

**Navigating MMPSA: Understanding the Experiences of Individuals
Convicted of Sexual Offences Taking Medication to Manage Problematic
Sexual Arousal**

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Author Publications

Author publications from this thesis

Journal articles

Lievesley, R., Elliott, H. J., Winder, B., & Norman, C. (2014). Understanding service users' and therapists' experiences of pharmacological treatment for sexual preoccupation and/or hypersexuality in incarcerated sex offenders. *The Journal of Forensic Psychiatry & Psychology*, 25(3), 262-287.

Lievesley, R., Winder, B., Elliott, H., Kaul, A., Thorne, J., & Hocken, K. (2013). The use of medication to treat sexual preoccupation and hypersexuality in sexual offenders. *Prison Service Journal*, 208, 17-25.

Conference oral presentations

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Winder, B., Faulkner, J., Lievesley, R., Elliott, H., & Norman, C. (2017, September). *Evaluation of the use of medication to manage sexual arousal (MMSA) with individuals convicted of a sexual offence*. Invited workshop presented at the 20th Annual BASHH SAS Doctors' Conference. Keele, UK.

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- Winder, B., Lievesley, R., Elliott, H., Norman, C., Hocken, J., Kaul, A., & Faulkner, J. (2016, November). *Evaluation of the use of anti-androgen and SSRI medication to reduce sexual preoccupation and compulsivity with convicted adult male sexual offenders*. Paper presented at the Association for the Treatment of Sexual Abusers (ATSA) Annual Conference. Orlando, FL, USA.
- Elliott, H., Lievesley, R., Winder, B., & Norman, C. (2014, October). *The utility of qualitative methods in the evaluation of pharmacological treatment for convicted male sexual offenders*. Paper presented at the Association for the Treatment of Sexual Abusers (ATSA) Annual Conference. San Diego, CA, USA.
- Lievesley, R., Winder, B., & Elliott, H. (2014, October). *Understanding the pharmacological treatment of sexual offenders: A service user perspective*. Paper presented at the Association for the Treatment of Sexual Abusers (ATSA) Annual Conference. San Diego, CA, USA.
- Lievesley, R., Winder, B., & Elliott, H. (2014, September). *Understanding the pharmacological treatment of sexual offenders: A service user perspective*. Paper presented at the International Association for the Treatment of Sexual Offenders (IATSO) Conference. Porto, Portugal.
- Winder, B., Hocken, K., Lievesley, R., Elliott, H., Norman, C., & Payne, N. (2013, October). *Evaluation of the use of anti-libidinal medication with convicted sex offenders with high levels of sexual preoccupation*. Paper presented at the Association for the Treatment of Sexual Abusers (ATSA) Annual Conference. Chicago, IL.
- Lievesley, R., Elliott, H., Winder, B., Norman, C., Kaul, A., Hocken, K., Thorne, K., & Hamilton, L. (2012, September). *Understanding sexual preoccupation and the pharmacological treatment of it: Service user and staff perspectives*. Paper presented at the International Association for the Treatment of Sexual Offenders (IATSO) Conference. Berlin, Germany.

Conference poster presentations

- Lievesley, R., Norman, C., & Winder, B. (2018, August). *Understanding the journeys of individuals taking antilibidinal medication to manage their sexual preoccupation and hypersexuality: A case study approach*. Poster presentation at the International Association for the Treatment of Sexual Offenders (IATSO) Conference. Vilnius, Lithuania.
- Lievesley, R., Winder, B., Kaul, A., Hamilton, L., Hocken, K., & Thorne, K. (2012, September). *Impact of pharmacological treatment on sexual preoccupation: a service user experience*. Poster presentation at the International Association for the Treatment of Sexual Offenders (IATSO) Conference. Berlin, Germany.

Lievesley, R., Winder, B., Kaul, A., Hocken, K., Hamilton, L., & Thorne, K. (2012, July). *Impact of pharmacological treatment on sexual preoccupation: a service user experience*. Poster presentation at the Qualitative Research on Mental Health Conference. Nottingham, UK.

Lievesley, R., Winder, B., Kaul, A., Hocken, K., Hamilton, L., & Thorne, K. (2012, March). *Impact of pharmacological treatment on sexual preoccupation: A service user experience*. Poster presentation at the Mental Health Research Network Annual Research Meeting. Nottingham, UK.

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Elliott, H., Winder, B., Manby, E., Edwards, H., & Lievesley, R. (2018). "I kind of find that out by accident": Probation staff experiences of pharmacological treatment for sexual preoccupation and hypersexuality. *Journal of Forensic Practice*, 20(1), 20-31.

Winder, B., Lievesley, R., Elliott, H., Hocken, K., Faulkner, J., Norman, C., & Kaul, A. (2018). Evaluation of the use of pharmacological treatment with prisoners experiencing high levels of hypersexual disorder. *The Journal of Forensic Psychiatry & Psychology*, 29(1), 53-71.

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Winder, B., Lievesley, R., Elliott, H. J., Norman, C., & Kaul, A. (2014). Understanding the journeys of high risk male sex offenders voluntarily receiving medication to reduce their sexual preoccupation and / or hypersexuality. In D. T. Wilcox, T. Garrett, & L. Harkin, (Eds.), *Sex offender treatment: A case study approach to issues and interventions* (pp. 342-370). Chichester, UK: Wiley & Sons Ltd.

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Blagden, N., Winder, B., & Lievesley, R. (2019). "The resurrection after the old has gone and the new has come": Understanding narratives of forgiveness, redemption and resurrection in Christian individuals serving time in custody for a sexual offence. *Psychology, Crime & Law*. Paper in press.

Lievesley, R., Teicher, S., & Smith, L. (2019). Forensic psychology. In P. Banyard, C. Norman, G. Dillon, & B. Winder (Eds.), *Essential psychology* (3rd edition). London, UK: Sage.

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- Goodier, S., & Lievesley, R. (2018). Understanding the needs of individuals at risk of perpetrating child sexual abuse: A practitioner perspective. *Journal of Forensic Psychology Research and Practice*, *18*(1), 77-98.
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Abstract

Problematic sexual arousal (PSA) has been identified as a profound wellbeing issue, as well as a significant risk factor for sexual offending. However, psychological treatment programmes for individuals convicted of sexual offences (ICSOs) do not directly address PSA, potentially resulting in treatment needs relating to this being left unmet. As a result, in 2007 protocols were established within the UK to allow the voluntary pharmacological treatment of ICSOs, alongside psychological treatment, to assist with the management of PSA. This treatment was initially piloted at HMP Whatton before being rolled out as a national treatment pathway with the service termed medication to manage problematic sexual arousal (MMPSA).

This thesis presents one strand of the evaluation of this pilot project and explores the lived experiences of ICSOs on this treatment pathway. Specifically, it aimed to understand the development, awareness and management of PSA in ICSOs, explore the lived experiences of those taking MMPSA, explore the nuanced pathways of MMPSA treatment, and consider the potential implications of these experiences in relation to the use of MMPSA with ICSOs.

Study 1 ($N = 21$) uncovered themes related to early sexual experiences, the various functions of sex and the processes of escalation that led to the recognition that participants' sexual arousal levels were problematic. This escalation led participants to make a decision to address their PSA for various reasons, leading to the decision to engage with the MMPSA service. The subsequent studies explored the lived experiences of ICSOs while they were taking different form of MMPSA, namely, selective serotonin reuptake inhibitors (SSRIs; Study 2; $N = 13$) and anti-androgens (Study 3; $N = 10$). While there were some similarities in their experiences, the analyses elicited findings that highlight the differences in relation to their initial motivations, experiences of positive and negative medication effects, and their apparent intentions to continue taking their prescribed medications following release. Study 4 further explored the nuanced treatment journeys that individuals must navigate through MMPSA, establishing six distinct pathways through an analysis of the full clinical evaluation dataset ($N = 139$).

The work in this thesis is original, making important contributions to knowledge in this area, as it represents the first phenomenological analysis of the lived experiences of ICSOs taking MMPSA. In doing so, it complements the quantitative evaluation work by providing an additional depth of analysis that is not possible through purely quantitative analyses. Towards the end of the thesis, various recommendations are made about the effective and ethical use of MMPSA. The limitations of this work are also identified, as are opportunities for further research to understand the lived experiences of ICSOs on this developing treatment pathway.

Chapter 1

Introduction

Problematic sexual arousal (PSA; used here to encompass a number of terms related to problematic, excessive or intense sexual thoughts and / or behaviours, such as sexual preoccupation and hypersexuality) has been identified as a key risk factor for both first time sexual offending (Finkelhor, 1984; Seto, 2019; Ward & Beech, 2017) and sexual, violent and general recidivism among individuals convicted of sexual offences (ICSOs) (Hanson & Morton-Bourgon, 2004; Hanson & Harris, 2000; Hanson, Harris, Scott, & Helmus, 2007; Knight & Thornton, 2007). Despite this, psychological treatment programmes, which are accepted as the standard method of treatment for ICSOs, do not directly address PSA, potentially resulting in treatment needs relating to this being left unmet. Furthermore, PSA can impact upon individuals' ability to focus or participate effectively in treatment programmes, or apply the relevant management techniques (Grubin, 2018; Saleh, Grudzinskas, Malin, & Dwyer, 2010) potentially impacting upon treatment effectiveness. This treatment 'gap' led to the suggestion that pharmacological treatment could provide a useful supplement to psychological treatment based on the promising results observed in those with sexual disorders and paraphilic sexual interests (Bradford & Kaye, 1999; Guay, 2009). It was therefore considered that pharmacological treatment could be used to assist individuals to reduce symptoms associated with PSA and facilitate learning within psychological treatment programmes (Grubin, 2017; Saleh et al., 2010).

Consequently, in 2007 protocols were established within the UK to allow the pharmacological treatment of ICSOs (within the care of Her Majesty's Prison and Probation Service; HMPPS) on a voluntary basis (Home Office, 2007). This began with HMPPS facilitating a three year pilot trial at HMP Whatton for the use of pharmacological treatment of ICSOs (Lievesley et al., 2013). Due to promising results in relation to the effectiveness of these medications (as measured by changes on clinical scales of hypersexuality and sexual preoccupation; Winder et al., 2014; 2018), this treatment was embedded as a formal treatment option and later rolled out as a treatment pathway across the prison estate. As such, numerous sites specifically housing ICSOs now offer this treatment option, with the service later termed medication to manage problematic sexual arousal (MMPSA). Critics have argued that using medical interventions such as this with ICSOs diminishes the acceptance of responsibility for sexual offending (Meyer & Cole, 1997). However, MMPSA is viewed as a supplement to psychological treatment programmes rather than an alternative, and thus the prescribing of medication 'needs to happen in combination with psychological treatment to help people understand their sexual thoughts and to challenge deviant thought processes' (Home Office, 2007, p. 14; see also Grubin, 2018).

Research context

MMPSA service at HMP Whatton

The MMPSA service has been offered at HMP Whatton since 2009, with 183 individuals having been referred for the service to date (data correct as at March 2019). The criteria for referral, as outlined by HMPPS (2008), includes evidence of one or more of the following:

- hyper-arousal (e.g., frequent sexual rumination, sexual preoccupation, difficulties in controlling sexual arousal, high levels of sexual behaviour),
- intrusive sexual fantasies or urges,
- sexual urges that are difficult to control, or
- sexual sadism or other dangerous paraphilias, or highly repetitive paraphilic offending such as voyeurism or exhibitionism.

The service involves two main classes of medication: Selective Serotonin Reuptake Inhibitors (SSRIs; most commonly Fluoxetine), and testosterone lowering agents (anti-androgens such as Cyproterone Acetate (CPA) and Gonadotropin Releasing Hormone (GnRH) agonists). In brief, SSRIs have a traditional targeted use in the treatment of depression (Jakubovski, Varigonda, Freemantle, Taylor, & Bloch, 2015), and act by increasing the levels of the neurotransmitter serotonin in the brain. This has been reported to reduce dopaminergic activity in the limbic system, which in turn regulates goal-directed behaviours (Grubin, 2018; Pfaus, 2002). SSRIs are documented to reduce deviant sexual behaviours in patients with various paraphilias (Kafka & Hennen, 2000), the intensity of sexual fantasies and obsessions (Adi et al., 2002), and general levels of sex drive and deviant sexual behaviour among ICSOs (Garcia & Thibaut, 2011).

Anti-androgens act as a direct antagonist, blocking androgen receptors, resulting in reduced production and release of testosterone from the testes, as well as preventing the release of gonadotrophins which further inhibits testosterone secretion (Grubin, 2018; Jeffcoate, Matthews, Edwards, Field, & Besser, 1980; Maletzky & Field, 2003). This effect has been found to moderate sex drive (Thibaut et al., 2010) and, as such, has a well-researched evidence base for treating sexual disorders (Briken & Kafka, 2007; Cooper, 1981; Garcia & Thibaut, 2011; Jordan, Fromberger, Stolpmann, & Müller, 2011; Khan et al., 2015; Laschet & Laschet, 1975). Similarly, GnRH agonists also work by reducing levels of testosterone which is evidenced to reduce symptoms associated with sexual preoccupation and hypersexuality (Bradford & Pawlak, 1993; Thibaut et al., 2010).

However, much of the research evidence documented above has been conducted with individuals with paraphilias, and the evidence base for the use of MMPSA in ICSOs is considered to be

somewhat lacking (e.g. Khan et al., 2015). As a result, in a systematic review exploring the effectiveness of treatment for ICSOs, there were no reported studies on pharmacological treatment due to them not meeting the review criteria (a soundly matched control group or robust control for potential biases; Schmucker & Lösel, 2017). As such, while the research thus far demonstrates largely positive results of MMPSA, the findings are considered to be inconclusive, with a recognised need for more research (Grubin, 2007; Guay, 2009). This identified need for more research into the use of MMPSA led to the development of a mixed methods programme of research at HMP Whatton to provide a thorough evaluation of the service. This is outlined below.

The evaluation

In order to understand if or how MMPSA reduces PSA, improves responsivity to psychological treatments and reduces consequent sexual reoffending, the impact of the MMPSA is being evaluated. A comprehensive mixed methods programme of research commenced in 2010 and is being conducted by the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) in the Department of Psychology at Nottingham Trent University. The research reported in the current thesis forms part of this evaluation.

Quantitative research allows for investigation via statistical, mathematical or computational techniques (for a discussion of different approaches to statistical analyses in the social sciences, see Baguley, 2012). Data are numerical in nature and used to produce unbiased results which may be generalised to a wider population. This method has been used to investigate the effects of the medication within the current evaluation programme. This strand relies on large scale analyses of nomothetic (group-based) data in order to understand the relative effects of MMPSA on clinical measures of PSA as well as various psychometric measures (for a full list of the measures and results to date, see Lievesley et al., 2013; Winder et al., 2014; 2018). While the evaluation is ongoing, initial analyses of this clinical data appear positive with the treatment pathway contributing to significant reductions in measures of PSA, including hypersexuality (operationalised as masturbatory activity) and sexual preoccupation (operationalised as the amount of time spent thinking about sex, strength and intrusiveness of sexual thoughts) (Winder et al., 2014; 2018). While the author of this thesis has been involved in the full evaluation from initial design and set up, and is subsequently involved in these quantitative analyses, this element of the evaluation is led by Professor Belinda Winder and thus does not constitute part of this thesis.

Previous research, as well as the quantitative evaluation strand outlined above, is largely focused on investigating the clinical effectiveness of MMPSA in reducing measures of PSA, either by comparing those taking different forms of MMPSA or by comparing medicated and unmedicated

individuals. While this type of research is useful in eliciting findings regarding effectiveness at the global level (e.g. Khan et al., 2015), it does not consider service user perspectives, and thus there is a notable absence of research that considers the subjective lived experiences of those taking MMPSA. However, service user perspectives are considered vital in the research and evaluation of treatment interventions (Kolind, 2007; NICE, 2011), as evidence about what might be considered to be the most effective intervention for a particular health issue is to some degree irrelevant if service users are not willing to engage with or take it (e.g. Wilson, Vitousek, & Loeb, 2000). This is particularly important in relation to MMPSA, as the 'treatment is in the pill form and administered by the offender' (Harrison, 2008, p. 2). In the broader context of ethical concerns about the use of pharmacological treatments for ICSOs (particularly when treatment is mandated; Harrison, 2008), the potentially serious side effects of the medications (e.g. Lippi & van Staden, 2017) and what is considered an inconclusive evidence base for medication use with ICSOs for this purpose (e.g. Khan et al., 2015), understanding the lived experiences of ICSOs prescribed MMPSA becomes vital. These experiences are important to understand as they may be linked, for example, to engagement concerns such as treatment non compliance and drop-out that cannot be fully understood through quantitative research.

Qualitative methods are able to address this deficit in knowledge and understanding, becoming increasingly recognised for their ability to 'tell the program's story by capturing and communicating the participants stories' (Patton, 2002, p. 2). As such, this thesis is less concerned with the specific effectiveness of MMPSA in reducing PSA, but is instead focused on the lived experiences and perspectives of those taking MMPSA, which will add depth, richness and understanding to the quantitative findings of the evaluation. This thesis provides insight into the development of PSA in ICSOs and explores how they came to the realisation that their sexual arousal was problematic, and their phenomenological experiences of engaging in behaviour change. While not directly related to the lived experiences of taking MMPSA, this initial first step is vital as it could offer important insights related to the development of PSA as a risk factor for offending, and thus inform decision making regarding appropriate treatment, and treatment goals. Further, it offers the first qualitative exploration of the experiences of ICSOs engaging with MMPSA, exploring their experiences of the process of referral and prescription, and subsequently working through the expected and unexpected effects of the treatments that they are taking. This aspect of the evaluation aims to provide a deeper and more personal understanding of service user experiences of MMPSA. In addition, the thesis examines the quantitative evaluation dataset in order to develop knowledge and understanding of the nuanced pathways through which service users navigate MMPSA. It is this more individualised approach that is taken in this thesis, with the stories and experiences of ICSOs taking MMPSA being told throughout the empirical chapters.

Thesis aims and research questions

The aims of the thesis are to:

- Gain insight into the development, awareness and management of PSA in individuals taking MMPSA
- Understand the lived experiences of individuals taking MMPSA who are convicted of sexual offences
- Explore the nuanced pathways of the MMPSA treatment that these individuals must navigate¹

In addressing these aims, the thesis also sought to:

- Explore the potential implications of these experiences in relation to the use of MMPSA with ICSOs

In order to address these aims, the following research questions are used to guide this research:

- What contributes to the development and awareness of PSA in ICSOs?
- How do ICSOs manage their PSA prior to and during MMPSA treatment?
- What are the experiences of living with PSA for individuals taking MMPSA?
- What are the lived experiences of taking MMPSA?
- Do the experiences of individuals taking MMPSA differ based on medication type?
- What are the nuanced pathways of MMPSA for individuals that are taking it?

Thesis structure and outline of chapters

This thesis is comprised of eight chapters. Chapter 1 has provided a general introduction and background to the thesis, outlining the topic, context, rationale, and aims of the research programme contained within it. Chapter 2 of this thesis provides a review of the literature on sexual arousal, definitions of PSA, and how this concept is linked to risk of sexual offending. It also considers treatment approaches in relation to PSA in ICSOs, and how pharmacological treatments may enhance existing protocols. Chapter 3 details the broad methodological approach that underpins this thesis. Within this chapter, approaches to qualitative research design and data analysis are set out, and the epistemological approach that runs through the research is stated. This chapter also contains a

¹ While this was not a specific research aim at the outset of this project, the need to explore the various pathways through MMPSA became apparent as the research progressed, as detailed within the empirical chapters.

discussion of the ethical considerations and processes involved in designing and undertaking this kind of research with vulnerable populations.

Chapters 4-7 constitute the empirical portion of the thesis. Each of these chapters presents a study or analysis designed to elucidate the lived experiences and treatment journeys of ICSOs with PSA who are taking one of the aforementioned medications. Chapter 4 explores participants' experiences of the development of their PSA, looking at early experiences of sex and their journeys into problematic patterns of sexual arousal. Chapters 5 and 6 present qualitative accounts of participants' experiences of taking either SSRI (Chapter 5) or anti-androgen (Chapter 6) medications for their PSA. In these studies, the aim was to explore the lived experiences of engaging with pharmacological interventions and understanding the impact that these experiences had on the treatment process. In Chapter 7, quantitative clinical data from the evaluation dataset are used in order to explore the potential for varied and nuanced treatment pathways through MMPSA, taking into account starting prescriptions, changes in medication class and dosage, and the discontinuation and resumption of treatment.

Chapter 8 presents a general discussion of the findings of the thesis in relation to the research aims outlined above. In doing so the results of each of the studies are synthesised in order to demonstrate how they combine and tell the story of how MMPSA fits into a broader framework of treatment and desistance for ICSOs. The thesis closes with some personal reflections on the process of conducting this programme of research, as well as outlining the contributions of this thesis and some suggestions for progressing this line of research in future studies.

Chapter 2

Literature Review

This chapter will provide a review of the literature that is relevant to the contents of this thesis. In doing so, an overview of models of normative and problematic sexual arousal (PSA) is provided, before a discussion of the negative effects of PSA is offered. The review then turns directly to the topic of the treatment of PSA and the specific medications that are used with individuals convicted of sexual offences (ICSOs).

Understanding sexual arousal

General models of sexual arousal

There are a number of ways to conceptualise what is meant by sexual arousal in men, including how it comes about, how it is experienced, and how it becomes satiated (Janssen, 2011). An important distinction to make at the outset, however, is between physiological and psychological sexual arousal. While there does appear to be a strong relationship between genital response (i.e. physiological arousal) and subjective / self reported ratings of situational sexual arousal (e.g. Chivers, Seto, Lalumiere, Laan, & Grimbos, 2010), this distinction between physiological and more subjective states of arousal have been identified through a number of experimental procedures. For example, asking men to take part in another task (such as solving mathematical problems) while watching sexual stimuli decreases physiological sexual arousal (i.e. erection quality) but has no effect on subjective ratings of sexual arousal (van Lankfeld & van den Hout, 2004). Similarly, providing men with negative feedback about the size of their erections reduces genital response (but not ratings of psychological arousal) in subsequent tasks involving the judgement of sexually explicit material (e.g. Bach, Brown, & Barlow, 1999). Conversely, having repeated exposures to the same sexual materials can have the effect of decreasing subjective arousal but increasing physiological arousal over time (Both, Spearing, Laan, & Everaerd, 2010). Further, many men experience physiological sexual arousal in the form of erections during REM sleep (Anderson, Poyares, Alves, Skomro, & Tufik, 2007; Costa, 2019; Gordon & Carey, 1999) without experiencing any psychological sexual arousal (including the absence of sex related dream content; Karacan, 1982), or at seemingly random points in everyday life (Janssen, McBride, Yarber, Hill, & Butler, 2008). While this distinction is interesting at face value, it also identifies a key theoretical issue in the study of sexual arousal. That is, attempts to study this concept using a single factor approach (e.g. through a purely physiological or biological lens) will likely miss multiple

other emotional, cognitive and motivational factors that explain more psychological aspects of sexual arousal. In this section, various models of sexual arousal are outlined and discussed in order to build a coherent picture of the nature of this concept.

The biological underpinnings of (male) sexual arousal

While a consideration of sexual arousal requires a multifaceted approach (Nimbi, Tripodi, Rossi, Navarro-Cremades, & Simonelli, 2019), all models are underpinned by core biological mechanisms that regulate both physiological and subjective arousal. Testosterone (the primary sex hormone in men with an androgen classification; Grubin, 2018) has been implicated as a key factor in determining the general level of sexual arousal a man has (Jordan, Fromberger, Stolpmann, & Müller, 2011) As such, considering the biological aspects of sexual arousal is important to consider before looking at individual experiences and predictors of this phenomenon. For example, Bancroft (1989) found that men experiencing a 30-40% reduction in testosterone experienced significantly lower levels of sexual arousal (e.g. general levels of interest in sexual behaviour, frequency of erection, and masturbation frequency) than those with a more normal level of the hormone. Further evidence for this trend comes from naturalistic observations of aging men, whose declining levels of testosterone over time are associated with lower levels of sexual interest and higher incidence of sexual dysfunction (e.g. McBride, Carson, & Coward, 2016; Stanworth & Jones, 2008). As such, reducing levels of testosterone has become a primary target in attempts to treat people with paraphilic sexual interests, in spite of high levels of testosterone not being associated with excessive arousal or paraphilic interests in a direct way (Craissati, 2004; Thibaut, De La Barra, Gordon, Cosyns, Bradford, & the WFSBP Task Force, 2010). However, Jordan et al. (2011) stated that the amount of testosterone that is biologically active and circulating around the body at any one time is far in excess of the level that would be needed to initiate and maintain sexual arousal. This suggests that other purposes of testosterone (e.g. maintaining the appearance and function of secondary male sexual characteristics; Irwing, 2017) may require more testosterone than sexual arousal. In turn, this means that small fluctuations in levels of the hormone within the healthy range (or even high levels of testosterone in general) are not likely to result in marked changes in sexual arousal. That is, while higher levels of testosterone may simply lead to more masculinised physical characteristics (e.g. a deeper voice, a wider face, increased rates of body hair; see e.g. Lefevre, Lewis, Parrett, & Penke, 2013) and not increased levels of sexual arousal, having low levels of testosterone does lead to reductions in sexual arousal, as this is a secondary function of the hormone and therefore low levels will be allocated to its primary functions (Corona, Isidori, Aversa, Burnett, & Maggi, 2016). Thus, there are large individual differences in testosterone levels that do not relate in a straightforward way to an individual's experiences of the intensity of sexual thoughts or the

frequency of their sexual behaviour (Krueger & Kaplan, 2002), with other factors needing to be considered in order to fully account for levels of sexual arousal in men.

From an endocrinological perspective, testosterone is produced by the testes after being stimulated by luteinizing hormone (LH), which is produced by the anterior pituitary gland. LH itself is produced by gonadotropin releasing hormone (GnRH), which is produced by the hypothalamus – the structure in the brain responsible for maintaining the hormonal balance of the body as a whole via the anterior pituitary gland (Melmed & Jameson, 2005). Testosterone is either bound to blood proteins as a store of the hormone, or is free and biologically active throughout the body (Meston & Frohlich, 2000). It is most densely located in areas of the brain close to where it is synthesised, such as the amygdala, the hypothalamic nuclei, and the prefrontal and temporal cortices. Each of these areas have been implicated in the initiation and maintenance of sexual responses (e.g. Baird, Wilson, Bladin, Sling, & Reutens, 2007). For this reason it is unsurprising that higher levels of testosterone are associated with erectile function, tactile sensation, facilitating ejaculation, and sperm production.

Testosterone facilitates sexual arousal in part by stimulating dopaminergic neural responses in limbic areas of the brain when an individual is presented with sexual stimuli (Bancroft, 2005; Jordan et al., 2011). Dopamine is a neurotransmitter that is responsible for regulating and directing attention towards stimuli associated with incentive rewards – particularly where those rewards have been learned through experience as being of high personal or social significance (Pfaus, 2009). Sex is one of these outcomes, with stimuli being associated with gratification (the reward) through orgasm, which acts as a positive reinforcement of the sexual value of a particular stimulus or set of stimuli. Dopamine does this by activating appetitive systems related to goal-directed behaviour in the mesolimbic areas of the brain (e.g. the amygdala nuclei and piriform cortex) before projecting fibres to the medial prefrontal cortex – an area of the brain responsible for executive control, behavioural planning, and inhibition (Miller & Cohen, 2001). At the same time, the mesolimbic activation of dopamine also initiates a series of sympathetic (e.g. heart rate increased) and parasympathetic (e.g. genital blood flow) responses that allow for physiological sexual arousal (Pfaus, 2009). While testosterone serves to increase dopaminergic responses in the brain, it has the opposite effect on serotonin (Jordan et al., 2011; Simon, Colger-Clifford, Lu, McKenna, & Hu, 1998). Serotonin has an inhibitory effect on appetitive or goal-directed behaviours (Lorrain, Matuszewich, Friedman, & Hull, 1997). The precise mechanism by which it does this is unclear, as there are numerous serotonin receptors being located throughout the body (Grubin, 2018). However, in animal studies it has been shown how increases in levels of serotonin blocks the release of dopamine into the limbic system (Hull, Muschamp, & Sato, 2004), limiting the extent to which triggers for sexual arousal lead to sexual responses (Kafka, 2003).

In this sense, serotonin appears to be released when the body is satiated, stopping continued engagement in those behaviours.

These central effects are linked to neurobiological processes. However, the effects of hormones and neurotransmitters can also be peripheral to brain chemistry, as there are receptors for testosterone, dopamine and serotonin within the sex organs themselves (e.g. Ückert et al., 2003). While these biological processes seem to play an important role in sexual arousal, the activation of neurotransmitters such as dopamine and serotonin are also involved in the processing and experience of a range of phenomena, including emotional processing and behavioural planning (for a review, see Meneses & Liy-Salmeron, 2012). As such, these factors may also be important for understanding men's experiences of sexual arousal. These are considered in multifactorial theories of arousal, as discussed below.

Sexological and psychological approaches to studying (male) sexual arousal

Given the complexity of sexual arousal, it is important to examine some of the major models of the concept from within the sexological literature in order to build a more comprehensive understanding of 'normal' patterns of sexual arousal, as these will help to understand the types of factors that might be implicated in explaining how and why sexual arousal can become problematic. The most established theoretical models of sexual arousal begin from the same position as those already described (i.e. biological processes), and typically rely on descriptions of physiological arousal. With this in mind they tend to ignore subjective states of psychological arousal to a large degree (Janssen, 2011). However, they do provide a useful starting point for understanding the temporal processes related to sexual arousal, against which subjective experiences of arousal can be mapped. Below is an outline of some established models of sexual responses from this broader area of research. This acts as a way of introducing the multifaceted nature of male sexual arousal from a biopsychosocial perspective (Wade & Halligan, 2017).

The first major model based on empirical observations of people sexual arousal was proposed by Masters and Johnson (1966), whose sexual response cycle model identified four stages of physiological sexual arousal. While the model is applied to both men and women, due to the focus of this thesis only male sexual arousal will be considered here. The first stage of the cycle was labelled as excitement and describes the initial stage of arousal where, with sufficient stimulation, the penis becomes erect. This is said to be an automatic response where the autonomic nervous system is triggered by some form of sexual sensory stimulation, such as intimacy with an in vivo partner or due to exposure to other sexual stimuli (e.g. pornography; Archer & Lloyd, 2002). This typically occurs automatically via an interaction between sensory receptors, hormones, and neurotransmitters that

occurs within brain systems, as described above. Following a prolonged period of excitement, men then reach the plateau stage of arousal, before orgasm is reached. Following orgasm, there is typically a refractory period where a further orgasm and ejaculation is not physiologically possible (Puppo & Puppo, 2016). During this final stage (termed resolution in the Masters and Johnson model) sexual arousal returns to its initial baseline level. However, the Masters and Johnson (1966) sexual response cycle assumes that initial excitement occurs almost automatically following exposure to sexual stimuli, which sparks a physiological arousal response. Kaplan (1979) argued against this mechanistic view of sexual arousal in her triphasic linear model. She suggested that sexual activity must be desired (a psychological process) before physiological arousal can be experienced. The arousal cycle then ends with orgasm and a rapid reduction in experienced sexual arousal levels.

The Masters and Johnson (1966) and Kaplan (1979) models assume that sexual arousal acts in a linear fashion, from an initial point of excitement or desire, through to orgasm and arousal resolution. However, a more psychological approach would view the experience of arousal in a more cyclical manner, with sexual arousal and subsequent sexual behaviour forming a feedback loop to inform future sexual experiences. Basson (2000) formulated a non-linear model of sexual arousal based upon female sexual arousal (though this has since been applied to male sexuality with 5.4% of men endorsing this as their primary model of sexual arousal; Giraldi, Kristensen, & Sand, 2015). In this cyclical model, non-sexual motivations for sexual arousal (e.g. interpersonal intimacy) can act as a catalyst for seeking out sexual activity. While orgasm may reinforce the feeling of intimacy within this context, and thus form a feedback loop that strengthens the desire for further sexual activity in the future, this is not essential as the experience of intimacy in-and-of-itself provides positive reinforcement associated with sexual arousal.

Using similar behaviourist principles in relation to male sexual arousal patterns, Barlow (1986) put together a more advanced model of sexual arousal by looking at the differences between men both with and without erectile dysfunction that was caused by psychogenic factors. In this model it is proposed that sexual arousal (and physiological sexual responses) act as a catalyst for conditioned responses, in that an ability (or lack thereof) to perform in a sexual context can act as a source of positive or negative emotional feedback. In Barlow's (1986) model, feedback can either be positive (i.e. attention becoming more and more focused on the experienced state of sexual arousal) or negative (i.e. attention being focused on performance anxiety). This attentional distinction appears to provide some explanation for sexual arousal disorders and experiences of erectile dysfunction in some men (de Jong, 2009). That is, men whose attention is focused on their subjective state of sexual arousal tend to be less likely to experience sexual dysfunction than those whose attention is more directed towards anxiety (Barlow, 1986). Repeated negative feedback (via a lack of erectile response due to

anxiety-directed attention) has the effect of increasing expectations about sexual performance failure, with this leading to sexually dysfunctional men avoiding sexual activity altogether (Gregory, 2017). This avoidance can be deliberate or because of a generally reduced level of sexual arousal (Guay & Seftel, 2008; McCarthy, 1992).

Linked to this topic of attention, Wiegel, Scepkowski, and Barlow (2007) argued that sexual arousal has a limiting effect on men's attentional control. That is, for men who do not experience physiological sexual dysfunction it is known that the subjective experience of sexual arousal can have the effect of impeding their ability to make decisions in a rational and value-driven way (Ariely & Loewenstein, 2006; Bouffard & Miller, 2014; Imhoff & Schmidt, 2014). This is because, as outlined within Barlow's (1986) model, attention is goal-directed (i.e. motivated towards achieving sexual gratification in the moment; Everaerd, 1989). According to a range of theoretical and empirical research, low levels of sexual arousal are commonly experienced by many men throughout their normal everyday activities, but these are easily controlled and regulated (Adams, Motsinger, McAnulty, & Moore, 1992; Golde, Strassberg, & Turner, 2000; Hofmann, Vohs, & Baumeister, 2012; Trottier, Rouleau, Renaud, & Goyette, 2014; Winters, Christoff, & Gorzalka, 2009). However, according to Nolet, Rouleau, Benbouriche, Emond, and Renaud (2016) the extent to which somebody can self regulate their sexual arousal (and their physiological sexual response to this arousal) is dependent on the amount of cognitive resource that they have available, and on the strength of their state levels of self-control (vs. their levels of trait impulsivity). One model of impulsivity (the UPPS; Whiteside & Lynam, 2001; Whiteside, Lynam, Miller, & Reynolds, 2005) divides this concept into facets related to urgency (engaging in uninhibited behaviour in order to address extreme positive or negative emotional states), having a lack of premeditation (not considering the potential consequences of behaving in a particular way before acting out that behaviour), having a lack of perseverance (not being able to focus on or complete tasks that are perceived as boring or too difficult), and sensation seeking (actively seeking out new, varied or complex scenarios for the sake of experiencing them; Zuckerman, 1990). The latter of these – sensation seeking – is the most well supported facet of impulsivity that is linked to indices of sexual arousal. That is, higher levels of sensation seeking are associated with a greater number of lifetime sexual partners and a higher prevalence rate of ever having had sexual intercourse with a stranger (Derefinko et al., 2014), as well as broad measures of risky sexual behaviour (e.g. having sex with multiple partners and lower levels of condom use; Zapolski, Cyders, & Smith, 2009). While divided attention between tasks (as described by Barlow, 1986) can lead to a cycle of sexual dysfunction, anxiety and avoidance, there are some situations where divided attention can lead to increased rates of sexual arousal or behaviour. When this happens there is typically an interaction with broader personality traits. For example, Gailliot and Baumeister (2007) found that male participants who

engaged in an ego depletion task (limiting the extent to which they had the cognitive energy to maintain a high levels control over their behaviour; Baumeister, Bratslavsky, Muraven, & Tice, 1998) expressed a greater willingness to engage in infidelity. This effect was moderated by sociosexual orientation (Simpson & Gangestad, 1991), being heightened by a propensity to engage in numerous short term sexual encounters (as compared to long term relationships).

Considering the above factors it appears that the focus of divided attention and the emotional experience of this division are important factors to consider when understanding sexual arousal. Turning specifically to emotional processes, Wiegel et al. (2007) identified that maladaptive schemas related to expectations about sexual performance (and heightened levels of anxiety surrounding this) appear to be a key risk factor for low levels of physiological sexual arousal, even in the presence of psychological sexual arousal. With this in mind, having divided attention where competition for this attention is negative and directed towards the self may be predictive of decreased physiological sexual response. According to Janssen (2011) this highlights an important distinction in the roles of positive and negative emotion on the experience of sexual arousal. According to his dual control model, sexual arousal is brought about by an interaction between positive (or excitatory) and negative (or inhibitory) evaluations of a potential sexual stimulus or sexual context (Bancroft & Janssen, 2000). It was argued that by Janssen and Bancroft (2007) that prior theorising about the nature of sexual arousal focuses on the presence or absence of excitation. That is, arousal was previously only said to be present if a subjectively arousing stimulus is attended to, and not present if either a stimulus lacks some degree of arousability, or if an individual's attention is directed away from the stimulus (Janssen, 2011). However, Janssen and Bancroft (2007) added a second mechanism related to sexual inhibition, which they defined as the active suppression or inhibition of a sexual response, even in the presence of subjective sexual arousal. Inhibitory processes can take two forms and can be measured via self-report methods using the Sexual Excitation / Sexual Inhibition Scales (SES/SIS; Janssen, Vorst, Finn, & Bancroft, 2002). The first type of inhibition reflects anxieties about sexual performance failure, while the second reflects concerns about the consequences of sexual activity.

An important factor relevant to the role of emotion in moderating sexual arousal thus seems to be the target or stimulus that elicits the emotion to begin with. As with Barlow (1986) and Janssen and Bancroft (2007), if negative emotion is brought about by sex-related issues (e.g. past experiences of erectile dysfunction, a lack of subjective sexual arousal to a partner, or a consideration of the long term negative consequences of sexual activity), the degree to which arousal is experienced is likely to be reduced. However if positive emotion is experienced in relation to the sexual context (i.e. via excitatory processes; Janssen & Bancroft, 2007; Kaplan, 1979; Masters & Johnson, 1966), this enhances sexual arousal. In line with behaviourist approaches to reinforcement, continual exposure

to these positive or negative emotions in relation to sexual stimuli or situations strengthens the associations between situational sexual cues and the emotional response (Grey & Mathew, 2009). However, there is a range of evidence to suggest that trait emotional orientations can encourage greater levels of sexual arousal and behaviour. As highlighted by Mischel, Ayduck, and Mendoza-Denton (2003), high levels of stress can strengthen more impulsive cognitive mechanisms while decreasing abilities related to self control and regulation. This effect can be viewed from either an ego depletion perspective (Baumeister et al., 1998) or a motivational perspective. In relation to ego depletion, attending to stressful situations takes up cognitive resource that can prevent an individual from acting in ways that are consistent with their usual personal and moral beliefs, as was the case in Gailliot and Baumeister's (2007) study. From the motivational perspective, rewards associated with engaging in sexual activity drive sexual arousal and sexual motivation (Berridge, 2004). That is, the experience of emotion (both positive and negative) creates an action motivation (Frijda, 1986; Janssen, 2011; Toates, 2009) that orients an individual to either maintain positive emotional states or reduce negative ones. Longitudinal evidence for positive emotion motivating sexual arousal and behaviour comes from Zapolski et al. (2009) who found that men scoring high on the positive urgency facet of impulsivity were more likely to engage in sexual activity with a larger number of people when this outcome was measured one year after collecting baseline psychometric data. The role of negative emotion on sexual arousal and motivation is more mixed (Janssen, 2011), with a number of studies suggesting that negative affect generally has a suppressing effect of sexual arousal (for a review, see Nimbi, et al., 2019). However for a substantial minority of men (approximately 10-20%, depending on the type of negative emotion being experienced), negative emotion can lead to increased rates of sexual arousal (Bancroft et al., 2003). For these individuals, sexual activity acts as a form of escapism from a chronic negative emotional state (e.g. stress, anxiety or depression; Bancroft & Vukadinovic, 2004), or a direct way to increase physical intimacy with others and improve self worth (Bancroft et al., 2003). In this sense it is clear that for some the momentary relief that sexual arousal can have on alleviating low mood can become habitual and create a cycle of experiencing and reducing negative emotion (Toates, 2009).

This review of the sexological literature on models of normative sexual arousal demonstrates the multifaceted and complex nature of this concept. In doing so it also highlights how studying sexual arousal from a biopsychosocial perspective is likely to be the most effective approach to properly understanding this concept (Wade & Halligan, 2017). That is, while examining physiological arousal from a biological perspective is important, just focusing on this aspect of sexual arousal risks limiting our understanding and missing crucial information related to how emotional, cognitive, and motivational mechanisms play a role in bringing about psychological experiences of sexual arousal

(Nimbi et al., 2019). The next section applies these concepts to the subject of this thesis and considers these factors in relation to problematic expressions of sexual arousal.

Conceptualising 'problematic sexual arousal'

Problematic sexual arousal (PSA) is the term used here to refer to sexual arousal that is in some way problematic due to the excessive or intense nature of the arousal, or the distress it may cause the individual experiencing it. Numerous other terms are used synonymously to define different elements of PSA throughout the literature including, but not limited to, sexual preoccupation (Mann, Hanson, & Thornton, 2010), sexual compulsivity (Kalichman et al., 1994), hypersexuality (Kaplan & Krueger, 2010; Walton, Cantor, Bhullar, & Lykins, 2017), hypersexual disorder (Krueger & Kaplan, 2002), and sexual addiction (Carnes, 2001; Marshall, Marshall, Moulden, & Serran, 2008). For example, in their recent review and conceptual development of the sexbehavior cycle of hypersexuality, Walton et al. (2017) define this concept as being comprised of compulsive and addictive elements at the level of behaviour, and elements related to preoccupation with sexual stimuli and excessive engagement with sexual fantasy at the psychological level. This highlights the difficulty in teasing apart the various facets and concepts related to PSA. To date there have been no successful attempts to produce a unified definition, and instead these terms are repeatedly used interchangeably across multiple papers. However, it is clear from the literature that the common features relate to intense or excessive sexual thoughts and fantasies (i.e. psychological aspects) and physiological arousal and behaviours (i.e. behavioural aspects). As such, the term PSA is adopted here to encompass both of these elements, each of which are discussed below.

PSA: The psychological facet

Within the literature, the psychological element of PSA is often referred to as sexual preoccupation. Early definitions of this proposed that sexual preoccupation was characterised by spending in excess of one hour per day engaging in sexual thoughts and fantasy (Kafka, 2003). Later definitions built upon this, and conceptualised sexual preoccupation as 'an abnormally intense interest in sex that dominates psychological functioning' (Mann et al., 2010, p. 198), thus acknowledging the intense and ubiquitous nature of the sexual thoughts and fantasies. As such, sexual preoccupation constitutes a dysfunctional focus on sexual thoughts, including fantasy (Kalichman & Rompa, 2001; Kafka, 2003), and the sexualisation of non sexual objects, situations and people. These thoughts are frequent, intrusive, and often unwanted, causing distress to the individual (Krueger & Kaplan 2001). This intrusiveness of sexual thought may have links to an obsessive-compulsive disorder (OCD) based model of PSA (Bradford, 1999; Kaplan & Krueger, 2010; Krueger & Kaplan, 2001). Support for this model comes from

Grant et al. (2006) who reported that there was a lifetime prevalence of obsessive sexual thinking of around 25% among patients with a diagnosis of OCD. Furthermore, neurotransmitters such as serotonin and dopamine have been implicated as being important in the aetiology of OCD, in that reduced levels of serotonin binding in limbic areas of the brain (e.g. the thalamus, hypothalamus and nucleus accumbens) are present (Hesse et al., 2005; Müller-Vahl et al., 2019; Reimold et al., 2007). These are the same serotonergic processes and brain areas that have been suggested as important in the experience of sexual arousal (reviewed above; see Grubin, 2018; Jordan et al., 2011; Kafka, 2003). While these obsessional sexual thoughts can exist in isolation, in line with an OCD model they can become associated with a compulsive behavioural element, against which the individual struggles (often unsuccessfully) to resist (Kalichman et al., 1994). Consequently, this may result in a high frequency of sexual behaviours, described within the behavioural facet of PSA.

PSA: The behavioural facet

The behavioural element of PSA is more fraught with confusion over terminology (see above), with numerous terms used to describe what essentially constitutes excessive sexual behaviours that become problematic. The first reference to this type of behaviour was made by Krafft-Ebbing (1907), who coined the term hypersexual. Following this, researchers have referred to this excessive sexual behaviour as satyriasis (for men) and nymphomania (for women) (Rinehart & McCabe, 1997). However, more recently the most common terms used include hypersexuality (Kaplan & Krueger, 2010; Walton et al., 2017), hypersexual disorder (Krueger & Kaplan, 2002), sexual compulsivity (Kalichman et al., 1994) and sexual addiction (Carnes, 2001; Marshall, Marshall, Moulden, & Serran, 2008).

A measure of hypersexuality was first proposed by Kafka (1997) and was measured in relation to the number of total sexual outlets (TSOs), a term proposed by Kinsey, Pomeroy, and Martin (1948) to refer to frequency of orgasm. Kinsey et al. (1948) found that 7.6% of their male sample ($n = 14,083$) had a TSO score of seven or more orgasms per week (averaged over a six-month period), which was arbitrarily classified as being 'high'. Kafka (1997) used this figure of TSO to specify that in order to be classified as hypersexual, individuals must achieve at least seven TSOs per week, over a consecutive period of at least six months. However, Långström and Hanson (2006) asserted that a simple count of sexual activity was not enough to demonstrate pathology, with others acknowledging that a TSO score of seven may be conservative when taking into account age, new relationships, or relationships in which consenting adults are frequently sexually active (e.g. Wakefield, 2012). As such, Långström and Hanson (2006) expanded this definition of hypersexuality to include only those TSOs of a solitary or impersonal nature, or that do not occur within a primary intimate relationship (e.g. masturbation, infidelity, the use of prostitutes). Furthermore, it was proposed that hypersexuality did not constitute

a distinct category of behaviour, but instead ‘exaggerations or distortions of statistically normal sexuality’ (Walters, Knight, & Långström, 2011, p. 1317). As such, hypersexuality is not considered to be taxonomic in nature, but rather it exists along a continuum, from celibacy to normal levels of sexual activity to hypersexuality (Walters et al., 2011). As such it may be a positive step to examine what may be underpinning hypersexual behaviour from the perspective of normative frameworks of sexual arousal. Walton and Bhullar (2018) did this by collecting data from a large community sample of Australians (N > 1400) and examining their responses to a hypersexuality questionnaire alongside the SES/SIS scales pertaining to Bancroft and Janssen’s (2000) dual control model of sexual arousal. They found that higher scores in relation to hypersexuality were associated with higher levels of excitation. This has also been reported by both Rettenberger, Klein, and Briken (2016) and Winters, Christoff, and Gorzalka (2010), who went further to find that those who present as hypersexual also have lower levels of sexual inhibition in relation to thinking about the potential negative consequences of this type of behaviour. This process of sexual excitation and a lack of sexual inhibition is captured within Walton et al.’s (2017) sexhaviour cycle. This model suggests that hypersexual behaviour is maintained and reinforced by a process of cognitive abeyance (i.e. the suspension of normal cognitive capacity when sexually aroused; see also Ariely & Lowenstein, 2006) and sexual incongruence (i.e. negative evaluations of one’s own sexual activities) causing negative mood, which hypersexual people then often soothe using sexual activity (Bancroft & Vukadinovic, 2004).

The rate of hypersexuality (using Kafka’s (1997) criteria) appears to be increasing over time, with recent research placing prevalence at 12.1% in a community sample of more than 9,000 men (Klein, Schmidt, Turner, & Briken, 2015). More recently there has been a move to try to understand the extremes of hypersexuality, with some claiming that individuals may be diagnosed with hypersexual disorder (for a discussion, see Reid, 2016). Based on draft diagnostic criteria, an individual would be eligible for a diagnosis of hypersexual disorder if they met four or more of the following criteria over a period of at least six months:

1. Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behaviour
2. Repetitively engaging in these sexual fantasies, urges, and behaviour in response to dysphoric mood states (e.g. anxiety, depression, boredom, and irritability)
3. Repetitively engaging in sexual fantasies, urges, and behaviour in response to stressful life events
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behaviour

5. Repetitively engaging in sexual behaviour while disregarding the risk for physical or emotional harm to self or others

In addition to these symptom-based criteria an individual must also have been aged over 18 years, experience clinically significant personal distress impairments to their everyday (i.e. occupational, social or interpersonal) functioning, and not be experiencing these symptoms due to medications or other substances (Kafka, 2010). In this sense, the proposed criteria for hypersexual disorder were in line with other paraphilic disorders listed in various versions of the DSM (e.g. paedophilic disorder, exhibitionistic disorder or voyeuristic disorder; APA, 2013). Following much discussion within the scientific field the proposal to include hypersexual disorder in the DSM-5 (APA, 2013) was ultimately unsuccessful due to a lack of scientific consensus about whether it actually constituted a type of disordered behaviour.

Similar attempts to classify hypersexual behaviour as a sex addiction (and thus as a diagnosable mental health condition) have been rejected (see e.g. Kraus, Voon, & Potenza, 2016). Kotera and Rhodes (2019) defined sex addiction as a neurological disorder “characterised by acute sexually arousing fantasies and urges or behaviours that persist for a period of at least six months, causing distress and impairment in the professional, social, and personal life of the individual, despite repeated attempts to cut back or stop’ (p. 1; see also Potenza, 2006). This definition is strikingly similar to the proposed criteria for hypersexual disorder (Kaplan & Krueger, 2010; Reid et al., 2012), making it difficult to distinguish these concepts within the literature. However, research on sex addiction is much more developed, with models of both substance and behavioural addiction. Walton et al. (2017) are generally hostile to the notion that hypersexuality functions as an addiction as the behaviour itself may be a symptom of some other underlying psychological distress, rather than a reflection of a distinct disorder in its own right. They cite research that suggests how self-reported sex addiction is often accompanied or co-morbid with other conditions, such as substance misuse disorders, ADHD, or mood disorders (Brewer & Tidy, 2019; Carnes, 2001; Kaplan & Krueger, 2010). In this sense excessive sexual arousal (and associated behaviours), as characterised as either sex addiction or hypersexual disorder, may simply reflect an extreme manifestation of a normal emotional function of sex (i.e. to alleviate negative mood states or enhance positive ones; Bancroft et al., 2003; Bancroft & Vukadinovic, 2004; Zapski et al., 2009). For others, however, sexual behaviour has been found to activate the same neural circuits associated with other addictive behaviours (Carnes & Love, 2017). These circuits are typically located in frontal and limbic areas of the brain controlling impulse control and behavioural planning (Kraus et al, 2016). Grey matter reductions have also been observed in the temporal lobes of individuals demonstrating hypersexual behaviour (Baird et al., 2012; Seok & Son,

2018). These brain areas have all been implicated in both normative and paraphilic sexual functioning, as they form part of a network associated with the perception of stimuli within the environment, behavioural planning, and motor control (Cantor, 2018; Miller & Cohen, 2001). Specifically linked to the concept of sex addiction, studies have also found evidence that excessive use of online pornography can bring about neurological effects that correspond to tolerance and withdrawal cycles (Banca et al., 2016; Gola et al., 2017), which again corresponds to an addiction model of hypersexual behaviour. Thinking about these processes in relation to sexual arousal more generally, these brain areas are linked to serotonergic and dopaminergic processes (Jordan et al., 2011). Given serotonin's effect on the experience of satiation (Lorrain et al., 1999) and dopamine being linked to an increase in goal-directed behaviour (Pfaus, 2009), it could be that deficits in these neurobiological mechanisms controlling the feeling of satiation play a role in the development of excessive sexual arousal and behaviour.

The distinction between whether an individual can be seen as demonstrating problematic levels of sexual behaviour (e.g. hypersexuality, hypersexual disorder or sex addiction) thus appears to be in relation to the underlying function or psychological processes associated with that behaviour. That is, excessive sexual activity may be addictive or disordered if it is used as a predominant method of emotional regulation (Bancroft & Vukadinovic, 2004; Reid & Carpenter, 2009), is accompanied by experiences of progressive tolerance to sexual behaviours and withdrawal symptoms when these are not being engaged in (Banca et al., 2016; Carnes & Love, 2017; Garcia & Thibaut, 2011; Gola et al., 2017) or leads to individuals experiencing distress or impairments to their everyday functioning (Kaplan & Krueger, 2010; Kotera & Rhodes, 2019; Reid et al., 2012). However in other situations a high level of sexual activity and arousal may simply reflect an individual sitting at the top end of a normative continuum of sexual arousal; Walters et al., 2012).

The addiction model described here appears to link to the latter part of the aforementioned OCD approach to understanding PSA. In line with this argument, excessive sexual behaviour may take on a compulsive nature (Kalichman et al., 1994; Walton et al., 2017) that serves the function of satiating the negative mood states brought about by obsessional sexual preoccupation (Winters et al., 2010). Howard (2007) has suggested that people may use orgasm as a way of achieving a temporary relief from trauma, stress, and specific negative experiences (see also Walton et al., 2017). Compulsivity in this sense suggests a need to enact a particular behaviour, and is thus more than simply a desire for sexual gratification (Derbyshire & Grant, 2015). While there is limited research into the psychological factors associated with sexual compulsivity in a specific sense, the most frequently used measures of this construct ask questions in relation to control (e.g. 'I have to struggle to control my sexual thoughts and behaviours'; Kalichman et al., 1994). The idea of behavioural control (and its

opposite – a lack of behavioural inhibition) have been implicated in models of sexual arousal previously (e.g. Zapolski et al., 2009), with sensation seeking being a key predictor of greater numbers of sexual partners and risky sexual behaviours (Nimbi et al., 2019). Impulsivity in the sexual domain is said to be associated with goal attainment and hedonic gratification (Giugliano, 2009), which corresponds to the incentives and motivational accounts of normative sexual arousal outlined previously (see Janssen, 2011). When combined with the high levels of sexual excitation and low levels of sexual inhibition that are present in those demonstrating hypersexual behaviour (Rettenberger et al., 2016; Walton & Bhullar, 2018; Winters et al., 2010), it is thus perhaps unsurprising that hypersexual individuals might act in a more impulsive manner in order to seek out and satiate their sexual urges. As stated throughout this section of the review, then, it appears that those experiencing issues with their sexual arousal may do so because of excessive experiences of normal cycles of sexual arousal (Walton et al., 2017).

Language use in this thesis

It is clear from the above review that terms such as hypersexuality, hypersexual disorder, sex addiction and sexual compulsivity (and their many variants) are used interchangeably and synonymously within the broader literature. However, in reality this means that these concepts are typically described and explained using overlapping factors. Issues such as emotional or mood regulation, self-soothing, behavioural impulsivity and tolerance all feature across this field of research as explanatory factors in relation to each of these specific terms. It is also evident that individuals experiencing issues related to excessive sexual arousal (i.e. sexual preoccupation or hypersexual behaviour) may sit at the end of a continuum of normal sexual arousal (see Walters et al., 2017). In light of this interchangeability, this thesis uses the term ‘problematic sexual arousal’ (PSA) to refer to both the psychological (e.g. sexual preoccupation) and behavioural (e.g. hypersexuality) elements of this type of excessive sexual thinking and behaviour, as reviewed above. There will, however, be some necessity to use other terms (e.g. sexual preoccupation and hypersexuality) when discussing specific studies that focus on a particular aspect of PSA.

Importantly, while issues related to PSA have been correlated with paraphilic sexual interests (Klein et al., 2015), it is acknowledged that these interests may exist without the presence of PSA (i.e. without impairments to mood regulation or everyday functioning, or excessive engagement in sexual thoughts and / or behaviours related to these interests; Reid et al., 2012). Thus, the presence of PSA is not determined by an individual having a specific sexual interest, but rather by the intensity, frequency and effects of these sexual thoughts and behaviours on their everyday functioning. As such, the use of PSA in this thesis does not assume any deviant or paraphilic sexual interest in terms of the

targets or triggers of sexual arousal, but is limited to this latter point in relation to the intensity, frequency and effects of an individual's experience of sexual arousal.

Another term used throughout this thesis that could lead to confusion is 'sexuality'. In common phrasing, this term is typically used to refer to sexual orientation (i.e. to describe whether somebody is heterosexual, homosexual, bisexual, etc.; MacIntyre, Vega, & Sagbakken, 2015). However, from a more academic perspective this term has a broader meaning and encompasses a range of concepts, including experiences of intimacy, and sexual arousal varied sexual behaviours (including masturbation) (Carpenter & DeLameter, 2012; Williams, Thomas, Prior, & Walters, 2015). Owing to the focus of this thesis, any references to 'sexuality' in this work relates to this broader academic definition.

Why is PSA problematic?

Problematic sexual arousal and wellbeing

The presence of PSA (or elements of it, as discussed above) is a health concern, being linked to a number of adverse outcomes in relation to wellbeing. For example, PSA is associated with psychiatric co-morbidities that impact upon psychological wellbeing, including feelings of shame, loneliness, hopelessness and coping deficits (Reid, 2007; Reid, Bramen, Anderson, & Cohen, 2013). Individuals with PSA are also prone to experiencing mood disorders such as anxiety, depression, stress (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Garcia & Thibaut, 2010; Reid et al., 2013; Schultz, Hook, Davis, Penberthy, & Reid, 2014; Walton et al., 2017) as well as social isolation and low self esteem (Reid, Carpenter, & Loyd, 2009). In addition, engaging in a high frequency of sexual behaviours (the behavioural facet of PSA) is associated with less satisfaction with health (Långström & Hanson, 2006) as well as a range of physical health concerns, for example, physical injury (McBride et al., 2008), and sexually transmitted infections and diseases (Långström & Hanson, 2006; McBride et al., 2008; Walton et al., 2017; Yoon et al., 2016).

Detrimental effects related to the presence of PSA may also occur across wider aspects of an individuals' life, for example, by contributing to intimate relationship difficulties and the breakdown of such relationships (Långström & Hanson, 2006; Spenhoff, Kruger, Hartmann, & Kobs, 2013; Walton et al., 2017) as well as unplanned pregnancies (McBride et al., 2008). Other associated negative consequences include financial difficulties and debt (Reid et al., 2009; 2012), loss of employment (Paunović & Hallberg, 2014), dissatisfaction with life (Långström & Hanson, 2006), and in some cases may lead to inappropriate or illegal sexual behaviours (Reid et al., 2009; Walton et al., 2017) with the association between PSA and sexual offending discussed below.

Problematic sexual arousal and sexual offending

Understanding the relationship between PSA and sexual offending

While PSA is implicated as a profound wellbeing issue (see above), it has also been implicated as a key risk factor for sexual offending behaviour. Given the focus of this thesis (understanding the lived experiences of ICSSOs who are taking medication for PSA) it is important to first understand the role of sexual arousal in the process of committing a sexual offence, and how these links map onto the above discussions about models of normative and problematic sexual arousal patterns. Theoretical models of sexual offending always include some element of sexual arousal or sexual interest as an aetiological factor that can be implicated in the build up to an offence taking place (Seto, 2019). In some models, this sexual arousal is a primary motivator for offending. For example, in Finkelhor's (1984) preconditions model, sexual arousal sets an individual on a trajectory towards offending behaviour. The source of sexual arousal can come from specific paraphilic sexual interests (e.g. paedophilia sexual interests, or interests related to forced or coercive sexual interactions), blockage (i.e. obtaining sexual activity through offending is the only strategy that is available to the individual who commits a sexual offence), emotional congruence with a particular victim group (i.e. for ICSSOs whose offences are perpetrated against children, the offending allows them to feel emotionally intimate with another person), or sexual preoccupation (Seto, 2019).

As outlined earlier in this chapter, there are links between the psychological processes that moderate sexual arousal and the motivation to commit a sexual offence, in line with this theory. For example, if an individual has a specific sexual interest, their attention is likely to be attracted to this type of stimulus when it emerges within the social context (Archer & Lloyd, 2002; Hofmann et al., 2012), and this has the effect of limiting or suspending their usual decision making processes (Ariely & Lowenstein, 2006; Imhoff & Schmidt, 2014). Similarly, a sexual interest account of emotional congruence is the most well supported model of the emotional motivation to sexually offend (McPhail, Hermann, & Nunes, 2013). That is, in a sample of ICSSOs who committed their offences against children, emotional congruence with children was most strongly associated with specifically being sexually aroused by children (relative to being sexually aroused by adults), and more weakly associated with general deficits in emotional maturity. This suggests that, for some people who commit sexual offences against children, they are doing so in order to meet some emotional need they have, in line with how normative sexual arousal often functions (e.g. Bancroft et al., 2003).

These themes are also present in Seto's (2019) emerging motivation-facilitation model (MFM), which posits that issues related to sexual arousal (due to paraphilic interests, general sexual preoccupation and / or hypersexuality, or blockage) act as key motivators for this type of offending behaviour. Where Seto (2019) deviates from Finkelhor (1984) is in the offence chain. While Finkelhor

(1984) sees concepts related to sexual arousal as a precondition to sexual offending in a linear manner (i.e. this initial motivation leads to somebody seeking to overcome any internal inhibitors to sexual offending, and once these internal inhibitors are overcome, opportunities to offend are sought), Seto (2019) sees these motivators as interacting with other facilitating / inhibiting trait (e.g. antisocial personality characteristics) and state (e.g. temporary intoxication through alcohol or other substances) factors. For example, an individual may have high levels of sexual blockage or deviant sexual interests, and will likely act on these if his personality is characterised by antisocial facilitating traits. However, if his personality is generally prosocial, this will inhibit sexual offending, even in the presence of offence-motivating features of his sexual arousal. However, what Seto (2019) does suggest is that having some kind of deviant, excessive or problematic sexual arousal provides an individual with an initial impetus that, in some cases, sets them on a trajectory towards sexual offending.

