Medication to manage problematic sexual arousal: Exploring avenues to assist individuals with problematic sexual arousal in the community

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Author publications related to this thesis

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Abstract

Problematic sexual arousal (PSA), especially sexual preoccupation, is a risk factor for sexual offending. Despite this, psychological interventions fail to address sexual preoccupation. Individuals with PSA are unable to concentrate on psychological interventions due to their intrusive sexual thoughts. In attempts to bridge this gap in interventions, the use of medication to manage problematic sexual arousal (MMPSA) was introduced in 2007. Evidence suggests that MMPSA effectively reduces PSA in individuals serving custodial sentences. To date, there is little evidence of the effectiveness of MMPSA in the community. The thesis was designed using a mixed methods approach to address the following research aims: (1) to illustrate the characteristics of males who had been assessed as suitable for the use of MMPSA in custody and outline how this may assist them when released into the community; (2) to understand the experiences of individuals seeking help for PSA in the community; (3) to understand the views of community-based General Practitioners of using MMPSA to treat PSA.

Study one addressed the first research aim and demonstrates how individuals with PSA exhibit higher levels of sexual compulsivity, anxiety and depression when compared with other clinical samples. The study presents evidence to show how with the use of MMPSA, levels of sexual compulsivity, anxiety and depression can be lowered to resemble that of individuals without PSA. The study also explores the relationships between sexual compulsivity and protective factors enabling individuals to achieve desistance from offending and provides evidence that emotion regulation may be an important factor to consider when treating PSA. Study two provides an insight into the experiences of individuals living with PSA in the community. The study identified three superordinate themes from the data; (1) infinite torment, (2) Facing the music to fall on deaf ears, and (3) quietening the beast. The first superordinate theme illustrates the torment individuals felt when living with PSA. The second superordinate theme highlights the challenges faced when seeking help for their PSA and how they felt they were “facing the music to fall on deaf ears”. The study also demonstrates how individuals with PSA were able to “quieten the beast” following treatment for their PSA, enabling them to live better lives. The study proposes recommendations for practice to encourage help seeking in the community and remove the shame associated with living with PSA. The findings from study three have illustrated the barriers General Practitioners face when treating PSA in primary care. The study identified two superordinate themes; ‘a balancing act’ and ‘the problematic prescribing of MMPSA’. The first superordinate theme ‘a balancing act’ illustrates the difficulties GPs encounter when attempting to balance the potential risk of an individual whilst also encouraging them to be open about their problematic sexual arousal. The second superordinate theme ‘the problematic prescribing of MMPSA’ illustrates the

potential challenges in prescribing MMPSA in primary care. The study proposes recommendations for practice, which if implemented, will improve the transition of individuals from custody into the community but will also contribute to secondary prevention, ensuring individuals are able to seek help prior to coming into contact with the CJS.

Abbreviations

AA	Anti-androgen
ADHD	Attention Deficit Hyperactivity Disorder
BNM+	Becoming New Me Plus
CBT	Cognitive Behavioural Therapy
CJS	Criminal Justice System
CPA	Cyproterone acetate
CSBD	Compulsive Sexual Behaviour Disorder
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
GnRH	Gonadotrophin-releasing hormone
GP	General Practitioner
GPs	General Practitioners
HADS	Hospital Anxiety and Depression Scale
HBCS	Hypersexual Behaviour Consequences Scale
HD	Hypersexual Disorder
HMP	His Majesty's Prison
HMPPS	His Majesty's Prison and Probation Service
HRA	Health Research Authority
HSDD	Hypersexual Desire Disorder
ICD-11	The International Classification of Diseases
MMPSA	Medication to manage problematic sexual arousal
MPI	My Private Interests
NMS	New Me Strengths
NRC	National Research Centre
NTU	Nottingham Trent University
PSA	Problematic Sexual Arousal

RCT	Randomised Controlled Trial
RNR	Risk Need and Responsivity Model
SCS	Sexual Compulsivity Scale
SIPP-118	Severity Indices of Personality Problems - 118
SOCAMRU	Sexual Offences, Crime and Misconduct Research Unit
SOTP	Sex Offender Treatment Programme
SSRI	Selective Serotonin Reuptake Inhibitor
TSO	Total sexual outlets
WGSDSH	The Working Group on the Classification of Sexual Disorders and Sexual Health

1 Introduction

Sexual offending often receives much attention from the media due to the harm experienced by victims of such offences. The attention from the media that sexual offences receive, together with the harm caused to the victim, has understandably meant that public safety is of major concern. For individuals who have been convicted of sexual offences, sentencing is often influenced by current levels of social concern (Cochran et al., 2021). Individuals with sexual convictions are a population deemed to be the least likely to change by the general public and policy makers. This is evidenced in the lifetime registrations, lengthy sentences and social controls that are imposed (Hanson et al., 2018).

