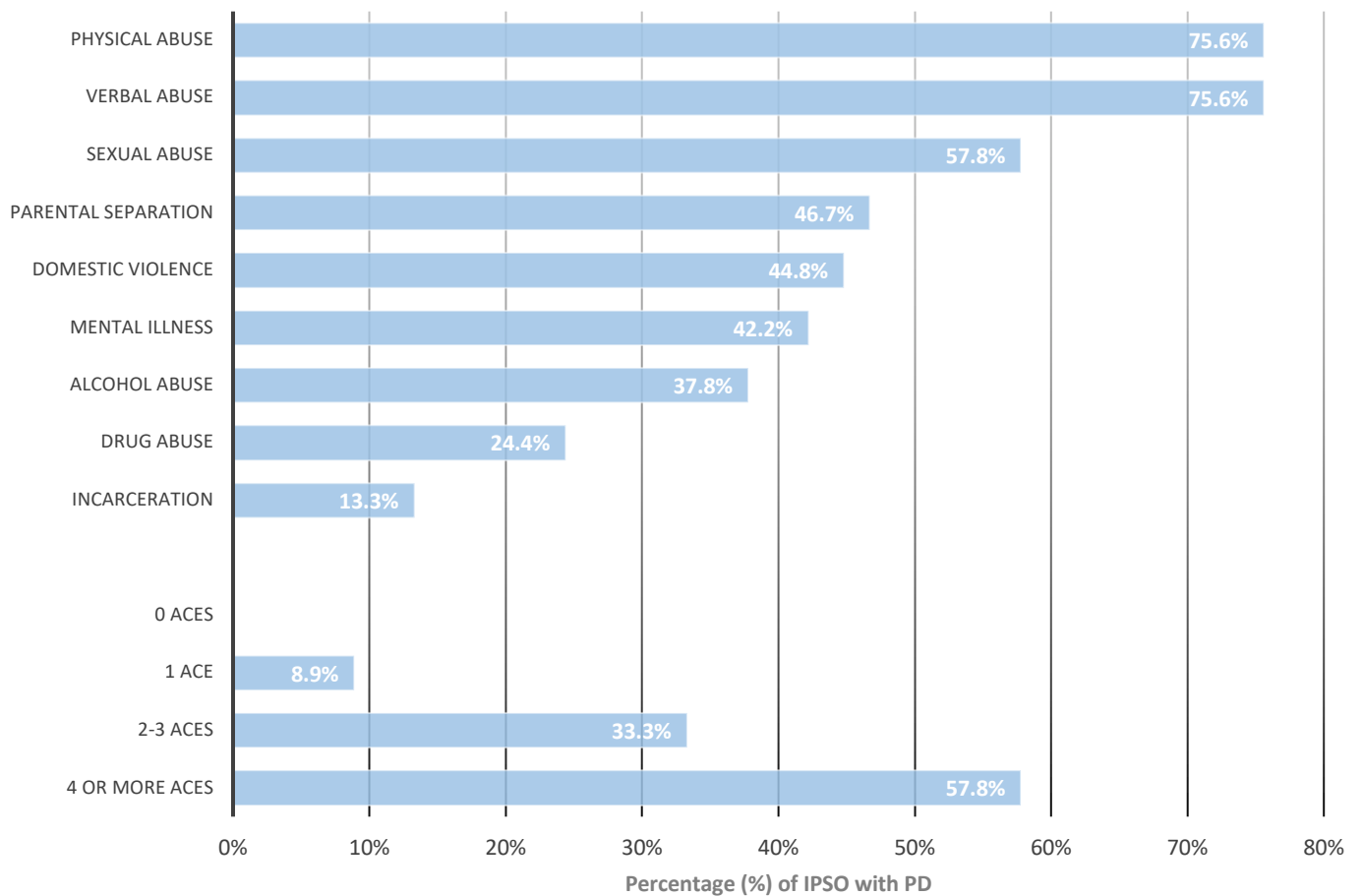


Figure 13. Prevalence rates and distribution of ACEs among IPSO with PD

5.4.4.1.2 Prevalence of ACEs compared to general, prison, IPSO and psychiatric populations

Table 18 shows the proportion of IPSO with PD endorsing each ACE item compared with prevalence in a general population sample (from England; Ford et al., 2016), general prison population sample (from Wales; Ford et al., 2019), and an IPSO population (from US; Levenson et al., 2016). The results were also compared to a community IPSO sample from England (Craissati & Blundell, 2013) and a psychiatric population (Stinson, Quinn & Levenson, 2016), however, only data in relation to childhood maltreatment (verbal abuse, physical abuse and sexual abuse) was available for the English IPSO sample and the psychiatric population. Comparative ACE data were not available among a PD specific sample; therefore, a forensic inpatient psychiatric sample was used (data used in relation to males only; participants had committed violent or sexual offences; psychiatric diagnoses included intellectual disability, mood disorder, psychosis spectrum disorders, personality disorders).

Odds ratios (OR) were used to compare the relative odds of an event occurring (e.g. childhood physical abuse) in one group with the odds of it occurring in another group (Szumilas, 2010). OR were calculated as described above (see 5.3.5 Analysis for further details). In each category, the IPSO with PD reported higher prevalence rates than the general population, with binomial tests revealing that all differences

were statistically significant ($p < .01$; see table 18). IPSO with PD were 22 times more likely to experience child *sexual abuse*, 20 times more likely to report *physical abuse*, 11 times more likely for *verbal abuse*, and over four times more likely to experience all household dysfunctional items compared to the general population in England.

Regarding the general prison population, IPSO with PD reported significantly higher rates of child maltreatment, whereby the research sample had six times the odds of *sexual abuse*, almost five times the odds of *physical abuse*, and three times the odds of *verbal abuse*. In terms of household dysfunction, the research sample were almost twice as likely to report *mental illness* in the family household than general prisoners but were significantly less likely to have *incarcerated family members*. No significant differences were indicated among the other factors relating to household dysfunction.

In comparison to a sample of male IPSO (from the US), the research sample had more than four times the odds of *physical abuse*, nearly three times the odds of *verbal abuse*, and just over two times the odds of child *sexual abuse*. In terms of household dysfunction, IPSO with PD were more likely to report *domestic violence* and *mental illness* within the family home but were less likely to report *drug abuse* than the IPSO sample.

Results for the UK IPSO sample and psychiatric population were not presented within the table, as data were only available for *verbal*, *physical* and *sexual abuse*. However, in comparison to the UK IPSO sample, the current research sample were five times more likely to experience *physical abuse* (OR = 5.39, 95% CI = 2.92, 9.95), almost three times more likely to report *verbal abuse* (OR = 2.95, 95% CI = 1.60, 5.35), and over twice as likely to have been *sexually abused* as a child (OR = 2.25, 95% CI = 1.28, 3.97; all binomial tests were significant, $p < .01$).

Furthermore, in comparison to the psychiatric population, IPSO with PD had more than nine times the odds of *verbal abuse* (OR = 9.01, 95% CI = 5.37, 15.18), over three times the odds of *physical abuse* (OR = 3.56, 95% CI = 2.16, 5.95), and almost two times the odds of *sexual abuse* (OR = 1.84, 95% CI = 1.16, 2.87; all binomial tests were significant, $p < .05$). Due to multiple testing the Benjamini-Hochberg procedure was used, which revealed that all results remained significant after adjusting for multiple tests (see appendix 20.9).

Among the forensic psychiatric population, Stinson et al. (2016) reported that 75% of the sample experienced at least one form of childhood maltreatment (physical, verbal or sexual abuse). In the current sample of IPSO with PD, 98% reported at least one of these. As can be seen in the lower half of table 18, compared to the general population, IPSO with PD had 14 times the odds of experiencing four or more ACEs, and over 1.5 times the odds compared to the general prison population and IPSO samples.

Table 18. ACE item comparisons between IPSO with PD and (i) a general population sample, (ii) general prison population sample, and (iii) IPSO sample

ACE Items	IPSO with PD	General population	Odds ratio (95% CI)	Prison population	Odds ratio (95% CI)	IPSO population	Odds ratio (95% CI)
	(n = 45)	(n = 5,454)		(n = 470)		(n = 679)	
Verbal abuse	76%	23%***	10.60 (5.23, 20.49)	50%***	3.17 (1.73, 5.79)	53%**	2.81 (1.37, 5.50)
Physical abuse	76%	14%***	19.45 (9.57, 57.61)	41%***	4.56 (2.48, 8.37)	42%***	4.40 (2.13, 8.57)
Sexual abuse	58%	6%***	21.56 (11.75, 39.17)	18%***	6.29 (3.30, 12.01)	38%**	2.25 (1.21, 4.12)
Parental separation	47%	18%***	4.03 (2.21, 7.19)	58%	0.64 (0.37, 1.12)	54%	0.76 (0.41, 1.36)
Domestic violence	44%	16%***	4.16 (2.32, 7.59)	40%	1.18 (0.67, 2.07)	24%**	2.50 (1.37, 4.68)
Mental illness	42%	11%***	5.81 (3.25, 10.75)	28%*	1.86 (1.03, 3.36)	26%*	2.06 (1.12, 3.84)
Alcohol abuse	38%	11%***	4.94 (2.67, 9.03)	31%	1.36 (0.76, 2.45)	47%	0.69 (0.37, 1.28)
Drug abuse	24%	4%***	7.58 (3.89, 15.54)	32%	0.67 (0.36, 1.25)	47%**	0.36 (0.18, 0.73)
Incarceration	13%	3%**	4.81 (2.07, 11.89)	33%**	0.30 (0.15, 0.62)	23%	0.50 (0.21, 1.24)
0 ACEs	0%	56%	0.01 (0.0, 0.14)	16%	0.01 (0.00, 0.96)	16%	0.01 (0.00, 0.96)
1 ACE	9%	18%	0.45 (0.16, 1.24)	18%	0.45 (0.19, 1.06)	14%	0.61 (0.21, 1.71)
2-3 ACEs	33%	17%	1.96 (1.31, 1.56)	21%	1.85 (0.98, 3.50)	25%	1.48 (0.79, 2.85)
4+ ACEs	58%	9%	13.94 (7.6, 25.17)	46%	1.62 (0.87, 2.96)	46%	1.62 (0.87, 2.96)

Note. ACE = Adverse Childhood Experiences; IPSO = individual who has previously sexually offended; PD = personality disorder; CI = confidence intervals. Significant at *.05 level, **.01 level, ***.001 level (please note SPSS does not produce coefficients for one sample binomial tests).

5.4.4.1.3 Composite scores compared to the general population

Finally, composite scores for *household dysfunction*, *physical/emotional abuse*, and *sexual abuse* were explored in comparison to the general population (composite scores enable the ACE data to be analysed continuously and are used in Chapter Six for further analytical purposes). A series of one sample *t*-tests enabled comparisons between the research sample ($n = 45$) and the general population ($n = 57,703$; Ford et al., 2014) in relation to the three composite scores. A statistically significant difference was reported for *household dysfunction*, $t(44) = 4.24, p < .001$, indicating that IPSO with PD ($M = 1.64, SD = 1.38$) reported more *household dysfunction* than the general population ($M = 0.77, SD = 1.12$). A statistically significant difference was also established for *physical/emotional abuse*, $t(44) = 8.44, p < .001$, demonstrating that IPSO with PD ($M = 1.96, SD = 1.02$) reported more *physical/emotional abuse*

than the general population ($M = 0.67, SD = 0.94$). Additionally, a statistically significant difference was revealed for *sexual abuse*, $t(44) = 5.81, p < .001$, demonstrating that the research sample ($M = 1.33, SD = 1.30$) reported more *sexual abuse* than the general population ($M = 0.21, SD = 0.64$).

5.4.4.2 Summary

Among the sample of IPSO with PD, all IPSO experienced at least one ACE, with over half of the sample reporting four or more ACEs. Childhood maltreatment was common, whereby over three quarters of the sample had been *physically or verbally abused* as a child, and over half had been *sexually abused*. Additionally, *household dysfunction* was also typical among IPSO with PD. IPSO with PD were 22 more times likely to have been *sexually abused* as a child in comparison to the general population, over six times more likely compared to general prisoners, and twice as likely compared to IPSO and psychiatric patients. IPSO with PD reported 20 times the odds of *physical abuse* in contrast to the general population, four/five times that of general prison and IPSO samples, and three times against a psychiatric sample. Furthermore, in terms of *verbal abuse*, IPSO with PD were eleven times more likely to experience this than the general population, nine times compared to a psychiatric population, and three times the odds of general prisoner and IPSO samples.

5.5 Discussion

5.5.1 Offence characteristics

The findings revealed that the majority of the IPSO sample used throughout this thesis committed a contact offence, with over two thirds of the sample offending against a child, and almost two thirds of victims being female. This aligns with the overall IPSO sample residing at Prison 1, as approximately 70% have committed sexual offences against children (Bloomstein, 2015). Interestingly, although a large proportion of the sample offended against children, only a quarter of the sample reported a sexual attraction to children, corroborating previous research which shows 40-50% of those who offend against children do not have paedophilic interests (i.e. they do not have a preferential attraction to children; Blanchard et al., 2001; Schaefer et al., 2010; Seto et al., 2004). Research suggests that IPSO who offend against children do so without a sexual attraction to children and may do so because they lack essential social skills required to create and sustain emotional and sexual relationships with appropriately aged peers, therefore, they may use children as a kind of 'surrogate' partner (Bejer, 1998; Mokros et al., 2012; Seto, 2008). However, due to the data being self-report, the sexual attraction to children may be under reported because of the stigma attached to this sexual attraction (Harper, Bartels & Hogue, 2016). Additionally, the preferential attraction of IPSO was not taken into account, however, research suggests there may be differences among IPSO who are exclusively attracted to children and those who are not (McPhail, Olver, Brouillette-Alarie & Loomans, 2018).

5.5.2 Personality disorders

Among the sample of IPSO, 63% met the criteria for PD, which is in line with previous research (Borchard, Gnoth & Schulz, 2003; Chen et al., 2016; Craissati & Blundell, 2013; Dunsieith et al., 2004; Kingston et al., 2015; McElroy et al., 1999). Comorbidity of PDs was also found among the sample of IPSO, with 71% of IPSO demonstrating two or more PDs, which is considerably higher in comparison to previous research (McElroy et al., 1999; Dunsieith et al., 2004; Craissati & Blundell, 2013). However, when focusing specifically on the six PDs that were retained according to the DSM-5 AMPD (which aims to reduce comorbidity among PDs), comorbidity was only present among 8% of the sample, indicating that the rate of comorbidity improved when focusing on the six PDs that have been demonstrated to empirically exist (according to the DSM-5 AMPD). The findings from this study challenge previous research which suggests that antisocial PD is the most common PD among IPSO (Chen et al., 2016; Kingston et al., 2015; Sigler, 2017), as it provides evidence that a range of PDs are prevalent among IPSO, similar to what was found by Craissati and Blundell (2013), Francia et al. (2010), and Perrot et al. (2014).

The results reveal that dependent, depressive, borderline and avoidant PDs were the most prevalent among IPSO, although all twelve PDs were present among the sample, with antisocial PD being the least prevalent. This provides support for Francia et al.'s (2010) proposal that IPSO are more likely to have PDs relating to emotional and social distress. The research sample were significantly more likely to experience dependent, borderline, histrionic and narcissistic PDs when compared to general and IPSO samples, and twice as likely to present with avoidant PD than the general population. These results support previous research which indicates that IPSO are more likely to present with avoidant, dependent and depressive PDs in comparison to non-IPSO, who have previously been reported to present with more narcissistic and antisocial PDs (Ahlmeyer et al., 2003; Francia et al., 2010; Perrot et al., 2014), whilst also finding that borderline PD was highly prevalent among the sample, which is in line with previous research (Borchard et al., 2003; Dunsieith et al., 2004; Sigler, 2017). In particular, compared to the two UK studies, these results support the prevalence of avoidant PD (Fazel et al., 2002) and dependent PD (Craissati et al., 2008) among IPSO in the UK.

One benefit of using the DSM-5 AMPD is that as well as being able to look at categorical PDs, the scales provide incremental information relating to personality functioning and pathological personality traits, meaning that you can establish where an individual (or group of individuals) experiences difficulties with their personality, rather than focusing just on PD categories, which research has shown to be controversial (Clark, 2007; Skodol et al., 2011; Trull & Durrett, 2005; Widiger & Trull, 2007). In terms of personality functioning, among the main sample of IPSO, almost half demonstrated impairments in identity integration and relational capacities, and 30% presented with difficulties in the self-control domain, with research indicating that self-control and difficulties with relationships are linked to sexual

recidivism (Hanson & Morton-Bourgon, 2005). In comparison to a community sample, IPSO demonstrated significantly greater impairments in all five domains, similar to research by Garofalo et al. (2018). IPSO demonstrated significant impairments in self (self-control and identity integration) and interpersonal functioning (relational capacities), which aligns with self-regulation theories of sexual offending that suggest that impairments in self-regulation are essential in the understanding of sexual offending (Stinson et al., 2008; Ward & Beech, 2006), as well as being consistent with research and theories that show that intimacy deficits are prevalent among IPSO (Ward, Loudon, Hudson & Marshall, 1995). In comparison to a sample of IPSO taking MMPSA, the overall IPSO sample were similar in terms of identity integration and relational capacities impairments, but were significantly better in relation to self-control functioning, indicating that a large proportion of IPSO present with difficulties relating to their identity and ability to form and maintain relationships with others. In line with this, IPSO with SP demonstrated significantly worse impairments in self-control, suggesting that SP may be related to deficits in self-control, something which will be explored within the subsequent chapter.

In relation to IPSO with PD, they showed similar impairments in personality functioning to that of a PD population (Andrea et al., 2007), with the most prevalent impairments shown in the facets of self-reflexive functioning, effortful control, feeling recognised, intimacy and self-respect. Of note, IPSO with PD experienced impairments mainly in the domains of identity integration, relational capacities, and self-control, and less so in the domains of responsibility and social concordance. IPSO with PD demonstrated significantly worse functioning in the facet of intimacy in comparison to the PD population, providing support for previous research which suggests that IPSO demonstrate problems with intimacy (Bumby & Hansen, 1997), which is thought to be linked to sexual recidivism (Hanson & Morton-Bourgon, 2005). When compared to a sample of IPSO taking MMPSA, the research sample demonstrated a similar personality profile to that of IPSO taking MMPSA, indicating that IPSO that experience problematic sexual arousal may also demonstrate personality difficulties.

Regarding pathological personality traits, the main sample of IPSO demonstrated the greatest dysfunction in the domain of negative affect, in accordance with previous research (Smallbone & Dadds, 2000; Ward & Hudson, 2000). The top five pathological personality traits among IPSO were anxiousness, separation insecurity, depressivity, impulsivity and intimacy avoidance, which parallels previous research that reports similar results for anxiousness and depressivity (Baxter et al., 1984, Lehne, 1994), impulsivity (Giotakos et al., 2003; Hanson & Morton-Bourgon, 2005), and intimacy deficits (Ward, Hudson, Marshall & Siegert, 1995). In comparison to a PD sample, IPSO demonstrated significantly greater dysfunction in intimacy avoidance, callousness, impulsivity and unusual beliefs and experiences, which aligns with previous research that shows intimacy is problematic for IPSO (Ward et al., 1995), and the psychopathy literature which indicates that callousness and impulsivity are also problematic (Cooke & Michie, 2001; Neumann, Hare & Pardini, 2015; Patrick, Fowles & Krueger, 2009). IPSO with PD demonstrated significantly more dysfunction among most of the traits compared to the

general population, and demonstrated a personality profile that was similar to the PD population, indicating that the inclusion criteria used for study three was successful in identifying IPSO that may demonstrate PD. Furthermore, in comparison to the PD population, the sample of IPSO with PD had significantly more dysfunction in intimacy avoidance, depressivity, suspiciousness, callousness, impulsivity, eccentricity and unusual beliefs and experiences.

Although psychopathy has not been included in the DSM-IV, and the decision was made for it not to be included as a central feature of this research, it is still one of the most empirically validated forms of personality pathology (Miller, Gaughan & Pryor, 2008), and it is possible to look at the prevalence of psychopathic traits among the research sample of IPSO. In terms of trait domains, it has been suggested that the antagonism and disinhibition domains are related to psychopathy (Strickland, Drislane, Lucy, Krueger & Patrick, 2013), which were low among this sample of IPSO. Additionally, traits such as manipulateness, callousness, impulsivity, grandiosity and irresponsibility are also predictive of psychopathy (Cooke & Michie, 2001; Neumann et al., 2015; Patrick et al., 2009). As the results demonstrate, these traits were the least prevalent traits among the sample of IPSO, excluding impulsivity, which was prevalent in 21.9% of IPSO. This low prevalence of psychopathic traits may be indicative of IPSO in category C prison establishments (as opposed to category A or B prisons), however, it may also be explained by offence type, as research suggests that psychopathic traits are less common among IPSO against children (Olver & Wong, 2006; Porter, Woodworth & Birt, 2000; Seto, 2008), which make up the majority of this research sample.

Additionally, in terms of traits, anxiousness and depressivity were two of the most prevalent traits among the sample, which supports previous research that reports anxiety and depression to be some of the most common mood disorders among IPSO (Dunsieth et al., 2004; McElroy et al. 1999; Raymond, Coleman, Ohlerking, Christensen & Miner, 1999). Chantry and Craig (1994) showed that IPSO against children were more emotionally labile with anxiety and depression in comparison to IPSO against adults or IPVO, which may therefore explain the high prevalence of anxiousness and depressivity traits among the sample, as almost two thirds offended against a child. Additionally, the prevalence of anxiety or depression may be linked to the shame and stigma associated with being in prison and being labelled a 'sexual offender' (Bedaso, Kediro & Yeneabat, 2018; Harris & Socia, 2016), due to the shame and stigma attached to being attracted to children (as is also seen in the non-offending paedophile literature; Stevens & Wood, 2019), or as a functional response to ACEs (Manyema, Norris & Richter, 2018).

5.5.3 Sexual preoccupation

Among the sample of IPSO, 45% met the criteria for SP, which is in line with previous research (Blanchard, 1990; Carnes, 1989; Marshall & Marshall, 2006; Marshall et al., 2008). However, these rates are higher than results by Hanson et al. (2007), Briken (2012), and Kingston and Bradford (2013), who reported prevalence rates between 9% - 12%. Furthermore, of the 45% IPSO that demonstrated SP, a significant difference was established between victim type, with IPSO against children demonstrating higher rates of SP (66.2%) than IPSO against adults (17.7%) and IPSO against both children and adults (17.7%). This corroborates previous research by Blanchard (1990) who also demonstrated higher rates of SP among IPSO against children, but, differs from research by Marshall et al. (2008) who reported no significant differences dependent on victim type. With regard to the two different prison establishments (one with an MMPSA treatment pathway and one without), similar rates of SP were shown among both prisons, with slightly higher rates found among the prison without the pathway. This result was surprising as it may be expected that a higher rate of SP would be prevalent at the treatment prison due to IPSO specifically being transferred there in order to access medication, however, it also theoretically makes sense as the prison without the MMPSA pathway may not be targeting SP, and therefore there remains a large amount of untreated IPSO with SP.

5.5.4 Adverse childhood experiences

The findings reveal that the prevalence of early trauma is significantly higher among IPSO with PD than for males in the general population, which is similar to what previous research has reported (Ford et al., 2016; Jespersen et al., 2009; Levenson et al., 2016; Reavis et al., 2013). This current study also revealed that IPSO with PD were significantly more likely to report child maltreatment in comparison to general prisoners, psychiatric patients, and general IPSO, which also aligns with previous research (Craisatti & Blundell, 2013; Ford et al., 2019; Levenson et al., 2016; Stinson et al., 2016). Among the IPSO that experienced personality difficulties, all of them experienced at least one adverse experience, whereas, 56% of the general population reported experiencing zero ACEs (Ford et al., 2019), which supports the notion that PD symptomology may be a functional response to adverse experiences and child maltreatment (Battle et al., 2004).

Additionally, multiple maltreatments and household dysfunction appeared to co-occur together, with 58% of the research sample reporting four or more ACEs, which corroborates with Levenson et al.'s (2016) proposal that IPSO may have been raised within disordered environments with caregivers that were unable to provide adequate support and protection from physical, emotional and sexual harm. These results are similar, albeit slightly higher, to findings by Levenson et al. (2016), Marshall (2016a) and Reavis et al. (2013). IPSO with PD were 14 times more likely to report four or more ACEs than the general population, and over 1.5 times more likely compared to general prison and IPSO samples.

Among IPSO with PD, factors relating to child maltreatment were the most prevalent out of all of the nine ACEs, with three quarters of the sample reporting verbal and physical abuse, and over half experiencing sexual abuse. The research sample were 11 times more likely to report verbal abuse than the general population, 9 times more likely than the psychiatric population, and three times more likely than prison and IPSO populations, which is similar to previous research which demonstrates that IPSO were thirteen times more likely to experience verbal abuse than the general population (Levenson et al., 2016). In terms of physical abuse, IPSO with PD had 20 times the odds compared to the general population, around five times the odds compared to prison and IPSO populations, and three times the odds of psychiatric populations. This is considerably higher than previous research, which indicates that IPSO were only twice as likely to report physical abuse (Levenson et al., 2016). These results also contradict findings from a meta-analysis which reported no differences in relation to physical or emotional abuse among IPSO and non-IPSO (Jespersen et al. 2009), suggesting that for IPSO with personality difficulties physical and verbal abuse may have been a contributing factor to the development of PD symptomology.

However, sexual abuse showed the greatest odds, with the research sample being almost 22 times more likely to have been sexually abused as a child compared to the general population, over six times more likely compared to general prisoners, and twice as likely than IPSO and psychiatric populations. Previous research indicates that IPSO were three times more likely to report sexual abuse than non-IPSO (Jespersen et al. 2009; Levenson et al., 2016), whereas this study demonstrates that IPSO with PD were six times more likely than general prisoners, and twice as likely than general IPSO populations. This distinct population appears to experience child sexual abuse at alarmingly high rates compared to the general population, whereby their childhood experience of sexual abuse may be linked to their own offending behaviour (Burton et al., 2002; Eisenman, 2000; Glasser et al., 2001), for example, Eisenman (2000) proposes that early sexual experiences may imprint the individual's sexual interests later in life. These results also provide support for the sexually abused-sexual abuser hypothesis (see Seto [2008] for a review). Additionally, Dong et al. (2003) suggest that individuals that experience sexual abuse are twice as likely to experience other forms of maltreatment or family dysfunction, indicating that sexual abuse rarely occurs in isolation and overlaps with other adverse experiences. This is supported by the results of this study, as among the IPSO that reported sexual abuse, 85% reported one or more additional adverse experiences, with 69% experiencing three or more additional ACEs, which again indicates that IPSO with PD were brought up in chaotic environments with caregivers that were unable to protect them from harm (Levenson et al., 2016). This may not only relate to the likelihood of becoming a perpetrator of abuse, but also to the development of personality difficulties (Burton et al., 2002; Battle et al., 2004).

Regarding household dysfunction, IPSO with PD were significantly more likely to experience all adverse experiences compared to the general population, and were at greater odds of experiencing parental

separation, domestic violence, mental illness, alcohol abuse, drug abuse and incarceration. In comparison to the general prison population, the research sample were almost twice as likely to have lived with someone with mental illness in the family household but were less likely to have lived with someone who had been incarcerated. In contrast with the IPSO population, IPSO with PD were over twice as likely to experience domestic violence and mental illness, yet were significantly less likely to report drug abuse.

5.5.5 Implications

5.5.5.1 Implications relating to personality disorder services for IPSO

At present, the OPD pathway predominantly screens for antisocial and borderline PD, with a focus on high risk IPVO and IPSO, however, there is little regard for other PDs. The latest guidance for the OPD pathway (Craissati et al., 2018) acknowledges that the screening procedures do not easily identify individuals with odd or avoidant traits, with anecdotal clinician feedback highlighting that individuals with schizoid, schizotypal and avoidant traits are regularly missed by the screening tools, and clinical override has to be used in order for these individuals to be included in the pathway. Therefore, the results from this study which focuses on a sample of IPSO specifically from two UK prison establishments, and the results from previous research, further reinforce the fact that a proportion of IPSO that require treatment and support with their personality difficulties may be being missed due to the current OPD screening procedures, as dependent, depressive, borderline, and avoidant PDs were the most prominent among IPSO. The current results indicate that antisocial PD was the least prevalent PD among IPSO in two UK prison (category C) establishments, and as previous research has suggested, antisocial PD may be more prominent among IPVO rather than IPSO. This suggests that the personality profile of IPSO may be different to that of IPVO, as IPSO were more likely to experience a broader range of PDs.

A critical implication of these findings is that the HMPPS and NHS (OPD pathway) may need to amend the current screening procedures to be more inclusive of avoidant, dependent and depressive PDs found among IPSO, particularly for avoidant PD (if using the DSM-5 AMPD approach). This is especially pertinent if taking into account the homogeneity of PDs and utilise the new DSM-5 AMPD approach, whereby avoidant PD should be implemented into the screening procedures for IPSO, characterised by inhibition, relationship difficulties with adults, a fear of being rejected or judged, and social isolation (Perrot et al., 2014). Additionally, if using this approach, schizotypal and narcissistic PDs were also prevalent (4.5% and 3.9%, respectively), and may warrant further exploration within this sample. These results, combined with previous research, suggest that a separate pathway may be required which distinguishes IPVO from IPSO, accounting for the differences between the two groups. Due to IPSO presenting with a range of PDs, and low prevalence of antisocial PD, a separate PD pathway specifically

for IPSO may be required to account for the range of PDs and personality difficulties specifically among IPSO. This will enable a broader range of IPSO with personality difficulties to access appropriate treatment, enabling the OPD pathway to be more inclusive, whilst also preventing clinicians from having to use clinical override if specific pathways are developed.

Treatment plans should aim to address the most common symptoms of PDs prevalent among IPSO, and among the top four PDs that were prevalent (dependent, depressive, borderline and avoidant), there are similar traits that characterise the PDs which may be useful treatment targets. The trait anxiousness is present among all four PDs and is the most prominent trait reported among the sample of IPSO, with separation insecurity and depressivity being the second and third most prevalent traits which are also prevalent among the different PDs. Borderline PD is characterised by anxiousness, separation insecurity, depressivity, emotional lability, impulsivity, risk-taking and hostility; avoidant PD is associated with anxiousness, anhedonia, withdrawal and intimacy avoidance; depressive PD is characterised by anxiousness, depressivity and anhedonia; and finally, dependent PD is associated with anxiousness, separation insecurity and submissiveness. In terms of borderline PD, these traits may already be targeted during treatment via the OPD pathway, however, the results of this study indicate that the traits of anhedonia, withdrawal, intimacy avoidance and submissiveness may also warrant attention during the treatment of IPSO with PD.

Ideally, treatment plans should be individualised depending on the PD an individual presents with, as advocated by many clinicians within this field (Boccaccini, Rufino, Jackson & Murrie, 2013). Diagnostic frameworks do not provide explanatory frameworks that can be used to inform interventions (Jones & Willmot, 2017), and therefore individualised case formulations are the best approach (Jones, 2011), particularly in relation to complex cases (Drake & Ward, 2003). The OPD pathway supports the use of case formulation and argues against diagnostic labels for PDs (Skett & Lewis, 2019), enabling individualised treatment packages to be offered to individuals accessing the service. However, the original screening procedure and inclusion criteria for the pathway mean that individuals predominantly with antisocial and borderline PDs are included, whereas, individuals experiencing other types of PD may not be accessing similar individualised treatment options. The OPD pathway aligns with the PTM framework (Johnstone et al., 2018), which emphasises making sense of previous experiences as a central factor. With a range of PDs and a range of ACEs being reported among IPSO, these results demonstrate the need for a similar developmental and trauma focused service specifically for IPSO, but with adaptations made to the screening procedure in order to be more inclusive of the types of personality difficulty demonstrated among IPSO, so that they can also access this formulation approach to treatment.

Furthermore, the results of this study also have important implications for service development. Services designed specifically for IPSO with PD should bear in mind that when considering personality

functioning, of the most prevalent facets, four of those related to identity integration (self-reflexive functioning, feeling recognised, self-respect, and stable self-image), two were related to relational capacities (intimacy and feeling recognised), and two were related to self-control (effortful control and emotional regulation), therefore, there may need to be a focus on these domains during treatment. Regarding pathological personality traits, the most prevalent traits were anxiousness, depressivity, suspiciousness, impulsivity, and separation insecurity. In comparison to patients with PD, IPSO with PD demonstrated significantly worse dysfunction in intimacy avoidance, depressivity, suspiciousness, callousness, impulsivity, eccentricity, and unusual beliefs and experiences. Therefore, services developed specifically for the treatment of PD among IPSO should consider the impact of these personality traits, how they may present within treatment (individual or group), and how they may be targeted, for example, IPSO with strong traits of anxiousness or suspiciousness may struggle within a group context (Jones, 2009). Services designed for IPSO with PD should be aware of the high prevalence of ACEs among this population, and should aim to help individuals come to terms with their own traumatic experiences, before trying to focus on any victim awareness or offending behaviour work (Cluley, 2019). PD impacts an individual's ability to engage effectively in treatment (Howells et al., 2011), therefore, some of the PD services that form part of the OPD pathway firstly deal with PD (as a preparatory stage) in order to stabilize the individual, before moving on to offence-focused work (Howells et al., 2011). This implication may not only be relevant to services specifically designed for IPSO with PD, but also for all treatment programs for IPSO, as personality difficulties and ACEs have been reported to be highly prevalent among IPSO in general. Therefore, all treatment programs may benefit from enabling IPSO to come to terms with their own traumatic experiences before moving on to offence-focused work (Cluley, 2019), whereby Creeden (2004) argues that not addressing the impact of trauma will impede the learning and effective use of skills that are taught in treatment programs.

5.5.5.2 Implications relating to the treatment of sexual preoccupation among IPSO

The results demonstrate that almost half of IPSO in two UK prison establishments experienced difficulties with their sexual thoughts, feelings and behaviours (meeting criteria that would be indicative of a referral to the MMPSA pathway). With SP being identified as one of the strongest predictors of recidivism (Mann et al., 2010), acting sometimes as a barrier (or hindrance) to treatment (Grubin, 2018; Winder et al., 2018), this reinforces the importance of targeting this area with treatment in order to reduce risk and lower the likelihood of recidivism. Current treatment programs do not directly target SP, but may target some of the underlying mechanisms of it (i.e. self-control or emotional regulation). However, the underpinnings of SP are still relatively unknown, which is one of the aims of the following chapter (chapter six).

Nevertheless, the findings do show that a high percentage of IPSO may require treatment for this problem, which is important when it comes to commissioning services. Research by Winder et al (2014;

2018) demonstrates that medication is effective at reducing problematic sexual arousal, resulting in IPSO having more 'headspace' to help them better focus on cognitive behavioural therapy (CBT) treatment programs (Lievesley et al., 2014, p.269), and medication has been reported to be a useful adjunct to treatment programs (Guay, 2009; Home Office, 2007; Turner et al., 2012). The sequencing of treatment may need to be considered, for example, if an IPSO is highly sexually preoccupied, treatment could start with medication to help reduce the frequency and intensity of the sexual thoughts, which may then enable them to engage in treatment programs. When considering the prevalence rates of SP across both UK prison establishments, similar rates were revealed across both, however, only one of these prisons (prison 1) offers medication as a treatment option. The results of this study, combined with previous research, suggests that MMPSA should be available at all UK prison establishments that specifically house IPSO.

However, not all IPSO may be willing (or able) to take medication to treat their SP, and therefore, other ways of targeting the problem may also be beneficial, such as specific psychological interventions which aim to reduce SP among IPSO. This will be discussed further within chapter 6, when the underlying mechanisms of SP are explored in more detail. Furthermore, the current study demonstrates that the sample of IPSO taking MMPSA displayed a similar personality profile to that of IPSO who met criteria for PD, suggesting that people who demonstrate high rates of SP may also experience personality difficulties, which further reinforces the need for both pharmacological and psychological treatment to help target all problematic areas.

5.5.5.3 Implications relating to the general prison establishment and treatment of IPSO

Impairments in identity, self-control, and relational capacities were not only found among IPSO with PD, but among the general sample of IPSO too. Therefore, these may be useful treatment targets for IPSO in general, which is consistent with current treatment programs for IPSO as they give attention to self-control, intimacy, emotion regulation, and impulse control (HMPPS, 2016; HMPPS, 2018; McCartan & Prescott, 2017). However, as pointed out by Garofalo et al. (2018), although there is currently no evidence that improvements in identity integration would decrease recidivism, the findings of this study support the notion that identity may be a useful treatment target in the context of IPSO rehabilitation and desistance (Garofalo et al., 2018; Maruna, 2001; Ward & Marshall, 2007), as establishing a coherent, prosocial identity is thought to be crucial for rehabilitation and desistance from crime (Maruna, 2001). By using the principles of the Good Lives Model (GLM; Ward, Mann & Gannon, 2007), services can help to address some of the issues surrounding identity by understanding and addressing central beliefs about the self, world, and another people, enabling people to adopt pro-social identities (Skett & Lewis, 2019). Individuals who have an incoherent identity may be more likely to reoffend as they may not possess the necessary skills and attitudes required to lead fulfilling lives and to meet their needs pro-socially (Ward & Marshall, 2007), therefore, supporting individuals to develop a clear GLM

that aligns with their interests will help them to form a more appropriate narrative identity (Ward & Marshall, 2007). This is important for rehabilitative purposes and desistance from crime as individuals tend to act in accordance with the stories that they present about themselves (Maruna, 2001; McAdams, 1985).

The National Institute for Health and Clinical Excellence (NICE) guidance highlights the importance of developing and nurturing relationships (NICE, 2009a; 2009b), which has been employed by housing services by implementing Psychologically Informed Environments (PIEs) which attend to the relational, emotional and psychological needs of individuals (Johnson & Haigh, 2010), and have been shown to improve mental health, social exclusion and staff morale (Cockersell, 2016). These are similar to Psychologically Informed Planned Environments (PIPEs) that are utilised within the OPD pathway, and other services in the pathway that adopt a relational approach (Skett & Lewis, 2019). Given that a large proportion of IPSO demonstrate impairments in their abilities to form and maintain relationships with others, the prison system in general and all services that come into contact with IPSO may benefit from becoming more psychologically informed, attending to the relational, emotional and psychological needs of IPSO (even in terms of small factors such as consistency, enabling IPSO to begin to trust other people). One particular way of doing this may be to introduce level 1 formulations (as used within the OPD pathway) as a way of enabling prison officers to understand problematic behaviours (Craissati, 2019). A level 1 formulation 'describes a pattern of problem behaviours linked to an underlying psychological idea' (Craissati, 2019, p. 75), which would allow prison officers to work in a more psychologically informed way, and have been designed to be used by offender managers and prison officers (please see Craissati (2019) for more information regarding formulations used within the OPD pathway).

In addition to working in a psychologically informed and relational manner, due to the high prevalence of ACEs and trauma among this population, it is also important that the milieu of the prison establishments are trauma informed (Jones, 2018). Trauma-informed care (TIC) is becoming more recognised among mental health services, and more recently in custodial establishments (Miller & Najavits, 2012), with Levenson (2014) suggesting that TIC should also be used with IPSO. Being trauma informed means thinking about IPSO as an individual (rather than just their offending behaviour), whilst focusing on what happened to them as a person, not what they did (Akerman, 2019). Instead of asking what is wrong with the individual, professionals should be asking 'What happened to you?' (Jarvis, 2018) in order to get a better meaning and understanding of the individual's life events and how problematic behaviours may once have been adaptive during an abusive childhood environment (Levenson, 2014), which links closely to the overall concept of the PTM framework (Johnstone et al., 2018).

TIC requires being collaborative, compassion-focused, and respectful, whilst providing a safe environment for individuals to validate their emotions (Akerman, 2019). Having a trauma informed justice service would enable the workforce to understand the individuals they work with and their complex needs, whilst supporting individual's that have been impacted by trauma (Ford et al., 2019). Jones (2015) contends that prison establishments may retraumatise individuals due to certain aspects of the custodial milieu which may echo earlier adverse experiences (see Jones [2015] for further details), therefore, adopting a TIC approach means trying to ensure that prison establishments do not retraumatise already traumatised individuals. Regarding treatment, IPSO only receive psychological treatment programs if they are medium or high risk, meaning that a proportion of individuals who may have experienced ACEs or demonstrate personality difficulties may not receive adequate care and support due to not meeting specific criteria. Therefore, it may be advantageous for the whole prison milieu to become more trauma informed, rather than just clinicians (psychology/program staff) that deliver treatment programs (Allcock, 2015; Mulcahy, 2018).

Although the more recent treatment programs for IPSO in the UK (Kaizen and Horizon) have begun to utilise a more trauma informed approach, whereby they acknowledge difficult childhood experiences and work in a way that avoids re-traumatisation (Henfrey, 2018), various clinicians and researchers advocate that it is not enough for just psychology services and offender behaviour programs to deliver services in a trauma informed manner. All services that come into contact with IPSO should be trauma informed, including wing staff, health care staff, offender management staff and probation staff, in order to ensure that services do not re-traumatise individuals, whilst also considering an individual's behaviour in relation to their past experiences (Akerman, 2019; Allcock, 2015; Cluley, 2019; Lynch, 2019; McCartan, 2019; Mulcahy, 2018). If all staff members are trauma-informed and able to identify individuals who require support, then early intervention during the first time that an individual enters the criminal justice system may prevent subsequent incarceration (Ford et al., 2019). It is important for all services to work together as multidisciplinary teams in order to create a trauma-informed and relational environment (Skett & Lewis, 2019), rather than the disparities often seen in prison establishments between different services.

In order for all services to be trauma informed, high quality, accessible training is vital so that staff can gain a thorough understanding about the nature and impact of ACEs, as well as feeling confident in their abilities to create a safe, non-threatening environment (Jervis, 2019). Cluley (2019) argues that all staff should be acknowledging trauma and giving a voice to it, rather than ignoring it or being fearful of such sensitive information. Allcock (2015) visited prison establishments in Norway that adopted a trauma informed approach and noted that prison staff talked about 'interacting' with prisoners, whilst having a strong focus on rehabilitation, rather than viewing their job roles as a way of keeping peace within the prison. For example, staff members did not wear uniform and at lunch time staff and prisoners ate their dinners together. Staff and prisoners were respectful of each other, whereby their

body language and tone of voice were calm, with staff members showing a genuine interest in helping to improve outcomes for prisoners. Within the prison establishment, there was a strong emphasis on a multidisciplinary approach, and Allcock (2015) suggests that for prison establishments in the UK all staff members need to develop 'soft skills' (compassion, patience, empathy) when working with prisoners. Regarding training, prison officers in Norway receive three years' mandatory training (in comparison to six weeks in the UK), which covers a range of topics including: mental health, criminology, psychology, law and the legal system. This means that staff start their new job role with a comprehensive understanding of mental health and the impact of trauma. A critical implication of the results from this study is that high quality, accessible, in-depth training regarding trauma should be required for all staff that interact with prisoners, in order for them to develop the necessary knowledge and skills required to work in a trauma informed way (Allcock, 2015; Jervis, 2019). Additionally, it is important to consider the impact that this approach may have on staff (such as vicarious trauma; McCann & Pearlman, 1990), and to ensure that appropriate supervision and support services are available for staff members at all times.

Treatment programs for IPSO are mainly based on a cognitive behavioural model that aids individuals in learning skills required to improve their interpersonal skills, however, they do not deal with the underlying trauma which may be at the developmental foundation of the maladaptive interpersonal skills (Yates, Prescott & Ward, 2010). Reavis et al. (2013) suggest that the role of adversity is a relevant treatment consideration for IPSO, with Dudeck et al. (2007) proposing that having therapeutic interventions which focus on childhood abuse may improve IPSO psychosocial well-being and functioning, as well as their criminal prognosis. In addition, the findings of the current study demonstrate that separation insecurity is problematic for IPSO, therefore, a focus on separation insecurity and attachment style may also be warranted in the treatment of IPSO. The more recent treatment programs for IPSO in the UK have become more trauma informed by acknowledging difficult childhood experiences, however, a stronger focus on helping IPSO to deal with their childhood trauma may be necessary. Clinicians are required to work in a compassionate, validating, and respectful way in order to create a therapeutic relationship which will result in a corrective emotional experience where new skills can be learned and practiced (Levenson, 2014).

Finally, among both of the research samples, anxiousness and depressivity were two of the most prevalent traits among IPSO. Anxiety and depression are reported to be some of the most common mood disorders found among IPSO (Dunsieth et al., 2004; Chantry & Craig, 1994; Kafka & Prentky, 1994; McElroy et al. 1999; Raymond et al., 1999), therefore, these results provide support for a stronger focus on anxiety and depression more generally within prison establishments that house IPSO. It is important to bear in mind that the onset or longevity of these mood disorders are not known amongst the sample, whereby it is unknown whether these disorders were prevalent before incarceration, or may be as a result of being incarcerated (including the impact of incarceration, as well as the stigma and shame attached to being labelled a 'sexual offender'; Bedaso et al., 2018; Harris & Socia, 2016; King & Roberts, 2017).

5.5.5.4 Preventative action and early intervention for adverse childhood experiences

Beyond the scope of the prison establishment, ACEs are now seen as a public health ‘crisis’ (Anda et al., 2010; Felitti, 2002; Larkin et al., 2014), whereby preventative action and early intervention should be paramount in order to tackle ACEs during childhood, which may potentially prevent crime and reduce costs for the criminal justice system (Ford et al., 2019). Ford et al. (2019) suggest that attention should be placed on early intervention for individuals that are at risk of ACEs, whereby if a child shows any signs of adversity at school or within the neighbourhood, services should intervene at this point in order to prevent individuals from going on to offend (Lynch, 2019). Parenting and family programs that are known to be effective at reducing child maltreatment should be offered to the parents of children that are at risk (Ford et al., 2019; Larkin, 2018), as these parents may have experienced a range of ACEs themselves, and may never have learned the core skills required to bring their children up in a safe, protective environment (Larkin, 2018). Interventions with at-risk parents are crucial in order to help them develop skills that foster attachments and healthy family functioning (Levenson & Grady, 2016a). Social policies should be responsive to the impact of ACEs, offering immediate and appropriate support to all children that experience child maltreatment (Levenson & Grady, 2016a), whereby mental health, child protective, and criminal justice systems must invest in early intervention programs for at risk families and children (Anda et al., 2010; Baglivio et al., 2014), and multi-agency working must be employed so that a joined up approach is utilised to help the individual child (Lynch, 2019).

Another way in which the impact of ACEs can be addressed during childhood is through the use of trauma informed schools (Donovan, 2018; Larkin, 2018). The results from both of these current studies confirm that IPSO experience impairments in the way that they view themselves (identity), how they interact and form relationships/friendships with other people (relational capacities), and how they manage their emotions (self-control), which are all skills that could be developed during school, for example, teaching children how to appropriately regulate their emotions and how to effectively interact with other people. Larkin (2018) argues that schools focus more on intellect and grades and less on emotional/social development, however, it is much harder to develop these interactional skills (emotional regulation, interpersonal skills, being assertive, negotiating) later on in life. Being a trauma informed school involves teaching children compassion and empathy, as well as teaching them about the brain from an early age (Donovan, 2018). The curriculum should not just be focused on intellectual activities, but should also consider whether children can maintain friends, manage their emotions, and resolve conflict on their own, with the aim of raising healthy well-adjusted adults (Donovan, 2018; Larkin, 2018). Additionally, for children that demonstrate challenging behaviour or signs of adversity, there should be opportunities for them to come in early and do activities to prepare them for the day ahead and get them accustomed to the classroom environment before the other children arrive (Donovan, 2018). This will also enable children to work closely with staff and potentially build a bond with a trusted adult, which has been shown to mitigate the impact of ACEs (Bellis et al., 2017).