While the Finkelhor (1984) and Seto (2019) models identify sexual arousal as an important potential precursor to sexual offending, they do not give a comprehensive account of how these arousal patterns come about, and how motivating and facilitating factors develop in tandem. Marshall and Barbaree (1990) sought to address the lack of developmental psychology in Finkelhor's (1984) early model, and formulated the first integrated theory of sexual offending. They suggested that sexual offending has its roots in early attachment experiences which set a template (via the internal working model; Bretherton & Munholland, 1999) for personal and intimate relationships. Disrupted attachments commonly lead to a reduced ability to negotiate social and interpersonal interactions, which has the subsequent effect of making the development and maintenance of close intimate relationships more difficult (Simpson, 1990). At the onset of puberty and the development of sexual interests, a lack of confidence or success in gaining potential intimate or sexual partners due to these difficulties can lead to frustration. Marshall and Barbaree (1990) described how this frustration, when combined with a growing desire for sexual contact, can be translated into the formation of deviant or aggressive sexual fantasies (Marshall & Barbaree, 1990). The link to sexual arousal comes in the form of emotional responses to other people, and how their reciprocal responses make a potential ICSSO feel about themselves. That is, all individuals have a need to feel connected with other people (Ward & Brown, 2004), and striving to achieve intimacy is a key motivator (and reinforcer) of sexual arousal in non-offending context (Basson, 2000). However, upon rejection by a potential sexual partner, somebody with a lack of emotional competence may begin to engage in sexual fantasy as a surrogate to actual sexual contact (Marshall & Barbaree, 1990). Through this fantasy engagement and masturbation, these fantasies become stronger and more vivid (Bartels, Harkins, & Beech, 2017), and in the absence of healthy sexual experiences become a blueprint for future sexual encounters (for a

review of the link between sexual fantasy engagement and sexual offending, see Bartels & Beech, 2017).

In an attempt to formulate a more comprehensive framework of the various causal pathways into sexual offending, Ward and Siegert (2002) used a theory knitting approach to bring together the best and most explanatory parts of existing theories into one unified model of sexual offending. This is an integrative approach to theory development that looks at the various aspects of a range of competing theories to understand how their core assumptions and underlying concepts could work together and be unified into a single explanatory theory (Kalmar & Sternberg, 1988). Through their work, Ward and Siegert (2002) identified four causal mechanisms from the previously discussed theories of sexual offending: deviant sexual arousal, emotional dysregulation, intimacy and social skills deficits, and distorted cognition or antisocial personality traits. Interestingly, these factors were also identified by Marshall (1999) as being important to understanding child sexual abuse, and were proposed by Hall and Hirschmann (1992) in their quadripartite model of sexual offending. However this earlier work looked more like a typology of ICSOs than an integrative explanation of different aetiological pathways into offending behaviour.

Ward and Siegert's (2002) framework divided these four mechanisms into five pathways of sexual offending (one pathway per mechanism and a final general or multiple deficits pathway). While a full description of each pathway is beyond the scope of this thesis, the interactions between these identified mechanisms does have some relevance, as emotional dysregulation (Bancroft et al., 2003; Toates, 2009), intimacy-based motivations (Basson, 2000; Giraldi et al., 2015), and personality traits related to impulsivity and behavioural control (Whiteside & Lynam, 2001; Whiteside et al., 2005; Wiegel et al., 2007; Zolowski et al., 2009) have all been implicated in moderating normal sexual arousal. According to Ward and Siegert (2002), these mechanisms are defined as "a set of psychological processes that cause specific outcomes or effects ... and a dysfunctional mechanism is one that fails to work as intended or designed" (p. 331). As such, sexual offending may come about after a dysfunction of some mechanism associated with normative sexual arousal, in line with the discussion of PSA presented above. Within the Ward and Siegert (2002) model, one mechanism is predominant for each ICSO, meaning that one mechanism is the primary deficit that an individual has that is setting them on a trajectory into sexual offending. However all ICSOs will have deficits across all mechanisms which interact to cause their offending behaviour. It is thus suggested that "all sexual crimes will involve emotional, intimacy, cognitive, and arousal components" (Ward & Siegert, 2002, p. 335). Again, this is particularly relevant to the current thesis, as each of these components relate to specific facets of PSA. For example, sexual offending may be a behavioural response to (1) maladaptive sexual scripts where ICSOs have early experiences of sexual abuse that lead them to equate sex with emotional

intimacy), or (2) emotional dysregulation which may be tied to anxieties about attachment and interpersonal vulnerability (Sperling & Berman, 1994).

The high prevalence rate of insecure attachment among ICSOs, coupled with sex being used as both an emotional coping tool and a predominant way of expressing emotional closeness, can cause problems in firstly initiating but later maintaining effective intimate relationships with others. According to Cortoni and Marshall (2000) compulsive masturbation in adolescence may become a way of improving self-esteem and low mood during early developmental years, where romantic rejection may be experienced more severely (Marshall & Barbaree, 1990). This creates a link between achieving orgasm and alleviating negative emotional states in a manner that is consistent with the theorising of Bancroft et al. (2003) and Bancroft and Vukadinovic (2004) in relation to normative and addictive sexual arousal, respectively. ICSOs who are predominantly driven by emotional dysregulation appear to continue this trend of using sex as a coping strategy into adulthood, and may turn to pornography or sexual offending when they feel powerless, stressed, lonely, or angry (Yule, Brotto, & Gorzalka, 2017). As such, sexual offending for these individuals is not driven by a specific sexual interest among these ICSOs, but is rather a method of alleviating negative mood states. The link to PSA here is that this process of using sexual activity (either partnered in consensual or coercive ways, or through masturbation) as a coping strategy can become habitual (Brewer & Tidy, 2019; Cortoni & Marshall, 2010; Hughes, 2010), leaving these individuals with the perception that they have no other viable method of resolving negative emotional experiences.

From a cognitive perspective it is possible that PSA can translate into beliefs about sexuality that are offence-supportive. These beliefs could be formed in a number of different ways. From a social-cognitive perspective, repeated exposure or personal rumination on sexual themes begin to build implicit or automatic associations in cognitive structures, making it easier for situational triggers to make arousal-related thoughts accessible (for a theoretical discussion, see Gawronski & Bodenhausen, 2006). These beliefs may otherwise be developed more proactively as a way of seeking self-permission for sexual offending (Meridian, Perkins, Dustagheer, & Glorney, 2018), or to justify it after-the-fact in order to maintain offending behaviour (Ward, Hudson, Johnston, & Marshall, 1997). For example, individuals may begin to think that men's sexual arousal is uncontrollable, that they are entitled to sex, that women are sexual objects to be used for sexual gratification, or that children are sexual beings who are capable and willing to consent to sexual activity (Polaschek & Gannon, 2004; Polaschek & Ward, 2002; Ward & Keenan, 1999). In this sense, satiating some sexual and emotional arousal state (consistent with the discussion above) is an underlying motivation for sexual offending, and with these beliefs allow an ICSO to overcome any internal barriers to acting on these motivations (Finkelhor, 1984). This is consistent with Seto's (2019) MFM as it does not assume a direct link

between sexual motivations and sexual offending, but rather sees offending behaviour as only taking place if other facilitating factors are present.

The most cited theoretical model that discusses the aetiology of sexual offending and brings together the commentaries of those outlined above is the integrated theory of sexual offending (ITSO; Ward & Beech, 2006; 2017). The ITSO takes the position that this type of behaviour (and the mechanisms that lead to it; Ward & Siegert, 2002) results from interaction between biological factors (e.g. evolutionary pressures, genetics and hormones), environmental factors (e.g. in-the-moment situations and personal circumstances), neuropsychological and cognitive functions (e.g. emotional processing and executive control), and factors related to personal agency, responsibility and behavioural propensities. In doing this, the ITSO brings together the key causal concepts described above (Finkelhor, 1984; Marshall & Barbaree, 1990; Ward & Siegert, 2002), but also considers behaviour as being formed through unique interactions between genetic predispositions and specific learning experiences within an individual's particularly cultural context (Odling-Smee, Laland, & Feldman, 2003), before explaining the specific clinical symptoms that they produce. It also incorporates (though not explicitly) all of the biological and psychological factors associated with sexual arousal, which it classifies as a clinical factor associated with sexual offending.

Biological antecedents of sexual offending

At the biological level, brain development in childhood and adolescence is seen as a crucial factor that contributes to the development of sexual offending. Brain development is borne out of a combination of genetic influences and neurobiological functioning. At the genetic level, it may be that specific human drives (e.g. those general drives to seek human universals such as intimate interpersonal relationships, sexual satisfaction, and mastery; Ward & Beech, 2017) set the blueprint for particular behavioural propensities related to courtship and the seeking out of sexual encounters. This approach has predominantly been focused around men and their innate needs to pass on their genetic characteristics onto the next generation (Brennan & Shaver, 1995; Darwin, 1859; Ward & Beech, 2017). However, when these evolutionarily hard wired drives are combined with genetic disadvantage on the mating market (e.g. lesser physical stature, lower intelligence, less earning potential, or poor interpersonal skills; Buss & Shackelford, 2008; Puts, 2016) this opens up the possibility that sexual offending will occur in order to ensure sexual competitiveness and genetic transmission are processes that are maintained (Thornhill & Palmer, 2000). This is similar to how sexually deviant behaviours related to obtaining sexual gratification (e.g. voyeurism and exhibitionism, among other paraphilias) are more prevalent among those men who traditionally may be disadvantaged on the mating market (Eher, Rettenburg, & Turner, 2019) with these behaviours representing maladaptive and socially

disapproved methods of mate attraction (commonly referred to as courtship disorder; Freund & Blanchard, 1986; Långström & Seto, 2006).

At the hormonal level, persistently high levels of sex hormones can result in an increased salience of sexual thoughts (Grubin, 2018; Ward & Beech, 2017). That is, those with high levels of sex hormones such as testosterone often demonstrate an increase in goal directed behaviour that is aimed at fulfilling sexual needs and desires, as well as achieving social and interpersonal dominance more broadly (Pfaus, 2009). As discussed previously in relation to general models of sexuality, testosterone can play an important role in sexual arousal, and an excess of this hormone can result in increased levels of sexual preoccupation (Grubin, 2018), which is in turn a predictor of the onset of sexual offending (Seto, 2019). In this sense, the ITSO is supported with hormone levels (a biological issue) interacting with social factors in order to produce specific neuropsychological changes in how an individual perceives their social environment (see below). These biological explanations are suggestive of the fact that unchosen and uncontrollable biological factors in somebody's physical makeup can modulate their propensity towards sexual offending.

Social antecedents of sexual offending

In addition to biological factors, the social environment in which an individual is raised, and continues operate in, has a profound effect on the behaviours that an individual presents with. Ward and Beech (2006; 2017) refer to this as an individual's ecological niche, which is comprised of a range of distal and proximal factors that contribute to offending behaviour. Distal factors are long lasting and generally static over an extended period of time, while proximal factors are those issues that directly contribute to the creation of specific situations in which offending behaviour is possible. In this sense, distal factors can be regarded as general psychological vulnerabilities, whereas proximal factors are more situational in nature.

Among the most studied life events that contribute to the development of distal risk factors for sexual offending is experiencing sexual abuse in childhood, and the downstream psychological effects that this has. Beitchman et al. (1992) reported how the effects of experiencing such abuse include poor social adjustment, emotional dysregulation, sexual dysfunction in adulthood, confusion over one's sense of sexual identity, and inappropriate, harmful, or excessive sexual behaviour aimed at regaining or reasserting a sense of masculinity (Easton, Renner, & O'Leary, 2013; Lamb et al., 2018; Romano & De Luca, 2001). Not only is this seen among ICSOs, but also in those demonstrating hypersexual behaviour (Engel et al., 2019). Each of these problems is associated with downstream impairments related to psychological and interpersonal abilities that translate into beliefs and behaviours associated with sexual arousal and subsequent escalations into sexual offending behaviour,

as described above (Bancroft et al., 2003; Bartels & Beech, 2017; Cortoni & Marshall, 2001; Giraldi et al., 2015).

Interlocking neuropsychological systems

As stated previously, long term sexual abuse has been associated with a range of lasting psychological effects, the most striking of which relates to emotional dysregulation. This is typically associated with conditions such as low self-esteem, low self-worth, increased rates of depression, anxiety, and post-traumatic stress, and expressions of anger and aggression (Beitchmann et al., 1992; Cutajar et al., 2010). According to Ward and Beech (2017), disruption to brain systems responsible for affective regulation (as well as planning behaviours and making attributions about the behaviour of others) are risk factors for sexual offending. While not being sufficient for the commission of sexual offences (i.e. not all people with disrupted emotional regulation will go on to sexually offend), it may be that having this predisposition to affective dysregulation makes somebody vulnerable to problematic sexual arousal (in that emotional distress is commonly alleviated through masturbation and partnered sexual activity; Bancroft et al., 2003; Cortoni & Marshall, 2001; Ward & Siegert, 2002; Yule et al., 2017) and subsequent sexual offending (Bartels & Beech, 2017; Gee & Belofastov, 2007). A number of studies have found that there is a higher than expected rate of mood disorders in samples of ICSOs (e.g. Kafka, 2003; Långström, Sjöstedt, & Grann, 2004). A reduction in general levels of sexual arousal are common symptoms of depression. However, using sex as a method for emotional regulation is also common among both ICSOs (Cortoni & Marshall, 2001) and people with PSA (Bancroft et al., 2003; Bancroft & Vukadinovic, 2004; Brewer & Tidy, 2019; Hughes, 2010), especially among those who experience high levels of sexual excitation or low levels of sexual inhibition (Bancroft, Graham, Janssen, & Sanders, 2009). Pennington (2002) outlines how these emotional functions are driven by networks and structures in limbic areas of the brain. In light of the review of the biological basis for sexual arousal presented at the beginning of this chapter (which invokes the neural structures within the limbic system as a key driver of sexual arousal processes; e.g. Pfaus, 2009), it is unsurprising then that dysregulation in this domain is prevalent among both ICSOs and people experiencing PSA.

Deficits in emotional regulation also translate into difficulties with perception and memory, as well as behavioural response selection (Ward & Beech, 2017). That is, those who experience emotional difficulties often demonstrate a range of cognitive biases, such as catastrophising and generalising (Tucker & Luu, 2007), and this leads to a number of downstream effects in relation to heightened experiences of low mood (i.e. chronic states of depression exacerbate low mood; Lara & Klein, 1999). In the area of sexual offending (and specifically with individuals demonstrating PSA), the use of sex as a coping strategy for negative emotional states might orient people towards: (1)

rehearsing self-soothing behaviours in a habitual way (e.g. compulsively masturbating or engaging in sexual offending; Brewer & Tidy, 2019; Cortoni & Marshall, 2001; Yule et al., 2017), remembering that this was a successful coping method in the past (a memory / perception process), and (2) seeking out sexual stimuli on a more frequent basis in order to avoid negative emotional experiences (an action selection strategy; Bancroft et al., 2003; Everaerd, 1989; Janssen, 2011).

These interlocking neuropsychological functions give rise to a range of clinical symptoms associated with sexual offending (Ward & Beech, 2017), such as social isolation and poor intimate relationships (due to emotional dysregulation), deviant or excessive sexual arousal patterns, and cognitive distortions about sexuality, as set out by Ward and Siegert (2002). By fully formulating a case within the context of a multi-factorial theory such as the ITSO, treatment targets (both in terms of desired outcomes and the psychological processes that need to be addressed in order to achieve them) can be identified. The overlapping nature of theories of sexual offending and models of PSA highlights the importance of considering how to best treat those ICSOs who may have problems with controlling their levels of sexual arousal, both from a health and wellbeing perspective at the level of ICSOs themselves, but also from a forensic risk reduction perspective. Based on this review of theories of sexual offending (Finkelhor, 1984; Marshall & Barbaree, 1990; Ward & Beech, 2006; 2017; Ward & Siegert, 2002), sexual arousal appears to be a necessary aspect of offending behaviour but is not sufficient in isolation to directly cause sexual offending to take place (Seto, 2019). With this in mind, individuals with PSA do not appear to be any more likely than those without PSA to commit a sexual offence, but rather a range of facilitatory factors alongside PSA will determine whether someone goes on to commit a sexual offence. However, based on these models of sexual offending, it is not surprising that PSA is considered a risk factor for recidivism in those already convicted of sexual offences, as discussed within the next section.

Understanding PSA as a risk factor for recidivism

For ICSOs, sexual preoccupation has been identified as a key risk factor for recidivism (both general and sexual) within the broader forensic literature (Hanson & Morton-Bourgon, 2004; Hanson & Harris, 2000; Hanson, Harris, Scott, & Helmus, 2007; Knight & Thornton, 2007). One dynamic measure of risk is the Structured Assessment of Risk and Need (SARN; Craig & Beech, 2009), within which sexual preoccupation is termed obsession with sex. High scores on this risk domain are consequently the most strongly present risk of reoffending factor in a study of over 1000 individuals serving prison sentences for a sexual offence (Hocken, 2014).

As stated previously, testosterone levels are implicated as being important for sexual arousal (Grubin, 2018; Jordan et al., 2011; Pfaus, 2009). One study found that testosterone levels were

significantly associated with sexual reoffending among a sample of more than 500 ICSOs (Studer, Aylwin, & Reddon, 2005). This was only the case among those who had not undergone psychological treatments to address their offending behaviour, potentially indicating a role for environmental influences on the expression of testosterone in relation to sexual offending. However, a recent meta-analysis of testosterone levels among ICSOs (Wong & Gravel, 2018) found no overall effect of group membership (i.e. offending status). A small difference was reported between those whose offences were committed against children vs. against adults. ICSOs who offended against children had significantly lower levels of testosterone. This supports broader forensic literature that suggests ICSOs who offend against children are often more emotionally or developmentally congruent with children (McPhail, Hermann, & Nunes, 2013), and seek children as sexual partners due to a lower biological propensity for competing with other men for age-appropriate mates (with testosterone being associated with a striving for social dominance; Eisenegger, Haushofer, & Fehr, 2011).

In attempting to reduce risk of reoffending in ICSOs (not just factors related to sexual arousal), psychological treatments are considered the global gold-standard (Williams, 2019). Despite some contradictory evidence (e.g. Mews, Di Bella, & Purver, 2017), it is known from the international evidence base that ICSOs who undergo treatment re-offend at significantly lower levels than those who do not experience such treatment (Gannon, Olver, Mallion, & James, 2019; Kim, Benekos, & Merlo, 2016; Lösel & Schmucker, 2005; Schmucker & Lösel, 2015). As such, engagement in psychological treatment programmes for ICSOs is considered vital in reducing the risk of future reoffending. For example, the integrative theory of desistance from sexual offending (ITDSO; Göbbels, Ward, & Willis, 2012) suggests that rehabilitation (i.e. the successful engagement with and completion of treatment programmes) allows ICSOs to learn the skills needed to successfully re-enter and reintegrate into society and lead offence free lives. As such, rehabilitation acts as an important first step on the road to long term desistance from sexual offending. However, it is acknowledged that PSA may interfere with engagement in treatment programmes and thus rehabilitation and long term desistance. That is, if sexual urges or thoughts are particularly intense, this can potentially impact upon individuals' ability to focus or participate effectively in treatment programmes and apply necessary risk management techniques (Grubin, 2018; Saleh et al., 2010) thus potentially impacting upon the effectiveness of treatment. As such, developing effective ways of managing PSA alongside psychological treatments is an important avenue for research and practice as we aim to reduce levels of sexual recidivism among those with convictions for sexual offences.

Treating PSA in ICSOs

Psychological treatment approaches

As discussed above, psychological interventions are accepted as the standard method of treatment for ICSOs within the UK (Gannon et al., 2009; Mews et al., 2017). The current suite of accredited HMPPS programmes for ICSOs, including those with learning disability (LD), consists of:

- Horizon (mainstream) or New Me Strengths (LD) for those assessed as medium risk
- Kaizen (mainstream) or Becoming New Me + (LD) for those assessed as high or very high risk
- Healthy Sex Programme (HSP; mainstream & LD) for addressing offence-related sexual interests

These were introduced after a national evaluation of the previous Sex Offender Treatment Programmes (SOTP; Core, Extended, and Adapted SOTP) indicated that these programmes had iatrogenic effect, increasing rates of sexual recidivism rather than decreasing them when treated ICSOs were compared to an untreated control sample (Mews et al., 2017). This data was incorporated into a later large scale meta-analysis that instead confirmed treatment programmes reduce the risk of reoffending, finding that 9.7% of ICSOs who underwent treatment are either re-arrested or reconvicted for a further sexual offence compared to 14.6% of those who had not experienced a treatment programme (Gannon et al., 2019). A total of 49 studies were included in this analysis, which examined the effectiveness of treatment for more than 40,000 ICSOs. This Gannon et al., (2019) analysis also identified the key factors that moderate this treatment effect and in line with other researchers' recommendations, they found that programmes that conform to risk-need-responsivity principles (Andrews, Bonta, & Wormith, 2011), have consistent professional psychological input (Gannon & Ward, 2014), regular staff supervision, sessions group-based treatment provision (Beech & Hamilton-Giachritsis, 2005), and arousal reconditioning (Kaplan & Krueger, 2012; Laws & Marshall, 1991; Marquis, 1970) were more successful in producing lower rates of recidivism in relation to further sexual offences. The Mews et al., (2017) report and the awareness that the old suite of SOTP did not conform well to these criteria (Williams, 2019), led HMPPS to develop and validate a new suite of psychological treatment programmes for ICSOs, as outlined above, all of which were in place by 31st March 2018.

In spite of the recognition that PSA is concerning for various reasons, as outlined previously, the current suite (or previous; i.e. Core, Extended and Adapted Sex Offender Treatment Programmes (SOTP)) of accredited HMPPS programmes does not directly address PSA. There are however elements of these programmes that attempt to address some of the key facets of PSA in some ICSOs, with some of the treatment programmes (i.e. Kaizen, Horizon, Becoming New Me+, New Me Strengths)

incorporating the development of skills and management techniques to assist individuals in recognising and managing key elements of PSA (e.g. sexual preoccupation) (HMPPS, 2018). This is achieved, for example, through developing an understanding of when non-sexual situations are being interpreted sexually, developing insight into personal triggers for sexual thoughts, and supporting individuals in mindfully acknowledging sexual urges (Williams, 2019). In addition to enhancing ability to recognise these elements of PSA, the programmes also incorporate the development of skills related to understanding and replacing unhelpful attitudes and developing healthy coping strategies (HMPPS, 2018). However, unless an individual is reporting PSA to be a current problem for them, thus requiring insight into this, this will not constitute a main focus of treatment.

In addition, HSP is a one-to-one programme that focuses on addressing specific paraphilic interests that are directly related to an individual's offending, and developing healthy sexual interests (Calder, 2017). However, this programme is restricted to individuals with a specific offence related sexual interest, meaning that those demonstrating more general PSA (e.g. unmanageable sexual thoughts and / or excessive masturbation that are not offence related) would not be eligible for treatment. As such, the current provision for addressing PSA within HMPPS treatment programmes is somewhat limited, resulting in some individuals with wellbeing concerns and treatment needs relating to PSA being left unmet and risk still at a heightened level. In order to be eligible for the programme, participants need to acknowledge their sexual thinking has been problematic for them in the past (or may be a problem in the future) and demonstrate motivation to work on this. HSP can be delivered to both those with and without learning difficulties. However, participants must have completed a primary treatment (e.g. the old Core SOTP or one of the new programmes) before HSP. Specifically, the programme aims to:

- Explore the participants unhealthy sexual interests
- Explore healthy sex
- Develop strategies for reducing the amount to which the participant is aroused to their unhealthy sexual interests
- Develop ways to strengthen their healthy sexual interests
- Strengthen relationship skills, including intimacy and self-esteem

The programme has been designed to be responsive to individual learning styles and treatment needs. As such, the core content is supplemented with optional exercises that are selected based on the individual's case details, which is broadly consistent with Gannon et al.'s (2019) finding of individualised treatment with an element of specific arousal reconditioning being an effective course of treatment for ICSOs.

Pharmacological treatment approaches

The treatment gap discussed above in relation to the limited extent to which psychological treatment programmes can address PSA, subsequently spawned the use of pharmacological treatment. This was suggested as a useful supplement to psychological treatment based on the promising results observed in those with sexual disorders (e.g. paraphilias) (Bradford & Kaye, 1999; Guay, 2009). It was therefore considered that pharmacological treatment could be used to assist individuals in managing their sexual arousal (Grubin, 2017), and facilitate learning within psychological treatment programmes (Saleh et al., 2010). As such, in 2007, protocols were established within the UK to allow the pharmacological treatment of ICSOs (within the care of HMPPS) on a voluntary basis, and in combination with psychological treatment programmes (Home Office, 2007 p. 14). This began with HMPPS facilitating a pilot trial at HMP Whatton in 2007 for the use of pharmacological treatment of ICSOs (Lievesley et al., 2013). Due to promising results, this treatment was embedded as a formal treatment option and later rolled out as a treatment pathway across the prison estate, at numerous sites specifically for ICSOs, with the service later termed medication to manage problematic sexual arousal (MMPSA). In this sense, it is important to understand the various possible approaches to treating problematic sexual arousal from a pharmacological perspective.

Classes of MMPSA

The most widely implemented, and considered to be the most effective, classes of medications used for the management of problematic sexual arousal in ICSOs are selective serotonin reuptake inhibitors (SSRIs) and anti-androgens (Grubin, 2018). Medications such as anti-psychotics, anxiolytics, and naltrexone have also been used for the management of problematic sexual arousal, however the evidence base for these is considered to be limited (Grubin, 2018; Thibaut, 2010).

Within the UK, the MMPSA service utilises these two main classes of medication for the treatment of problematic sexual arousal in ICSOs: SSRIs, and testosterone lowering agents. Both of these, and their role in the treatment of PSA will now be discussed in depth.

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs are a licenced anti-depressant and have a long history of use as a treatment for common and complex mental health conditions, such as depression, anxiety, and obsessive-compulsive disorder (OCD) (Bloch, McGuire, Landeros-Weisenberger, Leckmann, & Pittenger, 2010; Jakubovski, Varigondam, Freemantle, Taylor, & Bloch, 2015). Throughout their use in this traditional form, complaints regarding noticeable sexual side effects associated with SSRI use are common (Balon, 2006;

Grubin, 2018). These include inhibiting sexual arousal, erectile function, and ejaculation (Meston & Frohlich, 2000; Rosen et al., 1999; Waldinger et al., 1998). As such, the use of SSRIs for the purpose of managing sexual arousal is not surprising, with the evidenced side effects on sexual arousal instead becoming the targeted effects when SSRIs are used as MMPSA.

SSRIs are used off label in the treatment of PSA in ICSOs, with several theories being proposed regarding the mechanism of their effects. In the most commonly discussed model, SSRIs inhibit the transport of serotonin molecules back up into the pre-synaptic neuron. This results in serotonin remaining in the synapse for longer. Biopsychological explanations of sexual arousal and function propose that serotonin plays an inhibitory role in sexual function by reducing general levels of appetitive and motivationally driven behaviours, potentially by limiting the release of dopamine into the limbic system (e.g. Bancroft & Janssen, 2000; Hull et al., 2004; Lorrain et al., 1999; Pfaus, 2009). In this sense, an increase in the levels of serotonin in the brain has the effect of fuelling a sense of satiation, limiting the extent to which people seek out new sexual experiences (Fernandez-Guasti & Rodriguez-Manzo, 2003). There is a vast amount of evidence that increased rates of serotonin inhibit sexual desire and psychological arousal, physiological arousal / erection, and orgasm (Jordan et al., 2011; Meston & Frohlich, 2000) by reducing behavioural compulsivity and impulsivity (Bradford, 2001; Briken, Hill & Berner, 2003; Guay, 2009; Jordan et al., 2011) and cognitive rumination (Grubin, 2018). This links to the aforementioned OCD model of PSA, and may be particularly important among individuals with PSA that is associated with chronic low mood or emotional dysregulation (Bancroft & Vukadinovic, 2004; Thibaut et al., 2010). It is perhaps unsurprising that SSRIs may be implicated in the breaking down patterns of PSA in this way, with more recent evidence suggesting that these medications reduce the habitual effects of rumination and obsession associated with existing thought processes and give rise to a higher level of neural plasticity (Branchi, 2011). By affecting the brain in this way, SSRIs increase sensitivity to the environment, thus making individuals more susceptible to be influenced by external factors, such as alternative stimuli for sexual arousal and various forms of psychological therapy. As stated previously, while these central effects of SSRIs are linked to neurobiological processes the effects of serotonin can also be peripheral to brain chemistry, as there are serotonin receptors within the sex organs themselves (e.g. Ückert et al., 2003).

This effect of a reduction in sexual function was not sufficiently acknowledged until after the 1970s and prior to this, there were minimal reports of any association between SSRIs and sexual dysfunction (Higgins, Barker, & Begley, 2008). However, by the early 2000s, there were more than 200 case reports and studies detailing the use of SSRIs for the management of problematic sexual behaviour, with Fluoxetine and Sertraline being the most commonly prescribed (Grubin, 2018; Kafka, 2003). The majority of these case reports described reductions in the intensity and frequency of sexual

arousal, fantasy and urges. More recently, SSRIs have been documented to produce significant reductions in hypersexuality, sexual preoccupation and/or sexual compulsivity in ICSOs treated with SSRIs (Lievesley et al., 2013; Winder et al., 2014; 2018). Although the preliminary evidence base appears to be positive, it is also limited by methodological flaws. These include issues with the heterogeneity of samples, lack of randomised trials or studies with matched control samples, a lack of robust outcome measures, the reliance on self report methodologies, and short follow-up periods (Adi et al., 2002; Garcia & Thibaut, 2011; Grubin, 2018). Each of these limitations thus limit the generalisability and potential validity of any conclusions drawn regarding the clinical effectiveness of using SSRIs with this population.

SSRIs are taken orally, with recommended dosages ranging from 20mg to 80mg per day (Garcia & Thibaut, 2011; Grubin, 2018; Winder et al., 2019). This is consistent with the recommended dosage for people being treated for other mental health problems, such as depression (Jakubovski et al., 2016) and OCD (Bloch et al., 2010). This consistency in dosage across the treatment of different conditions suggests that the same types of neural networks and biological effects are being targeted in treatments with ostensibly different targets. As such, this indicates a cognitive or psychological underpinning to the use of SSRIs as a form of MMPSA. The side effects of SSRIs are considered to be much less severe than anti-androgens (see below). These include (but are not limited to) weight gain, drowsiness, restlessness and nausea. However, side effects are often transitory in nature (rather than chronic and enduring), and are not typically experienced to a severe degree (Cascade et al., 2009). SSRIs are almost completely removed from the body within a month of discontinuing use. For Fluoxetine specifically (the most common SSRI used as a MMPSA; Winder et al., 2019) this is the case after a period of 20-30 days, assuming a half-life of four to six days, and an average latency of five half-lives to completely remove a drug from the body; Little, Lin, & Reynolds, 2018; Nnane, 2019). The duration of the longer-term pharmacological effects of SSRIs on sexual dysfunction after discontinuing use is currently unknown, with reports suggesting these effects could persist for a period of months or even years after discontinuation (Ekhart & van Puijenbroek, 2014; Bala, Nguyen, & Hellstrom, 2018).

Testosterone lowering agents: Anti-androgens and gonadotropin-releasing hormone (GnHR) agonists

As discussed previously, testosterone is the primary sex hormone in males, involved in both physiological and psychological sexual arousal (Bancroft, 2005; Jordan et al., 2011). While it is not the case that increased levels of testosterone relate straightforwardly to increased sexual thoughts and behaviours (Krueger & Kaplan, 2001), it is well established that a 30-40% reduction in an individual's typical level of testosterone substantially reduces sexual arousal (Bancroft, 1989) as it appears that moderating sexual arousal could be a secondary effect of testosterone (the primary function of which

is in masculinisation; Lefevre et al., 2013). This observed effect provides the premise for testosterone lowering agents, such as anti-androgens and GnRH agonists, to be used for the purpose of reducing PSA, including in those with paraphilias (Craissati, 2004). Medication used to reduce testosterone levels are often referred to as anti-libidinals, and considered to be a form of chemical castration, though unlike surgical castration, the effects are often reversible (Grubin, 2018). The two types of testosterone lowering medications used within the UK MMPSA service are the anti-androgen Cyproterone Acetate (CPA) and GnRH agonists, each of which will now be discussed in depth.

Anti-androgens work by reducing levels of circulating testosterone, with much of the evidence relating to its use having been conducted with prostate cancer patients (Grubin, 2018). CPA was the first anti-androgen medication marketed specifically for the reduction of sexual drive in males (Maletzky & Field, 2003). Used to treat androgen-related medical problems (e.g prostate cancer, acne and excessive hair growth), it has been recognised for its ability to reduce sexual drive since the 1960s (Meyer & Cole, 1997). CPA works by inhibiting the uptake of testosterone, and the release of gonadotropin in the central nervous system. It achieves this by acting as a direct antagonist, blocking androgen receptors, resulting in reduced production and release of testosterone from the testes, as well as preventing the release of gonadotrophins which further inhibits testosterone secretion (Grubin, 2018; Jeffcoate, Matthews, Edwards, Field, & Besser, 1980; Maletzky & Field, 2003; Neumann & Kalmus, 1991; Neumann & Töpert, 1986).

Its first use with ICSOs took place in Germany and Switzerland, where positive results were obtained, including demonstrable reductions in deviant sexual behaviour and libido, with these effects also being reversible (Hoffet, 1968; Seebandt, 1968). This led to further research and positive outcomes from an eight year trial of the use of CPA with over 100 men with 'sexual deviations and perversions' (Laschet & Laschet, 1975, p. 821). Here, sexuality was inhibited in all men taking CPA; 80% of cases with a dose of 100mg CPA daily and 20% with a dose of 200mg CPA daily. Since this, a limited number of studies have taken place across the world to explore the effectiveness of CPA. For example, in 1981, Cooper conducted a placebo control study of CPA with nine men who were classed as hypersexual and reported that CPA reduced sexual arousal (including erections) and sexual interest/drive when compared to placebo. In a double blind placebo study (Bradford & Pawlak, 1993), participants reported reductions in sexual arousal, sexual activity and sexual fantasy over a 13 month period. In an overview of 10 open and controlled studies with ICSOs and/or individuals with paraphilias, Thibaut et al. (2010) report significant declines in self-reported sexual activity, sexual fantasy, frequency of masturbation and deviant sexual behaviour in 80-90% of cases treated with CPA. More recent research (which constitutes part of the UK evaluation of MMPSA) has reported significant

reductions in hypersexuality, sexual preoccupation and/or sexual compulsivity in ICSSOs treated with CPA (Lievesley et al., 2013; Winder et al, 2014; 2018). In addition, Lippi and van Staden (2017) conducted a comparison study of ICSSOs taking CPA (n = 13), from a non matched control group of ICSSOs who were not taking CPA (n = 63). The results indicated no significant difference in levels of sexual dysfunction, sexual desire, arousal, erection and orgasm between the treatment and control groups. However, the study was limited by the many confounding variables of the non matched group, including that of them were taking psychotropic medication (including SSRIs) for reasons unrelated to sexual arousal. Thus, it seems that despite their long standing use, there is still limited robust evidence for the use of antiandrogen treatment, including CPA, for the treatment of sexual thoughts, behaviour and arousal (Briken & Kafka, 2007; Garcia & Thibaut, 2011; Khan et al., 2015). This is because the research that exists to suggest CPAs efficacy is largely based on anecdotal and retrospective data (Maletzky & Field, 2003).

Within the UK, CPA is generally taken orally, with a daily recommended dose of between 50-100mg per day, although this can be increased to 200mg per day (Grubin, 2017). Regular medical monitoring is recommended due to the nature of the potential side effects, which include but are not limited to, gynaecomastia (breast development), weight gain, reduced bone mineral density (osteoporosis), reduced testicle volume, hot flushes, and hepatotoxicity (Cherrier, Borghesani, Shelton, & Higano, 2010; Khan & Mashru 2016; for a full list of possible side effects see Lippi & van Staden, 2017). These effects are considered to be similar to those of surgical castration, but are usually reversible within 4-8 weeks of discontinuation (Garcia & Thibaut, 2011; Grubin, 2018).

GnRH agonists are, in comparison to CPA, a more recent development in the field of use for the treatment of sexual arousal (Grubin, 2018). In a similar way to CPA, GnRH agonists reduce testosterone levels, but are one of the stronger forms of medication in this class, producing a reduction in testosterone that is similar to that of surgical castration (Grubin, 2018). GnRH agonists achieve this by stimulating the pituitary gland, which causes an increase in luteinising hormone (LH). This in turn leads to a marked increase in the individual's level of testosterone in the first instance (i.e. in the first three days after administration; Heidenreich, 2010; Lewis, Grubin, Ross, & Das., 2017). However, as the medication then leads GnRH to be released constantly, the pituitary GnRH receptors become desensitised, leading to a significant reduction in LH release and subsequently the production of testosterone over the course of the next three-to-four weeks (Grubin, 2018).

The evidence base for GnRH is somewhat limited. A review conducted by Briken et al. (2003) incorporated a total sample of 118 patients, from 13 studies, and while these each describe varying degrees of reductions in sexual arousal, fantasy and behaviour, the review concluded that the majority

of the studies were fraught with methodological difficulties making it difficult to draw any firm conclusions. In a more recent review, Lewis et al. (2017) reviewed all studies between 1969-2015 that used GnRH agonists for the purpose of reducing sexual arousal in ICSOs. They found 12 eligible studies, with a total of 323 participants, with all studies reporting a reduction in measures of sexual functioning to some degree. As with the previous review, Lewis et al. (2017) concluded that although the findings demonstrated promising results, a lack of randomised control trials, and methodological limitations of the individual studies means that further, more robust research is required to determine the effectiveness of this treatment.

GnRH agonists are administered using a depot injection, with a recommended dose of between 3.75mg to 7.5mg per month, depending on the specific medication being prescribed (Lewis et al., 2017). Due to the similar outcome in reducing levels of testosterone, the side effects observed in GnRH patients are similar to those receiving CPA (see above), however, some research has shown that the effects for longer term use of GnRH agonists are sometimes irreversible (Lewis et al., 2017) and as such, regular medical monitoring is recommended (Grubin, 2018).

Prescribing protocols

As discussed previously, the use of pharmacological medication was initially implemented for the treatment of deviant or paraphilic sexual interests that may, or may not, be accompanied by sexual offending behaviour. As such, many of the prescribing protocols for the use of pharmacological treatment are focused on replacing paraphilic sexual interests (e.g. Federoff, 2016; Winder et al., 2019) and / or reducing risk of sexual offending (e.g. Thibaut et al., 2010), therefore adopting a risk based approach to prescribing. For example, the most widely implemented guidelines were produced by the World Federation of Societies of Biological Psychiatry (WFSBP; Thibaut et al., 2010) and advocate for the progressive use of medication based on the nature of the paraphilic sexual interests and level of risk of offending posed by the individual. That is, it outlines a six level treatment continuum which begins with those considered to be least risky (i.e. those experiencing paraphilic sexual fantasies, but with no evidence of offending behaviour), for whom psychotherapy alone is indicated as an appropriate treatment option. However, if these fantasies begin to involve criminality or the individual is considered to be low risk of sexual violence, SSRIs are recommended to be combined with psychotherapy. If the service user engages in hands-on offending behaviour, anti-androgen medication alongside SSRIs and psychotherapy is indicated as the appropriate treatment choice. As such, the treatment choice and thus which level you commence on in this model is determined by the level of risk of offending, with the aim of treatment being 'complete suppression of sexual desire and activity' (p. 646) for those considered to be highest risk. Earlier proposed treatment algorithms also

advocate for a similar approach, ranging from psychotherapy alone, progressing through the use SSRIs, anti-androgens, GnRH (or luteinizing hormone releasing hormone) based on level of paraphilia and sexual risk (e.g. Bradford, 2000; Hill et al., 2003). However, it should be noted that while these models allow for individuals to progress through the different medications based on insufficient treatment effect, this is not a requirement and service users can enter the treatment directly onto anti-androgens and / or GnRH (alongside psychotherapy) if they present a high level of risk (e.g. Bradford, 2001; Thibaut et al., 2010).

In contrast, the MMPSA service within the UK is not risk focused, and the prescribing protocol is instead based on clinical indications of PSA (Grubin, 2017; 2018). That is, there are different recommendations dependant on the predominant clinical profile of the service user. For example, within this protocol, SSRIs are suggested as the most appropriate first line of treatment for those whose PSA is primarily associated with sexual preoccupation, rumination, impulsivity, or mood dysregulation (Grubin, 2017; Winder et al., 2019). This is perhaps unsurprising given the specific role that serotonin plays in the arousal process, as discussed above. That is, owing to the predominantly psychological (rather than physical) nature of serotonin (vs. testosterone), this drug class affects the more cognitive aspects of PSA. Where there is an insufficient treatment effect, progression to anti-androgens is recommended. In contrast, those service users who report having difficulty in controlling their sexual urges, or who demonstrate high levels of sexual behaviour are recommended to be treated with anti-androgens in the first instance, with progression to GnRH if insufficient treatment effect is observed (Grubin, 2017; Winder et al., 2019). This is due to the physical manifestation of PSA in these service users, and the specific physiological role of testosterone in the development and experience of sexual arousal (Grubin, 2018; Jordan et al., 2011). As with the previous models, MMPSA is recommended to be combined with psychological therapies (Grubin, 2017; 2018) with the additional assumption that prescribing MMPSA should be a collaborative process between the prescribing professional and the service user, balancing the clinical needs of the case with the broader wellbeing of the individual (Grubin, 2018). In this regard it is thus important to recognise that the elimination of sexual arousal and functioning is not the goal of using MMPSA, even with ICSOs assessed as having a high risk of reoffending, which is in direct contrast to other prescribing protocols (e.g. Thibaut et al., 2010). This is in line with the aims of the treatment, as rather than eliminating sexual arousal and / or sexual risk being the ultimate goal, instead here it is considered that MMPSA should be used to help individuals gain control over their sexual arousal, with a secondary effect being a reduction in sexual risk levels.

It should be noted that while this prescribing protocol is addressing different aims, all available protocols clearly classify the medications used along the same continuum from SSRIs, to anti-

androgens, to GnRH agonists, thus presenting the former as the 'milder' medications and the latter as the 'stronger' medications. While this is not necessarily the case in a strict dosage related sense, it could be suggested as accurate from the perspective of what each medication class achieves. That is, while SSRIs increase the levels of serotonin available to the body, allowing the individual to feel satiated (Hull et al., 2004; Jordan et al., 2011) they still allow an individual to produce testosterone, which acts as the key hormonal catalyst for sexual arousal (Bancroft, 1989; Grubin, 2018). In contrast anti-androgens (e.g. CPA) and GnRH have the ability to reduce this production to prepubertal levels and thus stop arousal capabilities almost entirely (Garcia & Thibaut, 2011; Grubin, 2018). As such, the aims of treatment should be directly linked to the relative 'strengths' and physiological effects of the medications being prescribed.

Chapter Conclusions

As indicated in the introduction to this thesis and further elaborated on in this review of the literature, PSA is currently studied in a disparate way by different research teams using a range of definitions for specific concepts interchangeably. In this thesis, these issues (e.g. sexual preoccupation and hypersexuality) will be considered under the label of PSA as a unified concept. From the review of the literature, it is clear that PSA represents a significant wellbeing issue, as well as being an important risk factor for both first time sexual offending and recidivism among ICSOs. However, PSA is not currently fully considered in formal treatment programmes. While there are several studies now emerging about the effectiveness of MMPSA as a treatment of PSA from a quantitative and clinical perspective (Winder et al., 2014; 2018), the qualitative accounts of individuals taking MMPSA in relation to their experiences of this treatment pathway are not yet known. Understanding these experiences is important because, as stated in Chapter 1, evidence about what might be considered to be the most effective intervention for a particular health issue is to some degree irrelevant if service users are not willing to engage with or take it (e.g. Wilson, Vitousek, & Loeb, 2000). Again, this is particularly important in relation to MMPSA, as the 'treatment is in the pill form and administered by the offender' (Harrison, 2008, p. 2). As such, understanding service users' motivations for treatment, as well as their experiences of it while the treatment is ongoing, may help researchers to develop an understanding about the broader positive (e.g. wellbeing) and negative (e.g. treatment engagement issues such as non compliance and drop-out) effects of MMPSA.

The central aims of this thesis are thus: (1) to gain insight into the development, awareness and management of PSA in individuals taking MMPSA, (2) to understand the lived experiences of individuals taking MMPSA who are convicted of sexual offences, (3) to explore the nuanced pathways of the MMPSA treatment that these individuals must navigate, and (4) to explore the potential

implications of these experiences in relation to the use of MMPSA with ICSOs. In doing so, the thesis will draw on the theories of sexual arousal, sexual offending, broader psychological concepts, as outlined above. The next chapter sets out the general methodology used to investigate this topic, before the empirical chapters discuss the findings of the various analyses that have been conducted as part of this research.

Chapter 3

Methodology

This chapter will outline the methodological approach adopted within this thesis. It aims to provide a rationale for the research design based on the original research questions and the empirical studies implemented to explore these questions. It will outline the research process, detailing the ethical considerations and procedures, methods of participant recruitment, data collection and analysis. This chapter discusses elements that are relevant to the full thesis, whereas the intricacies relevant to the individual studies are detailed within the empirical chapters.

Research aims and questions

This thesis was guided by a set of overarching research aims. These were to:

- Gain insight into the development, awareness and management of problematic sexual arousal (PSA) in individuals taking medication to manage problematic sexual arousal (MMPSA)
- Understand the lived experiences of individuals taking MMPSA who are convicted of sexual offences
- Explore the nuanced pathways of the MMPSA treatment that these individuals must navigate

Alongside these aims the thesis sought to explore the potential implications of these experiences in relation to the use of MMPSA with ICSOs. In order to guide this work, a number of research questions were designed to explore and capture the lived experiences of participants. The questions were:

- What contributes to the development and awareness of PSA in individuals convicted of sexual offence (ICSOs)?
- How do ICSOs manage their PSA prior to and during MMPSA treatment?
- What are the experiences of living with PSA for individuals taking MMPSA?
- What are the lived experiences of taking MMPSA?
- Do the experiences of individuals taking MMPSA differ based on medication type?
- What are the nuanced pathways of MMPSA for individuals that are taking it?

While these questions were designed to guide and provide structure and coherence to this thesis, due to the exploratory nature of the research, the purpose was never to provide a definitive answer to any of these but to instead provide an exploration and understanding of the lived experiences of

individuals taking MMPSA who are convicted of sexual offences, and to the nuanced pathways of the MMPSA treatment that these individuals must navigate. In order to achieve this, the following empirical studies were undertaken:

Study 1: Exploring the development of PSA in ICSOs

Study 2: Understanding the experiences of ICSOs taking SSRIs as a form of MMPSA

Study 3: Understanding the experiences of ICSOs taking anti-androgens as a form of MMPSA

Study 4: Exploring the treatment pathways of ICSOs prescribed MMPSA

Methodological approach

Traditionally, psychological research has adopted a single research paradigm (Alasuutari, Bickman, & Brannen, 2008), namely that of either positivism that assumes there is an objective reality that can be scientifically measured, or interpretivism / constructivism, adopting a subjective approach that recognises the possibility of multiple interpretations of reality (van Griensven, Moore, & Hall, 2014). Both paradigms stem from different ontological, epistemological and theoretical standpoints that guide the research in divergent directions. A positivist approach is nomothetic in nature, building on deductive theory and seeking explanatory scientific knowledge that can be quantitatively measured with a view that there is only one objective reality or truth that can therefore be tested. In contrast, an interpretivist approach is idiographic in nature, building on inductive theory and exploring subjective knowledge and understanding through methods such as interviews with the recognition that there can be multiple subjective truths (Henn, Weinstein, & Foard, 2005). Both approaches have received criticism with positivist research failing to acknowledge the subjective role of the researcher and participants, while interpretivist research is criticised for lacking theory, validity and reliability due to being overly subjective (Easton, McCornish, & Greenberg, 2000; Hall, 2012). In relation to prison based or offender related research, much of this is quantitative in nature adopting a nomothetic approach to subject matters such as risk and recidivism. While research of this nature has been invaluable in informing and developing our expertise, they have not provided us with rich descriptive data that illuminates participant experiences and worlds, as such there is still a need to focus on service user perspectives (Nee, 2004). Arguments such as these highlight the limitations of restricting research to one paradigm and instead recognise that when examining complex phenomena, the research may benefit from an exploration of both perspectives (Bergman, 2011).

A mixed methods approach refers to the integration of both qualitative and quantitative research methodologies (Creswell & Clark, 2017). The opposing paradigms that underpin qualitative and quantitative methods have resulted in much debate regarding mixed methods research

(Onwuegbuzie & Leech, 2005), with some advocating that combining methods would produce flawed outcomes or even rendering the concept of combining the two methods impossible (Guba & Lincoln, 1994). In contrast, others reject the requirement to adopt only one approach, attempting to combine the assumptions of both paradigms, embracing a more flexible and pragmatic approach (Tashakkori & Teddlie, 1998; van Griensven et al., 2014) arguing that it strengthens the research in that it contributes to both an explanation (positivism) and understanding (interpretivism) (Morgan, 2007). Those in support of this approach argue that a false dichotomy exists and rather than viewing the different paradigms as distinctly different and opposing, they should instead be viewed as lying on a continuum, with focus placed on the similarities between the approaches rather than the differences (Onwuegbuzie & Leech, 2005). The underlying principle of a mixed methods approach is that it allows researchers to utilise the strengths of the individual approaches while also compensating for the weaknesses of each (Kelle, 2006; Tashakkori & Teddlie, 1998). It is suggested that methodology that utilises this approach, integrating different methods and perspectives, generates a broader and more comprehensive understanding of the phenomena or research question under exploration (Onwuegbuzie & Leech, 2005). This view is largely supported in contemporary research, with researchers advocating that to fully understand a phenomenon the integration of both methods is required (Koshy, Koshy, & Waterman, 2011). This is particularly considered to be the case in complex research questions where an integration of methods provides a much more comprehensive understanding than one method alone could provide (Lund, 2012). More specifically, the need to account for both idiographic and nomothetic perspectives, particularly when related to human experience, is considered vital (Diener & Fujita 1995; Hindle & Franco, 2009).

In light of the above discussion, this research adopts a mixed methods approach which is well aligned with the overarching aims of the research. Thus, the overarching research paradigm adopted here is pragmatism, which is the most frequently adopted paradigm employed in mixed methods research (Tashakkori & Teddlie 2003; Johnson, Onwuegbuzie, & Turner, 2007). This prevents the researcher being restricted to only one world view, accounting for both positivist and interpretivist perspectives (Feilzer, 2010; Tebes, 2012). It offers a flexible approach, with the thesis drawing largely from interpretivism and phenomenology in its philosophy and theoretical underpinnings in terms understanding the lived experiences of participants in the qualitative empirical chapters, while also recognising the value the quantitative elements add within the pathways study in order to provide a more holistic and comprehensive understanding of the lived experiences of ICSOs taking MMPSA.

Research process

Ethical considerations and approval

As professionals and researchers, much of the work we undertake is governed by both the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC). Over the years, ethical guidelines and frameworks have been set out to guide our professional conduct, performance and the considerations we make (e.g. BPS, 2014; 2018). As such, it was imperative to consider and adhere to these throughout the course of planning and undertaking the research for this thesis.

Research of this nature, with ICSOs, required careful and thorough ethical consideration to ensure the relevant guidelines and frameworks were adhered to. Firstly, approval from the Governor at HMP Whatton (the research site) was sought in order to confirm that, in principle, they were happy for the research to go ahead within their establishment – it is a requirement to obtain this approval before requesting any detailed ethical approvals. Once Governor approval was obtained, an application to conduct each stage of the research was submitted to the Nottingham Trent University Research Ethics Committee. Additionally, as the research was being undertaken with participants who were at the time incarcerated, I was also required to submit an application and request to Her Majesty's Prison and Probation Service (HMPPS) ethics board. Both ethical applications were approved without further amendments and only at this point, once both ethics committees were satisfied that the proposed research had been carefully thought through and was ethically sound, could data collection commence (detailed later in this chapter). These ethical approval processes required the need for and provided an opportunity for thorough reflection on the research process, ethical considerations and any issues that may arise. This includes but is not limited to issues of confidentiality, informed consent, security and retention of the data, risk of harm to participants and researchers and disclosure of information. As this research is of a particularly sensitive nature and with a vulnerable population (in that it involves ICSOs), it yields many ethical concerns, some of which require further exploration and are outlined below.

Informed consent

While psychological research has in the past and can, in justifiable circumstances, be conducted without the full informed consent of participants, the approach adopted for the research outlined in this thesis was one of transparency. As such, in line with the BPS and HCPC guidance, full informed consent was obtained from all participants – a process in which potential participants are given all necessary information about the research in order to make an informed decision about whether or not to participate (Bryman, 2016). This was considered to be important since it is asserted that robust

consent procedures form the basis for credible and trustworthy research (Henn et al., 2005). The process of ensuring informed consent was particularly important in this context as there was the potential risk that individuals may have considered participation to be compulsory or may be influenced to participate or decline for various reasons. For example, taking time out of work to participate could result in a loss of pay, while in contrast participation allows them to take time out of their standard prison regime, potentially relieving boredom and providing the opportunity to talk to someone new (Bosworth, Campbell, Demby, Ferranti, & Santos, 2005). To try to further control for any influences of participation, no incentives or rewards were offered. This ensured confidence that participation was not influenced by a potential gain but instead because participants genuinely wished to contribute to the research and felt that they had something to offer (Bosworth et al., 2005). In addition, participants may hold the belief that participation in the research will benefit them in some way regarding their sentence or release. It was therefore vital to ensure that individuals understood that participating in the research was entirely voluntary. This meant ensuring that there were no perceived benefits (aside from having the opportunity to share their perspectives and experiences) or negative consequences of participating or not, and that either option would not impact upon their sentence, treatment or opportunities in any way.

During the initial information giving meeting, all potential participants were provided with an information sheet and consent form which were carefully explained by the researcher to ensure understanding and account for any potential literacy deficits. These outlined the purpose of the research, what their participation would involve, how the data would be stored and used, the voluntary nature of the research, confidentiality measures, their right to withdraw without the need for an explanation and contact details of the researcher. All individuals were given the opportunity to ask questions or to have time to go away and think through the information before reaching a decision with regard to participation. For those who consented to participate, a signature was required to confirm this and explicit consent for audio recording of the interviews was also obtained. Before the commencement of any subsequent data collection, the information was reiterated, and consent was again obtained from those who wished to continue their participation. This was a vital process in ensuring informed consent throughout the course of the research rather than assuming the initial consent, once obtained, was continually valid. In line with the Mental Capacity Act 2005, any concerns about a participant's capacity to give valid consent or continue with the research meant that they would be stopped from continuing to participate – however, this did not occur throughout the course of the research.

Confidentiality

Researchers working with convicted populations often face ethical dilemmas, particularly in relation to confidentiality conflicts – aiming to protect participants’ anonymity while also balancing a consideration for public protection and responsibilities within the prison establishment, the latter of which is always of paramount importance. As such, the approach adopted here in relation to confidentiality was one that Cowburn (2005) termed limited confidentiality in which clear boundaries as to what is confidential, and what is not, are established. In line with this, participants were made aware of the limits of confidentiality within the initial information giving interview and prior to each research interview as outlined within the participant information sheets and consent forms. They were informed that disclosure of certain information would result in confidentiality being broken and the information being passed onto the relevant authorities (e.g. prison staff, security, police). This included information relating to any breach of prison security, any risk of harm for themselves or someone else or offences for which someone had not been convicted.

When conducting the interviews, these were recorded using a passcode protected dictaphone and the participants name was not mentioned on tape instead, their chosen pseudonym was used. During the transcription of the interviews, any identifiable information was removed or changed appropriately. During the course of the research, the researcher acknowledged that interview dialogue that is transcribed verbatim runs some risk in terms of identifying the participant. Active efforts were therefore made to ensure that no identification was possible (e.g. through anonymising the names, locations, etc), and by remaining alert to possible ways that the participants may be identified (e.g. in-depth detail about the offences together with personal details of the offender may together increase the risk of recognition of the participants). All participants were informed that the research data would be stored in locked cabinets or password protected files and would only be accessible to the research team. Furthermore, research data were only removed from the prison establishment in an anonymised format. Participants were informed that the findings of the research would be published, and may include their pseudonym or extracts/quotes from their interview for qualitative participants, but any identifiable information would be altered or removed. Furthermore, any publications and dissemination would be submitted to HMPPS for consideration and approval before external dissemination.

Vulnerability and risk

The participants

As this research is of a sensitive nature with a vulnerable population, the matter of potential risk of harm to participants was an important consideration and required care and sensitivity. Allowing

participants to tell their stories and recount their experiences can evoke unexpected emotions and distress during the interview and may leave individuals feeling more vulnerable (Draucker, Martsof, & Poole, 2009; Flick, 2009). As such, an integral part of conducting this research was building rapport and creating a safe space in which participants felt able to do this (Waldram, 2007). In order to manage the potential risk of harm, all potential participants were made aware of the nature of the research prior to agreeing to participate, informed of their right to withdraw or stop the interview at any point, and also informed of their right to not answer questions during the interview if they did not feel comfortable to do so. Furthermore, different avenues of post interview support were included within the debrief should any participants have become distressed after the interview. It was also important to acknowledge that potential harm was not only possible on an individual participant level, but also how the findings of this research could impact upon the wider group, for example, those receiving MMPSA, those with PSA, or those convicted of sexual offences in general. Sieber and Stanley (1988) coined this as 'socially sensitive' research, where 'there are potential social consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research' (p. 49). When conducting research with convicted individuals who are an already stigmatised group, the ultimate findings must be treated sensitively as they may confirm messages in the media and add to the negative perceptions of the public (Liamputtong, 2007).

The researcher

Traditionally when we consider the risk of harm in research, the safety of participants takes priority (Coles & Mudlay, 2010). However, there is little consideration of the impact on researchers conducting challenging, sensitive and emotionally demanding research, despite a growing awareness of the need for this (Dickson - Swift, James, Kippen, & Liamputtong, 2008). As researchers we approach populations, groups and individuals and ask of them what some might consider a lot: to open up, to tell us their thoughts, feelings and experiences – essentially to tell us their story. As such, an integral part of conducting research, particularly with vulnerable populations, is building rapport and creating a safe space in which participants feel able to do this. In order to achieve this, some researchers place emphasis on establishing trust with participants by being open and honest with them (e.g. Roberts, 2011), with some even advocating self disclosure as a means of aiding this process (Dickson-Swift, James, Kippen, & Liamputtong, 2006). However, this is not always appropriate, particularly within a prison environment where you have to be alert about, and continually reflective upon, what personal information you discuss or share at all times. This can be a very difficult obstacle in a research interview, when asking for so much from the participant, but offering very little in return except listening. Listening is key as it is usually the case that participants want their story to be told and heard

but this can become difficult, as you are hearing the participants' story or version of events. It is therefore not unusual to hear minimisation or denial of offences, distorted viewpoints, or an offence account that does not match with their conviction in a setting that provides no opportunity to respond or challenge – a process that can leave the researcher in an uncomfortable position feeling as though they may have colluded with the participant's denial or minimisation. As a means of managing these potential challenges, it was imperative to ensure that I was embedded within an appropriate network of support throughout the course of this research. This took place in the form of regular supervision and formal debriefing processes, a practice that is considered to be essential for managing these potential challenges (Dickson-Swift et al., 2008). This facilitated recognition and discussion of the impact of the research on the researcher and how this could be managed effectively. Other methods of support, for example counselling were also available throughout the course of the research, however this was never required or utilised.

Furthermore, as the research was conducted within a prison establishment there were additional risks to safety that needed to be addressed. I attended the prison regularly (several days per week during data collection) which ensured that I was familiar with the environment including the layout of the prison, different staff, the prison regime, security procedures and procedures regarding meetings with prisoners. I underwent full vetting, prison induction talks, key training and breakaway self defence training. In addition, I avoided prisoner areas at peak 'movement' times unless absolutely necessary to reduce any risk, always carried a personal alarm and ensured that someone within the prison always knew my whereabouts.

Participant recruitment and sampling

The sampling and recruitment strategy was determined by the topic under exploration; as the current research was looking at ICSOs who were prescribed MMPSA, it required me to target a specific population (those receiving MMPSA) within a specific organisation (HMP Whatton as the site offering MMPSA). In order to achieve this, the overarching sampling strategy that was employed was purposeful (Patton, 2002) which allowed me to intentionally select participants on the basis that they are the 'experts' or the best placed individuals to contribute their knowledge of the subject area under study (Henn et al., 2005).

The same process of recruitment of participants was employed across all empirical studies with access to participants being granted by the prison establishment following ethical approval from HMPPS and a UK University (discussed previously). Inclusion criteria included any individuals that were referred for and (going to be) receiving MMPSA. Potential participants (all those that met the research inclusion criteria) were initially identified by the prescribing psychiatrist and letters were sent out to

all detailing the nature and purpose of the research. It was made clear that participating (or declining) in the research would not affect treatment programme selection, medical treatment or parole assessments. All potential participants were met by the researcher to outline further information regarding all aspects of the research and provide the opportunity for individuals to ask questions. Written consent was obtained from those agreeing to participate in the research (as detailed in the previous ethical considerations section) before data collection commenced.

Sample size

While sample size is a debated topic with qualitative research, the general consensus is that quality is far more important than quantity (Terry, Hayfield, Clarke, & Braun, 2017). As rich and complex data, that allow us to gain deep and nuanced insights, are considered to be the 'crown jewels' of qualitative research (Terry et al., 2017; p. 22), small sample sizes are accepted and often encouraged to allow the necessary level of depth and detail to be adopted within the analysis (Smith & Osborn, 2003). As such, recommendations for sample sizes to be adopted within qualitative research vary from single figures to 50+ (Bryman, 2016) where the aim is not to produce generalisable findings but to instead to provide depth of understanding (Howitt, 2016). In more recent guidance, and specifically with reference to thematic analysis (TA; the analysis adopted within this thesis – discussed later within this chapter), the recommended quantity to be utilised within a PhD thesis is between 15 – 30+ interviews (Terry et al., 2017). As such, the sample sizes within this thesis (a total of 38 interviews with 21 participants for the qualitative elements, as well as the pathways data and case studies) can be considered appropriate to provide rich and meaningful data. The sample for each individual study is outlined within the methods section of the empirical chapters.