Public perception of individuals with sexual convictions however are often inaccurate. Levenson et al. (2007) highlight how public perceptions of individuals with sexual convictions contradict the evidence provided by empirical research. There is a general acceptance that individuals with convictions of a non-sexual nature have the ability to change, and there is a desire to successfully reintegrate individuals back into the community. For individuals with sexual convictions however, the risk they pose to the public is often perceived to remain indefinitely (Hanson et al., 2014). This is despite findings that the longer an individual remains free of committing a sexual offence, the risk of ever doing so reduces greatly. For those who have committed sexual offences, Hanson et al. (2018) assert that after 10 years, individuals with sexual convictions are at the same risk of offending as individuals who have never committed a sexual offence. Recent meta analyses have indicated that, when taking into consideration the year of data collection, the rates of sexual recidivism have declined by 60% since the 1970's (Lussier et al., 2023a). In relation to young individuals with sexual convictions, there was less evidence of the decline in recidivism. However, the evidence indicates low rates of sexual reoffending with only 8% of individuals going on to commit further sexual offences (Lussier et al., 2023b).

The use of the label 'sex offender' evokes concern in the general public of a population of individuals who are at high risk of offending and unsusceptible to treatment (Harris & Socia, 2016). The label of 'sex offender' is associated with stigma and negativity and impacts the likelihood of individuals offering support (Lowe & Willis, 2020). The use of labels can be damaging to an individual's self-esteem and can negatively affect their wellbeing (Winder et al., 2021). Additionally, by referring to individuals as 'sex offenders' the person may begin to only see themselves in that way which is

detrimental to the desistance of offending (Maruna et al., 2004). As a result, Willis et al. (2010) sought to dissuade researchers from using the label of 'sex offender'. Further ostracising individuals by negatively labelling them reduces the likelihood of individuals reintegrating back into society (Willis, 2018). The language used in this thesis has taken the evidence of labelling theory into consideration. As a result of this, throughout the thesis, individuals who have been convicted of sexual offences are simply referred to as individuals with sexual convictions.

The effective treatment of individuals with sexual convictions is essential to reduce the risk of further offending. Reducing offending assists in protecting the public from harm, preventing future victims and improving the lives of individuals with sexual convictions. Research into the subject of sexual offending is important. Research into the effectiveness of interventions has the ability to improve the quality of available treatment packages, reducing the likelihood of further offending (Lösel & Schmucker, 2005). Research also enables an understanding of the causes of offending, which can in turn, assist the individual in making changes to enable them to live a better life.

One related area of sexual offending that warrants further investigation is that of problematic sexual arousal (PSA). PSA is an umbrella term which is used throughout this thesis to encompass two main areas of problematic sexual arousal. These include, problematic sexual thoughts and problematic levels of sexual arousal. Problematic sexual thoughts may cover deviant or paraphilic sexual interests and/or sexual preoccupation. Sexual preoccupation is defined by Mann et al. (2010, p.198) as "an abnormally intense interest in sex that dominates psychological functioning". Problematic levels of sexual arousal are often referred to as hypersexuality, whereby the individual needs to engage in a high number of sexual outlets to satisfy these sexual urges (Kafka, 1997). These two aspects of PSA will be discussed further throughout the thesis.

Individuals with PSA are often disadvantaged in terms of the interventions available to them. Traditionally, treatment for individuals with sexual offences is undertaken using psychological interventions (Levenson et al., 2020). Evidence suggests that individuals with PSA often have trouble engaging with psychological interventions as a result of their inability to manage their sexual thoughts (Akerman, 2008). PSA has also been recognised as a risk factor in relation to the reoffending of individuals with sexual convictions (Hanson & Morton-Bourgon, 2005; Thornton, 2013). Despite this, psychological methods of treating individuals with sexual offences, do not address PSA (Hanson & Morton-Bourgon, 2005). In order to further assist those with PSA, the use of medication to lower levels of sexual arousal is offered to individuals with sexual convictions. The

author refers to these medications as medication to manage problematic sexual arousal (MMPSA) throughout this thesis.