5.5.6 Limitations

5.5.6.1 Sample size

A limitation of study three (the further psychometric study) is in regard to the limited sample size ($n = 45$), whereby caution should be taken when interpreting these results. The small sample size was partly due to participants from the screening study being narrowed down to individuals that demonstrated PD (and left their contact details), meaning that only a limited proportion of IPSO met the criteria for the next study. In addition, the response rate for the first screening study among the prison sample was particularly low (less than 10%), suggesting that this narrow sample may not be truly representative of the wider IPSO population, and caution should be taken when interpreting these results.

5.5.6.2 Complications conceptualising and measuring personality disorder

Firstly, due to the self-report nature of the questionnaires and the restricted sample of IPSO (category C prisons only), there is a lack of breadth in regard to the PDs found among the sample. With participation consisting of voluntary self-report questionnaires, there was always the potential for a biased sample relating to PDs, as individuals with specific types of PD or pathological traits (i.e. paranoid PD, hostility, suspiciousness) may have been less likely to participate in the research, whereas, individuals that demonstrated traits of compliance, grandiosity or submissiveness may have been more likely to complete the questionnaires. Higher rates of avoidant and paranoid PDs were reported among the sample than was initially expected, as the researcher thought IPSO with these types of PDs may be deterred from participating in research. Antisocial, obsessive-compulsive and narcissistic PDs were the least prevalent PDs as they were prevalent in less than 4% of the sample.

There are numerous possible explanations as to why these types of PD may not be strongly present within the sample of IPSO. Firstly, they may genuinely not be present among this sample of UK IPSO housed in category C prisons, especially with two thirds of the sample being IPSO against children, as previous research has suggested that antisocial and narcissistic PDs may be less prevalent within this population. Additionally, it is important to bear in mind that this research was conducted in two category C prisons (one being a treatment focused prison, and the other encouraging active citizenship), meaning that a certain level of compliance and willingness to treatment is required for IPSO to be in a category C prison. Therefore, these individuals may be less likely to show antisocial traits and break the rules, and had the research been conducted at category A and category B prisons as well then different results may have been reported. The results of this research can only be generalised to other IPSO residing in category C prisons, rather than all IPSO. Another reason may be due to the algorithms used to specify each PD. For the six PDs that were retained in the DSM-5 AMPD, Samuel et al. (2013) postulated that the specific algorithms resulted in lower prevalence rates than previous

epidemiological studies had reported, and also found low rates of antisocial PD using the criteria set out in the DSM-5 AMPD, therefore, some of the PDs may be under represented due to the criteria used.

Furthermore, higher prevalence rates were shown overall for the PDs that were not retained in the alternative model, which were operationalised using the half (or half + 1 if an odd number) method. Samuel et al. (2013) argue that requiring half of the traits was not as stringent as the criteria set out by the alternative model and resulted in estimates that were more consistent with existing prevalence rates. Consequently, this could also explain why the PDs that were not retained are more prominent in the sample of IPSO, due to having less stringent criteria. Interestingly, the half (+1 if odd) method was utilised to assess the prevalence of the six retained PDs to establish if there was a difference in the two scoring methods. For antisocial PD, the rate increased from 1.29% to 3.9%, indicating that even after making the criteria more flexible, antisocial PD was still not strongly present among the sample of IPSO. Nevertheless, the rates for the other PDs (excluding borderline which remained the same) demonstrated an increase: avoidant (11% to 23.9%), schizotypal (4.5% to 10.3%), narcissistic (3.9% to 11.6%) and obsessive compulsive (2.6% to 15.5%). However, making the criteria more flexible contradicts the aims of the new DSM-5 AMPD, as it increases heterogeneity within PDs (for example, by only requiring two out of four elevated traits for obsessive-compulsive and avoidant PDs, and one elevated trait for narcissistic PD), resulting in a higher rate of false positives (Samuel et al., 2013). Therefore, for the purpose of this chapter, the more stringent DSM-5 AMPD algorithms remained the criteria used in order to denote a diagnosis of individual PDs. In relation to further analysis in chapter 6, only the 6 retained PDs in the alternative model will be used in order to reduce heterogeneity within PDs and homogeneity among PDs.

In addition to this, differences may also be explained by the variation in the diagnostic thresholds for each PD, as the number of elevated traits required for each PD varies enormously. For example, it is clearly a more stringent expectation for an individual to have six out of seven traits elevated for antisocial PD than it is to have four out of seven traits for borderline PD, or two traits for narcissistic PD (therefore, it might be expected that narcissistic PD would be highly prevalent due to the low requirements, however, the traits [grandiosity and attention seeking] associated with narcissistic PD were not strongly present within the IPSO sample, resulting in a low prevalence of the PD). Some of this variation in the thresholds may be explained by differences in the PD constructs, however, Samuel et al. (2013) argue that these unequal requirements may have implications for the prevalence rates of PD diagnoses, which could obscure public health decisions regarding PDs. Further research may be required to assess the variation within the DSM-5 AMPD criteria, and the impact it has on prevalence rates of PDs.

Another limitation relates to the studies that comparisons were made with, as different studies used various ways of measuring and categorising PDs, with some using structured interviews, others using

self-report psychometrics, and some coding from health records. Therefore, some of the differences between the prevalence rates may be due to the varying methods of assessing PD. Additionally, psychometric self-report questionnaires may result in over diagnosis of PDs because IPSO may answer based on their current functioning (whilst being incarcerated), rather than their personality functioning over a period of years (Jones & Wilmott, 2017), and due to the structure of the screening study and the measures used, follow up questions were not asked to assess whether a response was transient or stable across time (like which are included in some structured interviews). The self-report questionnaires may be capturing an individual's response to being incarcerated and the impact of this, rather than their personality functioning across several years of their life, therefore, future research should use follow up questions to ascertain whether these difficulties are transient or stable.

5.5.6.3 The use of psychometric scales

A more general limitation of both studies is regarding the use of psychometrics that rely on self-report data by IPSO, which is therefore reliant on the honesty and insight of participants (Craisatti & Blundell, 2013). However, due to their incarceration, there may be a desire to appear less dysfunctional than they actually are, meaning that self-report data may not be a true reflection of their psychopathology (Francia et al., 2010), or they may answer in a socially desirable way (Paulhus, 2002). In terms of adverse experiences, the use of self-report data may result in both the over-reporting and under-reporting of ACEs (Levenson & Grady, 2016a; Jespersen et al., 2009). Due to the sexually abused-sexual abuser hypothesis being well known, IPSO may be more likely to fabricate the truth and report a history of sexual abuse in order to elicit compassion, sympathy, or more lenient treatment (Hindman & Peters, 2001; Jespersen et al., 2009; Levenson et al., 2016; Stirpe & Stermac, 2003). Conversely, some IPSO may be less likely to report childhood abuse due to embarrassment or shame (Dhawan & Marshall, 1996), because they do not want to appear as vulnerable, or due to normalised perceptions of victimizing behaviour (Levenson et al., 2016). Hardt and Rutter (2004) argue that retrospective reports often result in underestimates of the incidence of child maltreatment. The design of the study did not allow for admissions of child maltreatment to be verified by official documentation, meaning that the number of ACEs among IPSO with PD may be an under or over estimation of the true amount. Future research should try to combine self-report data with information from clinicians and family members regarding the individual's criminal history, demographic information, and significant life events (Francia et al., 2010), as well as observational assessment (Jones & Willmot, 2017).

Additionally, it is important to note that the psychometric measures used were not developed specifically for the use of prisoners, and therefore, may not consider the impact of incarceration on the way individuals may answer questions. For example, an IPSO may appear to show traits of submissiveness or paranoia, however, this may be due to the context of the prison (i.e. they have to follow prison rules and may feel like they have to watch their backs or cannot trust other prisoners).

Moreover, although the measures may indicate that an individual has PD, other confounding variables such as intellectual disability or other diagnoses must be taken into consideration, with some overlap shown between Asperger's syndrome, autistic spectrum disorders and PDs (Dudas, Lovejoy, Cassidy, Allison, Smith & Baren-Cohen, 2017; Lugenard, Hallerback & Gillberg, 2012; Murrie, Warren, Kristiansson & Dietc, 2002). Also, in terms of SP, some of the questions asked may not be relevant to IPSO due to their current context (being housed in a prison). For example, the question from the SCS 'It has been difficult for me to find sex partners who desire having sex as much as I want to' may not be appropriate for incarcerated IPSO as they may not be looking for sexual partners within this context, or they may be looking but may not admit this due to a fear of negative repercussions from having relationships in prison. Furthermore, there are issues around interpreting the results in relation to norms, as the majority of psychometric assessments have been developed on relatively non-disordered populations, and therefore, difficulties arise when trying to use these norms with IPSO with PD (Jones & Willmot, 2017). Due to this limitation, throughout the analyses, mean scores or prevalence rates for PDs, SP and ACEs were also compared to available PD, IPSO or psychiatric populations as well, in order to establish the characteristics of the IPSO sample in comparison to other disordered populations (as well as normative data).

5.5.6.4 Difficulties around conceptualising and measuring sexual preoccupation

Similar limitations as described for PD are also relevant to the study of SP within this research. The difference among prevalence rates may be due to the various ways of measuring and conceptualising SP, as this study may be considered more subjective than other ways of measuring SP (Kingston & Bradford, 2013). Or, the high prevalence of SP reported among IPSO in comparison to the general population may be due to the limited availability of sexual outlets within prison establishments (Smith, 2006), meaning that sexual thoughts or preoccupation may increase as a consequence of incarceration. Also, although throughout this chapter it has been suggested that the results of the SCS scale are indicative of whether an IPSO would be suitable for the MMPSA pathway, it is important to recognise that this is only one of the initial screening questionnaires given to IPSO, and further in-depth interviews and clinical judgement are used to assess whether a IPSO is suitable for medication. Therefore, IPSO that are suitable for the MMPSA pathway may be over or under-represented within this study, however, it does indicate the proportion of IPSO that self-report having problems with their sexual thoughts, feelings and behaviours.

In relation to this is the cut-off that has been used to delineate whether an IPSO has SP or not. Previous research that uses the SCS suggests a cut-off of 2.1 based on the general population (Kalichman & Rompa, 1995; Kalichman & Rompa, 2001), however, the current study aligned with the cut-off used within the prison service (1.5). The MMPSA pathway takes into consideration clinical judgement and the fact that the person is in prison for committing a sexual offence, so what may be seen as normal

within the general population may actually be problematic for an IPSO. Again, this may result in an over-estimation of SP among IPSO, and it may be argued that the literature cut-off (2.1) should be used. When this criteria (2.1) was imposed on the data, the prevalence of SP was 37% (as opposed to 45%), which still indicates that a large proportion of IPSO reported difficulties with SP. Additionally, when the sample of IPSO that showed SP in these studies was compared with the sample of IPSO taking MMPSA, the mean score was more congruent with the MMPSA sample in comparison to the student/general IPSO sample.

It is important to recognise that although this thesis aims to explore sexual preoccupation as the cognitive aspect, the SCS looks at both sexual thoughts and behaviours, therefore, the results may also be referring to problematic sexual behaviours as well as thoughts. The SCS was chosen due to it measuring insistent, intrusive and uncontrolled sexual thoughts (Kalichman, 2010), and for comparative purposes with individuals taking MMPSA. In order to establish whether the SCS was measuring SP, the data were triangulated with the MPI 'obsessed with sex' scale, demonstrating a strong positive correlation (higher scores on the SCS were linked with higher scores on the MPI), suggesting that the SCS was able to successfully capture SP. Furthermore, the data (both SCS and MPI scores) were triangulated with clinical measures of SP as used by the MMPSA service (for the sake of brevity these have not been included in the main thesis, please see appendix 23 for more information). Again, the results demonstrated strong positive correlations between the SCS and clinical measures, suggesting that the SCS was successfully at capturing SP. Therefore, due to the SCS being completed with the larger sample (and showing similar results to the MPI and clinical measures), only the SCS will be used as the measure of SP throughout the rest of the thesis.

5.5.6.5 Limited data regarding adverse childhood experiences

Childhood trauma was only assessed in the further psychometric study (study three) during a face to face appointment, as it was deemed ethically inappropriate to include the ACEs questionnaire under cell doors (as in the screening study), whereby the researcher would not be able to assess whether participants were distressed by such sensitive questions. However, this has limited the data available on ACEs, as we only have the prevalence of ACEs among IPSO with PD, rather than among the general population of IPSO. Future research should assess the prevalence of ACEs among the whole population of IPSO that are housed in UK prison establishments. Equally, over half of the main IPSO sample showed personality difficulties and met the criteria for study three, therefore, the prevalence of ACEs among this population may be indicative of a large proportion of the main sample of IPSO, however, future research is required to confirm or refute this.

A further limitation relates to the way that adverse experiences were measured in the study, as using the ACE scale as a measure of early adversity is imperfect, and there are a range of traumatic

experiences other than child maltreatment and family dysfunction that are not included in the ACE questionnaire (Levenson & Grady, 2016b), such as bullying, bereavement, poverty, community violence, illness. The ACE scale is not an exhaustive measure of trauma, and Levenson and Grady (2016b) argue that it does not capture the full scope of variables that relate to sexually abusive behaviour. Furthermore, the scale fails to consider the frequency, duration, or severity of the ACEs (Levenson & Grady, 2016b), whereby totalling the number of ACEs may not actually add to our understanding, as one child may have experienced seven ACEs but be resilient, and another child may have only had one ACE which had a detrimental impact on that child. The impact of ACEs on children, what this means to them, and how it is now impacting them during adulthood is what should be of paramount importance, rather than just the total ACE score. Future research should consider looking at the impact of ACEs among IPSO from a qualitative perspective, in order to fully understand from an IPSO point of view what impact adversity had on their lives, the way they view themselves, and the way they view the rest of the world.

5.6 Summary

In summary, this empirical chapter explores the characteristics of IPSO housed in two UK prison establishments, demonstrating high prevalence rates of PDs, ACEs and SP among the sample. Over 60% of IPSO met the criteria for a categorical diagnosis of PD, with borderline, avoidant, dependent and depressive PDs being the most prevalent, and almost half of the sample demonstrated impairments in identity integration and relational capacities. The results indicate that a large proportion of individuals with personality difficulties may be being missed by the current OPD screening procedures, and that these may need amending to be more inclusive of the range of PDs present among IPSO. Or, specific services for IPSO with PD may need to be developed and implemented.

A large proportion of IPSO met the criteria for PD, and among these individual's that met the criteria, all of them experienced at least one ACE, with almost 60% experiencing four or more ACEs. This indicates that childhood trauma is prominent among this population and requires consideration during the designing of services and treatment options for IPSO. Due to the high prevalence of personality difficulties and childhood trauma, the whole prison environment should be working in a more psychologically informed, relational and trauma informed way. All services that come into contact with IPSO (not just psychology/programs staff) should value the impact of ACEs on understanding an individual's behaviour and the way that they may present, whilst being compassion-focused and respectful at all times, providing IPSO with a safe environment to validate their emotions. In order to do this, high quality training needs to be accessible to all staff that come into contact with IPSO, to enable them to have a thorough understanding about the nature and impact of ACEs.

Furthermore, preventative measures are crucial to try and prevent the cycle of ACEs being passed on from generation to generation, as well as aiming to prevent individuals coming into contact with the criminal justice system in the first place. Early interventions for children at risk of ACEs should be paramount, as well as parenting and family programs for parents of at-risk children. Additionally, all schools should adopt a trauma informed approach in order to try and mitigate the impact of ACEs, teach children how to be compassionate and empathic towards themselves and others, teach them how to build relationships and manage their emotions, with the aim of raising resilient, healthy, well-adjusted adults.

Regarding SP, almost half of the sample of IPSO experienced difficulties with their sexual thoughts, feelings and behaviours, reinforcing the need for treatment to target this behaviour, as well as a need to further understand the underlying mechanisms of this behaviour among IPSO. Treatment approaches, such as the MMPSA pathway, should be available in all UK prison establishments that specifically house IPSO, as there are a large proportion of IPSO that may benefit from this treatment. The sequencing of treatment may also need to be considered, as medication may be helpful for IPSO before starting traditional CBT programs, as this will enable them to have the 'headspace' needed to focus, rather than being overpowered by sexual thoughts. Medication may not be suitable for or desired by all IPSO, therefore, other ways of targeting the problem during treatment may also be advantageous (which will be explored further in chapter 6), as well as treatment programs designed specifically for SP among IPSO.

Chapter Six: An investigation into the relationships between personality disorder, sexual preoccupation, and adverse childhood experiences among individuals who have previously sexually offended

Overview

The previous chapter explored the prevalence of PD, SP, and ACEs among IPSO. This empirical chapter will explore the relationships between (i) PD and SP, (ii) PD and ACEs, and (iii) SP and ACEs. As with the previous chapter, data presented here are a combination of data from study 2 (screening study; main sample of IPSO) and study 3 (further psychometric study; sample of IPSO with PD). For the purpose of analysis, the research samples will be split into (i) IPSO with SP and (ii) IPSO without SP for comparative purposes. The results section consists of three separate parts: the relationship between PD and SP (part A), the relationship between PD and ACEs (part B), and the relationship between SP and ACEs among IPSO (part C).

6.1 Introduction

The main focus of this thesis is to explore the relationship between PD and SP in order to try and understand the underlying mechanisms of SP, and how best to treat this understudied phenomenon. Due to ACEs being implicated in the aetiology of sexual offending, PD, and SP, they have also been considered within this chapter.

6.1.1 The relationship between personality disorder and sexual preoccupation

As demonstrated in the literature review (section 2.5.1), the relationship between PD and SP is an understudied topic, however, some links have been established among general population samples. Prevalence rates among general population samples range between 44% - 92% (Black et al., 1997; Carpenter et al., 2013; Raymond et al., 2003). Among these, narcissistic, paranoid, obsessive-compulsive, passive-aggressive, avoidant, and borderline PDs were the most common PDs. Various personality domains and traits are thought to be associated with SP, including: high neuroticism, high extraversion, low conscientiousness, low agreeableness, impulsivity, anxiousness, emotional dysregulation, psychoticism, perfectionism, and many others (Bancroft, 2008; Heaven et al., 2013; Lee & Forbey, 2010; Reid et al., 2012; Walton et al., 2017).

In regard to IPSO, there are minimal empirical investigations into the relationship between PD and SP (Reid et al., 2009), however, it is imperative to learn more about the underpinnings of SP and the links with personality in order to inform and enhance assessment and treatment (Costa & McCrae, 1992).

Tentative results have been reported from the MMPSA service evaluation (Payne, 2014; Berman-Roberts, 2015; Hocken et al., 2016), whereby IPSO with SP displayed higher rates of paranoia, borderline, and antisocial features (Payne, 2014). Furthermore, Berman-Roberts (2015) highlighted that IPSO with SP demonstrated a different personality profile to that of the general population and clinical samples. These studies suggest that personality (particularly self-control; consisting of emotional regulation and effortful control) may be key underlying mechanisms of SP. The service evaluation data only includes IPSO taking MMPSA, whom consequently demonstrated high levels of SP. Further research is required to explore the relationship between PD and SP among a broader sample of IPSO in order to establish the psychological underpinnings behind SP. Thus, the main aim of this chapter is to explore in detail the relationship between PD and SP among a more general sample of IPSO (including personality functioning, pathological personality traits, and categorical PD diagnoses).

6.1.2 The relationship between personality disorder and adverse childhood experiences

There is an abundance of research which demonstrates a strong link between early adverse experiences and the later development of PD (Johnson et al., 1999; Zanarini, 2000; Laporte et al., 2011; Tyrka, et al., 2009). In the general population literature, the total ACE score has been found to be significantly associated with all ten DSM-IV PDs, indicating a dose-response relationship (Hengartner et al., 2013). Among general population and clinical samples, specific types of adverse experiences have been found to relate to specific PDs, whereby physical, emotional, and sexual abuse appear to be associated with almost all PDs (Afifi et al., 2011; Hengartner et al., 2013; Johnson et al., 2005; Lobbestael et al., 2010). However, Hengartner et al. (2013) conducted a path analysis of the relationship between childhood adversity and PDs, revealing that bullying victimization, conduct problems in school, and emotional abuse were the strongest predictors of most PDs.

Nevertheless, few studies have explored this relationship between PD and ACEs among male prisoners (Roberts et al., 2008), particularly IPSO, as the majority of research has focused on traumatic experiences in women, or have restricted the measures of negative experiences to that of abuse and neglect (Fondacaro et al., 1999; Keaveny & Zuzaszewski, 1999), rather than incorporating the full range of ACEs (which also includes household dysfunction). Although research demonstrates a high prevalence of PD and ACEs among IPSO (Gillespie & Beech, 2016; Levenson et al., 2016), there are minimal studies which have examined this relationship among specific samples of IPSO, particularly in the UK.

Within the UK, Craissati et al. (2008) reported that IPSO with two or more childhood difficulties (out of emotional neglect, physical abuse, or sexual abuse) were more likely to report PD. Roberts et al. (2008) explored the relationship between PD and ACEs among a sample of high risk prisoners (with sexual or violent convictions) in the UK, whereby paranoid PD was associated with a lack of affection from

parents, schizoid PD was linked with emotional abuse, borderline PD had strong associations with sexual abuse, bullying, and being placed in care, antisocial PD was associated with a lack of affection from parents, substance abuse and incarceration within the family home, and being placed in care, histrionic PD with sexual abuse, bullying, and mental illness within the family home, individuals with narcissistic PD were less likely to report incarceration or being placed in care, avoidant PD was associated with neglect, bullying, and incarceration, obsessive-compulsive PD was linked with neglect and emotional abuse, and no associations were found between ACEs and schizotypal and dependent PDs. Although this study confirms a strong relationship between PD and ACEs among high risk prisoners in the UK, it is not an exclusive sample of IPSO, and therefore, further research is required to explore the relationship between a range of ACEs and PDs among IPSO within UK prison establishments, which is consequently one of the aims of this chapter.

6.1.3 The relationship between sexual preoccupation and adverse childhood experiences

As discussed in section 2.5.3, ACEs are thought to be involved in the aetiology of SP (Courtois & Weiss, 2018), whereby SP can be considered a long-term effect of abuse, or a maladaptive coping strategy employed as a way of escaping the pain caused by trauma (Noll et al., 2003; Gartner, 2018). Various research has explored the relationship between childhood trauma (physical, emotional, and sexual abuse) and SP, even among IPSO (Davis & Knight, 2019; Kingston et al., 2017), however, the impact of wider adversity (including household dysfunction) has yet to be explored among IPSO within the UK. Within the general population, although sexual abuse is the most often ACE discussed in relation to SP (McKeague, 2014), other forms of ACEs have also been reported, including emotional abuse and neglect, physical abuse, parental mental illness, and a dysfunctional home environment (Black et al., 1997; Engel et al., 2019; Kingston et al., 2017).

Regarding IPSO, there are minimal studies which have explored the relationship between ACEs and SP. Marshall (2016a) reported that SP is significantly correlated with the total ACE score, and IPSO with SP had higher rates of sexual, physical, and emotional abuse, and emotional neglect (Green & Marshall, 2016; as cited by Marshall, 2016b). Kingston et al. (2017) highlight that emotional abuse was the most prominent correlate of SP among IPSO, and David and Knight (2019) report that emotional abuse and sexual abuse were correlates of SP among juvenile IPSO. The majority of this research which explores the relationship between ACEs and SP has mainly been conducted with non-offending samples, with a strong emphasis on sexual abuse (Kingston et al., 2017). There appears to be a paucity in the literature regarding the relationship between SP and wider adversity (such as household dysfunction), especially among IPSO housed in UK prison establishments. Given the high prevalence of ACEs and SP among IPSO, it is crucial to learn more about the underpinnings of SP and the links with ACEs within this population in order to inform and enhance treatment, which is consequently one of the aims of this chapter.

6.2 Research aims, objectives, and hypothesis

The main aim of this chapter relates to the overarching aim of this thesis; to explore the relationship between PD and SP among a sample of UK male IPSO. Additional aims of this chapter include examining the relationship between PD and ACEs among IPSO and exploring the relationship between SP and ACEs among IPSO. These aims will be met by meeting the following objectives:

- Compare the prevalence of categorical PDs among IPSO with SP compared to IPSO without SP
- Assess the relationship between categorical PDs and SP among IPSO
- Compare the prevalence of personality functioning (criterion A) and pathological personality traits (criterion B) among IPSO with SP compared to IPSO without SP
- Explore the relationship between personality functioning and SP among IPSO
- Examine the relationship between pathological personality traits and SP among IPSO
- Assess the relationship between categorical PDs and ACEs among IPSO with PD
- Compare the prevalence of ACEs among IPSO with PD and SP compared to IPSO with PD without SP
- Explore the relationship between ACEs and SP among IPSO with PD

Regarding categorical PD diagnoses, it was hypothesised that narcissistic, paranoid, obsessive-compulsive, avoidant, borderline, antisocial, and passive-aggressive PDs would be prevalent among IPSO with SP, and would be positively associated with SP (Black et al., 1997; Carpenter et al., 2013; Raymond et al., 2003; Payne, 2014). Considering personality functioning (criterion A), it was hypothesised that the domain self-control would be positively associated with SP, as well as the following facets: effortful control, emotion regulation, aggression regulation, intimacy, self-respect, self-reflexive functioning, frustration tolerance, and stable self-image (Berman-Roberts, 2015; Hocken et al., 2016). Furthermore, in regards to the pathological personality trait domains, which align with the FFM of personality, given previous research (Heaven et al., 2013; Rettenberger et al., 2016; Walton et al., 2017) it was hypothesised that the personality domains negative affect (neuroticism), antagonism (opposite of agreeableness), and disinhibition (opposite of conscientiousness) would be positively associated with SP, and detachment (opposite of extraversion) would be negatively correlated with SP. Finally, in terms of pathological personality traits, it was hypothesised that impulsivity, anxiousness, and depressivity would be positively associated with SP (Lee & Forbey, 2010; Reid et al., 2014; Walton et al., 2017).

For the relationship between PD and ACEs, it was hypothesised that the total ACE score would be positively correlated with all PDs. It was also hypothesised that child maltreatment (physical, sexual, and emotional abuse) would be positively correlated with PDs, however, no specific hypotheses were formulated regarding other ACEs as less research has explored this among IPSO, therefore, more of an

exploratory approach was taken with this data. Furthermore, regarding the relationship between SP and ACEs, it was hypothesised that the total ACE score would be positively correlated with SP, and IPSO with SP would demonstrate a higher prevalence of ACEs than those without SP.

6.3 Method

The data presented in this chapter were a combination of data from study 2 (screening study; main sample of IPSO) and study 3 (further psychometric study; sample of IPSO with PD). Therefore, the method section presented in chapter five (section 5.3) is also applicable to this study, and only a brief recap of relevant sections will be included here.

6.3.1 Participants

Study 2 (screening study) consisted of 155 male IPSO from two category C prison establishments, and study 3 (further psychometric study) included 45 IPSO that demonstrated signs of PD (referred to as IPSO with PD; see chapter five, section 5.3.2 for more information).

6.3.2 Measures

Study 2 utilised screening tools for PD and SP, namely the SIPP-SF, PID-5-SF, and SCS, as well as offence related questions. Study 3 consisted of more in-depth psychometric scales for PD, SP and ACEs, including the SIPP-118, SCS, MPI, and ACEs scale (see chapter five, section 5.3.3 for more information).

6.3.3 Analysis

6.3.3.1 Analytical procedures

In order to explore the relationship between PD and SP, the samples were split into IPSO with SP and IPSO without SP (explained further in section 6.3.3.4). Descriptive statistics were used to describe the samples in relation to the prevalence of PD and ACEs, whereby PD was split into personality functioning (criterion A), pathological personality traits (criterion B), and categorical diagnoses. As per the criteria defined in chapter four (section 4.3.5), no variables exceeded the range for skewness and kurtosis, and no extreme outliers were identified, therefore, all cases were used for analytical purposes. All assumptions were met before further analysis was conducted.

In terms of categorical PDs and ACEs (dichotomous variables), the associations between these and IPSO with SP were examined using chi-square tests for independence (with Yates' continuity correction). Effect sizes (Phi) were interpreted in relation to Cohen's (1988) criteria for .10 for a small effect, .30 for

medium effect, and .5 for large effect. For the PDs that had low prevalence rates (violating the chi-square test assumptions) the Fisher's exact probability test using the Freeman-Halton extension was utilised instead. Furthermore, for PDs and ACEs, odds ratios (OR) were used to compare the relative events of an event occurring among IPSO with SP compared to IPSO without SP (calculated as described in chapter five, section 5.3.5). Continuous PD and ACE variables were created to enable correlation and regression analysis to be performed, and correlation and multiple regression analyses were conducted to explore the relationships between categorical PDs and SP, personality functioning and SP, pathological personality traits and SP, PD and ACEs, and SP and ACEs. Finally, with regard to personality functioning and pathological personality traits, the means of the groups (IPSO with SP versus IPSO without SP) were compared to each other using independent samples *t*-tests.

For multiple regression analysis, various assumptions are required, including: linearity, independence of errors, homoscedasticity, multicollinearity and normality (Osborne & Waters, 2002). Therefore, linearity was assessed by examining scatterplots, boxplots were explored for independence of errors, homoscedasticity was assessed by looking at the plot of standardized residuals by the standardized predicted value, multicollinearity was examined via correlation coefficients, tolerance, and Variance Inflation Factors (VIFs), and normality via skewness and kurtosis. General rules of thumbs were used regarding multicollinearity, whereby tolerance levels below .10 would indicate multicollinearity, and VIFs above 10 would indicate a problem (Montgomery, Peck & Vining, 2001; Pallant, 2016).

6.3.3.2 Missing data

As per section 5.3.5.2, a missing value analysis revealed that data from study two were missing completely at random, therefore, as a way of retaining all cases due to a limited sample size, the Expectation Maximisation algorithm was used. Due to study three being a one-to-one assessment with the researcher, there were no missing data.

6.3.3.3 Multiple comparisons and type 1 error

As in chapter five (section 5.3.5.3), the Benjamini-Hochberg procedure will be utilised throughout this chapter to control for the false discovery rate.

6.3.3.4 Research samples

This chapter presents results from both study 2 ($n = 155$) and study 3 ($n = 45$), with some data (i.e. personality functioning facets) only being available for the latter, due to the psychometrics used within each. Study 3 was only conducted with IPSO that demonstrated signs of PD, therefore, it is important to bear in mind that this sample represents IPSO with PD, rather than IPSO in general. These are referred to as either the main IPSO research sample ($n = 155$), or IPSO with PD ($n = 45$). Similar to the

previous chapter, for the purpose of analysis, the main sample of IPSO was divided into IPSO that demonstrated SP (SCS scores of 1.5 or higher), and those that did not demonstrate SP, whereby 45% (69 out of 155) of IPSO showed an average score of 1.5 or above on the SCS. Additionally, of the 45 IPSO that demonstrated PD sample, 67% (30 out of 45) met the criteria for SP. Throughout the results section it will be made clear which sample is being analysed, referred to as either IPSO with SP ($n = 69$), IPSO without SP ($n = 86$), IPSO with PD and SP ($n = 30$), or IPSO with PD without SP ($n = 15$).

6.4 Results

6.4.1 Part A: The relationship between personality disorder and sexual preoccupation

This section will consider the (i) prevalence of categorical PDs among IPSO with SP compared to IPSO without SP, (ii) relationship between categorical PDs and SP, (iii) prevalence of impairments in personality functioning (criterion A) among IPSO with SP compared to IPSO without SP, (iv) relationship between personality functioning and SP, (v) prevalence of pathological personality traits (criterion B) among IPSO with SP compared to IPSO without SP, and (vi) relationship between pathological personality traits and SP.

6.4.1.1 Categorical PDs and SP

6.4.1.1.1 The prevalence of categorical PDs among IPSO with SP compared to IPSO without SP

The prevalence of PDs among IPSO with SP ($n = 69$) were compared to the prevalence among IPSO without SP ($n = 86$) using chi square tests for independence. However, due to the low prevalence of some PDs among the groups, the assumptions of the chi-square test were violated (less than 80% of cells had less than 5 expected frequencies), therefore, for these PDs a Fisher's exact probability test was used. Odds ratios (OR) were used to compare the relative odds of an event occurring (e.g. having borderline PD) in one group with the odds of it occurring in another group (Szumilas, 2010). The OR were calculated as described above, using the Haldane-Anscombe correction when zero incidences of PDs were found.

In regard to the main sample ($n = 155$), of the 69 IPSO that demonstrated SP, 73% also met criteria for PD, whereas, of the 86 IPSO without SP, 34% demonstrated PD. Additionally, for the sample of IPSO with PD ($n = 45$), 67% of the sample met criteria for SP, with both samples demonstrating high comorbidity between the two phenomena. The prevalence rates of PD among IPSO with SP compared to IPSO without SP can be seen in table 19. As can be seen, *borderline* and *avoidant* PDs were the most

Table 19. Prevalence of categorical personality disorders among IPSO with SP compared to IPSO without SP

	Personality disorders	IPSO with SP	IPSO without SP	Odds ratio (95% CI)	Chi-square test for independence		
		(n = 69)	(n = 86)		χ^2 (df)	p	phi
PDs retained in the DSM-5 AMPD	Borderline PD	26.1%	4.7%	7.24 (2.32, 22.59)	12.74 (1)	.001***	.31
	Avoidant PD	17.4%	5.8%	3.41 (1.14, 10.21)	4.14 (1)	.042*	.18
	Schizotypal PD ¹	8.7%	1.2%	8.10 (0.95, 68.94)	-	.031*	-
	Narcissistic PD ¹	8.7%	0%	16.29 (0.98, 320.13)	-	.007**	-
	Obsessive-compulsive PD ¹	4.3%	1.2%	3.86 (0.39, 38.00)	-	.232	-
	Antisocial PD ¹	2.9%	0%	5.11 (0.30, 135.71)	-	.197	-
PDs not retained in the DSM-5 AMPD	Dependent PD	14.5%	3.5%	4.69 (1.24, 17.78)	4.69 (1)	.030*	.20
	Depressive PD	15.9%	4.7%	3.89 (1.18, 12.82)	4.37 (1)	.037*	.19
	Passive Aggressive PD	14.5%	3.5%	4.69 (1.24, 17.78)	4.67 (1)	.030*	.20
	Schizoid PD ¹	2.9%	2.3%	1.25 (0.17, 9.14)	-	.603	-
	Paranoid PD ¹	2.9%	1.2%	2.54 (0.22, 28.58)	-	.418	-
	Histrionic PD ¹	4.3%	0%	7.77 (0.46, 179.34)	-	.086	-

Note. IPSO = individual who has previously sexually offended; SP = sexual preoccupation; PD = personality disorder; DSM-5 = Diagnostic Statistical Manual for Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders; CI = confidence intervals; df = degrees of freedom. ¹ = Fisher's Exact Test was used due to violations of chi-square assumptions. Significant at *.05 level, **.01 level, ***.001 level.

dominant retained PDs among IPSO with SP, with *depressive*, *dependent*, and *passive-aggressive* PDs being the most common non-retained PDs. Similar patterns are shown among the sample of IPSO without SP, although the prevalence was to a lesser extent.

In relation to the six retained PDs, IPSO with SP had over 16 times the odds of experiencing *narcissistic* PD, 8 times the odds of *schizotypal* PD, seven times the odds of *borderline* PD, and over three times the odds of having *avoidant* PD, whereby chi-square tests (or Fisher's exact test) revealed significant associations between SP and the prevalence of specific PDs. Furthermore, regarding the non-retained PDs, significant associations were found between SP and *dependent*, *depressive*, and *passive-aggressive* PDs, in which IPSO with SP were almost five times more likely to experience *dependent* and *passive-*

aggressive PDs, and almost 4 times more likely to report *depressive* PD. No significant associations were demonstrated for the other PDs. Due to multiple testing the Benjamini-Hochberg procedure was used, which revealed that only the results relating to *borderline* and *narcissistic* PDs remained significant (see appendix 20.10).

6.4.1.1.2 The relationship between categorical PDs and SP

For the purposes of the above analyses when focusing on prevalence rates, dichotomous variables were utilised to determine whether PD and SP were absent or present. However, as mentioned previously in chapter five (section 5.3.3), in order to retain the advantage of using a dimensional approach to PD, the sum method will be used, which keeps the scores continuous so that valuable information is not sacrificed. Therefore, for the purposes of correlation and regression analyses, continuous scores of PD and SP were utilised. All twelve PDs were found to correlate either moderately or largely with SP (see table 20), however, given the high comorbidity found between the PDs in chapter five, and in accordance with the DSM-5 AMPD, only the six retained PDs were included in the regression model.

Multiple regression analysis was conducted to explore if categorical PDs significantly predicted SP among the main sample of IPSO. The result for the entire regression model (including the six retained PDs) was significant $F(6, 148) = 23.29, p < .001$, and indicated that the six PDs collectively explained 48.6% (adjusted R square = 46.5%) of the variance in sexual preoccupation. However, only two of these PDs significantly predicted SP, with *borderline* PD making the strongest unique contribution ($\beta = .29, p < .05$), as well as *narcissistic* PD ($\beta = .26, p < .01$; see table 20). Results from the Benjamini-Hochberg procedure revealed that all significant results remained significant (see appendix 20.11).

Table 20. Correlation and multiple regression analyses for the interactions between categorical PDs and SP among IPSO

Personality disorders	Correlation		Regression				
	<i>r</i>	<i>b</i>	<i>SE</i>	β	95% CI for <i>b</i>		
					Lower	Upper	
PDs retained in the DSM-5 AMPD	Borderline PD	.61**	.45*	.21	.29	.04	.85
	Avoidant PD	.43**	-.08	.38	-.21	-.83	.67
	Schizotypal PD	.53**	-.18	.29	-.09	-.76	.39
	Narcissistic PD	.59**	1.54**	.54	.26	.47	2.62
	Obsessive-compulsive PD	.49**	.27	.38	.08	-.48	1.02
	Antisocial PD	.66**	.47	.25	.26	-.02	.97
PDs not retained in the DSM-5 AMPD	Dependent PD	.51**	-	-	-	-	-
	Depressive PD	.49**	-	-	-	-	-
	Passive Aggressive PD	.54**	-	-	-	-	-
	Schizoid PD	.35**	-	-	-	-	-
	Paranoid PD	.50**	-	-	-	-	-
	Histrionic PD	.63**	-	-	-	-	-

Note. IPSO = individual who has previously sexually offended; SP = sexual preoccupation; PD = personality disorder; DSM-5 = Diagnostic Statistical Manual for Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders; *r* = Pearson's correlation coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals. Significant at *.05 level, **.01 level, ***.001 level.

6.4.1.2 The prevalence of impairments in personality functioning (criterion A) among IPSO with SP compared to IPSO without SP

The approach to PDs taken within this thesis (which aligns with the DSM-5 AMPD) means that categorical PDs could be explored, as well as the scales providing insight above and beyond that of a categorical diagnosis, by enabling the exploration of personality functioning (criterion A) and pathological personality traits (criterion B).

6.4.1.2.1 Impairments in personality functioning domains among IPSO with SP

In the screening study (*n* = 155), personality functioning was assessed using three domains from the SIPP-SF (*identity integration, relational capacities, and self-control*). Figure 14 depicts the percentage of IPSO with SP (*n* = 69) that showed impairments (a score of less than 40 indicates impaired adaptive

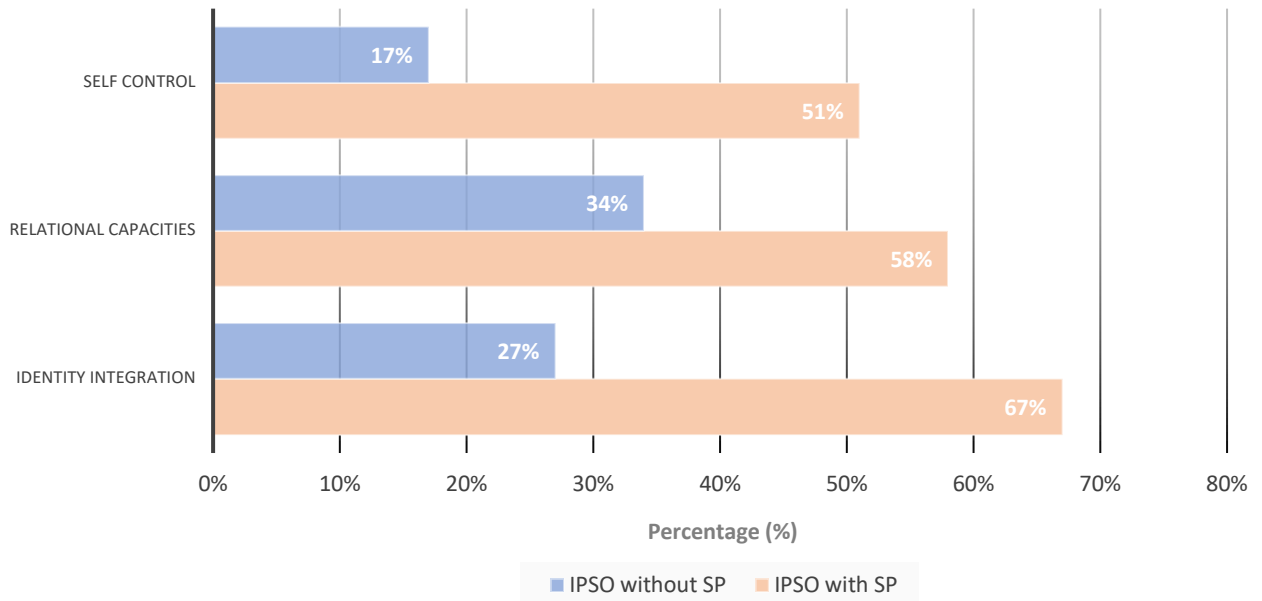


Figure 14. The percentage of IPSO with SP and IPSO without SP that demonstrated impaired functioning on SIPP-SF domains

functioning) in each domain compared to IPSO without SP ($n = 86$). As can be seen, impairments in all three of the domains were higher among IPSO with SP compared to IPSO without SP. Impairments in *identity integration* (67%) and *relational capacities* (58%) were particularly high, which are thought to comprise the personality functioning criterion of the AMPD.

6.4.1.2.2 SIPP-SF domains among IPSO with SP compared to IPSO without SP

A series of independent t -tests enabled comparisons of IPSO with SP against IPSO without SP, in terms of their adaptive personality functioning. Table 21 demonstrates that IPSO with SP had significantly lower (worse) adaptive personality functioning in comparison to IPSO without SP on all three domains. All results remained significant after using the Benjamini-Hochberg procedure (see appendix 20.12).

6.4.1.2.3 Relationship between personality functioning (SIPP-SF domains) and SP

Correlation analysis revealed that all three domains were moderately or largely correlated with SP, therefore, all three domains were included in the regression model. The regression model was significant $F(3, 151) = 25.21, p < .001$, indicating that the three domains collectively explained 33.4% (adjusted R square = 32%) of the variance in sexual preoccupation. *Self-control* made the strongest unique contribution ($\beta = -.47, p < .001$), however, *identity integration* was also a significant predictor of SP ($\beta = -.25, p < .05$; see table 21). Results from the Benjamini-Hochberg procedure revealed that all results remained significant (see appendix 20.13).

Table 21. Independent sample *t*-tests comparing the adaptive personality functioning (SIPP-SF) of IPSO with SP compared to IPSO without SP, and correlation and multiple regression analyses for the interactions between SIPP-SF domains and SP

SIPP-SF Domains	IPSO with SP (<i>n</i> = 69)	IPSO without SP (<i>n</i> = 86)		Correlation and regression analyses					
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	<i>r</i>	<i>b</i>	<i>SE</i>	β	95% CI for <i>b</i> <i>Lower</i> <i>Upper</i>	
Self-control	2.81 (.74)	3.45 (.63)	5.76*** (134)	-.56***	-.39***	.07	-.47	-.54	-.25
Identity integration	2.53 (.75)	3.21 (.70)	5.80*** (153)	-.46***	-.20*	.08	-.25	-.36	-.03
Relational capacities	2.54 (.63)	2.84 (.71)	2.77** (153)	-.30***	.12	.09	.13	-.06	.29

Note. Significant at *.05 level, **.01 level, ***.001 level (all *r* coefficients significant at .001 level). SIPP-SF = Severity Indices of Personality Problems Short Form; IPSO = individual who has previously sexually offended; *r* = Pearson's coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals. Lower scores equate to more impaired functioning.

6.4.1.2.4 Impairments in personality functioning domains among IPSO with PD and SP

As detailed in chapter 5, the more in-depth personality functioning scale (SIPP-118) was only conducted with IPSO with PD, therefore, for the domains and facets of the SIPP-118, it refers specifically to IPSO that met the criteria for PD. Figure 15 depicts the percentage of IPSO with PD and SP (*n* = 30) that demonstrated impairments in each domain (*social concordance*, *relational capacities*, *responsibility*, *self-control*, and *identity integration*), compared to IPSO with just PD (without SP; *n* = 15). As can be seen, both samples showed similar impairments in terms of *relational capacities*, however, the sample of IPSO with PD that also met the criteria for SP demonstrated more impairments in personality functioning, especially in the *identity integration*, *self-control*, and *responsibility* domains.

6.4.1.2.5 SIPP-118 domains among IPSO with PD and SP compared to IPSO with PD

A series of independent *t*-tests enabled comparisons of IPSO with PD and SP against IPSO with PD without SP, in terms of their adaptive personality functioning. Table 22 demonstrates that IPSO with PD and SP had significantly lower (worse) adaptive personality functioning in comparison to IPSO with PD (without SP) on the domains of *self-control*, *identity integration*, and *responsibility*. However, *identity integration* become non-significant after using the Benjamini-Hochberg procedure (see appendix 20.14).