Data collection

Various methods of data collection could have been utilised within this thesis and these were given careful consideration before deciding upon the final methods to be utilised. For example, for the qualitative data collection, structured interviews, semi-structured interviews and focus groups were all considered as potential options. Focus groups are often utilised in qualitative research, however, in a group setting such as this it is acknowledged that some individuals may be reluctant to open up and share their views in front of others and the research would become dominated by the more confident participants (Howitt & Cramer, 2017). As the focus of the thesis is on the individual experiences and perspectives of those receiving MMPSA, it was decided that this would be best captured through individual interviews that allow the opportunity for in depth discussion with each participant. Once this had been decided, the consideration was then between structured and semi-

structured interviews. However, due to the constraints of structured interviews in that they limit the questions that can be asked by the researcher, as well as what can be discussed by participants (Bryman, 2016), it was considered that these were not appropriate. Semi-structured interviews were therefore implemented as the most appropriate method of qualitative data collection for this thesis. These are explored in further detail below. This thesis also implements the use of case studies, however, as these are only utilised within one chapter (Chapter 7), and the decision to implement them arose from the previous empirical studies, the process and justification for these is outlined within that empirical chapter.

Semi-structured interviews

Semi-structured interviews involve utilising an interview schedule, or list of pre-determined questions, to initially guide the interview, while not restricting it (Howitt, 2016). This is important as it allows the flexibility for the researcher to follow up on points raised, or to probe to gain further information, while also allowing the participants to discuss anything they deem to be important or relevant to their experiences of the phenomenon being explored. For this reason, a more informal, conversational type of approach is adopted to allow in depth, unrestricted discussion and an opportunity for participants to share their experiences (Bryman, 2016).

Two interview schedules were initially designed for use in this thesis – one for the first study, and another for studies two and three. These were developed in line with guidance that suggests beginning the interview with broader questions before focusing on more specific elements with follow up questions and probes to allow participants to ease into the interview (Howitt, 2016). In addition, neutral, open ended questions were used to prevent against leading the participants in their responses. Once developed, the schedules were reviewed by supervisors and prison based professionals and amended where necessary to ensure they were fit for purpose – not leading, covering all necessary elements to address the research aims, had a sufficient amount of questions and probes, and were suitable for any individuals with intellectual disability .

The interviews for this thesis were conducted in purpose built interview rooms to allow participants a quiet and safe space to ‘tell their stories’ (Waldram, 2007). They were recorded using a dictaphone to allow me to focus on engaging with participants throughout the interviews without the need to take notes. In order to obtain ethical approval from HMPPS to conduct the research (as previously outlined) it was requested that the interviews for the studies be combined to ensure more efficient use of resources and time as they were recruiting from the same potential participant pool (i.e. all those referred for and (going to be) receiving MMPSA). As such the two separate interview schedules (discussed above) were combined into one final interview schedule (see appendix 4), and

one full set of interviews was obtained and used across all three qualitative studies. More detail regarding this process and how the interviews were split per study is outlined within the empirical chapters.

Data analysis and interpretation

Qualitative analysis was utilised in three of the empirical studies within this thesis. As such, the details of the considerations and decisions regarding the most appropriate method of analysis to be implemented and how this was conducted are detailed here as it is relevant to three empirical chapters (Chapters 4-6). The analysis and interpretation of the pathways and case studies is detailed within the final empirical chapter which outlines this study.

Qualitative data analysis

When considering the specific method of qualitative analysis to employ, there were initially numerous options that could have been adopted, for example, discourse analysis (DA), Thematic Analysis (TA) or Interpretative Phenomenological Analysis (IPA). DA is concerned with the study of language or communicative action (Johnstone, 2018) and how this is used to achieve objectives and create meaning (Bryman, 2016; Starks & Brown-Trinidad, 2007). As such, this method is useful for research interested in language as a social action (Howitt, 2016). However, as the aims of the qualitative elements of this thesis are focused on understanding lived experiences, and while DA can explore how participants construct accounts of experiences, it cannot explore the lived experiences themselves and how participants make sense of their experience (Smith, 2011). As such, DA was not considered to be appropriate for the analysis within this thesis.

Based on the overarching research aims, a method of analysis that is grounded in the lived experiences and perspectives of participants was required. Both TA and IPA achieve this, both concerned with how participants make meaning of their experiences within a broader social context, thus both are viewed as reflecting 'reality' (Braun & Clarke 2006; Smith & Eatough, 2007). However, as previously discussed (see methodological approach section), in order to achieve the aims of the thesis, a mixed methods approach was adopted and so it was important to select a flexible approach for data analysis that would sit well within the overarching pragmatic research paradigm. As some qualitative methods, including IPA, are tied to a particular epistemological or theoretical position which determines specifically how the research is conducted with very little flexibility in the approach (see Smith & Osborn, 2003), IPA was therefore considered unsuitable. TA offers greater theoretical freedom in comparison to IPA due to the fact that it is not bound by any theoretical assumptions and instead can be used across a range of research paradigms or theoretical and epistemological

approaches (Braun & Clarke, 2006; Terry et al., 2017). Consequently, a phenomenologically informed TA was chosen as the most appropriate method for the qualitative data analysis.

Thematic analysis

Thematic analysis (TA) is a 'method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun & Clarke, 2006, p. 79). Its aims are not simply to summarise and describe, but to also identify and interpret key aspects of the data in relation to the research question (Boyatzis, 1998; Clarke & Braun, 2017) without deviating too far from the data (Braun & Clarke, 2006). There are a number of benefits or advantages to using thematic analysis, including its theoretical flexibility (Braun & Clarke, 2006; Clarke & Braun, 2017), its ability to analyse large and small data sets, that it does not require any specific form of sampling and that it can be used for both theory driven (deductive) and data driven (inductive) analyses (Clarke & Braun, 2017; Terry et al., 2017). Consequently, thematic analysis was considered appropriate for analysis of the interviews in this thesis due to its ability to provide a complex, rich, detailed account of participant experiences and perceptions of reality, as well as the meanings and understanding in a flexible (both theoretically and methodologically) manner (Braun & Clarke, 2006). It also achieves this without deviating too far from the data in interpretation (Braun & Clarke, 2006) which was considered important in order to emphasise and understand participants' experiences and perspectives. For many of these reasons, TA is considered to be particularly valuable when exploring under researched topics (Braun & Clarke, 2006) as is the case here.

The flexibility of TA and lack of clear guidelines has in past led to an 'anything goes' critique of the method (Antaki, Billig, Edwards, & Potter, 2002; Braun & Clarke, 2006). However, Braun and Clarke (2006) attempted to refute this criticism and developed a six step guide to conducting thematic analysis in order to provide a structured framework while retaining its flexibility. It is also considered imperative that researchers make a number of decisions prior to conducting the research and that these should be made explicit, for example, their epistemological and theoretical underpinnings, and specifically how the analysis was conducted (Attride-Stirling, 2001; Braun & Clarke, 2006; Holloway & Todres, 2003). As previously outlined (see 'methodological approach' section) this thesis sits within the pragmatism research paradigm, adopting a mixed methods approach to address the overall aims. However, it largely draws from interpretivism in understanding the lived experiences of participants, and as such the qualitative studies adopt a phenomenologically informed thematic analysis.

Phenomenologically informed analysis

With the overarching research paradigm for this thesis being one of pragmatism (see earlier section on methodological approach), and thematic analysis being theoretically flexible, it allows the qualitative analysis and interpretation in this thesis to be underpinned by a phenomenological approach to the analysis. It is therefore important to consider what a phenomenological perspective will add to the analysis and interpretation of the interview data.

Phenomenology is an epistemological or philosophical stance, usually embedded within an interpretivist / constructivist research paradigm, and is concerned with the subjective meanings that individuals assign to lived experiences (Aresti, Eatough, & Brooks-Gordon, 2010). Thus, phenomenological analysis focuses on exploring and understanding participants' subjective perspectives and experiences of a particular phenomenon and how they interpret or make sense of this (Smith & Osborn, 2003). Phenomenological analysis therefore views the participants as 'experts' on the topic or phenomenon under exploration and aims to gain insider knowledge and insights from their understanding and perspectives (Larkin, Watts, & Clifton, 2006). However, this process involves active engagement and interpretation from the researcher and as such, results in a two stage interpretation, in which the researcher attempts to make sense of participants' sense making regarding a particular phenomenon (Aresti et al., 2010; Smith & Osborn, 2003).

Doing thematic analysis

The approach to conducting thematic analysis in this thesis was in line with the six phase process outlined by Braun and Clarke (2006). While each phase builds on the next, this process of analysis is not linear; instead movement between the phases is required throughout the process of analysis. Phase one (familiarisation of the data) involves becoming immersed in the data through repeated 'active' reading of the transcripts, searching for patterns and meaning, and writing down initial notes or ideas. The process of transcription is considered to be important in this process (Stuckey, 2014), generating a deeper understanding of the data and informing the early stages of analysis (Braun & Clarke, 2006).

Phase two (coding) involves assigning labels / codes to aspects of the data that are considered important or interesting. During this process the researcher works through each data item (transcript) thoroughly and systematically, writing notes on the transcripts or highlighting particular features. The codes identify interesting features of the data and may identify patterns across the data set (themes). The coded extracts are then collated for each code in separate word documents, therefore creating meaningful groups of data (Tuckett, 2005). Braun and Clarke (2006) provide the following advice for this phase: code for as many potential patterns / themes as possible; retain relevant information

around the coded extract to ensure context is not lost; code extracts in as many different ways as necessary and into as many different patterns / themes that they fit into; include contradictory data extracts or those that deviate from the majority in your coding.

Phase three (searching for themes) involves examining and analysing the codes and collated data to identify broader patterns of meaning (potential themes). In essence, this stage involves analysing the codes that have been identified and considering how they might combine to form themes. Within the analysis in this thesis, themes were generated based on both the prevalence / recurrence of codes as well as the importance of codes which ensures that points of significance are accounted for even if they are not necessarily recurrent in the data – this is in line with what Buetowe (2010) termed saliency analysis. This may be done visually using thematic mind maps or using ‘post its’ for each code to be able to physically move them around and see how they all fit – the latter of which was employed in this thesis. It is in this phase that an interpretative analysis of the data is required to examine and understand the meaning and relationship between the individual codes and themes and where this thesis employed a phenomenological approach to the analysis to consider the subjective and lived experiences of participants. During this process, codes will form main themes, sub themes or may be allocated to a miscellaneous pile and are later discarded. By the end of this phase, there will be a number of main and sub themes, each with all data extracts relevant to them collated together (again in separate word documents).

Phase four (reviewing themes) involves reviewing and refining the themes to ensure that the data within them meaningfully fits together, while ensuring clear distinctions between the themes. This process occurs at two levels. Level one involves reading and examining the collated data extracts for each theme and ensuring they form a coherent pattern. If they do not, then this is reworked (as in phase 3). Once this is complete, level two involves undertaking a similar process but instead considering the individual themes in relation to the data set and examining whether they reflect the data set as a whole. This involves re-reading all the data and assessing whether they are accurately reflected by the themes while taking account of the specific research question being addressed. During this process, coding aspects of the data that were missed in phase two and assessing where these fit occurs, moving throughout the different phases until satisfied that the themes are coherent in relation to the specific data extracts within them (level one) and that the themes tell a coherent story regarding the whole data set (level 2) in relation to the specific research question. By the end of this phase, Braun and Clarke (2006) advise that ‘you should have a fairly good idea of what your different themes are, how they fit together, and the overall story they tell about the data’ (p. 92).

Phase five (defining and naming themes) involves additional refining and defining the themes to ‘identify the ‘essence’ of what each theme is about (as well as the themes overall)’ (Braun & Clarke,

2006, p. 92). This involves reviewing the data extracts for each theme and organising them into a coherent account alongside a narrative that presents a detailed analysis and tells a story – for each theme individually as well as a whole in relation to the research questions, ensuring there is little overlap while also recognising the relationship between the different themes. Again it is in this phase where the analysis in this thesis employed a phenomenological approach to analysing the data. Within the refinement stages of this phase, any potential sub-themes (themes within a theme) will be defined. The authors warn against simply paraphrasing extracts here and instead ensuring that they are analysed, identifying interesting or important aspects and outlining why they are important (Braun & Clarke, 2006). The final aspect of this phase involves allocating, concise and informative names to the themes.

Phase six (writing up) is the final phase and involves weaving together the different aspects of the analysis to provide a ‘concise, coherent, logical, non-repetitive, and interesting account of the story the data tell – within and across themes’ (Braun & Clarke, 2006, p. 93). Data extracts are selected and embedded throughout the analysis to evidence the theme and illuminate the story being told.

Reliability and validity

Reliability refers to the stability or consistency of a measure, while validity refers to the extent to which it measures what it is intended to measure (Bryman, 2016). These traditional concepts of reliability and validity are easily applied to assess the rigour of positivist quantitative research in which it is considered that there is a single objective truth (Bryman, 2016; Howitt, 2016; Willig, 2013). In contrast, a qualitative interpretivist perspective acknowledges the importance of lived experience and interpretation which thus produces multiple subjective truths. As such, applying traditional criteria of reliability and validity is not as straightforward and there are no universal criteria for doing so (Bryman, 2016; Howitt, 2016; Willig, 2013). However, some have suggested that reliability and validity in qualitative research could be assessed using a criterion of trustworthiness (Lincoln & Guba, 1985). According to Lincoln and Guba (1985), trustworthiness is made up of four criteria: credibility, transferability, dependability and confirmability, each of which were considered within this thesis to ensure the trustworthiness of the research and will now be discussed in depth.

Credibility

Credibility is considered to be the qualitative parallel of internal validity in quantitative research (Bryman, 2016). While in quantitative research, the aim is not to establish the results as the only true account, the findings and results of the research should reflect one of the possible interpretations, with credibility determining the extent to which this account holds true and is plausible to others

(Bryman, 2016; Reid, Flowers, & Larkin, 2005). In order to establish credibility, the research has to have been conducted in line with principles and guidance regarding methods of good practice (Bryman, 2016). As such, ethical standards and procedures were adhered to throughout the research, methods of data collection were carefully considered in order to ensure they were the most appropriate in addressing the research aims, and the analysis was conducted in line with established procedures – all of which is outlined in detail earlier in this chapter. In addition, detailed records and reflective notes were maintained throughout the course of the research to provide a clear record of decision making and the methods and procedures that were employed (this is also relevant to the following sections). Another suggested method of ensuring credibility is the undertaking of member or respondent validation, a process that involves providing participants with a copy of the findings in order to obtain confirmation that these accurately reflect their social worlds and perspectives (Bryman, 2016; Lincoln & Guba, 1985). This was considered within the current thesis. However, it was acknowledged that the participants may not understand the findings or may feel unable to question the findings if they did not agree; as such, this is not a method that was formally implemented. Despite this, as participants were made aware that they could request a copy of the findings if they wished (within the information giving and consent procedures previously outlined), this was achieved on a more informal basis with those participants that requested a copy of the findings (n=5) then providing these credibility checks by confirming the findings of the research. Another method of ensuring credibility is through triangulation, a process involving the collection of multiple sources of data exploring the same phenomenon. While to some extent this has been achieved within this thesis through the collection of qualitative service user accounts and quantitative clinical data, this has also been achieved on a larger scale with the findings of this thesis designed to contribute to the mixed methods evaluation of the use of MMPSA. This involves the collection of service user accounts and clinical measures (discussed within this thesis), as well as psychometrics and a range of staff accounts (see Lievesley et al., 2013; Lievesley, Elliott, Winder, & Norman, 2014; Winder et al., 2014; 2018). How the current research fits with these different data sources is discussed throughout the empirical chapters and drawn upon within the concluding chapter of this thesis.

Transferability

Transferability is considered to be the qualitative parallel of external validity, or generalisability, in quantitative research (Bryman, 2016). While in quantitative research the findings are used to make predictions regarding other samples, it is recognised that generalisability to the whole population is not possible in qualitative research which focuses on developing an in-depth understanding of the experiences of a small, specifically selected, group of participants. Instead, this considers how useful

the findings are to other researchers regarding the possible transferability of the findings to similar contexts (Bryman, 2016). Lincoln and Guba (1985) propose that this can also be achieved through thick description-rich detailed accounts regarding the context of the research and field experiences in order to allow others to make sufficient judgements regarding the possible transferability of the findings. This was achieved within the current thesis by keeping detailed notes throughout each stage of the research (see next section regarding the process of auditing) and ensuring the context and process are clearly and sufficiently explained within any dissemination of the findings. Furthermore, as the current research included all participants in the prison based pilot of MMPSA at the time of recruitment, the findings can therefore be considered to have transferability, being applicable to other sites that now offer this treatment as well as informing other settings and contexts (i.e. use of the MMPSA in the community post release from prison).

Dependability

Dependability is considered to be the qualitative parallel of reliability in quantitative research (Bryman, 2016). In order to achieve this, a process of auditing is undertaken (Bryman, 2016), with Lincoln and Guba (1985) suggesting the use of an audit trail to clearly document each phase of the research. This was achieved within the current thesis by keeping detailed records throughout the process of undertaking the research from the initial idea, to research completion – formulation of research questions, ethical considerations, process of participant selection, data collection notes, additional observations, interview transcripts and data analysis and write up decisions. The research was then audited by the supervision team to ensure the correct processes are being followed, and a form of inter-rater reliability was undertaken with the analysis being audited by the supervision team as well as an independent researcher to ensure the interpretations being made were valid, coherent and grounded in the data (Bryman, 2016; Lincoln & Guba, 1985). In addition, undertaking thematic analysis (the six phase process previously outlined within this chapter) involves processes that are akin to auditing by the main researcher in that once the initial themes are established, these are reviewed against the codes and original data set to ensure the themes and interpretations accurately reflect participant narratives (Braun & Clarke, 2006; 2013). All of these processes ensure that any potential problems are picked up as early as possible and ensure that dependability is achieved.

Confirmability

Confirmability is considered to be the parallel of objectivity (Bryman, 2016). While recognising that it is impossible to achieve complete objectivity, this notion of confirmability requires the researcher to be aware of, and not overtly allow, personal values to sway the conduct and subsequent findings of

the research (Bryman, 2016). Lincoln and Guba (1985) propose that auditing (as outlined above) is important in establishing confirmability, a process that was undertaken within the current thesis. Reflexivity is viewed as a key aspect involved in establishing the quality of qualitative research by taking account of researcher influence and has also been proposed as a method of achieving confirmability (Howitt, 2016). Reflexivity acknowledges the influence that prior assumptions and lived experiences of the researcher may have on the research (Howitt, 2016) and while it is acknowledged that you cannot completely detach yourself from these as a researcher, being aware of these influences through a process of reflexivity allows these to be managed throughout the research thus limiting the potential effects of research bias and providing more trustworthy results (Willig, 2013). Keeping a reflective diary assisted with this process throughout the course of the research.

Summary and key points

This chapter has outlined the overarching methodological approach adopted for the thesis and offered a rationale for the research design. It has also outlined the research process, detailing the ethical considerations and procedures, participant recruitment, data collection and analytic techniques. The remaining chapters set out the empirical work underpinning this thesis, and discuss the broader implications of this body of work.

Chapter 4

Study 1: 'It's like you're chasing something that's always out of reach': Understanding problematic sexual arousal among individuals convicted of sexual offences

Introduction

As identified in Chapter 2, problematic sexual arousal (PSA; or facets of it, e.g. sexual preoccupation and / or hypersexuality) is implicated as a profound wellbeing issue (Bancroft, 1989; Garcia & Thibaut, 2010; Reid, Bramen, Anderson, & Cohen, 2013), as well as a key risk factor for both first time sexual offending (Finkelhor, 1984; Seto, 2017; Ward & Beech, 2017) and recidivism among ICSOs (Hanson & Harris, 2000; Hanson, Harris, Scott, & Helmus, 2007; Hanson & Morton-Bourgon, 2004; Knight & Thornton, 2007). Similarly, there was an acknowledgement that key factors implicated in the commission of sexual offences appear to overlap with psychological mechanisms that play a role in sexual arousal cycles. For example, deficits in emotional regulation and behavioural planning are prevalent among ICSOs (Ward & Beech, 2006; 2017), and a substantial minority of people use sexual activity to alleviate negative mood states (Bancroft & Vukadinovic, 2004) in a way that can become habitual and ultimately problematic (e.g. Brewer & Tidy, 2019; Hughes, 2010). As stated previously, from a social-cognitive perspective, repeated obsessive thinking about sex could facilitate the formation of cognitive structures (i.e. associations in long term memory that are activated automatically in response to triggering stimuli; Gawronski & Bodenhausen, 2006) and make it more straightforward for arousal to become accessible (Bartels & Beech, 2017). Further, individuals may begin to think that their sexual arousal is uncontrollable (an implicit theory associated with sexual offending; Polaschek & Gannon, 2004; Polaschek & Ward, 2002), leading to a lack of motivation to suppress their arousal patterns. In turn these thoughts become facilitators of sexual offending and allow sexual arousal to be acted upon, in line with Seto's (2019) motivation-facilitation model.

With these issues in mind, it is perhaps surprising that understanding the development of PSA in ICSOs has not been a major focus of empirical research. This is an important research gap to fill as developing an understanding of the process by which normal sexual arousal patterns develop into PSA, and how this then progresses into sexual offending, could help researchers, clinicians and policy makers to develop more evidence based strategies for intervening early in the cycle of PSA and sexual offending, reducing the chance of first time offending taking place. Furthermore, understanding the development, awareness and management of PSA among ICSOs could inform the decisions made

regarding the appropriate treatment for this as a risk factor, including the use of MMPSA and appropriate treatment goals.

There is currently no in-depth exploration of PSA among ICSOs that attempts to answer these questions. Exploring this in a phenomenological manner would allow the development of a greater level of understanding, with the narratives of lived experiences adding depth to cross sectional quantitative survey research. That is, the research mentioned previously in relation to the associations between the various facets of PSA and negative outcomes (i.e. mental health issues and sexual offending) are correlational. They tell us that a relationship exists between these concepts, but the data reported in these quantitative studies are not able to tell us anything about the quality, trajectory, or meaning of those relationships for the individuals that experience them. As such, this study sought to investigate the lived experiences of individuals convicted of sexual offences (ICSOs) with problematic levels of sexual arousal in order to develop a richer understanding of how these relationships may contribute to an individual committing a sexual offence. Specifically, it sought to examine their development of these patterns of arousal, their effects on individuals' everyday functioning, and how those with PSA managed this prior to engaging with MMPSA. As such, this initial study represents the first step in charting the development, maintenance and lived experience of PSA among ICSOs.

Method

Participants

The participant sample for this study comprised 21 adult males. At the time of data collection all participants were serving prison sentences for a sexual offence and were receiving some form of MMPSA due to their level of PSA. Participants were White British ($n = 20$) or White Other ($n = 1$), with a mean age of 46 years ($SD = 14.1$; 24-72) and a mean IQ of 87 ($SD = 15.5$; 59-108). Participation was voluntary with no incentive or benefit offered for participation. Further participant information is detailed in Table 1.

Table 1: Participant information (Study 1)

Participant	Index offence (s)	Previous sexual convictions	Number of interviews	Total interview time (hours & minutes)
1	Rape (child) x 3 Attempted buggery x 2 Rape (adult) x 2 Indecent assault (child) x 3	Yes	2	2.47
2	Rape (adult) x 2	Yes	1	2.01
3	Sexual assault (child)	Yes	1	2.05
4	Sexual activity with a child	Yes	2	2.21
5	Possessing indecent images	Yes	1	2.09
6	Murder Indecent exposure x 5	Yes	3	3.03
7	Indecent assault (child)	Yes	2	2.27
8	Sexual assault (child)	Yes	3	2.11
9	Sexual assault (child) x 2 Rape (child) x 12 Sexual activity with a child x 2	No	2	2.13
10	Murder	No	3	3.47
11	Sexual activity with a child	Yes	1	2.03
12	Indecent assault (child) x 5 Buggery	Yes	3	2.48

13	Rape (child)	Yes	1	2.19
14	Producing, distributing & possessing indecent images x 2	Yes	1	2.21
15	Sexual assault (child) x 2 Rape (child) x 2	No	2	2.51
16	Possessing indecent images	Yes	1	2.53
17	Rape (adult)	Yes	2	2.50
18	Indecent assault (adult) Sexual assault (child)	No	1	2.15
19	Arson Indecent exposure x 4	Yes	2	2.37
20	Assault occasioning actual bodily harm (adult) x 9 Battery (adult) x 2 Sexual assault (child) Possessing indecent images x 7	No	2	2.47
21	Producing, distributing & possessing indecent images x 7	Yes	2	2.25

Data collection

The sampling and recruitment strategy was determined by the topic under exploration; as the current study was looking at the experiences of the development, awareness and management of PSA in a sample of ICSOs, it involved targeting a specific population (those identified as having PSA via the MMPSA treatment pathway) within a specific prison establishment (HMP Whatton as the only site offering the treatment of MMPSA²). In order to achieve this, the overarching sampling strategy that was employed was purposeful (Patton, 2002) which allowed me to intentionally select participants on the basis that they are the 'experts' or the best placed individuals to contribute their knowledge of the subject area under study (Henn, Weinstein, & Foard, 2005).

The same process of recruitment of participants was employed across all empirical studies with access to participants being granted by the prison establishment following ethical approval from HMPPS and a UK University. Inclusion criteria included any individuals that were referred for or currently receiving MMPSA. Potential participants (all those that met the research inclusion criteria) were initially identified by the prescribing psychiatrist and letters were sent out to all detailing the nature and purpose of the research. It was made clear that participating in (or declining) the research would not affect treatment programme selection, medical treatment or parole assessments. All potential participants were then met by the researcher to outline further information regarding all aspects of the research and provide the opportunity for individuals to ask questions. Written consent was then obtained from those agreeing to participate in the research.

The data were collected through semi structured interviews which took place in purpose built interview rooms allowing participants the privacy to talk openly about their experiences without being overheard. A total of 38 interviews were conducted, with 1-3 interviews per participant and each lasting 25 minutes to two hours, 53 minutes (mean = one hour, 25 minutes). The majority of participants were interviewed on a one-to-one basis by the researcher. However, a small number of participants were on a 'high alert' status within the prison which indicates an increased level of risk and were deemed unsuitable to be interviewed by lone females. In such cases ($n = 5$), these were conducted on a two-to-one basis with another researcher present. Following each interview, participants were given the opportunity to ask questions and given information to take away with them. This reiterated key information regarding how their data and information would be used, the process of withdrawal from the research should they wish to and methods of support if needed. Further detail regarding the process of data collection is outlined within Chapter 3.

² While this was the case at the time of commencement of this thesis, more sites now offer this as part of a national treatment pathway.

Analytic approach

This research implemented the use of a phenomenologically informed thematic analysis as a method for ‘identifying, analysing and reporting patterns (themes) within data’ (Braun & Clarke, 2006, p. 79). This choice of analytic method was appropriate for use in this study, ensuring the analysis did not deviate too far away from the data in interpretation but instead provides a complex, detailed and rich account of the data (Braun & Clarke, 2006). The analysis adopted techniques outlined by Braun and Clarke (2006) entailing transcription, thorough reading to increase familiarisation and initial data reduction (coding). Data reduction was ongoing, the data were organised and displayed systematically to increase understanding and themes were identified and reviewed against the data set to ensure the final themes fit together and tell a coherent story in relation to the research question. Chapter three, which outlines the methodological approaches adopted within this thesis, provides a more detailed account of the analytic approach adopted.

Results and discussion

Three main themes were derived from participant narratives as being pertinent to understanding the development and awareness of the problematic sexual arousal. Each is outlined in Table 2 and discussed in depth below.

Table 2: Main themes and sub-themes for Study 1

Main Themes	Sub-themes
1. Developing an understanding of sexual behaviour	1.1. First exposure: A deviant introduction
	1.2. Developing beliefs about sex
2. The functions of sexual behaviour	2.1. Seeking something more
	2.2. Gaining control
3. Recognising a problem	3.1. Escalation: ‘it’s like you’re chasing something that’s always out of reach’
	3.2. ‘Something has to change’

Theme 1: Developing an understanding of sexual behaviour

This theme recounts the ways in which participants developed an understanding of sexual behaviours, with the first sub-ordinate theme depicting their early sexual experiences and the potential impact of these, before moving on to consider the development of knowledge and beliefs surrounding sex.

Theme 1.1: First exposure: A deviant introduction

All participants in the current study discussed becoming sexualised from a young age, resulting in a reflection on their first or early sexual experiences, which for many, was the result of sexual abuse:

I guess erm er my first contact, first sexual contact was when I was about four or five, maybe six but no older than that, with the babysitter...we were basically on the bed together and he, he came out with it...wanting me to play with him and I didn't know what he meant (P.7)

At the age of 4 to up to being an adult I was abused, used for sex and had to do whatever they wanted a bit like a slave really (P.12)

Basically I was abused in all the ways possible, I was physically and emotionally abused, the sexual abuse was by my brother from roughly when I was about 5 to when I was 16 (P.11)

As illustrated within the above extracts, for a number of participants in the sample, being the victim of sexual abuse was their first exposure to any form of sexual contact or behaviour. For some participants (11 & 12) their abuse spanned a number of years, dominating their childhood and adolescence. Long term sexual abuse of this nature has been associated with a range of lasting psychological effects, such as low self-esteem, low self-worth, increased rates of depression, anxiety, and post-traumatic stress, and expressions of anger and aggression (Cutajar et al., 2010). A propensity to experience these symptoms may be linked to the exaggerated rates of emotional dysregulation that have been reported in hypersexual populations (Miner et al., 2016; Walton et al., 2017), and may be sparked by early abuse experiences and the aforementioned effects on psychological development that this abuse has. Specifically in relation to ICSOs, disruption to brain systems responsible for affective regulation (as well as planning behaviours and making attributions about the behaviour of others) have been implicated as risk factors for sexual offending (Ward & Beech, 2005; 2017). While not being sufficient for the commission of sexual offences (i.e. not all people with disrupted emotional regulation will go on to commit acts of sexual violence), it may be that having this predisposition to affective dysregulation makes somebody vulnerable to PSA (see Bancroft et al., 2003; Bancroft & Vukadinov, 2004; Hughes, 2010), and (if this is paired with deviant fantasy and engagement over time, as is the case with hypersexual individuals) subsequent sexual offending (Bartels & Beech, 2017; Gee & Belofastov, 2007). Participant 12 likens the abuse he experienced to slavery, evoking a sense of

being owned and held captive, depicting the powerlessness he felt against his abuser(s). This lack of control over what was happening to them was present in many of the participant narratives owing to the helplessness they felt due to their young age when the abuse occurred or began. This would be consistent with a learned helplessness approach to understanding sexual abuse victimisation experiences (Turner, Taillieu, Cheung, & Afifi, 2017), with victims often reporting how they feel trapped in a cycle of victimisation from which they cannot escape (Kelley, 1986). This may particularly be the case for participant 11, who experienced a range of physical, emotional, and sexual abuse. Furthermore, as the abusers often represented a caring role or position of trust, this further instils a lack of control and vulnerability, with participant seven's use of 'I didn't know what he meant', emphasising his innocence and vulnerability in that situation. This also corresponds with data reported by Romano and De Luca (2001), who found that feelings of helplessness are increased among male victims of sexual abuse that was perpetrated by caregivers and family members. This lack of control over sexual experiences appeared to be important for a number of participants:

When I was 17 erm, erm, I had a full, full on sexual experience with an older woman, and erm, I don't know, I believed that had some kind of effect on me erm, you know it was something erm I wasn't sure of, erm but went along with and I suppose that's my biggest downfall in life is just going along with what's going on (P.19)

The first time I had sex was with an older woman, I was 16 so it wasn't illegal or anything but I had no clue what I was doing but she was quite experienced so she just took control and did everything before I even had time to think about it...it all just happened a bit too much too quickly and I didn't really know what was happening until it had happened and didn't really get a chance to think whether I wanted it or not (P.20)

Both of these extracts recount participant experiences that while not illegal or abusive in terms of being underage, there is however uncertainty regarding consent from the participants perspective with, for example, participant 19 describing this as something he just 'went along with'. In this sense, within both extracts the participants portray themselves as passive recipients, acknowledging that there was no conscious decision or choice to engage in the sexual activity and rather it was something that was done to them, with participant 20 stating how the other person 'took control'. This imbalance of power and thus perceived lack of control stems from the difference in age and experience and is subsequently interpreted as abusive by the participants. Despite this, participant 19 suggests some

element of self blame, with the recognition that his 'biggest downfall in life is just going along with what's going on', thus suggesting it was something he could have prevented or stopped. This type of response to sexual abuse is not uncommon among male victims, who commonly experience high levels of shame and guilt about their own experiences of victimisation (Romano & De Luca, 2001; Turner et al., 2017). This may be more pronounced in male victims due to masculine gender norms, which place value on strength, independence, and control over sexual interactions (Easton, Renner, & O'Leary, 2013; Spataro, Moss, & Wells, 2001). Indeed, those who endorse more traditional masculine ideals report greater levels of emotional distress in relation to their sexual victimisation (Mahalik et al., 2003), something which again may be linked to emotional dysregulation at a more neuropsychological level (Ward & Beech, 2005; 2017). This self-criticism about 'just going along' with his abuse is not consistent with a powerful or controlling masculine stereotype (Lamb et al., 2018). In this sense participant 19's framing of his abuse as a 'sexual experience' may be indicative of a defence mechanism to protect himself against negative emotional responses to this encounter in which he felt a lack of control.

Throughout the previous extracts, the participants early sexual experiences have been viewed in a negative way, largely due to the perceived lack of control that they felt regarding this. However, this was not the case for all participants, with some describing their early sexual experiences in a positive light:

I've gone to call for my mate and gone to the back door as I always did and there was stood his older sister in her bra and pants, it was the first time I'd seen a woman in her underwear and to say I was stunned would be an understatement, I was stood there staring at her for a good 10 to 15 minutes and she obviously didn't know I was there, I was stood there all that time and could feel myself getting excited, and maybe she felt my eyes on her because she looked up and I and ran off erm straight home erm into the toilet and masturbated for the first ever time (P.10)

The above extract depicts participant 10's first exposure to a woman in her underwear and the excitement he felt in relation to this. While this behaviour was unintentional in the scenario described in the above extract, the excitement associated with this and the reinforcement of this as a positive experience through masturbation would have encouraged an interest in this type of voyeuristic sexual behaviour. For this participant, this incident represents the start of a voyeuristic offending trajectory. This trajectory can be explained using a classical conditioning approach to behaviour development.

That is, participant 10's first sexual experience with a woman (at this time, an unconditioned stimulus) was voyeuristic, which concluded with him masturbating while thinking about this encounter. In this sense, the woman in question was an unconditioned stimulus, which was accompanied by an unconditioned response (initial feelings of sexual arousal). Through the pairing of masturbation (another unconditioned stimulus at the time for participant 10) and fantasies about looking at the woman, an association was built where the stimulus of being able to see women became conditioned to lead to sexual arousal. This rapid pairing and conditioning is not unsurprising with orgasm being a well-supported method of behavioural conditioning in forensic settings, both as an explanation for deviant sexual fantasies and behaviour (Bartels & Beech, 2017; Laws & Marshall, 1990) and as a tool of the treatment of deviant sexual arousal (Kaplan & Krueger, 2012; Laws & Marshall, 1991; Marquis, 1970). Throughout the narratives, other participants also recalled other early sexual experiences that they perceived as being positive:

I can't remember when I started getting the sexual feelings but it was definitely before I was 12 definitely because I remember that was the first time I'd done anything proper, I'd had an erection before then but not known what to do with it and my dad had seen me looking at his porn videos before and told me I was too young for that kind of thing erm it was on my 12th birthday he says for me to come down and watch something with him, it was the first time I'd ever seen anything like that, and not in a like er like he didn't touch me or do anything it wasn't like that but he just said I was a man now so I could watch it so he wanted to show me and I was so shocked but in er in a good way but erm it was quite rough erm not really violent but a bit and I remember watching and thinking 'oh that's what it's all about' and I remember I went straight upstairs and masturbated after that which was erm the start of me masturbating (P.21)

Again, the participant's response in terms of arousal and masturbation to this stimuli would have reinforced his sexual interest in 'rough' sexual practices. He clearly held the belief that what he was watching was an accurate depiction of sex, with the realisation that 'that's what it's all about' signalling some form of learning. These narratives depict the ways in which participants had become sexualised from a young age, with all discussing being part of at least one sexual encounter before the age of 13. Compared to the general population this rate appears to be high, with only 24% of British men reporting having a sexual encounter before the age of 16, and this rate decreasing as respondents in the general population are sampled at older ages (i.e. more young people are having sexual

encounters at an earlier age, as compared to older participants asked about their first sexual experiences; Clifton, Fuller, & Philo, 2016). While these early experiences were not always perceived as negative by the participants in this study, all can be considered deviant in some way, and likely shaped later sexual behaviours (discussed within the next theme).

Theme 1.2: Developing beliefs about sex

Throughout the narratives, participants discussed the development of their knowledge and beliefs regarding sex or sexual behaviours. The experiences discussed in the previous sub theme surrounding their first exposure to sexual behaviours inevitably provided the first source of sexual information for some, thus shaping their beliefs and subsequently their behaviours:

It was, I think it was just confusing erm, I, you know, because I would never say anything to anybody erm, it was our secret so I would never say anything to anybody because I obviously loved him and he loved me, so erm it wasn't something I saw as bad at the time so it was never upsetting, I just thought it was normal and something that some adults and children do so I never questioned it but I also knew I could never tell anyone which was the confusing part, I never understood that (P.8)

While participant eight describes the sexual abuse he experienced as 'confusing', he is not specifically referring to the abuse itself here but rather the need for this to be kept a secret, with love for his abuser preventing him from telling anyone or viewing the abuse in a negative way. The participants spoke about this secretive element to their abuse in that they were always aware that it was not something they could tell anyone or talk about, associating this with the nature of the behaviour, rather than the offending element due to a lack of awareness that they were the victim of abuse. This lack of awareness of the nature of sexual abuse when it occurs is prominent when considering people's likelihood to label their experiences as abusive. That is, several survey-based studies have found that only around one in three people who respond affirmatively to behaviourally anchored questions (e.g. 'before the age of 18, were you ever made to touch an adult's genitals?') will also answer affirmatively to the question 'were you sexually abused?' (Cook, Gidycz, Koss, & Murphy, 2011; Fricker, Smith, Davis, & Hanson, 2003; Olson, Stander, & Merrill, 2004; Peterson & Muhlenhard, 2004; Stander, Olson, & Merrill, 2002). For some participants, this in turn led to the belief that sexual behaviour should never be spoken about and was instead a secret between those involved. It is clear from the extract that participant eight's sexual abuse as a child led him to believe that sex with children was acceptable, a

belief that became entrenched over the years, later contributing to his offending against children. While there is limited support for a direct link between sexual victimisation in childhood and future sexual offending, there are some studies that do find an over-representation of sexual abuse victimisation experiences among perpetrators of sexual violence (e.g. DeLisi, Kosloski, Vaughn, Caudill, & Trulson, 2014). This is particularly the case among male perpetrators (Glasser, Campbell, Glasser, Leitch, & Farrelly, 2001). These early experiences of particularly long term sexual abuse are said to desensitise the victims to the concept of adult-child sexual relations, and normalise sexual activity at a young age (Ward & Keenan, 1999). This would also be consistent with the previous accounts above where experiences of sexual interactions with other people were not described as abusive in nature. This normalisation process is of particular concern, as attitudes supportive of (or that minimise the harm of) adult-child sexual relationships are important risk factors for sexual offending (Bartels & Merdian, 2016; Marziano, Ward, Beech, & Pattison, 2006; Ward & Keenan, 1999). That is, people convicted of sexual offences against children endorse a series of underlying beliefs about sex and children, including that children are sexual beings capable of experiencing sexual arousal and desire, and that they are able to consent to sexual activity with few negative outcomes. Applying this to the participants in the present sample, their perceptions about their own consent to their abusive experiences may act as the starting point for the development of such implicit theories. That is, if they perceive themselves as not experiencing harm as a result of these interactions, and these interactions provide a blueprint for future fantasy behaviour, these outcomes become generalised to all children, leading to the belief that all children have the potential for sexual enjoyment. This would be consistent with work in the broader cognitive psychological literature which suggests that people have a tendency to generalise self-oriented beliefs onto others, but not others-oriented beliefs to themselves (Bradford, Jentzsch, & Gomez, 2015).

For some participants, access to pornography was a key source of information surrounding sex:

I remember I found all these magazines in the cupboard and I thought “what are they?” and when I opened it up there was just all these naked men and women doin stuff (P.15)

I I er used to watch me dads videos er dirty videos ya know the porno ones and that’s basically how I learnt what sex was and what to do and like yeah through pornography (P.17)

The videos with my dad was how I learned about sex and all that er but as I said he liked to watch er rough sex so I just thought that was normal, it wasn't til I was here on programmes that I started to learn about healthy sex and intimacy and all that, I'd never seen anything like that and it isn't something you talk to people about so you just assume that's how it is for everyone (P.21)

Viewing sex through pornographic material was a primary source of learning and knowledge regarding sex as highlighted with the above extracts. For participant 15 this was accidental, demonstrating some level of curiosity and naivety, a reflection of his lack of awareness regarding sexual behaviour as this was the first time he had seen such material, likely due to his young age at the time (9 years old). However, this early introduction to explicit sexual imagery set him on a trajectory to understanding sexual behaviour in a way that was consistent with this stimuli. Similarly, both participants 17 and 21 acknowledge that access to pornography videos was how they 'learned about sex' (P.21). This is consistent with previous research that suggests that young people (particularly young men) use pornography as a source of sexual education (Albury, 2014; Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). In turn, increased rates of pornography use are associated with a greater propensity to see pornography as a real depiction of sexual interactions (Peter & Valkenburg, 2010). This has implications for young people who use pornography prior to engaging in sexual activity with other people, as this pornography use sets potentially unrealistic expectations about the types of experiences that they might have (Häggström-Nordin, Sandberg, Hanson, & Tydén, 2006; Štulhofer, Buško, & Landripet, 2010). Participant 17's use of the word 'dirty' in his description of the videos suggests that they are in some way inappropriate or immoral, something he should not be watching but continues to do so with the suggestion that this was a regular occurrence. While this description may simply be related to sexual behaviours generally, it may also reflect the nature of the pornography as being deviant. Despite this, participant 17 still considered this pornographic material to be an accurate source of information that subsequently guided his behaviours in teaching him 'what to do'. This was also the case for participant 21, with the nature of the pornography depicting 'rough sex' which subsequently shaped his beliefs that this was normal due to a lack of contradictory information to make him question this. Sex education can act as a way to reduce the effects of messages about sex and sexual behaviour that are presented in pornography (Wallmyr & Welin, 2006). Without this, there is a wealth of evidence suggesting that pornography plays an important role in shaping attitudes, beliefs, and preferences in relation to sexual behaviour in a way similar to that described above. For example, higher rates of pornography use have been associated with greater sexual variety (i.e. imitation-type behaviour) among heterosexual men (Træen & Daneback, 2013), generally increased

rates of sexual activity among university-aged males (Willoughby, Carroll, Nelson, & Padilla-Walker, 2014), a reduced likelihood of condom use during men's most recent self reported sexual interaction (Luder et al., 2011). At a more attitudinal level, pornography use is also linked with more permissive attitudes towards sexual promiscuity (Hunter, Figueredo, & Malamuth, 2010), a greater acceptance of traditional gender roles (Häggström-Nordin et al., 2006), and contribute to higher rates of sexual preoccupation (Peter & Valkenburg, 2008). However, since attending programmes, participant 21 suggests that he now has an awareness that this was unhealthy, with treatment programmes such as HSP focused on understanding the development of unhealthy sexual relationships, understanding and managing the triggers of deviant sexual thoughts, and addressing problematic beliefs about sex and intimate relationships (Lucy Faithfull Foundation, 2015). These skills are important for ICSOs to learn in order to promote desistance (Marshall, Marshall, & Ware, 2009; Murphy, 1990; Szumski, Bartels, Beech, & Fisher, 2018; Ward & Stewart, 2003).

The first time I saw a man and a lady having ya know having sex was on the tele, erm a film, I'd got up late at night because I couldn't sleep and turned the tele on and it was on. That was the first time I'd actually seen it and knew what happened. But then erm me erm me mum came down and went mental at me because I shouldn't be watching dirty stuff like that. I was so embarrassed, never spoke to anyone about that, and even though I knew it was dirty or wrong I did sometimes still watch stuff like but made sure I always hid it so I wasn't caught again, I dint want to be seen as dirty for watching it (P.14)

Similarly, participant 14 discusses viewing sex through a film as his first introduction to this. However, this experience itself appears to be overshadowed by the embarrassment he felt in response to being caught and subsequently disciplined for watching it. Again the perception of sex as being dirty is apparent here, instilling the belief that it is in some way 'wrong' or forbidden, and while this clearly did not prevent him from watching it, instead it resulted in him doing it in a secretive way, with the view that those who watch such material are themselves 'dirty'. This is consistent with recent theoretical work that posits that pornography use often leads to feelings of shame, self-disgust, social isolation, and depressive symptoms (Vaillancourt-Moral & Bergeron, 2019). However, owing to the use of pornography as a method of emotional regulation, these feelings may actually contribute to increased rates of pornography use over time, using this material in more covert and socially isolating ways (Grubbs, Perry, Wilt, & Reid, 2019).

Other participants recalled similar events and the notion that sex was 'not something you talk about' with their parents:

We never talked about sex no no no definitely not. I always got the impression that that was off limits, not something you talk about...they [parents] were really private about everything like that, like if my sister was ever showing erm erm how would you say erm a bit too much skin then it was always "go and cover up"...never saw me mam or me dad undressed, never so no it wasn't something I could really talk about (P.3)

The belief that the discussion of sex was 'off limits' for participant three is emphasised in his repetition of this, suggesting that it was not simply that the topic was not an issue discussed at home, but instead that it would have been considered inappropriate or unacceptable to talk about it if the subject had been raised. His discussion of 'everything like that' to summarise that it was not just sex that this perspective extended to, but that nudity, or showing parts of your body, was also considered inappropriate. This approach to sex is particularly common among socially conservative communities (Love & Farber, 2017). It is said that not discussing sex (or making it a taboo topic) can have a suppressing effect on sexual thinking, which can in turn lead to an increase in emotional and compulsive sexual behaviour (e.g. masturbation as a form of emotional coping) via a rebound effect (Efrati, 2019; Wetterneck, Smith, Burgess, & Hart, 2011). Participant three's suggestion that sex was something that he wanted to talk about, but was not able to, may identify an emotional need that was not being met. This feeling also extended to others, with participants acknowledging that they 'had no-one to talk to about it [sex]' (P.9). While it is clear for these participants that discussions surrounding sex never occurred, for those that did recall discussions regarding sex with parents, these were generally viewed as negative and reactionary:

I had a girlfriend and I was 15 and she was 15 and we'd stayed at a friends house and my dad was picking us up....when I got home he came up and sat on me bed. He knew what I'd done but I denied it and then my mum came up and she started talking about the birds and the bees and contraceptives and all that lot and she said "if you've had sex with her, there's nothing wrong in having sex with her but you should use a condom" And she said "did you have sex with her?" and I said "yeah" and then she started saying "you know you two can get in trouble because you're both under age for sex and if

you've got her pregnant" and then I wished I hadn't said nothing because then I was just worrying (P.6)

The only time I ever talked about it [sex] with anyone before coming in here was when erm it was after after my dad had come in and caught me touching myself and the next day they erm me mam and me dad sat me down and told me it was a sin and that I shouldn't be doing that erm and never spoke about it again after that (P.18)

Participant discussions with parents appeared to be characterised by negativity, often with the intention of discouraging sexual behaviour through instilling fear. For participant six, this was centred around the risks of having underage sex and the potential for unplanned pregnancy, while for participant 18, masturbation was branded as a sin and thus representing a transgression from their religion, making it an activity that is, and should be, forbidden. While this did not prevent individuals from engaging in this behaviour, instead it prevented them from discussing it with parents. This again corresponds to a suppression of sexual dialogue in religious communities that see sex as a taboo subject, with this having potentially negative effects on the development of deviant or maladaptive sexual coping strategies (Efrati, 2019; Karaga, Davis, Choe, & Hook, 2016; Kwee, Dominguez, & Ferrell, 2007).

Women used to come over when my mother was out and I could hear them at it and I knew what they were doing because I'd seen it on the videos and he'd always said it was our secret and that I couldn't tell her about it but there was one time when I'd asked him why they come over and he walloped me round the head and told me it wasn't my business but that all men had needs. I never asked him anything again after that but that always stayed with me, you know I guess I believed it was just a way to satisfy men and nothing else because of how he was and I had no other role models (P.17)

The above extract echoes the notion that sex was private, secret, and not something to be discussed. For participant 17, his fathers behaviours and opinions subsequently shaped his beliefs regarding sex, particularly as his father was someone he respected as his only role model, thus instilling the belief that sex was simply a means of satisfying men's sexual needs. This is in line with a sociocultural account of sexual offending where men's sexual pleasure and gratification is placed above that of their partners (Cherkasskaya & Rosario, 2018). Within this context, implicit theories about sexual dynamics,

sexual behaviour, and sexual gratification can begin to develop and spread through a complex system of media messaging, popular culture, and interpersonal interactions (Phillips, 2016). Implicit theories non-consciously guide the decisions that we make as we navigate through social interactions and scenarios, acting as mental scripts for everyday life (see Conrey, Sherman, Gawronski, Hugenberg, & Groom, 2005). Ward (2000) developed a framework for understanding the implicit theories of ICOS (see also Polaschek & Gannon, 2004; Polaschek & Ward, 2002). One of these implicit theories is that of entitlement, with people holding this theory believing that they are entitled to have access to sexual satisfaction, and that partners should be available for their gratification. The experience that participant 17 had with his father thus may have led to him gaining exposure to this implicit theory, which then became internalised and a part of his generalised worldview. For many, the negative response from parents, coupled with the belief that sex is 'dirty', taboo and generally not something that should be discussed, left participants isolated, with 'no-one to talk to' (P.9) and without any other appropriate sources of information. For example, none of the participants recalled having sufficient sex education at school:

I didn't get taught sexual education or anything...I didn't know nothing about sex or anything...I just learnt by mistakes you know what I mean (P.2)

Never did sex education at school so how are you supposed to know what's what? (P.16)

They didn't do sex education at my school, not properly it was just like here's a condom and this is how you put it on, the basics (P.6)

As illuminated within the above extracts, a number of participants acknowledged having no sex education at school. While participant six also clearly states this, he then contradicts himself stating that they covered the 'basics' relating to condoms, with the suggestion that this was insufficient and thus does not amount to sex education. However, he does not provide any suggestion of what he believes sex education should involve or what may have been sufficient. Formal sex education was not properly established (or was not accompanied by formal governmental guidelines) in UK schools until the 1950s (Pilcher, 2005), meaning that the older participants in this sample would have either experienced little-to-no formalised sex education, or unevaluated iterations of early national guidance. A recent review of sex education practices found that historically, school-based programmes have been focused around disease prevention and safe sex as a route to improving rates of sexually transmitted infection (Mason-Jones et al., 2016) which corresponds with participant six's

account regarding the content. Only since around 2005 has there been a more explicit focus on sex positivity in sex education programmes (Iyer & Aggleton, 2015), with a recent review and overhaul of sex education programmes in British schools teaching about LGBTQ+ relationships and pornography literacy as a core part of the curriculum (Long, 2019). For participant 16, the lack of sex education at school left him uninformed, with the suggestion that this is the only potential source of information without which gaining knowledge about sex was impossible, further emphasising that participants did not have any appropriate sources of information regarding sex. Participant two reports a similar lack of knowledge about sex due to the absence of sex education, and instead reports learning by his 'mistakes', suggesting some level of self awareness in that he was able to reflect on and recognise previous experiences as not being positive in order to constitute a mistake which he was then able to process and use to shape his future behaviour. This historical shortcoming of sex education is now being addressed in schools in the UK, who are now regulating and encouraging the teaching of sex positive messages about sexual orientation, sexual relationships, and the role of pornography in sex and relationships education curricula (Long, 2019). While there has been no systematic evaluation of such programmes on the behaviours, attitudes, and identities of young people, the narratives presented in this theme suggest that offering young people a space to talk about these themes can only be a positive thing in terms of their emotional development in relation to sex.

Theme 2: The functions of sexual behaviour

This theme is derived from participant's narratives regarding the ways in which they used sex or sexual activity as a means to achieve something, whether that be satisfaction, self soothing, or as a mechanism by which to gain perceived control, each of which are unpicked within the subordinate themes below.

Theme 2.1: Seeking something more

This theme draws upon the participant narratives to explore the ways in which participants use sexual behaviour to fulfil either a physical or emotional need (for a discussion as to how this process looks in relation to normative sexual arousal and behaviour, see Bancroft et al., 2003). For those in the sample that had experienced some form of sexual abuse, appropriate and consensual sexual contact that they were actively seeking came much later in adolescence. It was only at this point that participants began to consider that sexual contact could be positive:

The first sexual experience I chose to have was when I was 17 and erm, from then on, I saw the enjoyment in it from my my side where I actually wanted to do it and I enjoyed it and then my sex drive sort of started from then (P.13)

For participant 13, this realisation that sex can be consensual and positive, initiated his desire to actively seek and engage in sexual behaviour in order to address his sexual needs, suggesting that prior to this point he had no such needs but instead, sexual contact was the result of abuse. This awareness of sexual behaviour as a method of attempting to achieve sexual 'gratification' (P.16) or satisfaction was common among the participant narratives. This is unsurprising given that a primary aim of sexual activity for men is to achieve sexual satisfaction or gratification (for a review of sex differences in sexual motivation, see Hatfield, Luckhurst, & Rapson, 2010).

Masturbation has never really, has never really stopped to be honest I mean it was, even during relationships I used to masturbate erm sometimes I wouldn't be satisfied just by sex, I'd get up during the night and go down stairs to watch a porno then I'd have a masturbating session then go back to bed (P.9)

Yeah, yeah, erm, I'd always masturbate at least once a day as well as having sex with my partner because it took a lot to satisfy me, to quench it, which like I said is why I always cheated because I needed more (P.13)

These extracts highlight the participants' need for multiple forms of sexual behaviour in order to achieve sexual satisfaction, with the recognition from both participants that sex with their partner alone was not sufficient. This often results in individuals seeking other means of achieving sexual satisfaction outside of their primary relationship, for example, through masturbation, prostitution or seeking multiple relationships (Atkins, Yi, Baucom, & Christensen, 2005; Sanchez-Fuentes, Santos-Iglesias, & Sierra, 2014). This is in line with the methods discussed within the above extracts from both participants nine and thirteen. For participant 13, this is used to attempt to excuse his infidelity. Within the broader positive psychology literature, sexual satisfaction is conceptualised as a primary human good (Ward & Marshall, 2004). This means that all people are seeking this state of satisfaction in the sexual domain and therefore will seek out opportunities to achieve this when satisfaction levels drop. For some people, such as ICSOs, this will result in sexual offending whereby those without the requisite abilities to obtain satisfaction from sexual partners in a consensual way will result in coercive tactics to meet their sexual needs (Thornhill & Palmer, 2000; Ward & Beech, 2017). For individuals with PSA,

achieving true sexual satisfaction is difficult owing to the rate at which sexual activity is desired, obtained, and desired once more. Consistent with the extracts presented here, this often leads hypersexual individuals to participate in sexually diverse and sensation-seeking ways, including engaging in infidelity and procuring the services of prostitutes (Cantor et al., 2013).

While the above narratives depict the use of sexual behaviour in attempting to fulfil a physical need, for some participants, engaging in sexual behaviour was more related to seeking an emotional need:

It's, I don't know it's, it's strange because there's, there's wanting more sex and then there's wanting the contact, and that was kind of, that's, I don't know, I, I I think it was more that I wanted the contact (P.9)

I started to realise what it felt like to be close to a woman and to realise that sex could feel good, it didn't always have to be bad and I think that's why at first I always wanted to be having sex, to be able to feel that feeling of being close to someone and to feel loved because I'd never had that love (P.17)

For some of the participants, sexual contact was a method of achieving emotional closeness. In the above extract, participant 17 discusses the realisation that sex can be positive, reflecting on his previous sexual abuse and emotional neglect as a negative comparison, echoing the earlier narrative from participant 13. This highlights how abuse can taint the way sex is viewed, but how positive experiences can begin to alter the negative perceptions with the recognition that sex can be positive, intimate and loving. In interviews with men who have abuse histories, this theme of building a positive view of intimacy in future relationships has been found to be associated with self-reported recovery from abusive experiences. For example, Kia-Keating, Sorsoli, and Grossman (2010) reported how sexual intimacy was something that this population struggle with in relation to adult relationships, but that this can be managed through a process of building trust, setting appropriate boundaries, and developing intimacy over a period of time with a new partner. This highlights the important role that experiencing relational trust and intimacy can play in breaking down the negative associations that sexual abuse can produce. It is important to note that this effect of intimate relationships on promoting recovery from mental health issues is not limited to male survivors of childhood sexual abuse, having also been observed in female survivors (e.g. Feinauer, Callahan, & Hilton, 1996). In these extracts, sex is clearly perceived as a way of achieving emotional needs. Similarly, participant nine directly acknowledges wanting both sex and 'contact', the latter which he later defined as: 'it's more than sex, it is sex but it's also that feeling of being close to someone'. He is contrasting the physical

act of sex that is void of emotion, against the ‘feeling of being close to someone’, suggesting that sex is a potential method of achieving this emotional closeness, which for him was a priority over the physical act of sex. This separation of physical and emotional aspects of sexual activity is acknowledged within the literature and in measures of sexual satisfaction (e.g. Štulhofer, Buško, & Brouillard, 2010). Sexological research demonstrates how emphasis on these domains of satisfaction fluctuate throughout life, with women becoming more interested in physical satisfaction and men in emotional satisfaction as they age (Carpenter, Nathanson, & Young, 2017). In the sample here it may be that retrospective insights about the lack of emotional connection that was experienced through sex in their early years leads them to place a greater emphasis on the emotional aspects of sex at an earlier age. This importance placed on emotional connections with others is also consistent with positive psychological approaches to wellbeing and desistance from crime, with this aspect of life being proposed as a primary human good that everybody strives for (Maslow, 1943; Ward & Stewart, 2003). This drive to fulfil their emotional needs resulted in some participants seeking romantic relationships in an attempt to achieve this:

I'd just go out and meet a girl and she'd be really nice and I'd think yeah I can see myself being with her and all that and then nothing would happen or come of it and I'd feel heartbroken because I wanted something more, like a relationship because that was all I wanted, erm sometimes I'd see other people, like couples going to the cinema, or walking down the road holding hands and in love and I wanted that, I wanted to experience that but it never happened, it always ended up just one night or two nights or something and then nothing, they weren't interested so I'd go and find someone else because I just wanted to be with someone like properly (P.19)

From the above extract it is clear that participant 19's focus is on developing a relationship, with the recognition of a desire to ‘be with someone like properly’. Here ‘properly’ is used to imply his desire to have something ‘more’ than just a sexual relationship, something meaningful and emotional as observed in others, therefore evoking a sense of jealousy within his narrative. For him, this desire led to him seeking out relationships with multiple women, with sex considered as a feasible method of ‘showing her that I really liked her’ and initiating this desired relationship. Previous work has identified that relationship social comparison is associated with lower levels of self-esteem, and both anxious and avoidant attachment styles (LeBeau & Buckingham, 2008). These outcomes are commonly observed in survivors of sexual abuse (Alexander et al., 1998; Karakurt & Silver, 2014), and may explain participant 19's focus on comparing his own relationship success with the success of others.

Theme 2.2: Gaining control

For some participants in the sample, sex or sexual behaviour was viewed as a method of gaining control over something in their lives, for example, over negative emotional states:

It was all about making meself feel better. I was always trying to make something to make me feel better, even if I got told off by the old man, get abused by the old man, I'd go and masturbate (P.11)

When I get depressed or I'm feeling a bit down I masturbate to like my victims to make me feel good again (P.1)

From the above extracts it is clear that the participants use masturbation to gain control and act as a coping mechanism or self medication to overcome feelings of depression, vulnerability and helplessness. These narratives are consistent with Brewer and Tidy's (2019) findings where psychosexual therapists were clear that their clients who were experiencing 'sex addiction' engaged in compulsive sexual behaviour for this same reason. In prior work on the role of sex as an emotional coping strategy, Hughes (2010) found that people demonstrating sexually addictive behaviours made use of sex in order to self-soothe emotional insecurities in a similar way to the participants in the current study have (see also Bancroft & Vukadinovic, 2004; Walton et al., 2017). It is not only in samples of men with PSA where emotional dysregulation has been associated with increased rates of risky or excessive sexual activity. This relationship has also been seen in patients enrolled in a residential substance abuse treatment programme (Tull, Weiss, Adams, & Gratz, 2012) and in people with a diagnosis of bipolar disorder (Walton et al., 2017). One theoretical model of hypersexual behaviour put forward by Bancroft and Vukadinovic (2004) suggested that experiencing anxiety and depression can lead to substantial increases in sexual interest in approximately 15-25% of men. This figure is not markedly different from recent estimates of self-reported difficulties in controlling sexual arousal in the general male population (10.3%; Dickenson, Gleason, Coleman, & Miner, 2018). Bringing these findings together it appears that PSA might be rooted in some degree of difficulty in regulating responses to the negative emotional states that people with hypersexuality are more prone to experiencing (Miner et al., 2016; Walton et al., 2017). By masturbating to his victims, participant one is attempting to place himself in a position of power within his fantasy, recreating the feeling of control over his victims to enable him overcome these negative emotional states. Engaging in fantasy as a way of gaining a feeling of control is not necessarily deviant as a specific behaviour. That is, using

imagination and fantasy play has long been observed in children as a method for obtaining cognitive control over new situations and planning future behaviours (Gooderham, 1995; Hedegaard, 2016; Singer, 1979). However, forensic uses of fantasy to gain control have been observed in police interviews with suspected offenders (Napier, 2017). In the area of sexual offending, emotional regulation difficulties are associated with an increased risk of committing acts of sexual violence as a route to emotional control, and occurs through both a lack of emotional coping skills and misattribution processes in relation to the behaviour of others (Cortoni & Marshall, 2001; Ward & Beech, 2006; Ward & Gannon, 2006; Ward, Hudson, & Keenan, 1998). The reasons why sexual behaviour (such as the masturbatory practices described by participant one) might be used as an emotional coping strategy are presented in quite a theoretical way in the literature. Early work published by Marshall (1989; 2010) reported how this association of sexual activity with self-soothing of emotional problems appears in adolescence and might be linked initially to attachment difficulties (e.g. a fear of rejection from potential sexual partners or as a way of regaining control over traumatic or uncontrollable situations). However over time sexual behaviour, particularly masturbation, becomes “adopted as a way to dispel feelings of distress generated by any cause” (Cortoni & Marshall, 2001, p. 29), with engagement in sexual fantasy (or the use of pornography) conditioning sexual stimuli with a self-medicating response.