MMPSA covers two main types of medication which are discussed in further detail in Chapter 2, section 2.6.3. The two medication types include Selective Serotonin Inhibitors (SSRIs) and hormonal therapy medications, designed to lower the androgen testosterone, such as anti-androgens and Gonadotropin-Releasing Hormone Agonists (GnRH agonists). In most European countries, the use of MMPSA is a voluntary intervention. However, in 2010, Poland became the first European country to introduce mandatory pharmacological interventions for individuals convicted of contact sexual offending against children below the age of 15 (McAlinden, 2012). In the USA, the legislation regarding the use of pharmacological interventions in the form of hormonal therapy medications for individuals with sexual convictions, varies between states (Turner et al., 2019). Whilst the state of Texas allows for surgical castration, there is no legal provision for intervention with androgen reducing medications, such as Cyproterone Acetate (CPA), and GnRH agonists. The use of MMPSA is voluntary in the states of Wisconsin and Montana. For individuals with more than two sexual convictions however, pharmacological intervention in the form on androgen lowering medications is mandatory in Louisiana, Florida, Iowa and California, where an individual has convictions for two or more sexual offences (del Busto & Harlow, 2011; Scott & Holmberg, 2003). Following a systematic review, Turner et al. (2019) report estimates of the number of individuals with paraphilias are treated with medication to address sexual deviance. Their findings suggest that this is 14.6% in North America, 12.6% in Western Europe and 28.4% in Eastern Europe.

Despite pharmacological treatment being available for individuals with sexual convictions since the 1980s (Coleman et al., 1992), the use of medication to treat problematic aspects of sexual arousal, was not introduced in the UK until 2007. Although it is recognised that the use of MMPSA is not unique to the UK, the focus of this thesis is on UK systems. The aim of the thesis is to explore the avenues to increase the availability of MMPSA for individuals in the community, who may who have been released from custodial sentences for sexual convictions, and those who have not committed offences and have not come into contact with the Criminal Justice System (CJS).

1.1 Research Context

Following proposals made by the Home Office (2007), the use of MMPSA was first piloted in 2009 by His Majesty's Prison and Probation Service (HMPPS). The pilot commenced at HMP Whatton via the Medication to Manage Sexual Arousal (MMSA) pathway. Whilst the pathway is labelled the

MMSA pathway, the medication is referred to as MMPSA throughout the thesis. The Good Lives Model identifies that individuals require primary goods in order for the them to live a 'good life' (Ward & Stewart, 2003). Intimacy and relationships are identified as human needs. The purpose of MMPSA is not to diminish levels of arousal, but instead to reduce the problematic elements, enabling the individual to maintain a healthy sexual relationship (Winder et al., 2018). Accordingly, the medication is referred to as 'medication to manage *problematic* sexual arousal', to represent the problematic aspect of arousal the medication is aimed at. In the UK, the use of MMPSA is offered to individuals with PSA on a voluntary basis.

The current criteria for referral for MMPSA as outlined by HMPPS (2021) state that an individual may be considered for MMPSA if they have problems with one or more of the following:

- Sexual preoccupation
- Hypersexuality
- Using sex as a way of dealing with anxiety and low mood
- Experiencing deviant sexual fantasies that are difficult to control and cause distress.

If the individual themselves, or prison staff identify that intervention with MMPSA may be helpful, the individual is referred to the MMSA pathway. Following referral to the MMSA pathway, the individual is assessed by a psychiatrist to ascertain if they are suitable for intervention with MMSA. If assessed as suitable, they are offered the medication, be this SSRIs or anti-androgen medication, which is dependent on their level of need (Thibaut et al., 2020). At this point, if the individual decided to consent to the use of medication, they were also invited to take part in the long-term evaluation and consent was taken. Data collected as part of the long-term evaluation of the MMSA pathway indicates that 183 individuals were referred for medication between the start on the evaluation in 2010 and March 2019.

As the thesis is focusing on the delivery of MMPSA in the UK, when referring to the umbrella term of PSA, the definition includes aspects of problematic sexual arousal and behaviours, as defined by the referral criteria provided by HMPPS (2021) outlined above. For an individual to be prescribed MMPSA in UK custodial settings, the individual must consent to the use of pharmacological interventions and it should be an appropriate time to commence treatment (HMPPS, 2008). MMPSA is currently offered at eight prison sites in the UK including; HMP Whatton, HMP Frankland, HMP Hull, HMP Isle of Wight, HMP Usk, HMP Leyhill, HMP North Sea Camp and HMP Grendon. There are two types of medication available at the eight prison sites. SSRIs which are traditionally

used to treat anxiety and depression and hormonal therapy medications including GnRH agonsist and anti-androgens.