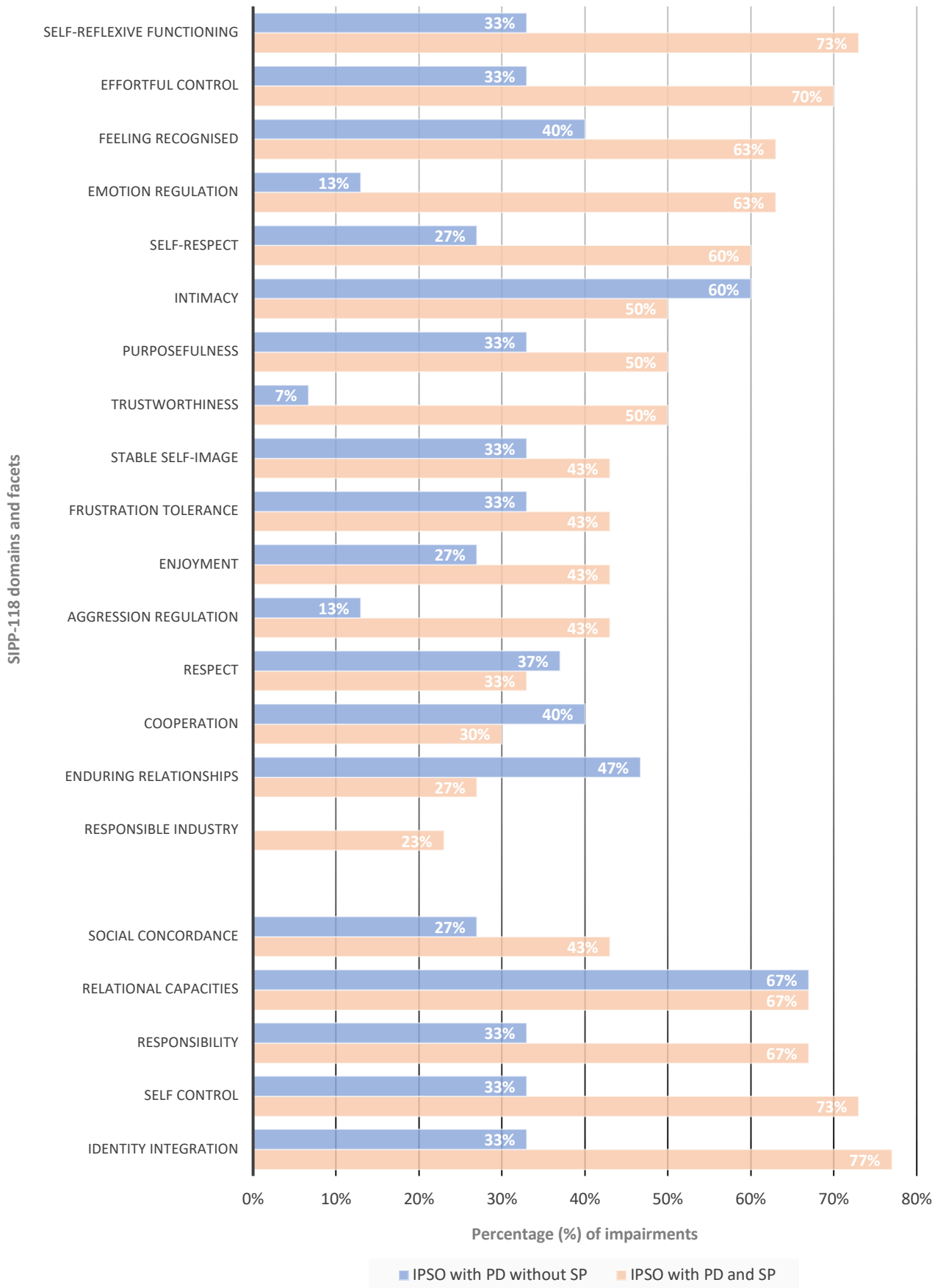


Figure 15. The percentage of (i) IPSO with PD and SP, and (ii) IPSO with PD without SP that demonstrated impaired personality functioning on SIPP-118 domains and facets

Table 22. Independent sample t-tests comparing the adaptive personality functioning (SIPP-118 domains) of (i) IPSO with PD and SP compared to (ii) IPSO with PD without SP, and correlation and multiple regression analyses for interactions between SIPP-118 domains and SP

SIPP-118 Domains	IPSO with PD and SP (n = 30)	IPSO with PD without SP (n = 15)		Correlation and regression analyses					
	M (SD)	M (SD)	t (df)	r	b	SE	β	95% CI for b	
								Lower	Upper
Self-control	2.43 (.71)	3.23 (.61)	3.77*** (43)	-.50***	-.50*	.22	-.53	-.94	-.06
Identity integration	2.43 (.66)	2.87 (.60)	2.17* (43)	-.39***	-.21	.16	-.19	-.53	.11
Responsibility	2.83 (.54)	3.4 (.32)	3.75*** (43)	-.36***	-.15	.23	-.11	-.61	.32
Relational capacities	2.43 (.61)	2.23 (.71)	-.99 (43)	.005	-	-	-	-	-
Social Concordance	3.09 (.46)	3.31 (.55)	1.45 (43)	-.25***	.36	.29	.25	-.22	.95

Note. Significant at *.05 level, **.01 level, ***.001 level (all *r* coefficients significant at .001 level). SIPP-118 = Severity Indices of Personality Problems 118; IPSO = individual who has previously sexually offended; *r* = Pearson's coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals. Lower scores equate to more impaired functioning.

6.4.1.2.6 Relationship between personality functioning (SIPP-118 domains) and SP among IPSO with PD

Correlation analysis revealed that four of the five domains (excluding *relational capacities*) were significantly correlated with SP, therefore these four domains were included in the regression model. The regression model was significant $F(4, 40) = 4.68, p < .01$, indicating that the domains collectively explained 25.1% (adjusted R square) of the variance in sexual preoccupation. *Self-control* was the only significant predictor of SP ($\beta = -.53, p < .05$; see table 22), which remained significant after conducting the Benjamini-Hochberg procedure (see appendix 20.15). However, these results must be interpreted with caution given the relatively small sample size for regression analysis.

6.4.1.2.7 Impairments in personality functioning facets among IPSO with PD and SP

The five domains of the SIPP-118 are broken down into 16 facets. The percentage of IPSO with PD and SP that had impairments in each of these facets can also be seen in figure 15, alongside IPSO with just PD (without SP). As can be seen, IPSO with PD that also met the criteria for SP demonstrated more impairments in personality functioning on 12 of the 16 facets, whereby they were most impaired in the facets of *self-reflexive functioning*, *effortful control*, *feeling recognised*, and *emotion regulation*. However, IPSO with PD without SP demonstrated more impairments in the facets of *intimacy*, *respect*, *cooperation*, and *enduring relationships*.

6.4.1.2.8 SIPP-118 facets among IPSO with PD and SP compared to IPSO with PD

A series of independent *t*-tests enabled comparisons of IPSO with PD and SP against IPSO with PD without SP, regarding their impaired personality functioning according to SIPP-118 facets. As can be seen from table 23, IPSO with PD and SP scored significantly lower (worse functioning) on over half of the facets (9 out of 16) than IPSO with PD but without SP. These facets include *emotional regulation*, *effortful control*, *self-respect*, *self-reflexive functioning*, *purposefulness*, *responsible industry*, *trustworthiness*, *aggression regulation*, and *frustration tolerance*. All results remained significant after using the Benjamini-Hochberg procedure (see appendix 20.16).

6.4.1.2.9 Relationship between personality functioning (SIPP-118 facets) and SP among IPSO with PD

Correlation analysis revealed that 10 of the facets were significantly correlated with SP, however, due to the limited sample size ($n = 45$) it was not possible to include all of these as predictors in a regression model. Therefore, given that *self-control* was found to be the only significant predictor of SP among IPSO with PD, as well as making the strongest contribution to SP among general IPSO, the facets which comprise *self-control* (*emotion regulation* and *effortful control*) were used as predictors to see if either or both contributed to SP. The regression model was significant $F(2, 42) = 9.64, p < .001$, indicating that the domains collectively explained 28.2% (adjusted R square) of the variance in sexual preoccupation. *Emotion regulation* was the only significant predictor of SP ($\beta = -.59, p < .001$; see table 23), which remained significant after conducting the Benjamini-Hochberg procedure (see appendix 20.17). However, these results must be interpreted with caution given the relatively small sample size for regression analysis.

Table 23. Independent sample *t*-tests comparing the adaptive personality functioning (SIPP-118 domains) of (i) IPSO with PD and SP compared to (ii) IPSO with PD without SP, and correlation and multiple regression analyses for interactions between SIPP-118 domains and SP

SIPP-118 Facets	IPSO with PD and SP (<i>n</i> = 30)	IPSO with PD without SP (<i>n</i> = 15)		Correlation and regression analyses					
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	<i>r</i>	<i>b</i>	<i>SE</i>	β	95% CI for <i>b</i> <i>Lower</i> <i>Upper</i>	
Emotion regulation	2.44 (.81)	3.21 (.41)	4.30*** (43)	-.56***	-.64**	.24	-.59	-1.12	-.16
Effortful control	2.22 (.63)	2.85 (.81)	2.85** (43)	-.44***	.04	.21	.04	-.40	.47
Stable self-image	2.52 (.65)	2.81 (.54)	1.48 (43)	-.33**	-	-	-	-	-
Self-reflexive functioning	2.43 (.48)	2.89 (.61)	2.73** (43)	-.32**	-	-	-	-	-
Aggression regulation	2.99 (.86)	3.58 (.55)	2.77** (43)	-.35**	-	-	-	-	-
Frustration tolerance	2.40 (.52)	2.78 (.55)	2.24* (43)	-.36**	-	-	-	-	-
Self-respect	2.43 (.54)	2.87 (.64)	2.40* (43)	-.47**	-	-	-	-	-
Purposefulness	2.56 (.61)	3.08 (.59)	2.57* (43)	-.40***	-	-	-	-	-
Enjoyment	2.66 (.64)	2.91 (.75)	1.18 (43)	-.13	-	-	-	-	-
Feeling recognised	2.48 (.45)	2.68 (.57)	1.31 (43)	-.19	-	-	-	-	-
Intimacy	2.48 (.66)	2.31 (.69)	-.81 (43)	-.01	-	-	-	-	-
Enduring relationships	2.53 (.66)	2.30 (.93)	-.99 (43)	.04	-	-	-	-	-
Responsible industry	2.76 (.53)	3.27 (.45)	3.15** (43)	-.33**	-	-	-	-	-
Trustworthiness	2.95 (.50)	3.51 (.26)	4.94*** (43)	-.40***	-	-	-	-	-
Respect	3.18 (.44)	3.40 (.49)	1.51 (43)	-.26	-	-	-	-	-
Cooperation	2.97 (.54)	3.12 (.75)	.67 (43)	-.08	-	-	-	-	-

Note. Significant at *.05 level, **.01 level, ***.001 level. SIPP-118 = Severity Indices of Personality Problems 118; IPSO = individual who has previously sexually offended; *r* = Pearson's coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals. Lower scores equate to more impaired functioning.

6.4.1.5 The prevalence of pathological personality traits (criterion B) among IPSO with SP compared to IPSO without SP

6.4.1.5.1 Pathological personality traits and domains among IPSO with SP

Pathological personality traits were assessed by the PID-5-SF, which consists of 25 traits that are organised into five domains. The prevalence of elevated personality traits and domains among IPSO are presented in figure 16. As demonstrated, the main elevated domain among IPSO with SP was *negative affect*, whereby 33% of IPSO with SP showed dysfunction in this area. Additionally, IPSO with SP demonstrated more dysfunction in all five trait domains in comparison to IPSO without SP. In relation to pathological personality traits, *anxiousness*, *separation insecurity*, *impulsivity*, and *depressivity* were the most prevalent traits among IPSO with SP. Furthermore, IPSO with SP showed a greater prevalence of all pathological personality traits compared to IPSO without SP, excluding intimacy avoidance.

6.4.1.5.2 Personality trait domains among IPSO with SP compared to IPSO without SP

A series of independent samples *t*-tests revealed that IPSO with SP demonstrated significantly more dysfunction in all five trait domains compared to IPSO without SP (see table 24). All results remained significant after using the Benjamini-Hochberg procedure (see appendix 20.18).

6.4.1.5.3 The relationship between personality trait domains and SP

Correlation analysis revealed that all five trait domains were largely correlated with SP, therefore, all five domains were included in the regression model. The regression model was significant $F(5, 149) = 31.67, p < .001$, indicating that the five trait domains collectively explained 51.5% (adjusted R square = 49.9%) of the variance in sexual preoccupation. *Antagonism* made the strongest unique contribution ($\beta = .41, p < .001$), however, *negative affect* was also a significant predictor of SP ($\beta = .23, p < .05$; see table 24). Results from the Benjamini-Hochberg procedure revealed that all results remained significant (see appendix 20.19).

6.4.1.5.4 Pathological personality traits among IPSO with SP compared to IPSO without SP

A series of independent samples *t*-tests revealed that IPSO with SP demonstrated significantly higher scores (more pathology) on 24 out of 25 pathological personality traits, other than *intimacy avoidance*, where no significant differences were found (see table 25). All results remained significant after using the Benjamini-Hochberg procedure (see appendix 20.20).

6.4.1.5.5 The relationship between pathological personality traits and SP

As demonstrated in table 25, correlation analysis revealed that 24 out of the 25 pathological personality traits (excluding *intimacy avoidance*) were significantly correlated with SP. Similar to above, due to the limited sample size, it was not possible to include all of these as predictors in one regression

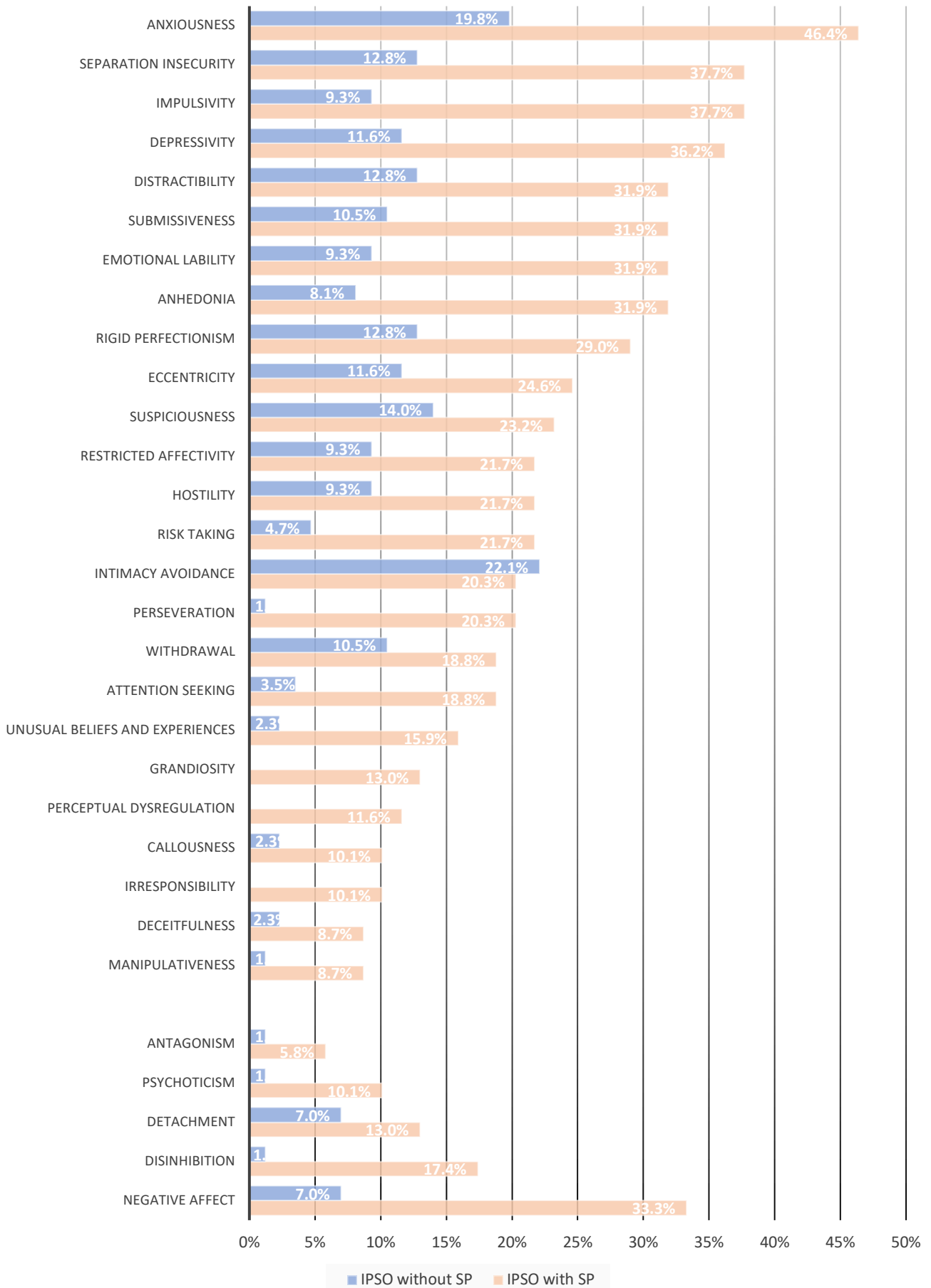


Figure 16. The percentage of IPSO with SP and IPSO without SP that demonstrate elevated personality traits and domains

Table 24. Independent sample t-tests comparing personality trait domains (PID-5-SF) of IPSO with SP compared to IPSO without SP, and correlation and multiple regression analyses for the interactions between trait domains and SP

PID-5-SF Domains	IPSO with SP (n = 69)	IPSO without SP (n = 86)		Correlation and regression analyses					
	M (SD)	M (SD)	t (df)	r	b	SE	β	95% CI for b Lower Upper	
Negative Affect	1.56 (.70)	.83 (.70)	6.55*** (153)	.54***	2.18*	.86	.23	.49	3.87
Detachment	1.20 (.65)	.86 (.65)	3.32*** (153)	.35***	-.68	.85	-.06	-2.35	.99
Antagonism	.73 (.71)	.26 (.38)	5.62*** (153)	.64***	5.20***	1.02	.41	3.19	7.21
Disinhibition	1.26 (.70)	.59 (.54)	6.75*** (153)	.61***	1.91	1.07	.18	-.21	4.04
Psychoticism	1.00 (.75)	.43 (.53)	5.62*** (153)	.59***	.75	1.15	.07	-1.41	3.02

Note. Significant at *.05 level, **.01 level, ***.001 level (all *r* coefficients significant at .001 level). PID-5-SF = Personality Inventory for the DSM-5 – Short Form; IPSO = individual who has previously sexually offended; *r* = Pearson’s coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals.

model. Therefore, given that the *antagonism* and *negative affect* domains were previously found to be predictive of SP in the above results, and in previous research (Heaven et al., 2013; Walton et al., 2017), two regression models were used to explore which facets of each domain were predictive of SP. The model relating to *antagonism* includes *deceitfulness*, *grandiosity*, and *manipulativeness*, and the model relating to *negative affect* includes *anxiousness*, *emotional lability*, and *separation insecurity*.

The regression model for *antagonism* was significant $F(3, 151) = 36.07, p < .001$, indicating that the three facets collectively explained 41.7% (adjusted R square = 40.6%) of the variance in sexual preoccupation. *Deceitfulness* made the strongest unique contribution ($\beta = .32, p < .01$), however, *grandiosity* was also a significant predictor of SP ($\beta = .31, p < .001$; see table 25). Results from the Benjamini-Hochberg procedure revealed that all results remained significant (see appendix 20.21). Furthermore, the regression model for *negative affect* was also significant $F(3, 151) = 22.14, p < .001$, indicating that the three facets collectively explained 30.5% (adjusted R square = 29.2%) of the variance in sexual preoccupation. *Emotional lability* made the strongest unique contribution ($\beta = .34, p < .001$), however, *separation insecurity* was also a significant predictor of SP ($\beta = .21, p < .05$; see table 25). Results from the Benjamini-Hochberg procedure revealed that all results remained significant (see appendix 20.22).

Table 25. Independent sample t-tests comparing pathological personality traits among IPSO with SP compared to IPSO without SP, and correlation and multiple regression analyses for the interactions between personality traits and SP

PID-5-SF Traits	IPSO with SP (n = 69)	IPSO without SP (n = 86)		Correlation and regression analyses					
	M (SD)	M (SD)	t (df)	r	b	SE	β	95% CI for b Lower Upper	
Emotional lability	1.44 (.92)	.75 (.75)	5.14*** (153)	.51***	2.87***	.80	.34	1.28	4.45
Anxiousness	1.73 (.81)	.97 (.90)	5.42*** (153)	.44***	.65	.80	.08	-.94	2.23
Separation insecurity	1.53 (.87)	.76 (.76)	5.94*** (153)	.46***	1.77*	.77	.21	.25	3.30
Submissiveness	1.38 (.74)	.88 (.73)	4.18*** (153)	.39***	(Facets of negative affect)				
Hostility	1.24 (.81)	.59 (.72)	5.50*** (153)	.51***	-	-	-	-	-
Perseveration	1.27 (.77)	.42 (.55)	7.78*** (119)	.64***	-	-	-	-	-
Withdrawal	1.22 (.79)	.90 (.73)	2.62** (153)	.32***	-	-	-	-	-
Intimacy avoidance	1.05 (.82)	1.03 (.95)	.16 (153)	.10	-	-	-	-	-
Anhedonia	1.34 (.86)	.64 (.70)	5.60*** (131)	.44***	-	-	-	-	-
Depressivity	1.44 (.95)	.70 (.81)	5.21*** (134)	.45***	-	-	-	-	-
Restricted affectivity	1.12 (.83)	.83 (.67)	2.39* (129)	.21**	-	-	-	-	-
Suspiciousness	1.21 (.78)	.81 (.80)	3.18** (153)	.37***	-	-	-	-	-
Manipulativeness	.79 (.77)	.33 (.45)	4.45*** (153)	.55***	.95	1.24	.08	-1.51	3.40
Deceitfulness	.78 (.79)	.27 (.49)	4.94*** (108)	.59***	3.51**	1.17	.32	1.20	5.83
Grandiosity	.72 (.86)	.19 (.33)	4.84*** (85)	.58***	3.54***	1.00	.31	1.57	5.51
Attention seeking	.98 (.83)	.40 (.59)	4.87*** (119)	.48***	(Facets of antagonism)				
Callousness	.70 (.84)	.24 (.48)	4.02*** (103)	.51***	-	-	-	-	-
Irresponsibility	.88 (.77)	.35 (.42)	5.19*** (101)	.58***	-	-	-	-	-
Impulsivity	1.39 (.95)	.63 (.77)	5.38*** (130)	.52***	-	-	-	-	-
Distractibility	1.51 (.82)	.79 (.82)	5.39*** (153)	.48***	-	-	-	-	-
Risk taking	1.16 (.79)	.52 (.68)	5.26*** (135)	.49***	-	-	-	-	-
Rigid perfectionism	1.46 (.88)	.79 (.79)	4.96*** (153)	.44***	-	-	-	-	-

Unusual beliefs and experiences	.98 (.86)	.45 (.63)	4.29*** (121)	.52***	-	-	-	-	-
Eccentricity	1.26 (.92)	.65 (.81)	4.36*** (153)	.42***	-	-	-	-	-
Perceptual dysregulation	.77 (.83)	.18 (40)	5.43*** (93)	.62***	-	-	-	-	-

Note. Significant at *.05 level, **.01 level, ***.001 level. PID-5-SF = Personality Inventory for the DSM-5 – Short Form; IPSO = individual who has previously sexually offended; r = Pearson’s coefficient; b = unstandardized coefficient; SE = standard error; β = beta; CI = confidence intervals.

6.4.1.5.6 The relationship between borderline personality disorder traits and SP

Due to *borderline* PD being the most prominent PD among IPSO, and the most predictive of SP, the pathological personality traits related to *borderline PD* (*emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk-taking, and hostility*) were further explored in relation to SP. Correlation analysis revealed that all seven pathological personality traits were correlated with SP, therefore, all seven were included in the regression model. The regression model was significant $F(7, 147) = 13.32, p < .001$, indicating that the seven pathological personality traits collectively explained 38.8% (adjusted R square = 35.9%) of the variance in sexual preoccupation. However, *separation insecurity* was the only significant predictor of SP ($\beta = .19, p < .01$; see appendix 24). Results from the Benjamini-Hochberg procedure revealed that all results remained significant (see appendix 20.23).

6.4.1.6 Summary

Almost three quarters of IPSO with SP met the criteria for PD, whereby all twelve PDs were found to be prevalent among the sample, demonstrating high comorbidity between the two phenomena. *Borderline* and *avoidant* PDs were the most prominent PDs, however, IPSO with SP (compared to IPSO without SP) were significantly more likely to experience *borderline* and *narcissistic* PDs. All PDs significantly correlated with SP, yet *borderline* and *narcissistic* PDs were the only significant predictors of SP.

In terms of personality functioning, IPSO with SP demonstrated significantly worse impairment in the domains of *self-control, identity integration, and relational capacities*, in comparison to IPSO without SP. All three domains were positively correlated with SP, however, only *self-control* and *identity integration* were found to be significant predictors. Considering the sample of IPSO with PD that also met the criteria for SP, they demonstrated significantly lower (worse) adaptive functioning in the *self-control* and *responsibility* domains, whereby *self-control* was found to be the only significant predictor of SP. Furthermore, in relation to the facets prevalent, IPSO with PD and SP were significantly more likely to have worse functioning in *emotion regulation, effortful control, self-respect, self-reflexive functioning, purposefulness, responsible industry, trustworthiness, aggression regulation, and*

frustration tolerance. When considering the facets that comprise *self-control*, *emotion regulation* was found to be the only significant predictor of SP.

Finally, regarding pathological personality traits, IPSO with SP demonstrated significantly more dysfunction in all five trait domains compared to IPSO without SP, whereby dysfunction in *negative affect* was the most prominent. All five domains were positively correlated with SP, nonetheless, only *antagonism* and *negative affect* were predictors of SP. Additionally, IPSO with SP demonstrated significantly greater dysfunction in all pathological personality traits (except for *intimacy avoidance*), whereby these traits were also significantly correlated with SP. In relation to the traits which comprise *antagonism*, *deceitfulness* and *grandiosity* were found to be significant predictors of SP, and for the domain *negative affect*, *emotional lability* and *separation insecurity* were significant predictors of SP.

6.4.2 Part B: The relationship between personality disorder and adverse childhood experiences

ACEs were explored during study three only, therefore, the prevalence of ACEs are only available among IPSO who met criteria for PD (as presented in section 5.4.4). Among this sample, all IPSO with PD experienced at least one ACE before the age of 18 years, and over half (58%) experienced four or more ACEs. The total ACE score was significantly correlated with *borderline* ($r = .34, p < .05, n = 45$), *paranoid* ($r = .35, p < .05, n = 45$), and *passive-aggressive* ($r = .32, p < .05, n = 45$) PDs, however, no associations were found with the remaining PDs. All IPSO with *obsessive-compulsive*, *schizotypal*, *paranoid*, *schizoid*, and *passive-aggressive* PDs reported four or more ACEs, whereas, 88% of IPSO with *depressive* PD experienced four or more, 83% of IPSO with *avoidant* and *borderline* PDs had four or more ACEs, 80% of IPSO with *dependent* PD, and 50% of IPSO with *narcissistic* PD had four or more ACEs (no cases of *antisocial* or *histrionic* PD were identified in study 3).

Crosstabs were calculated to determine the prevalence of adverse experiences among IPSO who met criteria for specific PDs, as demonstrated in table 26. Among IPSO with *borderline* and *schizotypal* PDs, *physical* and *verbal* (emotional) abuse were the most prevalent adverse experiences. Whereas, for IPSO with *avoidant* PD, *physical abuse* and *parental separation* were the most common. IPSO with *narcissistic* PD experienced *physical abuse* the most, and for IPSO with *obsessive-compulsive* PD, *sexual* and *physical abuse* were the most prominent adverse experiences (however, caution should be taken when interpreting these results, as there were only 2 cases of each PD in the sample). A small number of cases were also found for PDs not retained in the AMPD (specifically *schizoid* and *paranoid* PDs), however, for IPSO with *dependent* PD, *parental separation* was the most common adverse experience, whereas, for IPSO with *passive-aggressive* PD, *verbal abuse* was the most common. Finally, *physical abuse*, *verbal abuse*, *parental separation*, and *mental illness* in the family home were the most prevalent ACEs among IPSO with *depressive* PD.

Table 26. Prevalence of adverse childhood experiences among IPSO with personality disorder

Personality Disorders	Child Maltreatment			Household Dysfunction						
	Sexual Abuse	Physical Abuse	Verbal Abuse	Dom Violence	Par Sep	Mental Illness	Alcohol Abuse	Drug Abuse	Incarceration	
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
PDs retained in the DSM-5 AMPD	Borderline PD	7 (58)	10 (83)	11 (92)	9 (75)	9 (75)	7 (58)	7 (58)	2 (17)	2 (17)
	Avoidant PD	3 (50)	5 (83)	4 (67)	2 (33)	5 (83)	4 (67)	1 (17)	1 (17)	1 (17)
	Schizotypal PD	3 (75)	4 (100)	4 (100)	2 (50)	3 (75)	1 (25)	1 (25)	2 (50)	2 (50)
	Narcissistic PD	1 (50)	25(100)	1 (50)	0 (0)	0 (0)	1 (50)	0 (0)	1 (50)	1 (50)
	Ob-comp PD	2 (100)	2 (100)	1 (50)	1 (50)	1 (50)	2 (100)	1 (50)	0 (0)	1 (50)
	Antisocial PD	-	-	-	-	-	-	-	-	-
PDs not retained in the DSM-5 AMPD	Dependent PD	3 (60)	3 (60)	3 (60)	3 (60)	4 (80)	2 (40)	1 (20)	0 (0)	0 (0)
	Depressive PD	5 (63)	6 (75)	6 (75)	4 (50)	6 (75)	6 (75)	3 (38)	1 (13)	1 (13)
	Pass-Agg PD	4 (57)	6 (86)	7 (100)	5 (71)	6 (86)	5 (71)	3 (43)	3 (43)	1 (14)
	Schizoid PD	1 (50)	2 (100)	2 (100)	2 (100)	2 (100)	2 (100)	1 (50)	0 (0)	0 (0)
	Paranoid PD	2 (100)	2 (100)	2 (100)	2 (100)	2 (100)	1 (50)	1 (50)	1 (50)	2 (100)
	Histrionic PD	-	-	-	-	-	-	-	-	-

Note. PD = personality disorder; DSM-5 = Diagnostic Statistical Manual for Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders; Dom violence = domestic violence; Par sep = parental separation. No cases of antisocial or histrionic PDs were found among the sample of IPSO with PD.

Logistic regression analyses were used to determine the association between each ACE and PD, however, due to the limited number of cases in each PD category, the assumptions of logistic regression were not met (except for *borderline* PD). However, no significant associations were found between specific ACEs and *borderline* PD. Correlation analyses (using continuous PD scores and categorical ACEs) revealed that *borderline* PD was moderately correlated with *domestic violence* ($r = .37, p < .01$) and *parental separation* ($r = .34, p < .05$), *schizotypal* and *paranoid PD* were significantly correlated with a member of the family being *incarcerated* ($r = .34, p < .05$; $r = .55, p < .001$ respectively), *passive-aggressive* PD was associated with *parental separation* ($r = .34, p < .05$), and *depressive* PD was correlated with *mental illness* within the family home ($r = .31, p < .05$). When utilising the ACE composite scores (*household dysfunction, emotional/physical abuse, and sexual abuse*), only one significant correlation was found between *borderline* PD and *emotional/physical abuse* ($r = .33, p < .05$).

6.4.3 Part C: The relationship between sexual preoccupation and adverse childhood experiences

The prevalence of ACEs among IPSO with PD and SP ($n = 30$) were compared to the prevalence among IPSO with PD without SP ($n = 15$) using chi square tests for independence (see table 27). Due to the low prevalence of some ACEs among the groups, the assumptions of the chi-square test were violated, therefore, a Fisher's exact probability test was used. OR were also used to compare the odds of an event occurring in one group with the odds of it occurring in another group. As can be seen from the table, no significant differences were found for any of the ACEs among IPSO with PD with SP compared to those without SP.

Table 27. Prevalence of adverse childhood experiences among (i) IPSO with PD with SP compared to (ii) IPSO with PD without SP

Adverse Childhood Experiences	IPSO with PD with SP ($n = 30$)	IPSO with PD without SP ($n = 15$)	Odds ratio (95% CI)	Chi-square test for independence		
				χ^2 (df)	p	ϕ
Verbal abuse	73.3%	80.0%	0.69 (0.15, 3.09)	0.02 (1)	.902	-.07
Physical abuse ¹	76.7%	73.3%	1.20 (0.29, 4.96)	-	1.00	-
Sexual abuse	60.0%	53.3%	1.31 (0.38, 4.58)	0.01 (1)	.915	.06
Parental separation	43.3%	53.3%	0.67 (0.20, 2.32)	0.10 (1)	.751	-.09
Domestic violence	50.0%	33.3%	2.00 (0.55, 7.27)	0.55 (1)	.458	.16
Mental illness	43.3%	40.0%	1.15 (0.33, 4.05)	0.00 (1)	1.00	.03
Alcohol abuse	36.7%	40.0%	0.87 (0.23, 3.10)	0.00 (1)	1.00	-.03
Drug abuse ¹	30.0%	13.3%	15.17 (2.82, 81.47)	-	.288	-
Incarceration ¹	10.0%	20.0%	0.44 (0.08, 2.53)	-	.384	-
0 ACEs	0%	0%	-	-	-	-
1 ACE ¹	6.7%	13.3%	0.46 (0.06, 3.67)	-	.591	-
2-3 ACEs	33.3%	33.3%	1.00 (0.27, 3.72)	0.00 (1)	1.00	.01
4+ ACEs	59.9%	53.3%	1.31 (0.38, 4.58)	0.01 (1)	.915	.06

Note. IPSO = individual who has previously sexually offended; SP = sexual preoccupation; PD = personality disorder; CI = confidence intervals; df = degrees of freedom. ¹ = Fisher's Exact Test was used due to violations of chi-square assumptions. Significant at *.05 level, **.01 level, ***.001 level.

Correlation analyses (using a continuous SP score and categorical ACEs) revealed no significant associations between ACEs and SP, and the total ACE score was not significantly correlated with SP ($r = .04$, $p = .805$). Furthermore, independent samples t -tests examined the differences in composite scores between IPSO with PD with SP and IPSO with PD without SP. No significant differences were reported for *sexual abuse* among IPSO with PD with SP ($M = 1.30$, $SD = 1.26$) and IPSO with PD without SP ($M = 1.40$, $t(43) = 0.24$, $p = .811$), *physical/emotional abuse* among IPSO with PD with SP ($M = 2.00$, $SD = 1.05$) and IPSO with PD without SP ($M = 1.87$, $t(43) = -0.41$, $p = .69$), and *household dysfunction* among IPSO with PD with SP ($M = 1.63$, $SD = 1.3$) and IPSO with PD without SP ($M = 1.67$, $t(43) = 0.08$, $p = .940$).

6.5 Discussion

6.5.1 Part A: The relationship between personality disorder and sexual preoccupation

6.5.1.1 Categorical personality disorders

The findings reveal that among the sample of IPSO with SP, almost three quarters (73%) met the criteria for PD, which aligns with previous research (among general population samples) that shows prevalence rates between 44% - 92% (Black et al., 1997; Carpenter et al., 2013; Raymond et al., 2013), demonstrating high comorbidity between these two phenomena. All twelve of the PDs were found to be prevalent among the research sample, but borderline PD was the most prominent among IPSO with SP. This opposes some research among general population samples (Black et al., 1997; Carpenter et al., 2013; Raymond et al., 2013), who show that although borderline PD was prevalent, it was one of the least prevalent PDs. However, these results offer support for previous research on highly sexually preoccupied IPSO (Payne, 2014) who reported high rates of borderline PD, and among samples of women with borderline PD that demonstrate strong links between borderline PD and SP (Hurlbert, Apt & White, 1992; Jardin et al., 2017; Northey et al., 2016).

Theoretically, this makes sense, as many of the behaviours central to the concept of SP and subsequent harmful sexual behaviours are also seen in individuals with borderline PD (Lloyd et al., 2007). It is well known that difficulties with impulsive behaviour, relationship difficulties, and emotion regulation problems (characteristics of borderline PD) can influence the development of risky sexual behaviours (Hurlbert et al., 1992; Zanarini et al., 2003). For example, two symptoms of borderline PD are impulsivity and risk-taking behaviours, which may be presented through risky sexual behaviour and sexual acting out (Raymond et al., 2003), as demonstrated by individuals in this study who are serving a custodial sentence for committing a sexual offence. Additionally, difficulties with emotions are also common among both individuals with PD and SP (Miner et al., 2009; Prince, 2008). These results support Lloyd et al. (2007), who propose that for men with borderline PD, it may be that they are more likely to

present with sexual complaints rather than suicidal/parasuicidal behaviour that often brings women into contact with mental health professionals.

To the best of the author's knowledge, this is the first study that has assessed the prevalence of PD among a sample of IPSO with SP and compared this to a sample of IPSO without SP in the UK. IPSO with SP were 16 times more likely to experience narcissistic PD, 8 times more likely to report schizotypal PD, seven times more likely to have borderline PD, and three times more likely to have avoidant PD. Furthermore, this study is the first to explore the relationship between categorical PDs and SP among IPSO, whereby all twelve PDs were found to be positively correlated with SP. This supports the hypothesis that narcissistic, paranoid, obsessive-compulsive, avoidant, borderline, antisocial, and passive-aggressive PDs would be prevalent among IPSO with SP, and would be positively associated with SP. IPSO with greater levels of SP indicate a greater degree of personality dysfunction, most notably reflected in borderline, narcissistic, schizotypal, and avoidant symptoms, however, only borderline and narcissistic PDs were predictive of SP. This provides evidence for Montaldi's (2002) theory that borderline traits would likely be observed among a subset of individuals with SP, as well as the parallels between SP and borderline and narcissistic PDs. The results of this study extend previous work to suggest that IPSO with borderline and/or narcissistic features may be more vulnerable to the development of SP (or vice versa).

6.5.1.2 Personality functioning (criterion A)

Considering personality functioning among the main sample of IPSO, IPSO who met the criteria for SP demonstrated significantly worse impairments in the domains of self-control, identity integration, and relational capacities, providing support for previous research with IPSO taking MMPSA (Berman-Roberts, 2015; Hocken et al., 2016). The hypothesis that self-control would be positively associated with SP was supported. These results provide support for the notion that personality, particularly self-control, may be a key mechanism underlying SP, and that improved management of this may help in the management of SP (Berman-Roberts, 2015; Hocken et al., 2016). Self-control (comprising of emotion regulation and effortful control) being the largest contributor suggests that for individuals with SP they may experience difficulties with controlling their emotions, and problems focusing their concentration and directing their impulses. This provides support for the notion that SP may be linked to emotion regulation difficulties (Bancroft, 2008; Bancroft et al., 2003; Miner et al., 2009), and that it may be a psychological and behavioural manifestation of maladaptive self-control, presenting as an inability to manage sexual thoughts and urges (Berman-Roberts, 2015). Taken together, these results lend support to theoretical conceptualizations that difficulties with impulsivity and emotional regulation may be important antecedents to SP (Jerome et al., 2016; Rickards & Laaser, 1999), as well as providing tentative support for the impulsivity model of SP and the addition of CBSD as an impulse control disorder in the ICD-11 (Barth & Kinder, 1987; WHO, 2018).

Moreover, the results demonstrate that difficulties with identity integration may also be an underlying mechanism of SP. This is similar to findings among a sample of undergraduate students, whereby Northey et al. (2016) reported that identity disturbance (symptom of borderline PD) was found to be predictive of SP. Interestingly, difficulties with both self-control and identity are prevalent among individuals with borderline PD, which aligns with the previous results that borderline PD is predictive of SP, and is in agreement with previous literature, as Northey et al. (2016) demonstrated that borderline PD symptoms (affective instability, identity disturbance, negative relationships, and self-harm) were predictive of SP. Due to only the short version of the SIPP being used during the screening study, only the overarching domains are available for analysis, rather than the individual facets (one of the limitations of this study, discussed further in section 6.5.5). Therefore, further research is required with a general sample of IPSO to further explore this relationship in more-depth, and to determine specifically which aspects of self-control and identity are related to SP.

This more in-depth approach including the facets of personality functioning has been explored within a subset of IPSO within this chapter, as it was explored among IPSO with PD. For IPSO that met the criteria for both PD and SP, they demonstrated significantly worse impairment in self-control, identity integration, and responsibility, compared to IPSO with PD without SP. Interestingly, both groups showed the same prevalence of impairment in relational capacities. Theoretically, this makes sense as difficulties with relationships aligns with having PD (in which criteria for the study included either impairment in relational capacities or identity integration). However, this result suggests that difficulties with relationships are not associated with SP, as both groups of IPSO with PD (irrespective of whether they had SP or not) had equal amounts of impairment in this domain. This is similar to what Lloyd et al. (2007) reported, as they found that among individuals with SP there was no evidence of unstable interpersonal relationships. In the current sample, although difficulties with relationships were prevalent, this may be due to the nature of PD, as opposed to being related to SP. Nevertheless, what was interesting among the sample of IPSO with PD and SP was that they showed the most impairment in identity integration, which was also found to be predictive of SP in the main sample of IPSO. This indicates that as well as self-control, identity integration may also be an underlying mechanism of SP, for example, some IPSO may struggle with their own identity and self-worth, and SP may be adopted as a maladaptive coping mechanism (Carnes & Adams, 2002). Due to the limited sample size of study three, and consequently the limited analysis, further research is required to explore facets of identity integration among a general sample of IPSO to better understand how it relates to SP.

Although four of the domains were found to positively correlate with SP, self-control was the only significant predictor of SP, further suggesting that SP may be a psychological and behavioural manifestation of maladaptive self-control (Berman-Roberts, 2015; Hocken et al., 2016). When the facets which comprise self-control were explored, emotion regulation was found to be the only

significant predictor of SP, supporting previous research which has identified a link between emotion regulation and SP (Bancroft & Vukadinovic, 2004; Miner et al., 2009). These results provide support for Bancroft and Vukadinovic's (2004) pathway model that states SP and resulting sexual behaviours are thought to be due to negative emotions, as some IPSO may use these sexual thoughts and behaviours to regulate their emotions and manage stress (Bancroft & Vukadinovic, 2004; Cortoni & Marshall, 2001; Parsons et al., 2008; Miner et al., 2009; Raymond et al., 2003). Emotion regulation being a significant predictor of SP also aligns with earlier results (borderline PD being a significant predictor of SP), as difficulty regulating emotions has also been linked to borderline PD symptomology (Silvers et al., 2016). Reid et al. (2012) suggest that emotional regulation problems and difficulties coping may constitute precipitating or perpetuating risk factors in the onset or maintenance of SP, as an individual may use sexual thoughts and behaviour as a way of coping with or distracting from intense emotional experiences.

Regarding the facets of personality functioning, support was provided for the hypothesis that SP would be positively correlated with eight facets (effortful control, emotion regulation, aggression regulation, intimacy, self-respect, self-reflexive functioning, frustration tolerance, and stable self-image), except for intimacy. As previously mentioned, relationship and intimacy difficulties were not found to differentiate between IPSO with SP and IPSO without SP. Other than for intimacy, these results support previous findings of IPSO taking MMPSA (Berman-Roberts, 2015; Hocken et al., 2016).

6.5.1.3 Pathological personality traits (criterion B)

The results relating to pathological personality traits demonstrate a similar pattern as above, whereby IPSO with SP demonstrate greater pathology in all domains and all personality traits, excluding intimacy avoidance. In this instance, there were no differences among IPSO with SP and IPSO without SP (among the main sample of IPSO rather than IPSO with PD) in terms of intimacy avoidance, suggesting that it fails to distinguish between those with and without SP. This means that despite the presence or absence of SP, IPSO in general demonstrate dysfunction in intimacy avoidance, which supports previous research that also failed to identify a relationship between unstable relationships and SP (Lloyd et al., 2007).

In terms of personality domains which align with the FFM of personality, the results support the hypothesis that negative affect (neuroticism), antagonism (opposite of agreeableness), and disinhibition (opposite of conscientiousness) would be positively associated with SP, as well as supporting previous research (Heaven et al., 2013; Rettenberger et al., 2016; Walton et al., 2017). However, the results do not support the hypothesis that detachment (opposite of extraversion) is negatively correlated with SP, as this study found a positive correlation. On the other hand, when detachment was included in the regression model (controlling for other variables), though non-

significant, the relationship was negative, demonstrating that once other variables were controlled for the relationship between detachment and SP was in fact negative, as hypothesised.

Furthermore, antagonism and negative affect were found to be the only significant domains predictive of SP. When exploring the personality traits which comprise each of these domains, for the negative affect domain, emotional lability and separation insecurity domains were significant, and for the antagonism domain, deceitfulness and grandiosity were significant predictors. Again, these results support the notion that SP may be linked to emotional difficulties (Bancroft, 2008; Bancroft et al., 2003; Miner et al., 2009), and as per the results above regarding personality functioning, the emotional lability and separation insecurity traits align with borderline PD being predictive of SP. Additionally, the antagonism domain links with narcissistic PD being found to be predictive of SP, as grandiosity is a pertinent feature of narcissistic PD, and has previously been found to be related to SP (Giugliano, 2008; Parker & Guest, 2003). This links with previous research that identifies narcissistic individuals as having a high need for positive regard and admiration (Morf & Rhodewalt, 2001), which makes them particularly orientated towards sexual relationships (Wryobeck & Wiederman, 1999). They also have an inflated/distorted view of themselves/abilities (Morf & Rhodewalt, 2001), which may result in them believing victims desire or benefit from their sexual advances (Baumeister, Catanese & Wallace, 2002). Given that grandiosity was found to be a significant predictor of SP among IPSO, a preoccupation with sex and resulting sexual behaviours may be used as a way of validating their sense of self-importance. Furthermore, previous research has reported a link between deceitfulness and narcissistic PD (Miller, Gentile, Wilson & Campbell, 2013; Ronningstam, 2011), and Levine (2002) argues that sexual motivation is often deceitful. The link between deceitfulness and SP suggests that individuals with SP may not be honest about their intense sexual thoughts and feelings, which may be of particular importance if their thoughts are associated with illegal sexual behaviour (given that participants were serving custodial sentences for illegal sexual behaviour). Schneider (1989) proposes that this secrecy may be due to shame stemming from the SP and resulting behaviours, whereby Zitzman and Butler (2005) suggest this may be based on feelings of hopelessness and loss of control.

All pathological personality traits (excluding intimacy avoidance) were positively correlated with SP, which supports the aforementioned hypothesis, particularly in terms of impulsivity, anxiousness, and depressivity. Anxiety and depressivity were two of the most prevalent traits found among IPSO with SP, which is consistent with literature that reports significant associations between depression and SP, and anxiety and SP (Raymond et al., 2003; Reid & Carpenter, 2009; Rickards & Laaser, 1999). These findings provide support for the notion that SP may be used as a coping mechanism for negative emotional states such as anxiety and depression (Bancroft & Vukadinovic, 2004), and supports the sexual compulsivity model of SP (Kalichman et al., 1994; Krueger & Kaplan, 2001). Additionally, the results support the idea that SP may be driven by a lack of impulse control (Coleman, 1990; Raymond et al., 2003), providing support for the impulsivity model of SP (Kafka, 2010; Raymond et al., 2003). Thirty

eight percent of IPSO with SP demonstrated difficulties with impulsivity, which is similar to previous research (Reid et al., 2015), and supports earlier findings that maladaptive self-control may be an underlying mechanism of SP. Impulsivity being prevalent among IPSO with SP may help to explain the mechanisms underlying demonstrations of individuals with SP being more likely to engage in risky sexual behaviours (Bancroft & Vukadinovic, 2004). However, it also demonstrates that although impulsivity may be related to SP, other factors may also help to explain this type of problematic behaviour. Similar to Lloyd et al. (2007), no evidence of problematic impulsivity was found in over half of IPSO with SP. This may be due to there being multiple presentations of SP, whereby individuals range from impulsive to compulsive extremes. Previous research has found both compulsive and impulsive SP presentations (Black et al., 1997; Lloyd et al., 2007; Raymond et al., 2003), suggesting that they may lie on a continuum from highly compulsive to highly impulsive (Lloyd et al. 2007).

These findings are consistent with two of Walton et al.'s (2017) taxa found among general population samples, whereby SP can be explained (i) by greater trait impulsivity, or (ii) as an adaptive coping mechanism to relieve depression and anxiety (compulsivity). Moreover, the results support previous research into sexual addiction which suggests that during child development, if the child is pushed to separate too early, this may result in some form of narcissism (Kohut, 1978), including grandiosity (Parker & Guest, 2003), whereby for individuals with narcissistic patterns, SP and the resulting sexual behaviour is primarily used to validate the self by proving superiority over others (Montaldi, 2002). Alternatively, the child may develop borderline traits (Parker & Guest, 2001), whereby these individuals experience emotional lability, difficulties with impulse control and relationships, and may use SP and resulting sexual behaviour as a way of coping with their internal sense of emptiness (Montaldi, 2002; Parker & Guest, 2003). As proposed by Montaldi (2002), these results support the notion that a large proportion of SP may be explained by an Axis 1 model (addiction, obsessive-compulsive disorder, impulsive-control disorders, mood-related disorders), however, some cases of SP may be better explained using an Axis II model (personality disorders), particularly borderline and narcissistic PDs. As well as the links with depression and anxiety, these results highlight the possibility of two PD pathways for IPSO with SP, whereby some demonstrate a pattern of grandiosity and need for admiration (narcissistic PD), in which feelings of entitlement and self-centredness may be central, and SP and sexual behaviour may be used as a way of gaining attention and validation. Whereas, for others, they may experience difficulties with impulsivity, emotional regulation, identity, relationships, and fear of abandonment (borderline PD), and therefore SP may be utilised as a maladaptive coping strategy to deal with these difficulties, and as a way of fulfilling emotional needs (Montaldi, 2002).