A number of participants also reflected on the impact of their prior abuse, and discussed the use of sexual behaviour as a method of achieving control in this way:

I'd wank all the time because it was a way of feeling erm I did it when I wanted and it made me feel in control of something because it was my choice (P.4)

I dint have control over nothing in my life so so that, ya know wanking, was the one thing I could choose to do that made me feel good (P.12)

Consistent with the above analysis, both participants discuss masturbation as an explicit means of seeking control. Both extracts directly reference their choice to engage in masturbatory behaviour, contrasting this against their abuse and lack of control over anything else in their lives. For men with extreme levels of PSA, it may seem as though their sexual arousal is the only thing that they can focus on – particularly when this is used to regulate negative emotions, as described by Bancroft et al. (2003), Nimbi et al. (2019), and Walton et al. (2017). By being able to use this sexual arousal to gain control (via masturbation), these individuals are able to exercise and foster a sense of personal agency.

As discussed within the Good Lives Model of the rehabilitation of individuals who have committed criminal offences (e.g. Ward & Gannon, 2006; Ward & Stewart, 2003), and other positive psychological frameworks that fall outside of the forensic realm (e.g. Larson, 2000; Maslow, 1943; Ryan & Deci, 2006), developing a sense of agency and control in life is something that all people strive for. Given the preoccupation around sex that is characteristic of people with PSA (Kalichman & Rompa, 2001; Kafka, 2003; Mann, Hanson, & Thornton, 2010), it is unsurprising that masturbation is used as a means of achieving this in the current sample. For other participants, this relationship between control and sexual behaviour was not discussed in such an explicit way:

I was about 14 when I started actually having girlfriends well not girlfriends but girls I was having sex with from school and it obviously felt different from what had happened to me before but it felt good but it was different again as well because it was always on my terms then, not theirs and like if a girl had come on to me I wouldn't have been interested because I had to come on to her and then I wouldn't be bothered afterwards, which I can see that is bad now and got me a bit of a reputation but I didn't really care about that then I was just getting my leg over when I wanted (P.5)

The discussion of 'always on my terms' within the above extract highlights the primary need for this participant to have control and power over the situation, more so than the desire to have sex, with the recognition that without this he would not be interested. A lack of intimacy and emotional connection resonates throughout this narrative, with a blunt awareness of the intention of the behaviour to simply engage in sex and the discussion of not being 'bothered afterwards' once the desired outcome of 'just getting my leg over' has been achieved. This impersonal description of sexual activity with others speaks to some of the literature related to offence-supportive cognition and implicit theories about sex that are present among many ICSOs (Bartels & Merdian, 2016; Polaschek & Ward, 2002; Ward, 2000). Specifically, seeing men (or in the present sample, oneself) as being entitled to sexual gratification, and viewing women as objects for this gratification, are particularly prevalent themes in the belief systems of men convicted of rape (Polaschek & Gannon, 2004). In his narratives, participant five verbally demonstrates these themes related to the purely physical act of obtaining gratification. As with the previous extracts, he also discusses the difference between this sexual behaviour and his prior abuse, in that he was not only choosing to engage in this but also seeking it out, allowing him to assert control over the situation. However, there was a recognition among participants that the positive effects of achieving (perceived or actual) control was not long lasting:

It did, it did work but erm but it always wears off after a bit so I'd like you know feel good at the time and in control and like nothing else matters when I was havin a wank or havin sex but then later it would wear off and i'd feel shit again and so on and so on (P.14)

It is evident from the extract that the feelings of control and enjoyment from engaging in sexual behaviour, as highlighted throughout the narratives of this theme, are only temporary and short lived. There is an awareness that this desired effect 'wears off', with participants reverting back to previous emotional states of feeling 'shit', or depressed, vulnerable and helpless due to a lack of control as discussed within the previous extracts. Participant 14's use of 'and so on and so on' emphasises the cyclical nature of this relationship in that participants are engaging in sexual behaviour, whether that be sex or masturbation, in an attempt to seek control and overcome negative emotions or states of mind, and while this may be successful, it is not permanent, resulting in the constant need to again engage in this behaviour to achieve the desired outcome.

There is also an acknowledgement by some participants that the social effects of being seen as sexually active play a role in identity formation:

Erm I used to go out with my mates and I always consider that I had mates that were a lot better looking than me, but I was always a lot better at talking to them than they was and so I would always be the one that approached them and erm, therefore I would always get my pick and they would have to have what was left...there was also the fact that erm, erm, once I started to doing that I had, I suppose I felt that was my place in, I hung around with a lot of people that were, I suppose a lot bigger than me, probably, most likely a lot stronger than me and erm, so I, I had to have a place within that group and so once I found that position of, I suppose the person that just goes and sleeps with everybody then I, I maintained that position over the years (P.13)

While the narratives above discuss a direct effect of sexual activity on alleviating negative emotions, participant 13's extract identifies an indirect route to this. That is, his PSA and the behaviours associated with this led to him being established as somebody in his social group who would 'get my pick' of sexual partners. He discusses this in a manner that suggests that this was something he did with pride, juxtaposing his 'skill' against other members of the group who were 'better looking', 'bigger', and 'stronger' than him. In line with theories related to masculinity and intrasexual

competition (Buunk & Fisher, 2009), being smaller, less attractive, and weaker than peers leads to the possibility that participant 13 could have been assigned a low ranking status with his social group. As such, by carving out a niche identity for himself within the group ('the person that just goes and sleeps with everybody then I, I maintained that position over the years'), participant 13 took an active role in controlling his social status by conforming to established masculinity ideals, as discussed in the sociological and sexological literatures. That is, society in general endorses a (hetero)sexual double standard that glorifies male sexual promiscuity and shames the same behaviour in women (Farvid, Braun, & Rowntree, 2017). In engaging in lots of sexual activity with different partners, participant 13 is upholding this ideal, and further gained positive reinforcement from this in terms of identity and reputation. In doing so, this reinforcement maintained his cycle of sexual promiscuity, and facilitated the escalation of his hypersexual behaviour (this process of escalation is discussed within the next theme).

Theme 3: Recognising a problem

This theme is characterised by a process of reflection in which participants are becoming aware of the escalating nature of their sexual arousal as something that is problematic, thus leading some to contemplate change.

Theme 3.1: Escalation: 'it's like you're chasing something that's always out of reach'

While participants sought to regain control of their lives through engaging in sexual activity, they also reported losing control of their arousal in this process. While participants did not directly discuss the escalation of their sexual thoughts, they reached a point at which they realised their sexual thoughts were excessive:

I think I thought about sex more than anybody else...sex was on my mind most of the time (P.11)

Literally every day, 24 hours a day, seven days a week, I was thinking of sex (P.10)

I was just thinking about sex, sex, sex, sex, sex (P.6)

As highlighted within the above extracts, sexual thoughts were considered to be constant and enduring, emphasised by the use of periods of time and repetition of 'sex' to signal the ubiquitous

nature of the sexual thoughts. For participant 11, he appears to draw this conclusion based on a comparison to others, formulated from an assumption regarding quantity of sexual thoughts, however, he demonstrates his uncertainty regarding this with the use of 'I think'. This corresponds to the findings presented in the first theme related to a lack of discussions with others regarding sexual content. This suggests that he may not have an awareness of a baseline against which to compare himself, thus creating uncertainty in his assumptions. However, this apparent ubiquity of sexual thoughts is consistent with established definitions of sexual preoccupation as "an abnormally intense interest in sex that dominates psychological functioning" (Mann et al., p. 198).

I suppose that's what, got my taste for sex erm and from that point started sleeping with everyone and anybody, you know I just wanted more and more and more (P.13)

I had a high sex drive, yeah. Because I experienced it the first time I wanted it more and more (P.6)

For some participants, their first experience of sexual intercourse is cited as the catalyst for their sexual drive, with the discussion from both participants of wanting 'more and more' (P.6). As such for some individuals, their desire to engage in sexual behaviour, was not something that they considered to have increased, but rather it 'just started' (P.9) with the onset of sexual activity. Rather than increasing over time, it was recognised as a 'constant high' from the very beginning with an escalation in behaviours in order to fulfil this sexual need or reach sexual satisfaction. This 'constant high' is consistent with the work of Rettenberger, Klein, and Briken (2016) and Winters, Christoff, and Gorzalka (2010) who found high levels of trait sexual excitation among those who were prone to exhibiting hypersexual behaviours.

Erm, well erm, I were masturbating a lot...erm, ohh, I'd say about, thr-three or four, three or four, three or four times a day (P.18)

I was masturbating five, six times a day by then erm it didn't start that high but it slowly crept up you know what I mean and I was doing it more to get the frustration out and get that release (P.7)

Considering that the median average frequency of male ejaculation is four-to-twelve times per month (i.e., up to three times per week; Rider et al., 2016), for the participants here reporting this to

consistently be multiple times per day, the recognition from participant 18 that this is 'a lot' is warranted. Participant seven acknowledges the change in both the frequency and purpose of his masturbation, with 'slowly crept up' suggesting that the escalation was gradual and something he was oblivious to until this point of reflection. For him, masturbation had become driven by the need to relieve sexual frustration rather than an act of pleasure. This use of masturbation is well observed within the sexuality literature, with around 35-57% of women and 64% of men (Carvalho & Leal, 2013; Yule, Brotto, & Gorzalka, 2017) reporting a primary reason for masturbation as frustration or stress relief. Further, Yule et al. (2017) reported how 15% of men masturbate because they felt like they had to, indicating a compulsive explanation to their masturbation-related behaviours. The escalation in the frequency of masturbation discussed above was acknowledged by all participants in this sample, with some also discussing an increase in sexual activity with numerous partners:

I'd probably have sex every day and, if I'm honest, some weeks it would probably be a different bird a day. Erm, between the age of 17 and 21 er, I must of, er, I mean realistically I, about 150 people minimum...Most of them would be, most of them, most of them would be er, there was occasions where erm I'd like see them for a few weeks at a time erm, you know... I would see the same person several times over a few months...Also I'd sleep with other people at the same time (P.13)

The above extract illustrates the casual attitude towards sex that was held by a number of participants, resulting in sexual promiscuity and thus a large number of sexual partners. This is consistent with a range of sexological literature that suggests that men take less time to consent to sexual activity with strangers, and have more permissive attitudes towards casual sex or short term sexual relationships than women (e.g. Buss & Schmitt, 2011). However, while this trend is a general trend for men, the narratives of the participants in this study suggest that the behavioural effects of these outcomes are heightened among those with PSA. One participant attempts to offer an explanation for this escalation in sexual activity:

It was kind of erm kind of that feeling that it wasn't as good as it could be, like it wasn't as good as the first time so I'd keep wanting more and more and sleeping with different women erm it's like you're chasing something that's always out of reach because it's never going to be that good again (P.2)

Here participant two's extract perfectly depicts this notion of seeking something that is 'out of reach', alluding to this being unachievable. However, this is only apparent on reflection with the discussion of his previous behaviours as a method of 'chasing' this, prior to the awareness that his attempts were futile. While for some participants this was in relation to sexual satisfaction generally, for participant two, this is specifically in relation to 'the feeling that it wasn't as good as it could be'. This description resonates with concepts of tolerance, whereby the initial high that he experienced during 'the first time' turned into something that was constantly being sought in subsequent sexual encounters (Walton & Bhullar, 2018). The notion of these effects wearing off over time, or needing 'more' to attempt to achieve the same level of satiation is consistent with the broader addictions literature, both in relation to drug / alcohol addiction and behavioural addiction (e.g. Griffiths, 2005; Koob, 2011; Siegel, 1979). Consistent with the process of "hedonic habituation" (Koob, 2009, p. 19) that is common in cycles of addictive behaviours, the initial high of achieving orgasm in relation to a specific stimulus acts as a positive reinforcement of that stimulus. This then contributes to a cycle of expectation of the same high in subsequent sexual scenarios which may not be met. In turn this leads to the individual engaging in more frequent or extreme forms of sexual behaviour in order to chase the initial feeling of euphoria. Similar behavioural trajectories have been reported in the literature on sex addiction. For example, Briggs, Gough, and das Nair (2017) reported how self-reported hypersexual individuals suggested that their sexual behaviour became progressively more frequent or deviant over time. Similarly several studies have reported how sexual addiction (particularly in relation to pornography) typically presents with the same tolerance and withdrawal phases that are observed in people with other forms of addiction (Andreassen, Pallesen, Griffiths, Torsheim, & Sinha, 2018; Banca et al., 2016; Gola et al., 2017; Griffiths, 2012).

For those in relationships, there was a clear recognition that the level of sexual activity desired by participants was not something they could satisfy within their relationships, resulting in them seeking out additional sexual partners:

*Needing that much sex obviously meant that I was cheating because my girl
girlfriend at the time didn't didn't want that much and yeh we'd have sex
every day but I needed more so I'd have to get that somewhere else (P.17)*

Here participant 17's need for sex is used to excuse or justify his infidelity, with 'obviously' suggesting this to be inevitable as it constitutes an amount that was unreasonable to expect within a relationship. Despite sex being discussed as occurring daily within his relationship, which is high considering the average frequency of sexual intercourse within a relationship is one-to-three times per month (Muise,

Schimmack, & Impett, 2016), participant 17 still considered this to be insufficient to meet his needs. His discussion of 'needing' sex alludes to a lack of choice or control, presenting sex as simply a means of addressing a purely physical outlet for frustration. This is consistent with Yule et al.'s (2017) observation that, for some men, sexual activity has a compulsive quality related to need rather than pleasure. This also again demonstrates the progression from sexual activity as something pleasurable that individuals are choosing to engage in, to something that is a necessity or requirement, again instilling a sense of lack of choice and control. For some, this progression in the nature of the functions of sexual behaviour, led to more deviant means of fulfilling their sexual needs:

The more I got the more I wanted so ended up having sex with anyone, erm in public toilets looking for men, erm I erm prostituting myself to other men because it was easy money but I was also getting what I wanted (P.9)

The awareness from participants that they were never satisfied, and instead always wanting more, echoes participant two's earlier narrative regarding 'chasing something that is always out of reach'. This resulted in participants continually seeking out more sexual behaviours or interactions in an attempt to meet their needs, with some resorting to illegal and risky behaviours to achieve this as demonstrated within the above extract, providing a clear example of tolerance being built up (Koob, 2011). For participant nine, his escalation in sexual behaviour increasingly put him at physical risk as he sought to experience more and more sexual gratification. For example, men operating as sex workers (and their clients) are at a significantly increased risk of contracting HIV and other sexually-transmitted infections than the general male population (Estcourt et al., 2000; Minichiello, Scott, & Callendar, 2015; Rich, Leventhal, Sheffer, & Mor, 2019). This trend of placing oneself in risky sexual contexts in order to achieve sexual gratification is consistent with the addiction literature whereby those experiencing addictions of substances will resort to illegal, illicit or dangerous activities in order to gain access to their substance or activity of choice (e.g. Dissabandara et al., 2014). While participant nine's extract demonstrates a very clear progression of behaviour in terms of deviancy, for others, this escalation was much more subtle:

I was always watching a lot of porn. It was adult porn to start with, where they look like teenagers, like pretending to be teenagers but still adults but then that stopped doing it for me so it got younger and younger so then it was more child porn instead of adult porn (P.5)

Yes erm my fascination did increase over the years and like before I could masturbate just to the thought of it so yes you could say it progressed because as I said I started erm stealing the underwear to masturbate with later, erm and I would lay it all out while I was naked and I'd get a very powerful erection and then I'd use them to masturbate and have a very powerful ejaculation (P.10)

Participant five's discussion of his progression to viewing indecent images of children is to some extent presented as accidental, something that just happened without consciously engaging in this decision, as a result of a lack of sexual satisfaction from the more appropriate stimuli. Both extracts highlight the changing nature of sexual behaviours in order to reach sexual satisfaction, with participant five acknowledging that the more appropriate material had 'stopped doing it for me', and participant 10 acknowledging that sexual thoughts alone were now insufficient for masturbation, leading them both to increase the deviancy of their sexual behaviours. Escalation in terms of the extremity of the types of thoughts and behaviours that these participants are engaging with in order to achieve the same degree of sexual satisfaction and gratification relates to the types of tolerance arguments that are put forward by those who make the case for an addiction model of PSA, as described above (Banca et al., 2016; Briggs et al., 2017; Gola et al., 2017; Griffiths, 2012). That is, having been able to achieve satisfaction using milder sexual fantasies or appropriate pornographic stimuli, an individual becomes desensitised to this and therefore need more extreme thoughts and stimuli to achieve the same initial high. This, to some degree, corresponds with the earlier narrative of participant two, who had 'the feeling that it wasn't as good as it could be'. Here though, participants five and ten are actively escalating their behaviour in order to reach this same sense of satisfaction. For others, rather than an escalation in deviancy in order to achieve sexual satisfaction, instead there was an awareness of the escalation of sexual arousal generally:

It got to the point where I'd have a hard on and masturbate over anything, women, men, kids, I'd see a kid on a TV programme and start masturbating (P.12)

For this participant, his sexual interest and arousal had escalated to the point of becoming indiscriminate, and rather than recognising a specific sexual preference that was increasing in intensity, he is instead reporting a general increase in arousal and masturbation to 'anything'. This trend of sexualising neutral stimuli is relatively under-researched. However, there is some evidence to suggest that exposure to sexualised themes in pornography can be translated onto non-sexual

contexts. For example, Paul (2004) found that consumers of 'barely legal' pornography (i.e. where female performers who are aged over 18 are made to look younger) more easily classified neutral images of children as being arousing in an implicit association test than participants who did not consume this type of pornography. In the current context it is clear that there is an escalation in terms of increases in the frequency of masturbation (P. 7), the deviance or extremity of sexual fantasy and pornography consumption (P.5 & P.10), and the variety of sexual outlets and behaviours (P.9 & P.17), which creates a social and cognitive environment of sexual preoccupation in which all contexts and stimuli have the potential to become sexualised. In this sense, men with an extreme form of PSA may be classified as being "sexually omnivorous" (Meridian, Curtis, Thakker, Wilson, & Boer, 2013, p. 126), in that they become aroused to and can achieve sexual gratification and satisfaction from a wide range of both sexual and non-sexual stimuli. This point reflects the point at which escalation has reached a peak, and some individuals finally recognised the problematic nature of their sexual arousal patterns. This is discussed in the next theme.

Theme 3.2: 'Something has to change'

This theme depicts the process of reflection that participants engage in to recognise their sexual arousal as being problematic and reaching a point of contemplation regarding potential change. Initially, this is simply beginning to question whether their sexual arousal and behaviours are 'normal':

I guess erm I started to think it wasn't normal way before erm when I noticed, like when I actually thought about what I got erected to because even though I was having appropriate ones [fantasies], they didn't give me as much pleasure or satisfaction as the inappropriate ones and I was getting more and more of them...the inappropriate ones (P.15)

I thought it was normal until I spoke to other people about it, erm you know I'd speak to other people about how many they'd been with and it was always really low like three or four and then I'd be like 'oh mine's 30' even though its much higher and you know, they'd be like you know they'd be so shocked and would say that was weird so then I started to question that a bit really (P.13)

As demonstrated within the above extracts, participants are reflecting on events or situations in which they began to consider that their arousal 'wasn't normal'. For participant 15, this was related to the

nature of the stimuli that he got aroused to, and an awareness that inappropriate fantasies provided more sexual satisfaction and were getting more frequent than appropriate fantasies. This increase in inappropriate fantasies is likely due to a process of reinforcement through masturbation. According to Bartels & Beech (2017) fantasy engagement (elaborating on sexual fantasies in a conscious way) is a more important part of this reinforcement process than is merely having sexual thoughts themselves, which can be short-lived or fleeting. In their dual-process model of sexual thinking, actively attending to sexual thoughts through fantasising and masturbating strengthens mental associations between the stimulus (the sexual target) and the response (sexual arousal) in a similar manner to what is discussed in relation to arousal conditioning earlier in this chapter. Participant 15's appreciation that maybe his arousal 'wasn't normal' only comes to light once actively reflecting on this. That is, this was not a perspective that he held at the time, or when the inappropriate fantasies began, meaning he had no reason to not engage and act upon these. This may reflect an initial step towards contemplation on the problem of PSA for participant 15, which indicates the first stage of behavioural change (Prochaska & DiClemente, 1983). For participant 13, rather than a process of self reflection, instead discussion with and comparison to peers, coupled with their negative reaction to his disclosure led him to question whether the extent of his sexual activity was normal. Here it appears that hiding the true extent of his sexual activity from his peers may represent embarrassment regarding this, and an attempt to avoid being judged by others. This is consistent with a range of sexual minorities who may choose to hide their sexual orientations and behaviours in order to shield themselves from societal stigma (e.g. D'Amico & Julien, 2012; Medley, 2018).

Throughout the narratives, the different ways in which participants came to the realisation that their sexual arousal was problematic were discussed:

I do it [masturbate] because I have to...I can't help it, I have to...and its like 10 to 15 times a day and maybe 4 of them for pleasure (P.20)

I think the best way of describing it is if a person has got a problem with their mind and it's and it's there constantly, 24 hours a day, 7 days, you know what I mean. I mean it's, eventually you just, eventually all you think about is that problem... Erm, and that's basically what it was that, sexual wise it was really doing my head in at the time (P.9)

These accounts accentuate the difficulty and distress the participants are experiencing in relation to their sexual arousal, with the participant extracts highlighting the psychological aspects, with the

constant and intense sexual thoughts and fantasies as well as the behavioural aspects through excessive masturbation. Both accounts echo the notion that the thoughts/fantasies, and behaviours are unwanted, are impairing functioning and is something they are consumed by, or give in to, without choice. This is consistent with survey research with community based men which suggests that a substantial proportion of masturbatory activity is compulsive in nature (Yule et al., 2017). While participant 20 still considers some of his masturbation to be for pleasure, there is an acknowledgment that the large majority is not, and is instead to satisfy a sexual urge or to relieve sexual frustration that otherwise results in discomfort or pain which is only relieved through orgasm: 'my penis actually hurts, like aches, until I do it' (P.20). In addition, some participants discussed the awareness of their sexual arousal as a trigger for their offending behaviour:

You shouldn't be thinking about things like that, cus you start thinking like that you start committing offence and you start creating victims (P.16)

This extract demonstrates the participants awareness that his sexual thoughts are inappropriate or immoral, suggesting some level of choice or active participation in establishing the thoughts. Furthermore, the way in which this is discussed depicts an immediate increase in risk, suggesting that offending is inevitable following the thoughts, again depicted as a conscious decision.

Recognising the escalation in the frequency, intensity and breadth of their sexual urges, as well as the links between these factors and their risk of committing a sexual offence, led a number of participants to the realisation that their sexual arousal was problematic and thus 'something has to change' (P.1). However, for others, it was the consequences of their offending which was attributed to their PSA, which led participants to this conclusion:

When erm when when they found the pictures that was it, I'd lost everything erm my wife, my house, my friends erm family and that was the point I realised that it wasn't worth it and something had to change (P.19)

I'd crossed that line and I'd hurt people...all so I could get my sexual satisfaction, all because I couldn't control my sexual thoughts so it just got more and more erm but I didn't I didn't I I can see now that I was making it worse by acting on them and masturbating but at the time I didn't see any wrong in it until it was too late...I knew I needed to get it under control because I didn't want to be that person (P.14)

The above narratives echo a sense of regret, brought about by the awareness that the gains of their offending 'wasn't worth it' in relation to the consequences, which for participant 19 was everything he had subsequently lost. The extent of the loss he feels is emphasised in the way he lists these, however, he discusses this being the result of the pictures being discovered, rather than accessing the images themselves. The recognition by participant 19 that he had lost social capital in the form of family and friends (Weaver & McNeill, 2015; Zoutewelle-Terovan, van der Geest, Liefbroer, & Bijleveld, 2014), and that this acted as a catalyst for behaviour change, is conceptually similar to the criminological idea of turning points (Sampson & Laub, 2005). While turning points are typically viewed as positive things (e.g. becoming a father or becoming involved in an intimate relationship), the loss of a positive stimulus can also lead people to realise what their behaviour has cost them. This experience can be explained using established cognitive psychological theory. For example, it is commonly observed that people experience losses as being more negative than gains are perceived as positive (the so-called negativity bias; Kahneman, 2011). In losing his relationship, his home and his family, participant 19 feels extreme negative emotions, which leads him to become motivated to change his behaviour in order to regain what he once had. For participant 14, his offending behaviour is directly attributed to the need for sexual gratification and a lack of control over his sexual arousal, with an awareness that he had reinforced this, however at the time this was something he was oblivious to. He goes on to discuss not wanting to be 'that person', referring to the version of himself that was not able to control his sexual arousal and had offended. According to Maruna (2001) some people with criminal convictions experience feelings that they are "doomed to deviance" (p. 74), and this notion is consistent with the narratives presented here (see also Maruna & Copes, 2005). However, establishing control over his sexual arousal is therefore seen as a way of participant 14 of addressing his risk of future offending. This allows him to "knife off" (Maruna & Roy, 2007, p. 104) from his past self and the associated negative emotions that he experiences. This in turn allows him to move forward towards contemplating and constructing a positive potential future self – a process that acts as a key first hurdle to long term behaviour change (Prochaska & DiClemente, 1983).

However, while there is recognition of a desire to change or control their sexual arousal, for some this awareness was filled with apprehension regarding what the consequences of change may be:

I needed to do something because it was too much, there was something wrong because it wasn't normal to think about sex and masturbate that much, but I still wanted to be able to, you know, when I want to masturbate

I want to be able to because it's always made me feel good, it's always been something that made me feel good (P.8)

Something had got to give because I couldn't carry on like that but it was also a worry, I'd always thought about sex erm every day since I was young, erm watching and thinking and fantasising about women was what gave me pleasure so although I knew I had to do something about my obsession it it was all I'd ever known so then I worried what would I be without it? And that was a really big thing for me (P.10)

While both of these participant extracts depict the clear understanding of the need to change or do 'something' regarding their PSA, these are both cast with doubt and uncertainty. The use of 'but' is used to introduce and emphasise the potential barriers to change that are working in competition against the recognised need for change. For participant eight, a major barrier to change was his desire to continue to masturbate, and so while he acknowledged that this needed to reduce, this was considered in relation to the potential cost of losing his masturbation and everything that affords him. In this sense, he is referring to the role of masturbation and sexual outlets as making him 'feel good' in that they act as a way of him relieving tension, stress and emotional distress. The role of sexuality in the relief of negative emotional states was discussed earlier in this chapter in relation to the functions of sex. However, as an individual moves towards the realisation that this is problematic, anxiety builds as they also recognise a need to replace this method of self-medication with a healthier alternative. There are also issues around identity at play in this process. Similar patterns have been witnessed in people recovering from problematic alcohol use (Buck et al., 2013), with the removal of their drug of choice leading to a void in their life on which they used to rely as an escape from the stresses of everyday life. This process in itself brings its own challenges and worries, particularly around the development of alternative emotional coping strategies. In managing this process, the development of new viable positive identities becomes increasingly important for maintaining intrinsic motivations for change and for improving the chances that long term behaviour change will be achieved (Prochaska & DiClemente, 1983; Ryan & Deci, 2006). This potential loss of identity represented a particular concern for participant 10. For him, this was the recognition that his 'obsession' with sex and the thoughts and behaviours that accompany it were entrenched from a young age, therefore leading him to question who he would be without it. In this sense it is clear that he views his sexual arousal as constituting part of him and a key part of his identity. The discussion of this as constituting 'a really big thing' emphasises the turmoil he felt in contemplating the need to change.

Conclusion

This chapter sought to understand the development of PSA in a sample of ICSOs. The narratives of participants demonstrate a journey based around the loss, regaining, and subsequent re-loss of control over sexual arousal that characterises their sexual development. Early negative sexual experiences, be they through direct experiences of contact abuse victimisation or the coerced or pressure use of pornography, led participants to begin to develop unhealthy sexual beliefs. As discussed throughout the chapter, the development of problematic beliefs about sex can sometimes occur because of abuse experiences due to either the lack of acknowledgement that such experiences are abusive (Cook et al., 2011; Fricker et al., 2003; Olson et al., 2004; Peterson & Muhlenhard, 2004) or by forming implicit theories about the nature of sex and sexual interactions (Marziano, Ward, Beech, & Pattison, 2006; Ward & Keenan, 1999). On the point related to these experiences not being labelled as abusive, this is consistent with previous work on how men retrospectively label their victimisation as a way of reducing feelings of guilt and shame (Romano & DeLuca, 2001), as well as reasserting a sense of masculinity (Easton et al., 2003). This reconstruction of abuse experiences and embedding this into identity may go some way to explaining the development of deviant or problematic levels of sexual arousal in the participants here. That is, if abuse experiences were reconstrued in such a way that they were incorporated as a non abusive incident in the course of sexual identity development, then using sex as a way of maintaining masculinity (and thus a core part of their identity) might be associated with why sex (and the escalation of sexual activity) is used as a coping strategy and a way of (re)gaining control for individuals with PSA (Walton et al., 2017)

These findings highlight the importance of high quality sex and relationship education from a young age. There should be an emphasis here on the relationship aspect, and an acknowledgement that abuse experiences should be labelled as such. Public awareness campaigns such as the NSPCC's 'pantosaurus' initiative encourage parents and teachers to have constructive and open conversations with young people about the importance of protecting themselves and reporting cases of apparent sexual abuse as early as possible. While this does not necessarily prevent first time victimisation, early reporting does increase the chance of repeated victimisation being avoided, limiting the potential negative effects that long term experiences of sexual victimisation can have on emotional wellbeing (Cutajar et al., 2010). Thinking about the implications of this, it is possible that this type of education might be the first point at which it may be possible to intervene in the cycle of abuse, sexual identity development, and subsequent escalations into PSA and sexual offending. A lack of such sufficient sex education was highlighted in many of the participant narratives in this chapter. This meant that messages being communicated in abuse experiences (i.e. that sexual interactions between adults and

children are acceptable or to be expected) and pornography (in relation to the range of sexual activities engaged in during pornographic clips, or the often violent undertones of the material itself; Flood, 2017) could be normalised without challenge. This engagement with pornography without appropriate sex education facilitated the development of paraphilic sexual interests among some of the participants, which is consistent with the violent, objectifying, and otherwise deviant themes that underpin much online explicit material (Træen & Daneback, 2013). These interests served as a basis for fantasy engagement and masturbatory stimuli as participants aged and began to use these behaviours as a way of self medicating against emotional dysregulation (Bancroft et al., 2003; Brewer & Tidy, 2019; Hughes, 2010; Marshall & Barbaree, 1990; Walton et al., 2017).

Participants went on to discuss how they gained control of their sexual arousal over time by considering the various functions that sex can fulfil. They began to realise that sex was not purely a physical act allowing them to experience gratification, but also can enable them to feel close to others. While there is evidence in the sexological literature that this trend of men placing an increasing importance on the emotional aspects of sexual interactions as they age being normal (Carpenter et al., 2017), for participants here this new found function of sex allowed them to discover a way to relieve negative emotional experiences in a way that they had not previously known. That is, prior to this point, high levels of emotional dysregulation (possibly stemming from their own histories of abuse; Ward & Beech, 2017) led to feelings of shame, embarrassment and frustration. These are all common responses among men who have experienced sexual abuse in childhood and adolescence (Easton et al., 2003; Mahalik et al., 2003; Romano & De Luca, 2001; Spataro et al., 2001; Turner et al., 2017). Like many men in the community (Yule et al., 2017), they then resorted to masturbation and engaging in sexual fantasising as a form of escapism from these negative thoughts, and as a method of self-soothing (Brewer & Tidy, 2019; Hughes, 2010). However, on engaging in intimate relationships with other people they learned that sex not only had a physical outcome as its aim, but also an emotional one. They learned that sexual intimacy could allow them to feel an emotional closeness to another person that was positive and not abusive, which is something all people need in order to build and maintain attachments and regulate their experience of the emotions they felt that were associated with this interpersonal contact (Bowlby, 1969; Mikulincer & Shaver, 2008).

The frustration associated with the experience of negative emotional states, however, was still accompanied by a reliance on sexual gratification as a method of achieving physical relief and controlling physiological responses to emotional distress. This cycle was further maintained by high levels of sexual preoccupation and ruminating about sexual themes, with participants seeming to build up an appetite and compulsive self perpetuating cycle of sexual thinking, sexual behaviour and negative emotion (for a description as to how this is maintained from a theoretical perspective, see

Walton et al.'s (2017) sexhaviour cycle). This attempt to regain control (over negative emotions) was initially successful, but led to escalation and a further loss of control in a number of other domains (e.g. intensity and deviance of sexual thoughts, masturbation frequency, seeking out multiple sexual partners, and finally offending behaviour), to reach a point where their sexual arousal was viewed as problematic, with the recognition that 'something had to change' (P. 19), both in relation to their PSA and their offending behaviour. For the participants in this study this led to them consenting to move onto MMPSA as an initial step to changing their behaviour, and thus beginning to distance themselves from their existing identity which was tied in with PSA and sexual offending. Again, this could be construed as a method of seeking control. That is, while their PSA felt like something that they were unable to regulate by themselves, the conscious decision to begin MMPSA treatment gave participants a sense of agency to bring PSA under control and start to work towards becoming their possible positive (i.e. non-PSA and non-offending) future self (Göbbels et al., 2012). The following studies outline their experiences while taking MMPSA.

Chapter 5

Study 2: ‘I still get the odd one...it’s still there in a sense I’d say, clawing at the cage wanting to be let out’: Understanding the experiences of individuals receiving Selective Serotonin Reuptake Inhibitors (SSRIs) for the treatment of problematic sexual arousal³

Introduction

At the end of the previous chapter participants were at a point at which they had now recognised the problematic nature of their sexual arousal and that ‘something has to change’. With their current prison establishment offering the first pilot of medication to manage problematic sexual arousal (MMPSA), this was something that was considered suitable to address the needs of these individuals and as such, all had subsequently consented to commence the treatment. This chapter explores the next step in that journey, having now begun the treatment, presenting the first of two empirical studies focusing on the participants lived experiences of individuals taking MMPSA. Due to the vastly different mechanisms by which both Selective Serotonin Reuptake Inhibitors (SSRIs) and anti-androgens affect levels of sexual arousal and the associated side effects of each (discussed in depth within the literature review in Chapter 2), the experiences of those on each medication type appeared to differ, hence these were explored separately. This chapter specifically focuses on those receiving the SSRIs, while the following chapter focuses on those receiving anti-androgens.

SSRIs are currently used off label for the treatment of problematic sexual arousal (PSA) following the recognition that individuals taking these for the treatment of other health concerns for which SSRIs are used (e.g. depression) experienced reductions in their levels of sexual arousal and interest (Montejo, Montejo, & Navarro-Cremades, 2015). SSRIs work by increasing levels of serotonin, which has been evidenced to inhibit sexual desire, psychological and physiological arousal and ejaculation (Jordan, Fromberger, Stolpmann, & Müller, 2011; Meston & Frohlich, 2000). This occurs as

³ The main findings of this chapter have been published in the below journal articles:

Lievesley, R., Elliott, H., Winder, B., Norman, C., & Kaul, A. (2014). Understanding service user and therapists’ experiences of incarcerated sex offenders receiving pharmacological treatment for sexual preoccupation and/or hypersexuality. *Journal of Forensic Psychiatry and Psychology*.

Lievesley, R., Winder, B., Elliott, H., Kaul, A., Thorne, J., & Hocken, K. (2013). The use of medication to treat sexual preoccupation and hypersexuality in sexual offenders. *Prison Service Journal*, 208.

they increase the body's feeling of satiation, preventing dopaminergic activity that drives goal-directed behaviour such as sex (Jordan et al., 2011; Pfaus, 2009). Findings such as these have led to the view that SSRIs could be used specifically for their anti-libidinal effects, despite these not being considered a targeted use of SSRIs as outlined within the NICE guidelines⁴ (NICE, 2015; Thibaut et al., 2010; Winder et al., 2018). While research thus far has tentatively indicated positive results of SSRIs in the treatment of PSA in ICSOs, the findings are currently considered to be inconclusive highlighting a need for further, more robust research (Grubin, 2018; Guay, 2009). In addition, research to date is quantitative and examines observed changes in measures of PSA (e.g. sexual preoccupation, hypersexuality), with a notable absence of research that considers the lived experiences of those receiving SSRIs for the treatment of PSA. Service user perspectives are considered vital in the research and evaluation of treatment interventions (Kolind, 2007; NICE, 2011), with qualitative methods becoming increasingly recognised for their ability to 'tell the program's story by capturing and communicating the participants stories' (Patton, 2002, p. 2). These experiences are important to understand as they may be linked, for example, to treatment expectations or goals, and if there is a mismatch between these and the formal aims of treatment this could have implications for things such as engagement, non compliance and drop-out (see e.g. Dixon, Holoshitz, & Nossel, 2016). However, these experiential details cannot be fully understood through quantitative research. This chapter therefore presents the first study of this kind, focusing on the participants lived experiences of taking the SSRI Fluoxetine as a form of MMPSA.

Method

Participants

The participants for this study are a subsection of the participants from study one, namely those receiving SSRIs. As such, the same methods of participant recruitment outlined within the first empirical chapter were also adopted here. The final participant sample for this study therefore comprised 13 adult males who were at the time of data collection serving prison sentences for a sexual offence. All participants were prescribed the SSRI Fluoxetine due to their level of PSA. Participants were White British ($n = 12$) or White Other ($n = 1$), with a mean age of 47 years ($SD = 13.7$; 29-72) and a mean IQ of 88 ($SD = 15.8$; 59-108). Participation was voluntary with no incentive or benefit offered for participation. Further participant information is detailed in Table 3.

⁴ While these guidelines exist specifically in relation to the treatment of hypersexuality, there are currently no other NICE guidelines for the treatment of the other facets of PSA (as defined in Chapter 2).

Table 3: Participant information (Study 2)

Participant number	Index offence (s)	Previous sexual convictions	Daily medication dose ⁵ (mg)	Length of time on medication
1	Rape (child) x 3; Attempted buggery x 2; Rape (adult) x 2; Indecent assault (child) x 3	Yes	20	4 months
2	Rape (adult) x 2	Yes	20	7 months
3	Sexual assault (child)	Yes	20	3 months
4	Sexual activity with a child	Yes	20	11 months
5	Possessing indecent images	Yes	40	9 months
6	Murder; Indecent exposure x 5	Yes	20	7 months
7	Indecent assault (child)	Yes	40	19 months
8	Sexual assault (child)	Yes	20	9 months
9	Sexual assault (child) x 2; Rape (child) x 12; Sexual activity with a child x 2	No	20	6 months
10	Murder	No	20	5 months
11	Sexual activity with a child	Yes	40	11 months
12	Indecent assault (child) x 5; Buggery	Yes	40	18 months
13	Rape (child)	Yes	20	3 weeks

⁵ At the time of data collection.

Data Collection and Analytic Approach

Approval to conduct the research was initially granted by the Governor of the prison establishment (HMP Whatton). An application to conduct the research was made via Her Majesty's Prison and Probation Service (HMPPS) research application system and ethical approval was obtained from this as well as Nottingham Trent University. Once ethical clearance was granted, access to participants was granted by the prison establishment.

The data were collected through semi-structured interviews which took place in purpose built interview rooms allowing participants the privacy to talk openly about their experiences without being overheard. A total of 22 interviews were conducted, with 1-3 interviews per participant and each lasting between 25 minutes to two hours, 15 minutes (mean = one hour, 15 minutes). These interviews are a sub-sample of those used in study one, namely those taking SSRIs, as discussed within the previous chapter. The majority of participants were interviewed on a one-to-one basis by the researcher. However, in the few cases ($n = 3$) where individuals were on high alert status within the prison and could not be interviewed by lone females, these were conducted on a two-to-one basis with another female researcher present. Following each interview, participants were given the opportunity to ask questions and given information to take away with them. This reiterated key information regarding how their data and information would be used, the process of withdrawal from the research should they wish to and methods of support if needed.

This study used the same phenomenologically oriented thematic analysis approach as outlined previously in this thesis (for a full discussion, see Chapter 3). This offered a method for 'identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79). This choice of analytic method was appropriate as it ensured that the analysis did not deviate too far away from the data in relation to the interpretations being made. Instead, it provides a complex, detailed, and rich account of the data (Braun & Clarke, 2006).

Results and discussion

Two main themes were derived from participant narratives as being pertinent to their experiences of receiving SSRI medication for the treatment of PSA. Each is discussed in depth (see Table 4 for breakdown of themes).

Table 4: Main themes and sub-themes for Study 2

Main Themes	Sub-themes
1. Impact on daily functioning	1.1. A clearer way of thinking: from sexually preoccupied to 'human'
	1.2. Reduced sexual arousal: a cost or benefit?
	1.3. Emotional management
2. Barriers to compliance and engagement	2.1. Participant concerns
	2.2. Not fully engaged
	2.3. Side effects

Theme 1: Impact on daily functioning

Participants discussed a range of ways in which the medication had impacted upon their daily functioning, including a reduction in sexual preoccupation, sexual arousal and improved management of emotions.

Theme 1.1. A clearer way of thinking: from sexually preoccupied to 'human'

Within the previous empirical chapter, specifically the 'something has to change' theme, the participant narratives portray the problematic nature of their sexual arousal prior to the medication. This is summarised in the extract below:

Before I went on this medication I was masturbating every day and erm, it got too much you know what I mean and I thought I need to sort this out because it was just getting too much and I was thinking about sex all the time and masturbating all the time and it just got too much you know (P.8)

This narrative is representative of many of the participants in this thesis and accentuates the difficulty and distress they were experiencing as a result of their PSA prior to the medication. The extract clearly highlights the psychological aspects, with the constant and intense sexual thoughts and fantasies as well as the behavioural aspect of excessive masturbation associated with this. The recognition that it 'got too much' was what led participants to reach the conclusion that something needed to change, thus chose to start taking the medication. As discussed in Chapter 4, this may reflect an early stage of change, whereby individuals contemplate the effect that sexual arousal has on their

lives and realise that something needs to be done in order to reverse these (Prochaska & DiClemente, 1983).

When discussing the impact of the medication, all participants report a reduction in sexual thoughts and fantasies in reports that it had 'lessened them to almost nothing most of the time' (P.5). However, each acknowledged that they still have some sexual thoughts and fantasies:

I still have some sexy thoughts about it 'cos if I didn't then I wouldn't be human know what I mean? (P.6)

I don't suppose I'll ever stop having sexual thoughts altogether but that's normal right? It's just natural (P.3)

I still get the odd one because the urge and the thoughts, the preoccupation it's it's still there in a sense I'd say, clawing at the cage wanting to be let out (P.7)

The extracts from participants three and six reflect the majority of the participants' views - that sexual thoughts are 'natural' and to be expected. While participant seven also acknowledges that the sexual thoughts are still present though rare, his extract highlights his belief that while the medication has repressed or locked away his sexual thoughts, fantasies and urges in a metaphorical cage. They are still there and actively trying to escape, 'clawing at the cage' and thus would return if given the opportunity, for example, if he was to stop taking the medication. In this sense, SSRIs were not a cure that totally eliminated all sexual arousal. Instead, the medication limited the ubiquity and intrusiveness of sexual thoughts, allowing participants to engage in other activities (but still express some degree of sexuality) while engaged in treatment. The majority of participants express being satisfied with this and were no longer viewing their levels of sexual arousal as problematic: 'I'm happy as I am now' (P.11). This is particularly positive as the aim of the medication is to allow individuals to maintain a healthy level of appropriate sexual functioning (Bradford, 2001; Thibaut et al., 2010). In recognising that some sexual thoughts are still present, but that these are generally manageable, participant 11 demonstrates the potential clinical effectiveness of SSRIs on addressing PSA. Generally participants discussed the reduction in sexual thoughts and fantasies in relation to inappropriate or deviant content, however one participant specifically referred to a reduction in appropriate fantasies also:

When I started taking the medication erm it also erm it lowered my sex drive completely and so erm, I, I was getting, I'd be having no thoughts of inappropriate sex, no inappropriate ones and very rarely I'm having even healthy ones at the moment (P.13)

This is an important finding as ideally the aim of MMPSA is to reduce or suppress deviant sexual interests, fantasies, urges and behaviours while maintaining those that are appropriate (Bradford, 2001; Bradford & Kaye, 1999). As participant thirteen is reporting 'rarely' having appropriate sexual fantasies, it is possible that this may reflect a general absence in appropriate fantasies due to his sexual preferences (e.g. offence related), rather than a reduction in his overall levels of sexual arousal. It would be concerning in circumstances in which medication was used to reduce inappropriate fantasies in individuals who have no appropriate alternative, as an absence of sexual thoughts and fantasies and thus sexual outlets would reduce the likelihood of it being a viable long term treatment option. Furthermore, according to the Good Lives Model, sexual satisfaction is a 'primary human good', thus eliminating capacity for sexual arousal and sexual outlets would be detrimental, reducing the individual's level of well-being (Ward & Marshall, 2004). Circumstances such as this support the argument that psychological treatment is important alongside medication (Guay, 2009) to aid the development of healthy sexuality. The combined engagement in psychological interventions alongside medication, for example, could involve engagement with the Healthy Sex Programme (HSP), which aims to help ICSOs to identify the triggers of their offending behaviour, manage them, and develop healthier sexual interests by incorporating the use of directed masturbation. In this effort, the less severe effects of SSRIs in relation to physiological arousal (in comparison to anti-androgen medications; Nguyen et al., 2015; see Chapter 6) may offer a useful treatment option for managing arousal while maintaining the possibility for arousal reconditioning via masturbation (Kaplan & Krueger, 2012; Laws & Marshall, 1991; Marquis, 1970). This is particularly important for those receiving SSRIs, with more recent research suggesting that by affecting neural plasticity, SSRIs increase sensitivity to the environment thus making individuals more susceptible to be influenced by external factors (Branchi, 2011). This therefore creates an ideal environment for positive psychological therapy to take place, with individuals receiving SSRIs being more easily influenced by environmental factors due to this increased neural plasticity and thus having an increased ability to change (Branchi, 2011; Carhart-Harris & Nutt, 2017).

In comparison to the sexual thoughts experienced prior to the medication, participants report the current thoughts and fantasies to be less frequent, less intense, easier to distract from and 'a lot more manageable and more controllable' (P.9), as the following participants also articulate:

I don't get many thoughts er I'm able to control it if I do I'm able to sort of push them aside quite easy you know (P.5)

Its erm er its helped bring the frequency down cause now I've got that little bit of control that I need to erm at least be able to turn turn round and do something else, I can ignore it now and can occupy myself in some sort of way (P.1)

These extracts portray how participants are recognising an increased control over the sexual thoughts and fantasies that they experience, in that they are now able to ignore and distract from them and focus on other things. This SSRI treatment effect is suggestive of the fact that the medication's key outcome is congruent with the reason that participants felt that something had to change with regard to their sexual arousal levels – to regain control over these thoughts and, ultimately, their lives (see Chapter 4). Furthermore, prior to the medication, participants conveyed their need to masturbate to all the sexual thoughts that they experienced in order to 'get the thoughts out of my head...relieve it more than anything else' (P.12). While this may seem specific to individuals with PSA, the use of masturbation to relieve stress and physical frustration (rather than as a route to hedonic sexual satisfaction) is often reported, with around half of women and up to two-thirds of men reporting this as their primary reason for masturbating (Carvalheira & Leal, 2013; Yule, Brotto, & Gorzalka, 2017). Further, Yule et al. (2017) report that just under one-in-five men masturbate because of a compulsive need in relation to these behaviours. In contrast, individuals now reported an increased ability to recognise inappropriate sexual thoughts and urges, and deliberately distract from them:

I mean because I'm not fantasising so much that I'm concentrating more and I can think more about the offenses an er so I know that when these come into my mind ...I can sort of helps help to push it away (P.5)

I suppose it's, it's given me the opportunity and the and and the space in mind to address inappropriate fantasies and and slowly bring them into the, bring to something more acceptable...I mean it is just, it's made me more able for me to ignore the inappropriate fantasies...yeah and then slowly given time and maybe because I'm ignoring them or because I'm not act acting on them they they're not returning...it's not been immediate it's just, it's over a week a few weeks or more just brings it all down (P.8)

As the above extracts articulate, over time the reduction in sexual thoughts and fantasies has given participants the capacity and head space needed to now recognise and address inappropriate sexual thoughts, when previously they were unable to do so. This allows them to 'choose' the stimuli that they masturbate to, and as participant eight articulates within the previous extract, this process of 'ignoring' inappropriate fantasies has stopped them from returning to them. Masturbating to appropriate fantasies has reinforced these, in turn impacting on the nature of the fantasies that they experience:

Erm it's given me, erm it's allowed me should I say to (3) develop my what are more appropriate sexual boundaries and erm what I'm attracted to and that. I've gone, I'm not quite away from children completely but I've gone up in the age group from really young to erm maybe late teens now so much more appropriate really (P.8)

Nature of the fantasies have changed considerably I'd say, I think that's the word considerably erm whereas the nature of my fantasies were victim related before erm with other things now taking over my thoughts, thought processes, erm I think my thought processes in that respect are more male related than victim related now (P.9)

Here both participants eight and nine convey how in turn the medication has altered the nature of their fantasies, so they have become less child or victim focused and are now what would be considered more appropriate sexual fantasies. As participant nine articulates, such changes are attributed to the general reduction in sexual thoughts and arousal, and having more head space to process thoughts and make conscious decisions. One potential advantage to this head space is a greater engagement with specific and formalised treatment approaches. This includes arousal reconditioning, as mentioned above, which a recent meta-analysis of sex offender treatment programmes has found to be a significant predictor of treatment success (Gannon, Olver, Mallion, & James, 2019). In addition to reconditioning their arousal through these treatment programmes (e.g. HSP), it is clear from the above narratives that participants were also engaging informally in this process. This indicates that the medication is not only allowing for fuller engagement with formalised treatments, but the observed positive effects on everyday functioning also encourage continued engagement with rehabilitation related behaviours outside of these specific treatment contexts.

Theme 1.2. Reduced sexual arousal: a cost or benefit?

The reduction in sexual thoughts and fantasies reported by participants has in turn resulted in specific changes related to the experience of arousal and masturbation:

Since taking it i'm not so erm preoccupied with sexual thoughts and erm everything else that goes with sexual thoughts has calmed down as well so masturbation and stuff like that and that's all calmed down (P.12)

I haven't masturbated this year yet, I think the last time was December but I only I think I can't remember for sure but I would say this calendar year for the first time since before I was 10 years old in a calendar year I haven't masturbated at all yet so what's that? Three months yeh so this is the longest i've gone without masturbating since before I was 10 (P.3)

Like I say I'm not masturbating so much as I used to (P.4)

Here the participants articulate how their reduction in sexual thoughts has also resulted in a reduction in arousal and thus a reduction in the frequency of masturbation, with comparisons to their previous selves. Participant three attempts to convey the extent of this change, reflecting on the knowledge that this is the longest period of time without masturbation since he was 10 years old. As participant three was in his early 40s at the time of data collection, this represents a significant amount of time. This again illuminates just how entrenched some of the problematic sexual behaviours are, having been established when participants were very young and been maintained over significant periods of time, as discussed in Chapter 4. In addition to this marked reduction in masturbation, the data also highlighted the effects the medication was having on physical arousal for the majority of participants. The reported effects include: an inability to achieve or maintain an erection: 'I can get a bit of an erection but I can't get a full erection' (P.2); an inability to ejaculate or difficulty reaching ejaculation: '...it just goes on and on and on and I won't ejaculate and I'll just give up on it' (P.9); and / or a reduction in the amount of semen if ejaculation occurs: 'There was hardly anything there at all and sometimes there was nothing there at all...although I ejaculated er it was, I suppose you could call it a dry ejaculation' (P.10). Previous research has also reported similar adverse effects of SSRIs (Hill, Briken, Kraus, Strohm & Berner, 2003). Participant reactions and responses to these effects largely varied across the sample, as the following extracts indicate:

But that's one of the side effects of taking it anyway...I just get fed up of it [masturbating] and think oh sod it I'll just go to sleep (P.11)

It doesn't bother me really...I'll just wait a few days and try it again (P.8)

What you don't have you don't miss (P.5)

As illustrated within the above extracts, for some participants these effects are something that they have just accepted, with participant five suggesting he has no issues with this, and that physical arousal is something he no longer has or misses. In slight contrast, it is apparent that both participant eight and eleven still have some desire to masturbate and still attempt to engage in this behaviour but eventually give up with the knowledge that it is futile and plan to try again in the future. This effect acts as a reverse of arousal conditioning – the process of building problematic patterns of sexual arousal and masturbatory behaviours associated with inappropriate fantasies, as discussed in Chapter 4 (see Kaplan & Krueger, 2012; Laws & Marshall, 1991). That is, the negative experiences associated with not being able to reach orgasm or ejaculate to established sexual fantasies acts as a form of reconditioning for those thoughts, reversing the positive associations with them that orgasm brings. However, as with participant five, neither participant above appear to be concerned by this change in masturbatory ability and have accepted it, with participant eleven suggesting that this was even expected as a recognised side effect of the medication. This highlights the importance of fully informing service users as to the potential side effects of MMPSA in reducing the potentially adverse implications of these effects on medication compliance. This is particularly the case when expectations are positively framed on information leaflets (Webster, Weinman, & Rubin, 2018). However, this acceptance was not the case for all participants:

And at first, it was rather annoying erm, I also found that the fantasies that I had used previously, were no good any longer...Erm, they weren't strong enough to tip me over the edge erm...and that became very difficult in trying to come up with a fantasy that was strong enough to enable me to ejaculate (P.10)

For some participants these effects are viewed as negative consequences of the medication and so they attempt to counteract these by becoming non-compliant or as in participant ten's case, as articulated in the above extract, by altering the nature of their fantasies. For him, the fantasies he had previously used before taking the medication were no longer strong enough to enable him to reach

ejaculation, and so he instead engaged in a process in which he attempted to 'come up' with a fantasy that was sufficient in achieving this. This is concerning as it may be that in such situations, individuals may seek and / or develop more sexually deviant fantasies in order to maintain arousal or reach ejaculation, which would of course undermine the purpose of taking the medication. This description resonates with concepts of tolerance that were discussed within Chapter 4, with the medications reducing the extent to which established sexual fantasies can lead to sexual gratification and satisfaction. The idea that previously satisfying sexual thoughts were not 'strong enough to enable me to ejaculate' (P. 10) is consistent with literature on behavioural addiction, specifically in relation to sex and gambling (Carnes & Love, 2017; Griffiths, 2005; Kotera & Rhodes, 2019). In the present context, it may be that previously unsuccessful attempts to reach orgasm using specific sexual fantasies leads to the rehearsal of more deviant or extreme sexual fantasies in order to raise hopes that satisfaction will be achieved through future masturbatory behaviours. In situations that have documented similar findings, it is suggested that when this inability to reach orgasm occurs, the dosage of medication should be altered (Hill et al., 2003) to more easily allow individuals to maintain an erection and reach ejaculation when desired and if appropriate. Some participants in this study undertook a process of deliberate non-compliance in order to overcome these effects, as discussed within the later theme of 'barriers to compliance and engagement'. This underlines the importance of psychological treatment alongside medication to reduce the likelihood of individuals developing more sexually deviant fantasies by increasing healthy sexuality (e.g. through arousal reconditioning; Gannon et al., 2019).

Theme 1.3. Emotional management

Unsurprisingly given the conventional targeted use of SSRIs in emotion regulation (Cools, Roberts & Robbins, 2008; Skandali et al., 2018), participants here reported recognising an increased ability to manage their emotions:

I don't seem to get pissed off so much with it all and get down (P.11)

I get a little snappy and moody but not as much as I used to, I don't get annoyed like I used to since I've been on this medication you know (P.4)

My concentration has improved a lot and well I used to get frustrated with little things like a a jigsaw puzzles if I couldn't sort of get the bits you know I'd get frustrated or something you know or I couldn't do it i'd get frustrated and really angry with it you know...but now I don't, I don't really get frustrated with it...now i'll just leave it and then get back to it (P.12)

As the previous extracts portray, through a process of reflecting on their past selves, participants are able to recognise the change in their ability to manage their emotions and respond calmly in situations when previously they would become angry or frustrated. This is reiterated in descriptions of themselves as 'more patient' (P.5), 'more mellowed' (P.11) and 'calm' (P.2). This is consistent with effects reported in clinical samples of patients receiving SSRIs for the treatment of a range of mental health concerns (e.g. depression; for a review see Ilieva, 2015) indicating that despite this not being a targeted treatment for the current service users, those with related co-morbidities are still observing positive treatment effects in these areas. Furthermore, as sexual frustration is known to generate stress, anxiety and depression (Reisinger, 2018), by reducing sexual frustration through the use of the medication it is possible that this is having an impact on mood. Two participants attempt to offer an alternative explanation for this:

I think it's, in a way, because my minds not so occupied with wrong thoughts that I'm able to recognise other thoughts coming in and feelings as well. So the fact that I know when I feel angry or I feel annoyed, I can think 'yep, I am feeling that' and then it's kind of like 'why?' and then I think why I'm feeling like that (P.7)

I think it's made me more human...erm, I think the, the fact is that because I wasn't willing to accept my other emotions that I used to use happy or sad, upset to cover them and I think that the medication it's helped me more concentrate on things and be able, erm its helped me be more expressive about my emotions and be more up front about how I feel and tell people how I feel (P.1)

These extracts emphasise the point that having more head space, due to the reduction in inappropriate or 'wrong' thoughts, allows these individuals to process and understand thoughts and emotions that they are experiencing when previously they could not, allowing them to now respond differently. This maps closely to Walton et al.'s (2017) sexhaviour cycle of hypersexuality, which suggests a fixation on sexual thoughts that bring about an incongruence between sexual and non-sexual identities can actually reinforce a self-perpetuating cycle of negative mood and sexual activity (see also Bancroft & Vukadinovic, 2004; Hughes, 2010; Miner et al., 2016). For participant seven, this has resulted in him becoming more self reflective, acknowledging his emotions and questioning why he feels certain emotions. For participant one, the effects of the medication have helped him to acknowledge and accept emotions that he previously chose to hide and has instead become more

expressive regarding his emotions. This new found ability to accept and express emotions is something he considers to have made him 'more human', suggesting that his previous actions of ignoring and covering them up was in some way unnatural. In addition, participants who reported difficulties with depression also reported improvements in their depressive symptoms since beginning the medication, acknowledging its use for such conditions: 'Cos it's like an anti-depressant anyway' (P.11). This was something that was relevant to a number of participants:

*I used to get depressed quite a bit erm but now I sort of hardly have at all
(P.4)*

*The depression is hardly ever there now I I I I manage it you know sort of its
not very often I get depressed now (P.10)*

I don't get down as much now and I'm always having a laugh and a joke (P.11)

As can be seen in the above extracts, participants reported improvements in depressive symptoms, and this was something that they spoke about very positively, often comparing themselves to previous situations, allowing them to reflect and recognise that the depressive symptoms had reduced. Participant eleven highlights an important point within the last extract that was also shared with other participants in which they felt that this reduction in depressive symptoms had allowed them to become sociable in general day to day life. This is a positive effect of the treatment in a number of ways. As outlined in the review of the literature in Chapter 2, and subsequently in the narratives of participants in Chapter 4, prior to MMPSA sex was often used by service users as a method of self-soothing or coping with emotional distress (see also Bancroft, Graham, Janssen, & Sanders, 2003; Brewer & Tidy, 2019; Hughes, 2010; Miner et al., 2016; Walton et al., 2017). By removing the immediate compulsion to deal with negative emotional states through masturbation or other sexual acts, the medication has encouraged participants to contemplate alternative coping strategies (Prochaska & DiClemente, 1983), while simultaneously developing new social interests. This latter point has a knock-on effect of encouraging desistance from sexual offending, with excellence in play and having a range of social activities to engage in being a conceptual predictor of desistance in this population (Göbbels, Ward, & Willis, 2012; Ward & Brown, 2004). Several participants reported similar effects:

*I think I associate more with other people than I did before but then I can put
that down to medication, the medication because of the depression side of it*

because it's also treating the depression side of it erm so yeah I think I associate more with, with erm with people than I used to before and I find I can concentrate on certain things better now than I could before (P.13)

I said to [PSYCHIATRIST] after I'd started taking the medication for a few months and he called me for a review and I said well I I'm getting better in various ways anyway, y'know back in the early 2000 I'd sit here like this and say absolutely nothing I could really be like that and especially in prison I wouldn't talk to no one and so I've definitely improved, I'm more communicative and more kind of outgoing. So I said to him I'm y'know improving in loads of ways (P.2)

Here both participants reflect on previous version of themselves, prior to the medication, and acknowledge being more sociable and able to concentrate more (P.13) and being able to engage, be more communicative and outgoing (P.2) as a result of the medication. For some participants, these effects appear linked to those discussed in the previous sub-themes related to reduced levels of masturbation:

I used to get really depressed, I don't get depressed as much now but I used to get depressed and when I was depressed or something or someone had upset me or something you know I'd sort of go into myself again you know and start having those thoughts and thinking about children more and then I'd masturbate to them to make me feel better...but I hardly ever get depressed now I'm on these (P.11)

As articulated here within the above extract, and discussed in detail within the previous empirical study, inappropriate sexual thoughts and masturbation to these were used by participants as an outlet to overcome depressive symptoms. In this way, the participants are using sexual activity or sexual outlets as 'self medication' (Mann, Hanson & Thornton, 2010;) or a coping mechanism to attempt to overcome distress or negative emotional states (Cortoni & Marshall, 2001). Whether these effects of reduced depressive symptomology, and also those of reduced arousal and preoccupation reported in this study, are direct or indirect effects of the medication is currently unknown, but the direction of this relationship could be an interesting avenue to explore in future research. There is also some degree of difficulty in determining which of these effects appears first. Nevertheless, a reduction in all of these symptoms is apparent after beginning SSRI treatment.