In 2010, a long-term evaluation of the effectiveness of MMPSA began at HMP Whatton. This was undertaken by members of the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) based at Nottingham Trent University (NTU). This was the first evaluation of the MMSA pathway to be undertaken in the UK. The evaluation received a favourable ethical opinion from the National Research Centre (2013-092). In 2016 the evaluation was extended to include the additional seven UK prison sites listed above (Health Research Authority (HRA) Ref, 17/NE/0335). The following PhD was originally designed in order to continue this evaluation by extending the research into the community. Unfortunately, as a result of the Covid-19 pandemic, it was necessary to redesign the structure of the thesis on a number of occasions. The originally designed studies are outlined below.

1. A quantitative study designed to measure the effectiveness of MMPSA in individuals recently released from a custodial sentence. The study mimics research undertaken by SOCAMRU in the custodial settings and continues the evaluation following the individual's release from their custodial sentence. All participants were intended to be recruited from a bank of individuals who had already given consent to take part in the long-term evaluation whilst serving their custodial sentence.
2. A qualitative study designed to gain an in-depth understanding of the experiences of individuals who continued to use MMPSA on their release from custody. It was intended that participants who consented to take part in study one, and continued their use of MMPSA in the community, would be recruited for this study.
3. A qualitative study designed to gain an understanding of the reasons why individuals may choose to stop taking medication. All participants were intended to be recruited from the sample used for study one who had chosen to cease the use of medication.
4. A qualitative study designed to gain an understanding of the views and experiences of General Practitioners (GPs) in prescribing MMPSA.

Unfortunately, the Covid-19 pandemic was announced in March 2020. This led to a considerable change in the way research was able to be undertaken across the world. The challenges faced as a result of this are outlined in detail in chapter 7 when considering personal reflections. Due to these challenges it was not possible to undertake the originally designed studies.

Of the four originally designed studies, the one study that was possible to undertake is now referred to as study three of this thesis 'Prescribing MMPSA in primary care: A thematic analysis'. This study was felt to be of particular importance when exploring the possibility of prescribing MMPSA in the community. In the UK prison system, the use of MMPSA is commissioned by both the National Health Service (NHS) and HMPPS as part of the Offender Personality Disorder Pathway (OPD). The commissioning of MMSA is a complex process which varies between the different countries which form the UK. Whilst health care in custody is commissioned nationally by the NHS, health care in the community is localised and commissioned via multiple Clinical Commissioning Groups (CCGs). Unfortunately, it is possible that this may lead to a gap in the treatment process for individuals leaving custody and entering the community. Problems arise with the lack of understanding as to whether the responsibility of the use of MMPSA is a matter for primary care, secondary care or the Criminal Justice System (Vollm et al., 2019).

Not only are their problems in identifying the responsibility of prescribing MMPSA, it is evident in the literature that there are problems when diagnosing and treating PSA in settings such as primary care. Borgermans et al. (2013) indicated that PSA in the form of Hypersexual Disorder was a controversial and poorly understood disorder. They argued that the lack of consensus in definition, limited understanding of causes and unvalidated diagnostic criteria made it difficult to identify the appropriate treatment facilitator and that the role of primary care in the treatment of Hypersexual Disorder was unknown. Since then, there have been advances in the definition of Hypersexual Disorder following proposals for it to be included in the DSM-5 (Kafka, 2010). A number of diagnostic tools have also been developed and evaluated (Womack et al., 2013). However, the role of primary care in the treatment of disorders involving PSA, remains relatively unexplored. Chapter 6 of the thesis explores the views and experiences of GPs prescribing MMPSA in primary care to explore this. The final studies designed to explore the importance of providing MMPSA in the community are outlined below.

1.2 The empirical studies

This research programme comprises three studies designed to gain an understanding of how to access help for PSA in the community. The main focus of the research was to understand how MMPSA may be used in the community as previous research had focused solely on individuals in custodial settings (Elliott et al., 2017; Lievesley et al., 2014; Winder et al., 2014a; Winder et al., 2014b; Winder et al., 2018). The research aimed to illustrate how PSA may impact an individual if they are unable to lower levels of sexual arousal and gain an insight into the experience of accessing

help for PSA in the community. The research also aimed to gain an understanding of the views and experiences of GPs in treating PSA in primary care, as in the UK, most individuals will seek help for sexual health problems from their GP (Hinchcliff et al., 2018). The three studies are outlined below.