Furthermore, when exploring the pathological personality traits associated with borderline PD, only separation insecurity was found to significantly predict SP. Previous research has found links between fear of abandonment and SP (Jardin et al., 2017; Parker & Guest, 2003), and attachment-based theories suggest that SP and the resulting sexual behaviours associated with borderline PD may serve to quell

abandonment fears (Sharp & Fonagy, 2008). Therefore, SP and sexual behaviours may be used as a way of fulfilling the internal emptiness (Montaldi, 2002), and desire to feel close to someone. Jardin et al. (2017) propose that SP may be partially responsible for risky sexual behaviour among women with borderline PD, and the results of this study suggest that this may be similar for male IPSO with borderline PD. This study indicates that for a subset of IPSO that demonstrate borderline PD and SP, the sexual thoughts and acting out may be due to a fear of being abandoned, and the longing of closeness with someone else.

Costa and McCrae (1992) argue that it is important to learn about the underpinnings of SP and the links with personality traits in order to inform and enhance assessment and treatment. Jardin et al. (2017) further contend that due to the harmful consequences of SP and associated sexual behaviours, it is important to understand the mechanisms underlying the phenomenon, in order to promote public, physical, and mental health. This study has provided an initial exploration of the links between personality and SP among a general sample of IPSO, revealing that traits of borderline and narcissistic PDs appear to be predominantly related to SP. Difficulties with emotion regulation, identity issues, a fear of abandonment, grandiosity, and deceitfulness may make an individual more vulnerable to the development of SP. The implications of these findings for services will be discussed further in section 6.5.4. In addition to preliminary findings from the MMPSA service evaluation, these results demonstrate a strong link between personality and SP among IPSO, suggesting that the MMPSA service currently residing under the umbrella of OPD services may be appropriate given the strong links and comorbidity between the two phenomena.

6.5.2 Part B: The relationship between personality disorder and adverse childhood experiences

The hypothesis that the total ACE score would be positively correlated with all PDs was not met, as correlations were only found for borderline, paranoid, and passive-aggressive PDs. This is in contrast to previous research which shows an association between ACEs and all DSM-IV PDs (Hengartner et al., 2013), however, it does indicate a dose-response relationship between ACEs and borderline, paranoid and passive-aggressive PDs. The majority of IPSO that met criteria for categorical PDs reported four or more ACEs, demonstrating that cumulative ACEs are linked to personality pathology. In terms of prevalence, sexual abuse, physical abuse, and verbal abuse were prevalent among all PDs, and various forms of household dysfunction were also common among all PDs, which is consistent with previous research (Afifi et al., 2011; Hengartner et al., 2013; Lobbestael et al., 2010). The patterns described above in relation to the most prevalent ACEs among specific PDs are also in accordance with previous research (Afifi et al., 2011; Drake et al., 1988; Hengartner et al., 2013; Johnson et al., 2005; Ruggiero, Bernstein & Handelsman, 1999).

It is important to acknowledge that these results should be taken with caution given the limited sample size, and the fact that the whole sample of IPSO met criteria for PD, meaning that there was no sample of IPSO without PD to compare the prevalence of ACEs with. This limited sample also hindered the analysis that could be conducted on the data. Additionally, in terms of correlations, the hypothesis that child maltreatment (physical, sexual, and emotional abuse) would be positively correlated with all PDs was not supported. Although highly prevalent among IPSO with PD, none of the child maltreatment factors were found to significantly correlate with any specific PD. This contradicts previous research (Afifi et al., 2011; Hengartner et al., 2013; Johnson et al., 2005; Lobbestael et al., 2010), but also supports Hengartner et al.'s (2013) path analysis results which revealed that physical and sexual abuse were not related to specific PDs.

On the other hand, some of the household dysfunction factors were found to relate to some PDs, which is consistent with previous research by Afifi et al. (2011). Borderline PD was linked with domestic violence and parental divorce, which has been reported in previous research (Afifi et al., 2011; Bandelow et al., 2005; Hengartner et al., 2013). Among IPSO with PD, schizotypal and paranoid PD were correlated with a member of the family household being incarcerated, which contradicts previous research with IPSO and IPVO (Roberts et al., 2008), who reported that incarceration was linked to avoidant and antisocial PDs, and no association between ACEs and schizotypal PD. In the current study, passive-aggressive PD was associated with parental separation, however, previous research by Brennan and Shaver (1998) found that parental divorce was linked to schizotypal and borderline PDs only. Finally, depressive PD was linked with mental illness within the family home, which supports previous research (McDermut, Zimmerman, & Chelminski, 2003).

Previous research exploring the relationship between ACEs and PDs reveals inconsistent results, with some studies finding significant associations, and others finding associations with different ACEs (Hengartner et al., 2013). Although this study is limited due to a constrained sample, and specific associations were not found as expected, it does demonstrate that among a sample of IPSO with PD, all of them experienced at least one ACE, with over half reporting more than four ACEs. Therefore, irrelevant of the links between specific ACEs and PDs, the research sample experienced high amounts of adversity and traumatic experiences, whereby over three quarters reported physical and verbal abuse, and over half were sexually abused during childhood. This highlights that among IPSO the presence of ACEs and traumatic experiences may be important for the development of personality pathology and potential PD, whereby the type of ACE (or the cumulative effect of ACEs) may not be of importance, but the meaning it has for an individual. This is in line with Kelly-Irving and Delpierre's (2019) critique of ACEs, who suggest that the severity, timing, and duration of certain life events may result in varying consequences for the individual, rather than assuming that the cumulative impact is the same for everyone. It is also in accordance with trauma-informed care and the PTM framework, which consider how traumatic experiences, adversity, and power impact an individual and how they

respond to these experiences (Johnstone et al., 2018). The fact that the whole sample experienced adversity, and over half reported four or more ACEs demonstrates in itself a link between PD and ACEs. However, further research is required to explore this relationship among a broader sample of IPSO in the UK, so the prevalence of ACEs can be compared among IPSO with PD and IPSO without PD.

6.5.3 Part C: The relationship between sexual preoccupation and adverse childhood experiences

The hypothesis that the total ACE score would be positively correlated with SP was not met, which is in contrast to previous research that shows an association between the total ACE score and SP (Marshall, 2016). Additionally, the hypothesis that IPSO with SP would demonstrate a higher prevalence of ACEs than those without SP was also not met, as no differences or associations between ACEs and SP were found, which contradicts previous research (Davis & Knight, 2019; Kingston et al., 2017; Marshall, 2016). However, as described above, it is important to acknowledge that these results should be taken with caution due to the limited sample size, and the homogeneity of the sample (given that all participants met the criteria for PD). ACEs were highly prevalent among the sample, irrespective of whether they had SP or not. However, this may be due to the whole sample meeting criteria for PD, whereby ACEs are more likely to be prevalent given the strong links between PDs and ACEs (Johnson et al., 1999; Zanarini, 2000; Laporte, et al., 2011; Tyrka, et al., 2009). Therefore, differing results may have been obtained if the sample consisted of a wider sample of IPSO, rather than just those with PD. Future research should further explore this relationship between ACEs and SP among a broader sample of IPSO, as well as considering factors that may mediate the relationship between ACEs and SP. For example, given that emotion dysregulation was found to predict SP among the wider sample of IPSO, it may be interesting to explore whether emotion dysregulation mediates the relationship between ACEs and SP. Jerome et al. (2016) suggests that experiences of trauma results in emotion regulation difficulties that, in turn, may lead to a greater amount of sexual thoughts and urges, something which future research should explore among IPSO.

6.5.4 Implications

The results of this study suggest that for some IPSO they may have a core personality presentation that predisposes them towards having SP, and having clinical knowledge of these personality features may help with clinical conceptualisation (Walton et al., 2017). In terms of categorical PDs, borderline and narcissistic PDs were found to be predictive of SP among IPSO, and a range of PDs were found to be highly prevalent among IPSO with SP. Therefore, clinicians should explore the possibility of PDs among sexually preoccupied patients, and vice versa (clinicians should also explore the possibility of SP among IPSO with PD). It may be beneficial for services provided for IPSO with PD (i.e. the aforementioned ACORN service) to include an assessment of SP as part of the assessment and treatment planning stages, and services for IPSO with SP (i.e. the MMPSA service) to include a personality assessment as

part of assessment and treatment planning. This is particularly the case for borderline and narcissistic PDs, as both were predictive of SP among IPSO, and therefore due consideration should be given to these when assessing and planning treatment for individuals.

In regard to borderline PD, separation insecurity was the only significant predictor of SP, and clinicians should consider this aspect during treatment, as treatments designed to target fear of abandonment and attachment difficulties may help to manage SP. Difficulties with emotion regulation and impulsivity were also related to SP among IPSO, and are also characteristic of borderline PD. Understanding how these factors are related enables clinicians to provide the most appropriate form of treatment (Jardin et al., 2017), for example, these results suggest that IPSO with SP may benefit from therapeutic interventions that target emotion regulation, which are common outcomes of borderline PD treatments (such as DBT). Therefore, such treatments may also decrease SP among IPSO (Northey et al., 2016), something which future studies should assess. Various treatments have been developed for the treatment of PD and SP, and future research should explore how best to integrate these treatments for IPSO with comorbid symptoms (Jardin et al., 2017).

For a subset of IPSO with SP, they may experience narcissistic PD/traits, including a grandiose sense of self-importance, and a need for admiration (APA, 2013a). Clinicians need to be aware of these traits and how to manage them within sessions, for example, individuals with narcissistic PD may attempt to control the session, and may need to feel superior to the clinician, resulting in belittling remarks or a sense of competition (Parker & Guest, 2013). For these individuals, treating some of the narcissistic traits (particularly grandiosity) may also help to manage SP. It is important to highlight that although talking about categorical PDs, a fully-fledged diagnosis of PD is not necessary (Montaldi, 2002). IPSO with SP that demonstrate borderline/narcissistic traits (such as separation insecurity, emotion dysregulation, and grandiosity) may benefit from treatment targeting these problematic traits, which may also help to treat aspects of SP as well. Further research is required to examine the effectiveness of treatment on reducing SP.

Additionally, given that impulsivity, anxiety, and depression were related to SP, the presence of SP may be explained by greater impulsivity, or as an adaptive coping mechanism to relieve depression and anxiety. SP cannot be explained by one underlying mechanism, but for different individuals SP will manifest differently, and for various reasons. SP among IPSO may be due to difficulties with emotions, a fear of abandonment, a grandiose sense of self-importance, impulsivity, as a way of dealing with anxiety and depression, or something else. Therefore, multiple kinds of SP presentations suggest the need for multiple treatment approaches (Montaldi, 2002), in which treatment offered should depend on the motivation for SP (Walton et al., 2017). Therefore, it is crucial for clinicians treating SP to identify which of these explains an individual's behaviour, and the motivations behind the SP and resulting sexual behaviour, in order to provide the most appropriate treatment.

Montaldi (2002) argues that, for some individuals who have addictive, compulsive, impulsive, or mood dysregulative forms of SP, traditional ways of treating SP/hypersexuality may be appropriate (such as focusing on developing alternative ways to regulate moods, and skills that interrupt behavioural cycles). However, for individuals with SP and problematic personality styles, their behaviours may be more 'steady state, i.e., a lifestyle' (Montaldi, 2002, p. 21). Therefore, clinicians need to ensure that IPSO see change as good and are committed to change, whereby during treatment more attention should be given to self-esteem, identity, and interpersonal issues. Cognitive distortions are thought to be prominent among IPSO with PD and SP, and clinicians should be aware that these beliefs may be difficult to change. Montaldi (2002) proposes that the worldview attitudes that individuals have towards sex, the self, and others that are characteristic of individuals with PD presentations of SP must be targeted before they can develop skills to alter day-to-day automatic thoughts.

Rather than just focusing on categorical PDs which may be prevalent among IPSO with SP, having a better understanding of the core personality presentation of an individual will aid assessment and treatment (Walton et al., 2017). Conducting personality assessments with IPSO with SP will help clinicians to conceptualise the case and decide the most appropriate form of treatment, for example, IPSO with SP that are high in negative affect and antagonism will benefit from interventions which are different compared to IPSO with SP who are low in both of these. Additionally, clinicians may find that IPSO with SP who exhibit high negative affect and antagonism may be difficult to engage in treatment (Cantor, Klein, Lykins & Rullo, 2013; Kaplan & Krueger, 2010), as sex is usually pleasurable and individuals may be reluctant to stop these behaviours (Canning Fulton, 2002). Furthermore, IPSO that are high in antagonism may not perceive their behaviour as problematic, therefore, clinicians should address the individual's nature and degree of motivation for treatment (Reid, 2007).

IPSO with SP may exhibit problematic self-control (which may present as difficulties regulating their emotions and/or concentrating and directing their impulses), and separation insecurity may also be prominent among this population. It is important for clinicians to bear these factors in mind when working with individuals to develop a therapeutic relationship, when creating a secure base, and when deciding on the best treatment approach. For example, for individuals with a strong sense of separation insecurity, attachment informed treatment may be suitable (Berry & Danquah, 2016). For IPSO where SP and resulting sexual behaviours present impulsively, clinicians may have difficulty engaging them in treatment due to the positive reinforcement of sexual thoughts and/or behaviour (Koob, 2006), which is a challenge that clinicians may have to overcome. Difficulties with identity may also be an underlying mechanism of SP, whereby IPSO may struggle with their own identity and self-worth. Clinicians should explore if this is problematic for the individual, and if so, they can tailor treatment to help with basic self-esteem, purposefulness, and identity integration, helping IPSO to develop a coherent, pro-social identity. Furthermore, in regard to grandiosity and deceitfulness, it is critical that clinicians are aware

that IPSO with SP may not be being honest about their thoughts, feelings, and behaviours. Clinicians should also consider the power imbalance in the professional/client relationship, and how some IPSO may feel the need to show superiority, whereby attempts should be made to reduce this within the therapeutic relationship (for example, by promoting collaborative decision-making, offering choice, and avoiding jargon [Craissati et al., 2018]).

Mood disorders and anxiety disorders are highly prevalent among IPSO with SP, and research suggests that these may be important risk variables for the onset, severity, and relapse of SP (Kaplan & Krueger, 2010), and that clinicians should treat SP individuals for depressed mood and anxiety alongside treating the SP (Raymond et al., 2003; Walton et al., 2017). Although treating anxiety/depression may not eliminate SP or sexual behaviours, Raymond et al. (2003) argue that it is difficult to reduce SP without treating anxiety/depression as well. Therefore, clinicians and services treating IPSO with SP may also need to consider the prevalence and treatment of anxiety/depression among this population.

Moreover, the results highlight that although anti-libidinal medication has been found to reduce sexual thoughts and behaviours, and may be appropriate for some IPSO, it is important that the underlying mechanisms of SP for that individual are also treated using psychological treatments. Pharmacological treatment may be beneficial in reducing sexual thoughts and behaviours so that IPSO can participate in treatment programs, however, the underlying mechanisms (i.e. separation insecurity, emotional dysregulation, grandiosity, impulsivity, impairments in identity) may also need targeting for long-term management of SP. For example, if an individual decides to stop taking medication, it would be beneficial if they had developed more effective emotion regulation strategies, rather than turning to sexual thoughts, fantasies or behaviours as a way of coping. The HMPPS Healthy Sex Program (HSP) is the only current treatment program for IPSO which addresses deviant sexual interests (Calder, 2017), however, this is restricted to IPSO who have a specific offence related interest, rather than those who may only have problems with SP or hypersexuality (Winder et al., 2018). Furthermore, there is no outcome data which demonstrates how successful this treatment is (Winder et al., 2019), thus, further research is required to evaluate the effectiveness of treatment for SP among IPSO.

In regard to ACEs and PD, due to the limited sample, no implications regarding specific ACEs and PDs can be taken from this study. Future research is required to explore the relationship between ACEs and specific PDs among IPSO in the UK. However, as discussed extensively in section 5.5.5, the presence of adversity among the whole sample of IPSO with PD demonstrates that services designed specifically for IPSO with PD should take into consideration the impact of ACEs, and work in a trauma-informed manner. Furthermore, the milieu of the prison establishments should be trauma informed (Jones, 2018), and all services that come into contact with IPSO should be trauma informed, including wing staff, health care staff, offender management staff, and probation staff (Akerman, 2019; Cluley, 2019; Lynch, 2019; McCartan, 2019).

6.5.5 Limitations

Due to the same data being utilised for analysis in this chapter and chapter five, the aforementioned limitations discussed in section 5.5.6 are also relevant here. However, this chapter should also be interpreted with attention to its limitations. Firstly, the data presented were cross-sectional and correlational, therefore, causal relationships between variables could not be ascertained. Secondly, although talking about IPSO with difficulties with SP and/or PD, it is necessary to point out that these are IPSO residing in two category C prison establishments, and these results may not be generalisable to all IPSO. Future work may expand on these results by exploring the relationship between PD and SP among a wider sample of IPSO (including category A and B prison establishments, and in the community).

In regard to ACEs, the design of study three, the limited sample size, and the restrained sample are the main limitations of this chapter. Due to the ACE questionnaire only being utilised in study three, unlike other results sections in this thesis, and previous research (Roberts et al., 2008), there is no option to compare the prevalence of ACEs among IPSO with PD to IPSO without PD. The whole sample consisted of IPSO with PD, resulting in a lack of comparison group (IPSO without PD). Additionally, the small sample size and the limited cases of each PD restricted the analysis that could be conducted on the data. Ideally, in hindsight, it would have been beneficial to conduct the ACE questionnaire during the screening study (study 2), so the presence of ACEs was examined among a more comprehensive sample of IPSO. However, due to the sensitive nature of the ACE questions, and the process of delivering questionnaires under cell doors, the author thought it would be unethical to do so. Conducting the questionnaires face-to-face during study three enabled the researcher to assess if the participant experienced any distress from the questionnaires, and she could provide information regarding available support services. Future research should explore ACEs among a broader (and larger) sample of IPSO in order to determine the relationship between ACEs and personality pathology among IPSO in the UK.

Following on from the above, data regarding the relationship between ACEs and SP shares the aforementioned limitations. A further limitation is the homogeneity of the research sample as all participants met the criteria for PD, meaning that ACEs were highly prevalent irrespective of whether they had SP or not. Therefore, these results may not reflect a true representation of the relationship between ACEs and SP among IPSO, and they cannot be generalised to the wider IPSO population. Further research is required to explore the true relationship between ACEs and SP among IPSO.

6.6 Summary

In summary, this empirical chapter explores the relationships between (i) PD and SP, (ii) PD and ACEs, and (iii) SP and ACEs. Firstly, borderline and narcissistic PDs were found to be predictive of SP among IPSO, meaning that services provided for either PD or SP should be mindful of this link during assessment and treatment planning stages. Separation insecurity and emotion regulation difficulties were also pertinent for SP, whereby treatment programs which target emotion regulation and attachment difficulties may help to manage SP. Moreover, for some IPSO, traits such as grandiosity and deceitfulness may be predictive of SP and may require attention during treatment. However, further research is required in this area to establish what treatment is effective for SP among IPSO.

The results of this study support the notion that there are various ways that SP may present, and for different individual's SP will manifest differently. SP among IPSO may be due to difficulties with emotions, a fear of abandonment, a grandiose sense of self-importance, impulsivity, as a way of dealing with anxiety and depression, impairments in identity, or something else. Therefore, multiple kinds of SP presentations suggest the need for multiple treatment approaches (Montaldi, 2002), in which treatment offered should depend on the motivation for SP (Walton et al., 2017). Clinicians should take an individualised approach and explore the underlying mechanisms of SP for the individual, and tailor treatment around this.

Adverse childhood experiences were found to be highly prevalent among IPSO with PD, and aspects of household adversity were linked to borderline, schizotypal, paranoid, passive-aggressive, and depressive PDs. Although the limited and restrained sample impacted the results, the results do demonstrate that among IPSO with PD all of them experienced at least one ACE. Therefore, irrespective of the relationships between individual ACEs and specific PDs, the presence of adversity alone may contribute to the development of PD. Additionally, it may not be the type or cumulation of ACEs that is important, but the meaning it has for the individual, and the impact it has had on their lives, the way they view themselves, and the way they view the rest of the world. Services designed specifically for IPSO with PD should take into consideration the impact of ACEs, and all services that come into contact with IPSO should be trauma informed. No associations were reported between ACEs and SP, however, this may be due to the homogeneity of the sample as all participants met criteria for PD, meaning that the results may not be a true representation of IPSO in general. Further research is required to explore both of these relationships among a broader (and larger) sample of IPSO in UK and international prison establishments.

Chapter Seven: An exploration of the life trajectories and narrative identity of individuals who have previously sexually offended that have experienced adverse childhood environments, personality disorder, and sexual preoccupation.

Overview

The previous two chapters have quantitatively explored the prevalence of PD, SP, and ACEs, as well as the relationship between all three of these factors among IPSO. However, given the need for service user perspectives (Nee, 2004), and the fact that IPSO are a marginalised group (Tewksbury, 2012), these quantitative studies fail to provide rich in-depth data about an individual's lived experiences, subjective meanings, or how they interpret the world (Walliman, 2015). Additionally, an individual's narrative identity is thought to be distinct from dispositional traits, rather, it is the internalised, evolving story of the self (McAdams, 1994). This self-narrative enables individuals to make sense of their lives, whereby a coherent, prosocial identity is thought to be pivotal to rehabilitation and desistance (Maruna, 2001). Therefore, this study aims to further enhance our understanding of the relationships between PD, SP and ACEs among IPSO by exploring the narratives of 'experts' in this area (Henn et al., 2005).

7.1 Introduction

Chapter five and six highlight the prevalence of PD among IPSO, and the complex interplay between PD, SP, and ACEs. Nevertheless, although psychometric scales are invaluable for the assessment of PD symptomatology, they do not explore the concept of narrative identity (Adler et al., 2012). According to McAdams (1994), there are three levels of personality: (i) broad dispositional traits, (ii) characteristic adaptations (an individual's goals, stresses, motives, interests, values, etc.), and (iii) the internalised life story. According to this theory, adults create a life-story (or personal myth) in order to provide their lives with unity, meaning, and purpose. An individual's experiences shape their narratives, and this changes at different times over their life span (McAdams, 2006b). McAdams (1985) argues that these stories become parts of who we are, and are just as much part of our personalities as dispositional traits and characteristics. Furthermore, self-narratives are thought to shape future behaviour because people act in accordance with the stories that they present about themselves (McAdams, 1985). Giddens (1991) suggested that 'a person's identity is not to be found in behaviour, nor – important though it is – in the reactions of others, but in the capacity to keep a particular narrative going' (p. 54), whereby Maruna (2001) suggests establishing a coherent, prosocial identity is crucial for rehabilitative purposes and desistance from crime. Constructing a coherent personal narrative on disorderly lives is sometimes a struggle for certain individuals, particularly those with mental health difficulties including anxiety, depression, and personality disorder (Adler et al., 2012; Maruna, 2001).

One of the defining features of PD in the DSM-5 AMPD is an impairment in identity integration (linked to criterion A - personality functioning; APA, 2013a), whereby 45% of the sample of IPSO used within this research (and 62% of the ones that met criteria for PD) demonstrated impairments in identity integration (results from chapter five and six). Furthermore, previous results demonstrate that identity integration was also found to be significantly predictive of SP among IPSO. However, the exploration of how these factors might interact in an individual's life story, and how they make sense of themselves and the world around them has not yet been explored. Thus, studying the personal narratives of these individuals offers a unique insight and great potential for understanding identity disturbance among IPSO with PD and SP, as well as allowing a usually marginalised group (IPSO) to have a voice and 'tell their story'. By adopting this perspective of PD which has been drawn from mainstream theoretical and empirical research on normal personality (e.g. McAdams, 1994), this study further contributes to the growing body of research on dimensional conceptualisations of personality disorders, which is in accordance with the shift from a diagnostic approach to a dimensional perspective in the DSM-5, and the PTM framework (APA, 2013a; Johnstone et al., 2018). This study extends the previous results (chapters five and six) beyond an emphasis on personality traits, thus, providing an additional perspective of PD and SP among IPSO, one that is grounded in research among nonpathological identity processes, which consequently forges a deeper joining between the study of PD and normal personality.

7.2 Research Aims

The main aim of this chapter is to explore the life trajectories and narrative identity of IPSO who have experienced adverse childhood environments, personality disorder, and sexual preoccupation.

7.3 Method

7.3.1 Participants

Participants ($n = 5$) were male IPSO who were serving a custodial sentence at two category C prisons. All participants who had completed the screening questionnaires (study 2) and demonstrated signs of PD were invited to take part in the further psychometric study (study 3), where they provided their consent to be contacted for future research. Participants who consented and displayed signs of PD, SP, and ACEs (and were still residing within the prison establishment at the time of data collection) were recruited for this study. Thus, purposive sampling was employed as participants were selected according to pre-determined criteria in relation to the research aims (Guest et al., 2006). See figure 17 for a breakdown of sample attrition over the three studies, and table 28 for participant information, whereby pseudonyms have been used in order to protect participants' confidentiality and ensure anonymity.

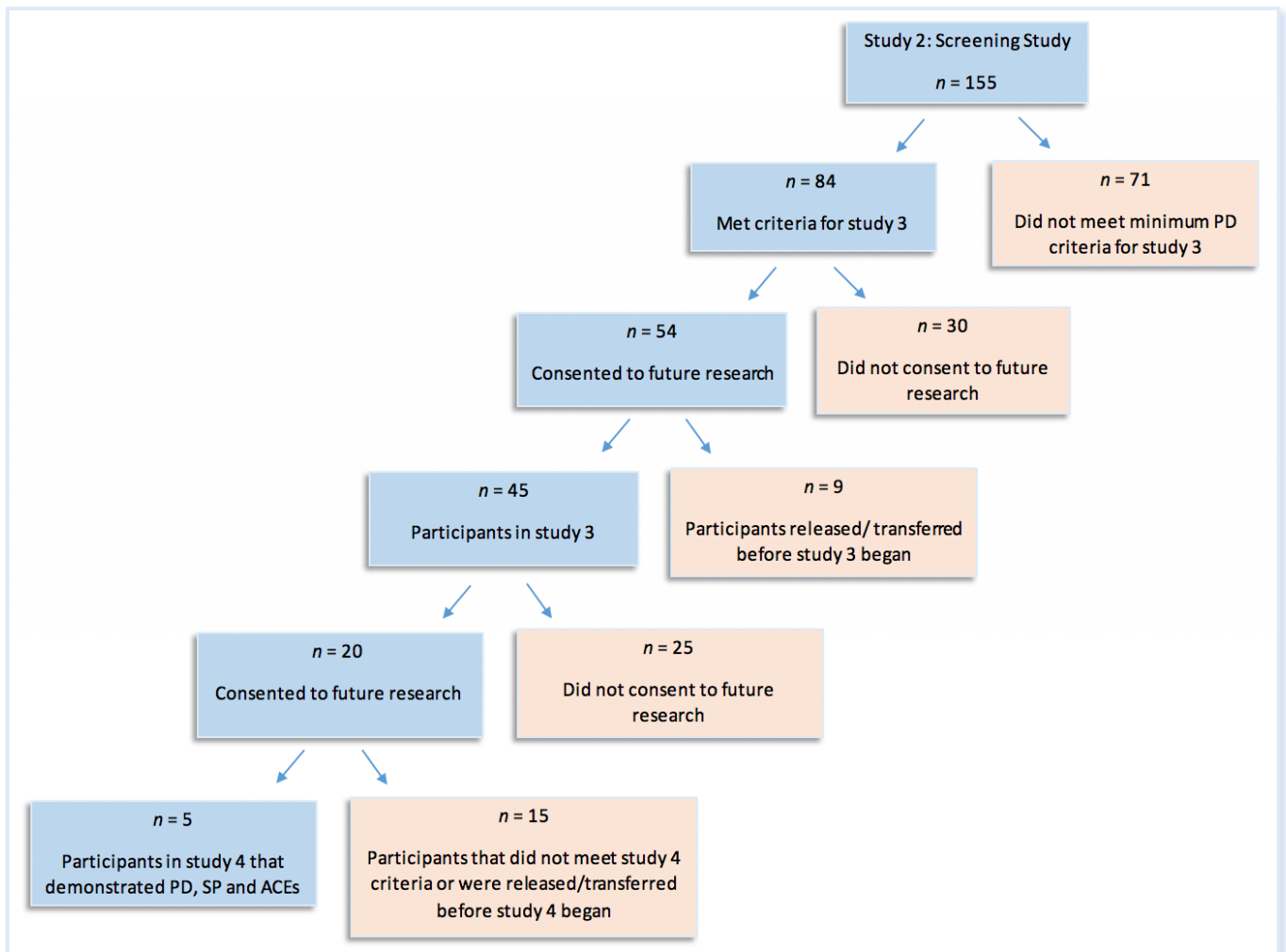


Figure 17. Sample attrition for study two, three and four

Experiencing adverse childhood experiences was a prerequisite for this study, however, concerns regarding risk and offence paralleling behaviours were raised for Steven. Offence paralleling behaviours are described as ‘any form of offence related behavioural (or fantasized behaviour) pattern’ (Jones, 2004, p. 38). Therefore, after discussions with the supervisory team, it was decided not to continue with the second part of the interview, and to exclude Steven from any further analysis.

7.3.2 Data collection

A modified version of McAdams’ (2008) Life Story Interview (LSI) was used in this study, as it allows people to ‘tell their story’ and is ideal for using with IPSO (Laws & Ward, 2011). The LSI asks participants to describe their life as if it were a book, dividing it into a series of chapters. It then asks about a series of key episodes in their life, including the following (see appendix 4 for the full interview schedule):

- Life chapters
- Key scenes in the life history – high point, low point, turning point, positive childhood memory, negative childhood memory, vivid adult memory, wisdom event

Table 28. Participant information for study four

Name	Age	Offence Type	Victim Type	Victim Sex	Personality disorder/ traits	ACEs
Roger	72	Contact	Child	Male and female	Depressivity, intimacy avoidance, restricted affectivity, separation insecurity, suspiciousness	Sexual abuse, physical abuse, verbal abuse, mental illness, alcohol abuse
Anthony	45	Contact	Child	Male and female	Attention seeking, depressivity, impulsivity	Sexual abuse, physical abuse, verbal abuse, domestic violence, drug abuse
Paul	55	Contact	Child	Male	Anxiousness, emotional lability, intimacy avoidance	Sexual abuse
Ben	65	Contact	Child & Adult	Female	Borderline PD – anxiousness, emotional lability, deceitfulness, Depressivity, distractibility, hostility	Sexual abuse, physical abuse, verbal abuse, domestic violence, mental illness, alcohol abuse, drug abuse
Steven	33	Internet	Child	Male and female	Impulsivity, rigid perfectionism	Sexual abuse, verbal abuse, parental separation, mental illness, alcohol abuse, drug abuse, incarceration

- Future script – the next chapter, dreams, hopes, and plans for the future, life project
- Challenges – life challenge, health, loss, failure, regret
- Influences on the life story – positive, negative
- Stories – stories watched, stories read, stories heard
- Personal Ideology – religious/ethical values, political/social values, change, development of religious and political views, single value
- Life Theme
- Reflection
- Other

The research was interested in how IPSO frame events in their lives, and what events are meaningful for them. Therefore, there were no specific questions around personality, sexual preoccupation or adverse childhood experiences. There was no guarantee that these topics would arise during the interview, as it was up to the participant to include moments in their life that they found pivotal in their own life history. This is similar to research conducted by Gibson and Morgan (2013) who chose not to directly ask about childhood sexual abuse, but left it to participants to decide whether or not to include this in their accounts, allowing participants to represent these experiences in any way they chose.

There is minimal research using the LSI specifically with IPSO. Previously, life history work has been completed with IPSO (Cowburn, 2005), and Maruna (2001) has used the LSI in general with individuals that have committed crimes. In addition, Farmer et al. (2016) have used the LSI with IPSO focusing on desistance, but, to the author’s knowledge, this current study is the first that uses the LSI with IPSO with PD and SP. Participants were provided with a detailed information sheet, consent form, and debrief form (see appendices 25-27). Interviews were conducted in individual interview rooms, were split over two or three sessions, and were recorded using a password protected dictaphone. The LSI produces a large amount of data; in this study the set of life stories comprised nearly 145,000 words of transcribed text, with details of individual interviews presented in table 29.

Table 29. Length of life story interviews

Participant	Length (hours)	Word length (after transcription)
Roger	3 hours 44 minutes	32,356
Anthony	3 hours 27 minutes	34,645
Paul	3 hours 20 minutes	23,373
Ben	5 hours 32 minutes	53,966

7.3.3 Analytic technique

This study adopted a narrative psychological approach (Crossley, 2000), which is largely influenced by McAdams’ (1993) theoretical and methodological approach towards personal narratives. Narrative research methodology makes it possible to examine the cognitive mediators between environmental influences and individual behaviour; it is concerned with subjectivity and experience. It does this by assuming a chain of connection between what a person says and how they think, feel and reflect about themselves, their bodies, other people, and the world more generally (Crossley, 2007). The narratives that participants tell about their lives are thought to represent their meaning making, whereby how they connect and integrate these experiences, and select which information to tell or omit, are all aspects of how they understand their lives (Josselson, 2011). These narratives also do important identity work as people tend to live by the stories that they tell about themselves (McAdams, 1985). Researchers conducting narrative research pay interest to both the content of the story (‘the told’), and the structure of the story (‘the telling’; Josselson, 2011), as well as what is unsaid or unsayable (Rogers et al., 1999). As Maruna (2001) points out, narrative researchers are not concerned with the facts contained within these narratives (whether they are true or false), but rather the meanings that individuals attach to these facts. Narratives are thought to consist of the story that we tell ourselves and other people about ourselves in order to answer the question ‘Who am I?’ (Polkinghorne, 1991). Crossley (2000) emphasises that ‘We have a sense of who we are through a sense of where we stand in relation to the good’ (p. 533), which is informed by our communities and society (Taylor, 2007).

Therefore, narratives have a purpose and function, which forms part of the analysis. A large part of narrative psychology is in relation to the self and identity, as individuals are constantly presenting and re-presenting their self-narratives. This involves the choice of presenting one narrative over another in order to present a preferred version of ourselves (Crossley, 2000), whereby choosing one narrative over another has implications for the development of responsibility, blame, and morality. A personal narrative provides coherence, and one of the key points regarding identities are that they contain a plot, actors, contexts, and narrative that connect past and future events together, which enables individuals to make meaning out of incongruent parts of their lives (Singer, 2004).

When it comes to conducting narrative analysis, there is an abundance of research but a lack of consensus on how the research should be conducted and analysed (Stobart, 2014). Several researchers have laid down 'how to' steps, however, there is no one widely accepted analytic method, which affords the researcher the opportunity to be creative and flexible (Stobart, 2014). Many empirical investigations of narratives analyse for themes, images, or features (Adler et al., 2015; Lilgendahl & McAdams, 2011). This research is interested in the whole narrative; therefore, the interviews were transcribed verbatim in their entirety. A research journal was also kept alongside the transcribing/analysis which included emerging thoughts, images, and emotional responses. Similar to Stobart (2014), a narrative summary for each interview was created, which revealed the key structural and content features of the life stories. This was structured using a beginning, middle and end, and was organised chronologically (Murray, 2003), documenting the narrative as a whole story. The tone of the narratives and the rhetoric function of the narratives were identified, whereby rhetoric discourse is concerned with specific functions such as excusing, justifying, arguing, criticising, distancing, or positioning the narrator in a particular way. Using this, the identity work being employed was then explored, with close attention paid to the uses of 'I', 'you', and 'it' statements, to see how individuals positioned themselves within the narrative. The next stage involved working through the narratives looking for themes and ideas, whereby Langridge (2007) proposes that a gentle approach should be taken so not to disturb the integrity of the narrative as a coherent whole. Therefore, systematic coding and reducing the text to individual codes was not used throughout the analysis, but themes that were prevalent within the data were noted. The structure and coherence of the narratives were also explored, including any ambivalence or ambiguity within the narratives. Initially, the narratives were analysed individually and themes from each narrative were noted. However, after each narrative was explored in-depth, cross-case analysis was performed to discover any patterns/themes across the narratives (Wertz et al., 2011). These ideas and themes were clustered together and moved around in an iterative process, organising them into narrative themes and subthemes.

As mentioned previously in chapter three (methodological review), narrative analysis is grounded in phenomenology (Josselson, 2011), which concerns the subjective experiences that individual's assign to their lived experiences (Aresti et al., 2010). Therefore, it is important to acknowledge that meaning

is co-constructed as it is an active process which the storyteller and audience are both part of, and storytellers may shape their narratives with the audience in mind (Griffin & May, 2017). Additionally, the researcher also actively participates in the analysis and interpretation of the narratives, as the researcher attempts to make sense of the participants' sense-making (a double hermeneutic process; Aresti et al., 2010). This is one of the reasons as to why phenomenology requires such an in-depth focus and attention to the data, as well as an awareness of the distinctions between the participant's account and the researcher's interpretation (Smith, 2011).

7.4 Analysis and Discussion

The notion of temporality permeates through all of the narratives, whereby all narrators located themselves in time invoking the past, the present, and the future, in order to fully convey their life stories. The understandings and meanings attributed by the narrators to significant events in their lives were moulded by their past experiences, particularly in relation to early childhood experiences. Narrators cast themselves as the protagonists in the stories, and entertain a range of plots, characters, and stories in order to explain their lives (McAdams, 2006c). The data were organised into three overarching themes which fitted comfortably into a chronological sequence of the narrators' lives (see table 30), starting off with early childhood experiences, leading on to what came next, and finally, where they are now. All themes and subthemes will be unpacked and discussed.

Table 30. Narrative themes and subthemes

Narrative themes	Subthemes
1. How did I get here: The impact of the past	1.1 Loss of communion and safe space 1.2 Feeling like a failure 1.3 Inability to trust and helplessness
2. What came next: An exploration of relationships and life challenges	2.1 Communion and agency turbulence 2.2 Sex as a coping mechanism 2.3 The internet as an enabler
3. Where I am now: Redemption 'I'm a different person having come to prison'	3.1 Time to reflect 3.2 Meaningful roles 3.3 Reconnecting with religion

Narrative theme 1: How did I get here: The impact of the past

The crux of this theme is how individuals, who are currently serving a prison sentence for a sexual offence, use their past experiences in different ways in order to make sense of their lives. Significant events that happened during childhood and the impact they had are explored since some of these are used to explain and account for what happens next (Narrative theme 2). For most narrators in this study, the plot begins with the protagonist starting out in an adverse setting, whereby the home

environment, family members, and adverse childhood experiences were repeatedly referenced. The quality of these relationships and the severity of adverse experiences are discussed, as well as the impact they had on the individual's life and sense of self. Interestingly, it transpired from individuals' narratives that all individuals experienced childhood sexual abuse, however, only one participant (Roger) described this as his 'low point'. Several narrators found it difficult to recall a positive childhood memory, stating '*if you're talking about a fond memory I don't really have em fond memories as a child*' (Ben), and '*mmm positive childhood memory there's nothing hugely significant that I can think back and go oh yeah that was er that was a really good thing*' (Paul), illustrating how these individuals literally could not find any positive childhood experiences, rather, their childhoods were infiltrated with negative adverse experiences. The three subthemes that are linked to the impact of childhood experiences and will be unpacked are 'Loss of communion and safe space', 'Feeling like a failure', and 'Inability to trust and helplessness'.

Subtheme 1.1: Loss of communion and safe space

Throughout the analysis it became evident that the narratives presented were anchored in stories of relationships, and all participants spoke about their relationships with others, particularly during their early years. According to McAdams (1993), communion is one of the central themes present in life narratives, and is concerned with the individual's motivation for attachment, love, intimacy, friendship, and nurturance (McAdams, Hoffman, Mansfield, & Day, 1996). As a result of adverse and traumatic experiences within the home, participants often reported strained or ruptured attachments and relationships with their parents. However, some individuals describe characters within their stories that acted as a significant other:

Extract 1, Roger

My aunty taught me that you can that you can er love people. . . I was a lot closer to my aunty than I was my mother I think er certainly a lot closer to my aunty than I was to her brother which was my dad erm erm my mother was she wasn't a loving type of person she wouldn't give you cuddles or anything of that type, my aunty was more an emotional person grabbed you cuddled you for no reason she would say 'Oh come here'. I used to see them as often as I could and as I got to sort of nine or ten I could cycle to see her and I used to see her as often as possible.

Extract 2, Anthony

I spent a lot of time at my grandma's or mama as we used to call her. My grandad had died a few years earlier erm mama lived in the same village that we did and I I used to go from school to hers for lunch every day. I'd most most Friday nights I'd sleep over I always wanted to be

with my mama she was just my idol. . . I actually doted on my Grandma my mama and er she was my life I I was at hers more than I was at home.

These positive relationships with extended family members were helping to fulfil Roger and Anthony's desires for communion. Roger's relationship with his Aunt, and Anthony's relationship with his Grandmother exposed them to alternative and more appropriate relationships, as opposed to the ruptured/inappropriate relationships they experienced within their family homes (particularly in relation to their fathers, whom both Anthony and Roger were sexually abused by). Supportive extended family relationships are thought to have several benefits for children and are associated with resilience in the face of adversity (Thomas, 2011), but more than this, in these instances, these family members provided Anthony and Roger with a place of safety they could retreat to when their home lives were difficult. McAdams et al., 1996) is evident in both Roger and Anthony's extracts as they were able to remove themselves from a negative family environment by surrounding themselves with love, positive relationships, and trusted adults.

However, these supportive relationships and positive narrative resulted in contamination sequences (a positive event that becomes negative; McAdams, 2009) due to the loss of these significant others during childhood. Roger describes his biggest challenge in life as the loss of his Aunt, and Anthony reports the death of his Grandmother as the lowest point in his life, especially as *'that was really the start of when things started to go wrong for me you know'* (Anthony).

Extract 3, Anthony

I wanted to say goodbye or go to her funeral or wanted to go and see her when she was in hospital I never got to because I was so young and it was basically you do this or you do that. . . I never ever got to say goodbye and it made me so angry and erm I stayed angry. I changed yeah things started you know I started just misbehaving, I started to rebel a bit, I just d didn't I I didn't I I turned into a pretty a different kid almost. Erm I'd been a devoted mama's boy and then I changed. . . the change in me is something that mama would really have disapproved of. . . I didn't have anywhere to go after that I didn't have mamas to go to I was at home all the time erm so after that it felt really claustrophobic so I was just at home all the time I'd got no outlet to go to you know. I couldn't go and sleep at mamas at the weekend I couldn't go around there whenever I wanted to I was stuck at home.

Anthony's main reaction to his Grandmother's death was that of anger and acting out, which is a common reaction to grief among children (Dyregrov, 2008). He was angry at the injustice of losing his Grandmother, and angry at his parents for not allowing him to say goodbye or grieve in the way that he wanted, as this removed his sense of agency. Having a sense of control over personal circumstances as a child is thought to moderate the negative impacts of childhood adversity (Bellis et al., 2017),

however, this sense of control was taken away from Anthony. His Grandmother's death resulted in grief and loss on multiple levels; not only did Anthony lose one of the only positive relationships present during his early years, he lost the adult that he trusted, the safe house (refuge) that he could escape to, and a loss of agency in that he could no longer choose to leave his challenging home environment as and when he wanted (a home life that was described as neglectful and abusive, whereby he was being sexually abused by his brother). All of these losses combined with Anthony's first experience of grief resulted in him becoming a very angry child that rebelled, transforming from a '*devoted mama's boy*' to '*something that mama would really have disapproved of*'. The loss of a loved one is thought to disrupt an individual's sense of self because of the impact it has on the identities that comprise it (Phipps, 2018), and in this case, Anthony also experienced a loss of identity as he could no longer identify as the dutiful grandson. After a bereavement, people are thought to develop new goals and new identities as a way of sense-making and meaning reconstruction (Gillies & Neimeyer, 2006; Stroebe & Schut, 2001), however, Anthony's way of dealing with his grief and challenging home environment resulted in an identity transformation from 'good' to 'bad'. The loss of his Grandmother appears to be a significant turning point in Anthony's life that also acted as a catalyst for further negative events. As a result of his rebellious behaviour, Anthony describes an incident where his father '*punished*' him:

Extract 4, Anthony

I carried on stealing I kept getting in trouble shop lifting in the village you know. We used to have the village policeman and I remember he came round one day I'd been of all the things I'd been caught stealing an Easter egg. . . after I got in a lot of trouble at the time, then one day there was just me and dad at home and he said I still needed to be punished for what I'd done, for the stealing and he punished me in a sexual way. . . he said something along the lines of erm 'that's what happens that's what's gonna [sic] happen when you do wrong'.

Within this extract, although Anthony describes an act of wrongdoing on his behalf, he positions his father as the antagonist and villain of the story (the impact of this abuse is discussed further in subtheme 1.3: Inability to trust and helplessness). The loss of his Grandmother is compounded by the sexual abuse from his father, as well as the sexual abuse from his brother that was also occurring at this time. In terms of communion and appropriate relationships, there were few constants in Anthony's life, whereby he experienced a lack of nurturing relationships that promoted positive growth. Children require sensitive, nurturing care in order to develop the capacities for trust, empathy, compassion, self-regulation, problem-solving skills, and a sense of morality (Brazelton & Greenspan, 2006), as well as appropriate adult-child relationships, since the blueprint for relationships and how to relate to other people are created through early family interactions (Whitbeck, Hoyt & Tyler, 2001). However, Anthony's adverse and abusive childhood meant that he did not develop the capacities for some of these skills, which became evident throughout his narrative as he later reports having difficulties relating to and trusting other people (discussed further in the next section: Narrative theme 2).

In relation to Roger, the only time he became visibly emotional during the interview was when he spoke about the loss of his Aunt, referring to her several times throughout (as a challenge in life, a health challenge, his biggest loss, and the most positive influence in his life). This suggests that the loss of his Aunt was particularly salient and meaningful for Roger, however, his narrative lacked depth in terms of the impact of this loss:

Extract 5, Roger

I was about eleven so I was quite young the er and it did affect me that you could say that was a challenge I don't strictly think that was a challenge but yes I suppose it was it was a challenge emotionally it was quite a big challenge

The loss of his Aunt presents a multitude of losses (similar to Anthony), however, Extract 5 demonstrates a lack of narrative coherence in terms of affect and integration, whereby Roger states that his loss was '*a challenge emotionally*', but, is unable to expand on how this impacted him or relates to his wider sense of identity (integration). Narrative coherence is one of the major structural components of stories, whereby they are considered to be coherent if they orient the audience by contextualising the specific episodes being recalled, follow a logical structure, use affective language to highlight salient points, and reflect on why this particular story was worth telling and how it links to their sense of identity (integration; Baerger & McAdams, 1999). This lack of coherence may be due to Roger experiencing personality difficulties, as impaired narrative coherence is thought to be common among individuals with poor mental health and personality pathology (Adler et al., 2012; Lysaker & Lysaker, 2006; Westen et al., 1991). Individuals with PD demonstrate difficulties orienting the audience to new episodes of the story, reflecting on the significance of a given episode or how it links with the broader sense of self, and affect being presented as both intense at times but notably lacking at others (Adler et al., 2012), similar to what was demonstrated throughout Roger's narrative. Close relationships during childhood play an important role in developing a coherent sense of identity (Jorgensen, 2010), whereby a lack of trusting relationships may result in the child not developing the inner representations of others required to form coherent narratives (Fuchs, 2007), which may be the case for Roger. Equally, he may have struggled to express his emotions on such a sensitive topic or may have chosen not to talk about the impact during the interview due to it causing pain or distress (Kavanaugh & Ayres, 1998).