Theme 2. Barriers to compliance and engagement

Generally the level of compliance demonstrated within the sample appeared high, with individuals presenting as engaged and motivated to take the medication. This was generally as expected, considering that taking the medication in the current context is on a voluntary basis. Nevertheless, some non-compliance was apparent within the sample and so this theme considers the potential challenges to compliance that individuals have to overcome.

Theme 2.1. Participant concerns

Participants appear to have experienced a number of concerns throughout the course of taking the medication:

Erm I always do, I, any treatment we are doing or any medication I always, I suppose get worried about you know, side effects, you know, is it going to work? Is it going to make things worse? (P.13)

I was really worried about some of the stuff because they said some people said you could get like man boobs and things like that, man boobs yeah so I was worried about that (P.11)

As can be seen in the above extracts, concerns were initially focused on the impact of the medication, what to expect and any side effects that they may experience. The extract from participant eleven highlights an important point that was also applicable to other individuals, that concerns reared from misinformation or rumours from within the prison, for example, regarding 'man boobs' as described within this extract. As the use of rumours "appears to be one way in which group members attempt to reduce the loss of control inherent in many dreaded events" (Bordia & DiFonzo, 2004, p. 34), the availability of accurate information would prevent such scenarios occurring, thus easing concerns. Although the points discussed here are not necessarily rumours (gynecomastia, or breast growth, is a known side effect of anti-androgen treatment (e.g. Thibaut et al., 2010), and this alternative medication is also prescribed within the same prison establishment; see the next empirical study for experiences of this drug), this side-effect was not applicable to participants in this study receiving SSRIs. Other concerns were also discussed throughout the participant narratives:

I still want to have a healthy sexual relationship with a woman and hopefully have a baby or whatever, know what I mean? I don't know if that medication makes you infertile or what, I don't know (P.8)

I want to be able to build a relationship with someone, be able to have intimacy with them and all that without the medication interfering (P.3)

As discussed within the previous extracts, concerns related to the impact the medication may have on future sexual relationships, particularly for individuals experiencing physical effects on arousal (e.g., loss of erectile function and ejaculation, as discussed previously in *Reduced sexual arousal: a cost or benefit?*). Both participants stated that this type of physical function is something that they 'want'. For participant eight, additional concerns regarding fertility are the result of a lack of information, thus leaving him with unanswered questions regarding the effect of the medication. Indeed, these are again concerns that may be avoided if individuals were fully informed. That is, infertility is not a direct side effect of this type of medication. However, as the effects on arousal and ability to achieve and maintain an erection may impact on an individual's ability to engage in sexual relationships in the future, this should be discussed with participants, ensuring that they are fully informed regarding the short and longer term effects of the medication. While SSRIs are almost completely (99%) removed from the body within a month of discontinuing use. For Fluoxetine specifically this is the case after a period of 20-30 days (assuming a half-life of four to six days, and an average latency of five half-lives to completely remove a drug; Little, Lin, & Reynolds, 2018; Nnane, 2019). The prevalence of the longer-term pharmacological effects of SSRIs on sexual dysfunction after discontinuing use is currently unknown, with reports suggesting these effects could persist for a period of months or even years (Ekhart & van Puijenbroek, 2014; Bala, Nguyen, & Hellstrom, 2018). As participant concerns are focused on such effects, as demonstrated within the previous extracts, it is vital that participants are made aware of this as a potential effect prior to consenting to the treatment.

Concerns about dependency were also present within the sample, or in contrast, concerns were raised that the medication may stop working as they build up a tolerance and start 'getting used to it' (P.11). Although these concerns do not appear to be impacting upon current compliance, some participants displayed uncertainty regarding their intentions to continue taking the medication after release - an uncertainty that can be attributed to some of these concerns:

I dunno I suppose what I could do what I could is take them for a while n then wha say is turn round look id like to come off these tablets for a while just to

see if i'm alright an if it feels, afterwards if I feel as though I need to go back on these tablets then I would say yes i'd go on em...its like its like I mean when you get a headache you know that you wanna take a tablet but after but after a while the headache goes away so you don't wanna take em no more becus you don't wanna start relying on em too much so I just think well I'll leave it, and well if that headache comes back again then you know you wanna take another asprin so therefore its more or less the same, if it comes back i'll take em again (P.4)

I'm not really sure. If it's going to help me most probably yeah, but I don't want to be independent on it, know what I mean? I try not to be independent on tablets but if it's going to help me in the long run, then I er, I don't know. I can't see no problem. As long as I still have a healthy sexual relationship with a woman (P.6)

These extracts clearly outline the cost / benefit analysis that is or may be vital for some of these participants, as while the medication is reducing the inappropriate sexual thoughts and fantasies as desired, it is for some creating concerns regarding their ability to have a sexual relationship. While this may not be problematic in prison, it may create difficulty in trying to achieve a meaningful intimate relationship when released. Participant six's statement that 'as long as I still have a healthy sexual relationship' within the previous extract implies that any impairment to this would result in ceasing the medication. However, as the aim of the medication is to reduce PSA, rather than all arousal, dosages should be titrated to allow individuals to maintain some sexual arousal and therefore engage in sexual relationships in the future (Bradford, 2001; Thibaut et al., 2010). It is also clear from the extract that participant four's intention is to stop taking the medication but to monitor this and commence the medication again if needed. He likens his concerns with PSA to a headache, as it's 'more or less the same'. This approach to prematurely discontinuing medication once key symptoms have been alleviated is often observed in the medical literature (Beebe, Smith, & Phillips, 2016; Manmohan et al., 2012). That is, people commonly stop taking medications on the cessation of the symptoms that led them to be prescribed, before needing to resume treatment after these symptoms return.

For all participants, it appeared that gaining knowledge and information was an effective method of easing these concerns:

I was worried about what the medication was gonna do to me well we had a long talk me and Dr [psychiatrist] and he told me it'd be just slight side effects and then they didn't worry me (P.4)

I spoke with psychology because I know that with one of the types of medication erm, which is the proper anti-libidinal drugs, erm obviously one of the side effects from them is, is, is er like growth of breast tissue and erm, distortion of the bones and things and erm, straight away I said, you know, I am not prepared for that and erm, you know, and erm, I'm not really fixated with the way I look but, I'm OK with the way I am, I never wanted to change and er, that's why erm, we discussed the other options so I wasn't afraid to, you know, to come forward and say "that's not happening" but they said that that doesn't happen with these medications anyway so that was all ok (P.9)

After talking to him [the psychiatrist] about the side effects like getting boobs and all that it was quite reassuring to know that I wouldn't get em and that wouldn't happen (P.2)

Knowledge and understanding of medication is vital, with commentaries suggesting that when understanding the effects, individuals are more likely to select SSRI medication over other medications (Winder et al., 2019). Furthermore, a good therapeutic relationship appears equally vital in providing participants with a safe environment to voice and discuss their concerns, have the opportunity to ask questions and make informed decisions (Beech & Hamilton-Giachritsis, 2005). Nevertheless, while concerns and worries will always exist in relation to medication or treatment, this theme highlights the importance of service users being informed and having an understanding of the medication in order to manage their concerns, and to prevent these concerns from impacting upon compliance and engagement.

Theme 2.2. Not fully engaged

Despite generally good levels of compliance (as observed through the actual taking of the medication), throughout the narratives there were instances in which it was clear that participants were not fully engaged or motivated, presenting a nonchalant attitude towards the medication:

I sometimes forget to take it but it's always ok...because its not the really serious medication, it's not cause I've got a heart defect or anything (P.3)

*when I remember to take them. I'm never very good at remembering tablets
(P.8)*

As with the above participants, most acknowledged occasionally forgetting to take their medication, remembering either later that day or the following day but were not worried or concerned about the effect of this recognising the medication is 'still in my system anyway' (P.5). Here participant three implies that his lack of concern regarding this is also related to the nature of the problem and the medication, comparing it to other medical conditions such as a heart defect and thus implying that it is not as serious. Such an attitude towards the medication or even viewing his arousal as unproblematic in comparison to other conditions could lead to significant periods of missing the medication due to lack of awareness regarding the importance of it. Furthermore, some non-compliance of periods of several days to over a week were apparent within the sample:

*erm I've had a week when I was stressed really stressed out and I've
forgotten to take all medications (P.12)*

*I do it when I if I feel when I if I get fed up looking at em and oooo and y'know
I bung em away or something like that (P.1)*

As can be seen in the above extracts, this was attributed to states of mind such as being 'really stressed out' or 'fed up taking em' in order to justify their choosing not to take the medication. This again highlights the importance of the medication being used in conjunction with psychological interventions (Grubin, 2018) to ensure individuals are still accessing treatment when engagement or motivation for the medication may falter. Motivation in pharmacological treatment, as with all sex offender treatment (Tierney & McCabe, 2002), is vital. As Harrison (2008 p. 2) points out, pharmacological 'treatment is in the pill form and administered by the offender', emphasising the need for individuals to want to change and take medication to achieve that. Furthermore, research has demonstrated diminishing levels of motivation in sex offender treatment that has impacted upon compliance following release from custody. This, coupled with the uncertainty demonstrated by individuals as to whether they will take the medication after release (discussed in previous theme: *participant concerns*), could present a cause for concern. The importance of motivation and engagement with this medication therefore becomes particularly vital when individuals are being released into a less controlled environment, where the level of support for the medication is far less than within the present establishment and as such their motivation may wane.

Theme 2.3. Side effects

The final sub theme within the barriers to compliance and engagement explores the presence and impact of side effects. The majority of participants ($n = 11$) reported at least one adverse effect that they believed to be associated with the medication, but that they were not expecting. These included constipation, sweating, headaches, tiredness, and nausea, which are in line with the current literature on the side effects of SSRIs (Carvalho, Sharma, Brunoni, Vieta, & Fava, 2016). In a small number of cases, participants became distressed about these or found them to be unmanageable:

Unfortunately I've had to stop [the medication] in the last couple of days, I've been getting some, some, I wouldn't say severe but some side effects from it that, it's stopping me from sleeping and so erm, you know, it's been making me feel quite ill, not getting much sleep...although it's been helping, it's also been hindering me, because of the lack of sleep and things (P.13)

It was like I was taking this medication to come off one thing, to stop doing one thing and then all of a sudden it it brings on another bad thing with the side effects which is which is frustrating cause I felt really tired (P.11)

I stopped [taking the medication] in December cus I was having sick feelin, making me sick all the time (P.3)

For the above participants, it is clear that the perceived costs of the medication (i.e. the side effects) were not sufficiently outweighed by the benefits, with participant thirteen recognising that this was hindering him in other ways. Participant eleven describes this as a process in which the medication felt as though it had simply replaced one undesired 'thing' with another 'bad thing' (the side effects), and for each of these participants, this became unmanageable and resulted in them stopping the medication. However, for most participants, these symptoms were short lived and were not a cause for concern, acknowledging that 'they've gone within a couple a day or two so' (P.8) or are 'adjusting to the medication' (P.7). This supports the literature regarding the transient nature of most side effects that are experienced with SSRIs (Carvalho et al., 2016). Some also discussed methods in which they were overcoming these effects: 'but err I take two at the moment err at night because if I take them during the daytime it tends to make me drowsy' (P.5).

In addition to the sub-themes discussed here, it is clear that the impact on physical arousal outlined within the previous theme (*Reduced sexual arousal: a cost or benefit?*), can also impact upon compliance. For at least one participant, non-compliance was a deliberate method of overcoming

these effects with participant one stating that he does not always take his medication 'cause I want my erection back' (P.1). For the small number of participants in this sample that chose to stop taking the medication for any one of these reasons, what is interesting about this is that after stopping, all participants recognised their need for the medication and were again referred at some point in the future. Despite some issues, participants appear able to manage and overcome these challenges and compliance and engagement within this sample seems generally high. This could be a result of the medication being voluntary, which means that these individuals are choosing to engage with the treatment and are intrinsically motivated to reduce their PSA. This level of compliance may not be demonstrated in circumstances in which the treatment is mandatory or motivation for the treatment may be related to extrinsic rewards (e.g. to secure release).

Conclusion

This study sought to generate a phenomenological understanding of the lived experiences of individuals receiving SSRIs as a form of MMSA. Overall, their experiences were extremely positive and support the view that, for some individuals, SSRIs can be effective in the management and treatment of PSA (e.g. sexual preoccupation and / or hypersexuality) (Grubin, 2017; Thibaut et al., 2010). The initial narrative presented in this study echoes the difficulty and distress that participants felt as a result of their PSA, which was discussed in depth within the previous empirical chapter (Study 1). However, this study goes a step further, exploring the experiences of participants once they have commenced the SSRI treatment. The use of SSRIs appears to be having a positive effect in reducing the frequency and intensity of their PSA (sexual thoughts, fantasies, and associated behaviours), as desired. While this was largely discussed in relation to a reduction in deviant sexual thoughts, fantasies and associated behaviours (i.e. masturbation and ejaculation to inappropriate stimuli), some discussed the impact that this was having on all sexual thoughts and general levels of physical arousal with an impact on ability to achieve or maintain an erection in relation to appropriate stimuli. This goes against the intended aims of use which should ideally allow individuals to achieve and maintain healthy and appropriate sexual thoughts and behaviours (Bradford, 2001; Bradford & Kaye, 1999) through the combined use of medication with psychological therapy. That is, the aim here is not the chemical castration of the individuals taking these medication, despite that being the primary aim in other countries (Douglas, Bonte, Focquaert, Devolder, & Stereckx, 2013). Where castration-like effects do occur, the dosages should be titrated to enable arousal, and ensure the medication is a long term viable option for all those who are prescribed them. This should take place through a process of communication and finding a balance of medication dosages that work for each individual, as if this is not achievable, there is an increased risk of non-compliance and dropping out of treatment (discussed

below). Other positive changes were also apparent, such as increased emotional control and mood enhancement. In addition, participants demonstrated more subjective control over their sexual thoughts, thus allowing them to alter the way in which they respond to them, helping them to formulate more appropriate sexual fantasies. This was also attributed to having more 'head space' as a result of the medication which allows them to process thoughts more effectively and make conscious decisions when previously they could not.

The analysis also uncovered a number of barriers to compliance and engagement with the medication. These were largely the result of unexpected side effects, a lack of awareness regarding the importance of the medication, or effects on physical arousal. The latter is particularly interesting in that individuals reported a positive response to reductions in the psychological aspects of their sexual arousal (e.g. thoughts and fantasies, as discussed previously), but viewed the impact on physical arousal (e.g. difficulty in achieving and / or maintaining an erection, or reaching ejaculation) in a more negative way, recognising the potential implications regarding future sexual relationships. It was clear from the narratives that each of these could potentially present as a reason to instil uncertainty regarding their intentions to continue taking the medication over the longer term, or lead individuals to cease the medication, as a small number of participants in this study did. However, without exception, all drop-outs subsequently resumed the medication. This highlights the complex nature of the use of the medication. This complexity is explored in depth through the identification of specific treatment pathways in Chapter 7. The concerns presented by participants are not unwarranted, as the use of Fluoxetine can indeed have such long term effects (e.g. Bala et al., 2018).

While for some these difficulties may not present as problematic now while in custody, it may become a significant issue for them after their release from custody. This might present a cause for concern if individuals subsequently choose to stop that medication without the necessary monitoring and support, in an environment that is much less supportive and controlled, and where risk of non-compliance for treatment (and thus recidivism) is increased (Hamilton & Belenko, 2016). These findings emphasise the importance of effective communication throughout all stages of the medication process – referral, consent and monitoring throughout use – in order to ensure individuals are fully informed (Grubin, 2017; Webster et al., 2018). These findings also emphasise the importance of a good therapeutic relationship which provides individuals with a safe environment to voice and discuss their concerns, have the opportunity to ask questions and make informed decisions. This has been identified as a key predictor of effectiveness in other forms of sex offender treatment (e.g. Beech & Hamilton-Giachritsis, 2005). While concerns and worries will always exist in relation to treatment of this nature, having appropriate information readily available will ease these, and reduce the potential impact on compliance and engagement. Despite such issues, participants appear able to

manage and overcome these challenges, and compliance and engagement within this study seemed generally high. This may be a consequence of the medication being voluntary, ensuring that the individuals are choosing to engage with the treatment and are motivated to reduce their arousal – a result of having recognised this as problematic in relation to their own wellbeing and offending behaviour (discussed within the previous chapter, empirical study one), potentially representing the first stage of long term desistance from sexual offending (Göbbels et al., 2012). However, this level of compliance may not be demonstrated in circumstances in which the treatment is mandatory or motivation for the treatment may be different (i.e. to secure release) (Harrison & Rainey, 2009).

Another important finding from this study is that, from a participant service user perspective, the treatment is by no means viewed as a cure; despite the apparent improvements, participants appear to recognise that sexual thoughts or urges are still present, though locked away, ‘clawing at the cage wanting to be let out’ (P.7) and demonstrate an understanding that if they stop taking the medication, without additional treatment, they would revert back to the levels of PSA experienced prior to the medication. Indeed this was the case for the few that chose to temporarily cease the medication, with symptoms returning within a short period of time due to the fact that Fluoxetine is almost completely (99%) removed from body within 20-30 days of discontinuing use (Little, Lin & Reynolds, 2018). As such, all participants accentuated that the medication should not be seen as a replacement to psychological treatment and instead felt that they worked well together. Combining psychological treatment and SSRIs appears most effective, with the latter increasing sensitivity to the environment. This makes individuals more susceptible to psychological therapy and more amenable to change (Branchi, 2011; Carhart-Harris & Nutt 2017), while also improving overall wellbeing through the reduction of symptoms, and providing ‘headspace’. The findings in the current study suggest that this in turn enhances participant engagement in psychological treatment programmes. The former then provides the necessary insight and techniques to recognise and manage PSA, inappropriate sexual interests and general risk factors in their offending which is considered key to successful desistance (Buschman & Van Beek, 2003; Chakhssi, Kersten, de Ruiter, & Bernstein, 2014). The development of these skills through psychological treatment also provides a potentially feasible option for individuals to be able to effectively manage their PSA without the need for medication in the future (e.g. by combining MMPA with HSP in custodial settings; Lucy Faithfull Foundation, 2015). The increased effectiveness of this combination in comparison to mono-therapy is supported in the literature (e.g. Guay, 2009; Thibaut et al., 2010). However, any process of discontinuing the medication should be carefully monitored to ensure it is managed appropriately and safely, from both a service user wellbeing angle, and a broader public safety perspective (Grubin, 2017).

In order to generate a comprehensive phenomenological understanding from a service user

perspective, the experiences of those on the different medication types available as MMPSA, is necessary. The next empirical chapter aims to build on this, exploring the lived experiences of individuals receiving anti-androgens as a form of MMPSA. This is again something that currently represents a void in the research literature with no known qualitative exploration of service user perspectives to date.

Chapter 6

Study 3: ‘One a day keeps the prison away’: Understanding the experiences of individuals receiving anti-androgens for the treatment of problematic sexual arousal

Introduction

This chapter presents the second of two studies exploring the lived experiences of the individuals taking medications to manage problematic sexual arousal (MMPSA). While the previous chapter focused on those taking SSRIs, this chapter considers the other subsample⁶ of those on medication, specifically those taking the anti-androgen, cyproterone acetate (CPA). As discussed within the previous chapter, due to the differences in the physiological and psychological effects of the medications as well as the potential side effects (see Chapter 2), it was evident that the experiences of those taking either SSRIs or anti-androgens were different. Thus, exploring the experiences of men taking these different medications separately was considered to be the most appropriate course of action.

Anti-androgens are among the most commonly used pharmacological treatments for the reduction of sexual drive with individuals convicted of sexual crime (ICSOs) across the world (Holoyda & Kellaher, 2016), having been used for this purpose since the 1960s (Meyer & Cole, 1997). As indicated in the literature review (see Chapter 2), anti-androgens work by reducing levels of circulating testosterone, a hormonal steroid found to be associated with sexuality, cognition, personality and aggression (Pfaus, 2009). More specifically, CPA works by inhibiting the uptake of testosterone, and the release of gonadotropin in the central nervous system, which further reduces testosterone secretion (Jeffcoate, Matthews, Edwards, Field & Besser, 1980; Maletzky & Field, 2003; Pfaus, 2009). Its use with ICSOs and for the reduction of sexual drive has shown positive results including; demonstrable reductions in deviant sexual behaviour and libido (Hoffet, 1968; Seebandt, 1968), reduced sexual arousal and sexual interest (Bradford & Pawlak, 1993; Cooper, 1981) and reductions in sexual activity and sexual fantasy (Bradford & Pawlak, 1993). However, these studies are not

⁶ While other medications aside from the two explored within this thesis (SSRIs and anti-androgens) also exist and are now used within HMP Whatton (as outlined within Chapter 2), there are very few individuals on the other types and at the time of the current research taking place, SSRIs and anti-androgens were the only two medications that were prescribed.

without their limitations (e.g. they are dated and sparse), leading to the conclusion that there is a somewhat limited robust evidence base for the effectiveness and suitability of the use of these medications (Briken & Kafka, 2007; Garcia & Thibaut, 2011; Khan et al., 2015). Thus the widespread use of anti-androgens is somewhat surprising, especially when considering their potentially serious long term side effects. These include gynaecomastia (breast development), weight gain, osteoporosis (reduced bone mineral density), and hepatotoxicity (liver damage caused by pharmaceuticals) (Lippi & van Staden, 2017). Some of which are known concerns for ICSOs who are taking MMPSA (see Chapter 5). With this in mind, it is important to understand the experiences of men taking anti-androgens for this purpose in order to explore their experiences of such side effects as this may have implications for understanding issues such as compliance with the taking of the medication. There is therefore a need to fully understand the effects of anti-androgen use among ICSOs who demonstrate problematic sexual arousal (PSA). As stated in Chapter 3, qualitative methods can assist with this - offering an opportunity to tell a story from the service user perspective (Patton, 2002). With the aforementioned ethical concerns in mind (i.e. the limited evidence base in relation to clinical effectiveness in this population and potential side effects), an exploration of service user experiences and perspectives is important, yet has not previously been explored. This chapter therefore focuses on the participants lived experiences of taking the anti-androgens as a form of MMPSA.

Method

Participants

The participants for this study were those participants from Study 1, who were receiving anti-androgens. Two participants were also recruited in study two when receiving SSRIs, prior to starting anti-androgens. As such, the methods of participant recruitment will not be repeated here but are outlined in detail within Chapter 3 and 5. The final participant sample for this study comprised 10 adult males who were serving prison sentences for a sexual offence at the time of data collection. All participants were prescribed CPA (trade name: Androcure) for the treatment of PSA. The participants were all White British with a mean age of 46 ($SD = 15.1$; range = 24-68), and had a mean IQ of 85 ($SD = 16.3$; range = 59-107). Further participant information is detailed in Table 5.

Table 5: Participant information (Study 3)

Participant	Index offence (s)	Previous sexual convictions	Daily medication dose⁷ (mg)	Length of time on medication
1	Producing, distributing & possessing indecent images x 2	Yes	50	6 months
2	Sexual assault (child) x 2; Rape (child) x 2	No	50	1.5 years
3	Possessing indecent images	Yes	50	9 weeks
4	Rape (adult)	Yes	50	5 months
5	Rape (child) x 3; Attempted buggery x 2; Rape (adult) x 2; Indecent assault (child) x 3	Yes	100	4 months
6	Indecent assault (adult); Sexual assault (child)	No	100	8 months
7	Arson; Indecent exposure x 4	Yes	50	7 months
8	Assault occasioning actual bodily harm (adult) x 9; Battery (adult) x 2; Sexual assault (child); Possessing indecent images x 7	No	100	4 months
9	Murder	No	50	2 months
10	Producing, distributing & possessing indecent images x 7	Yes	100	9 months

⁷ At the time of data collection.

Data Collection and Analytic Approach

As in all of the studies within this thesis, approval to conduct the research was initially granted by the Governor of the prison establishment (HMP Whatton). An application to conduct the research was made via Her Majesty's Prison and Probation Service (HMPPS) research application system and ethical approval was obtained from here, as well as Nottingham Trent University. Once ethical clearance was granted, access to participants was granted by the prison establishment.

The data were collected through semi structured interviews which took place in purpose built interview rooms allowing participants the privacy to talk openly about their experiences without being overheard. The interview schedule utilised was the same as that used within the previous empirical chapter in order to consider the differences and similarities in participant experiences on the two types of MMPSA (see appendix 4). A total of 16 interviews were conducted, with 1-2 interviews per participant and each lasting between 50 minutes to two hours, 53 minutes ($M =$ one hour, 40 minutes). The majority of participants were interviewed on a one-to-one basis by the researcher (with the exception of the two cases where individuals were on high alert status within the prison and could not be interviewed by lone females (see Chapter 3). Following each interview, participants were given the opportunity to ask questions and given information to take away with them. This reiterated the key information regarding how their data and information would be used, the process of withdrawal from the research should they wish to, and methods of support if needed.

This study used the same phenomenologically oriented thematic analysis approach as outlined previously in this thesis (for a full discussion, see Chapter 3). This offered a method for 'identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79). This choice of analytic method was appropriate as it ensured that the analysis did not deviate too far away from the data in relation to the interpretations being made. Instead, it provides a complex, detailed, and rich account of the data (Braun & Clarke, 2006).

Results and Discussion

Three main themes were derived from participant narratives as being pertinent to their experiences of receiving anti-androgen medication for the treatment of PSA. Each is discussed in depth and outlined in Table 6.

Table 6: Main themes and sub-themes for Study 3

Main Themes	Sub-themes
1. Differing needs: Motivations for treatment	1.1. Recognising a need: Intrinsic motivations for treatment
	1.2. Forced compliance: Extrinsic motivations for treatment
2. Medication as a risk management strategy	2.1. 'Too risky' without medication
	2.2. 'One a day keeps the prison away'
	2.3. A small price to pay
3. Discovering a 'new me'	3.1. Adjusting to new sexual norms
	3.2. An awakening

Theme 1: Differing needs: Motivations for treatment

Motivation for treatment is considered vital in the process of change and a key component of long term desistance according to the integrative theory of desistance from sexual offending (ITDSO; Göbbels, Ward, & Willis, 2012). Motivation can be either intrinsic or extrinsic (Ryan & Deci, 2006), both of which were present within the participant narratives regarding their reasoning for taking the medication. That is, taking MMPSA was either something they were doing for themselves having recognised a need for something to change (see also Chapter 4), or alternatively it was due to some externally motivating factor or simply feeling that they 'had no choice' (P. 4). The first theme explores the distinctions between each of these motivational experiences.

Theme 1.1. Recognising a need: Intrinsic motivations for treatment

Intrinsic motivation is considered to be particularly important with clinicians suggesting that, in the case of psychological treatment, treatment stands a better chance of being effective if the motivation to attend is intrinsically orientated (see Ryan & Deci, 2006). Furthermore, when the motivation for change is intrinsic, the likelihood of engaging, achieving and sustaining a change is increased, being linked to longer term treatment success (Ryan & Deci, 2006; Ward, Day, Howells & Birgden, 2004; for a full discussion of the effects of intrinsic vs. extrinsic motivations and their broader implications for engagement and compliance with treatment, see Chapter 2). Within the current research, all participants acknowledged an intrinsic motivation for the pharmacological treatment driven by the

self identified need for some type of change in their sexual thoughts and behaviours. This is in line with the final theme identified in Chapter 4 in relation to the development of PSA.

That's why I went on it [the medication] yeh the reason i'm on it is cus like in a real, like in an ideal world i'd want something what lowers my masturbation, to not, I don't wanna stop wanking I obviously wanna wank like three four times a day, not fucking ten to fifteen times a day yeh in an ideal world (P.8)

Here participant eight discusses the desire to lower his frequency of masturbation, contrasting 'real' and 'ideal' scenarios. His use of 'fucking' demonstrates his exasperation at his current reality of masturbating 10-15 times per day, with his ideal being three to four times per day. In this sense, masturbation has come to dominate participant eight's life, leading him to recognise that this behaviour needs to change. What is interesting though is that his end goal is a reduction in masturbation, rather than a total elimination of masturbation, stressing his desire to not stop masturbating entirely. However, there is no consideration as to whether this may be achievable. This coincides with the narratives in Chapter 4 in which participants discussed wanting to reduce their sexual thoughts and behaviours but not lose these completely. In this sense, the extract from participant eight may represent some degree of personal re-orientation in terms of his personal identity, and this may be common among individuals taking MMPSA. This re-orientation, possibly from somebody who is hypersexual (with this being the main aspect of his identity) to being a person with 'normal' levels of sexual thoughts and behaviours is an idea that is present in the narratives of other participants. Indeed, based on his pre-medication masturbation frequency being 10-15 times per day, a reduction to three to four times would constitute a large improvement and considered the 'ideal' frequency for participant eight. However for some participants this would still be considered to be excessive:

That's one thing I think about myself that before i'd masturbate 24/7, three, four, you know, five times a day, and I didn't really enjoy it, I didn't want to do it, it was just, that's to get rid of that frustration and everything else out...because I had this problem, I was thinking about sexual things all the time so I'd feel sexual things all the time so I'd feel aroused all the time (P. 4)

For participant four, masturbating between three to five times per day is described as '24/7', suggesting that this was something that consumed every hour of his life. In reality this portrayal is not

a true reflection of his frequency of masturbation, which is not as excessive as others' in the sample, including participant eight (see above). The subjectivity of participants' perceptions of excessive levels of masturbation is illustrated here, where participant eight's 'ideal' masturbation frequency (three to four times per day) is excessive according to participant four's subjective experience of his own PSA. In this case, it is not simply a measure of frequency that determines when sexual arousal becomes problematic, but also ability to cope with or manage this, both in relation to individual experiences of PSA and also in how it impacts on their potential for offending behaviour. However, the above extracts support the narratives of other participants to suggest that subjective levels of distress as a consequence of PSA, and the interference that PSA has in their lives, is also important. Here both participants discuss their thoughts and arousal as something that was problematic and relentless despite very different reported frequencies. As discussed in Chapter 4, masturbation is commonly used to alleviate stress and frustration (Carvalheira & Leal, 2013; Yule, Brotto, & Gorzalka, 2017), with 15% of men masturbating because they felt like they had to, indicting a compulsive explanation to their masturbation-related behaviours (Yule et al., 2017). Both participants recognised this motivation for their masturbation, in that it was not for pleasure or enjoyment, but instead something they felt they did not want to do, but had to:

It's annoying when you wake up through the night and you're so tired but you can't go to sleep because obviously you got a a an erection and it starts hurting...I'm tired but yet I can't go back to sleep and I can't get rid of it, unless I I masturbate so I just do it cus I have to (P.10)

I kept getting embarrassed nearly every day going to and from work with a like I say erected I was getting so annoyed coz I used to get a semi hard on and everything like that, just really embarrassed and uh that's where that's why I asked if I can take is there any medicine or any tablets I can take (P.1)

This involuntary nature of (particularly physiological aspects of) PSA was frequently discussed within participant narratives. For some, this impacted negatively on other aspects of their lives, as shown within the extract of participant ten as interfering with his sleep and causing physical pain that can only be relieved through masturbation. This again emphasises the notion that masturbation has almost become a chore – something that people with PSA do because they 'have to', rather than a normal aspect of healthy sexual expression. Participant one discusses his lack of control over sexual arousal in relation to feelings of annoyance and embarrassment. This perceived lack of control was present throughout many of the narratives. Thus, establishing and maintaining a healthy expression

of sexuality, and most importantly having control over this, could be a suitable and desirable outcome for men convicted of sexual offences with PSA.

One psychological process that underpins many of these narratives is the concept of learned helplessness (Seligman, 1972). This theory sets out how, when people are repeatedly faced with adversity or negative social conditions, they tend to give up hope of changing a negative stimulus in their life when they perceive a loss of control over its elimination. In relation to participants here, their learned helplessness is caused by the uncontrollability of their sexual arousal which leads them to believe that they are in some way destined to live a life of sexual deviance without intervention. However this is also accompanied by a desire to change and an imagined change in sexual identity. The control that PSA therefore has on the everyday lives of the individuals experiencing it is overwhelming, and leads to the kinds of decisive turning points that were described in Chapter 4 (e.g. that something 'has to change'). This is where MMPSA play an important role in the rehabilitation process. They provide a way of managing PSA in a controlled environment and can be used in conjunction with other psychological treatments in order to encourage a sense of personal agency and facilitate the reduction of a reliance on MMPSA over the longer term (Grubin, 2017). This is particularly important as personal agency and an individual's perception about their ability to change are crucial to the desistance process (Maruna, 2001) as the perspective that something is permanent or out of their control is incongruent to potential change (Maruna & Copes, 2005), a mindset observed within persistent offenders (Maruna, 2001). When adopting this mindset, these individuals are said to see themselves as being helpless and 'doomed to deviance' (Maruna, 2001, p. 74) with no potential to change. This idea mirrors the narratives reported in Chapter 4 where participants began to lose control over their sexual arousal. However, here the possibility of taking MMPSA offers a chance to break this cycle. That is, there is a motivational aspect of losing control that leads individuals with PSA to ask 'is there any medicine or any tablets I can take' (P.1) to attempt to regain control.

The decision to engage with MMPSA thus represents an intrinsic motivation by some participants to change their sense of self, rebuild their identity as a person with healthy sexual thoughts (rather than a person *dominated by them*, similar to participant eight above), and to take control over their long term behaviours and treatment outcomes. This sense of being able to have control or agency is particularly important in maintaining motivation and engagement in a range of treatment settings, whether this be medical (Bishop & Yardley, 2004), psychological (Adler, 2012), or in relation to sexual offending (Göbbels et al., 2012).

It is not only the effects of physiological sexual arousal and the obvious implications that this has on behaviour and everyday functioning that participants felt to be an important motivator of their

seeking MMPSA. Several also discussed the need for medication being influenced by the need to manage or control non-physiological facets PSA:

I was getting desperate...I knew I had to do something, my obsession with sex, was getting tiring umm from the moment I got out of bed in the morning to the moment I went to bed of a night, I was thinking about sex, I couldn't watch a TV programme without sexualising it, without objectifying the females in it, it could be any programme, a news programme, a female news reporter, all I'm thinking of is, is she going to open her legs, am I going to get a look at her knickers and I just couldn't stop myself (P.9)

In a similar notion to participant one reflecting on a lack of control over his physiological arousal, here participant nine reflects on his lack of control over his sexual thoughts. He uses the term 'obsession with sex' to define his condition. As this terminology forms part of the definition for sexual preoccupation risk factor within the Structured Assessment of Risk and Need (SARN; Craig & Beech, 2009) for ICSOs, this might suggest that participant nine possesses good levels of insight about the fact that his PSA represents, for him, a risk factor for sexual offending. The 'symptoms' he discusses as associated with this such as constantly thinking about sex, objectifying females and sexualising non-sexual situations that he outlines are known indicators of elements of PSA, as defined within Chapter 2 of this thesis (see also Meyer, 2018). That is, we should not necessarily think about 'hypersexuality' and 'sexual preoccupation' as separate and non-overlapping concepts, but consider them as different facets of a broader pattern of PSA. For participant nine, this results in 'getting desperate', fuelling a need to 'do something'. This represents a turning point for him (a concept discussed within the 'something has to change' sub-theme at the end of Chapter 4), and drives his motivation to engage in treatment in order to gain control and begin to build his redemption script (Maruna, 2001), rather than one based on condemnation and helplessness.

As highlighted throughout the narratives within this theme, the majority of participants reflected on their problematic sexual thoughts and behaviours as something that was constant and enduring, and impacting upon different aspects of their lives. These findings support the experiences of living with PSA that were discussed by those in Chapters 4 and 5. Furthermore, they allude to a perceived lack of control over their sexual thoughts and behaviours, which again supports a learned helplessness account of their approach to the PSA before taking medication. This availability of medication provided these participants with an opportunity to take back some degree of control over their sexual thoughts and move towards their idealised sexual identities. As such, their medication use was in part intrinsically motivated by this desire for personal agency and control.

Theme 1.2. Forced compliance: Extrinsic motivations for treatment

For some participants, while there was recognition of an intrinsic motivation, their primary motivation for taking the medication was related to an external factor, and while the medication is voluntary, for some participants there are apparent pressures to comply.

I'm on IPP, I had no choice, I can't afford not to do these things because everything I try and do for myself shows the board I've done this off my own back and I'm trying to change and they can see that I'm trying to change I'm trying to put things in place to try and stop me from reoffending (P. 4)

Because I'm on IPP I've got to do things that other prisoners don't have to do, they could say to an officer "no I'm not doing that" and they got no come, they got no come back on that but if I said it I'm never getting out an I've got to jump through more hoops than everyone else to get what I want or to get further on so I felt that I had to do it to get out (P. 6)

Here, both participants discuss the impact that their indeterminate IPP (imprisonment for public protection⁸) sentence had on their decision, with the belief that they had no choice and that the cost of not taking the medication would be prolonged imprisonment. This belief likely stems from the requirement of all those serving IPP sentences to demonstrate that they have sufficiently addressed their risk and that the parole board must be 'satisfied that it is no longer necessary for the protection of the public for the offender to be confined' (Bradford & Cowell, 2012, p. 1) before they will be granted release. The stark awareness of this requirement is evident in participant four's extract. Here, he emphasises that everything he does 'shows the board' that he is trying to change, and thus trying to reduce his risk, with a recognition that without demonstrating this he will not be released. However, his use and repetition of 'trying' suggests that this requires effort and is an ongoing process. This further casts doubt over whether demonstrating a reduction in risk is achievable for him under the scrutiny of the parole board.

The extracts echo a sense of desperation, born out of a need to progress towards release. This is not uncommon among IPP prisoners with many several years beyond their tariff (minimum sentence term) date and are essentially 'stuck' in the system and doing what they can to try to demonstrate a

⁸ Following a review, IPP sentences were abolished in 2012, however individuals sentenced to these prior to this date were required to continue to serve these sentences (Bradford & Cowell, 2012).

reduction in risk (Annison, 2018). For the IPP sentenced participants here, their consenting to take the medication appears to stem from a need to demonstrate a reduction in risk in order to progress, something they may otherwise not have done if they were serving a determinate sentence with a definite release date and no requirement to demonstrate a reduction in risk. It is recognised that IPP sentences cultivate a lack of hope and uncertainty (Annison, 2018) due to the difficulty in demonstrating a reduction in risk, so for participants here, consenting to take the medication presents some hope in achieving this and moving towards release. This is particularly important as it is proposed that having control over one's life and hope for the future is key to the desistance process for ICSOs (Göbbels et al., 2012). Control over sexual urges (and PSA in a more general sense) was a key idea spoken about by participants in relation to their intrinsic motivations for treatment (see above in the previous sub-theme). However, when hope and control over one's life feel unattainable, or driven by extrinsic motivations (e.g. due to a prison sentence), the medication presents a plausible way of overcoming this in the shorter term, but with a lower chance of longer term compliance and success (Hamilton & Belenko, 2016). This view was not just restricted to those serving IPP sentences, but also more generally for those serving indeterminate sentences.

Yes I have a lot of sexual thoughts but there is no harm in masturbating yeah, like as much as I do. Yes it's out of the ordinary, yes it's a bit extreme but it's not harming no one. It's not, you know, anything, like, sick you could say...But when I explained to him, this is the bit where we compromise to go on it, all the psychologists said I should go on something to control it and to not feel so basically horny I suppose you could say, and the com, the only reason I wanted to go on it is for one, to look good on the parole, cus I know it does yeah, I'm not stupid, some people say no it might not or it won't, but I know it does because something happened with someone else who was on it so this is my compromise for that (P.8)

While participant eight acknowledges his high level of sexual thoughts and masturbation to be 'extreme', at the same time he is defending this in arguing that 'it's not harming no one', fuelling his belief that the medication is not needed. Instead for him the medication is the result of a 'compromise' to show the parole board he is taking on board psychologist recommendations and actively trying to reduce his sexual arousal. In doing so, he believes that this would look good and increase his chances of release. This perspective that taking the medication would 'look good at the parole board' (P. 2) or ensure they 'get out quicker' (P.7) was held by a number of participants. Research with both offender managers and offender supervisors has found that they hold a sceptical view of the medication for

this very reason. This leads to the belief that individuals may take the medication to try to manipulate their perceived level of risk in order to be eligible for an earlier release, particularly as measures of change and effectiveness are based on self-report methods (Elliott et al., 2018). However, self-report methods are not limited to evaluations of MMPSA, with this approach being commonly used to evaluate the effectiveness of a range of treatment programmes for ICSOs (Harkins, Flak, Beech, & Woodhams, 2012; Jung & Gulayets, 2011; Letourneau et al., 2013; Stinson, Becker, & McVay, 2015). With this in mind, there is little to suggest that the process of collecting risk relevant data in relation to the use of MMPSA is any different to risk based data collected in relation to reductions in dynamic risk in group based psychological interventions. However the voluntary nature of taking MMPSA may suggest to some individuals taking MMPSA that members of the parole board could view them as more motivated and engaged in the process of addressing their PSA, and therefore see them as a lower risk. This perceived external pressure to take with MMPSA also relates to views regarding the use of the medication post release from prison:

I've got this private report and on that it said on release one of my err things what I have to do, one of my conditions will be, I'll probably have to take random drug tests...to make sure I'm taking the medication and if not i'll be straight back so I gotta take it (P.3)

When I get released erm, like I said I've got some licence left to do so i'll still take the medication cus it's on my licence conditions but once I'm off licence I will carry on taking them for a while and just gradually take myself off them (P.7)

I'll have to keep taking them if I get out whilst I'm on licence but what it is i'll probably like set myself a test and take myself off them for a couple of months, see how it goes and if not just go back on them (P. 4)

Despite the fact that within the UK the use of MMPSA is voluntary (and thus cannot be stipulated as a licence condition or requirement for release), a number of participants held the belief that the medication would be a requirement of their licence conditions. The effect of this is that they believe that taking MMPSA is something that they must continue with for the duration of their licence period. These extracts, when coupled with those from participants four, six, and eight (above), demonstrate how for some ICSOs taking MMPSA, compliance is something that feels mandatory or forced. Participant three holds quite strong views regarding this, believing that he will be monitored to ensure

he is taking the medication and the consequences of not doing so would be being recalled to prison. While this is indeed the case in other countries where the medication is mandatory and tied to licence conditions, this is not the case within the UK (Harrison & Rainey, 2009) demonstrating a lack of understanding regarding the voluntary nature of the treatment. This again highlights how individuals may feel pressures to comply, and demonstrates the need for accurate information to be provided to such individuals who may feel coerced into taking MMPSA. This is a fundamental aspect of the ethical prescribing of MMPSA for ICSOs – particularly in light of the voluntary nature of the treatment in the UK (Turner, Petermann, Harrison, Krueger, & Briken, 2017). For participants seven and four it is clear that once the perceived external pressure for taking the medication is removed, they no longer intend to take it, with both participants discussing how they will navigate the process of ceasing MMPSA. Participant seven outlines how he will gradually take himself off the medication, likely recognising the negative impacts of suddenly stopping medication such as this. However, participant four describes a more casual approach to stopping the medication. He suggests that he will ‘see how it goes’ (referring to this process as a ‘test’). This is potentially concerning when considering that such a test would usually have a pass or fail outcome, and that in this case failing may constitute problematic sexual thoughts or behaviours returning or, in a worst-case-scenario, participant four committing another sexual offence. Support for this latter point comes from considering the evidence that factors associated with increased sexual risk are amplified in the community after individuals with sexual convictions are released from custody (Lussier, Dahabieh, Deslauriers-Varin, & Thompson, 2012), and gaining access to the medication is not as straight forward (Elliott et al., 2018). In order to overcome this, it would be preferable for anyone intending to take themselves off the medication to do so while still in custody so this can be carefully monitored.

This suggestion of stopping the medication supports existing literature that describes how, when individuals are extrinsically motivated or feel coerced to comply with treatment programmes, engagement with interventions is poor (Sturgess, Woodhams, & Tonkin, 2016) and drop-out rates are high after the coercive influence is removed (Day et al., 2004). This notion highlights the importance of identifying sources of intrinsic motivation and establishing the imagination of viable ‘new me’ identities (see below) before starting MMPSA. Through a process of contemplation (Prochaska & DiClemente, 1983) therapists can work with service users in order to make sure that they are ready to change and engage fully in treatment (Barrett, Wilson, & Long, 2003), which has been identified as an important predictor of treatment success among ICSOs (Sowden, & Olver, 2017). In doing so, intrinsic motivations act as a buffer to negative experiences of MMPSA treatment, enabling service users to continue to have the required motivation to adhere to the treatment programme when side effects are severe or when extrinsic pressures to comply are removed. This is consistent with the broader

mental health literature, which identifies pre-treatment motivation as a key predictor of retention in treatment programmes, as well as clinical effectiveness and improved rates of treatment adherence (e.g. Chen, Mui, Cheung, & Gray, 2015).

Theme 2: Medication as a risk management strategy

As discussed within the previous subordinate theme, *Recognising a need: Intrinsic motivations for treatment*, the medication was viewed by some as a potential method of gaining control – not only of their sexual arousal for everyday reasons, but also as a way of managing their risk of sexual offending. Having insight into one's triggers for sexual risk is an important treatment target when working with ICSOs (Lucy Faithfull Foundation, 2015). In this theme, risk is acknowledged by participants to be associated with patterns of PSA, with the medication being recognised as an important and potentially useful way of managing this risk. This process of acknowledgement, and the experiences of it, is unravelled within the following subordinate themes.

Theme 2.1: 'Too risky' without medication

Throughout the narratives there was an awareness of and recognition that participants are unable to manage their sexual thoughts and behaviours on their own and are, in essence, considered to be 'too risky' without medication. This was a perspective held by the participants themselves in their personal narratives, as well as professionals that they engaged with (see Elliott et al., 2018).

I know that on my own, I'm not strong enough to deal with this, I've been doing this since I was 13 years old and I'm not strong enough without it, I don't trust myself without it (P.9)

There's children out there and I don't want to come back into prison so...I'm gonna carry on taking the medication until they put me 6 feet under...if not I'm just too risky out there (P.1)

Here both participants discuss their need for the medication. Participant nine discusses his recognition that without the medication he cannot 'deal with this' ('this' being the sexual thoughts, arousal and his inappropriate sexual interests), and would not trust himself without it, alluding to the view that without medication he would be at increased risk of reoffending.

Participant one is much more direct in discussing his views regarding this. For him, being released into a much less controlled environment where there are children presents an increased risk,

and medication is viewed as a method of managing this risk. This is summed up in his conclusion that without medication he is simply 'too risky'. In this sense, the medication is seen as a barrier, or something that will stop them from reoffending (discussed within the next sub-theme).

A number of participants had previously received SSRIs alone and there was a consistent narrative among them that this was ineffective or not sufficient in addressing their problematic sexual thoughts or behaviours.

Fluoxetine I was on first and it's just rubbish, it didn't do nothing...he increased that, nothing happened, increased it again and nothing happened and again and then he put me on the things we talked about last time, the ones beginning with C Cyproterone (P.8)

Yeah I before I was on fluoxetine but that wasn't doing nothing for me so...he decided to then put me on that and this new one a stronger one but I didn't see the point in that one I knew it wasn't doing anything so now i'm just on more of the stronger one which is working (P.7)

Here both participants articulate how the SSRI medication did 'nothing', suggesting that it had no impact on their sexual thoughts and behaviours, resulting in a process of several adjustments to the medication. As indicated in earlier extracts, this lack of perceived effect of past SSRI treatment may be real, but may also be related to the subjective nature of experiences of PSA. In Chapter 5 it was clear that SSRI treatment had a positive effect on indices of PSA. For the participants here though, it may be that such improvements were not deemed to be sufficient, and were thus viewed as not being present at all. This mode of thinking is similar to the catastrophising cognitive distortions often witnessed among people with depression (e.g. Blake, Dobson, Sheptycki, & Drapeau, 2018; Coyne & Gotlib, 1983). It is unsurprising to see this way of thinking in the current sample, given the high incidence of emotional dysregulation and sensitivity to negative affect that is found within particularly hypersexual populations (Miner et al., 2016; Walton et al., 2017). People are more likely to comply with certain treatment for both physical and mental health problems when they feel that they are involved in the treatment planning and that their voices are being heard (e.g. Thompson & McCabe, 2012). This occurs by increasing their sense of ownership and competence over taking control of their treatment goals (Ryan & Deci, 2006; Teixeira, Silva, Mata, Palmeira, & Markland, 2012). This comes through in the narrative of participants seven and eight, who worked collaboratively with their psychiatrist to find the right medication plan and dosage.

It was working fine at first, I was happy with the way things were going for the first week or so...but then I noticed erm a deterioration erm, I started to notice that not only was I having difficulty er distracting my inappropriate thinking that I was starting to revert back to the old me...sexualising the situations...so it didn't help, it didn't control it so now i'm on this and i'm happy with the way things are going (P.9)

It was working but not as much as I needed, the sexy thoughts and everything it was all still there... so he put me on the really strong ones to control it which is what I need because mine is really bad it's just too high so the other didn't work (P.3)

For participant nine the SSRIs appeared to work initially with their effects deteriorating over time. Whereas for participant three, while the SSRIs were having an effect, this was not considered to be sufficient, resulting in both participants going onto anti-androgens instead. There are parallels in this progression from one medication class to another with the literature around medication tolerance, with the body becoming used to a particular dose before something more potent is required to have therapeutic effects (that is, a starting dose introduces the body to the drug, before this is increased to the level of a maintenance dose). The progression as a result of a lack of sufficient change (as indicated in the narratives above), however, may reflect a distinct pathway through MMPSA treatment (see Chapter 7). This highlights the complex nature of the medication, with all four participants starting on SSRIs and ending on anti-androgens, but their individual journeys between those two points being distinctly different. It is therefore clear that a 'one size fits all' approach to the medication is not appropriate and does not work (Thomas & Daffern, 2014) and although guidelines exist outlining the appropriate progression from SSRIs to anti-androgens (Grubin, 2017), this is based on clinical judgement as every case is different and thus an individualised approach within the broad guidelines is required. Participant three's description of his sexual arousal being 'too high', and this being used to justify stronger medication, is in line with current prescribing guidelines for MMPSA. These guidelines state that anti-androgens are appropriate when 'sexual drive is exceptionally strong, there is evidence of a high level of sexual activity, or where fantasies/urges are associated with particularly high risk behaviours which in the past have proven difficult for the individual to control' (Grubin, 2017, p. 6). In this sense, participants are viewing themselves as too risky for SSRIs and need a stronger medication in order to control their PSA. In cases such as these, progression might be symptomatic of initially high levels of PSA that are resistant to first line SSRI treatment.

This concept of feeling 'too risky' without medication is not without potentially negative consequences. While some participants clearly held the view that the medication would be viewed positively by parole boards and assist with their release (as discussed as an extrinsic motivation for taking MMPSA in theme one), others also reflected on the contrasting perspective that being on the medication, and needing the medication to reduce their risk, could be viewed negatively.

All I think of is what [name] said about it the other day, that the parole board will see it as it being dangerous to release someone like me, someone on meds, how high my sex thing is (P.5)

Well it just looks bad don't it cus if I can't control myself and I need tablets to control it then they're never gonna let me out cus i'm too risky if I stop taking em (P.1)

Here the participant narratives articulate the belief that taking medication or having a need for medication increases the extent to which they are perceived as posing a risk of reoffending. For participant five, having high levels of sexual arousal and being on medication is viewed as his core defining feature in his use of 'someone like me...' and that until this changes so that his arousal is reduced and the medication is no longer needed, he will be viewed by the parole board as too dangerous for release. Similarly, participant one discusses the perceived increased risk due to his lack of control and thus need for medication in that he would become 'too risky' if he chose to stop taking them with the resultant perspective that 'they're [the parole board] never gonna let me out'. These ideas speak to these individuals living out a condemnation script (Maruna, 2001) where they see themselves as being doomed to a life of sexual deviance as a result of their PSA. A lack of perceived ability to change may also hinder the rehabilitation process itself. That is, not seeing a non-deviant identity as being viable prevents an individual from orienting themselves towards a reformed state of being. This 'new me' is an important aspect of long term desistance from sexual offending as it gives an individual something to aim themselves towards (Göbbels et al., 2012). Aiming towards a new identity (rather than having to engage in some form of coerced treatment) also acts as an intrinsic motivation to change (Ryan & Deci, 2006). This is a well supported predictor of deeper engagement in treatment and effective therapeutic outcomes in a range of health and correctional settings (Adler, 2012; Bishop & Yardley, 2004).

While neither participant explicitly says it, the potential risk they both allude to is the risk of reoffending. As such, both participants hold the view that the medication, in that they are taking it or have a need for it, is hindering their movement towards release particularly due to the voluntary

nature of it. That is, if they self identify a need for MMPSA then this could be perceived not only as a clinical need (as judged by professionals) but also as the individual declaring their lack of control over their sexual arousal. This is in line with previous research with offender managers and offender supervisors which identified prisoner concerns that the parole board would view them as more risky for taking MMPSA, with some even reporting being discouraged from the medication for this very reason (Elliott et al., 2018). While this should not be the case within the UK and the medication should not be taken into account throughout the parole process (as any indication of either increased or decreased risk), it is still not clear whether this is actually a factor in the decisions made by parole boards or professionals who are responsible for risk management (Elliott et al., 2018). This is concerning, as a perspective such as this could prevent individuals who recognise PSA from disclosing this or considering medication as a treatment option due to a worry it may hinder them in their movement towards release. In this sense, a cost benefit analysis would present a barrier to treatment if the perceived costs (e.g. hindering release) outweigh the potential benefits (e.g. reduced arousal), and would result in a lack of engagement with the treatment (Burrowes & Needs, 2009). Staff perspectives echo this, suggesting that in some cases this increases reluctance towards the medication in those that may benefit from it (Elliott et al., 2018; Lievesley et al., 2014). This is consistent with other areas of psychological treatment where a fear of therapist views of risk (e.g. of self-harm or suicidal behaviour) can sometimes limit the extent to which patients disclose their symptoms (Henry & Strupp, 1994). The view that professionals working with individuals taking MMPSA who are convicted of a sexual offence could fixate on this aspect of an individual when making risk decisions is consistent with the social psychological concept of the horn effect (Kennon, 2011), where a single negative trait (e.g. levels of PSA) are globalised into general negative judgements of an individual. The reverse of this – the halo effect (Thorndike, 1920) – would suggest that an individual's willingness to engage with MMPSA translates into globalised positive views about risk (i.e. that there is motivation to change, and the medication addresses a key risk factor). As indicated above, there is no current evidence for either a horn or halo effect in risk assessments of ICSOs taking MMPSA.

Furthermore, these perspectives could have a wider detrimental impact on rehabilitation and reintegration as participants may become influenced by what has been termed the Golem effect (Maruna, LeBel, Mitchel, & Naples, 2004; Maruna, LeBel, Naples & Mitchell, 2009) whereby low expectations of a person leads to poorer outcomes. Thus, the low expectations from others discussed here by participants could indeed result in poor outcomes, with individuals internalising these negative perspectives. In contrast, those who experience professionals demonstrating positivity about their potential for change can in turn have more positive therapeutic outcomes with these perspectives facilitating change (termed the Pygmalion effect; Maruna et al., 2004; 2009).

Theme 2.2: 'One a day keeps the prison away'

Having recognised that their PSA may be a risk factor for their offending or may be viewed as such by others (e.g. psychologists and parole boards), this theme considers the ways in which participants depict the belief that this risk is directly managed or mitigated by the medication:

I said I want something to stop me offending. The tablets will stop me offending...it's like a cure (P.5)

I'm thinking as, I'm thinking now, one a day keeps the doctor away or keeps the prison away, ahh that's good one a day keeps the prison away yeah (P.2)

...it's the only way, it's not the only way but it's one way of stopping me coming back [to prison] (P.1)

As can be seen in the above extracts, a number of participants quite strongly held the view that the medication would simply stop them from offending, thus acting as a barrier, preventing them from returning to a life of offending. In this sense, the medication is viewed as a 'cure' (P.5), and something that has eliminated all potential risk. This view potentially removes personal agency from the rehabilitation process. Personal agency is widely acknowledged as an important factor in service user adherence to psychological therapies, both in mental health settings in a general sense (Adler, 2012) and in relation to treatment for ICSOs (Göbbels et al., 2012). In a similar way, this also led participants to reflect on the potential difference that MMPSA could have made if they had started taking it earlier:

I was thinking about sexual things all the time so I'd feel sexual things all the time so I'd feel aroused all the time, but if I'd had gone and said to somebody like Drs, "this is the situation, this is what's gone on, can you put me on something or help me with something or point me in the right direction", I could have gone on that medication a lot sooner and stopped all these things going on in my head and I wouldn't have had another 8 year sentence over my head (P.4)

For participant four, it is evident in his narrative that he views the sexual thoughts and feelings he was experiencing as being uncontrollable and the cause of his offending, alluding to the fact that had he had the medication sooner, he would not have committed his current offence. This belief that the

medication eliminates all possible risk is concerning as it has created an overreliance on the medication and a reluctance in participants to reflect on or even consider other risk factors. This is highlighted in participant nine's use of 'it's like a cure', when discussing his offending, suggesting that the offending is a condition that can be cured, rather than a consideration of risk factors that led to the offending. This is problematic as having a clear understanding of and ability to identify risk factors is important, being associated with lower risk of reoffending (Bushman & Van Beek, 2003). Furthermore, it seems the participants are using their sexual preoccupation and hypersexuality as an excuse to justify their behaviour and downplay their accountability and level of risk. This is consistent with Polaschek and Ward's (2002) concept of implicit theories that are supportive of sexual offending. One such implicit theory is that male sex drive is uncontrollable – a theme that is apparent in the claims being made here that without medication sexual offending is unavoidable due to participants' PSA. While some research suggests that this mindset could be detrimental and facilitate future offending (Friestad, 2012; Maruna 2001), others suggest that taking full responsibility for offending could be detrimental through the internalisation of negative labels (Levenson & Grady, 2018; Maruna et al., 2009; Willis, 2018) whereas making excuses and distancing oneself could be beneficial to the desistance process (Marshall, Marshall, & Ware, 2009; Maruna, 2001). If participants feel they had no control over their offending due to PSA, and the risk of this is now eliminated by the medication, it may lead to a less pro-active approach to their desistance due to the belief that they are now cured. However, some participants have begun to move past this view point and adopt different strategies:

I thought that the tablet I was taking every day was supposed to stop these thoughts erm I didn't realise at the time that it works in conjunction with me, it's got to come from me, it's got to be my desire to change, these tablets will help me but I thought that taking these tablets and that would be it, I wouldn't have to do anything...but I did erm its not a magic pill, I've had to change the way I think, the tablets help but it comes from me and people don't realise that erm I didn't realise that and you just think you take the tablets and the thoughts are gone (P.6)

Here participant six reflects on the belief that he previously held that the medication would stop the thoughts, emphasised with the recognition that 'it's not a magic pill' and thus suggesting that it would be impossible for a tablet to achieve this. Instead, he reflects on the need to be motivated and want to change, and take the necessary steps to change alongside taking the medication. A method of achieving this, for some, was through engagement in programmes while taking the medication:

The meds help me think clearly, i'm not aroused all the time and i'm not thinking about sex all the time, I can sit in like programmes and focus on what's going on and been learning strategies and everything like that...i've got con i've finally got control over myself... (P.9)

I was on programmes and of course the more work I did on the HRP, it helped me to realise that...it's the programmes and the tablets together that's going to help me (P.3)

I got to go to programmes and learn all the strategies and techniques to help me manage them [sexual thoughts] if they ever do come back (P.8)

As can be seen in the above extracts, both participants nine and three discuss the combined effect of medication and psychological treatment programmes. For participant nine, this is about gaining control over his sexual thoughts and behaviours – the medication provides the headspace necessary to focus in programmes and develop appropriate strategies to manage sexual thoughts and arousal, a narrative consistent with that of individuals taking SSRIs for this purpose (discussed within Chapter 5). The increased effectiveness of combined treatment is widely accepted (e.g. Guay, 2009; Saleh, Grudzinskas, Malin, Dwyer, 2010; Thibaut et al., 2010) with prescribing guidelines for MMPSA clearly stating it to be an adjunct to psychological treatment (Grubin, 2017). The intention of developing the necessary strategies in programmes to be able to manage sexual thoughts, as participant eight articulates, is particularly important when considering long term plans for desistance from sexual offending. This is particularly important in light of the fact that the medication may not work or be taken indefinitely, particularly when considering the high drop-out rates for pharmacological treatment (Gordon & Grubin, 2004). This may result in the return of symptoms of PSA as demonstrated in individuals taking MMPSA who choose to cease the medication (see Chapter 7). By combining pharmacological and psychological treatments, this headspace can be gained in order to acquire the necessary cognitive and behavioural skills to manage sexual arousal in more uncontrolled environments over the longer term once medication is discontinued.