1.2.1 Study One

Study one is a quantitative study that uses secondary data collected as part of the national long-term evaluation of the effectiveness of MMSA in reducing sexual compulsivity and improving wellbeing. Secondary data was analysed as it was not possible, as a result of the Covid-19 pandemic, to continue the evaluation with participants who have been released from custody, as originally intended.

Research Aim

The study aimed to describe the characteristics of males assessed as suitable for the use of MMPSA. The study illustrates how the use of medication impacts on sexual compulsivity and wellbeing. A secondary aim of the study was to explore the relationships between sexual compulsivity and protective personality facets. The study aimed to demonstrate the potential difficulties an individual with PSA may face in the community if they are unable to obtain MMSA following release from a custodial sentence.

Research Questions

1. How do levels of sexual preoccupation and sexual compulsivity in males with a sexual conviction identified as suitable for MMPSA compare to those (i) in the general population, (ii) with other males convicted of a sexual offence and (iii) with other relevant clinical groups?
2. How do levels of anxiety and depression in males with a sexual conviction identified as suitable for MMPSA compare to those in the (i) in the general population, (ii) with males convicted of a sexual offence, (iii) with other relevant clinical groups?
3. Are levels of good mental wellbeing, relationship capacities, and spending free time meaningfully associated with lower levels of sexual compulsivity?

1.2.2 Study Two

Study two was designed to gain an insight into the experiences of individuals seeking help for PSA in the community. Participants were recruited who had sought help for PSA via their health care practitioners. The study encompasses individuals convicted of sexual offences and those who are living with PSA but have not committed sexual offences. Individuals without convictions would not

have been referred for medication whilst in custody, as part of the MMPSA pathway. Should they not have been convicted of sexual offences, they would not have been offered treatment, either psychological or pharmacological without seeking this help independently. Therefore, participants were recruited regardless of whether they had been convicted of a sexual offence.

Research Aim

To understand the experiences of individuals seeking help for problematic sexual arousal in the community.

Research Questions

1. How was your experience of living with PSA on a daily basis?
2. How was the experience of seeking help with problematic sexual arousal from your healthcare practitioner?
3. How effective was the treatment in improving your wellbeing and day to day life?

1.2.3 Study Three

Study three focused on GPs who may be responsible for prescribing MMPSA to individuals seeking help for PSA in the community. The study was designed to gain insight into the opinions of these healthcare professionals on the use of MMPSA as a treatment for PSA.

Research Aim

To gain an understanding of the experience of community-based GPs in treating individuals with PSA and their views of the use of MMSA to manage excessive levels of sexual arousal.

Research questions

1. What are your views on prescribing MMPSA as a treatment method for individuals with problematic sexual arousal?
2. What are your experiences of prescribing medication as a treatment method for individuals with problematic sexual arousal?
3. Are there any barriers to prescribing MMPSA in primary care?

The empirical studies have been presented in this order in an attempt to demonstrate the journey an individual with PSA may undertake. Study one uses secondary data collected at baseline (pre-

intervention with MMPSA) and three and six-month post-intervention. This study provides an illustration of the challenges living with PSA has, by demonstrating the link to reduced wellbeing and reduced protective personality facets. Study two then demonstrates the help-seeking journey an individual will need to undertake, either following release from a custodial sentence, or in the community if they have not been referred for the medication via the MMSA pathway. The final study illustrates the challenges GPs may face in treating PSA in primary care and outlines potential solutions to enable MMPSA to be prescribed in the community.

1.3 Thesis structure

This thesis comprises seven chapters. Chapter 1 contains an overview of the thesis and introduction to the research project. Chapter 2 is an extensive review of the literature which has helped inform the design of the research project and the analysis of the three empirical studies. Chapter 3 is a discussion of the research philosophy, methodological design and ethical considerations taken into account when designing and undertaking the three empirical studies. The epistemological position is made clear within this chapter and details of the decision to use the various methods of analysis are provided.