Subtheme 1.2: Feeling like a failure

Feeling like a disappointment and failure within the family home was a common theme present among the narrators. Feeling accepted by parents is thought to be critical to a child's development (Gerhardt, 2004), and positive parent-child relationships are crucial during childhood (Malmberg & Flouri, 2011), which links strongly to the theme of communion.

Extract 6, Roger

I said 'you've never ever ever you never ever praise me' and he said 'when you do something to be proud of that I can be proud of I will praise you' and that really hit that did I felt like a failure like I was never good enough in my father's eyes.

Roger describes a vivid memory from his childhood where his father failed to offer any praise or recognition for his efforts. Roger's emphasis and repetition of 'never ever' demonstrates the dissonance between what his father never does (praise him), and his desire to be accepted by his father. However, he always felt like he was never good enough or worthy enough of father's praise. When a child feels rejected by their parents an essential human need is not being met (Rohner, 2004), which can result in detrimental effects to the attachment relationship and the child's psychosocial development (Hughes, Blom, Rohner, & Britner, 2005), particularly in terms of forming secure and trusting relationships during adulthood (Khaleque & Rohner, 2011). This is prominent throughout Roger's narrative when describing adult relationships (discussed further in the next section: Narrative theme 2). The following extract details the impact that this comment had on Roger:

Extract 7, Roger

It could have done one of two things. It could have either made me bury my head sort of that's it I'm not gonna [sic] do anything good or on the opposite what it did was the opposite I was determined that I would be successful and I have been successful. . . I've had positions of authority erm I've always been the sort of person that wanted to help other people you know that's part of my personality the er I've always been involved in charities and helping other people er people would come to you for advice and you would give the best advice you could that's the sort of position that I saw myself in society.

This comment from Roger's father resulted in a 'fork in the road' moment, whereby, he could have internalised this sense of being a 'failure' and perceived himself as a 'failure' throughout his adult years (akin to the looking-glass self; Cooley, 1983), or, he could have done the opposite. Roger's construal of this event takes more of a redemptive plot (a negative event that becomes positive; McAdams, 2009), in which he describes the protagonist as gaining agency and taking control of his future, with a determination to be successful and prove the villain of the story (his father) wrong. Roger's definition of success revolves around helping other people, whereby he casts himself into the role of the 'caregiver' or 'helper', which may have served as a form of self-validation by reinforcing that he is not a 'failure'. Interestingly, at a different point in the narrative Roger explains that his father was 'very big into charity work', therefore, the underlying motivation for his 'helping' behaviour may have been as a way of gaining acceptance and praise from his father, even during adulthood. This demonstrates unrelenting standards whereby Roger strives hard and focuses on other people's desires (Van Hanswijck de Jonge et al., 2003), in the hope that he will receive praise and acceptance.

Roger states that this behaviour is part of his core identity, establishing himself as playing a 'helper' role within society, whereby he offers advice to other people. This aligns with the wounded healer narrative (Jung, 1951), in which an individual may be compelled to help others because they themselves are 'wounded' or have experienced traumatic experiences (as well as never feeling good enough, Roger also reported sexual abuse from his father during childhood), whereby these lived experiences are thought to be the best possible form of training for a 'healer' (Jung, 1951). However, the extent to which Roger internalised this 'helper' or 'wounded healer' identity is questionable, given that he is in prison for a sexual offence. On the other hand, portraying this 'helper' identity may be doing important identity work for Roger, as it may be linked to Braithwaite's (1989) restoration process, whereby individuals look back into their past to find a redeeming value. It has been suggested that IPSO may put forward moral selves as a way of doing identity management (Blagden et al., 2014), demonstrating to the audience that 'deep down' they are good people. By falling back on this 'helper' identity, Roger is able to deemphasise the significance of his criminal behaviour in his life story and suggest that he was a normal person 'all along' (Maruna, 2001).

For Paul, this sense of feeling like a failure was prominent throughout his whole life story, and is attributed to events during his childhood around being dyslexic, not getting into Grammar school (his negative childhood memory), and realising he was homosexual.

Extract 8, Paul

I was dyslexic and and in certainly in the seventies in (place name) you weren't dyslexic you were thick. . . I suppose that was the first time really it dawned on me where I I was failing. I mean everyone knew I wasn't going to get into the Grammar school. . . you just feel you're a disappointment. . . that was the beginning of that feeling of being a failure.

Extract 9, Paul

During my teens I started realising I was gay and it was the seventies and my dad was quite conservative so there was a realisation that he wouldn't be overly comfortable with it. . . it ended up that I was the only male heir. . . that seems to have had quite a significant impact that that feeling of I'm a failure I'm not going to carry on the family name.

These extracts highlight two instances in Paul's childhood where he felt like he was not meeting other people's expectations and felt like a 'failure'. Paul was not diagnosed with dyslexia until his adult years, meaning that, throughout his childhood and adolescent years, society and family members perceived him as 'thick'. Paul began to internalise this view of himself, whereby he started to define himself as a reflection of how others perceived him (the looking-glass concept; Cooley, 1983), as 'thick' and a 'failure'. The 'golem effect' (Maruna, LeBel, Naples & Mitchell, 2009) postulates that low expectations of people leads to poor outcomes, which may be the case for Paul as everyone expected him to fail, he

therefore expected himself to fail, and in the end he did fail: *'it goes to that I'm a failure thing that's always been an under pinning of my life it's that well of course you knew you were gonna [sic] fail so you've achieved what you expected'*. This narrative of being a *'failure'* is how he accounts for some of his failings during adulthood (discussed further in the next section: Narrative theme 2).

In addition to feeling *'thick'*, Paul also felt like a failure due to his sexuality and not being able to *'carry on the family name'*. The pressure of conforming to familial and societal expectations and the associated stigma of homosexuality in the *'seventies'* (as well as a *'conservative'* father) resulted in Paul feeling like he had to keep his sexuality a secret. To others, Paul presented an *'inauthentic self'* (*'I played football, I did sport, that wasn't me'*), someone that was qualitatively different to his *'authentic self'*. This dissonance between who he really was and the persona that he portrayed may have been linked to a fear of discrimination and rejection from family members and society, which are common problematic elements of coping with a homosexual identity (Allen & Oleson, 1999). This desire to keep his sexuality a secret may also be linked to shame, as Kinston (1983) proposes that hiding your sexuality is an action component to shame. In addition, Paul appeared to be displaying an *'inauthentic self'* during the beginning of the interview, as although he talked openly and honestly about his dyslexia and homosexuality whilst describing the different chapters of his life, he failed to mention that he had a preferential attraction to underage children (which he became aware of around the same time as realising he was homosexual).

Extract 10, Paul

Erm initially it was just an interest I'm attracted to teenage boys always have been. . . as I was growing up and that it that realisation of being gay yes yes I definitely was I knew I was gay and I knew I liked boys definitely.

Paul decided to withhold this information when first describing his life, and later describes the shame associated with being *'plastered across the local press as a paedophile'*, and how he felt like *'a massive disappointment and a complete failure'*. This demonstrates incoherence within Paul's narrative; at the beginning, his life story was largely defined by him being dyslexic and homosexual, but he later describes his sexual interest in children as a salient part of his life. As previously mentioned, incoherent narratives are common among individuals with personality pathology, whereby the audience may be left unclear to which elements of the narrative are most salient (Adler et al., 2012). Living with a sexual interest in children has also been found to be a contradictory and incongruent experience, whereby individuals have difficulties construing certain aspects of themselves (Blagden, Mann, Webster, Lee & Williams, 2018). For Paul, the desire to withhold this information may be due to the stigma faced by individuals with deviant sexual interests (Jahnke, Imhoff & Hoyer, 2015), as one of the biggest challenges for individuals that have been labelled as deviant is how they manage their identity during interactions with other people (Goffman, 1963). If the label (such as *'paedophile'*) is perceived as

threatening towards the interaction, then an individual may attempt to take specific measures to cope with the situation via a process of 'deviance disavowal' (see Davis, 1961), which is an attempt to minimise the stigma associated with the label, and allows for a 'normal' identity to be presented (Blagden, Winder, Thorne, & Gregson, 2011). Therefore, this may be one reason as to why Paul decided to omit this piece of information at the beginning of the interview, as a way of doing identity management by rejecting the label 'paedophile', avoiding the associated stigma, and maintaining a viable identity. Acknowledging the labels 'dyslexic' and 'homosexual' may have been easier for Paul to identify with due to society (nowadays) being more accepting of these concepts, and less stigma being attached to them in comparison to 'paedophile' or 'sexual offender'. Additionally, it may be that during the course of the interview and due to rapport building, Paul felt comfortable enough to talk about his sexual interest without a fear of being judged or stigmatised. Nevertheless, although he later talks about this sexual attraction, Paul was explicit in his attempt to distance himself from this identity, and present a 'normal identity', for example, as a well-regarded businessman, town councillor, and school governor (positions that are all of high importance within society). Similar to Roger, this may have been Paul's way of putting forward a moral self (Blagden et al., 2014), demonstrating that although he has done bad things, 'deep down' he is not a bad person, and is a 'respected' person within the community.

Subtheme 1.3: Inability to trust and helplessness

A sense of helplessness and the development of trust issues were common among individuals that experienced bullying and childhood sexual abuse within this sample. Two narrators described their experience of being bullied as their most 'negative childhood memory', and sexual abuse was described as a 'negative influence' and the 'lowest point' of two narrators' lives.

Extract 11, Roger

I found the best thing to do was isolate myself from people I er the bullying erm I think it no I think the trust issues definitely kind of started then I was quite nervous I I started to become withdrawn which is probably the reason I couldn't make friends. . . I always had and I still do erm difficulty making friends.

Extract 12, Roger

I was very introverted I didn't trust anybody at all I think and what my father had done just really reinforced what had happened through the bullying you know. Mmmm I never really got my trust back it has changed as I've become an adult it has changed er I just accept that the majority of people in this world can't be trusted. . . I lost confidence in myself, I I always had a confidence er probably still have if the truth be known, but the confidence thing has always been a problem for me.

Extract 13, Ben

I didn't I didn't want to mix in with other children after they'd been going on to me. . . that's the one thing that actually had an impact on me not just for that particular day but I think well for most of my life I didn't trust anybody I didn't want to be around anybody I I'm still the same now, I don't trust anybody, even now I spend most of my time on my own.

These extracts highlight the impact of bullying and sexual abuse, whereby narrators found it difficult to trust people after being victimised, which resulted in them becoming withdrawn and socially isolated. There appears to be a shift in Roger and Ben's identities from children that sought out friendships and connections, to ones that became introverted and withdrawn. Trust issues, difficulty making friends, social isolation, and self-esteem issues are common long-term effects of bullying and sexual abuse (Carlisle & Rofes, 2007; Gilmartin, 1987). These avoidant forms of coping (e.g. withdrawing from others) are not thought to be beneficial as friendships and a peer support system are essential for human development (Hodges, Boivin, Vitaro & Bukowski, 1999), which links to human interaction being employed as a survival strategy among our ancestors (Walton, 2019b). It is evident from these extracts that these negative experiences resulted in long-term effects, with both narrators referring to the negative impact they experience to this present day. This is also illustrated in the wider narrative as they portray a lack of friendships throughout childhood and adulthood, difficulty trusting during intimate relationships, and multiple problematic relationships. It is thought that individuals that have experienced abuse may not have learned the relevant social and interpersonal skills required for adult relationships (Filipas & Ullman, 2006).

Although these extracts make it explicit that both Roger and Ben expressed no desire to interact with their peers (since isolation equals safety), there appears to be some ambivalence within Ben's narrative. On the one hand, he claims that he did not want to socialise with other children, yet he describes his only positive childhood memory as a short-lived connection with a girl on a beach:

Extract 14, Ben

I was at the beach and I er there was another girl that was er a few places down sitting on the beach and we er we had never even spoken to each other but we our eyes was always meeting and er I think I used to think about that meeting for er a couple of years afterwards. I actually went back down the beach many times to see if she ever turned up again. . . she was smiling at me a lot and I smiled back.

Ben's construal of this memory is akin to that of a 'love story', whereby the protagonist is a hopeless romantic that hopes to fall in love, portraying himself as high in communion and ascribing to 'the lover' imago (McAdams, 1993). This extract demonstrates a strong underlying desire for communion, but also a profound sadness. A fleeting look with a random girl on the beach is the only moment of positive

connection with another person that Ben can recall from his childhood, whereby it may have been the only time he felt accepted by someone. At school he was rejected by his peers (bullying) and known as the boy that 'messed my pants' due to an incident on his first day at school. This incident infiltrated into his home life also, as when he returned home his mother did not have any clean clothes for Ben to wear, so she dressed him in his sister's clothes. This resulted in his father (and later his whole family) referring to him as 'Susan', which he saw as an extended version of the bullying at school. Whereas, the girl on the beach knew nothing about him, did not judge him, but simply 'smiled' at him. For Ben, this was a glimmer of acceptance and a connection with someone else, which was in stark contrast to his home and school life. This interaction on the beach enabled Ben to distance himself from the negative identities he was associated with at school and home, allowing him to be whoever he wanted to be. This may function in a similar way to Goffman's (1961) process of reverting to an 'unspoiled identity', whereby for those few minutes Ben may have been able to revert to an old identity that had not been 'spoiled' by his experiences of victimization, and was able to feel a positive connection with another person.

A sense of helplessness was also prevalent throughout the narratives, particularly in relation to Roger and Anthony who were both sexually abused by their fathers (Anthony was sexually abused by his brother also). A fundamental loss of control is thought to be a crucial aspect of experiencing abuse (Lisak, 1994), and both Roger and Anthony report a loss of control over their self-efficacy, agency, and their own fate.

Extract 15, Roger

I couldn't stop him er and that was devastating that really was. I couldn't do anything about it erm. . . I was very dependent on my family and living at home I couldn't just run away or anything like that. . . I did say no to him every time but he took no notice which is exactly my father so I just turned my emotions off I was just cold I felt nothing.

Extract 16, Anthony

I was really scared when it first happened with dad because dad was quite a big imposing figure. . . So with dad it was if I knew it was coming I was petrified if I knew it was coming I was and I didn't know how to get out of it. I think my way of dealing with it was to just let it happen let it let it get it over with and he'll go away. . . the stuff that my brother was doing to me I think it sort of like I don't know like sowed a seed in me or what I don't know, even though I knew it was wrong I wasn't horrified by it if that makes any sense?

Within these narratives, both Roger and Anthony ascribe to the 'victimic' narrative, with their fathers (and brother) being the villains of the story. In the 'victimic' plot, the protagonist is passive and receptive, depicting their lives as out of their control (Polkinghorne, 1996). This is evident in both Roger and Anthony's transcripts as they describe that they 'couldn't do anything about it' and 'just let it

happen'. The protagonist in these stories demonstrate a loss of power to affect change in their lives and describe being trapped in circumstances that were beyond their control, whereby there is a sense of helplessness and hopelessness. Within this 'victimic' narrative, the protagonist's life outcomes are determined by other peoples' actions and by chance. By referring to the abuse as sowing '*a seed in me*', Anthony demonstrates a sense of being 'doomed to deviance' (Maruna, 2001). This is akin to de Charms' (1968) description of the 'Pawn' self, whereby Pawns feel that their outcomes are based on life circumstances and chance, as opposed to being masters of their own fate. This passive and acquiescent stance towards life is apparent throughout the life stories, whereby both narrators describe similar experiences during their adult years where they felt helpless and unable to affect change in their lives (for example, Roger stayed in a marriage which involved multiple cases of infidelity, and Anthony reports being sexually abused by his brother up until he came to prison).

There appears to be incoherence and ambivalence within Anthony's narrative. On the one hand, he describes his brother as the most negative influence in his life, at times stating that he wanted to '*say fuck off leave me alone don't touch me*', but, on the other, he states that '*some of it I enjoyed. . . what he did to me made me feel good*'. Additionally, at times he describes his brother as not being aggressive or threatening, but later contradicts this by saying '*he threatened me with a knife*'. This illustrates a lack of coherence within Anthony's narrative and ambivalence in his sense-making, in which impaired narrative coherence has been found among individuals with personality pathology (Adler et al., 2012). Caspi & Moffitt (1995) argue that individuals that subscribe to Pawn stories may engage in situations that reinforce a sense of self-victimisation, which may be the case for Anthony. Aligning with this 'victimic' narrative and this sense of feeling unable to exert agency and control over his life may be linked to the abuse from his brother continuing throughout his adolescent and adult years.

Anthony's construal of the abuse in this way positions himself as a victim of his past experiences, which renders him helpless, hopeless, and out of control of his life experiences. Viewing oneself as a victim is thought to be common among individuals that have experienced childhood abuse, particularly those that fall into the 'strugglers' life pattern, as opposed to individuals that are 'thriving' (Thomas & Hall, 2008). 'Strugglers' are described as having life trajectories that have been tarnished by contamination sequences, which was a common occurrence among narratives in this study. This victim narrative may be one way of Anthony accounting for his behaviour, as the reference to a 'seed' being sown suggests that his behaviour was inherent and out of his control, thus reducing his level of accountability for his offending behaviour. This may be a way of Anthony doing identity management, in which Goffman (1963) highlights that a challenge for people that are labelled as deviant is how they manage their identity when interacting with others. Therefore, Anthony is able to portray a victim identity which may elicit understanding, sympathy, and empathy from the audience, whilst distancing himself from the 'sexual offender' label which is highly stigmatised. Although belonging to a group normally has benefits for wellbeing and links to the 'social cure' perspective (Kellezi & Reicher, 2012), if the identity is with a

stigmatised group of individuals (such as 'sexual offenders') then this becomes a 'social curse', which has several negative implications (Stevenson et al., 2014). Making excuses, justifying behaviour, and portraying oneself in a positive light is thought to be beneficial to individuals as it prevents them from internalising the criminal label (Marshall, Marshall & Ware, 2009; Maruna, 2001), allows them to maintain a coherent sense of self (Blagden et al., 2011), and may reduce the 'social curse' associated with the 'sexual offender' label.

Narrative theme 2: What came next: An exploration of relationships and life challenges

While the focus on the previous theme was to explore meaningful events that happened during childhood, this theme concentrates on what happened next in the narrators' life stories, and how they account for this. Each of the participants use their past experiences in various ways to make sense of their lives, and how the narrators account for various aspects of their lives such as work, relationships, and criminal behaviour will be discussed. After adverse childhoods, the plots often take an upward turn in trajectory, characterised by an increased sense of agency and new characters (especially 'love interests') being introduced. Nonetheless, these upward turns frequently result in contamination sequences, and the three subthemes that will be unpacked are 'Communion and agency turbulence', 'Sex as a coping mechanism', and 'The internet as an enabler'.

Subtheme 2.1: Communion and agency turbulence

Throughout the analysis, it became evident that the next stages of the narrators' lives were linked to an increase in agency, autonomy, and communion. The protagonist of the story is described as taking control of their lives, whether that was through leaving home, starting up a business, or entering into a meaningful relationship. These are common features of getting older, whereby individuals must take on the roles of adulthood, and assume increasing responsibility for their life courses (Bandura, 2005).

Extract 17, Anthony

I left to join the Navy by the time I was seventeen I think if I had stayed at home any longer I don't know if I would have made it. . . dad tried something, he hadn't tried anything in ages and he tried it and I was like nah nah nah [sic] not again and that's that's when it stopped with dad cuz [sic] I threatened him I physically threatened him that if he ever touched me again then I'd kill him and said I'm leaving for the Navy. That was the first time I'd ever stood up to him.

Extract 18, Paul

Oh yeah I'd left home at that point. . . I set up my own business just there was me to start with and I just did IT support for small businesses and I wasn't earning a fortune but I was working for myself I was literally my own boss and it was quite enjoyable

Both Anthony and Paul exerted control over their lives by engaging in activities that were meaningful to them. For Anthony, he describes a 'Warrior' imago whereby he stands up to the antagonist (his father) in the story, and escapes the traumatic home environment, which is akin to Booker's (2005) 'overcoming the monster' plot. This also aligns with Thomas and Hall's (2008) notion of 'becoming resolute', whereby survivors of childhood abuse demonstrated courageous actions such as challenging an abuser or refusing to be left alone in the house with the abuser. Anthony construes this event in an almost heroic way, whereby he describes saving his own life as '*I don't know if I would have made it*' if he did not leave, demonstrating a shift in identity from the previous 'victimic' narrative to a new 'heroic' narrative, which links to the idea of self-redemption (Thomas & Hall, 2008). Whereas, for Paul, his overall narrative was dominated by an underlying theme of agency, with most of his experiences relating to work and his career. Paul was made to feel like he was 'thick' and a 'failure' when he was younger due to his dyslexia, thus, setting up a business was a huge achievement. This may have acted as a form of self-validation, as well as enabling Paul to distance himself from the aforementioned negative labels. Escaping the home environment was essential for both narrators to move beyond purely survival and be open to alternative futures, which include an autonomous, healthy self (Bowen, 1976).

Participants narratives were anchored in stories of relationships, with various relationships and marriages forming several of the 'life chapters' discussed during the interviews, whereby two narrators described their marriages as the 'high points' of their lives. Narrators present 'lover' imagoes (McAdams, 1993), in which they describe agentic episodes where they met a partner, started a family, and thought '*it was the best thing in the world*' (Roger). Their means of escaping the adverse home environment was accomplished by getting into a relationship and moving out, however, all of these relationships later broke down for various reasons. Anthony describes how him and his partner '*couldn't stand each other*', and Roger explains how '*I didn't love her, I didn't know what love was until I was a lot older*', whereby the relationship broke down due to infidelity on his wife's behalf. The breakdown of these relationships may link to narrators not learning appropriate ways of relating to and interacting with others due to their early family experiences (Whitbeck et al., 2001). Thomas and Hall (2008) report a similar pattern among adult female survivors of child maltreatment, whereby 63% of marriages ended in divorce, especially the ones that were started as a means to escape. This is slightly higher than the general population statistics, which suggest that 42% of marriages in England and Wales end in divorce (Office for National Statistics, 2017). However, moving on from their first relationships, narrators describe their second relationships as more meaningful:

Extract 19, Roger

I never recognised love as an emotion until I met my second wife. . . It completely completely changed me. It made me a lot more aware of other people's wishes thoughts and it made me a more rounded person. . . she needed erm emotional support and that was great from my

point of view because it suited my personality down to the ground someone needed me my god come to think of it the the only the biggest aphrodisiac in my life is when someone wants me. . . it felt like a key in a lock sort of what I really needed I think.

Extract 20, Anthony

When we first got married I thought I'd made it you know I thought life was brilliant. That period of my life I couldn't have I couldn't have wanted for anything more, I was I was really really happy. . . At that point yeah it was all about the future at that time yeah my past was gone as far I was well I thought it had erm and it was just all about the future.

Evident in these narratives is a dominant redemptive figure who helped narrators move away from their difficult past experiences. Both narrators demonstrate a strong sense of communion and present 'lover' imagoes, with Roger further reinforcing his 'caregiver' imago and 'helper' identity. For Anthony, this new relationship enabled him to forget about his traumatic past with his brother and father and focus on his future. Roger and Anthony's experiences align with Thomas and Hall's (2009) 'redemption by a loving relationship' narrative, however, although narrators describe being happy and wanting to be close to their partners, relational ambivalence was also prevalent throughout the narratives:

Extract 21, Ben

I always felt there was something er something not right I was yes I was dominant I er I ain't [sic] going to deny that one bit but the reason I was dominant was because I didn't trust my wife and I always thought she was lying so unfortunately I've had I've had this situation throughout my marriage throughout all my relationships. . . my trust my trust is not just against females it's against people that tell you they're going to do one thing and don't do it.

Extract 22, Roger

I had I had a a trust issue from childhood and I couldn't trust anybody including my wife. In my first marriage my erm after well after about five years my wife started having affairs and all she was going was reinforcing the fact that I couldn't trust anybody.

Despite the narrators' self-confessed happiness within their relationships, diverse feelings were also expressed, particularly in terms of a dispositional lack of trust. Individuals that experience attachment difficulties during childhood have been found to be ambivalent in their relational tendencies; on the one hand wanting to be close to their partner, whilst also fearing rejection (Mikulincer, Shaver, Bar-on, & Ein-Dor, 2010). This may be the case for Roger and Ben due to their adverse childhoods and lack of secure attachments with parents, whereby overcoming the levels of mistrust they developed during childhood may be difficult for them. The instability is linked to their adverse childhoods and is further reinforced by adulterous relationships during their adult years. This lack of trust and ambivalence act

as impediments to agency and communion for both narrators, and in relation to Ben, his attempt to assert some agency and control in his life results in him being constricted and dominant in his relationships.

Although narrators had a strong desire for communion and described their adult relationships as salient chapters in their life stories, they resulted in a contamination plot whereby they also broke down (described as their 'low point' or 'biggest regret'). Narrators blamed themselves for the failure of their marriages:

Extract 23, Anthony

I wasn't a great husband far from it you know I didn't really know how to be. . . The marriage just broke down she was fed up with me I was irresponsible with money, I was never there, it got to the stage where I would rather be with my mates than be at home. . . I couldn't give it the full commitment that maybe a man should have done to his marriage. . . I'd have these spouts where I'd go off with my mates, she'd be okay about it but then I'd go with them again and again and again.

Extract 24, Roger

Second marriage failure I do regret that er I was somewhat selfish I've always been like that all my life erm what I wanted to do I did. . . even my second wife I was still pretty selfish with my my own needs my own neediness is that the word I don't know but I had er my feelings would be would go before anybody else's yeah and if I wanted to do something I would go and do it.

Anthony and Roger attribute the failing of their marriages to their own selfish behaviour, positioning themselves as the villains in regard to their relationships. Children that experience maltreatment may not develop the relevant social and interpersonal skills required for adult relationships (Filipas & Ullman, 2006), particularly those relating to empathy, perspective taking, and abiding by usual social expectations (Music, 2011). Furthermore, children that experience adverse childhoods and feel 'wronged' demonstrate more selfish behaviour through an increase in entitlement (Zitek, Jordan, Monin, & Leach, 2010). Anthony and Roger may be enacting the interaction styles they learnt when they were younger whereby their fathers also acted in selfish and abusive ways. Although not explicitly stated in relation to the breakdown of their marriages, it later transpires that both Anthony and Roger offended against their victims (daughter/stepdaughter/son) during these marriages, therefore, this sense of selfishness and putting their own 'needs' first may link to their knowledge of and shame around their offending behaviour.

Roger's extract also highlights the dissonance and identity conflict that he is experiencing. On the one hand, he portrays a 'helper' identity where he is very caring and charitable, describing how the

relationship with his wife '*completely changed*' him as he became more considerate of others' feelings. Yet, within this extract he describes being selfish his whole life. A fragmented sense of self has been linked to individuals with personality pathology, whereby individuals have shifting views of themselves, characterised by sharp discontinuities and rapidly changing roles and relationships (Fuchs, 2007). Fuchs (2007) argues that when trustful relationships are missing during childhood then the child will have difficulty forming a coherent narrative. This aspect of his identity (being selfish) is something that Roger struggles with and regrets, whilst also having concerns regarding the future:

Extract 25, Roger

I'm never going to go after another relationship again I can't be trusted in a relationship erm because I because will I gradually go back to being a selfish bastard again. I don't want to be a selfish person again.

This illustrates the uncertainty felt by Roger regarding the prospect of a relationship in the future, which returned Roger to the feared self. A feared self is an image that the individual does not want to become, and can sometimes act as a powerful motivator for change as the individual may intentionally avoid it (Paternoster & Bushway, 2009), which is consistent with Roger's narrative in that he intends to avoid becoming the feared self ('*a selfish bastard*') again by not entering into a new relationship.

Subtheme 2.2: Sex as a coping mechanism

Throughout the interviews, many of the narrators used their past experiences to claim a consequential chain reaction (i.e. this particular event happened during childhood, so I am this particular way, which is why the next thing happened) between their previous experiences and their offending behaviour. As well as this, as a way of accounting for their behaviour, narrators use rhetorical devices such as justifications and excuses (Maruna, 2001). All of the narrators conceded the negativity of their actions when talking about their offences, whereby concessions or admissions of wrongdoings were common: '*I let them down in the worst possible way*' (Roger), '*It was the biggest mistake I ever done*' (Ben), and '*It was the ultimate betrayal of my my marriage*' (Anthony). However, similar to that which Maruna (2001) identified among a group of individuals that were either persisting or desisting from crime, accepting responsibility for their crimes resulted in a 'chaotic jumble of excuses and justifications mixed in with concessions and admissions of shame' (p. 134). Only one participant described their offending behaviour as their 'low point' and 'biggest regret', whereas, for others, their offending behaviour was brought up in the context of other chapters/events (such as the failure of their marriage or business).

For some of the narrators, their criminal behaviour was closely linked with their emotions, and an inability to deal with these emotions, whereby sexualised thinking and/or behaviours became a coping mechanism:

Extract 26, Ben

I went off sex completely with Sarah but unfortunately my emotions turned to me granddaughter my emotions weren't where they should have been er I should have told Sarah when Sarah refused to give up her bloody job I should have told her what was going on inside my head

Extract 27, Paul

If life got rough, if life got shitty I just thought about teenage boys and you get that you get that emotional lift and you feel better and it just became my coping strategy my crutch. . . I hadn't told the family I was gay I was struggling with body image because sport had died off by that point erm the business was in the flat and the business was failing erm so yeah I felt like a failure again. . . it just became a compulsion and it just takes over.

Extract 28, Roger

It wasn't a sexual thing at all really it was an emotional thing. I'd pinned so much on the on the marriage and then she's having affairs I completely lost everything and I turned to the I turned to the nearest thing I had to to someone that I was really close to emotionally involved with. . . it's really quite a er my own fault but it didn't start out as sexual in any way it was emotional I needed someone to lean on emotionally maybe it was my er a failure in my personality, my upbringing or whatever.

As illustrated in these extracts, narrators link their offending behaviour to their inability to manage their emotions in appropriate ways. This supports previous research which has shown that IPSO have difficulties with emotional skills (Gillespie & Beech, 2016), as well as aligning with results from the preceding chapter (six) and previous research that suggests sexual thinking and/or resultant behaviour may be used as a maladaptive coping strategy (Courtois & Weiss, 2018; Gartner, 2018). These narratives also align with Bancroft and Vukadinovic's (2004) model of SP, with Roger aligning with pathway one (a way of gaining emotional support) and Paul with pathway two (a way of distracting from negative affect).

Within these narratives, participants attribute a cause or give reason for their behaviour, which aligns with attribution theory, and is a common occurrence among individuals when they are asked why they did a certain thing (Heider, 1958; Maruna & Mann, 2006). Attributions can either be situational (external factors) or dispositional (internal factors; Heider, 1958), whereby, in this case, some of the extracts appear to show dispositional attributions: *'my own fault'*. However, it is also evident from these extracts (and the admissions previously discussed) that narrators have a conflicted sense of responsibility for their offending behaviours, they feel worthy of blame for some of their actions, but also feel like parts are outside of their control. This concept of their behaviour being out of their control

is emphasised by the use of 'it' during the narratives, which has also been found among previous studies of criminal behaviour (Maruna, 2001), and is something that Petrunik and Shearing (1988) refer to as 'the It'. Petrunik and Shearing (1988) added 'the It' to the conceptualization that the self consists of an 'I' (the I who acts) and a 'Me' (the me who is known). They suggest that 'the It' is where people believe that behaviour comes from an alien source of action, rather than the 'I'. This autonomous 'It' is part of the self but is responsible for behaviour that is unintentional and uncontrollable, with individual's experiencing the behaviour as something that happens *to* them, rather than something they *do*. This dissonance highlights incoherence in the individuals' narratives and confusion in their sense-making, as on the one hand they attribute their behaviour to themselves, but, on the other, a sense of external influence is present. This may be a way of doing identity management in that by referring to the 'It', narrators are able to explicitly (or implicitly) distance themselves from their offending behaviour, and indirectly from the 'sexual offender' label.

Another identity management strategy employed by narrators involves comparing their own actions to other, worse criminal activity, which acts as a way of reinforcing their alignment with traditional values:

Extract 29, Ben

It's black and white I haven't dragged anybody off the bloody street im not erm I'm not sexually motivated where if somebody turns me on on the street ive got to have sex with them that isn't that wasn't the case.

Extract 30, Roger

My father what he did to me was something else, my father was er he raped it wasn't a question of in my case where it was they didn't say no rather than anything else and they were really young erm they didn't say no so it wasn't like in my case where I was pleading with him not to and he did

Both Ben and Roger appear to be managing their identity by shifting emphasis away from their behaviour to crimes that they perceive to be 'worse', in which they position themselves as far away from these perceived villains as possible. These downward social comparisons (Taylor, 1989) enable narrators to do shame management and maintain a viable identity. Similar to Maruna's (2001) sample they are confirming to themselves and the audience that they are not the 'real' bad guys, they haven't '*dragged anybody off the street*'. By demonstrating this narrators provide an insight into their values, and attempt to put forward 'moral' selves (Presser & Kurth, 2009). This may enable individuals to distance themselves from their past offending identity, and may allow them to live up to such 'moral' selves. This is particularly important for Roger as it also allows him to distance himself from his father who 'raped' him. As explored within Roger's early years, he describes his father as fulfilling the villain role in the narrative, and he takes on a victim role. Therefore, by arguing that what his father did '*was*

something else' and minimising and justifying his own behaviour ('*they didn't say no*'), Roger is able to distinguish himself as qualitatively different to the 'bad' guy in the story (his father), rather he is still positioning himself as the 'victim'. If Roger was to acknowledge the similarities between the abuse endured from his father, and his own sexual offences against his son, then 'the character' or self that he had developed would be shattered, and instead he would be a character that is vilified in a similar way to his father, who he describes as a '*nasty old man*'. Thus, by distinguishing between his father's actions and his own behaviour he is able to maintain his 'performance' of the character that he portrays (Goffman, 1959). Rejecting the 'villain' identity and distancing himself from that of a 'rapist' appears to be doing important identity work and shame management for Roger, allowing him to keep a coherent and positive sense of self, similar to what has been found among individuals persisting and desisting from crime and IPSO who were in denial (Blagden et al., 2014; Maruna, 2001).

Subtheme 2.3: The internet as an enabler

Some narrators appear to have a conflicted sense of responsibility for their criminal activities, and at times, attribute their behaviour to something external (such as the internet). Paul describes the internet as the 'greatest negative influence' in his life, and Anthony defines it as a 'turning point' in his:

Extract 31, Paul

Probably the internet really whilst it provided a career ultimately it ended up with me being in here really that brought me to prison. . . when the internet came along erm it just became easier and easier and easier to feed and then it just became a complete addiction really and the novelty of the sex wore off and it just became I just collected I was an obsessive collector I had to have people would post sets of pictures and I had to have complete sets I've got a degree of OCD so I think that initially it was an interest and the sex then it just became a compulsion and it just takes over.

Extract 32, Anthony

Then a big turning point in my life was erm we got connected to the internet round about 1999 2000 and erm I say that was a turning point because that put into my head that it was ok to do what they were doing. . . So the internet I'm not blaming the internet for what I did of course I'm not but first looking at pornography on the on the internet changed my it changed my way of thinking, it changed my sexual interests into something into something really really wrong. I think that's where it started really and that's when I started building up fantasies in my head.

Both narrators experience a conflicted locus of control, and although they are not '*blaming the internet*' or making excuses, they indirectly do, demonstrating a perceived lack of agency over their actions, which is similar to what was found among a sample of IPSO who offended through the use of the

internet (Winder & Gough, 2010). This theme resonates with the literature regarding cognitive distortions, in which IPSO minimise, deny, or rationalise their offending behaviour (Blumenthal, Gudjonsson & Burns, 1999; Howitt & Sheldon, 2007). The act of making an excuse and the subtle linguistic devices (such as referring to the 'It') allows narrators to avoid directly acknowledging responsibility for their criminal behaviour, which is common when referring to behaviours that are socially loathed such as sexual offending (Ware & Mann, 2012). Making excuses is thought to be beneficial in some instances, as it prevents individuals from internalising the criminal label (Marshall & Ware, 2009; Maruna, 2001), reduces negative sanctioning (Blumstein et al., 1974), preserves the narrators reputation (Crant & Bateman, 1993), and allows them to claim for their status as a 'normal' person, which restores their bond with society (Maruna, 2001).

Anthony describes the internet as fundamentally changing his thinking, and Paul describes his internet (pornography) use as an 'addiction', 'compulsion', and 'OCD', rendering themselves completely out of control of their actions (*'it just takes over'*). Similar to what was found among a sample of internet IPSO (Winder, Gough & Seymour-Smith, 2015), Paul ascribes to a psycho-medical discourse whereby he attenuates his personal choice and responsibility by referring to his behaviour as an *'addiction'*, *'compulsion'* and *'OCD'*, absolving himself from culpability. As above, these rhetorical devices may be best understood as part of an impression management strategy (Goffman, 1959), whereby separating the actions of the 'It' (external) from the 'I' and 'Me' (internal) means that narrators are able to protect themselves from the internalisation of blame and shame (Maruna, 2001). This is thought to help protect an individual's self-esteem, reduce anxiety, and increase their sense of worth (Harvey, Weber & Orbuch, 1990; Northey, 1999), which may be necessary aspects required for desistance (Rotenberg, 1987). Furthermore, if an individual admits that they wilfully and purposefully committed a sexual offence they will be admitting they are the 'type of person' who would commit this type of crime, which distinguishes them as fundamentally different from the rest of society (Maruna, 2001). Individuals that fail to provide accounts (excuses and justifications) for their criminal activity are sanctioned more severely by the audience (Felson & Ribner, 1981), therefore, narrators do not want to admit to themselves and others that they are the 'kind of person' that commits sexual offences, as this would be synonymous to admitting they are irredeemable. Thus, the way in which they construe their offending may be a way of them managing their shame and identity, preventing them from internalising the criminal label, and enabling them to desist from crime by having a sense of the self as 'noncriminal' (Meisenhelder, 1982).

Narrative theme 3: Where I am now: Redemption – 'I'm a different person having come to prison'

The crux of this theme is where the narrators are now, in prison, and the opportunities and redemptive properties that prison has afforded them. For some people, imprisonment can be a 'turning point' in their lives (McNeill & Schinkel, 2016; Sampson & Laub, 2005), as it is one of the social contexts where

self-identity is likely to be questioned, and provides a context which allows for ‘quantum personality change’ (Maruna, Wilson & Curran, 2006, p. 163). When asked to describe an important turning point in their lives, both Ben and Roger stated that coming to prison had been their turning point. From their experiences in prison, narrators appeared to transform from a ‘victimic’ life plot to an ‘agentic’ one (Polkinghorne, 1996). Previously, narrators had come to understand themselves as powerless and passive due to their adverse experiences, however, through various experiences whilst in prison, narrators were able to change this ‘victimic’ sense of themselves to an understanding of themselves as active agents who were able to take control of and influence their own lives. Narrators within this study appear to be engaged in a classic ‘rebirth’ plot (Booker, 2005), whereby they follow a basic structure: the protagonist is initially under a dark spell that has them trapped, this culminates in the second part of the narrative and is described as a ‘nightmare crisis’ (p. 203), and the third part is an ‘act of redemption’ whereby the protagonist is liberated from the entrapment, which results in awakening, health, growth, happiness, hope, and love (Robinson & Smith, 2010). Narrators often describe feeling like *‘a different person having come to prison’*, and the ways in which individuals have been able to re-story aspects of their lives in order to achieve agency, acceptance, forgiveness, and redemption are explored throughout the following three subthemes: ‘Time to reflect, ‘Meaningful roles’, and ‘Reconnecting to religion’.

Subtheme 3.1: Time to reflect

Initially narrators described the act of being arrested and coming to prison as *‘the most horrendous thing that probably ever happened to me’* (Roger), and for most individuals the experience of being in prison resulted in suicidal thoughts. However, similar to Maruna et al.’s (2006) sample of prisoners, despite their painful experiences in prison, all of the narrators in the current sample reconstrued their experience of imprisonment as a gift or opportunity. This concept of coming to an unfamiliar and strange place (prison), and learning important lessons aligns with Booker’s (2005) ‘Voyage and Return’ plot, whereby the protagonist goes to a strange land, overcomes threats and learns important lessons, and returns with experience. Although the protagonists within this study have not yet returned to the community, the following extracts (and the next two subthemes) highlight ways in which the narrators have gained during their imprisonment, and how they will return with new experiences and knowledge.

Extract 33, Ben

I didn’t regret coming to prison I didn’t regret it I thought no get away from it all because there its only gonna [sic] go downhill. . . I’ll be quite honest with you the thing that’s changed changed through all this the good thing is me going inside that’s the turning point as far as I’m concerned. . . because you’ve got time to sit back and reflect on what on what you’ve done in life, and when I look back at my life what a bloody mess I’ve made.

Extract 34, Roger

When you're out there you're so busy living you're so busy doing this and that and making making a career and having a family doing all the things you do that you don't have time to think er anything at that time. But when you get locked up suddenly that's what you have got time for, that's all you really do is sit there and think er that was that was a huge event that was huge huge event and actually being locked up I think the best thing that could have happened to me was to be locked up. . . that is er one of the benefits of coming to prison having time to sit down and think through.

Here, Ben articulates how imprisonment has been a positive turning point for him, describing how he wanted to 'get away from it all' (his life in the community). For some individuals, positive testimonies regarding prison may indicate that imprisonment offers a form of 'respite or refuge' from their lives in the community (Crewe & Levins, 2019; p. 3), whereby they describe being 'saved' from 'some greater harm on the outside' (Schinkel, 2014, p. 59). Both narrators describe how the prison environment created space for internal reflection, which has enabled personal change. Imprisonment can offer 'space' for contemplative reflection (Comfort, 2012; Frois, 2017), which can enable prisoners to engage in narrative construction (Crewe & Levins, 2019). Blagden et al. (2016) have termed this type of reflection 'headspace', suggesting that it is fundamental in order for individuals to self-evaluate and realise that change is possible. The prison establishment that Ben and Roger reside at is described as a therapeutic prison and is exclusively for males that have previously sexually offended. Previous research has demonstrated that such an environment results in individuals feeling safe and relaxed, enabling the 'space' for reflection (Blagden & Wilson, 2019), whereby a positive rehabilitative environment is pivotal for individuals to be able to 'reconstruct themselves as moral subjects' (Ugelvik, 2012, p. 217).

Subtheme 3.2: Meaningful roles

Peer-support roles have not only been found to help those in need of support, but, are also beneficial for the individual providing the support (Stevens, 2012). These roles have been found to provide meaning, purpose, and constructive inputs into an individual's life, as well as a sense of autonomy, independence, and feeling more 'human' (Perrin & Blagden, 2014; Perrin, Blagden, Winder & Dillon, 2018). Three of the participants in this study were involved with peer-support roles and described them as their 'wisdom event' or 'turning point'. Two of the participants were involved with the Samaritan's prison 'Listener' scheme (Foster & Magee, 2011), and one with the 'Shannon Trust Mentoring' scheme (Shannon Trust, 2005). Listeners provide face-to-face support to other prisoners that require help, and Shannon Trust mentors help students to read via a reading program over a period of several months.

One prominent aspect of the individual narratives was their perception of sameness or consistency in how they saw themselves now and in the past. Similar to what was found among a group of IPSO that denied their offences (Blagden et al., 2014), individuals actively encouraged narratives that had a temporal consistency, demonstrating that they had not changed, and were the same moral character that they had always been:

Extract 35, Paul

I'm a I'm a trained er when I became a school governor I was asked to teach a level IT so I'm a teacher too I've got a teaching qualification as well. So I got involved with the Shannon Trust and when the previous co-ordinator left erm he asked if I'd be interested in taking over being co-ordinator.

Extract 36, Roger

When I first came to prison in 2010 I erm I became a listener I've always been the sort of person that wanted to help other people you know that's part of my personality the er I've always been involved in charities and ways of helping other people. . . I've always tried to be that sort of person yeah I think that I think that is really me yeah so I'm not all bad. . . that's the sort of position (helper) that I saw myself in society erm come to prison and you are suddenly nothing er everything's stripped away it's a horrible horrible unless you've actually been to prison you probably wouldn't even know what coming to prison is actually really like. . . so I became a listener er and you know it's the best the best thing I could have done I was fulfilling that need in me to help other people and I genuinely felt that I did did quite a lot quite a lot of good.

Narrators link their new roles within the prison environment back to their old prosocial identities in the community, describing themselves in terms of consistent roles 'I'm a teacher' and wanting to 'help other people'. Narrators articulate a stable narrative in which the core self was one that had always been, and these peer-support roles enabled them to enact these pro-social identities whilst in prison. Ross (1989) suggests that how an individual makes sense of their histories, and how they make sense of their current lives, is rooted in implicit theories of 'stability' and 'change'. These implicit theories are important for stability of the self as a lot of our personal identity originates from the perception of temporal consistency or sameness (Ross, 1989). As highlighted by Roger, the act of imprisonment strips an individual of their identity, which Lofland (1969) refers to as the 'horrors of identity nakedness' (p. 288), whereby being stripped of identity is a 'fate worse than death' (p. 282). Faced with this difficulty, individuals may seek to maintain a consistent and coherent sense of who they are, which is what these peer-support roles may provide for some prisoners. They may enable people to look back into their past and find a redeeming value (akin to Braithwaite's [1989] restoration process), which they can then use as a way of putting forward a moral self. Rather than accepting the 'sexual offender' label, narrators align themselves with previous pro-social identities, which demonstrates to the audience that they are

and were fundamentally good people (Crewe & Levins, 2019). Although crime desistance research suggests that those who desist from crime view themselves as qualitatively different from their past self, a lot of our personal identity originates from the perception of temporal consistency (Ross, 1989). Therefore, similar to a group of IPSO that denied their offences (Blagden et al., 2014), these pro-social identities may be personally meaningful for participants as their identity is invested in them. Whilst this may be perceived as a way of engaging in impression management, the enacting of these 'moral' and 'good' selves can promote self-esteem and self-appraisals (Harter, Waters & Whitesell, 1998). Stone (2016) asserts how important identity-repairing narratives are in the desistance process, in which allowing narrators to enact/portray these 'good' and 'moral' selves may result in them 'living' up to these roles, as people tend to act in line with the stories they present about themselves (Blagden et al., 2014; McAdams, 2013). Furthermore, engaging in 'purposeful activity' may aid prisoners to make positive contributions to their own rehabilitation (Blagden, Perrin, Smith, Gleeson, & Gillies, 2017).

Whilst describing their peer-support roles, narrators often alluded to ways in which they themselves were benefiting from these roles. Not only were they helping other people to read or supporting them through difficult times, they were gaining something in return. For some, this resulted in an increased sense of agency and achievement, whereby they felt like they were doing something right and felt proud of themselves (Anthony and Paul), but for Roger it was more than this:

Extract 37, Roger

What I found was I was getting so much back erm it was enabling me to think about what I'd done what other people had done what other people's feelings and emotions were and to be honest you know I I think the way I was brought up you don't you know stiff upper lip and all that rubbish the er maybe a lot of my problems have been because of that I don't know I don't know maybe it er the fact that I haven't been able to be open and explore my own thoughts because they were buried. I don't know but suddenly I started feeling emotions feeling feelings and thinking about what I'd done. It's like I've got these thoughts and these emotions and these these events from childhood the thoughts of them the idea of them all nailed down in a box erm and I was gradually levering the nails out very painful erm levering these nails out because they were so firmly buried does that make sense? But being a listener, I suddenly found I was able to think these things through.