Theme 2.3: A small price to pay

The negative aspects of the medication were acknowledged and discussed by participants, however, the dominant discourse when discussing this was that taking the medication was 'worth it' or simply a 'small price to pay'. This indicates that consent and compliance to MMPSA is the result of a rational choice (Becker, 1978) after considering the apparent benefits of reducing (or appearing to reduce)

PSA and perceptions of sexual risk. Indeed, some participants had reservations prior to taking the medication:

I was a bit um dubious because you hear these stories of like erm taking the medication an men who grow breasts an you know all like this (P. 4)

I wasn't really sure about it because I'd heard from other blokes that umm, how you start taking this and it kills you completely like chemical castration well I was, I was unsure about that, I really didn't want that...but I asked Dr [name] and he was able to put my mind at ease straight away...once you stop taking it, after a certain length of time everything's back to normal again so it's fine (P.9)

Here both participants discuss the impact of hearing others talk about the effects of the medication in that it instilled a sense of uncertainty regarding whether they wanted to take the medication. This echoes the findings from service users receiving SSRIs (outlined within Chapter 5) as well as staff perspectives (Elliott et al., 2018; Lievesley et al., 2013; 2014), both of which highlight the negative effect of rumours on service user views of the medication. As rumours arise in situations of uncertainty in order to reduce anxiety and instil a sense of control (Bordia & DiFonzo, 2004), increasing the availability of accurate information about the medication and its effects may reduce this. However, while some of the points discussed by participants here may be exaggerated, for example regarding castration, they are factual as documented effects of anti-androgens include gynecomastia (breast growth) and an inability to gain an erection (Nguyen et al., 2015). It is also true that anti-androgens are used in some countries to achieve a state of chemical castration (Douglas, Bonte, Focquaert, Devolder, & Stereckx, 2013). While these effects are reversible, with CPA being fully removed from the body within approximately 10 days of discontinuing use (Nnane, 2019; Tan & Lake, 2016), having accurate information readily available would reduce anxiety and uncertainty regarding this. This is demonstrated in participant nine's extract discussing his concerns and how these were managed and eased through a discussion with the psychiatrist – again emphasising the importance of readily available and accurate information. For those that do not obtain the necessary information to ease this, this uncertainty and concern remains as they begin the medication:

I'm gunna always take these until they say oh there's no point or whatever. I don't particularly want to cus I think, you know I'm young and with the side effects sort of thing, I don't want anything to go wrong with my sperm or

whatever, you know obviously I want a family and err I don't wanna risk anything but, if it's gunna help me get out, then I'll take it and i'll keep taking it (P.3)

What I'm saying is if it's gunna cause me depression, or anger, or weight gain, or my tits to get huge like it states, I would rather stay happy and not get depressed erm not get fatter and just carry on masturbating so much but in a real world that's not gonna happen because I wanna get out I don't wanna spend my life in here so i'll take em (P.1)

Within both extracts above, participants acknowledged how they do not want to take the medication because of potentially serious side effects (e.g. infertility), however in both cases this is mitigated by the belief that taking them would support their release. In this sense, the benefits of the medication (helping towards their release) far outweigh the costs (potential side effects) resulting in an indisputable decision to take the medication regardless of the additional or unanticipated effects. This resonates with the discussion in the previous theme of forced compliance, in which the motivation and decision to take the medication was linked to external or extrinsic factors such as release decisions being made by the parole board, with research demonstrating that external coercion is the usual motivation for such treatment (Garcia & Thibaut, 2011).

When taking the medication, participants reported a number of unanticipated effects, for example, weight gain (P.8), tiredness (P.6), inability to maintain an erection (P.2). However, the concerns and side effects were all considered 'a small price to pay' (P.9) in return for the perceived positives of the medication. As such, the benefits of the medication far outweigh the costs, resulting in the decision to begin and continue taking the medication. While this may be the case presently, as the effects are not of a concerning nature and are to some extent to be expected (e.g. the effects on physical arousal) this perspective may change longer term if participants were to begin experiencing some of the more severe side effects such as gynecomastia, as alluded to in the extracts at the beginning of this theme in terms of instilling concerns and uncertainty regarding the medication. This is particularly the case upon release when extrinsic motivations for taking the medication are removed, further supporting the idea that individuals taking MMPSA should be carefully monitored, as advised within the prescribing guidelines and wider recommendations related to the use of MMPSA (Grubin, 2018).

Theme 3: Discovering a 'new me'

As described throughout this thesis the taking of MMPSA has led to personal transformations in many participants, from them gaining control of their sexual behaviour specifically through to how they view themselves as people in a more general sense. This theme is characterised by participants reflecting upon the changes that they have experienced as a result of the medication through a complex process of adjustment. As a result of the effects of the medication, participants described the notion of discovering a 'new me' (P.8), a process that is captured within this theme.

Theme 3.1: Adjusting to new sexual norms

Throughout the narratives, participants discussed a number of ways in which their sexual arousal, encompassing both sexual thoughts and behaviours, had changed as a result of the medication:

Well it's just reducing my sexual thoughts. I haven't had one for god knows how long now (P.5)

I haven't had any sexual thoughts for ages. They're just gone...if I did have any sexual thoughts then that could lead to having more and just getting out of hand again. So I'm just glad they are gone away (P.7)

I always had the sexy thoughts until just recently when I went on this medication... but it wasn't an instant change er it took about 2½, 3 weeks before the fantasies of having sex, even with a woman then, it just goes right down to nothing, now I don't get any (P.2)

Within the above extracts, the participants reflect on the change in the frequency of sexual thoughts as a result of the medication, with all acknowledging that they had reduced. All three participants convey that their sexual thoughts are now 'gone', reporting that they no longer get any, even appropriate ones as participant two emphasises. Furthermore, participant seven articulates the 'risk' he perceives in that having some sexual thoughts could lead to more sexual thoughts, continuing to escalate until it is no longer manageable. This notion of losing control is not an unjustified concern, with the 'something has to change' theme within the first empirical chapter depicting similar accounts, prior to the recognition that it was problematic. As a result, he goes on to state that he is 'glad' about no longer having any sexual thoughts, a perspective that was generally shared among the participant group. While the reasons for being pleased about these changes are not explicitly articulated in the

extracts, they may be linked to changes in levels of PSA being associated with observed moves towards the idealised identities developed in the contemplation and preparation stages of change (Prochaska & DiClemente, 1983). As these changes become embedded into participants' identities, they also begin to become routinised and a part of their everyday functioning. This process of actually becoming the 'new me' that they planned at the beginning of treatment serves to further increase intrinsic motivations to maintain engagement and compliance with treatment (for an example of this in the broader healthcare literature, see Donnelly et al., 2013) and continue their journeys towards desistance from sexual offending (Göbbels et al., 2012). While these extracts highlight the change in sexual thoughts and fantasies that they experience, participants also reflected on the identifiable changes in their sexual behaviours:

...since the medication I haven't [had sexual thoughts or masturbated] and that's it. Nil, nil, nil all the way down, no masturbating, no erections, no fantasies (P.2)

He asks me questions about how many times within the last week have you masturbated, how many times have you masturbated to ejaculation... and whilst I'm on the meds it's always none...I haven't masturbated, not at all, I haven't masturbated, I haven't masturbated to ejaculation (P.9)

Here both participants emphasise the lack of sexual arousal and behaviours through the use of repetition. The participant narratives within this theme resonate with the accounts provided by those receiving SSRI medication (explored within Chapter 5), where participants discussed the reductions in their sexual thoughts and behaviours. However while the SSRI participants acknowledge that their sexual arousal remained to some extent, here the anti-androgen participants portray these as being completely gone. Some of the participants went on to reflect further about these changes:

I've got so much free time now, so many free hours from when yeh well when I used to masturbate 5 erm 5, 6 times a day and now none...so yeh I think I'm still adjusting to that (P.6)

I'm happy they're gone, it's just weird you know, didn't feel normal at first cus I'd been like that for so long but I guess this is normal for me now, its been quite a few months now (P.1)

Here participants reflect on how they were previously in order to fully comprehend the scale of the change in their current situation. This is cast with uncertainty, particularly for participant one in descriptions of his new patterns of behaviour as being 'weird', how the concept of what he once considered to be normal is changing, and the realisation that this new state, as a result of the medication, is now normal for him. As participant six articulates, this is not a simple process of accepting the change, but instead a process of adjustment, that for him is still ongoing. This sense of apprehension and adjustment towards the changes being experienced were also discussed by other participants:

I obviously knew what it was meant to do erm reducing the thoughts and all that but I didn't expect to not have any, you know it just cut it out, and I'm glad I'm happy now you know but erm at first it er it erm felt like I'd lost part of me because I was so used to always having them (P.4)

For participant four, while he was aware of the purpose of the medication in reducing sexual thoughts and behaviours, his expectations of how this would occur and to what extent were different from reality. The perceived drastic removal of sexual thoughts and behaviours initially left him feeling as though he had 'lost' a part of himself. This was a feeling shared by other participants, particularly when the sexual thoughts and behaviours provided coping mechanisms to deal with other aspects of life (as discussed within the previous two empirical studies). Not only did this loss mean that participants had to replace a physical need, but also an emotional coping strategy (Bancroft & Vukadinovic, 2004; Brewer & Tidy, 2019; Cortoni & Marshall, 2001; Hughes, 2010; Walton et al., 2017). This notion is also consistent with individuals treated for mental health conditions (Buck et al., 2013) and recovering alcoholics, with a recognition that there is a need to fill the void with something else (Rodriguez & Smith, 2014), which for the current participants is through the development of new hobbies and activities (discussed within the next subordinate theme). This again links to the importance of developing a range of viable identities from the outset of treatment (in order to enhance intrinsic motivations to fully engage and comply with MMPSA). Further, it is vital to fully inform service users about the extent of the physical and emotional effects that they will experience. By laying the foundations of identity change (including preparing participants for emotional turbulence during the change process; see Berking et al., 2011; Brown & Bloom, 2009; Liebling, 2012), intrinsic motivations for compliance and engagement with MMPSA can be maintained throughout the difficult periods that may be experienced during the treatment process. For many participants, the process of adjusting to their new behavioural patterns was not straightforward:

It's been a journey erm yeh I mean I I started off where you don't think anything is wrong, erm you think what you're thinking and feeling and doing is normal erm all about sex erm and then you realise it's not normal and it's a problem but it can be fixed...it wasn't a a wake up the next day and you're fixed no, it took time and so many changes of medication but erm I er now I feel like I'm fixed and I don't know how I ever thought that was normal (P.6)

Here participant six attempts to articulate the stages of reflection, acknowledgement, and change that he has gone through in the process of recognising his sexual arousal was problematic and reaching the point he is at now where this is under control. This was not something that was achieved quickly, with the recognition of the numerous medication changes again highlight the complex nature of the medication, and difficulty in finding the right balance of medication type and dosage for each individual. This further underlines the importance of careful and consistent monitoring of individuals taking MMPSA (Grubin, 2018) and the pivotal role that collaboration between professionals and service users has on maintaining treatment motivation (for an example from the broader healthcare literature, see Roest, van der Helm, & Stams, 2016). His discussion of being 'fixed', suggests that he was at some point broken and that the sexual thoughts and behaviours were part of the broken past version of himself, which is something he is now able to leave behind and move on from. From an identity perspective this is an important piece of self-insight and shows how this individual is starting to adopt change and move towards becoming his 'new me' (for a discussion of this concept, see Chapter 2).

Previously in this thesis, participants have discussed their desire to reduce their sexual thoughts and behaviours but were clear that they did not want to lose these completely. This desire is consistent with the aims of MMPSA, for which guidance is explicit in that the medication should reduce PSA while maintaining the ability to express a healthy sexual identity (Grubin, 2018). This has not been achieved with anti-androgens as all sexual thoughts and behaviours appear to have ceased since participants started taking the medication. Despite this, while these narratives highlight the difficulties that some participants experienced in adjusting to their new sexual norms from an emotional and identity perspective (i.e. finding other ways of managing emotional dysregulation), they also reflect an emergent alternative position. This is that, in general, all participants are pleased with these changes in sexual behaviour once they are over the initial period of adjustment. This final observation may be associated with the previous theme of the various trade-offs between the costs of the medication (i.e. the loss of sexual arousal) and the benefits that it brings (i.e. the chance of a new start, new hobbies, and reduced risk).

Theme 3.2: An awakening

Participants discussed the medication, or rather the changes they experienced from the medication, as giving them a 'second chance at life':

It's just given me a, a second life, I would put it, it's given me a better life than the one I was leading before because all I was into was sex, sex, sex, sex, sex mad (P.3)

Its like a light was switched on, I was in the dark before these [the medication] but now the lights been switched on, or I've woken up or whatever, but I can think and do things I couldn't do before, I've got a second chance at life now I'm on these (P.2)

Participant two's use of being 'in the dark' is used to represent a lack of understanding and links well to participant six's extract within the previous subordinate theme of not realising anything is wrong and believing it to be normal until a point where you realise that is not the case. For participants here, this represents them being in a pre-contemplative stage of change prior to engaging with the medication (Prochaska & DiClemente, 1983). For participant two here, this is described as a light being switched on, as he can now see what was previously wrong. Both participants' discussion of a second (chance at) life, suggests far more than simply a chance to change. It implies a rebirth, and a chance to start again with the recognition that the new life is better than the one they previously had. Now that their lives are no longer consumed by sex, participants are able to reflect on the wider impact of the medication and what it allows them to achieve. As participant two articulates in the previous extract, this is the ability to become somebody new, to develop a new identity, and to 'think and do things I couldn't do before'. This is something also discussed by other participants:

Being on these tablets have helped a heck of a lot...I can watch my programmes that I couldn't watch before um (P.1)

Before [the medication] I would be unable to just sit there and help this person to read because my mind would be occupied on sex all the time, as I said to you before, I couldn't sit and watch a TV programme...I wouldn't have the patience to sit down and help someone to read because my mind would be too clouded with everything else but now I can do all of those things (P.7)

I've started new hobbies erm yeh I'm doing my first jigsaw which I've never done before because all I used to think about was sex and I'm reading more (P. 4)

Here each of the participants discuss their ability to now engage in what might be considered by some as simple or mundane activities such as watching the television or reading, reflecting on how previously this would have been problematic due to their sexual arousal. For these participants the void left by the removal of sexual thoughts and behaviours has been filled by pro-social activities. The development of such activities is desirable from a rehabilitation perspective, as according to the Good Lives Model, excellence in play is considered a primary human good, the attainment of which provides individuals with more fulfilling lives (Ward & Brown, 2004; Ward, Mann & Gannon, 2007). In their previous lives, participants would meet this need in destructive or problem-enhancing ways (e.g. engaging in deviant fantasies and masturbating to these). However, the reduction in PSA experienced as a function of the anti-androgen medication has allowed (or, as identified in the previous subordinate theme, has required) them to develop these more positive alternatives. This process, in addition to helping participants to develop their new identities, is also an important part of the desistance process for ICSOs. According to the ITDSO (Göbbels et al., 2012), the achievement of primary human goods is a cornerstone of the good lives plan that should accompany re-entry into the community. By starting to develop these skills in custody, such individuals stand a better chance of normalising these new routines more quickly upon their release (e.g. Caulfield, Wilkinson, & Wilson, 2016; Nugent & McNeill, 2017).

Once I started taking the meds it all became clear...I realised now what I had put hundreds, excuse me, hundreds of women through, alright, I hadn't physically attacked them, no, I had done worse, it's the surreptitious looking, looking where I'm not supposed to be looking, looking without being given permission to look, this is the realisation, you know, the turning on of the light, I suddenly realised and now I've got another chance to make amends and to be different and not just be known for being the person who is always looking, always waiting to look, waiting to get an eyeful, instead people might start to see me as something else, something better and people have already started to notice, wing staff and [psychologist] have already said they've noticed the change in me (P.7)

For participant seven, having more time to think and reflect without the distraction of his arousal allowed him to acknowledge the extent and impact of his offending, with the recognition that at present his offending behaviours define him in the eyes of others in that he is known for being 'the person who is always looking'. However, the medication provides an opportunity for him to change that, through changing the behaviours and being noticed for something different, and allowing him to begin to positively re-define himself and re-story his life going forward. This echoes the sentiments in the previous extracts with participants two and three discussing being given a second chance at life. In this sense, participant seven is using his new identity to 'signal' his early process of desistance (Maruna, 2012). According to Maruna (2012) when others believe in these signals, this strengthens our own belief in them, to the extent that we then begin to behave in ways consistent with the signals we have presented. For participant seven, having recognition from others of this change ('wing staff and [psychologist] have already said they've noticed the change in me') will encourage him to behave in ways consistent with the change he has presented. Furthermore, the recognition from others creates a Pygmalion type effect, reaffirming and strengthening this new reformed identity (Maruna et al., 2004).

*I don't think my sex drive is anywhere dangerous now cus I know what I'm like, you know I know I'm in control of myself now...I'm not the person I used to be, that was the old me, I'm you know I'm different now...I don't think them things or do them things no more since the tablets, I'm a new me now
(P.8)*

Here participant eight is also attempting to re-define himself as a 'new me' as a result of the changes from taking the medication. He acknowledges that at one point his sexual arousal was dangerous and out of control, while emphasising that he is 'different now'. In this sense, by construing 'the old me' as the stigmatised part (someone with PSA convicted of a sexual offence), he is in a sense 'knifing off' (Maruna & Roy, 2007) these past elements of himself and leaving these behind to be able move forward with the 'new me'. Being able to achieve this in a rehabilitative environment, to enable an individual to rid themselves of stigma and move forward with a new identity, as participant eight is trying to achieve, is an important process in desistance from sexual offending (Göbbels et al., 2012), denoting a potentially positive step forward.

Conclusion

This study sought to generate a phenomenological understanding of the lived experiences of individuals receiving anti-androgens as a form of MMPSA. While overall participant experiences of the use of the medication were positive, as the medication appears to be working in reducing PSA as desired, for some this 'journey' (P.6) was at times fraught with apprehension and uncertainty. The findings highlight the differing motivations for the medication, with all participants acknowledging an intrinsic and self identified need for a change in their sexual arousal, whether that be thoughts or behaviours. Importantly though, these narratives also highlighted the subjective nature of what may be viewed as problematic by each individual, and as a result, what the intended gains of the treatment should be. Despite this intrinsic motivation, for a number of participants the primary motivation was related to an external factor - largely linked to their indeterminate sentence and wanting to demonstrate a reduction in risk in order to progress towards release. Typical sentiments included that consenting to the medication will help them to 'look good at the parole' (P.2) or 'get out quicker' (P.7). In contrast, others report a concern that a need for medication makes them look 'too risky' to be released. The subsequent effects of these different types of motivation on compliance should be considered in relation to whether somebody is a viable candidate for MMPSA. That is, somebody who is intrinsically motivated to engage in treatment of this kind is somebody who is more likely to maintain a higher level of engagement over the longer term (Sturgess et al., 2016), particularly when the potentially severe side effects of taking anti-androgens are considered (Nguyen et al., 2015). For those who appear to be more extrinsically motivated (or, in the language of change theory, are pre-contemplative; Prochaska & DiClemente, 1983), engaging in more psychological treatments geared around readiness for change may be more appropriate than proceeding straight away with MMPSA.

Regardless of whether individuals were fuelled by intrinsic or extrinsic motivations, their primary concerns appear to be most related to a lack of control – either over their sexual arousal (intrinsic) or their sentence and ability to demonstrate a reduction in risk (extrinsic). For both of these groups, the medication presents a potentially viable way of gaining control over these issues. For some, the medication was viewed as a 'cure' for their PSA, with the suggestion that it may have even prevented offending in the first instance had it been available. While the medication is not known to be used in a preventative way within the UK, and is only used with ICSOs, this is an approach used in other contexts, with some researchers suggesting that that 'antiandrogen medication should be initiated as early as possible if the risk to sexually offend against children is considered high' (Konrad, Amelung, & Beier, 2018. p. 292). As preventative efforts are continually evolving, the wider use of MMPSA outside of the criminal justice system may be something to consider for those individuals who recognise a need and are actively seeking support and treatment to prevent them from offending.

The results of this research have highlighted that for some, while the initial decision to use anti-androgens may feel like a last chance to regain control over their lives, the medication has positive effects in reducing PSA. While these stark reductions in arousal were not always desired to begin with, this was something participants were able to adjust to. Once they had reached a point whereby they were happy with their 'new sexual norms', participants were able to begin to construct a 'new me' without being dominated by their sexual arousal. This is important as being able to regulate emotional states and engage in prosocial recreational activities are important predictors of successful desistance among ICSOs (Byne, Brogue, Egan, & Lonergan, 2016; Gillespie, Mitchell, Fisher, & Beech, 2012). By freeing participants from the constraints of their PSA, the medication not only helped but required them to develop new coping strategies in relation to emotional regulation and find other activities to occupy their time – issues that people with high levels of hypersexuality typically struggle with (Bancroft & Vukadinovic, 2004; Hughes, 2010; Walton et al., 2017). Developing these skills in custody and being able to practice them in a controlled setting with psychological and pharmacological support is likely to have a positive effect on the ease and speed at which these individuals will be able to re-enter the community at the end of their prison sentence (Göbbels et al., 2012).

However the issues surrounding motivation, 'forced compliance' and challenges faced by participants in relation to experienced and potential side effects must be taken seriously. This is because these are all likely to increase the likelihood of treatment drop-out – particularly when extrinsic motivations are removed (Day et al., 2004). It is currently unknown how the level of MMPSA treatment compliance may look within community settings. However, with many of the current participants reporting a desire to discontinue medication use in the future, individuals must be sufficiently prepared and supported to come off the medication gradually and under supervision to allow changes to sexual arousal to be carefully monitored. This supports the argument for the medication combined with psychological treatment (Grubin, 2018; Guay, 2009; Saleh et al., 2010; Thibaut et al., 2010) to ensure individuals are developing the necessary skills to manage their sexual arousal independently if it was to return after treatment discontinuation.

An overarching observation within this study relates the complexity of the MMPSA treatment on an individual level, with participants highlighting the process of regular change between medication type and dosage. This was something that was also discussed by those taking SSRIs (Chapter 5). However, the true extent of this became apparent within the current analysis, with a number of participants beginning on SSRIs and eventually progressing on to anti-androgens. However, each individual journey between these points was very different. This accentuates the view that a 'one size fits all' approach to the medication does not work (Thomas & Daffern, 2014) and while guidelines exist (e.g. Grubin, 2017), an individualised approach within these broad guidelines is necessary.

However, further exploration of these journeys is required to fully comprehend the true complexity and individuality of the treatment. The work in this thesis thus far has explored the lived experiences of service users and has illuminated the complex nature of the medication and the journeys of the service users taking them (as discussed previously). However, as previously stated there is a need to embed these individualised journeys within a more systematic landscape, within which guidelines can be issued and enacted. To this end, it is necessary to identify whether there are a range of specific pathways through which individuals navigate MMPSA. The next empirical chapter aims to address this by exploring the various treatment journeys undertaken by service users within the broader evaluation dataset in order to gain a clearer understanding of the individuality, impact, and complexity of MMPSA treatment.

Chapter 7

Study 4: Navigating MMPSA: Pathways to effective treatment

Introduction

The previous two empirical chapters explored the experiences of individuals receiving either SSRIs or anti-androgens as a form of medication to treat problematic sexual arousal (MMPSA). These studies illuminated the complex nature of recognising the need for, and receiving, MMPSA, which is not something that has yet been explored or been given sufficient attention within the literature. Exploring this complex and often nuanced treatment was not an initial aim of the thesis, but emerged as something that may be an important consideration for exploring the specific experiences of individuals convicted of sexual offences (ICSOs) taking MMPSA as the research progressed. As discussed in depth in Chapter 2, research into MMPSA largely focuses on quantitative analysis of the effectiveness of taking medications in relation to a range of clinical measures related to problematic sexual arousal (PSA), either by comparing those taking different forms of MMPSA (Winder et al., 2014; 2018) or by comparing medicated and unmedicated individuals. While this type of research is useful in eliciting findings regarding treatment effectiveness at the global level (e.g. Khan et al., 2015), it does not tell us about the unique and nuanced treatment pathways of individuals taking MMPSA, which the previous chapters have alluded to. That is, all of this previous work considers those taking MMPSA in homogeneous ways (e.g. those taking medications vs. not, or those taking SSRIs vs. anti-androgens). However, it is clear from the previous chapters that a 'one size fits all' approach is not appropriate and will not work (Thomas & Daffern, 2014). Despite guidelines regarding the use of pharmacological treatment (e.g. Grubin, 2017), the individualised pathways of taking MMPSA are complex, and lack empirical exploration. For example, as highlighted by the broader evaluation of MMPSA (outlined in Chapters 1 & 2), individuals often change medication class or dosage, withdraw from treatment, return to treatment and, for some, the medication does not reduce sexual arousal as desired (as described in Chapters 5 and 6; see also Elliott et al., 2018; Lievesley et al., 2013; 2014; Winder et al., 2014; 2018). These different pathways are thus not reflected in the analysis of large scale data sets. Although there are clear benefits to larger scale investigations, looking at the detail of individual cases provides a different opportunity - to bridge the gap between scientist and clinician, and thus provide meaningful findings to inform practice (Hershenberg, Drabick & Vivian, 2012). This is particularly important in situations where treatment changes (in this case, to dosage or medication class) can be frequent or happen in a relatively short space of time. When this happens, nomothetic quantitative

analyses of large data sets (e.g. Winder et al., 2014; 2018), where data points are at systematically separated time intervals (e.g. three, six, nine, twelve months, etc), risks missing the nuanced experiences and divergent journeys of individual treatment pathways that may be reflected between these time points. This chapter therefore identifies the various pathways that are currently present within the evaluation database, and provides an individual case example to illustrate each of these. As such the chapter captures the different pathways of MMPSA in order to gain a clearer understanding of the effects, individuality and complexity of the treatment.

In line with the broader aims of the thesis, this chapter is less concerned with the specific effectiveness of MMPSA in reducing measures of PSA. These outcomes are discussed in detail in other publications stemming from the broader UK evaluation of MMPSA prescribing among ICSOs (see Winder et al., 2014; 2018). Although these measures will be discussed in relation to each of the individual cases presented later in this chapter, these should be viewed as examples of representative journeys taken by men convicted of sexual offences to navigate their way through the taking of MMPSA from their initial referral, through any necessary changes to dosage or medication class, and finally (in some cases) to the discontinuation of the medication. In this sense, while each representative case is not comprehensive in covering every possible circumstance of each pathway, the essence of each pathway is present in these examples. As such these examples are illustrative rather than comprehensive. The presentations of the cases themselves will be descriptive in nature, bringing together a triangulation of the clinical data reported in Winder et al. (2014; 2018), the narratives of participants in Chapters 5 and 6, and personal discussions with professionals charged with managing individuals taking MMPSA who have been convicted of sexual offences. These are presented alongside an in-depth discussion of the pathways generally and how they operate. As such this chapter remains focused on the nuanced lived experiences of men taking MMPSA (rather than on examining the specific effectiveness of MMPSA in terms of addressing clinical issues), in line with the broader aims of the thesis.

Method

Procedure

Approval to conduct the research was initially granted by the Governor of the prison establishment (HMP Whatton). An application to conduct the research was made via Her Majesty's Prison and Probation Service (HMPPS) research application system and ethical approval was obtained from this as well as Nottingham Trent University. Once ethical clearance was granted, access to the participant data was granted by the prison establishment.

The data used within the case studies is information that is routinely collected. Specifically, individuals who consent for referral for an assessment for MMPSA and subsequently consent to the medication complete a number of clinical measures (outlined below) at regular meetings with the psychiatrist (see Lievesley et al., 2013; Winder et al., 2014; 2018). In addition, a range of pre-collected file information was collated for each case. The current research draws from all data sources to provide a number of detailed case examples and utilises visual inspection of the graphs in the analysis and interpretation of the cases.

Data sources

File information

The file information included was collated from prison, healthcare, psychology and programme files and reports. The data collated included: demographics, IQ (assessed via WAIS-IV; Wechsler, 2008 or WASI-II; Wechsler, 2011), referral and medication information, offending and sentence history, static risk (RM2000; Risk Matrix 2000; Thornton et al., 2003), dynamic risk (SARN; Structured Assessment of Risk and Need; Thornton, 2002), treatment information, and a range of relevant information related to life history (e.g. medical history, education, family, relationships, and any information relevant to the presence of PSA).

Clinical measures

Two brief scales (proposed by Grubin, 2008; 2017) were used to explore different facets of PSA (see Chapter 2):

Hypersexual behaviour (the behavioural facet of PSA) was assessed with the following two items:

- Number of days in the past week masturbated to orgasm? (0-7 days)
- Number of days in the past week masturbated not to orgasm? (0-7 days)

Sexual preoccupation (the psychological facet of PSA) was assessed with the following three items:

- How much time do you spend thinking about sex? (0: Very little; 7: All the time)
- What is the strength of your sexual urges and fantasies? (0: Low; 7: High)
- What is your ability to distract yourself from sexual thoughts? (0: Easy; 7: Difficult)

Interviews

In addition to the above data collection, information gathered from prior interviews with participants (as outlined within the previous studies in Chapters 4-6) were used to inform both the identification of specific pathways and the selection of appropriate illustrative case studies, where appropriate. Additionally, structured discussions took place with the prescribing psychiatrist regarding each case to assess the accuracy of the information being presented and the interpretations being made. This process was performed in order to enhance the reliability of the discussion and recommendation points throughout this chapter.

Development of the pathways

Six core pathways were identified from the full sample of those receiving MMPSA ($N = 117$) as at mid 2017. This involved reviewing the medication journey for each individual that had received medication from the commencement of the MMPSA service in 2009, to the point of data collection for this study (mid 2017). Through observations of the treatment journeys, clinical data, and discussions with the prescribing psychiatrist, particular features of each participant's treatment experience were examined in order to identify specific treatment pathways. These features were:

1. Changes and maintenance of medication class
2. Changes and maintenance of medication dosage
3. Medication starts, ends, and restarts

From this, six pathways were identified as being representative of those having received MMPSA. A brief overview of each pathway is presented in Table 7.

Table 7: Descriptions of representative MMPSA pathways

Pathway	Description
1: SSRI pathway	The service user begins SSRI medication. There may be medication adjustments (i.e. to the specific type of SSRI prescribed or dosages), however they remain on SSRIs for the duration of their treatment. Successful completion of this pathway would involve ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.
2: Anti-androgen pathway	The service user begins anti-androgen medication. There may be medication adjustments (i.e. to the specific type of anti-androgen prescribed or dosages), however they remain on anti-androgens for the duration of their treatment. Successful completion of this pathway would involve ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.
3: Progression pathway	The service user begins medication – either SSRIs or anti-androgens. There may be medication adjustments within this medication class (i.e. to the specific type prescribed or dosages), before progressing to a stronger medication class (i.e. anti-androgens or GnRH) potentially alongside the initial prescribed medication. Once on this, there may be further medication adjustments within this medication class. Successful completion of this pathway would involve remaining on this stronger medication class until the point of ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.
4: Switching pathway	The service user begins medication – either SSRIs or anti-androgens. There will be multiple adjustments to the prescribed medication class (i.e. between SSRIs, anti-androgens and GnRH, or a combination of these) within their treatment journey. There may also be medication adjustments within each medication class (i.e. to the specific type prescribed or dosages). Successful completion of this pathway would involve remaining on MMPSA (any class of medication) until the point of ceasing the medication when PSA is at a desirable and manageable level. Ceasing the medication prematurely would result in movement to another pathway.
5: Drop-out pathway	The service user prematurely (i.e. before desired effects on PSA have been achieved) ceases medication due to a lack of desired effect, or the presence of unwanted effects (i.e. side effects), while on one of the above pathways.
6: Re-entry pathway	The service user re-starts some form of medication after ceasing treatment in any of the above pathways.

Reliability of pathway classifications

In order to establish whether these six pathways accurately represent the journeys of individuals taking MMPSA, an inter-rater reliability was undertaken using the full data set of those taking MMPSA. This included all individuals who had received some form of MMPSA since the commencement of the treatment service in 2009. Each of these cases, as of March 2019, ($N = 139$) were reviewed⁹, however six were excluded prior to the analysis due to incomplete information regarding the medication class. As such, 133 cases were included in the analysis and were coded by the author and one academic unrelated to both this thesis and the evaluation project. Using the pathways descriptions in Table 7, each rater coded every case individually. Inter-rater reliability was strong (Cohen's $\kappa = .87$), with 92% agreement between the raters in relation to pathway classification.

In the 11 cases (8%) where the raters disagreed, pathway assignment was subsequently decided through a discussion between the raters after jointly examining the clinical data. In total, all but six cases were subsequently able to be assigned to one of the pathways described above. A discussion surrounding why these other six cases could not be assigned to a pathway is provided within the later discussion of this chapter. Figure 1 represents the distribution of cases classified into each pathway.

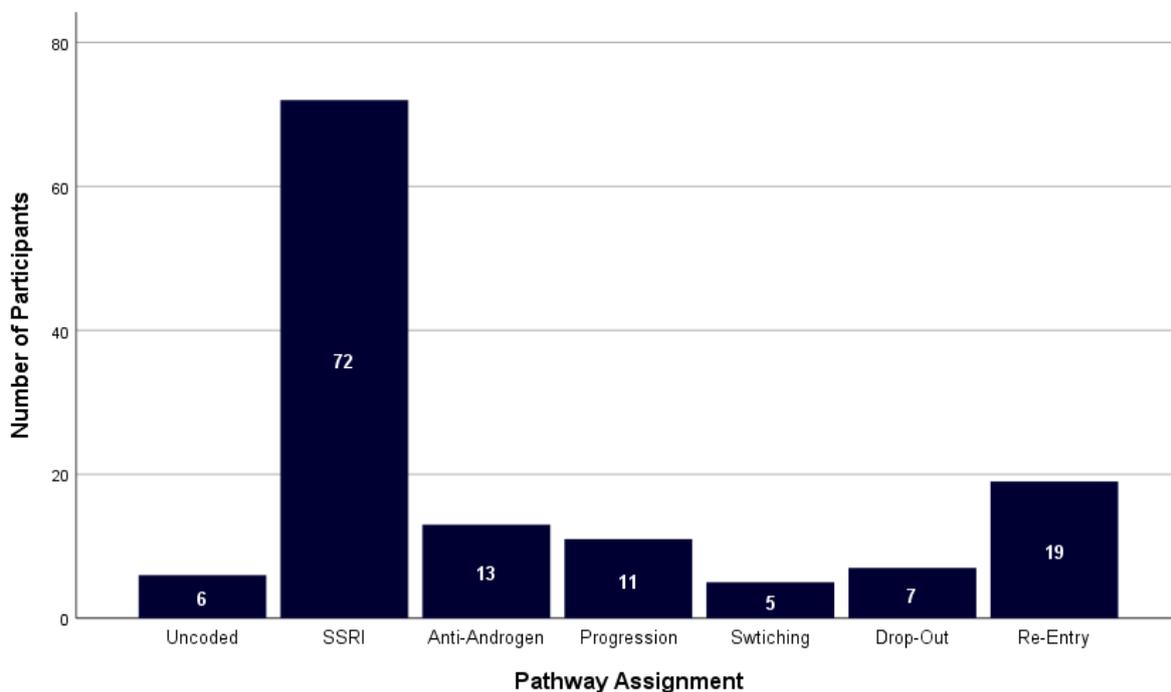


Figure 1. Distribution of pathway assignment

⁹ This number is different to the total number of participants listed in the introduction to this thesis. This is because the initial number relates to the number of referrals received by the MMPSA service. The number here relates to the those who, after being referred, actually went on to receive MMPSA.

Discussion of the pathways and representative cases

From the six identified pathways (outlined above), one representative case example was selected from the full dataset of participants to illustrate each pathway. A discussion of each pathway and the accompanying case example is provided below. While each representative case is not comprehensive in covering every possible circumstance of each pathway, the essence of each pathway is present in these examples. These specific cases were chosen due to having the most complete, relevant and up to date data to develop a case study that was relevant to each pathway. In order to protect confidentiality, identifying details have been omitted.

Pathway 1: SSRI pathway

Pathway 1 (*the 'SSRI pathway'*) involves only the use of SSRIs as a form of MMPSA. That is, individuals on this pathway will begin their MMPSA treatment journey on SSRIs, and while the dosage may be adjusted if necessary in order to achieve the desired effects, they will remain on SSRIs until the medication is no longer required. A change in medication (i.e. a move from SSRIs to anti-androgens) would result in a change of pathway.

Prescribing guidelines (Grubin, 2017) and literature regarding the use of SSRIs as a form of MMPSA (see Chapter 2) typically recommend SSRIs as the first line of treatment for individuals with more prominent psychological facets of PSA (e.g. sexual preoccupation or rumination vs. more behavioural facets such as hypersexuality). In line with this, individuals initially placed on this pathway reported high levels of these psychological facets of PSA that they experienced as being problematic prior to commencing MMPSA (an average of the three sexual preoccupation clinical questions pre medication; $M = 4.82$, $SD = 1.28$), with the treatment resulting in a reduction in these measures with individuals reporting reduced sexual thoughts and fantasies, and greater control over those that they do experience (most recent measure $M = 1.40$, $SD = 1.25$, $t(69) = 17.18$, $p < .001$; see also Chapter 5 for qualitative accounts of these changes in levels of sexual preoccupation). However, it is clear from the progress of individuals on this pathway that the more behavioural facets of PSA, such as hypersexual behaviour (operationalised here as high levels of masturbation to orgasm; Kafka, 1997; Långström & Hanson, 2006), are also addressed by SSRI treatment. This is illustrated in the case example provided below, the narratives of individuals taking SSRIs (see Chapter 5), and in an analysis of the clinical data for those on this pathway (pre medication $M = 4.03$, $SD = 2.35$; most recent measure $M = 1.05$, $SD = 1.38$; $t(68) = 11.80$, $p < .001$). This contradicts the basic assumptions within the literature and prescribing guidelines, which argue that hypersexuality should be treated using anti-androgen medication in the first instance (Grubin, 2017). With this in mind, it could be recommended that (unless otherwise indicated – discussed within the anti-androgen pathway below) all individuals

referred for MMPSA begin on the SSRI pathway, based on the clear documented improvements across all facets of PSA (as defined in Chapter 2). In addition to the marked improvements in both the psychological and behavioural facets of PSA, individuals on this pathway also report improvements in mood and general psychological wellbeing (Chapter 5) which is consistent with the more traditional use of SSRIs for emotion regulation (Cools, Roberts & Robbins, 2008; Skandali et al., 2018). This reduction in PSA, as well as improvements in general wellbeing, provides individuals on this pathway with the headspace necessary to actively engage in rehabilitation through psychological treatment programmes, when previously PSA would have presented as a barrier to this by interfering with engagement (Saleh, Grudzinskas, Malin, & Dwyer, 2010). This is particularly important for individuals on this pathway with SSRIs affecting levels of neural plasticity, thus increasing sensitivity to the environment and making individuals more susceptible to psychological therapy and more amenable to change (Branchi, 2011; Carhart-Harris & Nutt 2017).

Case example: Mr A

Mr A is in his early 60s and of white British nationality with an IQ level that demonstrates mild intellectual disability (WAIS score = 66). Mr A experienced physical and sexual abuse at school and in his home environment.

Offending information

Mr A has a total of 20 convictions for 53 offences, two of which were for sexual crimes. His first sexual conviction occurred at the age of 24 for the rape of a stranger, for which he received a five year custodial sentence. His second sexual conviction was shortly after his release, aged 29, for rape and murder. This conviction led to a life sentence which he was serving in prison at the time of data collection. Mr A attributes his sexual offending to feelings of entitlement for sex, a lack of significant or intimate relationships, and the use of sexual acts such as masturbation and sexual offending to make him feel better about himself. According to the RM2000, Mr A has a medium risk of violent reoffending and a high risk of sexual reoffending, with the SARN indicating areas of concern as¹⁰: sexual preoccupation (OC), sexualised violence (OC, G), adversarial sexual attitudes (OC, G), sexual entitlement (OC, G), believing women are deceitful (OC), inadequacy (OC, G), lack of emotional intimacy (OC, G), lifestyle impulsiveness (OC, G), poor problem solving (OC, G) and poor emotional control (OC).

¹⁰ Within the SARN, each risk factor is assessed within the offence chain (OC) and life generally (G) and assigned a score of 0 (not present), 1 (present), or 2 (strongly present). Factors with a score of 1 or 2 are included for the purpose of these cases.

History of PSA

Mr A has a preference for sexual violence, recognising that he is aroused by force and control. He reports having prolonged and unmanageable sexually violent fantasies, which he believes are related to his own previous abuse. He reports frequently using sex or masturbation as a method of coping with negative emotions and managing these sexual thoughts. Mr A reports being in numerous relationships, however he does not consider these to be close relationships due to his repeated unfaithfulness, often engaging in several overlapping sexual relationships.

Treatment journey

Mr A completed both the Adapted Sex Offender Treatment Programme (ASOTP) and Adapted Better Lives Booster (ABLB) and the Relapse Prevention Programme prior to his referral for medication. Mr A's ASOTP report indicated that he had gained a good knowledge of sexual consent and had developed his ability to recognise his own and others feelings. He also accepted responsibility for his offence and recognised the unhelpful and minimising nature of previous excuses and justifications. Following this, some years later Mr A participated in ABLB. According to the programme report, he participated well and was motivated to explore his risk areas. However, he continued to have difficulties in managing emotions following the programme and further work in this area was recommended. Mr A was then moved to a category D establishment where he spent three years before being recalled due to inappropriate sexual behaviours and was referred for HSP (Healthy Sex Programme). Through his assessments for HSP, it was deemed that due to his high levels of sexual thoughts and masturbation, he would not be able to engage with and therefore benefit from this programme without assistance to reduce his sexual arousal which led to a referral for medication by a psychologist. Reports indicated that HSP helped Mr A to recognise the significance of sexual arousal in his offending and to focus on developing and maintaining healthy sexual thoughts. Mr A's medication journey is summarised below and discussed in detail alongside graphical data (Figure 2).

Fluoxetine 20mg → Fluoxetine 40mg

Mr A was initially prescribed a daily dose of SSRIs (Fluoxetine) 20mg, as due to having undergone an orchidectomy (removal of the testes due to cancer) it was felt that anti-androgens would not be appropriate as they directly reduce levels of testosterone which are primarily produced by the testes. After approximately three months this was increased to 40mg as, while there had been a reduction in measures, these were not considered to be sufficient by Mr A or the psychiatrist and some measures had begun to increase again (T0-T3). Within the first 6 months of being on this increased dosage,

measures of PSA (both sexual reoccupation and hypersexuality) reduced to zero or one (between T3-T9) and stabilised at this low level. At T18 there was a slight increase in number of days masturbated not to orgasm from zero to one however, as this was still low, this was not considered to be problematic. Mr A remained on 40mg of Fluoxetine and had been taking this for almost two years when he moved to a category D establishment and planned to remain on this while there.

Mr A's initial reductions in scores are worth noting, as Figure 2 shows a reduction in measures of PSA prior to any medication being taken (T0-T0). According to the treatment timings and reports, the first T0 scores are likely to be elevated by the assessment and commencement of HSP which focuses on sexual thoughts, fantasies and behaviours (for example, using directed masturbation). By the time of the second T0 scores, this had settled and was more indicative of Mr A's average pre medication scores.

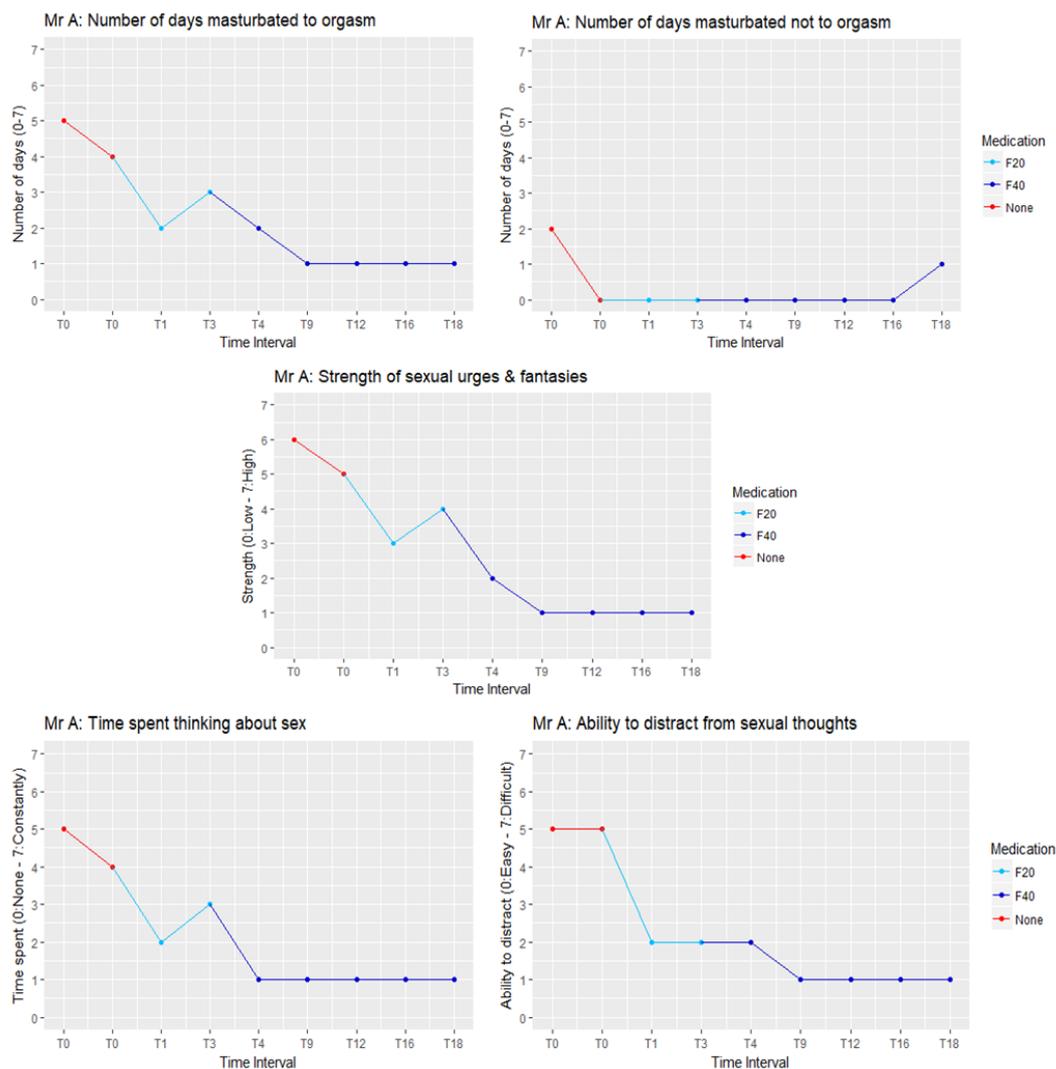


Figure 2. Changes in Mr A's clinical indicators of PSA

Mr A's case demonstrates an example of SSRIs (Fluoxetine) having the desired effect of reducing levels of PSA (both hypersexuality and sexual preoccupation). Stabilised scores of one across a range of measures indicate that Mr A still has some sexual thoughts and is able to masturbate to orgasm, but that these are manageable (i.e. they are low in strength and easy to distract from). This is likely due to a combination of the medication that helped Mr A control his levels of sexual thoughts and arousal, and attending HSP that focused on developing and maintaining healthy sexual thoughts and behaviours. This is particularly positive as the aim of the medication is to allow individuals to maintain a healthy level of appropriate sexual functioning (Bradford, 2001; Thibaut et al., 2010). Furthermore, accounts of individuals receiving SSRIs for this purpose indicate that concerns around their ability to have a sexual relationship in the future may result in non compliance or ceasing the medication (Chapter 5; Lievesley et al., 2013; 2014). As this is not a concern for Mr A, he continued to take the medication, which may aid his progress in the Category D establishment, where his previous lack of control and inappropriate sexual behaviours were the reason for recall. These difficulties now appear more manageable as a result of the medication and combined psychological treatment. It is also worth noting that according to the prescribing guidelines (Grubin, 2017), Mr A he should have commenced treatment on anti-androgens based on his presenting symptoms of PSA (high levels of hypersexuality, offence related fantasies and risk related behaviours), however, due to medical reasons he instead commenced on SSRIs. This clearly indicates that the guidelines do not always indicate the most appropriate course of treatment, as the SSRIs used here have been successful in managing his level of PSA. This highlights the importance of having a mechanism of clinical override, whereby those working with service users can use their professional judgement and case knowledge to act in a way that is contrary to formal guidance. Nonetheless, the potential utility of using SSRIs as a global first-line choice of MMPSA is potentially undersold in current prescribing guidelines. This is discussed in more depth later in this chapter.

Pathway 2: Anti-androgen pathway

Pathway 2 (*the 'anti-androgen pathway'*) involves only the use of anti-androgens as MMPSA. Individuals on this pathway will begin their MMPSA treatment journey on anti-androgens, and as with the SSRI pathway, while the dosage may be adjusted if necessary in order to achieve the desired effects, they will remain on anti-androgens until the medication is no longer required. Any change in medication would result in a change of pathway.

While it is suggested here that the first line of treatment for MMPSA should be using SSRIs (as discussed within the previous pathway), there are occasions where this is not appropriate. For example, and as illustrated within the below case example (Mr B), where SSRIs have been (or are

currently being) prescribed for co-morbid conditions (e.g. depression) but have not been accompanied by changes to indicators of PSA. In such cases anti-androgens would be the first option of MMPSA as it is already evident that SSRIs are not having the desired effect on PSA. The guidelines for MMPSA (e.g. Grubin, 2017) recommend the first line use of anti-androgens for people with excessive levels of hypersexuality. However, taking into account the SSRI pathway's effectiveness in reducing hypersexual behaviour (see SSI pathway discussion above; see also Winder et al., 2014; 2018), and these trends being present in participant narratives in Chapter 5, the recommendation made here is that it is only when SSRIs have been previously prescribed with no effects on PSA that anti-androgens should be the first line of treatment. This practice could have the added benefit of improving treatment compliance. This could occur by reducing the experience of the substantial unwanted side effects (e.g. weight gain, gynecomastia) that are experienced with anti-androgens and replacing them with the positive side effects (e.g. improved emotional wellbeing and some ability to engage in appropriate sexual behaviour) that are possible on SSRIs (see Chapters 5 and 6).

Individuals on this pathway demonstrated PSA across all facets (e.g. relating to sexual preoccupation and hypersexuality) and observed reductions in these during the treatment period (sexual preoccupation: pre medication $M = 5.57$, $SD = 1.00$; most recent measure $M = 1.88$, $SD = 1.15$, $t(11) = 9.24$, $p < .001$; hypersexuality: pre medication $M = 5.05$, $SD = 2.02$; most recent measure $M = 2.10$, $SD = 2.28$, $t(9) = 3.82$, $p = .004$). However, as anti-androgen treatment is associated with potentially severe side effects (Nguyen et al., 2015), individuals on this pathway often view these as problematic which may subsequently interfere with treatment progress and long term compliance with the medication (see Chapter 6). Rather than the milder forms of sexual dysfunction observed in those taking SSRIs, individuals taking anti-androgens reported more significant and problematic effects including an inability to gain or maintain an erection, and gynecomastia (breast growth). These complications are evident in the case example of Mr B as well as the narratives of those receiving anti-androgens in Chapter 6. As indicated above, and while these effects are to be expected on this class of medication, they do cause concern for individuals taking it and could lead to lower levels of compliance or reduce the likelihood of this being viewed as a viable long term treatment option. This is particularly worrying when extrinsic motivations for taking anti-androgens are removed (see Chapter 6). That is, the inability to gain or maintain an erection, or achieve sexual satisfaction could lead individuals taking anti-androgens to engage in more deviant or risky sexual fantasising, having the opposite effect as desired. This reduction in compliance with treatments that have adverse side effects once extrinsic motivations have been removed has parallels within the medical and general health literatures (e.g. in relation to smoking cessation and weight loss programmes; Ng et al., 2012; Teixeira, Silva, Mata, Palmeira, & Markland, 2012; Volpp et al., 2006) and the broader forensic field

(Hamilton & Belenko, 2016). As such, more regular or intensive monitoring of the effects and thus compliance may be necessary for individuals on the anti-androgen pathway.

Case example: Mr B

Mr B is in his mid 50s and of white British nationality and has borderline intellectual disability (WAIS score = 73). Mr B experienced both sexual and emotional abuse as a child.

Offending information

Mr B has a total of five convictions, two of which are for sexual offences. His first sexual conviction was aged 22 for indecent assault against a female under 14, for which he received a two year custodial sentence. His second sexual conviction, aged 36, was for a total of 11 counts of assault by penetration and indecent assault of a male and female under 14. At the time of data collection, Mr B was serving an indeterminate IPP (imprisonment for public protection) sentence for these offences. Mr B attributes his offending to his own abuse, his sexual preference for children and his inability to form intimate relationships with another adult due to his attraction to children which has contributed to his feelings of loneliness and worthlessness. According to the RM2000 Mr B has a low risk of violent reoffending and high risk of sexual reoffending, with the SARN indicating areas of concern as: sexual preoccupation (OC, G), sexual preference for children (OC, G), other offence related sexual interests (OC, G), child abuse supportive beliefs (OC, G), inadequacy (OC, G), distorted intimacy balance (OC, G), lack of emotional intimacy (OC, G), lifestyle impulsiveness (G) and poor problem solving (OC, G).

History of PSA

Mr B began engaging in sexual activity from a young age (before 10 years of age), masturbating several times per day and regularly using pornography. Mr B reports having over 30 sexual partners, with only two significant relationships. While in custody, Mr B reports having unmanageable sexual thoughts, being easily sexually aroused and masturbating multiple times per day.

Treatment journey

While in custody, Mr B completed the ASOTP and ABLB prior to referral for medication. Reports from these programmes indicate that they helped Mr B to develop his social skills, self-esteem, confidence and problem solving. However, he still discussed his sexual preference for children and often became aroused in group during any offence related discussion, making it difficult for him to fully engage at times. Due to this, and Mr B's ongoing sexual thoughts, it was recommended post programme that Mr B needed further help to manage his sexual thoughts and arousal, leading to a referral for

medication. While the medication allowed Mr B to feel more in control of his sexual thoughts and arousal (discussed in further detail below) he still struggled with the offence related nature of his sexual thoughts resulting in referral for and completion of HSP while taking the medication. Reports indicated that HSP helped Mr B to understand his pathway to offending and alternatives to this for the future, recognising and challenging inappropriate sexual thoughts and develop appropriate coping mechanisms and strategies. Mr B's medication journey is summarised below and discussed in detail alongside graphical data (Figure 3).

Androcur 50mg → Androcur 100mg → Androcur 50mg → Stopped

Mr B was initially prescribed a daily dose of anti-androgens (Androcur) 50mg. This was due to very high levels of both the psychological (i.e. sexual preoccupation) and behavioural (i.e. hypersexuality) facets of PSA which is in line with prescribing protocols for MMPSA (e.g. Grubin, 2017). In addition, as he had previously taken SSRIs for the treatment of depression but had observed no change in his sexual thoughts and arousal, it was felt anti-androgens would be most appropriate. Despite some improvement on this medication, Mr B was still experiencing intrusive sexual thoughts and arousal. Levels of masturbation to orgasm remained high, and masturbation not to orgasm increasing significantly from a pre medication level of zero to seven (T0-T4). After approximately four months, this was increased to a daily dose of 100mg which led to a decrease in all measures of PSA (sexual preoccupation and hypersexuality) from T4 onwards. Mr B remained on this for almost 2.5 years (until T33) and while measures of PSA fluctuated within this period, all measures remained below a score of two and were not considered problematic by the psychiatrist or Mr B. While the medication was considered to be working well in relation to clinical indicators, Mr B had begun to develop gynecomastia as a result of prolonged use of the anti-androgens (this is a documented side effect of this class of medication; Nguyen et al., 2015). As such, at T33 the prescribed dosage was reduced to 50mg. During this period, the scores fluctuated but remained low with Mr B reporting that he still felt he was able to manage his sexual thoughts and arousal. He remained on 50mg for a further 22 months before raising further concerns about the side effects, particularly gynecomastia. As Mr B had been on the medication for over 4.5 years, was experiencing concerning side effects and felt that he could cope without it, it was decided that he would stop all medication. Mr B has now been off the medication for seven months and has shown no increase in measures of PSA during this time, with some continuing to decrease (T55 onwards).

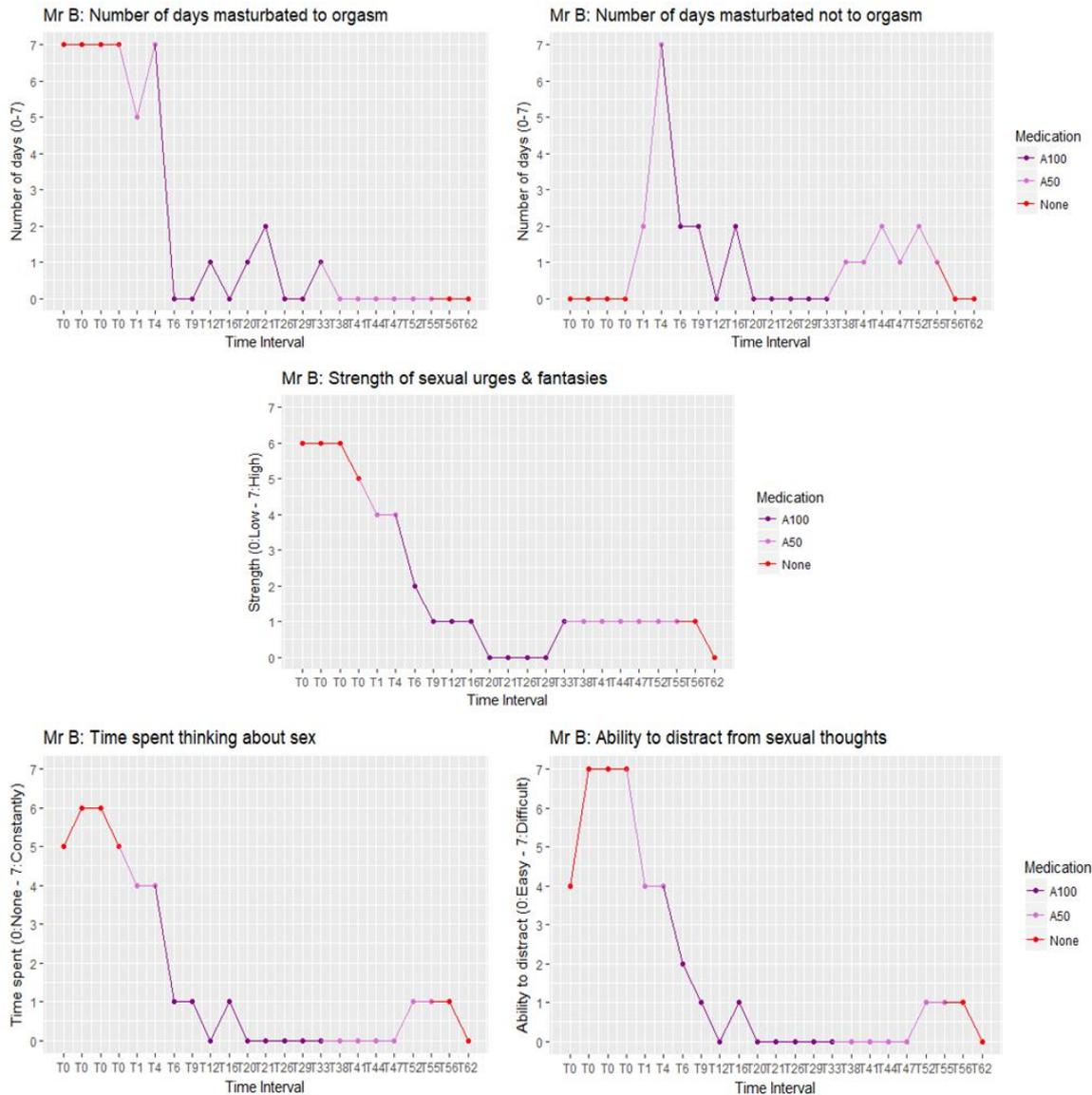


Figure 3. Changes in Mr B's clinical indicators of PSA

Mr B's case demonstrates an example of anti-androgens (Androcur) having the desired effect of reducing all levels of PSA (hypersexuality and sexual preoccupation). This allowed Mr B to engage effectively in HSP and develop effective coping mechanisms and strategies to manage his sexual thoughts and arousal independently so he was able to successfully withdraw from the medication.

Stabilised scores of one or zero across a range of measures indicate that Mr B still has some sexual thoughts but that these are manageable, being low in strength and easy to distract from. These are positive effects of the medication, in that they reduce the intensity of sexual thoughts while still allowing an acceptable amount to be experienced. However, self reported scores related to masturbation behaviours indicate that Mr B struggles to masturbate to orgasm after beginning the medication. This is demonstrated through the fluctuations in levels of masturbation not to orgasm,

where masturbation is attempted, but orgasm is not achieved. This is concerning as, as stated previously, the aim of the medication is to reduce inappropriate or problematic sexual thoughts and behaviours while still allowing individuals to maintain a healthy level of sexual functioning (Bradford, 2001). Thus, removing the capacity for sexual outlets could impact on the individuals wellbeing, with sexual satisfaction being considered a primary human good (Ward & Marshall, 2004). While this may not have been problematic for Mr B thus far, and he is no longer on the medication, this could present concerns for the future. Such problems may lead to increased fantasies, sexual frustration, and non-compliance (e.g. stopping the medication in order to achieve orgasm or engage in future sexual relationships), as has been demonstrated in others receiving MMPSA (see Chapters 5 and 6).

Pathway 3: Progression pathway

Pathway 3 (*the 'progression pathway'*) involves the deviation from either the SSRI pathway or anti-androgen pathway due to a lack of desired effect of the medication on service users' experienced levels of PSA, and thus a progression to a stronger medication class (i.e. anti-androgens or GnRH), potentially alongside SSRIs / anti-androgens. While there may be additional dosage adjustments or further progression, individuals on this pathway will remain on a stronger medication class than they were initially prescribed until the medication is no longer needed. A change in medication (i.e. back to the original or lesser medication class) would result in a change of pathway.

Individuals on this pathway either observed no effect as a result of their initial prescribed medication, observed some effect but felt that this was insufficient, or observed an effect in only certain measures of PSA (as illustrated within the below case example and participant narratives in Chapter 6). This is in line with the literature and guidance, for example, on the use of SSRIs as a form of MMPSA which suggests that we might expect individuals taking this to demonstrate more prominent improvements on measures of sexual preoccupation and compulsivity (the psychological aspects of PSA) rather than measures related to hypersexuality (the behavioural aspect of PSA). However as demonstrated in the wider evaluation data (Winder et al., 2014; 2018), the narratives in Chapter 5 and the case examples here, it is clear that SSRIs do have a positive effect in reducing measures of hypersexual behaviour. Nonetheless, the decision to progress an individual from their initial prescribed medication to a stronger class of medication (e.g. SSRIs to anti-androgens) may therefore be based on a number of key indicators. There may, as indicated above, be a lack of (clinically sufficient or subjectively perceived) improvement on measures of PSA which would lead to an increase in the initial medication dosage, followed by a progression to an alternative medication class if sufficient improvements are not observed. However, the subjective nature of PSA must also be acknowledged here in that even when measures of PSA are reduced, these may still be viewed as

being unmanageable or problematic by the service user experiencing them (as highlighted by the participant narratives in Chapters 5 & 6). Drawing on theories of control and self-determination, people are more likely to comply with certain restrictions on their liberty or maintain engagement with treatment for both physical and mental health problems when they feel that they are involved in the treatment planning and that their voices are being heard (e.g. Thompson & McCabe, 2012). This occurs by increasing their sense of ownership and competence over taking control of their treatment goals (Ryan & Deci, 2006; Teixeira et al., 2012). As such, careful and collaborative monitoring of the clinical effects of MMPSA and their associated effects is of paramount importance when managing people taking these medications and encouraging long term compliance. Once on a stronger class of medication (e.g. anti-androgens), the concerns regarding the use of this medication highlighted within Pathway 2 become relevant, and individuals on this pathway should therefore be closely monitored in relation to the effects experienced and potential impact upon treatment compliance too. Within this pathway there may be a clinical decision for individuals to pause the medication to allow safe and successful movement onto another medication class, however the intention to continue taking the medication remains and thus this does not constitute drop-out. While there are too few participants currently on this pathway to conduct meaningful statistical analysis (this is because being on this pathway represents a stage further along the treatment journey for those on it, having started on one medication class and then being assessed as needing some medication change), the trends in relation to clinical outcomes of sexual preoccupation (pre medication $M = 5.55$, $SD = 0.92$; most recent measure $M = 2.24$, $SD = 2.19$) and hypersexuality (pre medication $M = 4.65$, $SD = 2.65$; most recent measure $M = 0.90$, $SD = 1.60$) appear promising.

Case example: Mr C

Mr C is in his mid 40s and of white British nationality and has mild intellectual disability according to his IQ level (WAIS score = 63). At the age of 17, Mr C was sexually assaulted by a family member.

Offending information

Mr C has a total of six convictions for 29 offences, with five of these being for sexual crimes. His previous sexual convictions were for sexual assault of male under 16, shameless indecency and gross indecency in public. Mr C received his current conviction aged 35 for indecent assault on a male under the age of 16 for which he received an IPP. Mr C attributes his sexual offending to a number of factors including: alcohol and drug abuse; feelings of boredom and loneliness; his sexual attraction to children; lack of sexual relationships; and the enjoyment that sexual contact and offending gave him. According to the RM2000 Mr C has a low risk of violent reoffending and a very high risk of sexual

reoffending, with the SARN highlighting a number of areas of concern: sexual preoccupation (OC, G), sexual preference for children (OC, G), sexual entitlement (G), child abuse supportive beliefs (OC, G), believing women are deceitful (OC), inadequacy (OC, G), grievance thinking (OC), lack of emotional intimacy (OC, G), lifestyle impulsiveness (OC, G) and poor problem solving (OC, G).

History of PSA

Mr C has a sexual preference for children between the ages of 4-13. He reports thinking about sex daily, finding his sexual fantasies overwhelming. This sexual preoccupation was present in the lead up to his sexual offending, with his drinking also exacerbating his sexual fantasies and leading to a lack of control. Mr C has reported that sex makes him happy, which is what led him to seek this at the time of his index offence.

Mr C reports being in one serious relationship with another male which lasted for four years, before breaking down due to his current conviction. He reports that both he and his partner were unfaithful, acknowledging that he regularly engaged in sexual activity with other men, and was also being paid for sex.

Treatment journey

Mr C has completed a range of psychological treatment programmes while in prison including Adapted SOTP, ABLB, Enhanced Thinking Skills (ETS) and HSP. During his ABLB course Mr C disclosed thinking about sex with children and masturbating every night, which indicated that the strategies he was learning were not strong enough to properly challenge his sexual arousal and thoughts. This led to a referral for medication by a psychologist. Mr C has also since completed HSP, and while both he and the programme facilitators felt that he benefitted from this, he often struggles to remember what he has learned so will need to keep referring back to this and ensure he uses the management strategies and techniques he has been given. Mr C's medication journey is summarised below and discussed in detail alongside graphical data (Figure 4).

***Fluoxetine 20mg → Fluoxetine 40mg → Fluoxetine 20mg → Fluoxetine 40mg → Paused →
Androcur 50mg → Androcur 100mg → Androcur 50mg***

Mr C was initially prescribed a daily dose of SSRIs (Fluoxetine) 20mg, following which he experienced decreases in all clinical measures reported here, aside from ability to distract from sexual thoughts, which remained the same. Shortly after starting the medication, Mr C commenced HSP and reported struggling with the requirements of the course and increased focus on his sexual thoughts and

masturbation and requested that the dosage be increased to 40mg for the duration of his engagement in HSP. This increased dosage led to further decreases in clinical measures, or a maintenance of the scores already achieved through his 20mg dose. The most notable change was with his ability to distract from sexual thoughts which decreased from a score of seven to a score of zero. Once HSP was completed, the dosage was returned to 20mg of Fluoxetine (T7), however, shortly after this reduction, measures of PSA (aside from masturbation not to orgasm) largely increased (T7-T10) to pre-medication levels. This led to a return to his 40mg dose and decreases were seen once again. Despite these reductions, the extreme fluctuations in scores between dosage changes, and inappropriate behaviours being observed and reported by staff, led to the decision that anti-androgens may be more appropriate to better manage his sexual thoughts and arousal. Mr C paused all medication for a period of time due to complications with other medications which resulted in an observed increase in all measures except masturbation not to orgasm (T13-T15), before beginning a daily dose of anti-androgens (Androcur) 50mg at T15. As such, his gap in medication was not a cessation of treatment, but rather a necessary pause in order to allow the safe and effective switch from SSRIs to anti-androgens to take place, alongside his other medications. This led to a reduction in measures over the first four months, with all scores reaching zero, however by T31, after being on Androcur 50mg for approximately 16 months all scores had again increased, with Mr C reporting difficulty managing his sexual thoughts and arousal, resulting in a dosage increase to 100mg. Mr C remained on this for approximately ten months before requesting a dosage decrease due to concerns regarding side effects, particularly gynecomastia. The dosage was decreased to Androcur 50mg (T41) and he remained on this for approximately six months before moving to a category D establishment and while he intended to remain on this, it is unclear whether he did so.

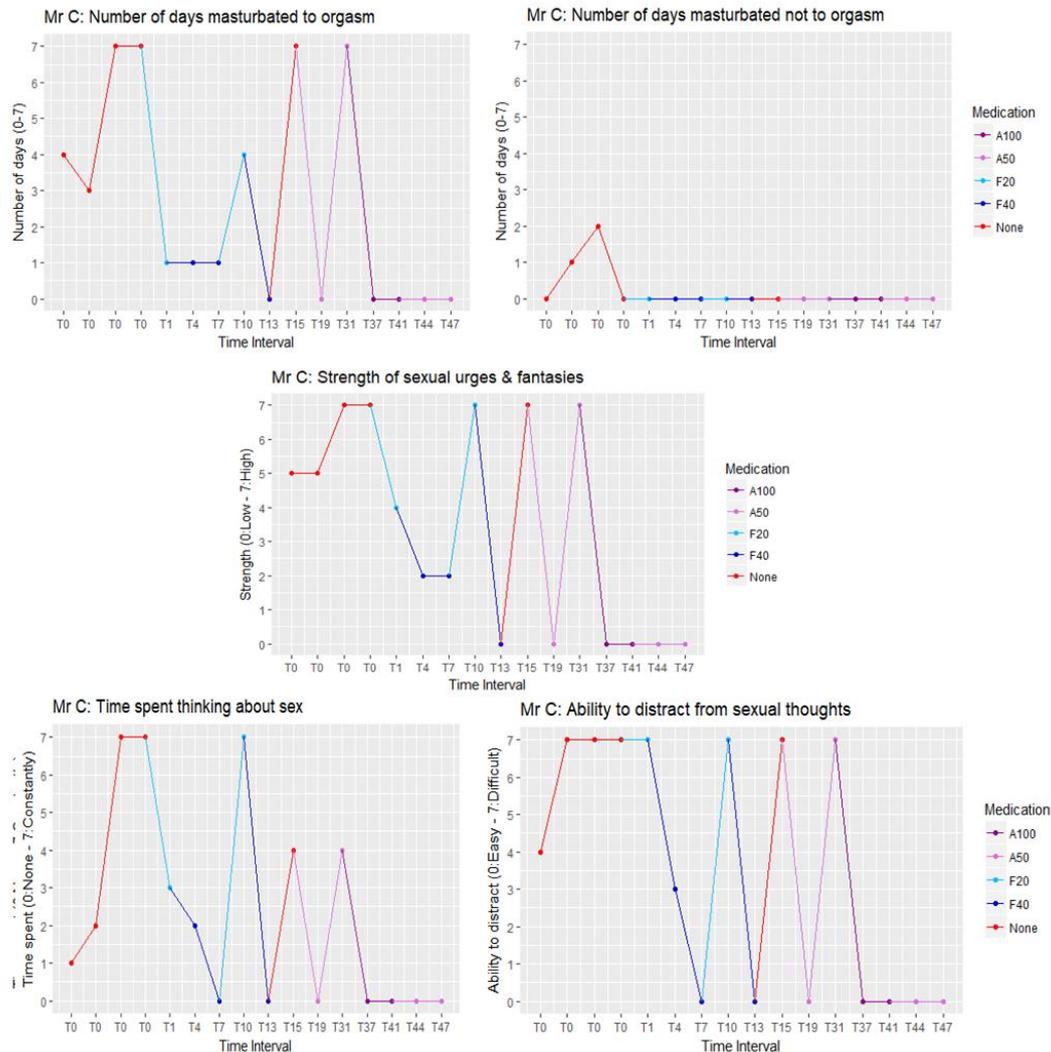


Figure 4. Changes in Mr C’s clinical indicators of PSA

Mr C’s case demonstrates an example of dosage adjustments and a progression from SSRIs to anti-androgens to sustain prolonged improvements in the management of PSA. This case clearly illuminates how these decisions and processes are not simply based on reported levels of problematic arousal, but instead need to take account of other demands and factors that could contribute to this, in this case for example, engagement with HSP. The combined engagement in HSP alongside medication in this case was problematic, with the aims of HSP requiring individuals to focus on developing healthy sexual fantasies and incorporating the use of directed masturbation. Naturally, engagement in this process increased scores across the clinical measures and so the understanding the context of this is key to determining the extent to which this is problematic. In such cases, the aims of HSP and the medication could indeed be competing against each other and so this is something to must be carefully monitored and managed as in this case. Furthermore, it is also possible that the use of the medication may prevent active engagement in programmes such as HSP if it impact upon

the ability to gain and maintain an erection, which is a recognised side effect of anti-androgens (Nguyen et al., 2017). In addition, this case highlights how despite a suitable medication being found (Anti-androgen, Androcur, 100mg) to manage levels of arousal, the known side effect of such medications mean that this is not a long term viable option and result in further adjustments in order to manage the undesired effects of the medication.

Pathway 4: Switching pathway

Pathway 4 (*the 'switching pathway'*) involves the commencement of MMPSA using either SSRIs or anti-androgens (pathways 1 or 2 respectively). Due to a lack of desired effect on indicators of PSA, or the experience of problematic undesired effects, adjustments to dosage or medication class are required. Individuals on this pathway experience numerous changes to the medication class (SSRIs, anti-androgens, GnRH or a combination) and dosage until the medication is no longer needed.

This pathway represents a careful process of monitoring and responding to both the desired and undesired effects of the medication in order to find the correct balance for each individual – which for some can involve a complex process with numerous switches (as with the illustrative case example, Mr D). For individuals on this pathway, the 'switching' is often linked to lack of (sufficient) improvement across all facets of PSA. This may, for example, first lead to a dosage increase or a progression from SSRIs to anti-androgens, (or a combination; the progression pathway). Similarly, for individuals on anti-androgens but still observing problems in relation to the psychological aspects of PSA, SSRIs may then be employed to attempt to address these symptoms. These switches are therefore the result of a response to insufficient clinical effect, and represent an attempt to find a medication class or combination and dosage that is suitable in addressing the different facets of PSA for each specific service user. However, alongside this is the need to balance the adverse effects of the medication. For some individuals on this pathway, while the desired effects of reducing PSA may be achieved, this is accompanied by undesired effects of the medication (e.g. gynecomastia or total loss of sexual function associated with anti-androgens; Nguyen et al., 2015), which then result in dosage changes or switching medication class in an attempt to address these, which may in turn result in an increase in PSA. For individuals on this pathway, it is therefore clear that working with the prescribing health professional in order to balance both the targeted and undesired effects through medication and dosage changes is vital in order to find a combination suitable for them. The switching process requires careful monitoring and it is during these transitions that the dual treatment approach of MMPSA and psychological programmes is particularly important. For example, by reducing a dose of anti-androgens in order to reduce the negative experiences of side effects, psychological treatment comes to the fore in order to provide a boost to the treatment process when considering all

interventions as a complete package. As with the progression pathway, there may be a clinical decision for individuals on this pathway to pause the medication to allow safe and successful movement onto another medication class, however the intention to continue taking the medication remains and thus this does not constitute drop-out.

While there are too few participants currently on this pathway to conduct meaningful statistical analysis (due to where participants are in relation to their individual treatment journeys), the trends in relation to clinical outcomes of sexual preoccupation (pre medication $M = 5.75$, $SD = 0.55$; most recent measure $M = 1.69$, $SD = 1.84$) and hypersexuality (pre $M = 3.75$, $SD = 3.78$; last measure $M = 0.50$, $SD = 0.58$) appear promising.

Case example: Mr D

Mr D is in his early 50s, of white British nationality and has an average IQ (WAIS score = 81). Mr D reports being sexually abused as a child by a family member.

Offending information

Mr D has three convictions for sexual offences. First, he received a two year probation order aged 15 for the indecent assault of a six year old female. He was convicted for his second offence aged 36, and received a six year custodial sentence for three counts of indecent assault of a female under 13. Mr D received his current conviction aged 45 for making and possessing indecent images of females under 16 for which he received an indeterminate sentence of imprisonment for public protection (IPP), which he was serving at the time of data collection. According to the RM2000 Mr D has a low risk of violent reoffending and a medium risk of sexual reoffending, with the SARN highlighting a number of areas of concern: sexual preoccupation (OC, G), sexual preference for children (OC, G), child abuse supportive beliefs (OC, G), inadequacy (OC, G), distorted intimacy balance (G), grievance thinking (G), lack of emotional intimacy (OC, G) and poor problem solving (OC, G).

History of PSA

Mr D reports using pornography and masturbating daily from the age of twelve. His first sexual relationship was at the age of 17. He has had a total of seven sexual partners in his life, although five of these were casual or one night stands. He reports having two relationships but was unfaithful throughout both. Mr D reports having regular sexual thoughts about adults and children that he finds difficult to distract from, becoming easily aroused and masturbating several times per day while in the community and in prison.

Treatment journey

Following his second offence, Mr D attended a community SOTP but acknowledges a lack of motivation and engagement in this, committing a further offence shortly after completion. During his current sentence, Mr D has participated in all suitable treatment programmes (i.e. Enhanced Thinking Skills, Becoming New Me, and Adapted Better Lives Booster), with reports demonstrating that he has engaged well and developed an understanding of his offending.

Mr D was referred for MMPSA by a programmes facilitator due to self reported difficulties managing his sexual urges. His medication journey is discussed in detail alongside graphical data below (Figure 5).

***Fluoxetine 20mg → Fluoxetine 40mg → Fluoxetine 20mg & Androcur 50mg → Androcur 50mg →
Fluoxetine 20mg & Androcur 50mg → Androcur 100mg → Androcur 50mg***

Mr D was initially prescribed a daily dose of SSRIs (Fluoxetine) 20mg. While he experienced some decrease in reported levels of the more psychological aspects of PSA (T0-T1), this was considered to be insufficient and the dosage was subsequently increased to 40mg (SSRI; Fluoxetine) after approximately one month. Over the next two months (T1-T3), the reported levels of the clinical measures either remained stable or increased, resulting in the decision to progress to a combination of SSRIs (Fluoxetine, 20mg) and anti-androgens (Androcur, 50mg). This led to a decrease in all clinical measures of PSA (except masturbation not to orgasm which remained at zero) over the next four months (T3-T7) however, by T11 a number of the measures had begun to increase. By this point, Mr D was reporting side effects of tiredness and headaches which were believed to be the result of the SSRIs, resulting in a discontinuation of these from T11, and thus a daily dose of anti-androgens (Androcur) 50mg. Over the next four months (T11-T15), while some measures decreased, his rates of masturbation and strength of sexual urges and fantasies continued to increase, resulting in the decision to return to a combination of SSRIs and anti-androgens at T15. This led to an initial reduction in clinical measures, which then fluctuated over the next eight months (T15-T23) coupled with continued side effects assumed to be associated with SSRIs, Mr D again requested to discontinue the SSRIs. At this point (T23) the dosage of anti-androgens was increased to 100mg due to concerns that 50mg alone had previously been insufficient. He remained on this for 11 months and while clinical scores fluctuated within this period, Mr D did not consider these changes to be problematic. This resulted in the dosage being reduced to 50mg (Androcur) at T34 due to the belief that Mr D was managing his arousal well. Mr D had been on this for approximately 20 months, with the clinical

measures decreasing and stabilising at a manageable level over this period, when he was released into the community with the intention to continue the medication.

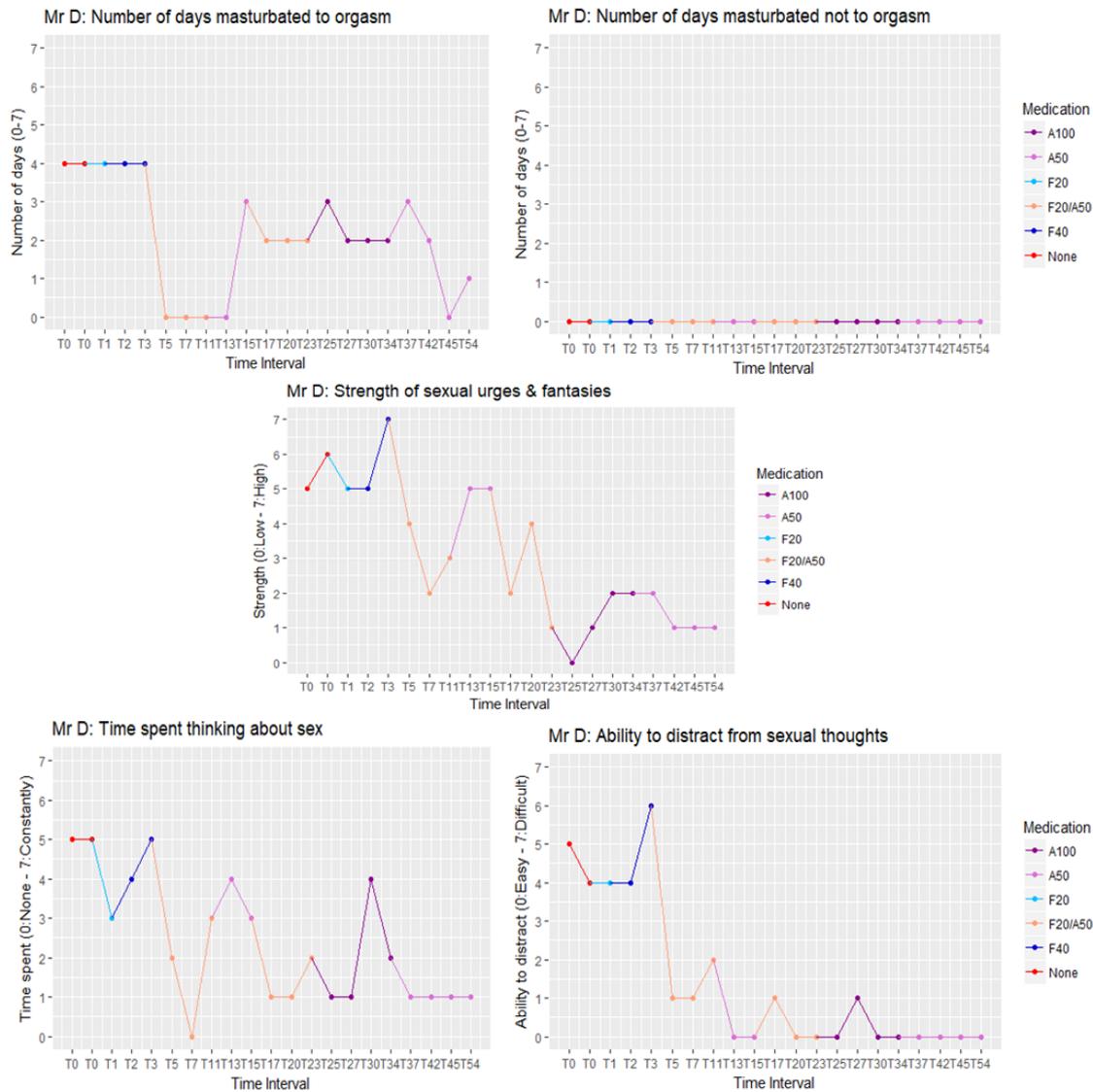


Figure 5. Changes in Mr D’s clinical indicators of PSA

This case demonstrates an example of the need to make frequent adjustments to both medication class and dosage in order to balance the desired effects on PSA, alongside the undesired effects of the medication. Mr D embodies this switching approach with six ‘switches’ over a 54 month period since his initial prescription of SSRIs. As can be seen in Figure 5, indicators of his PSA were unaffected by MMPSA until anti-androgens were added to his prescription. However throughout his treatment journey was characterised by repeated switching between various combinations of medication class and dosages. This constant switching in the absence of substantial movements in indicators of PSA indicates the result of careful monitoring on the part of the professionals charged with managing

individuals like Mr E. While the effects of MMPSA of clinical indicators of PSA appear to be driven by the presence of anti-androgens, these are accompanied by the negative side effects reported elsewhere in this chapter and in the broader literature (see Nguyen et al., 2015). In balancing these positive and negative effects in collaboration with the individual taking MMPSA, it is possible to work together in relation to acknowledging the achievements of the medication in bringing PSA under control. On stronger MMPSA (e.g. doses of CPA at 100mg) there will naturally be experiences of side effects that play a role in the motivations of individuals taking such medications to continue to engage in treatment (as described in Chapters 5 and 6). This is where we observe reductions in dose, or the attempted incorporation of SSRIs, into the prescription.

Pathway 5: Drop-out pathway

Pathway 5 (*the 'drop-out pathway'*) involves the commencement of MMPSA using either SSRIs or anti-androgens (pathways 1 or 2 respectively). As with the previous two pathways, due to a lack of desired effect on indicators of PSA, adjustments to dosage or medication class may be experienced (thus a move to pathway 3 or 4 dependent on the change). However a lack of desired effect on indicators of PSA, or the presence of unwanted effects (i.e. side effects), leads to individuals prematurely (i.e. before desired effects on PSA have been achieved) ceasing all MMPSA.

The most common reason for this treatment drop-out is related to the undesirable effects of the medication, for example, gynecomastia or inability to achieve or maintain an erection. However, it is acknowledged that when individuals drop-out for this reason, the majority later recommence treatment due to the awareness of a treatment need and will undergo a process of medication adjustments to allow them to manage these effects. Once the treatment re-starts, individuals would then be classified as the 're-entry pathway' (Pathway 6; see below).

Regarding drop-out that is related to a lack of desired effect on indicators of PSA, it is acknowledged that there is no biological explanation as to why MMPSA should not have some effect on clinical indicators of PSA. This is particularly the case for those receiving anti-androgens or GnRH which directly affect levels of testosterone, and thus a sufficient dose would eliminate physical arousal (Thibaut et al., 2010; Winder et al., 2019) and should therefore impact upon the clinical measures of PSA related to hypersexuality. Of course, any statistical lack of treatment effect could also be linked to the specific measure used (i.e. days masturbated, rather than total sexual outlets). That is, two individuals could be masturbating every day, but one may have reduced this activity from 10 times per day to just twice whereas the other has maintained a steady level of one sexual outlet per day. Both participants would be recorded as having no change on the current measure of hypersexuality. However, the first would be a false negative, as their total number of sexual outlets has actually

reduced substantially. As such it is suggested that the lack of any true treatment effect observed within this pathway (i.e. a clear lack of reduction in hypersexual behaviour) instead reflects a lack of motivation or full active engagement in the treatment process, rather than a lack of medication effect.

As indicated within the previous pathways, in order to achieve the desired effects, several adjustments to medication class or dosage may be required. Individuals on this pathway may not fully engage with this process, and instead may choose to discontinue the medication without allowing for the necessary changes to the medication or before allowing sufficient time for improvements in PSA to be observed (as in the below case example of Mr E), thus presenting a premature discontinuation which may be related to motivation or readiness to change. As highlighted at various points within this thesis, there is a substantial evidence base from within the medical, health, and forensic psychological literatures that people who are intrinsically motivated to change their behaviour are more likely to engage with treatment and sustain this level of engagement over an extended period of time (Göbbels, Ward, & Willis, 2012; Ng et al., 2012; McMurrin & Ward, 2004; Vancampfort et al., 2015). The limited engagement with MMPSA and quick discontinuation of the medication after no immediate changes in clinical measures of PSA observed within this pathway may reflect a lack of intrinsic motivation and instead indicate an extrinsic motivation for initially agreeing to MMPSA (e.g. wanting to show parole boards that they are doing 'something' to reduce their risk; see Chapter 6). Conversely it could simply indicate that the person taking MMPSA is not yet at the stage of the behaviour change process whereby they are ready to actively engage in treatment. Prochaska and DiClemente's (1983) stages of change model sets out the various stages of change that must be undertaken to make long term shifts in behaviour a reality. Their first three stages are generally preparatory in nature and help an individual to think about their reasons for change, and prepare themselves to actually make that change in their behaviour. Non-continuation of MMPSA might indicate that they are in the pre-contemplative or contemplative stage of change, where they may have identified their PSA as being something causing issues for them, but do not have a clear plan or desire to change this. In these cases, moving these individuals into the 'preparation' stage of change (where they consciously make a decision and a plan to change – like the 'decisive momentum stage of the ITDSO; Göbbels et al., 2012) should be an initial treatment target. In practice this corresponds to addressing readiness to change as an initial treatment target in the psychological treatment of ICSOs, with this being a key predictor of treatment engagement and success (Ward, Day, Howells, & Birgden, 2004).

While there are too few participants currently on this pathway to conduct meaningful statistical analysis (due to where participants are in relation to their individual treatment journeys), the clinical outcomes of sexual preoccupation (pre medication $M = 4.34$, $SD = 1.67$; most recent

measure $M = 3.97$, $SD = 1.07$) and hypersexuality (pre medication $M = 4.06$, $SD = 3.27$; most recent measure $M = 3.33$, $SD = 2.94$) do show some reduction over time, although to a much smaller degree than the other pathways.

Case example: Mr E

Mr E is in his early 30s of white British nationality and has an average IQ (WASI score = 91).

Offending information

Mr E has a total of three convictions for sexual and violent offences. Aged 22 he was arrested for his first sexual offences and received two convictions. The first was the result of a series of assaults occasioning actual bodily harm (x9) and battery (x2) on his partner over a two week period. Six counts of rape associated with this also lie on file, for which he was not convicted. The second was for sexual assault of a male child under 13 (his son) and for the possession of extreme pornographic images involving animals. At the time of data collection, he was serving an IPP sentence for these offences. Mr E reports having had violent thoughts and fantasies about killing people since the age of 10 and his violent behaviour commenced around the age of 13. He states that he uses violence so as not to appear weak and that this behaviour is often in response to perceived rejection or feeling humiliated. According to the RM2000, Mr E has a high risk of both sexual and violent reoffending. In addition, he demonstrates a high risk of violence towards his partner and others according to the Spousal Assault Risk Assessment (SARA). A SARN was not available at the time of data collection. While in prison, Mr E has received a number of adjudications, including possession of images of bruised and battered women, pornography, unauthorised medication and various incidents of bullying.

History of PSA

Mr E reports engaging in sexual activity with his partner between one to five times per day. In addition, he would also masturbate up to 15 times per day and reports being easily aroused and having an interest in sexual violence. He reports regularly using pornography, particularly that of an extreme or violent nature (including materials depicting bestiality). While in custody, Mr E reports having constant offence related sexual thoughts and masturbates 10-15 times per day, often waking in the night for this purpose. Despite this, he reports that his sexual thoughts and behaviours are something that he enjoys.

Treatment journey

Mr E has previously completed the Thinking Skills Programme but reports suggest that he gained very little from this with a reluctance to engage and has not yet completed any treatment programmes that are specifically related to sexual offending. Mr E was referred for medication by a psychologist due to reporting high levels of masturbation. His medication journey is summarised below and discussed in detail alongside graphical data (Figure 6).

Androcur 50mg → Androcur 100mg → None

Mr E was initially prescribed a daily dose of Androcur 50mg. This was due to extreme levels of masturbation and offence related sexual fantasies that he found difficult to manage. After approximately one month, there had been no marked improvement, with the measures of PSA remaining the same (T0-T1). After his first month on medication, due to a lack of desired effect Mr E's dosage was increased to 100mg of Androcur, which he remained on for a further four months. However, he reported no substantial changes in any of the clinical measures during this period, with all of these remaining high (save for a small decrease in the amount of time spent thinking about sex (T1-T3)). Throughout the period of receiving medication, Mr E reported numerous side effects that he considered to be unmanageable including weight gain and headaches. As a result of this, and believing that the medication was having no impact on his levels of PSA (as observed in relation to the clinical measures), he subsequently decided to discontinue the medication after five months (the graphs only illustrate three months as Mr E did not attend further follow up meetings).

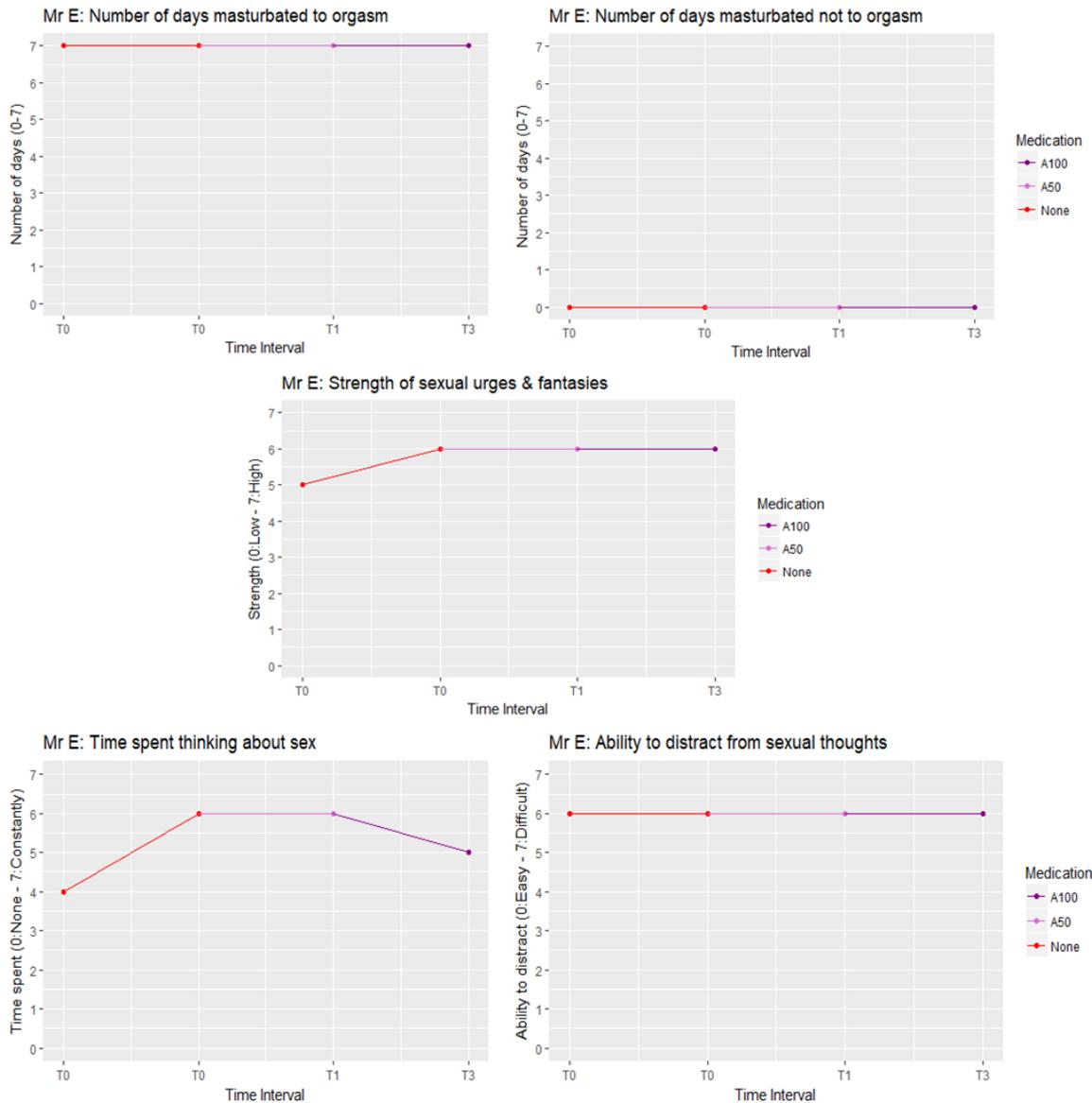


Figure 6. Changes in Mr E’s clinical indicators of PSA

Mr E’s case demonstrates an example of when medication alone is not sufficient to manage high levels of PSA. This may be in part due to the high levels of sexual behaviour and thoughts he was experiencing prior to taking any medication. Although at face value Mr E is reporting the same level of hypersexuality as others in the sample, the framing of the questions used in the clinical measures means that their comparability is limited. That is, for Mr E a score of seven may be indicative of a much higher level of sexual behaviour or thoughts than other participants who also are scoring seven, particularly based on the level of masturbation reported. This is because, for one participant, a score of seven could indicate seven total sexual outlets (i.e. masturbating once per day), whereas for Mr E this could equate to up to 105 outlets (given that he reports masturbating up to 15 times per day). In this sense, the clinical measures themselves may lack the necessary sensitivity to observe the nuance

in these behaviours, even among those exhibiting hypersexual behaviours. This is further discussed below.

Mr E's lack of progress on medication may also be due to his lack of psychological treatment as he has not developed any insight into his offending or awareness regarding the problematic levels of arousal with reports that he enjoys these. As such, it is a possibility that Mr E does not want these to reduce and may instead be taking the medication for alternative reasons, for example, to attempt to demonstrate a reduction in risk to the parole board, which was an extrinsic motivator discussed by individuals taking anti-androgens (see Chapter 6), and are typically associated with lower levels of engagement with treatment. It is also worth noting here that for Mr E, his treatment journey lasted only five months (just three of which were accompanied by clinical observations). This is potentially not long enough to witness significant changes on the types of measures used to examine clinical changes in PSA. At the very least there were no substantial changes in MMPSA dose or class which indicates the rapid discontinuation of treatment at the first opportunity, potentially alluding to a lack of motivation or readiness to change.

Pathway 6: Re-entry pathway

Pathway 6 (*the 're-entry pathway'*) involves the commencement of MMPSA using either SSRIs or anti-androgens (or a combination of the two; Pathways 1 or 2 respectively). Individuals on this pathway may require dosage or medication changes to gain the desired effects on PSA (thus representing a move to pathway 3 or 4 dependent on the change). At some point they choose to cease the medication, either because they reach a level of arousal that they are happy with and feel is manageable and thus feel the medication is no longer needed (completion of pathways 1 or 2), or alternatively, due to the reasons discussed within the drop-out pathway (Pathway 5) above. However, to classify within this pathway, individuals then make the decision to re-start some form of MMPSA due to the recognition that it was a premature discontinuation.

The eventual aim of MMPSA with ICSSOs is to discontinue treatment, allowing individuals to live with an appropriate and healthy level of sexual functioning (Bradford, 2001; Bradford & Kaye, 1999) which corresponds to the 'normalcy' stage of desistance according to the ITDSO (Göbbels et al., 2012). Individuals on this pathway will have observed improvements in the clinical measures related to their sexual thoughts and behaviours while taking MMPSA, leading to the belief that their sexual arousal is no longer problematic, thus choosing to cease the medication. However, for individuals on this pathway, this discontinuation of the medication occurs too soon, and before they are able to appropriately manage their sexual arousal without the medication, leading to an increase in symptoms and thus return to the medication. This act of the premature discontinuation of medication is apparent

within the broader health literature. For example, it is a well documented finding that many people will stop taking antibiotic medications before the end of a treatment course once the symptoms of the infection are no longer present (Beebe, Smith, & Phillips, 2016). The reasons for the early discontinuation of medications are subjective to each individual, but this practice is most commonly related to a perception that the patient is cured of their initial illness (e.g. Branthwaite & Pechère, 1996; McMullen & Herman, 2009). Further, men in particular who are taking medications for hormone deficiencies have been found to have low rates of treatment adherence, with around half of those who prematurely discontinue treatment needing to restart this (Schoenfeld, Shortridge, Cui, & Muram, 2013). In the case of discontinuing MMPSA, it may be that those who no longer experience negative symptoms related to their sexual arousal simply forget the extent to which such symptoms impacted their daily lives (such impacts are well documented in the narratives provided by participants in Chapters 5 and 6). This could map onto the 'preoccupation' facet of PSA. That is once sexual arousal is not a constant part of everyday experience, an individual can focus on other aspects of their life – other interests or activities – making their levels of sexual thinking appear less important or problematic.

This pathway highlights the importance of careful monitoring throughout the process of taking the medication, as well as during and after discontinuing its use for a number of reasons. First it may be that individuals are overestimating the extent to which the problematic aspects of their sexual arousal have improved. This may have implications for whether the medication should be withdrawn, with a potential recommendation from the prescribing health professional to continue the medication if changes in relation to measures of PSA are not deemed to have been sufficient, or with the potential to recommend reducing the medication dosage rather than simply discontinuing its use. Performance and engagement in psychological interventions is also an important consideration for this pathway, with the need for individuals to demonstrate alternative methods of managing PSA without the use of the medication. As such, individuals demonstrating reductions in PSA alongside high engagement in psychological treatment may be better equipped to manage the discontinuation of MMPSA than somebody with the same reductions in PSA but low engagement in psychological treatment. This is due to the development of skills and techniques to identify and manage sexual arousal that are gained through engagement in psychological treatment programmes. Thus, high engagement with psychological treatment may indicate that an individual is better prepared to manage their sexual arousal without the assistance of MMPSA than somebody with lower levels of psychological treatment engagement, thus reducing the likelihood of relapse.

Once the decision to discontinue the medication has been made, this should be undertaken in a controlled way in order to monitor any signs of potential relapse (e.g. return of symptoms of PSA)

and the individuals' ability to manage these without the medication. Within the current sample, all incidents of PSA relapse have been effectively managed due to the ability of service users and professionals to recognise the return of symptoms, it occurring in a controlled and therapeutic environment, and the relatively straightforward availability of the medication, meaning that individuals could return to the MMPSA treatment relatively quickly.

The data in relation to clinical outcomes of sexual preoccupation (pre medication $M = 4.98$, $SD = 1.33$; most recent measure $M = 1.48$, $SD = 1.46$; $t(18) = 8.55$, $p < .001$) and hypersexuality (pre medication $M = 3.87$, $SD = 2.69$; most recent measure $M = 0.63$, $SD = 0.96$; $t(18) = 5.64$, $p < .001$) do show that after resuming MMPSA there can be positive results being achieved.

Case example: Mr F

Mr F is in his late 40s, of white American nationality and has an average IQ (WASI score = 95).

Offending information

Mr F has a total of six convictions, two of which are for sexual offences. His first sexual offence occurred when he was 29 for which he was convicted of indecent assault against a female under 14 and received a community sentence. Twelve years later he received his current conviction for 19 counts of rape, indecent assault, and causing a child to engage in sexual activity against his three daughters, all under the age of 16. He was serving an IPP sentence for these offences at the time of data collection. According to the RM2000 Mr F has a high risk of violent reoffending and a medium risk of sexual reoffending, with the SARN highlighting a number of areas of concern: sexual preoccupation (OC, G), sexual preference for children (OC, G), sexualised violence (OC, G), other offence related sexual interests (OC, G), adversarial sexual attitudes (OC), sexual entitlement (OC), child abuse supportive beliefs (OC), believing women are deceitful (G), inadequacy (OC), distorted intimacy balance (OC, G), grievance thinking (G), lack of emotional intimacy (OC, G), lifestyle impulsiveness (G), poor problem solving (OC, G) and poor emotional control (G).

History of PSA

Mr F reports frequent masturbation to images of both males and females from the age of nine, with his first sexual contact with another person aged 12 and regularly engaging in sexual contact with peers from the age of 13. While Mr F reports only two stable relationships. He is open about his past unfaithfulness and his casual attitude towards sex. In being so open, he reports having had over 100 sexual partners which is partly due to working as a prostitute for a short period.

Mr F reports having constant sexual thoughts and becoming easily aroused with a prolonged high frequency of masturbation - masturbating approximately 17 times per day while in the community five times per day while in custody. He reports this to be unmanageable and interfering in daily activities.

Treatment journey

During his current sentence, Mr F completed the Enhanced Thinking Skills and Resolve treatment programmes and engaged with CARATs (Counselling, Assessment, Referral Advice, Throughcare) to address his drug and alcohol misuse prior to referral for medication. He is reported to have engaged well with each of these. During his assessment for SOTP, Mr F disclosed difficulty controlling his arousal and frequent sexual thoughts that he found intrusive and problematic. It was determined that this may impede his ability to progress within a treatment group, and so a referral for medication was made by a psychologist and he did not commence SOTP. Mr F's medication journey is summarised below and discussed in detail alongside graphical data (Figure 7).

Fluoxetine 20mg → None → Fluoxetine 20mg → Fluoxetine 40mg

Mr F was initially prescribed a daily dose of Fluoxetine 20mg due to high levels of PSA, particularly hypersexuality that demonstrated a compulsive element. This dosage resulted in reduced levels of both the psychological (i.e. sexual preoccupation) and behavioural (i.e. hypersexuality) facets of PSA. Despite some fluctuations in relation to his clinical measures of PSA, he remained on this dosage for approximately 12 months before stopping the medication as he felt he no longer needed it. After approximately one month of no medication, Mr F requested to go back onto the medication after reporting increases in relation to all clinical measures since stopping the medication (T10-T13). As such, he was restarted on Fluoxetine 20mg at T13. Mr F remained on this for approximately 19 months, demonstrating a reduction in all measures over the first 10 months (T13-T23). However, towards T32 Mr F noticed an increase in his levels of sexual thoughts and arousal, and his ability to manage these had decreased. This led to an increase in his levels of masturbation. As a result of this, his dosage was increased to Fluoxetine 40mg. This led to all clinical measures decreasing and stabilising at a low level from T32 onwards. Mr F was still on this dosage, and had been for approximately 20 months, at the point of data collection.

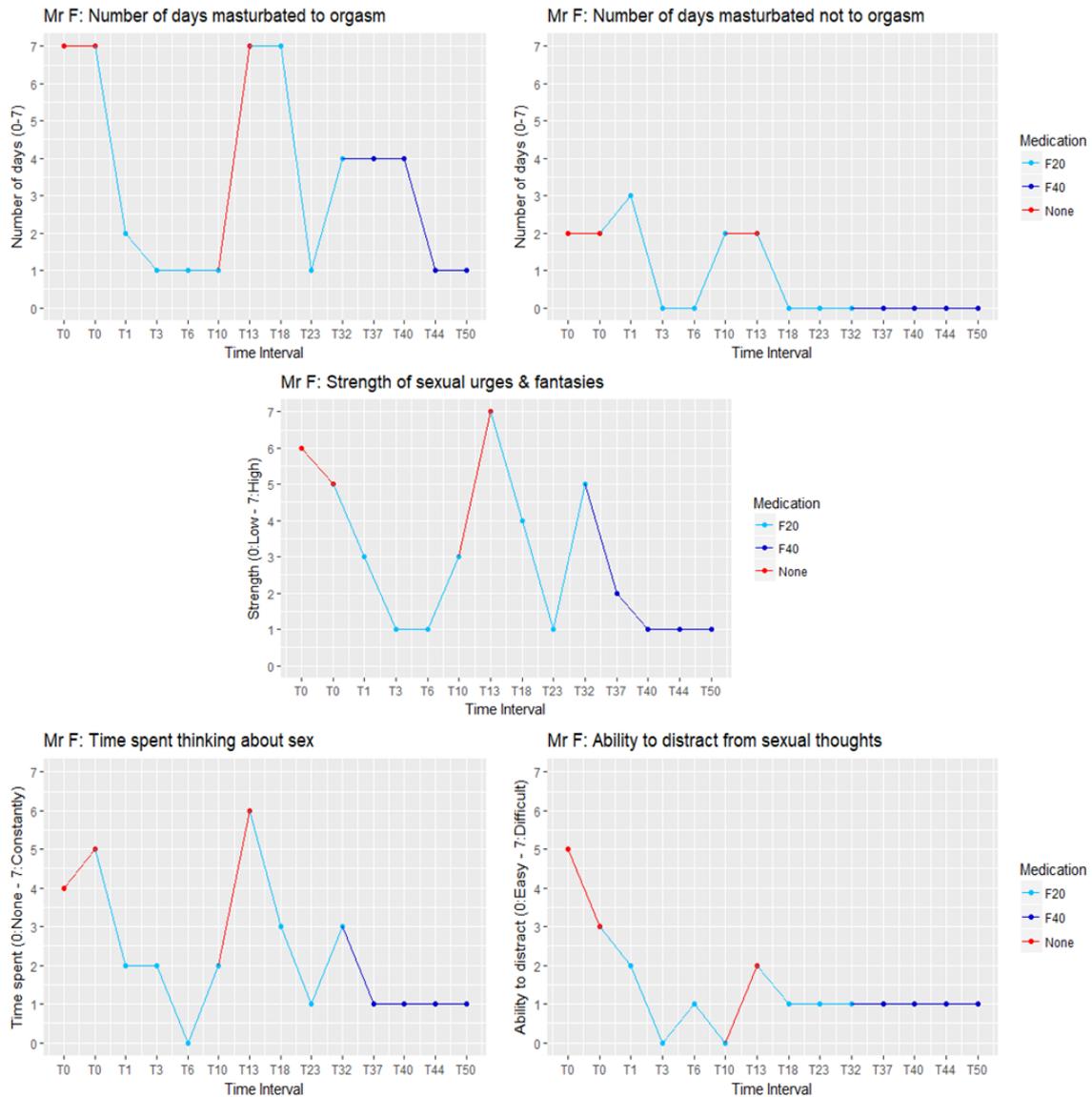


Figure 7. Changes in Mr F’s clinical indicators of PSA

Mr F’s case demonstrates a disrupted journey by stopping the medication prematurely with no intention to resume it. It is often the case in medicine that once the symptoms of a condition have reduced or ceased to be problematic, patients then discontinue treatment (Beebe et al., 2016; Manmohan et al., 2012). It is possible that the same effect is being observed in relation to Mr F. That is, he reported significant reductions across a range of clinical measures of PSA, with these being perceived to be at a low and manageable level for a prolonged period of time. Thus, he felt that this issue was no longer problematic, and that the medication was no longer needed. Once the medication was stopped and the symptoms returned (as observed through marked increases in the clinical measures of PSA) the need for medication was re-established. This may be a reflection of the lack of engagement in psychological treatment, meaning that Mr F has not developed the necessary skills and

strategies to manage his PSA without the need for medication, further highlighting the need for combined psychological and MMPSA treatment.

This relapse was managed without any detrimental impact due to occurring within a prison setting which allowed Mr F to return to medication when needed. However, the possibility of this occurring in a less controlled environment (e.g. in the community following release from custody) could be a cause for concern. That is, in a less controlled environment there is undoubtedly an increased level of exposure to potentially sexual stimuli, as reported in Chapter 2. These stimuli could then trigger an increase sexual thoughts and arousal. With this in mind, it may be advisable that service users such as Mr F receive careful monitoring, not only while they are taking MMPSA, but also after the discontinuation of the treatment. This is in line with recommendations made by Grubin (2018). Further, some degree of communication and joined-up service provision should be encouraged in order to facilitate the easy access of the medication in the community upon release if required.

Discussion

This chapter sought to address the current gap in the literature surrounding MMPSA by examining individual case examples in order to capture the different pathways of MMPSA treatment and gain a clearer understanding of the individuality and complexity that is missed within large scale nomothetic approaches to examine the use of MMPSA. In doing this, six core pathways were identified from the full sample of those receiving MMPSA and have been discussed at length and illustrated using a representative case example in order to highlight the treatment journeys of those receiving MMPSA. This discussion will now consider these pathways in light of the current prescribing guidelines, alongside implications for practice before discussing the relevant limitations.

Reflections on the current prescribing guidelines

According to prescribing guidelines for the use of MMPSA within the UK (Grubin, 2017), direct entry onto anti-androgens is recommended for individuals who demonstrate an exceptionally strong sexual drive, high levels of sexual activity (hypersexual behaviour), or risk related behaviours (i.e. offending related behaviours that are difficult to control) (Grubin, 2017; Winder et al., 2019). However, there is no specific criteria or clear threshold within the guidance for what constitutes an 'exceptionally strong' sexual drive or 'high' levels of sexual activity, or how hypersexual behaviour is operationalised. As such, this process of deciding who meets this criteria relies on the clinical judgement of the prescribing health professional, leading to subjectivity in the decision as to whether SSRIs or anti-androgens are the most appropriate first line option for MMPSA. In some circumstances this may be considered a strength as it allows clinicians to take individual service user preferences and subjective experiences

of PSA into account (see the differences in subjective experiences of participants with PSA in Chapter 6) when deciding between the medication types. However, this may also be problematic and lead to individuals being prescribed anti-androgens with potentially severe side effects (Nguyen et al., 2017; see also Chapter 6 for narrative accounts of these effects) when SSRIs could have the same clinical benefits in addressing all facets of their PSA (as indicated within the current pathways, case examples, and the participant narratives presented in Chapter 5). Furthermore, the guidelines do not consider the prior or current use of SSRIs for co-morbid conditions (e.g. depression) which should be taken into account when making a decision regarding their suitability to be used as MMPSA. This is because a previous or current prescription for SSRIs that has not been accompanied by reductions in indicators of PSA suggests that this class of medication may be insufficient for the individual under consideration, leading the service user to require a stronger class of MMPSA, and thus direct entry to the anti-androgen pathway.

There is inconsistency within the current literature in relation to various prescribing protocols that are used internationally (see Chapter 2). For example, SSRIs are used as a first line of treatment within the MMPSA service for those whose primary clinical indication is sexual preoccupation (Grubin, 2017), as well as for individuals with low level paraphilic interests who are not deemed to be at high risk of reoffending within the WFSBP protocol (Thibaut et al., 2010). In spite of this, other guidance suggests that SSRIs should not be used as a primary treatment option for this purpose as addressing sexual drives can be addressed more effectively with anti-androgens and GnRH analogues (Federoff, 2016; see also Winder et al., 2019). Within the context of the current thesis these contradictions are combined with further concerns in relation to both the aims of treatment and ethical prescribing practices. According to Winder et al. (2019) an aim of pharmacological treatments for PSA is to replace paraphilic interests with alternatives that are not associated with distress, personal impairment, or increased risk of sexual offending. Other protocols have the aim of totally eliminating the capacity for sexual arousal in those who pose the highest risk of sexual offending (Thibaut et al., 2010). From an ethical perspective, there is an argument to be made that the least severe class of pharmacological treatment should be used in order to achieve the required clinical effect. This is particularly important when thinking about the effects of medication on ICsOs (Garcia, Delavenne, Assumpção, & Thibaut, 2013), particularly when sexual satisfaction is cited as being a primary human good (Ward & Marshall, 2004). This consideration of the strengths of the various medication classes (i.e. their effects on physiological sexual arousal) and the subsequent implications that this has on everyday functioning and personal identity is consistent a health based approach to prescribing. That is, contrary to the risk-related aims of the prescribing protocols described above, the goal of MMPSA treatment should ultimately be to prescribe the least potent class of MMPSA for the individual that is needed to help

service users to achieve their personal treatment goals, rather than to over-prescribe a stronger class and titrate this as treatment progresses.

There is thus a need to standardise a coherent and ethical approach to prescribing MMPSA, both in the UK and internationally in line with emerging evidence in relation to both clinical effectiveness and lived experiences of service users taking these pharmacological treatments (Turner et al., 2017). Based on the concerns regarding the current prescribing guidelines and protocols raised here, coupled with the effects of both types of medication on psychological and behavioural facets of PSA as indicated throughout the current thesis and the wider evaluation of the MMPSA treatment service, it is recommended here that all individuals begin their MMPSA treatment journey on the SSRI pathway. There are of course exceptions to this rule, namely where SSRIs have been (or are currently being) prescribed for co-morbid conditions (e.g. depression) but have not been accompanied by changes in PSA - in such circumstances, it is recommended that individuals commence their treatment journey on the anti-androgen pathway as it is already evident that SSRIs are not having the desired effect. This recommendation to commence on the SSRI pathway allows the potential to attempt to address PSA using SSRIs in the first instance, with evaluation results to date demonstrating their positive effects in reducing all facets of PSA (psychological and behavioural; Winder et al., 2014; 2018). While these previous findings have been based on intention to treat criteria (i.e. SSRI grouping in these existing publications was based on initial or primary prescribing practices rather than pathway assignment), analyses of the data here show that those on the SSRI pathway demonstrate a statistically significant reduction on the clinical measures related to rates of masturbation to orgasm ($t(68) = 11.80, p < .001, d_z = 1.42$) and sexual preoccupation (based on an average of the three clinical items used here; $t(69) = 17.18, p < .001, d_z = 2.05$)¹¹. These are broadly in line with the same tests run on the much smaller sample of participants on the anti-androgen pathway (masturbation to orgasm: $t(9) = 3.82, p = .004, d_z = 1.21$); sexual preoccupation: $t(11) = 9.24, p < .001, d_z = 2.67$). In both of these cases the size of the effect of SSRIs on clinical measures of PSA is very large. With this clinical effectiveness established as being in line with the known effects of anti-androgens, and service users who take SSRIs reporting less severe side effects and a great intention to comply with medication in the longer term (as compared to those taking anti-androgens), it may be a logical first step to use SSRIs in the first instance with people experiencing PSA. Where this medication is not sufficient, movement onto the progression pathway should then be considered. This also fits with service user preferences, with a recognition that if making an informed decision, service users would choose SSRIs over other

¹¹ While statistical comparisons of the clinical changes across each of the identified pathways using a factorial (i.e. ANOVA) design would be useful to establish whether these SSRI effects are comparable to the other medications, the subgroup sizes for each of the other pathways are currently unsuitable for this type of meaningful statistical analysis to be undertaken.

treatment options (Bourget & Bradford, 2008) likely due to the potentially severe side effects which are not present with SSRIs. Furthermore, as it is also recommended that all individuals be carefully monitored throughout their MMSPA treatment, this would allow easy monitoring of the effects of SSRIs, and thus if the SSRI pathway is not observed to be effective, changes in dosage or medication class (and thus movement through the pathways as discussed above and illustrated within Figure 8) can be easily actioned until the desired treatment effects are achieved, ensuring that individuals are not confined to particular pathways.

The vast majority of cases could be classified into one of the six pathways identified in this chapter. However, six cases could not be. These cases either started MMPSA on a prescription that combined both SSRI and anti-androgens before either reducing the dosage of anti-androgens or removing this class of medication altogether ($n = 2$), were only prescribed GnRH medication ($n = 2$), had missing information about whether MMPSA was continued during a release from custody ($n = 1$), or was too early in the treatment process for an accurate assessment of the journey to be made ($n = 1$). While the latter two cases are unclassifiable for logistical reasons, there were features of the first four cases that could call into question the comprehensiveness of the six pathways identified above. However, this criticism may be unwarranted when taking into account both the current prescribing guidelines (Grubin, 2017) and the clinical recommendations listed in this chapter discussion, particularly in relation to the potential effectiveness of SSRIs (as a single treatment option) as a first-line approach to MMPSA. That is, those beginning treatment on either a combined prescription of SSRIs and anti-androgens or GnRH medications may represent cases that are over-medicated in the first instance, and thus represent anomalous cases driven by a clinical override decision. This claim is supported through the observation that both cases starting on a combined prescription were titrated to either a lower dose of anti-androgen medication, or the removal of this drug class altogether over the course of their treatment. These cases were also only present in the database at the time of the inter-rater reliability task being completed (May 2019). As such, these case examples are too new to warrant a specific pathway being identified (e.g. these cases may well eventually being classified under the switching pathway). Nonetheless, the potential presence of a potential 'titration pathway' should be considered as the national evaluation develops.

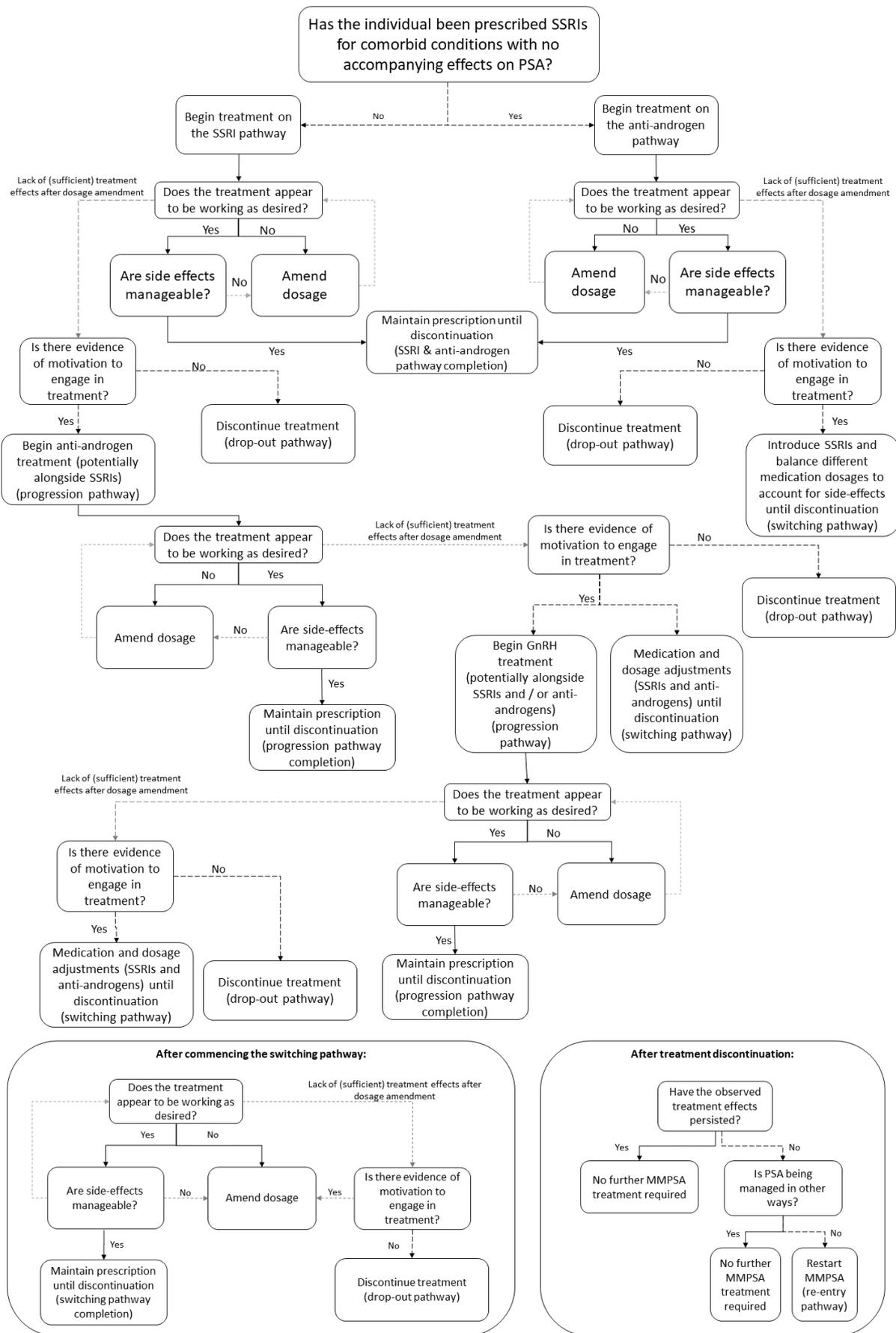


Figure 8. Recommended pathways through MMPSA (solid black arrows = within-pathway decisions; dashed grey arrows = within-pathway assessments; dashed black arrows = between-pathways movement).

Limitations

Despite the advantages of identifying the pathways of MMPSA treatment, and the use of case studies to illustrate these, the data used to produce these pathways are not without limitation. For example, as the research here forms part of the national evaluation of MMPSA (see Chapter 1 & 2), and uses clinical measures that are routinely collected as part of the MMPSA treatment service, there was little control over the collection of data to ensure that it was regular and consistent across the sample. In practice this means that some participants do not have data available for all time points, with the time points being unique to each participant based on clinical need (as they were collected at each meeting with the prescribing psychiatrist) and thus inconsistently spread across the sample. Added to this, from the current data it is not possible to identify exactly when any change in medication was actually started by the participant. This is because the data collected regarding medication class and dosage at the time points indicate what the participant is on at that specific time, and so where a change in medication occurs between two time points we know that the prescription was amended at the first, and was started sometime before the second, but as the time between these meetings may vary between weeks to months, it is impossible from the current data to determine exactly when the new prescription was started. The collection of additional data regarding when prescriptions were collected, and when the new medication was actually started would overcome this.