Roger demonstrates here how his role as a Listener enabled him to reflect on his own traumatic experiences as a consequence of hearing those of other prisoners, which allowed him to make sense and reconcile his troubled past. This has been termed 'exorcising trauma' by Perrin (2017), which alludes to the notion that helping others may prompt reflection and elicit realisations about personal challenges. Perrin (2017) argues that by supporting others, narrators are double-sense making: they assist people with their issues but also reflect on their own traumatic experiences, which seems to be

the case for Roger. Similar results have also been found during ‘circle’ processes (Circles of Support and Accountability consist of a group of volunteers [with professional supervision] that support IPSO as they reintegrate into society after imprisonment), in that listening to other people share their stories allowed individuals to process, edit, reinterpret, and retell their own stories, which resulted in a ‘broader and more integrative narrative identity’ (McAdams & McLean, 2013, p. 235; Petrich, 2016). Within peer-support literature this is recognised as a mechanism of formal social support, whereby individual’s increase their own insight as a result of mutual reflective work (Sirdifield, 2006). Roger highlights how he has learnt a lot about himself, as well as the skills he has developed through being a listener, which he contrasts with deficits he had in the past. Roger recognises that, when he was younger, he ‘buried’ his emotions, however, being a Listener has enabled him to develop the necessary skills required to address these challenging emotions, and he has learnt ways of dealing with them. This has been referred to as ‘addressing deficits’, whereby peer-support roles have been found to provide individuals with the opportunity to develop social and emotional skills (Perrin, 2017). When Roger spoke about these skills he developed, he contrasted who he is now to who he used to be, referring to the ways in which he has grown and developed:

Extract 38, Roger

I’m a new person from having come to prison I’m a totally different person because er because I’ve had that time and the inclination to open that box and to think to think through all of the things I’ve done and er it was an amazing thing being a listener it really was being able to give something back. . . I’m more relaxed now, erm I I think of other people’s feelings very very much more that’s probably the biggest change I think I now appreciate other people’s viewpoints very much more than I ever did before and I’m I’m a lot calmer person inside you know er that’s why I say I could never never recommit my offences I could never I couldn’t hurt people I can’t hurt people it’s not in my nature to hurt people

Roger appears to be engaged in a ‘rebirth’ plot, whereby he starts in an adverse setting, but through various plots and twists becomes a ‘new’ person. Similar transformative episodes have previously been found after traumatic events and are linked to shifts in identity (see Robinson & Smith, 2009). Roger describes how he is a new, different person due to his time spent in prison and his role as a Listener, and how he is now able to achieve redemption. He draws comparisons between his old-self and new-self, however, he still aligns with his old ‘helper’ identity as he reiterates that ‘*it’s not in my nature to hurt people*’. Although this part of his identity remains, Roger describes ways in which he has developed new skills which create a new sense of self, which are incongruent to his old-self. He appears to be cementing new ways of dealing with his emotions and his social surroundings via his role as a Listener, whereby these positive adjustments fulfil deficits that he recognised in his old-self. Addressing these deficits is reminiscent of what a typical treatment program for IPSO would encourage (Hanson et al., 2002), whereby viewing the ‘self’ in positive terms is an important factor (Mann et al., 2010).

This extract demonstrates that, for Roger, he was not just ‘talking good’ but ‘doing good’ (Perrin, 2017), as he was illustrating pro-social behaviour through his Listener role, and links this to his future and how he ‘*could never never recommit my offences*’. Research suggests that recycling a deviant history may enable individuals to make sense of and re-story their trauma, whilst taking important steps to their more desirable future selves (Maruna, 2001; Perrin & Blagden, 2014). Peer-support roles may enable people to experience a positive identity change within prison (Perrin, 2017), and may constitute important ‘turning points’ or ‘constructive outlets’ that allow individuals to construe themselves in a positive light. Regarding Roger, there appears to be a narrative shift in identity, whereby he views his new-self as qualitatively different from his old-self, and this self-narrative may shape future behaviour as people tend to act in line with the stories they present about themselves (Blagden et al., 2014; McAdams, 2013). Shifts in personal identity are important for desistance (Gobbels, Ward & Willis, 2012), and identity transformation has been associated with redemption (a negative past being reconstrued as a positive; McAdams, 2006a), in which Roger is able to use his negative past experiences as a means of providing support for others and to ‘give *something back*’. This process may be described as ‘making good’, rather than ‘knifing off’ one’s troubled past (Maruna, 2001), and allows an individual to rewrite a shameful past into something that is productive and worthy. Research on crime desistance has revealed that individuals who were desisting from crime developed a ‘redemption script’ which was characterised by wanting to ‘give something back’ and an awareness that although they could not change the past, they were in control of their present and future (Maruna, 2001). McAdams (2006a) argues that the redemption narrative is a powerful motivator of change as an individual’s identity becomes invested in this narrative of change. The process of developing a new internal narrative (a new me) is accomplished by individuals realising that their old-self is qualitatively different with their new self (Blagden et al., 2011), and therefore the old self is perceived as incongruent with the new-self, so previous negative behaviour is rejected in favour of the new identity (Vaughan, 2007), which seems to be the case for Roger, although certain pro-social aspects of his old identity (being a ‘helper’) are retained.

Furthermore, Roger demonstrates the notion of adversarial growth (positive changes resulting from struggles with adversity; Joseph, Yule & Williams, 1993), in which stressful and traumatic events have been found to act as a trigger towards personal growth and positive change (Joseph & Linley, 2006). Roger is able to turn traumatic life experiences into something positive, which has been found to reduce the likelihood of psychological distress and depression (Taylor, 1989). This is an important aspect of how peer-support roles afford individual’s the opportunity to re-story negative pasts into wisdom for the future (Maruna, 2001). Therefore, it appears that through the process of listening to other people’s stories and the reanalysis of the individual’s own story, the Listener scheme provides the opportunity for individuals to make sense and find benefit in their past experiences. Discovering redeeming qualities in their past and developing a sense of redemption through the process enables people to develop an

adaptive new narrative identity, which may provide coherence to their life story and guide future behaviour to align with such a narrative (Petrich, 2016).

Subtheme 3.3: Reconnecting with religion

As previously mentioned, imprisonment is thought to be one of the social contexts where self-identity is likely to be questioned (Maruna et al., 2006), and individuals are more likely to be receptive to religious ideologies when their self-identity is placed under strain or questioned (Lifton, 1961). Maruna et al. (2006) report that among a group of prisoner 'converts', the religious conversion narrative works as a coping strategy and as a way of doing shame management by providing a new social identity, providing the experience of imprisonment with purpose and meaning, empowering an individual, providing a language and framework for forgiveness, and enabling a sense of control over their future. Furthermore, Blagden et al. (2020) found that religious beliefs and forgiveness from a higher power facilitated redemptive selves and the enacting of these among Christian IPSO. Individuals that espouse religious identities might do so in an attempt to develop and portray a positive and coherent narrative identity (Perrin, Blagden, Winder, & Norman, 2018). A reference to religion was present in several of the narratives in this current study, suggesting that religion or other 'appeals to higher loyalties' may influence or transform an individual's narrative identity (Perrin et al., 2018), and is an important aspect when individual's make sense of and construe their life. Anthony re-discovered religion whilst in prison (Christianity), and his experience with religion appears to have clear redemptive properties:

Extract 39, Anthony

It helps that I know that to me erm to me God has took my offending as part of my sins and he's taken it away and the actual what happened back then it doesn't take away with what I've got to deal with but he's taken it away as a sin and that helps me er that helps me to talk about my offending helps me be more open about it erm because I don't feel trapped or a burden anymore.

Anthony reveals a sense of forgiveness from God, whereby God '*has took my offending as part of my sins*' and accepted what he has done. As demonstrated by Blagden et al. (2020), forgiveness from a higher power is thought to be crucial for individuals to transform their identity and eradicate any dissonance related to their past identity and behaviour. The act of being forgiven by God has redemptive properties for Anthony as it has enabled him to become more open and honest and has stopped him from feeling '*trapped*'. This is important because it affords Anthony the belief that change is possible and he is not '*doomed to deviance*' (Maruna, 2001) as he no longer feels '*trapped*' in a deviant life with no hope of escape (Maruna & Copes, 2005). This links with Skyes and Matza's (1957) neutralisation technique '*appeal to higher loyalties*', however, as highlighted by Blagden et al. (2020), rather than facilitating offending this technique appears to be encouraging Anthony to re-story his life

in a positive manner. Feeling that God has forgiven him and believing that a higher power is 'behind' him may make Anthony's journey to redemption seem more achievable, whilst also allowing him to forgive his own prior transgressions and enable active responsibility taking (Bakken, DeCamp & Visher, 2014). There was a sense from Anthony's narrative that, through religion, he was able to re-story his life, whereby he emerged as a new person:

Extract 40, Anthony

I think that Anthony's gone, that character has gone, that Anthony is not there anymore. I remember him, he he wasn't he was selfish he was obnoxious he just wasn't a very pleasant guy. I'm just not him anymore I know I'm not, I've just got to get out there and erm prove it. . . I'm not just a prison Christian. I'm six months from release and you know that's when you start looking at churches or organisations out there that I could probably go to in the area that I'm going back to. . . I will need and want some sort of church to go to when I get out definitely because it's part of who I am.

There appears to be a narrative shift in identity for Anthony, whereby he views his new-self as qualitatively different from his old-self. His religious beliefs have enabled him to emerge as someone that has changed from their old 'selfish' and 'obnoxious' ways, to someone that wants to do 'good'. Anthony has been able to establish two qualitatively separate identities, whereby he has 'knifed off' his old self and past behaviours as these are incongruent with his new-self (Maruna, 2001). Through such a process, Anthony is able to portray a 'good' and 'moral' self, demonstrating to the audience that the person who offended is not the real him (Presser & Kurth, 2009). The redemptive properties of religion enabled Anthony to go through a process of self reconstrual and identity change, whereby he is changed (and redeemed) through God, which links to a sense of identity metamorphosis (Robinson & Smith, 2009). Here, Anthony appears to be engaged in a 'rebirth' plot, in which he started in an adverse setting, but through various plots and twists has been able to become a 'new' person. Maruna et al. (2006) report that religious 'conversion' facilitated individuals in maintaining a viable identity during a time characterised by identity crisis, in which this conversion was perceived as an adaptive mechanism in shame management, allowing individuals to replace negative labels with a new identity. This is a distinctive narrative for Anthony as his past offending behaviour is construed as part of his old identity which is not congruent with his new-self (Vaughan, 2007), and this new positive self-narrative may help to shape his future behaviour as people tend to act in line with the stories they present about themselves (Blagden et al., 2014; McAdams, 1985). Through his religious experiences and forgiveness from God, Anthony articulates that he can be redeemed and that it is now up to him to 'prove' that he has changed. McAdams (2006a) argues that the redemptive self is a powerful motivator of change because an individual's identity is invested within this narrative. Redemption begins with a negative emotional event which transforms into a positive ending, in which this positive ending may be a positive self-transformation within the identifying-life story (McAdams, 2006a).

Allowing Anthony to replace negative labels (such as 'sexual offender' and 'criminal') with a new, redeemed self is likely to have positive implications, as research shows that internalising such negative labels results in difficulties achieving self-respect and affiliating with mainstream society (Maruna et al., 2009). When identity is with a stigmatised group of individuals (such as 'sexual offenders') then this becomes a 'social curse', which has several negative implications (Stevenson et al., 2014). Therefore, rejecting the 'sexual offender' label and adopting a new identity that is associated with God and the church may allow Anthony to engage with a social group and to identify with them (as he is beginning to look for '*churches and organisations out there*'), which may function as a protective factor (Bell, Winder & Blagden, 2018), and reduce the 'social curse' that the label 'sexual offender' brings with it (Stevenson et al., 2014). This also links to his future self as Anthony explicitly states that he wants to continue enacting this new identity and attend church when he is out of prison as it is '*part of who I am*', this new identity is now part of his core self, which may result in him 'living' up to these 'good' and 'moral' selves.

Conversely, for Roger, redemption was not acquired through forgiveness from a higher power but from active responsibility taking and an increased sense of agency and empowerment. Roger was brought up as a Christian, however, he converted to Buddhism whilst in prison. Religious conversions are thought to enable individuals to portray themselves in a prosocial light and gain a sense of control over their lives (Bell et al., 2018; Kerley & Copes, 2009; Maruna et al., 2006).

Extract 41, Roger

But it's (Buddhism) not a god if there's a god it's you you know you've got to spark the godship in you because you are making a decision of what you do with your life and you can't turn to outer god and say forgive me because it's your decision you are doing what you want. . . I believe that I am responsible now for my own. I can't go and ask someone for forgiveness because any action I take and I have taken it's my responsibility it's my fault erm if I make the wrong decision it's nobody else's fault but my own. . . something else that appeals to me it says what you've done in the past you've done there's nothing you can do about that you have done it you take responsibility for that and you've done it forget it there's nothing you can do erm you haven't done your future yet and so there is nothing you can do about that except for what you're doing right now so the only important thing is now so your actions actions this moment this moment is now because that will lead you on to the future.

Converting to a different religion has provided Roger with a new lens through which he can view and interpret his life, and a chance to reinterpret his current imprisonment as something more positive and manageable (Kerley & Copes; 2009; Maruna et al., 2006). One element of Buddhism pertains to taking responsibility and making your own decisions (The Eightfold Path; Bell et al., 2018), which Roger's narrative aligns with, and instils in him a newfound sense of responsibility and an increased sense of

agency and empowerment. Roger construes himself as an agentic individual that is actively choosing to pursue change and an intent to control the future direction of his life. Similar results were found among a sample of Buddhist IPSO as they also described how Buddhism helped them to recognise their own responsibility, that they had a choice, and associated consequences if they chose the wrong option (Bell et al., 2018). This is linked to acquiring positive skills required for desistance as taking responsibility for one's action and feeling in control (as demonstrated by an internal locus of control) would be considered a positive treatment outcome (McAnena, Craissati & Southgate, 2016). Roger ascribes to the idea that you cannot change the past, but you are in control of your future, which mirrors the concept of 'redemption scripts'. 'Redemption scripts' are characterised by wanting to 'give something back' and an acknowledgement that although individuals cannot change their past, they control their present and future behaviour (Maruna, 2001; although not directly mentioned here in terms of religion, Roger does talk about wanting to 'give back' via his peer-support role). Additionally, this mirrors the concept of active responsibility taking, a form of responsibility that is concerned with not looking backwards, but instead concentrating on seeing oneself as responsible for changing one's future behaviour (Ware & Mann, 2012). Roger appears to be articulating how he is going to 'live' up to the 'possible' self that he is enacting here. Furthermore, through taking responsibility for his own behaviour, and following the Buddhist principles, Roger is able to redeem himself:

Extract 42, Roger

It has changed me I'm a lot more of a thinking person so yeah there is a big change there from what I was to what I am now. I think I possibly before I was arrested I think I think I might have been looking for excuses for what I had done and now I don't. I'm not the same person at all now. . . it's (Buddhism) really accelerated it erm because I've had time to think to reflect on me inside my own thinking erm I've had time to do that I've been encouraged by it with Buddhism but erm it's really been me it's been me and I think there's nobody in this prison or in this world in fact who er who can change the way they've been unless they want to do it themselves.

Similar to Anthony above, there appears to be a narrative shift in identity for Roger, as he views his new-self as qualitatively different and incongruent with his old-self ('*what I was to what I am now*'), someone that is better than his old-self. Individuals that have converted religions whilst in prison often construct a 'prosocial narrative identity' that accounts for why their past criminal behaviour are not true reflections of their core selves (Kerley & Copes, 2009), which is important for the desistance process and the construction of a pro-social identity. All of the redemptive properties of religion that are described above for Anthony are also applicable here for Roger, particularly how the master status (Goffman, 1963) of 'Buddhist' or 'Christian' can aid people to move away from denigrating labels ('sexual offender') which may contribute to a 'social curse' (Stevenson et al., 2014). Interestingly, at the end of this extract Roger asserts how '*it's been me*' that has made these changes and is solely responsible for his future, however, throughout his narrative he has attributed blame to his childhood

and other external influences. This notion of making excuses for past failures but taking responsibility for the present and future accomplishments has been found to be common among healthy adults (Bandura, 1989), as described by Seligman (1991):

Failure events tend to be external, temporary, and specific, but good events are personal, permanent, and pervasive. 'If it's bad, you did it to me, it'll be over soon, and it's only this situation. But if it's good, I did it, it's going to last forever.' (p. 110)

Brickman et al. (1982) split the concept of responsibility into two dimensions (blame and control), whereby they distinguished between taking responsibility for the *origin* of a problem and taking responsibility for the *solution* to that problem. The framework identifies four orientations that a person can have towards their behaviour: the moral model, enlightenment model, medical model, and compensatory model. Roger's narrative aligns with the compensatory model in that he does not blame himself for his past problems but holds himself responsible for the solutions to his problems, which characterises the general pattern of the redemption script (Maruna, 2001). Throughout the narratives when individuals described their adverse childhoods or offending behaviour at times they referred to the 'it' or other external force (which links to an external locus of control), however, when talking about the future almost everything appears to be within their own personal control, and the use of the 'I' reappears (an internal locus of control; Rotter, 1954), as demonstrated in Roger's narrative.

7.4.1 Discussion

The final study of this thesis explored the narratives of IPSO who experienced adverse experiences during childhood, sexual preoccupation, and personality difficulties, and attempted to convey how individuals construe their life stories. The understandings and meanings attributed to significant events in their lives were moulded by their past experiences, particularly in relation to their childhood experiences. As demonstrated throughout the narratives, problematic PD symptomology (such as difficulty relating to other people and impairments in identity) and sexual preoccupation appear to be learned and evolved threat responses that developed as a response to adverse experiences, which supports the dimensional conceptualisation of PD and the PTM framework, as well as previous research that indicates PD and SP may be better understood as maladaptive strategies that are developed as a way of coping with ACEs (Carvalho Fernando et al., 2014; Courtois & Weiss, 2018; Engel et al., 2019; Laporte et al., 2011). Due to problematic parental relationships and disrupted attachments, and, in some cases, bullying, participants found it difficult to trust other people and had difficulties regulating their emotions, which resulted in them avoiding friendships and having complications within their intimate relationships during adulthood. This aligns with the PD and trauma literature (Filipas & Ullman, 2006; Rutter, 2012; NOMS & NHS England, 2015), as well as contemporary theories of sexual offending which argue that adverse environments may result in individuals developing social functioning

problems (such as emotional dysregulation, mistrust, and insecure attachment), which, in turn, are related to social rejection, loneliness, and delinquent behaviour (Hanson & Morton-Bourgon, 2005; Levenson, 2014).

Each of the participants within this study used their past experiences to make sense of their current lives. Jones (2011) argues that individuals' narratives are likely to link childhood abuse and adversity to their adult offending behaviours, and it is important to ensure this aspect of their sense-making is not ignored. When discussing their lives, it became evident that the narratives were anchored in stories of relationships from their early attachment experiences to relationships during adulthood, which is in accordance with McAdams (1993) central theme of communion. However, although the desire for communion was strong among narrators, problematic relationship histories were often reported. This is a common finding among individuals with PD, whereby Adler et al. (2012) highlighted that the narrative identities of individuals with borderline PD were significantly lower in themes of communion fulfilment, in which the protagonist reports difficulties '*fulfilling his or her deep wishes for connection*' (p. 509). The underlying theme of agency (or lack of) was also prevalent, and it became clear that throughout their lives, narrators experienced a lack of agency and autonomy, at times portraying themselves as at the whims of external forces. This sense of disempowerment has been documented among individuals with PD who have difficulties construing one's sense of self as empowered or able to influence their own direction in life (Adler et al., 2012; Bateman & Fonagy, 2006; Fuchs, 2007). Furthermore, problematic attachments and mistrustful relationships during childhood are linked to incoherent narratives (Fuchs, 2007; George, Kaplan & Main, 1996), as the child may not develop the relevant inner representations required for a coherent self-narrative. Incoherence, ambiguity, ambivalence, and a lack of affect and integration were noted throughout several of the narratives, suggesting that these individuals may have difficulty constructing a coherent self-narrative due to their earlier experiences. Having a coherent self-narrative enables individuals to make sense of their lives, in which a coherent, prosocial identity is thought to be crucial to rehabilitation and desistance (Maruna, 2001).

Scott and Lyman (1968) highlight that narrative allows individuals to portray 'good' selves by denying responsibility or reframing wrongdoing in a good light, and Blagden et al. (2014) report that denial among a sample of IPSO can be seen as a form of sense-making, which may be a protective factor given that individuals may 'live up' to the identities that they portray. Although narrators within this study did not deny their offences, excuses, accounting, minimisation and subtle linguistic devices were often used throughout. These rhetorical devices may be acting in the same way as denial in that they may be doing important identity work (Goffman, 1959); allowing the narrator to avoid directly acknowledging responsibility for their behaviour, whilst also allowing them to manage their shame and identity by preventing them from internalising the criminal label and putting forward a moral self (Blagden et al., 2014; Presser & Kurth, 2009). Goffman (1963) contends that one of the main issues for stigmatised

individuals is how they manage the spoiled identity when interacting with others (and interpersonally), whereby individuals may deny or disavow that identity in order to present oneself in a different light. This helps to protect their self-esteem, reduce anxiety, and increase their sense of worth (Harvey et al., 1990; Northey, 1999), which are all necessary aspects required for desistance (Rotenberg, 1987). Maruna et al. (2009) illustrate that those who are formally labelled are significantly more likely to recidivate within two years, and, if the identity is linked with a stigmatised group (such as 'sexual offenders'), then it becomes a 'social curse' (Stevenson et al., 2014). Therefore, this resistance to being labelled a 'sexual offender' may have positive implications as it allows individuals to distance themselves from this negative label, which enables them to achieve self-respect and affiliation with mainstream society (Maruna et al., 2009), and maintain a coherent sense of self (Blagden et al., 2011). Individuals are thought to act in accordance with the stories they portray about themselves (McAdams, 1985), and the narrators within this study were keen to present socially desirable and viable selves, whereby through presenting them, participants may enact and 'live up' to the identities they are portraying.

All participants within this study reported sexual abuse and adverse experiences during their childhoods. The trauma literature explores the life trajectories of survivors of sexual abuse and child maltreatment (Arias & Johnson, 2013; Easton, Leone-Sheehan, Sophis & Willis, 2015; Harvey, Mishler, Koenen & Harney, 2000; Thomas & Hall, 2008), in which these studies report that survivors of abuse and maltreatment recalled a *'particular incident that served as a turning point, leading to a shift in understanding and opening up possibilities to break out of the plot that previously imprisoned [them]'* (Harvey et al., 2000, p. 297). Examples of these turning points include: disclosing the abuse, pursuit of justice, reaching a new understanding of the abuse, entering treatment (professional and group support), volunteering/helping others, confronting the abuser, spiritual transformation, and personal relationships (Arias & Johnson, 2013; Easton et al., 2015; Harvey et al., 2000). These turning points were instrumental in helping individuals to reconstruct their narrative, gain a more coherent life story, and reclaim agency and identity (Easton et al., 2015). However, for the sample of IPSO within this study, it became evident throughout their narratives that they were not afforded these opportunities (potential turning points) until they came to prison. Although not discussed directly within the analysis, several of the participants did not disclose their childhood abuse until they were in prison. Roger reported that he disclosed to his mother when the abuse from his father first began, but he was disbelieved, and never spoke about the abuse again until he came to prison. Unlike the 'survivors' previously discussed, the act of disclosing was not a positive turning point for Roger since he was not believed, and he kept this information to himself for a long time, preventing him from dealing with the abuse and healing from it (Easton et al., 2015). Furthermore, similar turning points that have been reported among survivors in the trauma literature were found among this sample of IPSO whilst they were in prison (disclosing the abuse, volunteering/helping others, spiritual transformation, and a new understanding of the abuse).

Linked to these turning points is a sense of identity metamorphosis (Robinson & Smith, 2010) in that participants seemed to describe a 'rebirth' plot, whereby they began in an adverse childhood setting, but through various plot twists were able to become a 'new' person. This was particularly relevant for individuals who reported experiences with religion and peer-support schemes. Being forgiven by God was an important aspect for narrators, as it enabled them to feel redeemed, which allowed for the construction of viable identities (Krause & Hayward, 2015). Peer-support roles have also been linked to identity change and redemption within prison (Perrin, 2017), enabling individuals to construe themselves in a more positive light. The redemptive properties of religious beliefs and peer-support roles appear to be assisting narrators to re-story their lives and construe themselves differently, as a 'new' and changed person, as demonstrated in previous research (Bell et al., 2020; Blagden et al., 2020; Perrin & Blagden, 2014). Attaching to a 'new' and 'clean' values system provides validation for the individual and society that change has either occurred or is occurring (Perrin et al., 2014). McAdams (2006a) argues that the redemptive self is a powerful motivator for change because an individual's identity becomes invested in this narrative of change. A negative event becomes the opening act in a redemptive sequence, whereby the positive ending of being a 'new' or 'reborn' person (due to religion or peer-support roles) may act as a positive-self transformation within the identity-defining narrative (McAdams, 2013). Moreover, not only did these religious beliefs and peer-support roles facilitate redemptive selves, they also facilitated the enacting of these selves. Presenting a 'moral self' is thought to allow for the enacting of this 'moral self', whereby individuals are thought to live up to the 'stories' that they present about themselves (McAdams, 2006a; Presser & Kurth, 2009). Therefore, through such narratives, individuals can portray 'good selves', reinforcing that the person who offended is not who they really are (Presser & Kurth, 2009). For some participants, although they were keen to show that they had changed and become a 'new' person, they were also keen to look back into their past and find a redeeming value (Braithwaite, 1989), suggesting that 'deep down' they were good people, and were normal 'all along' (Maruna, 2001). Constructing a prosocial narrative identity that can account for why an individual's prior actions are not true reflections of their core selves and demonstrating that change has occurred is important for the desistance process. These narratives may allow for a new lens through which individuals can view their lives, providing them with the opportunity to reinterpret their current situation into something more positive (Kerley & Copes, 2009; Maruna et al., 2006).

Furthermore, both religious and peer-support narratives appear to be doing important identity work as individuals were able to live up to their desired selves by 'doing good' in prison, 'giving back', and consequently distancing themselves from the 'sexual offender' label, which is thought to impact on the desistance process (Willis, 2018). Feelings of stigmatisation and feelings of being 'doomed to deviance' are linked to an increased likelihood of recidivism (McCulloch & McNeill, 2008), however, positive roles and attachments to cohesive groups may act as a social cure, whereby a Pygmalion effect may occur (high expectation, high outcome; Maruna et al., 2009). The resistance to being labelled a 'sexual offender' has positive implications (as discussed above), and the hope of 'better futures' and possible

selves are important as having a positive self-image and self-identification are predictors of post-prison outcomes (LeBel et al., 2008).

7.4.2 Limitations

Although the analysis here highlights the life trajectories of IPSO with PD and SP, there are clear limitations. With the use of a small sample size, and such a targeted population, generalisation is problematic. However, first and foremost, this study wanted to emphasise understanding and the opportunity to explore the individual narratives that participants use to make sense of their lives. Another limitation regarding life story work is that individuals' narratives are retrospective, meaning that the narratives presented could have been influenced by biased recall or personal motivation. Finally, the individuals in this study were all convicted of sexual offences and had engaged in treatment at some point throughout their imprisonment, therefore, it is important to recognise that their construing of current and future self may have been influenced by treatment experiences. As a way of trying to minimise this, interviews were conducted with individuals from both prison establishments as a way of providing some variation in their experiences of treatment.

7.4.3 Implications

Individuals are likely to link childhood abuse and adversity to their offending behaviours throughout their narrative, and it is important to ensure that this aspect of an individual's sense making is not ignored (Jones, 2011). Clinicians should give due time and attention to previous adverse and traumatic experiences, with an emphasis on TIC (Leitch, 2017). Within treatment programs for sexual offending, abusive childhood experiences used to be considered an 'excuse', however, these parts of an individual's life should be acknowledged, dealt with appropriately, and handled sensitively during treatment programs, in which the whole prison environment should be trauma informed. In addition, more effective interventions should be provided at an earlier stage before individuals come to prison, preferably during childhood in order to foster earlier thriving and mitigate any suffering (Thomas & Hall, 2008).

A useful treatment target among this sample of IPSO with PD and SP is in relation to incoherence in the self-narrative. Incoherent narratives are a prominent feature among individuals with PD (particularly borderline PD; Adler et al., 2012; Bradley & Westen, 2005), and having a coherent, prosocial identity is thought to be crucial to rehabilitation and desistance (Maruna, 2001). Ward and Marshall (2007) suggest that individuals who have an incoherent identity may be more likely to reoffend as they may not possess the necessary skills and attitudes required to lead fulfilling lives and to meet their needs pro-socially. Thus, working from a GLM (Ward et al., 2007) perspective may help to identify the goals and values that are important for an individual, which in turn helps in making sense of the way in which

these values and goals shapes the narrative that an individual creates to make sense of their life (Jones, 2011). This can then be used to help individuals develop a clear GLM that aligns with their interests and will enable them to form a more appropriate narrative identity (Ward & Marshall, 2007). For this population, it is important that treatment aligns with the GLM with a focus on the development of good lives, which will help to address the individual's specific criminogenic needs (Ward & Marshall, 2007). Moreover, conceiving the individual as having diminished agency, a lack of communion fulfilment, and narrative incoherence may be easily transformed into therapeutic techniques. These narrative themes would be simple to assess and are anchored in the individual's own approach to meaning making, indicating that they may be useful targets for intervention (Adler et al., 2012).

Peer-support roles provided individuals in this study with a sense of purpose and meaning, whilst also giving them autonomy, independence, and a sense of achievement. These roles have been found to assist with desistance-based narratives, whereby 'purposeful' activity in prisons can help individuals to make positive contributions to their own rehabilitation (Blagden et al., 2017). Similar to findings by Perrin et al. (2014), IPSO within this study appeared to be addressing their risk through the enactment of prosocial selves, whereby helping others appears to have adaptive qualities for prisoners. LeBel et al. (2015) argue that there should be an increase in opportunities for reintegrating individuals to become engaged in roles which involve reciprocal helping, enabling them to reshape delinquent life histories into wisdom and advice via 'wounded healer' type roles (Maruna, 2001). De Vries Robbe, Mann, Maruna and Thornton (2015) suggest that an individual's protective factors should be taken into account and developed, whereby peer-support roles and religiosity may play important roles in protecting individuals from future offending and should be considered by clinicians. Although clinicians working with IPSO may find religious beliefs difficult to manage or work with, it is important for clinicians to appreciate the positives that religious beliefs can have (such as positive shifts in identity, belonging to a group, assisting with desistance; Blagden et al., 2020; Johnson & Jang, 2011; Roberts & Starecr, 2016). Aiding individuals to move away from the negative 'sexual offender' label is important both individually and clinically (Willis, 2018), therefore, it is important that clinicians are educated about religious beliefs so they can understand, encourage, or challenge when necessary (Blagden et al., 2020). Blagden et al. (2020) also argue that it is necessary for chaplains to be brought into the treatment picture as they can help to educate clinicians, whilst also managing and addressing the expectations of religious IPSO.

Chapter Eight: Synthesis and Conclusions

Overview

This thesis sought to explore the relationships between PD, SP and ACEs among a sample of IPSO. This was explored through a mixed-methods research design, consisting of four empirical studies which are detailed in chapters four to seven. The first study explored the psychometric properties of two PD scales in a UK general population sample, before these psychometrics were employed for use within a prison population. The second and third study explored the prevalence rates of PD, SP and ACEs among IPSO, as well as the relationships between PD and SP, PD and ACEs, and SP and ACEs. Finally, the fourth study explored the life trajectories and narrative identity of IPSO that experienced adverse environments during childhood and developed a preoccupation with sex and problematic personality traits. The aim of this chapter is to provide a synthesis of the findings, highlight the original contributions to knowledge, discuss the implications and practical applications of the research, offer a critical appraisal of the research, propose future research ideas, and reflect on the research experience and ethical considerations.

8.1 Synthesis of findings and original contributions

The main aim of this thesis was to explore the relationship between PD and SP among IPSO, and in doing so, this thesis offers several original contributions of knowledge to the literature. The initial aims of the research will now be restated, and a synthesis of the findings and original contributions will then be presented.

The main aim of this thesis:

- To explore the relationship between PD and SP among a sample of IPSO housed in UK prison establishments

Additional aims of the thesis:

- To assess the psychometric properties of the SIPP-SF and PID-5-BF in a UK male sample.
- To assess the prevalence rates of PD, SP, and ACEs among a sample of IPSO.
- To examine the relationship between PD and ACEs among IPSO.
- To explore the relationship between SP and ACEs among IPSO.
- To examine the life trajectories and narrative identity of IPSO who have experienced ACEs, PD, and SP.

This thesis explores in-depth, both quantitatively and qualitatively, the relationships between PD, SP, and ACEs among IPSO. It represents the first set of studies that assess the prevalence of PD, SP, and ACEs among IPSO housed in two UK prison establishments. Although the relationship between PD and SP has previously been explored among a sample of IPSO taking MMPSA, this thesis offers the first exploration of PD and SP among a general sample of IPSO, rather than those who only demonstrate high levels of SP. This allows for the relationship to be explored more in-depth, as well as being able to establish any similarities or differences between those with SP and those without. Unlike other research that explores the prevalence of categorical PDs among IPSO, the studies presented here provide information above and beyond that of a categorical diagnosis as they explore continuous dimensions of PD (personality functioning and pathological personality traits) and the life stories of IPSO. All three levels of McAdams's (1994) personality model are explored within this thesis, as not only does it focus on broad dispositional traits and personality functioning, the studies provide a more comprehensive view of personality by delving into an individual's goals, motivations, values, and internalised life story. By adopting this continuous approach to PD, this thesis contributes to the growing body of research on dimensional conceptualisations of PDs (such as the DSM-5 AMPD and the PTM framework) and forges a deeper joining between the study of PD and normal personality. Furthermore, it also offers an exploration of the psychometric properties of two continuous measures of PD (SIPP-SF and PID-5-BF) among a UK, male sample.

Sixty-three percent of the general IPSO sample demonstrated signs of PD, which aligns with previous research that demonstrates high prevalence rates of PD among this population (Chen et al., 2016; Dunsieath et al., 2004). The results challenge previous research which suggests that antisocial PD is the most common among IPSO (Kingston et al., 2015; Sigler, 2017), as dependent, depressive, borderline, and avoidant PDs were found to be the most prevalent, and antisocial PD was the least prevalent. These results support Francia et al.'s (2010) proposal that IPSO may be more likely to have PDs relating to emotional and social distress, whilst also demonstrating that the personality profile of IPSO may be different to that of IPVO, as IPSO experience a broader range of PDs. Among the sample of IPSO with PD, the prevalence of early trauma was significantly higher in comparison to the general population and general prisoner population, whereby all IPSO with PD demonstrated at least one ACE and over half of the sample reported four or more ACEs. The high prevalence of ACEs among this sample suggest that PD and SP symptomology may be better understood as effective survival strategies or functional responses to abnormal circumstances, which aligns with the PTM framework that focuses on the learned and evolved threat responses which develop from past experiences (Johnstone, 2018). Traumatic experiences are thought to lay the groundwork for a range of interpersonal problems and maladaptive coping strategies (although adaptive and functional at the time, they may later become problematic for the individual), in which SP and high-risk behaviours may be considered ways of coping with these traumatic experiences (Elliot et al., 2005; Teyber & McClure, 2011; Whitfield, 1998). In line with the PTM framework, the findings highlight how the cumulative effect of ACEs may not be the most

important aspect, but the meaning and impact it had for the individual. The narrative analysis in chapter seven further corroborates these findings, whereby the impact of early traumatic experiences is undeniably evident throughout all of the participants' narratives. Difficulties with their identity, their emotions, making friends, and problematic relationships were all linked back to their childhood experiences, and in some instances, SP (and resulting sexual behaviours) appeared to be a way of managing these emotions.

Both the quantitative and qualitative analyses highlight the relationship between SP and difficulties with emotions, which supports the notion that SP may be linked to emotion regulation difficulties (Bancroft, 2008; Miner et al., 2009), and that it may be a psychological and behavioural manifestation of maladaptive self-control, presenting as an inability to manage sexual thoughts and urges (Berman-Roberts, 2015). These results provide support for Bancroft and Vukadinovic's (2004) pathway model that states SP and resulting sexual behaviours are thought to be due to negative emotions, as some IPSO may use these sexual thoughts and behaviours to regulate their emotions and manage stress (Bancroft & Vukadinovic, 2004; Parsons et al., 2008; Raymond et al., 2003). In addition, separation insecurity, impulsivity, and emotional lability were all linked to SP, which aligns with borderline PD also being predictive of SP, in which IPSO may use SP (and resulting sexual behaviour) as a way of coping with their internal sense of emptiness (Montaldi, 2002; Parker & Guest, 2003). These results support Lloyd et al. (2007), who propose that for men with borderline PD, it may be that they are more likely to present with sexual complaints rather than suicidal/parasuicidal behaviour that often brings women into contact with mental health professionals.

Additionally, deceitfulness and grandiosity were found to be significant predictors of SP, which links with narcissistic PD also being predictive of SP given that grandiosity is a pertinent feature of narcissistic PD, and has previously been found to be related to SP (Giugliano, 2006; Parker & Guest, 2003). This links with previous research that identifies narcissistic individuals as having a high need for positive regard and admiration (Morf & Rhodewalt, 2001), which makes them particularly orientated towards sexual relationships (Wryobeck & Wiederman, 1999). A preoccupation with sex and resulting sexual behaviours may be used as a way of gaining attention and validating their sense of self-importance (Montaldi, 2002). Therefore, this thesis highlights the possibility of two potential PD pathways for IPSO with SP, whereby some demonstrate a pattern of grandiosity and need for admiration (narcissistic PD), in which feelings of entitlement and self-centredness may be central. Whereas, for others, they may experience difficulties with impulsivity, emotional regulation, identity, relationships, and fear of abandonment (borderline PD), and therefore SP may be utilised as a coping strategy to deal with these difficulties, and as a way of fulfilling their emotional needs (Montaldi, 2002).

It is important to highlight that anxiety and depressivity were two of the most prevalent traits found among IPSO with SP, which supports the concept that SP may be used as a coping mechanism for

negative emotional states such as anxiety and depression (Bancroft & Vukadinovic, 2004), and supports the sexual compulsivity model of SP (Kalichman et al., 1994; Krueger & Kaplan, 2001). Impulsivity was also found to be related to SP, which supports the idea that SP may be driven by a lack of impulse control (Coleman, 1990; Raymond et al., 2003), providing support for the impulsivity model of SP (Kafka, 2010; Raymond et al., 2003), and the addition of CBSD as an impulse control disorder in the ICD-11 (WHO, 2018). These findings are consistent with two of Walton et al.'s (2017) taxa found among general population samples, whereby SP can be explained (i) by greater trait impulsivity, or (ii) as an adaptive coping mechanism to relieve depression and anxiety (compulsivity). This thesis provides further evidence for Montaldi's (2002) proposition that a large proportion of SP may be explained by an Axis I model (addiction, obsessive-compulsive disorder, impulsive-control disorders, mood-related disorders), however, some cases of SP may be better explained using an Axis II model (personality disorder), particularly borderline and narcissistic PDs in relation to IPSO. An important finding from this thesis is that the relationship between personality and SP among IPSO is complex, and it cannot be explained by one underlying mechanism. SP will manifest in various ways among IPSO and for numerous reasons, therefore, multiple kinds of SP presentations suggest the need for multiple treatment approaches (Montaldi, 2002). Treatment should be tailored to the individual and should depend on their motivation for SP (Walton et al., 2017). Due to the cross-sectional and correlational design of this research, it is not possible to claim causality or know which came first, however, the overall findings support the concept that adverse experiences during childhood may result in difficulties relating to other people, as well as identity, self-regulation, and emotional regulation difficulties (Elliot et al., 2005; Teyber & McClure, 2011), whereby SP (and resulting sexual behaviours) may act as a functional response or coping mechanism to these difficulties.

Furthermore, a common thread throughout all stages of the analysis is linked to identity, whereby almost half of the general sample of IPSO demonstrated impairments in identity integration. These impairments were particularly prevalent among IPSO with SP, whereby 67% of them experienced difficulties in this domain, and as expected, a large proportion (62%) of IPSO with PD also reported these difficulties. In regard to SP, this suggests that for some IPSO impairments in identity integration may be an underlying mechanism of SP, which was also reported by Northey et al. (2016), whereby IPSO may use SP (and resulting sexual behaviours) as a coping mechanism in order to manage their identity and self-worth (Carnes & Adams, 2002). Although impairments in identity are common among individuals with PD, these results indicate that these difficulties may also be present among IPSO with SP, and IPSO in general, meaning that a focus on identity within treatment may be important. Chapter seven enabled the narrative identity of IPSO with PD and SP to be explored, which offers a unique contribution to the literature as this has not previously been studied. The results further corroborate the previous quantitative findings, highlighting that narrative incoherence and an incoherent sense of self was prevalent throughout the narratives of IPSO. This may act as a useful treatment target among IPSO, as having a coherent, pro-social identity is vital for rehabilitation and desistance (Maruna, 2001).

A sense of identity metamorphosis appeared to be prevalent throughout the narratives, in which narrators were engaged in a 'rebirth' plot, where they began in an adverse setting but through various plot twists and turning points were able to become a 'new' person, particularly for IPSO who reported experiences with religion and peer-support schemes whilst in prison. These positive experiences whilst in prison enabled IPSO to re-story their lives and construe themselves as a 'new' and changed person. This appears to be doing important identity work and is an adaptive mechanism in shame management, allowing narrators to put forward 'moral selves', whilst also distancing themselves from the denigrating 'sexual offender' label by replacing negative labels with a new identity. These positive aspects align with the GLM perspective, in which IPSO are able to form more pro-social and viable identities that are crucial for successful rehabilitation and desistance (Maruna, 2001).

8.2 Implications and practical applications of the thesis

8.2.1 The clinical utility of the SIPP-SF and PID-5-BF

Study one provides support for the reliability and validity of the SIPP-SF and PID-5-BF in a UK male sample, in which both scales provide clinicians with efficient screening tools that could be used to evaluate the need for further assessment, whilst also offering a broad overview of an individual's personality functioning and trait domains. The availability of brief screening tools for personality pathology could potentially enable earlier detection of personality pathology (Fossati et al., 2017), and may also offer the opportunity to create a stepwise diagnostic approach for the DSM-5 AMPD (Rossi et al., 2016). Clinicians could utilise the screening tools as a first step in an ongoing process, or equally, these brief tools may be beneficial for research purposes, e.g. for screening purposes. A review by Rodriguez-Seijas, Ruggero, Eaton and Krueger (2019) highlighted that jointly assessing personality functioning and pathological personality traits together has important treatment value, particularly around streamlining assessment, case conceptualisation, and treatment. These screening tools may provide clinicians with a concise way of measuring PD according to the DSM-5 AMPD, which has direct utility for case conceptualisation and treatment planning (Rodriguez-Seijas et al., 2019).

8.2.2 The treatment of sexual preoccupation among IPSO

In relation to SP, the results demonstrate that a large proportion (almost half) of IPSO in two UK prison establishments reported difficulties with their sexual thoughts, feelings, and behaviours. This reinforces the importance of targeting this area with treatment in order to reduce the risk and lower the likelihood of recidivism, suggesting that MMPSA should be available to all UK prison establishments that house IPSO. However, a stronger evidence base regarding the effectiveness of the medication used to treat problematic sexual arousal may be required (such as a randomised controlled trial) in order to warrant the funding and widespread use of MMPSA. Furthermore, this thesis highlights the need for both psychological and pharmacological treatment of SP, as it is important to also target the underlying mechanisms of SP.

Chapter six explores the underlying mechanisms of SP, and the results suggest that IPSO may have a core personality profile that predisposes them towards having SP, which may be useful for clinicians to know when working with such individuals (Walton et al., 2017). It may be beneficial for services provided for IPSO with PD (i.e. the aforementioned ACORN service) to include an assessment of SP as part of the assessment and treatment planning stages, and services for IPSO with SP (i.e. the MMPSA service) to include a personality assessment as part of assessment and treatment planning. SP will manifest in various ways among different IPSO, and it may be important for the clinician to establish the underlying motivation behind the SP in order to provide appropriate treatment (Walton et al., 2017). The results highlight that SP may be explained by greater impulsivity, as an adaptive coping mechanism to relieve anxiety and depression, as a way of dealing with emotion regulation difficulties, or due to impairments in identity. As proposed by Montaldi (2002), these results support the notion that a large proportion of SP may be explained by an Axis I model (addiction, obsessive-compulsive disorder, impulsive-control disorders, mood-related disorders), however, some cases of SP may be better explained using an Axis II model (personality disorders). The findings highlight the possibility of two PD pathways for IPSO with SP, whereby some demonstrate a pattern of grandiosity and need for admiration (narcissistic PD), in which feelings of entitlement and self-centredness may be central, and SP and sexual behaviour may be used as a way of gaining attention and validation. Whereas, for others, they may experience difficulties with impulsivity, emotional regulation, identity, relationships, and fear of abandonment (borderline PD), and therefore SP may be utilised as an adaptive coping strategy to deal with these difficulties, and as a way of fulfilling emotional needs (Montaldi, 2002). Furthermore, treatment which has a focus on the identity of IPSO may also be beneficial given the strong links between SP and impairments in identity. It is important for clinicians to be aware of these differences in SP presentation, and to tailor treatment according to the individual's needs. Multiple kinds of SP presentations require several treatment approaches (Montaldi, 2002), and treatment should be offered and tailored dependent upon the individual's motivation for SP (Walton et al., 2017).

8.2.3 Implications relating to personality disorder services for IPSO

The prevalence of PD among IPSO in UK prison establishments highlights that a proportion of IPSO that require treatment and support with their personality difficulties may be being missed due to the current OPD pathway screening procedures, as they predominantly focus on antisocial and borderline PDs. Although it may be appropriate for the OPD pathway to focus on violence and antisocial PD due to the strong links with recidivism (Mann et al., 2010), it is also important to consider that a proportion of IPSO with other personality characteristics (such as avoidant, schizotypal, depressive) may be being missed. This may also be important for prisoners serving sentences of Imprisonment for Public Protection (IPP), who appear stuck in the prison system, whereby a focus wider than antisocial/borderline PD may be beneficial. Therefore, a critical implication of these findings is that the OPD pathway may need to amend the current screening procedure to be more inclusive of avoidant,

schizoid, dependent, and depressive PDs, and have an awareness and understanding that the personality profile of IPSO may differ to that of IPVO. It may be beneficial to have a separate pathway specifically for IPSO which accounts for the differences between IPSO and IPVO, allowing the pathway to be more inclusive of the range of PDs present among IPSO, thus, preventing clinicians from having to use clinical override.

The results of this research have been used to inform the development of a PD service designed specifically for IPSO at prison 1. The Adapt, Change, Opportunity, Reflect and Navigate (ACORN) service was developed in April 2018, and provides treatment specifically for IPSO with PD. The prevalence of PDs, impairments in personality functioning, pathological personality traits and number of ACEs were shared with the service, in order to help develop and tailor their PD service specifically for IPSO (please see appendix 28 for a statement of impact from the ACORN service). In particular, the results highlighted the prevalence of ACEs among IPSO, which resulted in the investment of EMDR training and schema training for ACORN staff, as well as the prevalence of personality traits associated with over-controlled profiles, resulting in the service including radically open dialectical behaviour therapy as part of the stabilisation phase.