These inconsistencies in data collection made it difficult to conduct systematic analyses of participants' journeys while taking MMPSA in the case examples provided. This is due to the fact that single case design analysis using either inferential statistics or formal visual inspection methods (i.e. that explore changes in means, levels, trends and latencies; Kazdin, 2011) require systematic, consistent data collection, and clearly defined phases of treatment (Nock, Michel, & Photos, 2007). Not knowing exactly when prescriptions are started, how long medications had been being taken prior to specific data collection points, and the numerous changes in medication class and dosage within the MMPSA data means that discrete treatment phases cannot be accurately identified. Thus this type of detailed analysis – particularly in relation to more time-sensitive issues such as latencies of changes on clinical measures – is virtually impossible to conduct on data of this nature. As such, this study relied on visual inspections of graphical data whereby trends were observed at a global level and interpreted in a descriptive way, and supplemented by participant experience data as reported in the previous empirical chapters. This was also an appropriate approach to use in relation to the aims of this particular study (and the thesis more broadly) as specific ratings of clinical effectiveness were not the outcome being sought. Instead, this study was designed to explore the various journeys and experiences of individuals taking MMPSA in relation to their starting points, navigation through various medications and dosages, and their eventual exit routes away from the treatment.

Not only is the inconsistent nature of data collection an issue to contend with, but the data that is collected may also be too broad to capture the sensitivity in different experiences, and change across different facets of PSA. For example, there have been cases in this thesis where two participants have been regularly masturbating to orgasm seven days per week, but one does so up to 15 times per day and the other just three to four. Both of these participants would score at the top of the scale for hypersexuality using the current clinical measures (i.e. number of days masturbated to / not to orgasm). However, their experience of PSA (and their behavioural manifestations of it) are clearly different in scale. Instead of using 'days masturbated to orgasm', it may be more appropriate to use measures that are more sensitive to the vast differences that may be observed among people scoring the same on the measure used here. This also could have implications for examining treatment effectiveness. It is widely acknowledged that desistance is a long-term process that is made up of many false starts, relapses, and slowly made improvements (Göbbels et al., 2012; Maruna, 2001). With this in mind, it is quite likely that an individual with higher levels of hypersexual behaviour (e.g. masturbating every day up to 15 times) may be slow to move down from this figure of 'seven days'. Nonetheless, their level of masturbation may drop to five times per day, indicating a two-thirds reduction in their overall level of hypersexuality without showing any improvement on the clinical measures used here. Although data regarding 'maximum number of times masturbated in any one day' is now also collected, this again does not give a true reflection of overall masturbation habits, or an accurate reflection of hypersexuality. With this in mind, a measure that looks at total sexual outlets per week may offer more sensitivity to these more subtle changes in behaviour. This would also be consistent with broader theoretical conceptualisations of hypersexuality that are available within the existing literature (e.g. Kafka & Prentky, 1992; Långström & Hanson, 2006; see Chapter 2 for a full discussion of definitions of the key facets of PSA).

Finally, it is important to acknowledge the relatively small sample size for identifying distinct pathways through a treatment option. This is due to an assignment to one of the latter four pathways (progression, switching, drop-out, or re-entry) being contingent on a service user's experiences of either the SSRI or anti-androgen pathway. As such, with the passage of time it is inevitable that numbers on these latter pathways will increase. While the six pathways described in this chapter do seem to have face validity as the only possible journeys through taking MMPSA (when considering logical medication changes and discontinuation routes; e.g. a potential titration pathway), it is possible that other pathways were not represented in this particular dataset, and may be uncovered with a larger sample as the MMPSA service becomes more established as a treatment option for ICSOs with PSA. As such, as larger samples do become available through the national roll-out of the MMPSA service to the broader prison estate it would be advisable to test these pathways against formal

quantitative cluster analysis techniques in order to examine whether they can be identified in a more empirical way, and whether other pathways exist.

Conclusions

This chapter has considered the various pathways through taking MMPSA by ICSOs. In the previous empirical chapters, the *experiences* of MMPSA were considered in depth in lieu of any evidence about their *effectiveness* in relation to addressing clinical indicators of PSA. While the clinical effectiveness of MMPSA for this population has been considered elsewhere (see Winder et al., 2014; 2018), these publications use nomothetic approaches to group ‘SSRI’ and ‘anti-androgen’ users together. While this is useful information to have when looking at how these medications work over time, this approach misses the nuanced treatment journeys that have been identified in the analysis presented in this chapter, and as such may not be fully representative of the range of treatment journeys present with large datasets. By identifying the various pathways through which ICSOs move while taking MMPSA, it is possible to more fully understand the effectiveness of these medications for specific subgroups. This further highlights the importance of a mixed methods approach, bringing together the use of qualitative interviews (Chapters 4-6) and more quantitative analyses of treatment experiences (based on the graphical clinical data that informed the development of the six pathways presented in this chapter).

Overcoming the limitations of nomothetic approaches to data analysis is not the only contribution of this chapter. Combining the above discussion of the pathways with narrative accounts from the participants in Chapters 5 and 6 it is clear that many individuals could obtain the same clinical effects on PSA from SSRIs, as they can from anti-androgens, but with much less severe side effects. This points to a weakness in current prescribing guidelines (Grubin, 2017), which explicitly offers some scope for the direct first line use of anti-androgens when an individual has ‘exceptionally strong’ sexual drive, or ‘high’ levels of hypersexuality (which, further, are not operationalised). As such it is suggested that SSRIs always be considered the first line form of MMPSA, unless in clearly defined exceptional circumstances (i.e. where SSRIs have been prescribed for co-morbid conditions and have not led to meaningful changes in experiences or behaviours related to PSA). This is outlined in Figure 8, which acts as a flowchart demonstrating each pathway’s place within the broader landscape of using MMPSA.

The key message stemming from this chapter is that the nuanced pathways through MMPSA require constant and careful monitoring, and the embedding of the medications into established psychological treatments for ICSOs. The individualisation of treatment journeys, as well as the extent to which they involve collaboration with service users themselves, also correspond to important issues

in the rehabilitation of people with sexual convictions, such as being responsive to individual needs (Gannon, Olver, Mallion, & James, 2019; Lösel & Schmucker, 2015) and fostering personal agency (Göbbels et al., 2012).

As highlighted in Chapter 5, SSRI treatment in particular provides such individuals with the headspace to more actively engage in psychological treatment. The increased effectiveness of this combination in comparison to mono-therapy is supported in the literature (e.g. Guay, 2009; Saleh et al., 2010; Thibaut et al., 2010), as psychological interventions aid the development of practical techniques that help individuals to recognise and manage their PSA, inappropriate sexual interests, and general risk factors for sexual offending over the longer term. These techniques have been identified as key skills that are linked to successful desistance (Buschman & Van Beek, 2003). The development of these skills through psychological treatment also provides a potentially feasible option for individuals to be able to effectively manage their PSA without medication in the future. The pathways identified in this chapter offer clear routes through which to achieve this aim, from the initial prescription to the eventual discontinuation of MMPSA.

Chapter 8

General Discussion and Conclusion

As outlined in Chapter 1, this thesis has presented an element of the evaluation project related to the use of medication for managing problematic sexual arousal (MMPSA) among people convicted of sexual offences in the UK. While other work within the evaluation has examined the clinical effectiveness of these medications on indices related to problematic sexual arousal (PSA) (Winder et al., 2014; 2018), the central aims of the work here were to provide a rich, in-depth exploration of the lived experiences of men taking MMPSA. Specifically it aimed to:

- Gain insight into the development, awareness and management of PSA in individuals taking MMPSA
- Understand the lived experiences of individuals taking MMPSA who are convicted of sexual offences
- Explore the nuanced pathways of the MMPSA treatment that these individuals must navigate

In addressing these aims, the thesis also sought to explore the potential implications of these experiences in relation to the use of MMPSA with individuals convicted of sexual offences (ICSOs). This is embedded within the discussion of each of the previous three aims. Specifically, the research was guided by a series of questions related to these aims. These were:

- What contributes to the development and awareness of PSA in ICSOs?
- How do ICSOs manage their PSA prior to and during MMPSA treatment?
- What are the experiences of living with PSA for individuals taking MMPSA?
- What are the lived experiences of taking MMPSA?
- Do the experiences of individuals taking MMPSA differ based on medication type?
- What are the nuanced pathways of MMPSA for individuals that are taking it?

While these questions were designed to guide and provide structure and coherence to this thesis, due to the exploratory nature of the research, the purpose was never to provide a definitive answer to any of these but to instead provide an exploration and understanding of the lived experiences of individuals taking MMPSA.

This chapter brings together all of the results reported in the thesis. It starts by offering a discussion each of the research aims (and thus the research questions associated with each aim),

before placing these findings within a broader model of desistance from sexual offending. It then provides some recommendations for the use of MMPSA with ICSOs, along with a discussion of the contributions of the thesis itself.

Addressing the aims of this thesis

Research aim one: To gain insight into the development, awareness and management of PSA in individuals taking MMPSA

In Chapter 4 it was identified that participants' early experiences of sex and sexuality were often either negative (e.g. they involved direct experiences of sexual abuse) and / or were not accompanied by adequate sex education (e.g. when pornography was introduced early in adolescence). These experiences set in motion a cyclical process of losing and gaining control of sexuality and the emotions that accompany this, with participants developing unhealthy sexual beliefs as a way to rationalise or justify their escalating levels of sexual arousal. That is, some participants began to develop implicit theories that served to, for example, normalise adult-child sexual relationships, or consider sexual interactions (both consensual and those that constituted sexual offending) an appropriate way of displaying emotional intimacy with another person (Ward, 2000; Ward & Keenan, 1999). There was sometimes a lack of acknowledgement that such early experiences were abusive, in line with prior research on male victims of sexual abuse (Cook, Gidycz, Koss, & Murphy, 2011; Peterson & Muhlenhard, 2004). This reconstruction of abuse experiences, and the embedding of these beliefs into one's identity, may go some way to explaining the development of deviant or problematic levels of sexual arousal in the participants here. This is particularly the case when their PSA involved unhealthy sexual interests. However, these experiences were also accompanied by feelings of shame and embarrassment – emotions that are consistent with the broader literature on male victims of sexual abuse (Romano & DeLuca, 2001; Turner, Tallieu, Cheung, & Afifi, 2017). The emotional incongruence brought about by this feeling of helplessness may have been particularly heightened among the participants here within the context of masculine social norms (Easton, Renner, & O'Leary, 2003). That is, the participants were battling between not acknowledging their own abuse as a method of coping with these experiences alongside the normal trauma based expression of negative emotion, all within a social context that glorifies male strength, independence and control within the sexual domain (Lamb et al., 2018; Mahalik et al., 2003).

Alongside this confusion about abuse experiences, engagement with pornography without adequate sex education facilitated the development of paraphilic sexual interests consistent with violent, objectifying, and otherwise deviant themes that underpin much online explicit material (Albury, 2014; Häggström-Nordin, Sandberg, Hanson, & Tydén, 2006; Peter & Valkenburg, 2010;

Štulhofer, Buško, & Brouillard, 2010; Træen & Daneback, 2013). These interests served as a basis for fantasy engagement and masturbatory stimuli as participants aged and began to use these behaviours as a way of self medicating against emotional dysregulation (Bancroft & Vukadinovic, 2004; Brewer & Tidy, 2019; Hughes, 2010), fuelling a sexhaviour cycle where negative emotion was soothed by masturbation and sexual activity, which in turn strengthen increasingly problematic levels of sexual arousal (Walton, Cantor, Bhullar, & Lykins, 2017).

Participants discuss how they sought to regain control over their sexual arousal by considering the various functions that sex can fulfil. They began to realise that sex was not purely a physical act allowing them to experience gratification, but also can enable them to feel close to others. While there is evidence in the sexological literature that this trend of men placing an increasing importance on the emotional aspects of sexual interactions as they age being normal (Carpenter, Nathanson, & Kim, 2009), for participants here this new found function of sex allowed them to discover a way to relieve negative emotional experiences in a way that they had not previously known.

Attempts to regain control (over negative emotions, as well as sexuality more broadly) were initially successful, but led to escalation in a number of domains (e.g. intensity and deviance of sexual thoughts and behaviours, masturbation frequency, and seeking out of sexual partners, and sexual offending), to reach a point where 'something had to change' (P. 19) due to the negative effects that PSA was having on participants' lives. The realisation that they could lose something that they found valuable (e.g. an intimate relationship), and this acting as a catalyst for change, is consistent with Sampson and Laub's (2005) developmentally based ideas around turning points encouraging desistance from criminal behaviour, with ICSOs (as is the population here) looking to reconstruct their identities in response to a change in life circumstances. This process of identity change correlates with a shift in life scripting. That is, Maruna (2001) spoke about the distinction between individuals living a 'condemnation script' and 'redemption script'. Those men who do not have a reason to change, or perhaps do not have the motivation to do so, are said to adopt a condemnation script and perhaps see themselves as "doomed to deviance" (Maruna, 2001, p. 72; see also Maruna & Copes, 2005). In contrast, men who are motivated to change and who orient themselves towards developing a new identity are said to adopt a redemption script, where they set out to improve themselves and move towards a crime-free life (Maruna, 2001).

While the traditional view of turning points relate to concrete changes in the lives of people who are working to desist from crime, this process took on a different form for the men here with PSA. Instead of life gains that they had made encouraging them to maintain positive behaviour (as is the standard criminological turning points approach outlined above), the individuals in this sample decided to change their behaviour after losing something of value. Insights from operant conditioning

(Skinner, 1938) can be used to explain this distinction in behaviourist terms. That is, the standard turning points approach works on the basis that behaviour change operates on the principle of positive reinforcement (i.e. the introduction of a positive stimulus, such as a new relationship or job, encourages positive behaviour in the form of desistance from crime). In contrast, behaviour change here in men with PSA was motivated by the [potential] loss of something positive. This could be related to a sensitivity to loss. That is, their initial escalation into PSA was based around regaining control over the sexuality that they had lost through abuse experiences. However, this quickly led to them losing that control through an appetitive process of hedonic habituation (Koob, 2009; 2011) and identity reinforcement (exemplified by participant 13 in Chapter 4 stating 'I had to have a place within that group and so once I found that position of, I suppose the person that just goes and sleeps with everybody').

As highlighted previously in this thesis, there is a vast amount of evidence from research in a range of topic areas that people who are intrinsically motivated to change are more likely to engage with treatment and sustain this over time (Göbbels, Ward, & Willis, 2012; McMurrin & Ward, 2004; Ng et al., 2013; Vancampfort et al., 2015). As such, these naturally occurring turning points provide an initial intrinsic motivation for engaging in formal treatment in relation to managing PSA. Despite having some recognition of the problematic nature of their patterns of sexual arousal, participants in this thesis did not have the necessary skills to effectively bring this under control. This led to them consenting to move onto MMPSA as an initial step to changing their behaviour, and thus beginning to distance themselves from their existing identity which was tied in with PSA and sexual offending. The effects of MMPSA on this management process is discussed in the next section.

Research aim two: To understand the lived experiences of individuals taking MMPSA who are convicted of sexual offences

Chapters 5 and 6 of this thesis presented the accounts of ICSOs who were taking different forms of MMPSA. While there was some overlap between the experiences of those taking SSRIs (Chapter 5) and anti-androgen medication (Chapter 6), there were also some striking differences. This warranted separate analyses of each of these groups in order to understand the unique experiences of individuals taking these different classes of MMPSA. The all-encompassing nature of PSA (identified in Chapter 4) led to the internalisation of a sexually preoccupied identity in participants in this research. For many, the taking of SSRIs helped them to become 'human' rather than somebody who was driven by their excessive and problematic levels of sexual arousal. This effect allowed them the headspace to engage in more meaningful activities which is important as having a range of prosocial activities to distract from both experiences of emotional dysregulation and motivations / triggers for offending behaviour

is an important concept related to desistance from crime (Ward & Stewart, 2003). That is, having 'excellence in play' develops a sense of personal agency and choice in what one can do in life, as well as opening up opportunities to engage with other people and rehearse interpersonal and emotion regulation skills that are obtained in more formalised treatment settings (Ward & Gannon, 2009; Williams, 2019). Although perhaps a by-product of the use of SSRIs (which traditionally are used as a form of mood regulator or anti-depressant; Jakubovski, Varigonda, Freemantle, Taylor, & Bloch, 2015), participants taking this class of MMPSA reported more profound positive effects on their emotional wellbeing. Feeling happier within themselves meant that previous problematic patterns of sexual behaviour as a form of self medication were not needed by this sample, allowing them to focus on the aforementioned other activities and maintain their new levels of emotional stability. Not only is this positive from a wellbeing perspective, but also from a specific treatment perspective with PSA often being brought about by a reliance on sex as an emotional coping strategy (e.g. Bancroft & Vukadinovic, 2004; Cortoni & Marshall, 2001; Hughes, 2010). As a result, those on SSRIs discussed concepts around personal growth, the impact on everyday functioning and identity reformation, alongside a reduction in PSA, as the key benefits of engaging in MMPSA. While there were concerns regarding pre-medication rumours and fears about side effects that may act as barriers to engagement or compliance, these were generally overcome by participants.

In contrast, those prescribed anti-androgens placed much more emphasis on the extent to which taking MMPSA helped them to manage their (perceived and actual) levels of risk (typically tied to extrinsic motivations related to parole assessments and compliance with perceived licence conditions). Participants discussed substantial reductions in levels of PSA which was viewed positively, with some even discussing this as a cure. However, this perspective may mean that active engagement with other forms of treatment (i.e. psychological interventions designed to address both their PSA and sexual offending) may be viewed as being unnecessary. This is particularly problematic given that all protocols related to the prescribing of pharmacological treatments for PSA stress the importance of combining medication with psychological interventions (e.g. Grubin, 2017; Hill et al., 2003; Thibaut et al., 2010). In addition, those on anti-androgens discussed the positive effects of the medication in relation to a shift in identity as a result of a reduction in levels of arousal, thus viewing the medication as having given them a 'second chance at life'.

There was an acknowledgement in the sample of individuals taking SSRIs that sexual arousal can be experienced in healthy ways while on MMPSA, and that arousal was still an essential aspect of their identity. This is a positive related to the use of SSRIs as a form of MMPSA, with participants discussing this in a way that accepted the continued presence of sexual thoughts and behaviours but these were now considered to be manageable. This was not echoed in the sample of participants

taking anti-androgens, where reductions in levels of sexual arousal were more prominent, with some acknowledging that they were unable to achieve physiological arousal, and these effects generally being more limiting. While it is to be expected due to the pharmacological effects of the medications themselves (Bancroft, 1989; Grubin, 2018; Jordan, Fromberger, Stolpmann, & Müller, 2011; see Chapter 2), it is important to appreciate the implications of these effects on engagement and long term compliance with treatment. That is, being able to achieve sexual satisfaction is a primary human good (Ward & Marshall, 2004), meaning if this is not physiologically possible due to the effects of MMPSA it may be that participants' motivations to continue to engage with the treatment in the longer term decreases. This was highlighted within the narratives, with these unwanted effects being linked to ambivalence towards continuing to take the medication post release. Furthermore, side effects such as weight gain and gynecomastia (breast growth) which are commonly experienced by people taking anti-androgen medications for a range of other health conditions (e.g. as a treatment for prostate cancer; Nguyen et al., 2015) were also experienced by participants here. As such, those taking the anti-androgen class of MMPSA should be closely monitored in relation to their feelings about the physical effects of the medication, as well as potentially serious side effects, in order to encourage continued engagement with treatment.

Research aim three: To explore the nuanced pathways of the MMPSA treatment that these individuals must navigate

In Chapter 7 an analysis of the full evaluation dataset was undertaken in order to explore whether a system of distinct pathways through MMPSA could be identified. Using information about medication commencement, discontinuation, and medication class / dosage changes, six specific pathways were identified. These were labelled as follows:

1. SSRI pathway: The service user begins SSRI medication. There may be medication adjustments (i.e. to the specific type of SSRI prescribed or dosages), however they remain on SSRIs for the duration of their treatment. Successful completion of this pathway would involve ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.
2. Anti-androgen pathway: The service user begins anti-androgen medication. There may be medication adjustments (i.e. to the specific type of anti-androgen prescribed or dosages), however they remain on anti-androgens for the duration of their treatment. Successful completion of this pathway would involve ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.

3. Progression pathway: The service user begins medication – either SSRIs or anti-androgens. There may be medication adjustments within this medication class (i.e. to the specific type prescribed or dosages), before progressing to a stronger medication class (i.e. from SSRIs to anti-androgens, or from anti-androgens to GnRH) potentially alongside the initial prescribed medication. Once on this, there may be further medication adjustments within this medication class. Successful completion of this pathway would involve remaining on this stronger medication class until the point of ceasing the medication when PSA is at a desirable and manageable level. Any deviation from this would result in movement to another pathway.
4. Switching pathway: The service user begins medication – either SSRIs or anti-androgens. There will be multiple adjustments to the prescribed medication class (i.e. between SSRIs, anti-androgens and GnRH, or a combination of these) within their treatment journey. There may also be medication adjustments within each medication class (i.e. to the specific type of medication that is prescribed, or in relation to dosages). Successful completion of this pathway would involve remaining on MMPSA (any class of medication) until the point of ceasing the medication when PSA is at a desirable and manageable level. Ceasing the medication prematurely would result in movement to another pathway.
5. Drop-out pathway: The service user prematurely (i.e. before desired effects on PSA have been achieved) ceases medication due to a lack of desired effect, or the presence of unwanted effects (i.e. side effects), while on one of the above pathways.
6. Re-entry pathway: The service user re-starts some form of MMPSA after ceasing treatment in any of the above pathways.

Through the development of a model of distinct treatment pathways (and criteria for determining movement between such pathways, as outlined in Figure 8), this specific study represents an initial step to overcoming some of the limitations that are inherent to considering the effects of MMPSA using large scale nomothetic and statistical approaches (as in Winder et al., 2014; 2018; see Chapter 7). The key finding that has emerged from the identification and consideration of these pathways, in addition to the qualitative accounts provided in Chapters 5 and 6, is that ICSOs taking MMPSA across all pathways appeared to demonstrate improvements in clinical measures of PSA in both the psychological (e.g. sexual preoccupation) and behavioural (e.g. hypersexuality) facet. For example, those on the SSRI pathway and anti-androgen pathway both demonstrated significant reductions across all facets of PSA (see Chapter 7). These are important findings that are in contrast to what is expected based on the literature, previous use, and current prescribing guidelines and thus raises

questions regarding the suitability of such prescribing guidelines. This is discussed in more depth within the recommendations below.

In addition, the identification and discussion of these pathways (and accompanying case examples) has also provided a clearer understanding of the individuality and complex nature of MMPSA treatment. While these pathways provide an understanding of the core ways in which individuals may navigate MMPSA, the exact process and journey for each individual may be very different (as highlighted within the narratives in Chapter 6). As such, it is clear that this process involves careful monitoring and collaboration with service user themselves, which corresponds to important issues in the rehabilitation of people with sexual convictions, such as being responsive to individual needs and fostering personal agency (Gannon et al., 2019; Lösel & Schmucker, 2015).

Medicating towards desistance?

As outlined previously within this thesis, a secondary aim of MMPSA is the reduction in risk of reoffending (despite this being the primary aim for other pharmacological prescribing protocols; see Chapter 2), particularly when this offending took place as a result of unmanageable or escalating levels of PSA (see Chapter 4), and through increasing capabilities to engage in psychological treatment programmes. From the data presented throughout this thesis, it appears that MMPSA has an important role in the effective treatment of ICSOs with PSA, and subsequently may be contributing to a process of desistance from sexual crime.

Göbbels et al.'s (2012) integrative theory of desistance from sexual offending (ITDSO) is a four-phase comprehensive framework for understanding the process by which ICSOs (1) make the decision to change (decisive momentum), (2) work through formal rehabilitation programmes (rehabilitation), and (3) re-enter the community as reformed citizens (re-entry) to (4) live their lives free from further offending behaviours (normalcy / reintegration). It has been observed that many professionals working within the criminal justice system define desistance as the absence of offending upon release from custody (e.g. Ministry of Justice, 2013). However, this is at odds with theorising about the nature of desistance from a criminological perspective, which sees this as a process that may contain backwards steps, temporary lapses, and multiple false starts (Ward & Maruna, 2004). This conceptualisation of desistance as a process is more in line with the ITDSO, which sees desistance beginning much earlier than at the point of an individual's release from custody (Göbbels et al., 2012).

The following sections thus demonstrate how the findings reported in this thesis correspond with the ITDSO model. Given that all of the research presented in this thesis was conducted with participants who were in custody at the time of data collection, there is little that can be concretely said about the role of MMPSA in the re-entry and normalcy phases of desistance at this moment in

time. As such the discussion around desistance will, by necessity, be predominantly focused on the first two phases (i.e. decisive momentum and rehabilitation). A discussion about how MMPSA and potential barriers may impact upon the re-entry and normalcy / reintegration stages is however provided.

Phase 1: Decisive momentum

The first phase of the ITDSO argues that desistance is a long term process that begins well before an individual leaves custody, and thus this stage of decisive momentum represents a process of initial desistance. The phrase 'decisive momentum' implies that the individual has made a specific and conscious decision to change their lives and alter their behaviour over the long term. When looking at general theories of desistance from crime, this decision will often be linked to a specific 'turning point' (Sampson & Laub, 2005) in their life. As outlined previously within this chapter (see the discussion of research aim one, above), for participants in the current sample, this took the form of a perception that they were potentially losing something of value, such as an intimate relationship. This perception acted as a 'focal incident' (Baumeister, 1994, p. 290) that was accompanied by feelings related to the fact that 'something had to change' (P. 19). This is consistent with research about stages of change that has proposed how actual or anticipated negative experiences trigger change motivations more effectively than positive experiences (Taylor, Neter, & Wayment, 1995). While these turning points or life events are important in this phase of initial desistance, representing the 'decisive' element, alone they are not sufficient to bring about behaviour change. In addition there is the recognition of the need for a motivation to change and taking advantage of opportunities to do so, which represents the 'momentum' element of this phase. As such, these turning points or life events present a catalyst for change, leading individuals to a process of re-evaluation whereby they begin to establish a 'replacement' or 'emerging positive possible self' (Göbbels et al., 2012 p. 456).

This process is evident within the narratives here, with participants engaging in a process of self evaluation, recognising their PSA and subsequent offending behaviour as problematic, and thus making a decision to change. For these participants, the availability of MMPSA provides an opportunity to potentially gain control over their PSA, something that they previously have been unable to achieve. This allows them to begin to distance themselves from their current offending selves as someone with PSA, and instead consider a positive possible self.

Phase 2: Rehabilitation

This second phase of the ITDSO stresses the importance of following on from decisive momentum, building on the emerging possible self that was established in phase one. In order to achieve this,

individuals require a viable pro-social identity to work towards through a process of cognitive transformation (Maruna, 2001). This is the central premise of the 'new me' aspect of prison based psychological treatments for ICSOs (Williams, 2019). Once again ideas of identity are important here. The aim at this stage of the desistance process – aside from developing motivations for treatment (commonly referred to as readiness to change / treatment readiness; see Howells & Day, 2007) – should be to help somebody with sexual convictions to develop a range of viable new identities (Maruna, 2001) and orient them to achieve one or more of these. Only when these viable identities have been established and committed to can an individual begin to actively engage in rehabilitation in an effort to reform themselves (Maruna, 2001; Prochaska & DiClemente, 1983). This process of change may be achieved through the engagement with formal treatment programmes, or through adopting strategies such as a Good Lives Plan (Laws & Ward, 2011) with appropriate support to achieve necessary goals. This all aids the individual in a 'successful reconstruction of the self' (p. 457), which is the overall aim of this phase of the model.

This process is evident within the narratives here, with MMPSA contributing to the rehabilitation phase, and thus reconstruction of self, for the current participants in numerous ways. As discussed earlier in this chapter, for example, those prescribed SSRIs, suggested that the medication allowed them to incorporate a sexual aspect of themselves into a broader sense of self. That is, their identity shifted from the sense that they were somebody who was dominated and controlled by their PSA (with PSA being seen as the defining element of the self), to becoming more human (as in Theme 1.1 of Chapter 5). Those taking anti-androgens also discussed a change in identity (demonstrated in the 'Discovering a new me' theme in Chapter 5). Specifically here though, the medications had a more profound effect on identity, with many participants reporting how MMPSA had given them a second chance at life (as reported in Theme 3.2 of Chapter 6). In addition, participants taking SSRIs reported feeling happier within themselves. This has the effect of directly reducing the motivations for some people with PSA to engage in sexual behaviour (including offending or offence related behaviours) as a form of self medication or emotional coping (Bancroft & Vukadinovic, 2004; Hughes, 2010; Nimbi, Tripodi, Rossi, Navarro-Cremades, & Simonelli, 2019). This allowed them to spend more time engaged in a broader range of social activities, which is an important aspect of the implementation of strengths based approaches to desistance from crime (Göbbels et al., 2012; Ward & Stewart, 2003).

The reduction of PSA also had a direct effect on the formalised treatment of ICSOs in this sample. That is, aside from being a form of treatment in its own right, MMPSA enabled participants to engage more fully in psychological treatment by providing them with the headspace to consider their patterns of sexual arousal and offending behaviour within the treatment context, and work on

strategies to manage these. This is important as it has been suggested that PSA in these settings can act as a hindrance to positive treatment outcomes (Grubin, 2018; Saleh et al, 2010). However, through the use of MMPSA, those with PSA were able to successfully engage in appropriate treatment programmes and work towards establishing a 'new me'. As such, by reducing PSA it appears that both SSRIs and anti-androgens allowed participants to distance themselves from their past selves (associated with PSA and offending behaviours) and reconstruct a new pro-social identity.

Phases 3 and 4: Re-entry and normalcy / reintegration

The latter two stages of the ITDSO talk about the final stages of the desistance process, both in the short term immediately following release from prison (re-entry) and in the longer term within the community (normalcy / reintegration). Given that all of the research presented in this thesis was conducted with participants who were in custody at the time of data collection, phases one (decisive momentum) and two (rehabilitation) are most relevant to the specific findings presented here. However, a discussion of these latter phases is still relevant.

The central premise of these stages is that an individual should be given the opportunity to live out their new identity (established in the rehabilitation phase) within the community. With this in mind, Göbbels et al. (2012) suggest that an ICSO is still within the change process at this stage of desistance (and particularly so immediately after re-entering the community). As such, the 'maintenance of a commitment to change' (Göbbels et al., 2012, p. 659) is vitally important here in order to sustain the momentum for identity reconstruction that was established in the earlier. In essence, the goal of these phases is to make the living of the new identity habitual in nature (for a broader discussion within the behaviour change literature, see Rothman, Baldwin, & Hertel, 2004), thus reducing the effort that is required to sustain this new identity. However, it is acknowledged that the re-entry phase is particularly difficult in light of the numerous potential barriers (Göbbels et al., 2012).

The narratives within this thesis highlighted a number of participant concerns that may act as potential barriers to these latter stages of desistance. While participants here discussed reductions in levels of PSA, it is acknowledged that this is within a controlled prison environment where exposure to stimuli that are potentially sexually arousing is much more limited than in the community (Lussier et al., 2012). As such, a greater level of exposure to sexual stimuli, coupled with a less restricted external environment may lead an increased propensity / temptation to engage with this new sexual stimuli, which in turn may lead to a re-escalation of PSA. This may particularly be the case among those who were more extrinsically driven in terms of their motivations for engaging with MMPSA, and more reluctant to commit to continued compliance upon release. Similarly, HMP Whatton is renowned as

being a supportive and rehabilitation promoting environment (HM Inspectorate of Prisons; 2017) with the importance of a good therapeutic relationship being discussed by participants in this sample. It is unknown at this stage how compliance with MMPSA, sustained effects of MMPSA (as discussed previously), and individuals' motivations for continued identity change will be maintained within a social environment that is both hostile to ICSOs (Harper, Hogue, & Bartels, 2017; Willis, Levenson, & Ward, 2010), and where there are doubts about the willingness and competence of professionals to effectively take over the prescribing of MMPSA (Elliott et al., 2018). Not having access to social supports may act as a barrier to effective emotional coping in the immediate period following release (Willis & Grace, 2008), while having inconsistent or hostile relationships with professionals could act as a barrier to continued engagement with treatment services (Henry & Strupp, 1994; Roest, Van der Helm, & Stams, 2016).

In addition, the physiological effects of taking MMPSA on sexual arousal are well documented within the clinical data (e.g. Winder et al., 2014; 2018) and in the qualitative accounts of participants in this thesis (see Chapters 5 and 6). While these effects are generally viewed positively in the prison context, this may not be the case in the community when participants may begin to form intimate relationships with others. That is, being constrained in relation to their ability to, for example, achieve an erection within prison is viewed as a good thing in relation to gaining overall control of their PSA. However, this effect of MMPSA is in competition with the maintenance of a satisfactory sex life with an intimate partner (a primary human good; Ward & Marshall, 2004), potentially reducing motivations to comply with the medication in the longer term. While the discussion of these latter phases is speculative at present due to the current research not expanding beyond a custodial setting, the findings do still highlight important potential barriers that must be considered for those nearing release to support this process of desistance and is something that could be more extensively explored within future research (see below).

Recommendations for the effective and ethical administration of MMPSA

The various findings presented in this thesis lead naturally into a number of recommendations regarding approaches to the effective and ethical administration of MMPSA to ICSOs. These are discussed below.

Recommendation one: Intrinsic motivation should be developed prior to prescribing MMPSA

One of the starkest differences in the findings between those taking SSRIs and those taking anti-androgens in the present sample was in relation to initial motivations for treatment. While those receiving SSRIs appeared to have intrinsic motivations for engaging with MMPSA, the narratives of

individuals receiving anti-androgens appeared to suggest that these participants placed at least as much importance on extrinsic motivations (e.g. showing reductions in risk or seeking release via the parole board). While this difference may simply be related to sentence status, with a larger number of those taking anti-androgens being on IPP sentences at the time of data collection, the effects of being motivated by extrinsic reasons seemed to be important.

Those who stressed extrinsic motivations for taking MMPSA also reported how their motivations for continuing with the medication post release (i.e. when the external pressure is removed) were generally low. With this in mind, focusing on building decisive momentum prior to beginning MMPSA treatment might be an important first step in order to encourage and maintain an intrinsic motivation for treatment (Ryan & Deci, 2006). This would also limit the importance of extrinsic motivations and encourage longer term desistance from sexual offending (Göbbels et al., 2012). This may help to maintain compliance with MMPSA during periods of substantial side effects, in line with findings from other areas of psychological and correctional treatment (Thompson & McCabe, 2012; Ward, Day, Howells, & Birgden, 2004). This active decision to engage in treatment also fosters a sense of agency and enables participants to feel as though they have a say in their treatment, rather than the treatment being something that is imposed upon them. This approach thus eliminates the feelings of forced compliance with MMPSA that might be associated with the aforementioned reduced motivation for continued use upon release from prison (as reported by participants in Chapter 6). This point is particularly important given the intended voluntary nature of the treatment, and the vital role that personal agency and readiness play in the successful completion of treatment programmes and desistance focused behaviour (Göbbels et al., 2012; Prochaska & DiClemente, 1983; Ryan & Deci, 2006).

Recommendation two: Combine MMPSA with psychological interventions

While current MMPSA guidelines recommend combining medications with psychological treatment programmes for ICSOs (Home Office, 2007; Grubin, 2017; 2018), the narratives presented in this thesis suggest that this is not always happening. MMPSA plays a vital role not only in directly influencing levels of sexual arousal – an acute dynamic risk factor for sexual offending in its own right (Seto, 2019; Ward & Beech, 2006; 2017) – but they also provide an opportunity for individuals with PSA to properly and fully engage in psychological interventions by decreasing the salience of sexual themes within treatment programmes.

The importance of combining treatments is highlighted in light of the aims of MMPSA, which include developing the ability to manage one's own sexual arousal without the need for medication (Grubin, 2018). However, this outcome is sometimes not met, as demonstrated by service users who

initially drop out of treatment and subsequently resume MMPSA at a later date (i.e. those on the re-entry pathway described in Chapter 7). These individuals prematurely cease taking MMPSA before acquiring the necessary skills to manage their own arousal. Ensuring that these treatment needs are met should be considered an important aspect of the use of MMPSA alongside accredited treatment programmes, particularly as arousal reconditioning and control is a significant predictor of effective treatment for ICSOs (Gannon et al., 2019; Lösel & Schmucker, 2015). There may, however, be occasions whereby the effects of MMPSA and psychological treatments come into conflict. For example, in order to effectively engage in arousal reconditioning tasks (present within HSP), it is important for individuals to have the capacity to experience some degree of physiological and subjective sexual arousal. With this in mind, medication classes with more profound effects (particularly on physiological arousal; i.e. anti-androgens or GnRH that lower testosterone levels) may actually hinder the implementation of specific treatment strategies that are known to be effective when working with this population. As such, balancing the treatment goals and effects of both MMPSA and psychological treatment is vital.

Recommendation three: Adopt a health based approach using SSRIs as a first line form of MMPSA

As highlighted in Chapter 2, there are various prescribing protocols for using pharmacological treatments to treat individuals with PSA, with the UK model based around clinical indication. That is, SSRIs should be used as the first line class of MMPSA if the primary indicators are psychological in nature (equivalent to starting on the SSRI pathway; Chapter 7), while anti-androgens should be used first if primary indicators of PSA are behaviour-based (equivalent to starting treatment of the anti-androgen pathway) (Grubin, 2017). This direct entry onto anti-androgens is recommended for individuals who demonstrate an exceptionally strong sexual drive, high levels of sexual activity (i.e. hypersexual behaviour), or risk related behaviours (i.e. offending related behaviours that are difficult to control). However, there are no specific criteria within the guidance for what constitutes an 'exceptionally strong' sex drive, nor is hypersexual behaviour operationalised.

In Chapter 7, it was reported how those on the SSRI pathway demonstrated the same clinical reductions on both behavioural and psychological facets of PSA as those on the anti-androgen pathway. In addition, SSRIs also have less severe side effect profiles than anti-androgens, and further positive effects on general levels of social and emotional wellbeing. Thus, the aforementioned lack of clarity in the current MMPSA prescribing guidelines could lead to individuals receiving the anti-androgen class of MMPSA, with more severe side effects than SSRIs (Nguyen et al., 2015; see also Chapter 6) without clear additional benefits over SSRIs. It is therefore recommended that all individuals begin their MMPSA treatment journey on the SSRI pathway. Exceptions to this would be

for individuals where SSRIs have been (or are currently being) prescribed for co-morbid conditions (e.g. depression or OCD), but changes in levels of PSA have not been observed while SSRIs have been being taken. In such circumstances, it is recommended that individuals commence their treatment journey on the anti-androgen pathway. There may also be other medical reasons for not commencing on SSRIs, and as such a clinical override to this general recommendation should always be available. However, there should be an assumption that SSRIs are an appropriate first line class of MMPSA, and individuals would progress to other medication classes based on clinical need (i.e. after demonstrating insufficient treatment effects while taking SSRIs).

This approach also corresponds with a general health-based medical model of ethical prescribing, in which medications are slowly introduced to the body and dosage is increased where necessary to a maintenance level, rather than over-medicating at the beginning of treatment and subsequently titrating the dosage to reduce the experience of unwanted effects (Turner et al., 2017). Such an approach would fit with the aims of MMPSA by allowing service users to manage their sexual arousal, rather than to eliminate it completely (Grubin, 2017). This further corresponds with service user preferences (demonstrated in the narratives presented in Chapters 5 and 6), with a recognition that if making an informed decision, service users would likely choose SSRIs as the first line of treatment over other more severe treatment options (see also Bourget & Bradford, 2008) likely due to the potentially severe side effects which are not present with SSRIs. As such, this would have the added benefit of reducing the unwanted physical effects of stronger medication classes, and the subsequent need for titration.

Further, it is recognised that sexuality and sexual satisfaction is a primary human good (Ward & Marshall, 2004). As such, limiting the extent to which somebody can experience sexual arousal and sexual satisfaction could have adverse effects on emotional wellbeing (Muisse, Schimmack, & Impett, 2016). Among individuals with PSA who may have a long and engrained personal history of using sexual behaviour as a coping strategy for alleviating negative emotional states (e.g. Bancroft & Vukadinovic, 2004; Hughes, 2010) this is also potentially dangerous as it could lead to them engaging in increasingly deviant sexual thinking in an effort to obtain a state of arousal. With this in mind being able to use MMPSA alongside treatment programmes that allow for the development of strategies for expressing sexuality in a healthy way (e.g. HSP), may not only lead to more positive wellbeing outcomes for individuals with PSA but also encourage longer term compliance with taking medications to help manage this. SSRIs offer this opportunity due to its less extreme effects on physiological sexual arousal. As such, while the aim of MMPSA is not to change paraphilic sexual interests (Grubin, 2018; though see Federoff, 2016; Winder et al., 2019), this process of change through directed masturbation and arousal reconditioning is something that can be explored while taking SSRIs. As such, the narrative

accounts of participants in Chapters 5 and 6, the analysis of clinical progress on specific treatment pathways in Chapter 7, and existing research about the pharmacological and clinical effects of SSRIs and anti-androgens (Grubin, 2018; Winder et al., 2014; 2018), all come together to suggest that SSRIs may represent a safer, equally effective, more tolerable, and more flexible class of MMPSA than anti-androgens.

Recommendation four: Establish and manage individual treatment goals and expectations

Throughout this thesis, a commonly occurring theme has been that service users should be seen as collaborators in the MMPSA treatment process, from initial referral, prescription and through continued treatment. This is particularly important as service users are more likely to maintain engagement with treatment protocols for both physical and mental health problems when they feel that they are involved in the treatment planning and that their voices are being heard (e.g. Thompson & McCabe, 2012). While this is also something that is recommended in commentaries about the use of MMPSA with ICSOs (e.g. Grubin, 2018), its importance is specifically supported in the narratives of service users in this thesis.

In line with this perspective, it is suggested here that individual treatment goals are established prior to the commencement of treatment for each service user. This will allow the consideration of viable identities to work towards, which is seen as key in the desistance process (see previous desistance section). This would allow the development of an 'ideal' future self to work towards in terms of their level of sexuality, which could then be taken into account within the prescribing and monitoring process. For example, the clinical evidence, and findings presented here, demonstrate significant effects of these medications on the abilities of service users to, achieve an erection and maintain an ability to masturbate (Grubin, 2018; Winder et al., 2014; 2018). However, as the narratives here illustrate, these are unwanted effects for many participants, who desire the ability to keep some degree of sexual arousal but to be able to manage this and incorporate it into a new healthier sexual self (see Chapters 5 and 6). The negotiation and setting of clear treatment goals would allow the consideration of this, thus informing the prescribing process with both the service user and medical professionals being clear regarding the overall goal that is being sought which will differ for each individual. This again is in line with the stated aims of the MMPSA treatment and health models of prescribing, with the suggested the use of SSRI as a first line treatment likely making this process more manageable (see recommendation three).

In addition, being realistic about the types of changes to be expected on each medication type (including the almost total elimination of physiological sexual arousal with some medication classes; Nguyen et al., 2015) and how these fit with the aims of treatment, and individual treatment goals is

vital in maintaining engagement with MMPSA treatment. As such, this will help to overcome the presence of unexpected effects (e.g. inability to achieve physiological arousal), as service users should be made aware of this potential where relevant.

Working collaboratively to explore and set individual service user goals will also encourage an ongoing dialogue about these effects and facilitate an open therapeutic relationship between service users and prescribers. This again has a subsequent effect of maintaining adherence and motivation throughout treatment, as any effects that are experienced will be foreseen, planned for and worked through in a collaborative manner.

Contributions of this thesis

The key contributions of this thesis to the broader literature are three-fold. First, this thesis provides the first qualitative exploration of ICSOs journeys through the development of PSA, decisions to address problematic patterns of arousal, and their lived experiences of engagement with MMPSA treatment. In doing so, it provides depth, richness and understanding to the existing literature on the clinical effectiveness of MMPSA for ICSOs (see Winder et al., 2014; 2018; 2019) which could not be obtained through quantitative methods alone. That is, these large-scale nomothetic analyses do not account for the individualised treatment journeys and everyday experiences of taking MMPSA, which is vital considering that these factors have substantial implications for the day-to-day management and care of individuals taking MMPSA.

Second, the thesis sets out clear recommendations for the effective and ethical use of MMPSA with ICSOs. That is, Chapter 7 identified six distinct pathways through which service users may navigate the medication, with these six pathways classifying almost all service users that have received MMPSA at the current establishment. Further, the definitions of these pathways are clear, as demonstrated by the high agreement rate and inter-rater reliability when each case was blindly assigned to one of the pathways by the author and a researcher unconnected and unfamiliar with the database. This conceptualisation of pathways offers professionals working with ICSOs taking MMPSA a framework to effectively manage their caseloads and ensure that the journeys of service users are as effective as they can be.

Third, the thesis offers the first discussion of how the MMPSA treatment pathway can contribute towards the desistance process, by embedding this into the existing literature on desistance from sexual offending (Göbbels et al., 2012). That is, the desistance literature currently focuses on strengths based psychological approaches to treatment and desistance in this population, but largely ignores biological explanations for offending or medical options for treatment. Here, each phase of the ITDSO is considered and the use of MMPSA is discussed in the context of this framework.

The findings from this thesis can be used to clearly embed MMPSA into the first two stages of the ITDSO. However, further research in community settings is required to extend this fusion of paradigms into a unified explanation as to how MMPSA can play a role in the full process of desistance.

Limitations and future research

Despite the aforementioned contributions of this thesis, it is not without some limitations. What might be considered to be the most obvious limitation of this thesis is the focus on the lived experience, rather than a quantitative investigation of the effectiveness of MMPSA. As stated in the rationale of this thesis (see Chapter 1) this was a clear decision made in the early stages of the research, in order to supplement and add richness and depth of understanding to the quantitative elements of the evaluation (i.e. Winder et al., 2014; 2018). As with all qualitative research, due to the relatively small sample size, the ability to generalise and draw concrete conclusions from the qualitative aspect of this research is limited. However, this was never the intention, and the overall aim of this thesis was to provide an exploration and understanding of the lived experiences of ICSSOs taking MMPSA, an aim which has been achieved. In addition, it should be noted that the sample recruited within the qualitative elements of this thesis consisted of all individuals receiving MMPSA at HMP Whatton at the time of data collection.

A further potential limitation that must be acknowledged is that this research was conducted within a single prison site. At the time of the research design and commencement, HMP Whatton was the only prison site offering the MMPSA treatment service within HMPPS. While other sites now offer this service, this occurred post completion of the qualitative studies and the clinical data from these sites was limited due to low numbers of service users and was not available for inclusion in the pathways analysis. However, it must be acknowledged that the experiences of service users receiving MMPSA in other prison sites may differ. For example, the research here has highlighted the importance of a good therapeutic relationship, feeling supported and informed, and having a say in their journey through the MMPSA treatment process. HMP Whatton is recognised for the therapeutic focus and rehabilitative culture (HM Chief Inspector of Prisons, 2017), and thus presents an environment that would support such service user needs, however, individuals receiving MMPSA in prisons that have less of a therapeutic or rehabilitative focus may experience this differently. Future research could address this by conducting similar research across the other MMPSA treatment sites.

In addition, the fact that this research is restricted to the prison environment also limits the conclusions that may be drawn. For example, with regard to understanding whether the apparent shifts in identity will be maintained long term and post release, or how the experiences of MMPSA may change post release and during the transition period, or how it may contribute to the latter stages

of the desistance process (re-entry and normalcy / reintegration phases; Göbbels et al., 2012). A consideration of these phases was beyond the scope of this thesis which has focused on the experiences of those within a custodial setting. However, as service users on the MMPSA treatment pathway are beginning to be released, these questions could be explored by following individuals through the gate to explore their experiences of MMPSA in the community. A programme of PhD research has recently commenced to explore community use of MMPSA. Based on the findings highlighted here in relation to the contribution of MMPSA to the desistance process, it would be useful for research with those in the community to focus on phases three and four of the Göbbels et al. (2012) model around the re-entry and reintegration processes. Combined with the results in this thesis, this would provide a more complete understanding of the impact of the use of MMPSA on the desistance process. For example, studies might look to explore general practitioner or prescriber attitudes and perspectives towards the use of MMPSA in ICSOs and a consideration of how this may impact upon continuation and use of the medication post release from prison.

A further limitation is the reliance on self report data, and thus the potential that participants may have been providing socially desirable responses must be considered. This method of collecting data is consistent with the majority of evaluation work in relation to the treatment of ICSOs (e.g. Harkins, Flak, Beech, & Woodhams, 2012; Jung & Gulayets, 2011; Letourneau et al., 2013; Stinson, Becker, & McVay, 2015). The clinical data utilised within the pathways chapter was collected within regular meetings between the service user and the prescribing psychiatrist and thus within the context of a professional, medically based, therapeutic relationship. This relationship is centred around the treatment of health based issues, rather than risk related factors and so there may be a lower level of motivation for service users to engage in deception when talking about their PSA in these contexts. For example, the specific scores on indices of PSA are not made available for risk related decision making, such as in parole board settings (though this was a concern for some service users – particularly those taking anti-androgens; see Chapter 6). Service users are reminded of this in consultations with the psychiatrist, further limiting their motivation to report scores that appear to be more positive than the reality of their PSA. In addition, service users are not reminded of their previous scores to be able to take this into account in their responding. Multiple meetings and lengthy interviews conducted with each participant for the qualitative elements of this thesis would have helped to reduce the likelihood of this, thus providing the opportunity to build rapport and ‘improve the interviewer’s chances of overcoming potential social desirability biases and getting at the truth’ (Rubin, 2000, p. 175). Furthermore, it is possible that the participants stories that were recounted within the interviews are in some way biased and their recollection and perspectives of these

experiences may have altered over time due to a process of reflection, imprisonment, and / or engagement in psychological treatment.

Despite the advantages of identifying the pathways of MMPSA treatment in Chapter 7, the clinical data used to produce these pathways were not without limitation. These limitations were detailed in depth within Chapter 7 and will therefore not be laboured again here. However, they included irregular and inconsistent record keeping which meant that some individuals had limited data available, while the data collection intervals were varied for each participant within the sample. While this is arguably more problematic when interpreting findings from the quantitative aspects of the evaluation (which reports clinical change at specific time points in relation to the commencement of treatment; Winder et al., 2014; 2018), it does make it difficult to describe the typical experiences of individuals on each pathway. As the research here forms part of the national evaluation of MMPSA (see Chapter 1 and 2), and uses clinical measures that are routinely collected as part of the MMPSA treatment service, there was little control over the collection of data to ensure that it was regular and consistent across the sample. These limitations do, however, highlight the importance of effective planning of evaluation projects, and the value of having consistent oversight of the efficient implementation evaluation protocols.

In addition to the future research ideas outlined above, the research in this thesis has led to the identification of number additional avenues of research that should be explored. As highlighted at various points in this thesis (particularly among those taking anti-androgens; Chapter 6) some service users thought that taking MMPSA could aid their release (by showing a willingness to engage in new treatment options on a voluntary basis). In contrast, others felt that it could increase perceptions of their level of risk of reoffending (as the medication could indicate a lack of personal control over their sexual arousal). However, no research has been conducted with those involved in assessing the risk of ICSOs that specifically considers the effect of PSA and medication status on decision making and risk assessment outcomes. As such, it could be a useful line of research to examine whether taking MMPSA actually affects the views of those involved in risk management processes and decisions. Potential participants in this line of research include risk assessors, offender managers, offender supervisors and members of the parole board.

In addition, it is possible that other pathways that were not represented in Chapter 7 may be uncovered within a larger sample of participants as the MMPSA service becomes more established as a treatment option for ICSOs with PSA. This is particularly the case when considering only one treatment site was used in the current thesis. As such, as larger samples do become available through the national roll-out of the MMPSA service to the broader prison estate, it would be advisable to test

these pathways against formal quantitative cluster analysis. In addition to exploring how the experiences and pathways of those taking MMPSA translate across other prison treatment sites and into the community (both discussed above), future research should also look at the experiences of those taking GnRH agonists as a form of MMPSA. At the time of commencing this research there were no service users prescribed GnRH agonists and thus this was not incorporated into the qualitative element of this research. Since then, there are still very few individuals prescribed this medication type. However, if these numbers do increase, then an exploration of their experiences may be warranted to see if these differ from those taking SSRIs and anti-androgens.

Personal reflections

Before beginning this research project, I had very little research experience in this field. I had several years experience as a healthcare worker within forensic secure hospitals and I had recently (within a matter of weeks) completed an MSc in Forensic Psychology. While I had been afforded the opportunity to conduct my MSc research project, as well as an additional piece of consultancy work at HMP Whatton, I had not had the experience of working directly with individuals incarcerated within a prison setting. As such, this research presented a learning experience like no other. During the eight year course of this research I have grown considerably, both personally and professionally, embarking on a range of research projects, first working as a Research Assistant, before progressing to a Research Fellow to my current position as a Senior Lecturer. As such, at this point of drawing this research together, I feel it is important to reflect on the journey and the key learning points and obstacles I have faced in conducting this research.

Researcher and participant dynamics

The relationship and dynamics between the researcher and participants is considered to be of paramount importance in building rapport and conducting credible research. Fisher (2009) outlined how researchers must demonstrate some aspect of care, particularly when researching vulnerable populations and should instead view this process as research we are conducting 'with' our participants rather than 'on' them. This was something I was particularly aware of throughout the process, recognising that without participants coming forward and volunteering for the research, it would not have been possible to conduct. As such I was always grateful and appreciative of the time and effort they contributed to take part in the interviews as I recognised that talking about these topics was not easy for some of the participants.

Maintaining the safety and wellbeing of the participants is vital within research, and was particularly important here when working with vulnerable individuals on a sensitive research topic. As

such I was mindful of appropriately managing situations when participants became upset or distressed, allowing them to express this if they wished but also offering the opportunity to move on or change the topic of discussion. In addition, I always ensured that the interview meeting ended on a positive note of some sort, encouraging participants to talk about something of interest to them. Where I had concerns regarding wellbeing this was addressed by discussing the different support options available within the debrief information and making other staff members aware as part of my duty of care (this process is discussed below). It can also be the case, particularly for long-term data collection, that a participant becomes in some way emotionally dependent on the research/researcher (Renold, Holland, Ross, & Hillman, 2008), as such careful consideration should always be given to research endings to ensure participant safety (Morrison, Gregory, & Thibodeau, 2012). In the case of this research, some participants began to view me as part of their support system due to seeing me at regular intervals (for the data collected as part of this thesis as well as the wider evaluation). This resulted in them asking questions about their prison sentence or treatment plan which was nothing to do with my role and at times felt as though the lines were blurred, with participants viewing me as part of the prison system. This signifies the importance of consent and their understanding of my role. As a researcher, I continually maintained this necessary boundary, referring back to the information and consent to explain that the research is entirely separate to their sentence. However, I always re-directed participants' enquiries appropriately, as well as setting clear expectations of our contact (e.g. nature of the meetings, when they would occur, how long they would last, what was involved and things that were and were not within my role to discuss) which helped establish clear boundaries.

While the interviews were the most enjoyable element of the research, they were also the most challenging for various reasons. The sensitive nature of the research, in that it required me to explore participants' sexual interests as well as their offences in great depth made the consideration of the researcher and participant dynamic even more important as the likelihood of eliciting strong emotional responses to the topic and their disclosures was high. While the offences committed and sometimes the views and opinions held by participants were in complete opposition to my own views, perspectives and morals, this was something I had to hold back and instead approach the interview in an open, understanding and genuine manner which was at times difficult. However, as Gemignani (2011) argued, recognising and exploring researcher reactions helps to promote sensitive and reflexive research, reducing the likelihood of the findings being clouded by the researcher's own reactions at a later stage. The research required me to ask difficult questions, and explore responses that I would normally instinctually avoid in everyday life regarding sexual activity and sexual arousal. Throughout the research I have experienced how these participant stories remain embedded within memory,

reappearing and replaying at sometimes random and unexpected moments. At times this led to an avoidance to engage with the material and commence the analysis process, a response acknowledged by other researchers in the field (Coles & Mudlay, 2010). In contrast to this, there have been experiences of feeling emotionally moved by participant narratives within this research. This experience can challenge the stereotypical negative view that may be held about an individual who has committed a sexual crime as you begin to hear about their history, traumatic events and more often than not in the case of this research, their own experience of being a victim of sexual abuse. At times this left me feeling emotionally impacted and often empathic to their story, with more understanding of their progression into offending. However, a consequence to this was a notion of guilt for feeling this way, particularly when thinking about the victims of the offences that they had committed. These were all emotions that I managed through supervision and debriefing with the wider supervision and research team at the prison.

In addition, I had to be mindful about how these topics of discussion were experienced by the participants. I was very aware throughout the course of the research that as a female researcher, asking questions regarding sexual activity and sexual interest could potentially feel uncomfortable for participants. As such, being clear about the nature of the interviews, and the type of questions being asked was vital to ensure that participants were aware of what they were consenting to, as well as the option to withdraw or skip questions if they did not feel comfortable, however none of the participants chose to do this. In addition, building rapport prior to the interview was essential so that participants could feel comfortable discussing these sensitive topics with me. There were a few occasions during the course of the research where participants became aroused during the interviews, this was something I had not considered prior to the interviews, but had to be managed sensitively and non judgementally to ensure that participants did not feel uncomfortable or embarrassed and was generally achieved by temporarily changing the topic of discussion.

Navigating the limits of participant confidentiality

Despite taking steps to safeguard confidentiality (as outlined in Chapter 2), conducting this research made me realise that there are limits that are unavoidable when working on a particular research project in a specific and restricted environment. With only certain rooms available for appointments and specific times for these to take place, there are potential breaches to confidentiality when simply walking a participant to a research appointment. Crossing paths with other participants or staff members who are aware of the research that I was conducting at times felt like a potential infringement on participant's privacy and confidentiality. These difficulties can blur the lines of confidentiality and were not anticipated in the planning and design of the research. However, once

the potential for this became apparent, this was discussed within the limits to confidentiality during the consent process, explaining that although we will not share details of the participant with anyone outside the research (except in the previously discussed exceptions), individuals at the prison are aware of the nature of the research and this could therefore compromise confidentiality.

An additional unanticipated confidentiality issue that arose on many occasions is the interest and inquisition of prison staff regarding the progress of participants. This is a difficult position for a researcher, as an outside party who may be less familiar with the prison environment and the expectations in terms of confidentiality. Concerns over the rules and requirements about such information within a prison can lead researchers to question whether they should abandon the instinctive response to protect participants' anonymity. Without clear guidance or policies on this, I was required to make clear and defined decisions about these sorts of scenarios as they arose. As a general rule, I took care not to reveal details about a participant's progress or engagement with the treatment or the research itself. This is in line with Roberts (2011), who argued that confidentiality should only be breached where safety is an issue – as outlined previously in relation to limits of confidentiality. This leads me to the cases in which confidentiality was deliberately broken due to concerns regarding the safety of participants or others. Throughout the course of this research, there were numerous cases in which I had to discuss participants with those outside of the research and supervision team – largely this was in relation to participants becoming distressed or upset during interviews and resulted in me contacting wing staff to make them aware and allow them to 'keep an eye on' those participants. This was in line with the information and consent procedures of the research and participants were always made aware when this was going to happen, with none objecting to this process. In addition, there was one participant who disclosed information regarding the safety of others and as such this had to be disclosed in a more formal way, with a security information report at the prison being completed. Again, the participant was informed that this was going to happen and this did not impact upon future engagement in the research for any of these participants and instead they discussed the appreciation of me being honest with them in these situations which facilitated the development of trust and rapport.

In summary, this thesis not only tells the story of knowledge discovery, but also the story of my own personal development. It equipped me with the skills needed to conduct and lead independent research and to support others embarking on similar journeys, and overall helped shape me as a better, more thoughtful and reflective researcher.

Concluding comments

This thesis has presented series of studies that explore the lived experiences of ICSOs taking MMPSA. This work formed part of the broader evaluation of the MMPSA treatment pathway for ICSOs. While other work from the evaluation has demonstrated that MMPSA can have positive effects on clinical measures related to PSA, the work presented here adds to this quantitative work by providing a deeper understanding of how ICSOs construct the development of their PSA, and how they feel about their experiences while taking the medication. This added depth of analysis – which represents the first phenomenological analysis of the lived experiences of PSA among ICSOs and it's treatment using MMPSA – is particularly important, as there is some evidence to suggest that an intervention's effectiveness is of little importance if service users are not willing to engage with it (Wilson, Vitousek, & Loeb, 2000). In the case of MMPSA and ICSOs, understanding and maximising this engagement is vital, as the 'treatment is in the pill form and administered by the offender' (Harrison, 2008, p. 2).

The narratives of service users do highlight the positive effects of MMPSA in reducing measures of PSA, suggest generally high levels of compliance, and the complementary role that MMPSA can play in more formal treatment settings. For example, participants spoke of important and positive shifts in their identities, the role of the medication in providing them with an increased cognitive capability to cope with negative mood states, and how MMPSA gave them the opportunity to gain control over their sexual arousal and subsequent offending behaviour. However, it is important to acknowledge that these effects could be, to some degree, artificial due to the context in which they are observed. That is (and as discussed previously), all participants in this thesis were taking MMPSA within HMP Whatton – a therapeutically minded prison where they have little to no access to the types of sexually explicit stimuli that are available within the community. As such, initially promising results should be followed up into the community in order to explore the enduring nature of these effects. The uncovering of six core treatment journeys that individuals must navigate through MMPSA also represents an original contribution, further underlining the nuanced ways in which MMPSA is experienced by service users. This framework does, however, offer professionals a coherent model within which to manage their caseloads and make informed decisions about how to progress service users along their treatment journeys. Further work in relation to the specific experiences on these pathways should be conducted as the national treatment pathway begins to be fully rolled out and service users start to move between pathways.

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