8.2.4 Taking a more relational and trauma informed approach

The results demonstrate that a large proportion of IPSO experience difficulties with their emotions, their identity, and their ability to relate to other people, meaning that all services that come into contact with this population should attend to the relational, emotional, and psychological needs of these individuals. All services (such as wing staff, health care staff, offender management staff, and probation staff) taking this approach will ensure that all IPSO who experience these problems will receive a more psychologically informed approach, rather than just those who are referred to the OPD pathway or to specific services (such as the ACORN service). It is important for services to have a deeper understanding and broader knowledge so that they can gain a better understanding of an individual's behaviour and how best to work with them effectively. Furthermore, given the high prevalence of PD among this population, and consequently high rates of ACEs, it is important that all services become psychologically and trauma-informed, in order to ensure that they do not re-traumatise individuals (Akerman, 2019; Cluley, 2019; Jones, 2015). Therefore, a critical implication of this thesis is that high quality, accessible, in-depth training regarding trauma should be available for all staff members that interact with prisoners, in order for them to develop the necessary 'soft skills' required to work in a psychologically and trauma informed manner (Allcock, 2015; Jervis, 2019). One way of encouraging a trauma informed approach among prison officers may be by providing appropriate training regarding the use of level one formulations with prisoners (as used within the OPD pathway), which 'describes a pattern of problem behaviours linked to an underlying psychological idea' (Craissati, 2019, p. 75). This would allow prison officers to work in a more psychologically informed way, whereby they would be

taking an individualised approach and attempting to understand an individual's behaviour. In addition to this, it may be beneficial for prisons to adopt a relational approach, whereby all services work together as multidisciplinary teams, in order to reduce some of the disparity often seen among services in prison establishments.

In order to provide a trauma-informed and rehabilitative culture for IPSO, it may be important that IPSO are housed in prisons that are specifically for IPSO, as this will enable them to feel safe, less anxious, and less fearful of being identified as a 'sexual offender' (Blagden & Wilson, 2019). Whereas, traditional prison settings result in IPSO feeling anxious, unsafe, and constantly victimised (Ricciardelli & Moir, 2013), which is not conducive to rehabilitation. Treatment programs and services designed for IPSO should consider the role of adversity and childhood trauma, as this may help to improve psychological well-being and functioning, as well as criminal prognosis (Dudeck et al., 2007). It may be beneficial to help individuals come to terms with their own traumatic experiences before trying to focus on victim awareness or offending behaviour (Cluley, 2019), as not addressing the impact of trauma may impede the learning and effective use of skills that are taught in treatment programs (Creeden, 2004). This is also supported by the narrative analysis in study four, as IPSO often use their past childhood experiences to make sense of their present lives, and it is important that this part of their sense-making is not ignored during treatment (Jones, 2011), whereby there should be an emphasis on TIC (Leitch, 2017).

The researcher is aware that these suggestions may not be realistic for or implicated straight away in all prisons due to the current climate (due to the worsening situation relating to the safety of prisons in England and Wales, and currently being in an 'enduring crisis of prison safety'; House of Commons Justice Committee, 2019, p. 6), however, all services should be aiming towards this, and these implications may be particularly relevant to prisons that hold IPSO. Beyond the scope of the prison establishment, this thesis also highlights important implications for early intervention and preventative action, whereby services should be offered at earlier stages in an attempt to prevent individuals from going on to offend (Lynch, 2019). Parenting and family programs, multi-agency working, and trauma informed schools are all ways in which the impact of ACEs can be addressed during childhood (see chapter five [section 5.5.5] for more information).

8.2.5 The importance of identity and the self-narrative in rehabilitation and desistance

A common thread throughout all chapters in this thesis is how impairments in identity appear to be common, for IPSO in general, for the sample of IPSO with PD, and in relation to IPSO with SP. Therefore, a useful treatment target among IPSO is in relation to incoherence in the self-narrative, as having a coherent, pro-social identity is thought to be crucial to rehabilitation and desistance (Maruna, 2001). Clinicians should work from a GLM (Ward et al., 2007) perspective in order to help individuals identify appropriate values and goals, and work towards a more appropriate narrative identity (Ward &

Marshall, 2007). Clinicians should aim to get an understanding of how individuals narrate their lives and think about their future, whereby assessments could assess the extent to which they use condemnation narratives ('doomed to deviance') or redemption narratives (believing that it is possible to change and redeem oneself). Jones and Wilmot (2017) argue that this is critical for identifying the complex role that trauma and attachment play in an individual's narrative. Exploring these narratives will enable clinicians to identify the individual's values and goals, as well as recognise any incoherence or difficulties that they may need to address during treatment.

Furthermore, De Vries Robbe et al. (2015) suggest that an individual's protective factors should be taken into account and developed, whereby peer-support roles and religiosity may play important roles in protecting individuals from future offending and should be considered by clinicians. Peer-support roles were found to provide IPSO with a sense of purpose and meaning, enabling them to reshape delinquent life histories into wisdom and advice via 'wounded healer' type roles (Maruna, 2001), therefore, clinicians should consider how these roles may protect individuals from future offending, and more opportunities should be available for IPSO to become engaged in roles which involve reciprocal helping (LeBel et al., 2015). Clinicians should also be educated about religious beliefs and the positive benefits they can have, so that they can understand, encourage, or challenge these beliefs when necessary (Blagden et al., 2020), whereby it may also be beneficial for chaplains to be brought into the treatment picture. Clinicians should be aware of the positive impacts that these peer support roles and religiosity can have on an individual's narrative, such as: positive shifts in identity, belonging to a group, assisting with desistance, rejecting the 'sexual offender' label, 'doing good' and living up to these 'moral selves'. These protective factors should be encouraged by clinicians working from a GLM approach in order to help IPSO lead good and pro-social lives.

[8.3 Critical appraisal of the thesis](#)

8.3.1 Constraints of the sample

The conclusions of this research are limited by the specific nature of the sample: adult male IPSO serving a custodial sentence in category a C prison establishment. Therefore, the results are only applicable to this specific sample, and the prevalence of PD, SP, and ACEs may be different in IPSO serving sentences in category A or B prison establishments. Given that this research was conducted in category C prisons (one being a treatment focused prison, and the other encouraging active citizenship) may mean that a certain level of compliance and willingness to treatment was prevalent among the prisoners, whereby they may have been less likely to show antisocial traits or break prison rules, which may help to explain the low prevalence of antisocial PD among this sample. Additionally, the results may be influenced by the fact that over two thirds of the sample offended against children, and previous research demonstrates that IPSO against children tend to show different PDs compared to those who offended

against adults, which may help to explain the high prevalence of dependent, depressive and avoidant PDs among the research sample, and the low prevalence of antisocial and narcissistic PDs. The self-report nature of data may also link to a biased sample of PDs as individuals with specific types of PD or pathological traits (i.e. paranoid PD, hostility, suspiciousness) may have been less likely to participate in the research. Therefore, the self-report nature of the research and the limited sample of category c prisoners may have resulted in a lack of breadth of PDs found among the sample.

One of the main limitations of this thesis is that ACEs were only explored in study three, meaning that ACE data is only available for IPSO with PD, rather than among the general sample of IPSO. Therefore, the whole sample consisted of IPSO with PD, resulting in a lack of comparison group (IPSO without PD), meaning that it was not possible to examine the differences in the prevalence of ACEs among the two groups. Additionally, the small sample size and the limited cases of each PD restricted the analysis that could be conducted on the data, as well as limiting the exploration between PD and ACEs, and SP and ACEs. Ideally, in hindsight, it would have been beneficial to conduct the ACE questionnaire during the screening study (study 2), however, due to the sensitive nature of the ACE questions, and the process of delivering questionnaires under cell doors, the author thought it would be unethical to do so. Furthermore, in relation to ACEs, another limitation is the way in which ACEs were measured, as a range of traumatic experiences are not included in the ACE questionnaire (such as bullying, bereavement, illness). These experiences (particularly bullying and bereavement) were discussed extensively throughout chapter seven when participants narrated their life stories, whereby the analysis demonstrates the impact that these salient events had on an individual's life, the way they viewed themselves, and the rest of the world.

Finally, the use of a small sample size in study four ($n = 5$) means that generalisation may be problematic, however, it is important to highlight that the purpose of this study was to emphasise understanding and to explore the individual narratives of IPSO with PD and SP.

8.3.2 The nature of self-report data

A more general limitation relating to the quantitative studies is regarding the use of psychometrics that rely on self-report data, as this is reliant on an individual's honesty and insight (Craissati & Blundell, 2013). However, due to their incarceration, there may be a desire for IPSO to appear less dysfunctional than they actually are, meaning that self-report data may not be a true reflection of their psychopathology (Francia et al., 2010). Participants may be responding in socially desirable ways (Paulhus, 2002), or may be concerned about the impact on how staff or other prisoners might view them. This is particularly relevant to the reporting of ACEs, as it has been suggested that IPSO may be more likely to fabricate the truth and report a history of sexual abuse in order to elicit compassion, sympathy, or more lenient treatment (Jespersen et al., 2009; Levenson et al., 2016). Conversely, some

IPSO may be less likely to report ACEs due to embarrassment or shame (Dhawan & Marshall, 1996), due to a fear of appearing vulnerable, or because they may not readily recognise that early adversity relates to them as it may have become 'normalised' (Levenson et al., 2016). Furthermore, retrospective accounts may mean that results were influenced by biased recall or personal motivation, or underestimates of the incidence of child maltreatment (Hardt and Rutter, 2004). Due to the self-report nature of the studies, the design did not allow for information to be verified by official documentation, so it is difficult to ascertain whether individuals were responding in certain ways or being truthful.

In addition, the response rate for the first screening study among the prison sample is particularly low (less than 10%), suggesting that this narrow sample may not be truly representative of the wider IPSO population, and caution should be taken when interpreting these results. The low response rate may be due to the research being voluntary, the focus on 'personality', or the timing that the screening study was conducted. The questionnaires were distributed around a similar time that the Ministry of Justice review of treatment programs for IPSO was released, which suggested that the 'Core' treatment program had no impact on recidivism rates (Mews et al., 2017). Therefore, some IPSO at the time were angry and confused about treatment programs, and given that the study was associated with the psychology department at the prison, some of the responses to the questionnaires detailed their frustrations and dismay with psychology and research.

8.3.3 Conceptualising personality disorder

A further limitation of this thesis may be the use of the DSM-5 AMPD as a way of exploring PD. At the commencement of this thesis (2015) the DSM-5 had not long been released and was gaining popularity within the literature. However, although there is a substantial body of literature supporting the reliability, validity and factor structure of the DSM-5 AMPD (Bastiaens et al., 2016; Krueger & Markon, 2014; Morey et al., 2015), Jones (2011) argues that neither categorical nor dimensional approaches to PDs are used much in clinical practice, rather, formulations are preferred. Nevertheless, some services (such as the OPD pathway) still utilise inclusion/exclusion criteria, therefore, by adopting the AMPD approach within this thesis, the results have been able to provide important implications for categorical PD diagnoses, as well as gaining insight above and beyond that of a categorical diagnosis. Furthermore, by utilising the AMPD and exploring the personal narratives of IPSO, this thesis further contributes to the growing body of research on dimensional conceptualisations of PD, forging a deeper joining between the study of PD and normal personality. The narrative approach taken within this thesis also aligns with the PTM, which focuses on the types of power present in an individual's life, the threat that it poses for the individual, what meaning it has, and the learned and evolved threat responses that developed as a reaction to this.

8.3.4 Difficulties defining and measuring sexual preoccupation

A further limitation relates to the difficulties around defining and measuring SP due to the majority of literature using a variety of terms interchangeably, describing both the cognitive and physical behaviours. The purpose of this research was to focus more on the cognitive aspect rather than physical, however, the scale used assesses both sexual thoughts and behaviours, meaning that the results may also refer to problematic sexual behaviour as well as sexual thoughts. The SCS was chosen due to it measuring insistent, intrusive and uncontrolled sexual thoughts (Kalichman, 2010), and for comparative purposes with individuals taking MMPSA. As a way of trying to minimise this limitation, the SCS was triangulated with the MPI scale and clinical measures of SP, whereby strong positive correlations were reported. Additionally, given the cross-sectional and correlational design of the quantitative studies, it is difficult to claim causality or know which came first in terms of PD and SP, however, the narrative analysis provides the first insight into how these developed throughout the lives of IPSO.

8.4 Recommendations for future research

Future research ideas have been discussed extensively in the previous chapters, but, will briefly be mentioned here. Due to some of the limitations discussed above, future research should assess the prevalence of PD, SP, and ACEs among a wider sample of IPSO from a range of prison establishments (rather than just category C) in order to provide a more accurate representation of IPSO. Currently, IPSO that pose a low risk do not receive psychological treatment, therefore, it may be useful to consider the relationships between level of risk and PD/SP to ascertain whether problematic personality and SP are prevalent among all IPSO, or just those who pose a medium or high risk. If personality difficulties (as found among the whole sample of IPSO within study three) are prevalent among all risk levels, this would further reinforce the need for all services to be trauma informed, in order to benefit all individuals including those who are low risk (who consequently do not currently receive treatment).

In relation to ACEs, future research should assess the prevalence among a broad sample of IPSO, including those that show impairments in personality functioning and PD and those who do not. This will also allow the relationship between PD and ACEs, and SP and ACEs to be assessed properly, as study three failed to appropriately address these aims given that all IPSO with PD demonstrated at least one ACE. It may also be important to consider factors that may mediate the relationship between ACEs and SP, for example, emotion dysregulation. Jerome et al. (2016) suggests that ACEs may result in emotion regulation difficulties that, in turn, may lead to an increase in sexual thoughts and urges, and is something that should be explored further among IPSO. Furthermore, future research should combine self-report data of ACEs with information from other sources such as clinicians, official documentation, family members, or observation (Francia et al., 2010; Jones & Wilmot, 2017).

Through exploring the relationship between PD and SP, the results of this thesis reveal that borderline and narcissistic tendencies are particularly prevalent among IPSO with SP. For IPSO who demonstrate difficulties with emotion regulation and impulsivity, it is thought that they may benefit from therapeutic interventions that target this problematic behaviour, such as DBT. However, further research is required to determine whether such treatments may also decrease SP among IPSO (Northey et al. 2016). Additionally, individuals that demonstrate narcissistic traits (such as grandiosity) may benefit from treatment that targets these problematic traits, as this may help to treat aspects of SP as well. Various treatments have been developed for the treatment of PD and SP, but future research is required to explore if they are effective at reducing SP, and how best to integrate these treatments for IPSO with comorbid symptoms (Jardin et al., 2017).

8.5 Reflections on the research experience

Blagden and Pemberton (2010) argue that the impact carrying out research and collecting data has on researchers themselves is often overlooked, however, conducting a PhD can be a very emotional experience, characterised by various highs and lows. Reflecting on some of the issues encountered whilst conducting research has become more common within the social sciences, and provides a sense of what it is like to conduct research in a prison setting (Bosworth et al., 2005; Liebling, 1999). Thus, this section will outline some of the main issues and learning curves that I encountered throughout my PhD journey.

Before starting this PhD, I had minimal experience of working within this field. I had previously conducted an MSc in psychological research methods and had experience of working in secure hospitals as a support worker and honorary assistant psychologist. However, I had no direct experience of working with incarcerated individuals, or within a prison setting. Thus, this opportunity afforded me a huge learning experience, whereby I have learnt and developed considerably throughout the process; academically, professionally, and personally. I feel extremely privileged to have been given this opportunity to conduct research in such a fascinating and interesting area.

8.5.1 Data collection

8.5.1.1 Practical considerations

Given my lack of experience in a prison setting, attempting to design and conduct three studies within this environment came with several hurdles. Firstly, I had to become aware of the prison environment, the strict prison regime, what you can and cannot do, how to assess the risk of individuals, knowing the limits of participant confidentiality, and how to handle sensitive situations appropriately. I began by spending two days a week at prison 1 since the commencement of the PhD in order to familiarise myself

with the prison environment, the routines, and the staff members. This enabled me to have a good knowledge of how the system works, and the best way to conduct research within such an environment. Whilst planning my studies I sought advice from various members of staff from the psychology and programs department, wing staff, and members of the WASREP group. Crucial information was gained from each of these, for example, the studies were designed in a way that they followed on from each other, meaning that contact details were required so that the researcher could contact participants for the following stages of the research. However, concerns were raised about asking participants for their details as some may want to remain anonymous. Advice from staff members and service users was that some IPSO would be happy to leave their details and to be contacted for future research, therefore, it may be beneficial to give participants the option of remaining anonymous or leaving their contact details if they wish. Furthermore, the WASREP group enabled potential barriers to be minimised by advising on the best way to collect completed questionnaires (placing labelled boxes on each of the wings for IPSO to place questionnaires in as some may be wary of handing completed questionnaires to wing staff). Service user involvement in the development of research is considered important and has been recognised in the UK (Department of Health, 2006; National Institute for Health Research, 2012), and the WASREP groups contributions to the style of the questionnaire, the language used, and the practical aspects of distributing questionnaires has been invaluable to this research.

In terms of practicality, there are two other points worth mentioning. Firstly, one hurdle that I encountered after conducting the screening study was around removing the anonymised data file from the prison establishment. Ethical approval had been granted so that the anonymised data file could be removed via a password protected USB stick, however, when it came to removing data, HMPPS guidelines and policies had changed regarding who could have USB access. Although access was later granted, the approved USB sticks that I had access to no longer worked on the new system. This resulted in a long back-and-forth process with IT in order to get details of the new and approved USB sticks which took around eight months to resolve. This was something that I had not previously considered to be an issue or factored into time scales, but, is something that I was consciously aware of when conducting future studies. Secondly, I also experienced obstacles when it came to gaining access to private rooms in order to conduct psychometric scales and interviews. The use of the rooms was shared with other services within the prison establishment, meaning that at times it was difficult to access a room. However, whilst conducting the face-to-face psychometrics during study three in the assessment rooms, I realised how it was possible to hear very clearly the conversation in the room next door, in which at times people were talking about very sensitive and personal topics. This made me reflect on my own research practices, as well as considering the sensitive nature of the following study I would be conducting (life story interviews). I did not feel that it would be appropriate to conduct the life story interviews in these rooms given that individuals would be talking about some of the most intricate parts of their lives, and other prisoners or staff may be able to hear this information. I spoke to members of the psychology team at prison 1 to see if there were any other rooms that would provide more privacy

and was informed that one of the counselling rooms may be more appropriate. Therefore, I liaised with the counselling team and was able to use the room on a Tuesday afternoon when the room was not being used. This ensured the confidentiality of participants whilst also putting them at ease, enabling them to talk in depth about their life stories without fearing that other prisoners or staff members could hear.

8.5.1.2 Rapport building and confidentiality

The most enjoyable element of the research for me was conducting the life story interviews with participants. It was a privilege to be able to listen to the participants stories, particularly when one participant stated *'I've told you more about my life these past two weeks than I ever told my wife'* (Roger). I felt very fortunate that participants felt able to and comfortable enough to open up and be honest about their lives and their feelings. Rapport building is thought to be crucial in conducting credible research as it aims to build trust and connection with participants, whilst enabling a safe space to be developed where they feel able to explore intricate details of their lives (Hannabuss, 1996; Waldram, 2007). This was something I was particularly aware of whilst conducting the interviews and tried to provide a non-judgemental, empathic, and secure space where participants could explore their stories. Fisher (2009) suggests that researchers should demonstrate some aspect of care and should view the research process as being conducted 'with' participants rather than 'on' participants. I remained mindful of this throughout data collection and was aware that without participants volunteering their time and stories then this research would not have been possible.

In terms of demonstrating care, it was vital that the safety and wellbeing of participants was maintained at all times throughout the research process, particularly when conducting life story interviews as these can cause unexpected emotions and distress to arise (Cowburn, 2010; Draucker et al., 2009). During the interviews two participants became visibly upset and distressed when discussing certain life events, and I allowed them to guide what happened next (Pietkiewicz & Smith, 2014; Winder & Blagden, 2008). Participants were provided with tissues and given the necessary time and space they needed to express their emotions and compose themselves, and then were given options as to whether they wanted to continue with the research, take a break, or stop the interview. Both participants decided to continue with the interview, and I tried to ensure that the interview ended on a positive note by focusing on the participants hopes and plans for the future. I checked in with them at the end of the interview to see how they were feeling and provided a debrief form (which I talked through with them) which detailed several avenues of support. I also explained to each participant that after the interview I would be contacting relevant wing staff to inform them that the participants had been involved in a difficult interview which may have brought up some unexpected negative emotions, whereby I asked wing staff to 'keep an eye on' these individuals in case they required any additional support (both participants were happy for me to pass this information on). Although researchers aim to protect the anonymity

and confidentiality of participants, at times this must be broken if there are concerns around the safety of participants or others (further information in section 3.6.2). Therefore, it was part of my moral, professional, and legal duty to pass on relevant information (Cowburn, 2005) to wing staff in order to ensure the safety of the participants well-being, which was in line with the information and consent procedures.

As previously mentioned in chapter seven, the second part of the interview was not conducted with Steven and he was subsequently excluded from data analysis. Steven appeared to be demonstrating offence-paralleling behaviour through the use of the interview, therefore, after discussions with the supervisory team it was decided not to continue with the second part of the interview. In this instance, confidentiality was not broken and information was not passed on as there were no threats to safety (of himself or others), no plans to escape prison or break prison rules, and no further offence related or victim related information was disclosed (which are scenarios in which confidentiality would need to be broken). As a way of minimising distress by not continuing the research I met with Steven in person to thank him for taking part in the research, and informed him that we had covered everything in the last session and therefore no further participation was required.

8.5.2 Personal reflections

Due to the sensitive nature of the life story interviews, whereby participants spoke in depth about their childhoods and traumatic experiences of being abused or neglected, I often found that their stories elicited strong emotional responses within myself. I found myself being emotionally moved by participants and feeling a great deal of empathy and compassion towards them, whilst gaining a deeper understanding of their trajectory towards offending. This opposes the traditional negative, stereotypical view of IPSO, and at times I felt myself experiencing compassion towards the participant whilst also considering the impact on their victims. In contrast to this, at times, I found that some of the participants views, perspectives and morals were opposite to mine. In these instances, I had to hold back my own morals and perspectives, as challenging participants views is strongly recommended against during research (Blagden & Pemberton, 2010), as they should be able to construe their world and talk freely without being interrupted. At times this was difficult, and it was important to ensure that I did not collude or affirm their views. This difficulty between challenging and colluding has been described by Blagden and Pemberton (2010) as 'walking the line' (p. 277), which can be particularly tough and uncomfortable for researchers. Any challenges or difficult emotions that I encountered were discussed through supervision and debrief sessions with members of the supervisory team.

Whilst conducting this research, particularly the analysis, I became aware that participants' stories would randomly reappear and replay in my head at unexpected times, for example, whilst driving down the road listening to music. At times this resulted in me avoiding the material and analysis for a short

while and taking a break to focus on other aspects of the thesis. Similar responses have been recognised by other researchers exploring sensitive areas (Coles & Mudaly, 2010; Lievesley, 2019). However, at other times, the replaying and remembering of these stories had a different impact on me. Particularly during the analysis stage, I found that whilst I was attempting to make sense of the participants' experiences, by listening to their early childhood experiences I started to think about and reflect on my own childhood experiences. Thoughts and emotions that I had buried for a long time, particularly around my mother leaving when I was eight years old, had now resurfaced and were brought to the forefront. This enabled me to consider how my earlier experiences have impacted on my life, shaped me into the person I am today, and influenced the relationships I have developed over the years. Similar to Roger's experience of being a Listener (chapter seven), I was finding that through listening to others' traumatic experiences I was making sense and reconciling my own past. Listening to other people share their stories allows individuals to process, edit, reinterpret, and retell their own stories (Petrich, 2016), resulting in a more integrative narrative identity. Although at times this was difficult as some of these realisations and feelings were uncomfortable, I feel like I have learnt a lot about myself and have grown a lot throughout this process, and now have a deeper understanding of my own identity and sense of self.

Through conducting this research, I have developed in various ways; academically, professionally, and personally. I have advanced, and honed in on, skills required to conduct independent research, as well as learning how to become a more reflective researcher. I am able to work in a much more empathic and compassionate way now, holding the belief that all individuals have a life story that explains their trajectory in life, and it is important to listen to and consider an individual's narrative. Moreover, I have learnt a lot about myself and have a greater insight into my own life story thanks to this journey.

8.6 Concluding remarks

Through utilising a mixed-methods approach, this thesis offers the first in-depth exploration of the relationship between PD, SP, and ACEs among a sample of IPSO housed in two UK prison establishments. PD and SP symptomology may be better understood as effective survival strategies or functional responses to abnormal circumstances, which is in agreement with the PTM framework (Johnstone, 2018). Traumatic experiences may lay the groundwork for a range of interpersonal problems and coping strategies, in which SP and high-risk behaviours may be considered ways of coping with these traumatic experiences (Elliot et al., 2005; Teyber & McClure, 2011; Whitfield, 1998). Among this sample, the cumulative effect of ACEs may not be of import, but the meaning and impact it had for the individual, in which clinicians should address this aspect of an individual's sense-making during treatment (Jones, 2011). Given the high prevalence of PD and ACEs among this sample, it is crucial that all services that come into contact with IPSO are trauma-informed and operate from a relational, GLM perspective in order to provide an environment that is conducive to rehabilitation and desistance. In order to do this,

high quality training needs to be accessible to all staff that come into contact with IPSO, to enable them to have a thorough understanding about the nature and impact of ACEs. Encouraging positive experiences within prison environments (such as peer-support roles and opportunities to engage with religious practices) is vital in order to enable IPSO to re-story their lives, experience positive shifts in identity, and distance themselves from the negative 'sexual offender' label. This allows individuals to form more pro-social and viable identities, which are crucial for successful rehabilitation and desistance (Maruna, 2001), as people tend to live up to the stories that they present about themselves (McAdams, 1985). Furthermore, early preventative measures are crucial to try and prevent the cycle of ACEs being passed on from generation to generation, as well as aiming to prevent individuals coming into contact with the criminal justice system in the first place. Early interventions for children at risk of ACEs should be paramount, as well as parenting and family programs for parents of at-risk children, and trauma informed schools.

Attempting to understand the underlying mechanisms of SP is a complicated process, as SP manifests differently for each individual, and for various reasons. Although this research provides support for the impulsivity and compulsivity models of SP, and for it being used as a coping mechanism for anxiety and depression, it also highlights the relationships between SP and emotion regulation difficulties, and SP and impaired identity. SP (and resulting behaviours) may be used as a way to regulate emotions and manage stress (Parsons et al., 2008), and as a way of managing identity and self-worth (Carnes & Adams, 2002). Furthermore, the results bolster Montaldi's (2002) claim that some presentations of SP may be better understood through the use of PDs, whereby this thesis highlights the possibility of two PD pathways for IPSO with SP (in regard to borderline and narcissistic PDs). Multiple kinds of SP presentation suggest the need for multiple treatment approaches (Montaldi, 2002), in which it is important for clinicians treating this behaviour to be aware of the various underlying mechanisms of SP, and to tailor treatment according to the individual's motivation for SP (Walton et al., 2017).

A critical finding from this thesis is in relation to the prevalence of PD among IPSO, as the results provide tangible implications for services provided for IPSO, particularly the OPD pathway. The findings illustrate that the personality profile of IPSO may be different to that of IPVO, meaning that a proportion of IPSO that require treatment for their personality difficulties may be being missed due to the current screening procedures. Therefore, the OPD pathway may need to amend the current procedures to be more inclusive of a wide range of PDs, or a separate pathway and services (such as the ACORN service) for IPSO may be required, in order to account for the differences between IPSO and IPVO. However, limitations of this thesis include only exploring the prevalence of PD among IPSO housed in category C prison establishments, indicating that the current results can only be generalised to IPSO in comparable establishments. Thus, future research should explore the prevalence of PD among IPSO housed in category A, B, and C prison establishments in order to establish any differences in PD presentation between the different environments.

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Appendices

[Appendix 1: DSM-5 section II personality disorder descriptions](#)

Appendix 1 cannot be made publicly available online due to copyright or commercial restrictions.

[Appendix 2: Definitions of PID-5-SF trait domains](#)

Appendix 2 cannot be made publicly available online due to copyright or commercial restrictions.

[Appendix 3: Definitions of PID-5-SF pathological personality traits](#)

Appendix 3 cannot be made publicly available online due to copyright or commercial restrictions.

Appendix 4: Adapted life story interview for study four

Life Story Interview

(Adapted from McAdams, 1995; 2008, permission to reprint granted from McAdams [10.03.2020])

‘Play the role of storyteller about your own life’

Introductory comments

This is an interview about the *story of your life*. I am interested in hearing your story, including parts of the past as you remember them, and the future as you imagine it. The story is selective; meaning it does not include everything that has ever happened to you. Instead, I will ask you to focus on a few key things in your life – a few key scenes, characters, and ideas. There are no right or wrong answers to my questions. The interview is for research purposes only, and its main goal is simply to hear your story. I want to learn about your experiences and how you make sense of them, in order to understand the different ways in which people live their lives, and different ways in which people understand who they are.

I hope you enjoy being given the opportunity to talk about your life from your own perspective, and enjoy the interview. Do you have any questions?

Life Chapters

Please begin by thinking about your life as a story – as if it were a book or novel. Think about this book having a few different chapters, and imagine a contents page with the titles of the main chapters. To begin, please describe briefly what the main chapters in the book might be. As a storyteller here, what you want to do is give me an overall plot summary of your story.

[2-7 chapters, 20 minutes, purpose of this section is to establish the story’s outline.

Key Scenes in the Life History

Now that you have described the overall plot outline for your life, I would like you to focus in on a few key scenes that stand out in the story. A key scene would be an event or specific incident that took place at a particular time and place. Consider a key scene to be a moment in your life story that stands out for a particular reason – perhaps because it was especially good or bad, particularly vivid, important, or memorable. For each of the eight key events, I ask that you describe in detail what happened, when and where it happened, who was involved, and what you were thinking and feeling in the event. In addition, I ask that you tell me why you think this particular scene is *important* or significant in your life. What does the event say about who you are or were as a person?

[these events will provide a picture of the myths that the interviewee has created about himself as well as whether his behaviour agrees with these myths and stories]

High Point

Please describe a moment in your life that stands out as an especially positive experience. This would stand out in your memory as one of the best, most wonderful scenes or moments in your life story. Describe what happened, when and where, who was involved, and what you were thinking and feeling? Also, please say a word or two about why you think this particular moment was so good, and what it may say about who you are as a person.

[Interviewer should ensure participant addresses all of these questions, especially ones about impact and what the experience says about the person. Do not interrupt the description of the event, but ask for extra details afterwards if necessary]

Low Point

The second scene is the opposite of the first. Thinking back over your entire life, please identify a scene that stands out as a low point, if not *the* low point in your life story. Even though this event is unpleasant, I would appreciate you being as honest and detailed as you can be. What happened in the event, where and when, who was involved, and what were you thinking and feeling? Also, please say a word or two about why you think this particular moment was so bad and what the scene may say about you or your life.

[Interviewer note: If the participants balks at doing this, tell him or her that the event does not really have to be *the* lowest point in the story but merely a very bad experience of some kind]

Turning Point

In looking back over your life, it may be possible to identify certain key moments that stand out as turning points -- episodes that marked an important change in you or your life story. Please identify a particular episode in your life story that you now see as a turning point -- I am especially interested in a turning point in *your understanding of yourself*. Again, for this event please describe what happened, where and when, who was involved, and what you were thinking and feeling. Also, please say a word or two about what you think this event says about you as a person or about your life.

[If you cannot identify a key turning point that stands out clearly, please describe some event in your life wherein you went through an important change of some kind.]

Positive Childhood Memory

The fourth scene is an early memory -- from childhood or your teen-aged years -- that stands out as especially *positive* in some way. This would be a very positive, happy memory from your early years. Please describe this good memory in detail. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you or about your life?

Negative Childhood Memory

The fifth scene is an early memory -- from childhood or your teen-aged years -- that stands out as especially *negative* in some way. This would be a very negative, unhappy memory from your early years, perhaps entailing sadness, fear, or some other very negative emotional experience. Please describe this bad memory in detail. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you or your life?

Vivid Adult Memory

Moving ahead to your adult years (age 21 and beyond), please identify one scene that you have not already described in this section (in other words, do not repeat your high point, low point, or turning point scene) that stands out as especially vivid or meaningful. This would be an especially memorable, vivid, or important scene, positive or negative, from your adult years. Please describe this scene in detail, tell what happened, when and where, who was involved, and what you were thinking and feeling. Also, what does this memory say about you or your life?

Wisdom Event

Please describe an event in your life in which you displayed wisdom. The episode might be one in which you acted or interacted in an especially wise way or provided wise counsel or advice, made a wise decision, or otherwise behaved in a particularly wise manner. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you and your life?

Religious, spiritual, or mystical experience

Whether they are religious or not, many people report that they have had experiences in their lives where they felt a sense of the transcendent or sacred, a sense of God or some almighty or ultimate force, or a feeling of oneness with nature, the world, or the universe. Thinking back on your entire life, please identify an episode or moment in which you felt something like this. Please describe this experience in detail. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you or your life?

Future Script

The next chapter

Your life story includes key chapters and scenes from your past, as you have described them, and it also includes how you see or imagine your future. Please describe what you see to be the next chapter in your life. What is going to come next in your life story?

Dreams, hopes, and plans for the future

Please describe your plans, dreams, or hopes for the future. What do you hope to accomplish in the future in your life story?

Life project

Do you have a project in life? A life project is something that you have been working on and plan to work on in the future chapters of your life story. The project might involve your family or your work life, or it might be a hobby, avocation, or pastime. Please tell me what the project is, how you got involved in the project or will get involved in the project, how the project might develop, and why you think this project is important for you and/or for other people.

Challenges

Life challenge

Looking back over your entire life, please identify and describe what you now consider to be the greatest single challenge you have faced in your life. What is or was the challenge or problem? How did the challenge or problem develop? How did you address or deal with this challenge or problem? What is the significance of this challenge or problem in your own life story?

Health

Looking back over your entire life, please identify and describe a scene or period in your life, including the present time, wherein you or a close family member confronted a major *health* problem, challenge, or crisis. Please describe in detail what the health problem is or was and how it developed. If relevant, please discuss any experience you had with the health-care system regarding this crisis or problem. In addition, please talk about how you coped with the problem and what impact this health crisis, problem, or challenge has had on you and your overall life story.

Loss

As people get older, they invariably suffer losses of one kind or another. By loss I am referring here to the loss of important people in your life, perhaps through death or separation. These are *interpersonal* losses – the loss of a person. Looking back over your entire life, please identify and describe the greatest interpersonal loss you have experienced. This could be a loss you experienced at any time in your life, going back to childhood and up to the present day. Please describe this loss and the process of the loss. How have you coped with the loss? What effect has this loss had on you and your life story?

Failure, regret

Everybody experiences failure and regrets in life, even for the happiest and luckiest lives. Looking back over your entire life, please identify and describe the greatest failure or regret you have experienced. The failure or regret can occur in any area of your life – work, family, friendships, or any other area. Please describe the failure or regret and the way in which the failure or regret came to be. How have you coped with this failure or regret? What effect has this failure or regret had on you and your life story?

Influences on the life story

Positive

Looking back over your life story, please identify the single person, group of persons, or organisation/institution that has or have had the greatest positive influence on your life. Please describe this person, group or organisation and the way these have had a positive impact.

Negative

Please identify the single person, group of persons, or organisation/institution that has or have had the greatest negative influence on your life. Please describe this person, group or organisation and the way these have had a negative impact.

Stories and the Life Story

You have been telling me about the story of your life. In so doing, you have been trying to make your life into a story for me. I would like you now to think a little bit more about stories and how some particular stories might have influenced your own life story. From an early age, we all hear and watch stories. Our parents may read us stories when we are little; we hear people tell stories about everyday events; we learn about stories in schools, churches, etc. I am interested in knowing what some of your favourite stories are and how they may have influenced how you think about your own life and your life story. When I ask you about the different kinds of stories, try to identify a story that fits the description, describe the story very briefly, and tell me if and how that story has had an effect on you.

Television, Movie, Performance: Stories Watched

Think back on TV shows that you have seen, movies, or other forms of entertainment or stories from the media. Please identify one of your favourite stories, and tell me what the story is about, why you like the story so much, and if and how the story has had an impact on your life.

Books, Magazines: Stories Read

Now think back over things you have read – stories in books, magazines, newspapers etc. Please identify one of your favourite stories, and tell me what the story is about, why you like the story so much, and if and how the story has had an impact on your life.

Family Stories, Friends: Stories Heard

Growing up, many of us hear stories in our families or from our friends that stick with us, stories that we remember. Family stories include things parents tell their children about ‘the old days’, their family heritage, family legends etc. Children tell stories on the playground or on the phone, even in adulthood, friends and families tell stories about themselves and others. Try to identify one story like this that you remember, tell me a little about the story, why you like it, and what impact it has had on your life.

Personal Ideology

Now, I would like to ask a few questions about your fundamental beliefs and values and about questions of meaning and morality in your life. Please give some thought to each of these questions.

Religious/ethical values

Consider for a moment the religious or spiritual aspects of your life. Please describe in a nutshell your religious beliefs and values, if indeed these are important to you. Whether you are religious or not, please describe your overall ethical or moral approach to life.

Political/social values

How do you approach political or social issues? Do you have a particular political point of view? Are there particular social issues or causes about which you feel strongly? Please explain.

Change, development of religious and political views

Please tell the story of how your religious, moral, and/or political views and values have developed over time. Have they changed in any important ways? Please explain.

Single value

What is the most important value in human living? Please explain.

Other

What else can you tell me that would help me understand your most fundamental beliefs and values about life and the world? What else can you tell me that would help me understand your overall philosophy of life?

Life Theme

Looking back over your entire life story with all its chapters, scenes, and challenges, and extending back into the past and ahead into the future, do you discern a central theme, message, or idea that runs throughout the story? What is the major theme in your life story? Please explain.

Reflection

Thank you for this interview. I have just one more question for you. Many of the stories you have told me are about experiences that stand out from the day-to-day. For example, we talked about a high point, a turning point, a scene about your health, etc. Given that most people don’t share their life stories in this way on a regular basis, I’m wondering if you might reflect for one last moment about what this interview, here today, has been like for you. What were your thoughts and feelings during the interview? How do you think this interview has affected you? Do you have any other comments about the interview process?

Information Sheet

I would like to invite you to take part in a research study. Before you decide whether you would like to take part in this study, you should carefully read this form so you are aware of why the research is being done and what it involves. Your participation in this study is completely voluntary, and it is your own decision whether you wish to take part or not. If anything you read is not clear, or you would like more information please feel free to ask the researcher any questions.

What is the purpose of the study?

The researcher conducting this study is completing a PhD at Nottingham Trent University. The overarching aim of the doctoral research is to explore personality disorder among male prisoners in the UK. However, the current scales (questionnaires) that measure personality disorder have been developed in other countries (i.e. America) and not in the UK. Therefore, the purpose of this study is to see if a selection of scales are relevant to males in the UK, with the intention of then using them with male prisoners in the UK. The scales measure aspects of personality disorder; this means that you will be asked about your thoughts, feelings and behaviour (for e.g. the personality trait impulsivity may be measured by asking you to rate on a scale of 0-4 how much you agree with the statement 'I feel like I act totally on impulse').

Why have I been invited to participate?

You have been invited to take part primarily because you are male, and are either a tradesman, or work in a factory/warehouse/call center. We are aiming to get a sample of males that may have similar demographics to that of male prisoners (male, broad age range, working class).

What would I have to do?

If you decide to take part in the study you will be asked to complete a series of questionnaires that would take approximately 15 minutes. The questionnaires are distributed in a pre-paid envelope; you can choose to complete the forms during your lunch break and return them to the researcher (Jackie), or you can take them home to complete in your own time, and either return to the researcher at your place of work, or send back using the pre-paid envelope.

If you would like any help to complete the questionnaires then please let the researcher know, and you can complete the questionnaires alongside the researcher with their support.

What are the advantages and disadvantages of taking part?

+ We cannot promise that this study will benefit you directly, however, the information we get from the study will hopefully provide support for personality disorder scales in the UK, which can then help to increase the understanding of prisoners with personality disorder.

- Some of the questions you may be asked are quite personal, and ask about your own thoughts, feelings and behaviours. Some questions may result in a negative response, and you may become upset or distressed by them. If this is the case, you are free to stop participating in the research at any point; or you can choose not to answer specific questions if they make you feel uncomfortable. If you do become distressed by any of the questions you can talk to the researcher, or any of the support services detailed on the debrief form.

What happens to the information you provide?

Once you have returned your questionnaire pack to the researcher, they will be stored in a locked cabinet in the Graduate School at Nottingham Trent University. The researcher will input the information into a database, which will be password protected. Only the researcher and her supervisors will have access to this information. You are not required to give your name at any point, but you will be asked to provide a unique identifier to enable anonymity. The data may be re-used for similar projects in the future, however, the data will be destroyed after 10 years. A report will be written at the end of the study; you or your place of work will not be mentioned in the report.

Your participation in the study

Voluntary – Your participant in this study is completely voluntary and your own decision. There are no negative consequences if you choose not to take part.

Right to withdraw – If you participate in the study and then later change your mind, you can withdraw your results by calling/sending an anonymous postcard quoting your unique identifier. You have until 31st August 2017 to withdraw your results (no reason required).

**** You can keep this information sheet for your records ****

Consent Form

Consent

Please tick:

- ❖ I have been given an information sheet; I have read and understood the purpose of the study, and I am happy to participate in the research.

Signed..... Date.....

Researcher signed..... Date.....

Unique Identifier:

In order to ensure anonymity please create a unique identifier (a phrase/numbers/letters that you can remember e.g. orange365).

Unique Identifier:.....

Debrief Form

***** This form is for you to keep *****

Thank you for participating in this study. The purpose of this study is to validate three scales relating to personality disorder in males from the UK, so that these scales can then be used to assess personality disorder among prisoners in the UK.

All of the information you have provided will remain confidential and stored in a locked cabinet that only the research team will have access to. You have the right to withdraw your data (without providing a reason why) up until the **31st August 2017**. If you change your mind and wish to withdraw then please contact the researcher/supervisor via telephone (0115 848 5525) or send an anonymous postcard quoting your unique identifier to the address given below.

The questionnaire pack asks about things that are quite personal, therefore, if you feel upset or distressed by any of the questions then you can access the following support services:

- Mind (**Call:** 0300 123 3393, **Text:** 86463, **Web address:** www.mind.org.uk)
- Sane (**Call:** 0300 304 7000, **Web address:** www.sane.org.uk)
- Samaritans (**Call:** 08457 90 90 90, **Web address:** www.samaritans.org)

Contact details:

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Thank You

[Appendix 8: Breakdown of PID-5-BF domains](#)

Appendix 8 cannot be made publicly available online due to copyright or commercial restrictions.

[Appendix 9: Pathological personality traits associated with each PD, and relevant criteria for each diagnostic](#)

[PD category](#)

PDs retained in DSM-5 AMPD	Associated Traits	Number of elevated traits required (AMPD)
Antisocial PD	Manipulativeness Callousness Deceitfulness Hostility Risk taking Impulsivity Irresponsibility	Six (out of seven)
Borderline PD	Emotional lability Anxiousness Separation insecurity Depressivity Impulsivity Risk taking Hostility	Four (out of seven); One must be impulsivity, risk taking or hostility
Schizotypal PD	Perceptual dysregulation Unusual beliefs and experiences Eccentricity Restricted affectivity Withdrawal Suspiciousness	Four (out of six)
Obsessive-compulsive PD	Rigid perfectionism Perseveration Intimacy avoidance Restricted affectivity	Three (out of four); One must be rigid perfectionism
Avoidant PD	Anxiousness Withdrawal Anhedonia Intimacy avoidance	Three (out of four)
Narcissistic PD	Grandiosity Attention Seeking	Both

PDs not retained in DSM-5 AMPD	Associated Traits	Number of elevated traits required (half + 1 if odd)
Paranoid PD	Hostility Suspiciousness Intimacy avoidance Unusual beliefs and experiences	2 (out of four)
Schizoid PD	Restricted affectivity Withdrawal Anhedonia Intimacy avoidance	2 (out of four)
Dependent PD	Submissiveness Separation insecurity Anxiousness	2 (out of three)
Depressive PD	Anxiousness Depressivity Anhedonia	2 (out of three)
Histrionic PD	Attention seeking Emotional lability Manipulativeness	2 (out of three)
Passive Aggressive PD	Hostility Depressivity	Both

Note. PD = Personality Disorder; DSM-5 = Diagnostic Statistical Manual of Mental Disorders 5th Edition; AMPD = Alternative Model to Personality Disorders.

[Appendix 10: Cronbach's alpha values for the PID-5-SF](#)

Cronbach's α for the Personality Inventory for DSM-5 Short Form (N = 155)

PID-5-SF	α
Domains	
Negative affectivity	.92
Detachment	.87
Antagonism	.91
Disinhibition	.90
Psychoticism	.91
Facets	
Anhedonia	.82
Anxiousness	.87
Attention Seeking	.88
Callousness	.87
Deceitfulness	.83
Depressivity	.88
Distractibility	.87
Eccentricity	.89
Emotional Lability	.87
Grandiosity	.82
Hostility	.82
Impulsivity	.92
Intimacy Avoidance	.83
Irresponsibility	.70
Manipulativeness	.77
Perceptual Dysregulation	.85
Perseveration	.83
Restricted Affectivity	.75
Rigid Perfectionism	.86
Risk Taking	.82
Separation Insecurity	.81
Submissiveness	.82
Suspiciousness	.80
Unusual Beliefs & Experiences	.78
Withdrawal	.79

Note. α = Cronbach's alpha coefficient; PID-5-SF = Personality Inventory for DSM-5 Short Form.

[Appendix 11: A breakdown of SIPP-118 domains and facets](#)

Appendix 11 cannot be made publicly available online due to copyright or commercial restrictions.

Appendix 12: Cronbach's alpha values for SIPP-118

Cronbach's α for the Severity Indices of Personality Problems 118 (N = 45)

Domains and Facets	α
Self-control	.90
Emotional regulation	.80
Effortful control	.80
Identity integration	.86
Self-respect	.74
Stable self-image	.74
Self-reflexive functioning	.64
Enjoyment	.80
Purposefulness	.70
Responsibility	.72
Responsible industry	.70
Trustworthiness	.65
Relational capacities	.74
Intimacy	.73
Enduring relationships	.80
Feeling recognised	.67
Social concordance	.83
Aggression regulation	.89
Frustration tolerance	.72
Cooperation	.79
Respect	.64

Note. α = Cronbach's alpha coefficient

Information Sheet

You are being invited to take part in a research study. It is being conducted by a PhD student (Jackie Hamilton) from Nottingham Trent University.

The decision to take part in the research is completely up to you. If you take part you will not receive anything, and if you do not take part, you will not lose anything. Taking part will not affect your chances of parole or getting treatment or medication in prison.

This study is part of a wider research project; if you complete this questionnaire the researcher may be interested in talking to you in the future. However, this decision is completely up to you.

What is the research about?

This study looks at what personality characteristics are found in prisons. We are also interested in how they may relate to offending behaviour, and sexual thoughts and urges. You will be asked questions about the way you think and feel (e.g. 'I feel like I act totally on impulse'). You will also be asked about your previous offending, sexual thoughts and urges (e.g. 'I struggle to control my sexual thoughts and behaviour'). The aim of this research is to help yourself and others in the future (e.g. to inform future treatment). This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.

What would you be asked to do?

If you agree to take part you will be asked to complete a questionnaire (this will take around 10-15 minutes).

What happens to the information you give to me?

The completed questionnaire will be stored in a locked filing cabinet at the prison. Your answers will be put into a password protected database. **Only** the research team* will have access to this information. It will be used for research purposes **only**. Information will not be used by psychology or for parole purposes.

All information will be kept private, unless:

- You tell me that you want to harm yourself.
- You tell me that someone else is at risk of being harmed.
- You tell me information about an offence which you have not been convicted for (like the name of a victim and when the offence happened).
- You tell me any information relating to being a victim of an offence which hasn't yet been reported to the authorities.
- You tell me information about plans to escape prison or break prison rules.

If you mention any of these things to me, I will have to pass the information on to prison security, wing staff or the police.

There are two options for you to choose from;

- You can choose to remain anonymous (you do not have to give your name) and complete this questionnaire. Nobody will know that you participated.
- **Or**, if you are happy to be contacted about future research, you can leave your contact details. Only the research team will have access to this information.

*Jackie Hamilton, Belinda Winder, Nicholas Blagden, Kerensa Hocken, Jason Pandya-Wood

I will write a report at the end of this study. This report will not mention your name and nobody will know that you participated in the research. I will use the data to write papers, write my thesis for my PhD, and for presentation purposes. The data will be kept for five years and then it will be destroyed.

What happens if I don't want to take part anymore?

You can stop completing the questionnaires at any time, and you can choose not to answer individual questions.

If you change your mind and would like me to destroy your questionnaire, you have 4 weeks to let me know. You will not get into trouble for this, and you do not need to give me a reason why. The debrief form will provide you with further information.

Are there any risks to me if I participate in this research?

Some of the questions are quite personal, which may result in you becoming upset or distressed. Remember, you can stop at any point and can choose not to answer specific questions. If you feel upset/distressed, you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

Having any difficulties?

If you are having difficulties completing the questionnaire, please complete the 'Support Request Form'. Wing staff can help you with this.

Where do I get further information or whom do I complain to?

If you have any requests for further information, or have any queries then feel free to contact the main researcher (Jackie Hamilton) through safer custody department (by sending a general app). If you have any complaints please contact any member of the research team, or the lead psychologist through the psychology department.

**** You can keep this information sheet for your records ****

Consent Form

What am I consenting to?

- You are consenting to take part in a research study that involves you completing a questionnaire. This questionnaire asks about your personality characteristics, offending behaviour, and sexual thoughts and urges. This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.
- It is completely your choice if you participate or not. If you take part you will not receive anything, and if you do not take part, you will not lose anything.
- You can stop completing the questionnaires at any point, and do not have to answer individual questions.

Agreement to consent

I have read the information sheet, and understand the purpose of this research and my part in it. I understand that I can remain anonymous (nobody will know I participated) by not giving my name.

I consent (agree) to participate:

Signed Date

Unique ID

If you change your mind and would like me to destroy your questionnaire, you have 4 weeks to tell me. You will not get into trouble for this, and you do not need to give me a reason why. You can do this by sending me a general app quoting your unique ID (there is further information on the debrief form).

Your Unique ID is:

Future Research

The researcher may be interested in talking to you about future research. If you leave your name or prison number you may be contacted by Jackie Hamilton via a general app. Only the research team will have access to this information.

I consent (agree) to be contacted about future research:

Signed

Name

Prison Number

Debrief Form

Thank you for participating in this study.

This study looked at what personality characteristics are found in prisons. It also looked at how they may relate to offending behaviour, and sexual thoughts and urges. The aim of this research is to help yourself and others like you in the future (e.g. to inform future treatment). This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.

Taking part in this study will not have any effect on your chances of parole or the treatment you will receive in prison.

Only the research team will have access to the completed questionnaires. If you chose to leave your contact details you may be contacted about future research.

I will write a report at the end of this study, but nobody will know that you participated. I will also write papers, write my thesis for my PhD, and do presentations. Your name will never be used in any of these.

If you change your mind and would like me to destroy your questionnaire, you have 4 weeks to tell me. You will not get into trouble for this, and you do not need to give me a reason why. You can do this by sending a general app to Jackie Hamilton (c/o the safer custody department) quoting your Unique ID (see below). All of your information will then be deleted.

Some of the questions are quite personal. If you feel upset you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

The main researcher is Jackie Hamilton. The rest of the research team consists of Belinda Winder, Nicholas Blagden, Kerensa Hocken and Jason Pandya-Wood (Jackie Hamilton can be contacted through the safer custody department). If you have any complaints please contact Jackie Hamilton, or the lead psychologist through the psychology department.

Thank You

Support Request Form

If you would like help to complete the questionnaire, please complete this form. Or, you could ask a wing officer to complete this form with you. A researcher will arrange to meet with you to complete the questionnaire. Once you have filled out this form please put it back in the envelope provided, seal it, and give to wing staff.

Name

Prison number

Wing

Please tick the days and times that are best for you to meet the researcher:

Day	Morning (AM)	Afternoon (PM)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Information Sheet

You are being invited to take part in a research study. It is being conducted by a PhD student (Jackie Hamilton) from Nottingham Trent University.

The decision to take part in the research is completely up to you. If you take part you will not receive anything, and if you do not take part, you will not lose anything. Taking part will not affect your chances of parole or getting treatment or medication in prison.

This study is part of a wider research project; if you complete this questionnaire, the researcher may be interested in talking to you more in-depth in the future. However, this decision is completely up to you.

What is the research about?

This study looks at how personality characteristics may link with sexual thoughts and urges. The research also looks at how past events may have an impact on this. The aim of this research is to help yourself and others in the future (e.g. to inform future treatment). Here are some examples of the types of questions you might be asked; 'I feel like I act totally on impulse' or 'I struggle to control my sexual thoughts and behaviour'. This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.

What would you be asked to do?

If you agree to take part in this study you will be asked to complete a questionnaire. This will be done in a private assessment room. You can complete the questionnaire yourself, or the researcher can read the questions aloud. This will take around 1 hour, and can be completed over one or two sessions. You can have a break or stop at any time.

What happens to the information you give to me?

The completed questionnaires will be stored in a locked filing cabinet at the prison. Your answers will be put into a password protected database. **Only** the research team* will have access to this information. It will be used for research purposes **only**. Information will not be used by the psychology department or for parole purposes.

All information will be kept private, unless:

- You tell me that you want to harm yourself.
- You tell me that someone else is at risk of being harmed.
- You tell me information about an offence which you have not been convicted for (like the name of a victim and when the offence happened).
- You tell me any information relating to being a victim of an offence which hasn't yet been reported to the authorities.
- You tell me information about plans to escape prison or break prison rules.

If you mention any of these things to me, I will have to pass the information on to prison security, wing staff or the police.

I will write a report at the end of this study. This report will not mention your name and nobody will know that you participated in the research. I will use the data to write papers, write my thesis for my PhD, and for presentation purposes. The data will be kept for five years and then it will be destroyed.

*Jackie Hamilton, Belinda Winder, Nicholas Blagden, Kerensa Hocken, Jason Pandya-Wood

What happens if I do not want to take part anymore?

You can stop completing the questionnaires at any time, and you can choose not to answer individual questions.

If you change your mind and would like me to destroy your answers, you have 4 weeks to let me know. You will not get into trouble for this, and you do not need to give me a reason why. The debrief form will provide you with further information.

Are there any risks to me if I participate in this research?

Some of the questions are quite personal, which may result in you becoming upset or distressed. Remember, you can stop at any point and can choose not to answer specific questions. If you feel upset/distressed, you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

Are there any benefits to me if I take part in this research?

While there may not be any direct benefits, you might find the questionnaires interesting to complete. Hopefully, the results will help to inform future treatment. Your contribution would be valuable to research at the prison and Nottingham Trent University.

Where do I get further information, or whom do I complain to?

If you have any requests for further information, or have any queries then feel free to contact the main researcher (Jackie Hamilton), or a member of the research team through the psychology department. If you have any complaints please contact any member of the research team, or the lead psychologist through the psychology department.

**** You can keep this information sheet for your records ****

Consent Form

What am I consenting to?

- You are consenting to take part in a research study that involves you completing a series of questionnaires. These questionnaires ask about your personality characteristics, sexual thoughts, and past events. This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.
- It is completely your choice if you participate or not. Your decision will not affect your chances of parole or getting treatment or medication. If you take part you will not receive anything, and if you do not take part, you will not lose anything.
- You can stop completing the questionnaires at any point, and do not have to answer individual questions.

Agreement to consent

I have read and understood the purpose of this research and my part in it. I understand that only the research team will have access to my answers (it will not be used by the psychology department or for parole purposes). I am aware that I have 4 weeks to change my mind and ask for my answers to be destroyed.

I consent (agree) to participate:

Signed (or put an X)..... Date

Witnessed Date

Future Research

After this study, the researcher will be conducting some interviews. These interviews will explore personality characteristics and sexual thoughts in more depth. It is entirely your choice whether you might be interested in taking part or not.

If you are happy to be contacted about future research, you may be contacted by Jackie Hamilton via a general app. The researcher will then meet with you and explain the research in more detail.

I consent (agree) to be contacted about future research:

Signed

Debrief Form

**** This form is for you to keep ****

Thank you for participating in this study.

This study looked at how personality characteristics may link with sexual thoughts and urges. The research also looked at how past events may have an impact on this. The aim of this research is to help yourself and others in the future (e.g. to inform future treatment). This study does not aim to diagnose personality disorders, but to explore personality characteristics that may impact an individual's life.

Taking part in this will not have any effect on your chances of parole or the treatment you will receive in prison.

Only the research team will have access to the completed questionnaires. If you consented to being contacted for future research, a member of the team may be in contact in the future.

I will write a report at the end of this study, but nobody will know that you participated. I will also write papers, write my thesis for my PhD, and do presentations. Your name will never be used in any of these.

If you change your mind and would like me to destroy your questionnaire, you have 4 weeks to tell me. You will not get into trouble for this, and you do not need to give me a reason why. You can do this by sending a general app to Jackie Hamilton (psychology department) quoting your Unique ID (see below). All of your information will then be deleted.

Some of the questions are quite personal. If you feel upset you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

The main researcher is Jackie Hamilton, and the rest of the research team consists of Belinda Winder, Nicholas Blagden, Kerensa Hocken and Jason Pandya-Wood (these individuals can all be contacted through the psychology department). If you have any complaints please contact any member of the research team, or the lead psychologist through the psychology department.

Thank You

[Appendix 20: Benjamini-Hochberg procedure results](#)

Appendix 20.1 Benjamini-Hochberg critical values for SIPP-SF domains compared to a general population sample, and a sample of IPSO taking MMPSA

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Self-control vs MMPSA	1	.000	.008
Identity Integration vs general population	2	.000	.017
Relational Capacities vs general population	3	.000	.025
Self-control vs general population	4	.033	.033
Identity Integration vs MMPSA	5	.045	.042
Relational Capacities vs MMPSA	6	.706	.050

Appendix 20.2 Benjamini-Hochberg critical values for SIPP-118 facets compared to a general population sample, PD sample, and a sample of IPSO taking MMPSA

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Emotion regulation vs gen pop	1	.000	.001
Effortful control vs gen pop	2	.000	.002
Stable self-image vs gen pop	3	.000	.003
Self-reflexive functioning vs gen pop	4	.000	.004
Aggression regulation vs gen pop	5	.000	.005
Frustration tolerance vs gen pop	6	.000	.006
Self-respect vs gen pop	7	.000	.007
Purposefulness vs gen pop	8	.000	.008
Enjoyment vs gen pop	9	.000	.009
Feeling recognised vs gen pop	10	.000	.010
Intimacy vs gen pop	11	.000	.012
Enduring relationships vs gen pop	12	.000	.013
Responsible industry vs gen pop	13	.000	.014
Trustworthiness vs gen pop	14	.000	.015
Stable self-image vs PD pop	15	.000	.016
Enjoyment vs PD pop	16	.000	.017
Frustration tolerance vs PD pop	17	.001	.018
Purposefulness vs PD pop	18	.001	.019
Cooperation vs gen pop	19	.007	.020
Intimacy vs PD pop	20	.012	.021
Emotion regulation vs PD pop	21	.014	.022
Self-respect vs PD pop	22	.022	.023
Trustworthiness vs MMPSA pop	23	.024	.024
Cooperation vs PD pop	24	.056	.025
Emotion regulation vs MMPSA pop	25	.075	.026
Responsible industry vs MMPSA pop	26	.079	.027
Respect vs PD pop	27	.106	.028
Self-reflexive functioning vs MMPSA pop	28	.118	.029
Effortful control vs MMPSA pop	29	.127	.030
Cooperation vs MMPSA pop	30	.130	.031
Stable self-image vs MMPSA pop	31	.163	.032
Frustration tolerance vs MMPSA pop	32	.200	.033
Respect vs gen pop	33	.219	.034
Trustworthiness vs PD pop	34	.226	.035
Feeling recognised vs PD pop	35	.272	.037

Respect vs MMPSA pop	36	.302	.038
Aggression regulation vs PD pop	37	.343	.039
Self-reflexive functioning vs PD pop	38	.381	.040
Effortful control vs PD pop	39	.382	.041
Aggression regulation vs MMPSA pop	40	.401	.042
Enjoyment vs MMPSA pop	41	.427	.043
Responsible industry vs PD pop	42	.472	.044
Feeling recognised vs MMPSA pop	43	.611	.045
Intimacy vs MMPSA pop	44	.743	.046
Enduring relationships vs MMPSA pop	45	.828	.047
Self-respect vs MMPSA pop	46	.869	.048
Enduring relationships vs PD pop	47	.888	.049
Purposefulness vs MMPSA pop	48	.978	.050

Appendix 20.3 Benjamini-Hochberg critical values for PID-5-SF domains compared to a general population sample and PD sample.

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Negative affect IPSO vs gen pop	1	.000	.003
Negative affect IPSO vs PD pop	2	.000	.005
Detachment IPSO vs gen pop	3	.000	.008
Detachment IPSO vs PD pop	4	.000	.010
Negative affect IPSO with PD vs gen pop	5	.000	.013
Detachment IPSO with PD vs gen pop	6	.000	.015
Disinhibition IPSO with PD vs gen pop	7	.000	.018
Disinhibition IPSO with PD vs PD pop	8	.007	.020
Psychoticism IPSO with PD vs gen pop	9	.011	.023
Psychoticism IPSO with PD vs PD pop	10	.045	.025
Psychoticism IPSO vs PD pop	11	.053	.028
Disinhibition IPSO vs PD pop	12	.102	.030
Negative Affect IPSO with PD vs PD pop	13	.339	.033
Antagonism IPSO with PD vs gen pop	14	.351	.035
Psychoticism IPSO vs gen pop	15	.386	.038
Detachment IPSO with PD vs PD pop	16	.420	.040
Antagonism IPSO vs PD pop	17	.458	.043
Antagonism IPSO with PD vs PD pop	18	.480	.045
Disinhibition IPSO vs gen pop	19	.499	.048
Antagonism IPSO vs gen pop	20	.741	.050

Appendix 20.4 Benjamini-Hochberg critical values for PID-5-SF personality traits among IPSO compared to a general population sample and PD sample.

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Anxiousness vs gen pop	1	.000	.001
Separation insecurity vs gen pop	2	.000	.002
Intimacy avoidance vs gen pop	3	.000	.003
Depressivity vs gen pop	4	.000	.004
Manipulativeness vs gen pop	5	.000	.005
Grandiosity vs gen pop	6	.000	.006
Irresponsibility vs gen pop	7	.000	.007
Distractibility vs gen pop	8	.000	.008
Risk taking vs gen pop	9	.000	.009

Emotional lability vs PD pop	10	.000	.010
Anxiousness vs PD pop	11	.000	.011
Submissiveness vs PD pop	12	.000	.012
Perseveration vs PD pop	13	.000	.013
Withdrawal vs PD pop	14	.000	.014
Anhedonia vs PD pop	15	.000	.015
Depressivity vs PD pop	16	.000	.016
Distractibility vs PD pop	17	.000	.017
Rigid perfectionism vs PD pop	18	.000	.018
Perceptual dysregulation vs PD pop	19	.000	.019
Suspiciousness vs PD pop	20	.001	.020
Manipulativeness vs PD pop	21	.002	.021
Intimacy avoidance vs PD pop	22	.004	.022
Irresponsibility vs PD pop	23	.006	.023
Callousness vs PD pop	24	.007	.024
Impulsivity vs gen pop	25	.009	.025
Impulsivity vs PD pop	26	.009	.026
Attention seeking vs gen pop	27	.016	.027
Unusual beliefs and experiences vs PD pop	28	.027	.028
Restricted affectivity vs PD pop	29	.029	.029
Separation insecurity vs PD pop	30	.040	.030
Grandiosity vs PD pop	31	.055	.031
Eccentricity vs PD pop	32	.059	.032
Emotional lability vs gen pop	33	.098	.033
Eccentricity vs gen pop	34	.169	.034
Deceitfulness vs PD pop	35	.294	.035
Submissiveness vs gen pop	36	.296	.036
Attention seeking vs PD pop	37	.332	.037
Risk taking vs PD pop	38	.389	.038
Callousness vs gen pop	39	.438	.039
Deceitfulness vs gen pop	40	.490	.040
Unusual beliefs and experiences vs gen pop	41	.519	.041
Suspiciousness vs gen pop	42	.571	.042
Anhedonia vs gen pop	43	.637	.043
Hostility vs gen pop	44	.639	.044
Withdrawal vs gen pop	45	.645	.045
Rigid perfectionism vs gen pop	46	.691	.046
Perseveration vs gen pop	47	.730	.047
Restricted affectivity vs gen pop	48	.824	.048
Hostility vs PD pop	49	.928	.049
Perceptual dysregulation vs gen pop	50	.956	.050

Appendix 20.5 Benjamini-Hochberg critical values for PID-5-SF personality traits among IPSO with PD compared to a general population sample and PD sample.

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Emotional lability vs gen pop	1	.000	.001
Anxiousness vs gen pop	2	.000	.002
Separation insecurity vs gen pop	3	.000	.003
Withdrawal vs gen pop	4	.000	.004
Intimacy avoidance vs gen pop	5	.000	.005
Anhedonia vs gen pop	6	.000	.006
Depressivity vs gen pop	7	.000	.007

Suspiciousness vs gen pop	8	.000	.008
Impulsivity vs gen pop	9	.000	.009
Distractibility vs gen pop	10	.000	.010
Eccentricity vs gen pop	11	.000	.011
Impulsivity vs PD pop	12	.000	.012
Perseveration vs gen pop	13	.001	.013
Grandiosity vs gen pop	14	.001	.014
Irresponsibility vs gen pop	15	.001	.015
Intimacy avoidance PD pop	16	.001	.016
Unusual beliefs and experiences vs PD pop	17	.001	.017
Rigid perfectionism vs gen pop	18	.010	.018
Submissiveness vs PD pop	19	.011	.019
Anhedonia vs PD pop	20	.011	.020
Unusual beliefs and experiences vs gen pop	21	.012	.021
Eccentricity vs PD pop	22	.017	.022
Suspiciousness vs PD pop	23	.019	.023
Callousness vs PD pop	24	.019	.024
Submissiveness vs gen pop	25	.023	.025
Hostility vs gen pop	26	.024	.026
Depressivity vs PD pop	27	.036	.027
Perceptual dysregulation vs gen pop	28	.053	.028
Risk taking vs PD pop	29	.056	.029
Manipulativeness vs gen pop	30	.066	.030
Restricted affectivity vs gen pop	31	.077	.031
Hostility vs PD pop	32	.086	.032
Grandiosity vs PD pop	33	.130	.033
Separation insecurity vs PD pop	34	.131	.034
Callousness vs gen pop	35	.145	.035
Distractibility vs PD pop	36	.180	.036
Perceptual dysregulation vs PD pop	37	.236	.037
Deceitfulness vs gen pop	38	.246	.038
Deceitfulness vs PD pop	39	.324	.039
Anxiousness vs PD pop	40	.334	.040
Manipulativeness vs PD pop	41	.396	.041
Restricted affectivity PD pop	42	.448	.042
Attention seeking vs gen pop	43	.513	.043
Withdrawal vs PD pop	44	.672	.044
Risk taking vs gen pop	45	.684	.045
Perseveration vs PD pop	46	.733	.046
Rigid perfectionism vs PD pop	47	.768	.047
Emotional lability vs PD pop	48	.770	.048
Irresponsibility vs PD pop	49	.775	.049
Attention seeking vs PD pop	50	.886	.050

Appendix 20.6 Benjamini-Hochberg critical values for categorical PDs among IPSO compared to a general population sample an IPSO population sample

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Histrionic vs gen pop	1	.000	.003
Dependent vs gen pop	2	.000	.005
Dependent vs IPSO pop	3	.000	.008
Antisocial vs IPSO pop	4	.000	.010
Obsessive-compulsive vs gen pop	5	.000	.013

Obsessive-compulsive vs IPSO pop	6	.000	.015
Narcissistic vs gen pop	7	.000	.018
Avoidant vs gen pop	8	.000	.020
Borderline vs gen pop	9	.000	.023
Narcissistic vs IPSO pop	10	.000	.025
Schizotypal vs IPSO pop	11	.000	.028
Histrionic vs IPSO pop	12	.000	.030
Borderline vs IPSO pop	13	.000	.033
Schizoid vs gen pop	14	.028	.035
Antisocial vs gen pop	15	.057	.038
Schizotypal vs gen pop	16	.068	.040
Paranoid vs IPSO pop	17	.094	.043
Schizoid vs IPSO pop	18	.227	.045
Avoidant vs IPSO pop	19	.527	.048
Paranoid vs gen pop	20	.536	.050

Appendix 20.7 Benjamini-Hochberg critical values for SCS scores compared to various populations

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Research IPSO total vs MMPSA population	1	.000	.006
IPSO without SP vs male students	2	.000	.011
IPSO without SP vs male IPSO	3	.000	.017
IPSO without SP vs IPSO taking MMPSA	4	.000	.022
IPSO with SP vs male students	5	.000	.028
IPSO with SP vs male IPSO	6	.000	.033
Research IPSO total vs male IPSO	7	.001	.039
Research IPSO total vs male students	8	.008	.044
IPSO with SP vs MMPSA population	9	.027	.050

Appendix 20.8 Benjamini-Hochberg critical values for MPI scores compared to intellectually disabled IPSO

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Whole sample vs medium risk	1	.000	.017
Whole sample vs high risk	2	.000	.033
Whole sample vs very-high risk	3	.000	.005
IPSO with SP vs medium risk	4	.000	.022
IPSO with SP vs high risk	5	.000	.028
IPSO with SP vs very-high risk	6	.000	.033
IPSO without SP vs very-high risk	7	.704	.039
IPSO without SP vs medium risk	8	.852	.044
IPSO without SP vs high risk	9	.892	.050

Appendix 20.9 Benjamini-Hochberg critical values for ACE items compared to a general population sample, IPSO sample and psychiatric sample

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Verbal abuse vs general population	1	.000	.002
Physical abuse vs general population	2	.000	.005
Sexual abuse vs general population	3	.000	.007
Parental separation vs general population	4	.000	.009
Domestic violence vs general population	5	.000	.012

Mental illness vs general population	6	.000	.014
Alcohol abuse vs general population	7	.000	.017
Drug abuse vs general population	8	.000	.019
Physical abuse vs IPSO sample	9	.000	.021
Verbal abuse vs psychiatric sample	10	.000	.024
Physical abuse vs psychiatric sample	11	.000	.026
Incarceration vs general population	12	.002	.029
Verbal abuse vs IPSO sample	13	.002	.031
Domestic violence vs IPSO sample	14	.002	.03
Drug abuse vs IPSO sample	15	.002	.036
Sexual abuse vs IPSO sample	16	.006	.038
Mental illness vs IPSO sample	17	.013	.041
Sexual abuse vs Psychiatric sample	18	.033	.043
Incarceration vs IPSO sample	19	.081	.045
Alcohol abuse vs IPSO sample	20	.138	.048
Parental separation vs IPSO sample	21	.201	.050

Appendix 20.10 Benjamini-Hochberg critical values for categorical PDs among IPSO with SP compared to IPSO without SP

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Borderline	1	.001	.004
Narcissistic	2	.007	.008
Dependent	3	.030	.013
Passive-aggressive	4	.030	.017
Schizotypal	5	.031	.021
Depressive	6	.037	.025
Avoidant	7	.042	.029
Histrionic	8	.086	.033
Antisocial	9	.197	.038
Obsessive-compulsive	10	.232	.042
Paranoid	11	.418	.046
Schizoid	12	.603	.050

Appendix 20.11 Benjamini-Hochberg critical values for the relationship between categorical PDs and SP among IPSO

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Narcissistic	1	.005	.008
Borderline	2	.015	.017
Antisocial	3	.061	.025
Obsessive-compulsive	4	.474	.033
Schizotypal	5	.528	.042
Avoidant	6	.836	.050

Appendix 20.12 Benjamini-Hochberg critical values for SIPP-SF domains among IPSO with SP compared to IPSO without SP

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Self-control	1	.000	.017
Identity integration	2	.000	.033
Relational capacities	3	.006	.050

Appendix 20.13 Benjamini-Hochberg critical values for the relationship between SIPP-SF domains and SP among IPSO

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Self-control	1	.000	.017
Identity integration	2	.019	.033
Relational capacities	3	.183	.050

Appendix 20.14 Benjamini-Hochberg critical values for SIPP-118 domains among IPSO with PD and SP compared to IPSO with PD without SP

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Self-control	1	.000	.010
Responsibility	2	.001	.020
Identity integration	3	.032	.030
Social concordance	4	.155	.040
Relational capacities	5	.324	.050

Appendix 20.15 Benjamini-Hochberg critical values for the relationship between SIPP-118 domains and SP among IPSO with PD

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Self-control	1	.011	.013
Identity integration	2	.192	.025
Social concordance	3	.217	.038
Responsibility	4	.536	.050

Appendix 20.16 Benjamini-Hochberg critical values for SIPP-118 facets among IPSO with PD and SP compared to IPSO with PD without SP

Samples tested	Rank of <i>p</i> value	<i>p</i> value	Benjamini-Hochberg critical value
Emotion regulation	1	.000	.003
Trustworthiness	2	.000	.006
Responsible industry	3	.003	.009
Effortful control	4	.007	.013
Aggression regulation	5	.008	.017
Cooperation	6	.008	.019
Self-reflexive functioning	7	.009	.022
Purposefulness	8	.014	.025
Self-respect	9	.021	.028

Frustration tolerance	10	.030	.031
Respect	11	.136	.034
Stable self-image	12	.145	.038
Feeling recognised	13	.199	.041
Enjoyment	14	.245	.044
Enduring relationships	15	.327	.047
Intimacy	16	.424	.050

Appendix 20.17 Benjamini-Hochberg critical values for the relationship between SIPP-118 facets (relating to the self-control domain) and SP among IPSO with PD

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Emotion regulation	1	.000	.025
Effortful control	2	.868	.050

Appendix 20.18 Benjamini-Hochberg critical values for PID-5-SF domains among IPSO with SP compared to IPSO without SP

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Negative Affect	1	.000	.010
Antagonism	2	.000	.020
Disinhibition	3	.000	.030
Psychoticism	4	.000	.040
Detachment	5	.001	.050

Appendix 20.19 Benjamini-Hochberg critical values for the relationship between PID-5-SF domains and SP

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Antagonism	1	.000	.010
Negative Affect	2	.012	.020
Disinhibition	3	.077	.030
Detachment	4	.421	.040
Psychoticism	5	.513	.050

Appendix 20.20 Benjamini-Hochberg critical values for pathological personality traits among IPSO with SP compared to IPSO without SP

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Emotional lability	1	.000	.002
Anxiousness	2	.000	.004
Separation insecurity	3	.000	.006
Submissiveness	4	.000	.008
Hostility	5	.000	.010
Perseveration	6	.000	.012
Anhedonia	7	.000	.014
Depressivity	8	.000	.016
Manipulativeness	9	.000	.018
Deceitfulness	10	.000	.020
Grandiosity	11	.000	.022
Attention seeking	12	.000	.024

Callousness	13	.000	.026
Irresponsibility	14	.000	.028
Impulsivity	15	.000	.030
Distractibility	16	.000	.032
Risk taking	17	.000	.034
Rigid perfectionism	18	.000	.036
Unusual beliefs and experiences	19	.000	.038
Eccentricity	20	.000	.040
Perceptual dysregulation	21	.000	.042
Suspiciousness	22	.002	.044
Withdrawal	23	.010	.046
Restricted affectivity	24	.018	.048
Intimacy avoidance	25	.875	.050

Appendix 20.21 Benjamini-Hochberg critical values for the relationship between pathological personality traits (relating to the antagonism domain) and SP among IPSO

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Grandiosity	1	.001	.017
Deceitfulness	2	.003	.033
Manipulativeness	3	.447	.050

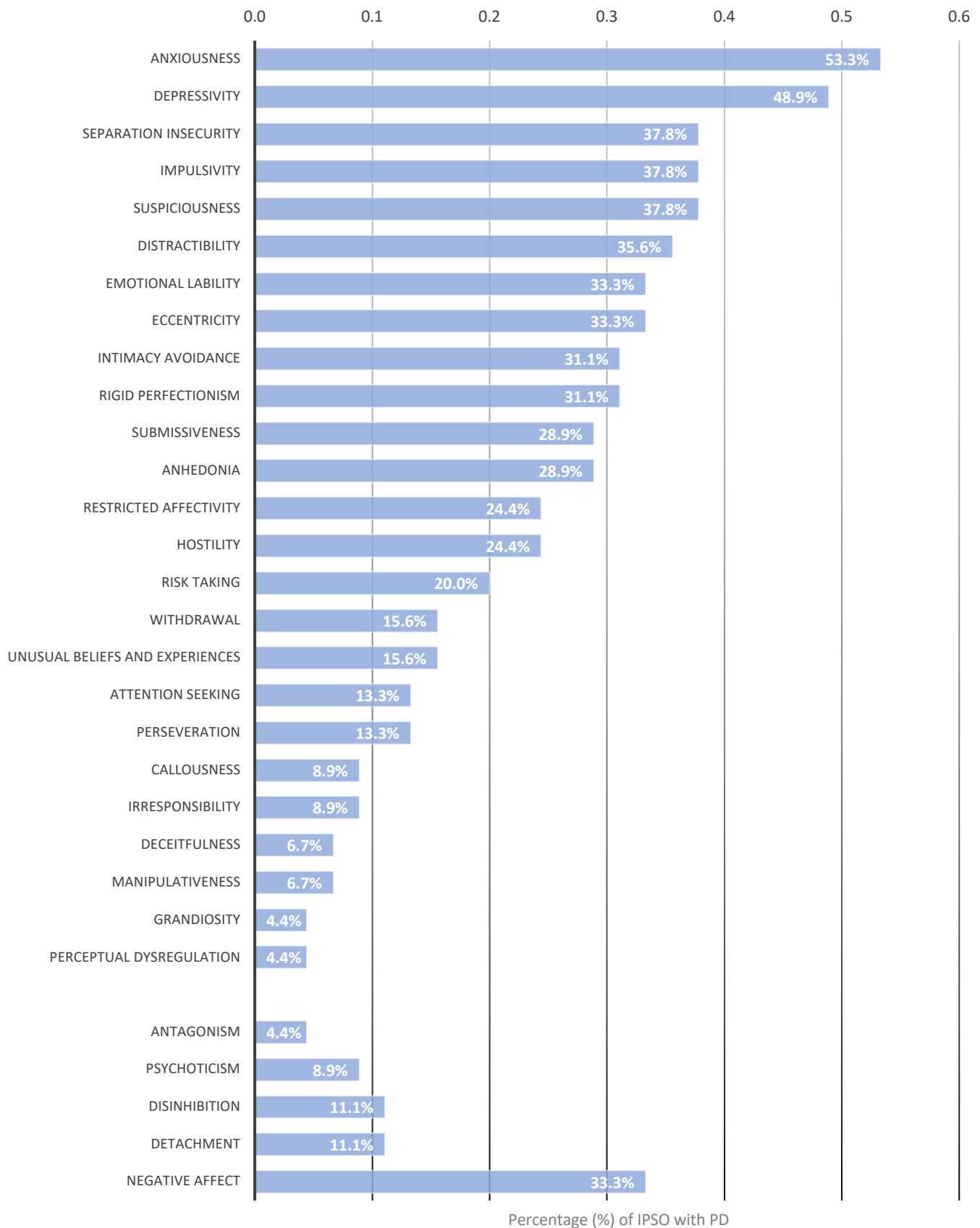
Appendix 20.22 Benjamini-Hochberg critical values for the relationship between pathological personality traits (relating to the negative affect domain) and SP among IPSO

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Emotion lability	1	.000	.017
Separation insecurity	2	.023	.033
Anxiousness	3	.422	.050

Appendix 20.23 Benjamini-Hochberg critical values for the relationship between pathological personality traits (relating to borderline PD) and SP among IPSO

Samples tested	Rank of p value	p value	Benjamini-Hochberg critical value
Separation Insecurity	1	.005	.007
Hostility	2	.100	.014
Impulsivity	3	.119	.021
Emotion Lability	4	.253	.029
Risk-taking	5	.417	.036
Depressivity	6	.433	.043
Anxiousness	7	.874	.050

Appendix 21: The percentage of IPSO with PD that demonstrate elevated pathological personality traits and domains



[Appendix 22: One sample t-tests comparing pathological personality traits \(PID-5-SF\) of IPSO with PD to a general population sample and PD sample](#)

PID-5-SF Traits	Personality (IPSO with PD) (n = 45)	General Population (n = 264)			PD Population (n = 101)		
		M (SD)	M (SD)	t (df)	p	M (SD)	t (df)
Emotional lability	1.52 (.76)	.94 (.74)	5.09 (44)	.000***	1.55 (.72)	-.29 (44)	NS
Anxiousness	1.93 (.64)	1.02 (.73)	9.57 (44)	.000***	1.84 (.66)	.98 (44)	NS
Separation insecurity	1.45 (.85)	.80 (.68)	5.08 (44)	.000***	1.25 (.84)	1.54 (44)	NS
Submissiveness	1.41 (.67)	1.17 (.66)	2.36 (44)	.023*	1.67 (.84)	-2.65 (44)	.011*
Hostility	1.19 (.80)	.91 (.67)	2.34 (44)	.024*	.98 (.60)	1.76 (44)	NS
Perseveration	1.22 (.71)	.82 (.62)	3.72 (44)	.001***	1.18 (.54)	.34 (44)	NS
Withdrawal	1.39 (.65)	1.01 (.72)	3.93 (44)	.000***	1.43 (.67)	-.43 (44)	NS
Intimacy avoidance	1.34 (.93)	.61 (.65)	5.27 (44)	.000***	.83 (.76)	3.69 (44)	.001***
Anhedonia	1.41 (.77)	.89 (.64)	4.49 (44)	.000***	1.71 (.63)	-2.65 (44)	.011*
Depressivity	1.73 (.79)	.53 (.62)	10.16 (44)	.000***	1.47 (.74)	2.16 (44)	.036***
Restricted affectivity	1.18 (.77)	.97 (.56)	1.81 (44)	NS	1.09 (.69)	.77 (44)	NS
Suspiciousness	1.48 (.78)	.95 (.58)	4.60 (44)	.000***	1.20 (.66)	2.44 (44)	.019*
Manipulativeness	.62 (.65)	.80 (.67)	-1.89 (44)	NS	.70 (.66)	-.86 (44)	NS
Deceitfulness	.66 (.75)	.53 (.54)	1.18 (44)	NS	.55 (.49)	1.00 (44)	NS
Grandiosity	.47 (.64)	.82 (.58)	-3.68 (44)	.001***	.32 (.39)	1.54 (44)	NS
Attention seeking	.74 (.75)	.81 (.65)	-.66 (44)	NS	.72 (.58)	.14 (44)	NS
Callousness	.57 (.78)	.40 (.50)	1.48 (44)	NS	.29 (.39)	2.43 (44)	.019*

Irresponsibility	.76 (.73)	.39 (.49)	3.43 (44)	.001***	.73 (.51)	.29 (44)	NS
Impulsivity	1.38 (.97)	.77 (.57)	4.25 (44)	.000***	.77 (.66)	4.25 (44)	.000***
Distractibility	1.59 (.71)	.82 (.69)	7.30 (44)	.000***	1.45 (.78)	1.36 (44)	NS
Risk taking	1.10 (.82)	1.05 (.51)	.41 (44)	NS	.86 (.41)	2.00 (44)	NS
Rigid perfectionism	1.41 (.88)	1.06 (.68)	2.68 (44)	.010**	1.45 (.71)	-3.00 (44)	NS
Unusual beliefs and experiences	.96 (.82)	.64 (.63)	2.61 (44)	.012*	.54 (.56)	3.43 (44)	.001***
Eccentricity	1.38 (.56)	.82 (.76)	4.36 (44)	.000***	1.06 (.75)	2.48 (44)	.017*
Perceptual dysregulation	.63 (.65)	.44 (.48)	2.00 (44)	NS	.75 (.57)	-1.2 (44)	NS

Note. Significant at *.05 level, **.01 level, ***.001 level. PID-5-SF = Personality Inventory for DSM-5 Short Form; IPSO = individual who has previously sexually offended; PD = personality disorder. Higher scores indicate greater pathology.

[Appendix 23: Clinical measures of sexual preoccupation](#)

Clinical measures of sexual preoccupation

In line with the MMPSA service and corresponding research evaluation, several self-reported measures of sexual thoughts were asked during study 3, as proposed by Grubin (2008), as a way of triangulating the data with the SCS score, to ensure that SP was being measured. SP was assessed by the following questions: 'How much time do you spend thinking about sex?' (responses collated on a 7-point Likert scale; 1 = very little, 7 = all the time), 'What is the strength of your sexual urges and fantasies' (1 = low, 7 = high), and 'What is your ability to distract yourself from these sexual thoughts' (1 = easy, 7 = difficult).

Data were triangulated with the SCS scores and cross verification of the data was conducted. Pearson's correlations demonstrated that SCS scores were significantly correlated with all clinical measures: time spent thinking about sex ($r = .63, p < .001$), strength of sexual urges and fantasies ($r = .60, p < .001$), and ability to distract from sexual thoughts ($r = .55, p < .001$). These results are similar to what has been found by Winder et al. (2019) when looking at IPSO who take MMPSA. Similar coefficients were found for the MPI and clinical measures, but for the sake of brevity only SCS correlations have been reported here.

[Appendix 24: Correlation and multiple regression analyses for the interactions between borderline PD traits and SP among IPSO](#)

Borderline PD Traits	Correlation		Regression			
	<i>R</i>	<i>B</i>	<i>SE</i>	β	95% CI for <i>b</i>	
					Lower	Upper
Anxiousness	.44**	-.14	.88	-.02	-1.87	1.59
Depressivity	.45**	-.64	.81	.08	-.96	2.24
Emotion lability	.51**	1.01	.88	.12	-.73	2.74
Hostility	.51**	1.53	.92	.17	-.30	3.35
Impulsivity	.52**	1.36	.87	.17	-.35	3.07
Risk-taking	.49**	.84	1.04	.09	-1.21	2.90
Separation insecurity	.46**	1.59*	.76	.19	.10	3.09

Note. IPSO = individual who has previously sexually offended; SP = sexual preoccupation; PD = personality disorder; *r* = Pearson's correlation coefficient; *b* = unstandardized coefficient; *SE* = standard error; β = beta; CI = confidence intervals. Significant at *.05 level, **.01 level, ***.001 level.

Information Sheet

You are being invited to take part in a research study. It is being conducted by a PhD student (Jackie Hamilton) from Nottingham Trent University.

The decision to take part in the research is completely up to you. If you take part you will not receive anything, and if you do not take part, you will not lose anything. Taking part will not affect your chances of parole or getting treatment or medication in prison.

This study is part of a wider research project; you have already participated in two stages of the research, and left your contact details for this study.

What is the research about?

The previous studies looked at how personality characteristics may link with sexual thoughts and urges, and how past events may have an impact on this.

This current study looks at your life story, and how events throughout your life have had an impact, and what this means to you.

You have been selected to participate because in earlier studies you showed personality characteristics that may make it difficult to get on with other people, problematic sexual thoughts and behaviours, and past childhood events.

The aim of this research is to learn about your life, and what past events are meaningful to you. The research also aims to help yourself and others in the future (e.g. to inform future treatment). This study does not aim to diagnose personality disorders, but to explore personality characteristics and past events that may have affected your life.

What would you be asked to do?

If you agree to take part in this study you will complete an interview with the main researcher (Jackie Hamilton). This will be done in a private assessment room. The interview will look at your whole life, and you will be asked to talk about important events in your life (such as; a high point, low point, turning point etc.). It will give you an opportunity to talk about your life in your own words. The interview will be recorded on a Dictaphone. This style of interview can take anywhere from 2-4 hours. It can be completed over one, two, or three sessions. You can have a break or stop the interview at any time.

What happens to the information you give to me?

The audio file will be put onto a password protected computer, in a password protected folder. It will be erased from the Dictaphone. The researcher will listen to the interview and type it onto a computer, and store it securely. **Only** the research team* will have access to this information. It will be used for research purposes **only**. Information will not be used by the psychology department at HMP Whatton or for parole purposes. Consent forms will be stored in a locked filing cabinet at the prison.

All information will be kept private, unless:

- You tell me that you want to harm yourself.
- You tell me that someone else is at risk of being harmed.
- You tell me information about an offence, which you have not been convicted for (like the name of a victim and when the offence happened).

*Jackie Hamilton, Belinda Winder, Nicholas Blagden, Kerensa Hocken and Jason Pandya-Wood

- You tell me any information relating to being a victim of an offence which hasn't yet been reported to the authorities.
- You tell me information about plans to escape prison or break prison rules.

If you mention any of these things to me, I will have to pass the information on to prison security, wing staff or the police.

I will write a report at the end of this study. This report will not mention your name and nobody will know that you participated in the research (any names or locations you mention in the interview will not be used). I will use the data to write up my PhD, and for presentations. The data will be kept for five years, and then will be destroyed.

What happens if I do not want to take part anymore?

You can stop the interview at any time without giving any reason. You can also choose not to answer specific parts of the interview if you don't want to.

If you change your mind and would like me to delete the interview, you have 4 weeks from the last interview to let me know. You will not get into trouble for this, and you do not need to give me a reason. The debrief form will provide you with further information.

Are there any risks to me if I participate in this research?

Some of the topics are quite personal, which may result in you becoming upset or distressed. Remember, you can stop at any point and can choose not to answer specific questions. If you feel upset/distressed, you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

Are there any benefits to me if I take part in this research?

While there may not be any direct benefits, you might find the interview interesting to complete. Hopefully, the results will help to inform future treatment. Your contribution would be valuable to research at the prison and Nottingham Trent University.

Where do I get further information, or whom do I complain to?

If you have any requests for further information, or have any queries then feel free to contact the main researcher (Jackie Hamilton), or a member of the research team through the psychology department at HMP Whatton. If you have any complaints please contact any member of the research team, or the lead psychologist through the psychology department at HMP Whatton.

Consent Form

What am I consenting to?

You are consenting to take part in a research study that involves you completing an interview with the main researcher (Jackie Hamilton). This interview looks at your life story, and how events throughout your life have had an impact, and what this means to you. This study does not aim to diagnose personality disorders, but to explore personality characteristics and past events that may have affected your life.

You have been selected to participate because in earlier studies you showed personality characteristics that may make it difficult to get on with other people, problematic sexual thoughts and behaviours, and past childhood events.

It is completely your choice if you participate or not. Your decision will not affect your chances of parole or getting treatment or medication. If you take part you will not receive anything, and if you do not take part, you will not lose anything.

The interview can take anywhere from 2-4 hours. It can be completed over one, two, or three sessions. The interview will be recorded using a Dictaphone. You can stop completing the interview at any point, and do not have to answer specific parts of the interview if you choose not to.

Agreement to consent

I understand that only the research team will have access to my answers (it will not be used by the psychology department at HMP Whatton or for parole purposes).

I am aware that I have 4 weeks from the last interview to change my mind and ask for my answers to be destroyed.

I confirm that I understand and accept the terms set out in the information sheet

I consent (agree) to participate:

Signed (or put an X)..... Date

Debrief Form

Thank you for participating in this study.

This study looked at your life story, and how events throughout your life have had an impact, and what this means to you. The aim of this research is to learn about your life, and what past events are meaningful to you. The research also aims to help yourself and others in the future (e.g. to inform future treatment). This study does not aim to diagnose personality disorders, but to explore personality characteristics and past events that may have affected your life. Taking part in this will not have any effect on your chances of parole or the treatment you will receive in prison.

Only the research team will have access to your interview. I will write a report at the end of this study. This report will not mention your name and nobody will know that you participated (any names or locations you mention in the interview will not be used). I will use the data to write up my PhD, and for presentations. The data will be kept for five years, and then will be destroyed.

If you change your mind and would like me to destroy your interview, you have 4 weeks *from the last interview*[insert date]..... to tell me. You will not get into trouble for this, and you do not need to give me a reason why. You can do this by sending a general app to Jackie Hamilton (psychology department at HMP Whatton) quoting your Unique ID (see below). Please keep the information and debrief forms until this date has passed, in case you change your mind. All of your information will then be deleted.

Some of the topics covered are quite personal. If you feel upset you should contact a member of your wing staff or use one of these services;

- *Support Volunteers* – have a look on the notice boards or ask wing staff if you are not sure who these are on your wing.
- *Listeners* – you can ask wing staff if you need to speak to a listener.
- *Counselling Psychology Service* – put an application in and speak to one of the team.

The main researcher is Jackie Hamilton, and the rest of the research team consists of Belinda Winder, Nicholas Blagden, Kerensa Hocken and Jason Pandya-Wood (these individuals can be contacted through the psychology department at HMP Whatton). If you have any complaints please contact any member of the research team, or the lead psychologist through the psychology department at HMP Whatton.

Thank You



Statement of impact: Jackie Hamilton's research in contribution to the development of the ACORN service (an offender personality disorder outreach service for individuals who have offended sexually in a category C prison).

The ACORN service is the first offender personality disorder service designed specifically for individuals who have offended sexually. Based at HMP Whatton, our core values include using good quality evidence to support the development of assessments and interventions that will support our population in managing problematic personality traits.

Jackie was kind enough to share her research findings with us while we were developing our service. Her research was invaluable in informing our understanding of the needs of our population, in particular Jackie's findings demonstrated:

- The prevalence of adverse early experiences in the population, and the associated need for trauma-focussed therapies. Jackie's research highlighted the prevalence and diversity of adverse childhood experiences in the population, and the association with problematic personality traits. This evidence contributed to our decision to invest in eye-movement desensitisation and reprocessing therapy (EMDR) training for our staff, as well as schema therapy training, in order to address the needs of our population.
- The nature and diversity of problematic personality traits within the population. Jackie's research highlighted the variety of problematic personality traits in our population, in particular the prevalence of personality traits associated with over-controlled profiles. This was invaluable in our decision to include therapies specifically designed for over-control (radically open dialectical behavioural therapy) as an aspect of our stabilisation (or emotion regulation) phase.
- The utility of the Severity Indices of Personality Problems (SIPP) as a dynamic assessment of problematic personality traits. In selecting core psychometrics for our service, we were very conscious of the need to identify meaningful assessments without unnecessarily burdening our service-users. Jackie's research really showed the utility of the SIPP, and it is now included as one of our baseline psychometric assessments.

The nature of Jackie's research was particularly relevant to the development of our service, and we are very grateful to her for sharing her findings.

Dr Kathleen Green (HCPC registered forensic psychologist, ~~C~~Psychol)

Joint Clinical Lead – ACORN service

A handwritten signature in black ink, appearing to read "Kathleen Green", is written over a horizontal line.