Chapters four to six are dedicated to each of the empirical studies. Chapter 4 is dedicated to what is referred to throughout this thesis as study one. Study one is a quantitative study that uses secondary data collected as part of the national, long-term evaluation of the effectiveness of MMPSA in reducing arousal and improving wellbeing. The study was designed in order to illustrate the characteristics of individuals who have been assessed as requiring the use of MMPSA. The study shows how levels of sexual compulsivity, wellbeing and personality facets are improved with the use of MMPSA and shows the benefits that may be gained by ensuring MMSPSA is available in the community. Chapter 5 focuses on study two which uses qualitative methods in order to gain an understanding of the lived experiences of those with problematic levels of sexual compulsivity, who have sought help for the PSA in the community from healthcare practitioners. Chapter 6 is dedicated to the final empirical study, study three. The study was designed in order to gain an insight into the viewpoints of community GPs. This study was designed as whilst the prescribing of MMPSA has been reviewed in custodial settings, there was little information in relation to prescribing MMPSA in the community. Semi-structured interviews were undertaken with GPs in order to gain an understanding of their experiences and views on this. Chapter 7 summarises and reflects on the findings of the thesis.

2 Literature Review

2.1 Introduction

The literature review begins with a discussion of male sexual arousal. Normal sexual functioning in males is initially explored to define what the author has termed "problematic sexual arousal" (PSA). Whilst it is recognised that females do experience PSA, this thesis focuses on PSA in males and therefore the focus is solely on males. Following the discussion of male sexual arousal and the theoretical models used to describe this, the various aspects of PSA are explored. The literature review outlines the various methods used in practice for assessing and measuring PSA. The literature review discusses the impact PSA has on wellbeing and what this may mean in terms of the likelihood or risk of committing a sexual offence. Both psychological and pharmacological interventions are available to assist those with sexual convictions, the effectiveness of these are outlined. As previous research into the effectiveness of MMPSA has focused on individuals serving custodial sentences, (Elliott et al., 2017; Lievesley et al., 2014; Winder et al., 2014a; Winder et al., 2014b; Winder et al., 2018) the literature concerning the factors impacting the transition from custody to the community is reviewed. This includes a discussion of protective factors that assist in enabling desistance from offending.

2.2 Understanding sexual arousal in males

In order to gain an insight into PSA, it is vital to consider the underpinnings of male sexual arousal in general. Unfortunately, defining sexual arousal is a complex process. Numerous attempts to define sexual arousal have been put forward in the literature over the years. Despite this, a general consensus of the definition of sexual arousal is still to be agreed (Janssen, 2011). This is the case whether in relation to males or females. In an attempt to explore this is more detail, the biological underpinnings of male sexual arousal will be discussed. This is then followed by an outline of the main theoretical models that have attempted to explain sexual arousal.

2.2.1 Biological aspects of sexual arousal

Hormones have been shown to influence sexual arousal. There are two forms of hormones responsible for sexual arousal: steroids, such as testosterone, and peptides (Bancroft, 2009). Steroids include androgens such as testosterone, progestogens and oestrogens (Bancroft, 2009). When considering male sexual arousal, testosterone is the androgen primarily responsible for sexual interest and responsiveness (Bancroft, 2002). Testosterone is pivotal in maintaining aspects of male sexuality such as sexual motivation, spermatogenesis and ejaculation (Bancroft, 2005).

Testosterone also has a role in enabling erections, however, this role is lesser, as males without testosterone have been shown able to achieve erection following stimulation (Darjee & Quinn, 2020). Whilst primarily the Leydig cells located in the testes are responsible for the production, testosterone is also created from cholesterol in the brain (Jordan et al., 2011). During puberty, the production of the peptide, gonadotropin-releasing hormone is increased in the hypothalamus. The increase in gonadotropin-releasing hormones incite the release of both follicle stimulating hormones and luteinizing hormones. This increases the levels of testosterone produced and the changes in the body associated with puberty in men, such as gaining body hair, changes to the voice, an increase muscle mass and higher sex drive (Bain, 2007).

Testosterone is responsible for coordinating the initiation and maintenance of erection and sexual drive, enabling sexual activity (Corona & Maggi, 2010). Evidence shows that as levels of testosterone increase in puberty, sexual interest and engagement in sexual activities increase. Engagement in sexual activity declines in later life, coinciding with the decrease in testosterone (Jordan et al., 2011). A decrease in levels of testosterone has been shown to reduce the frequency of nocturnal penile tumescence (Bancroft, 2003), decrease libido and increase levels of irritability and fatigue (Jordan et al., 2011). Testosterone binds to androgen receptors, which are located throughout the brain (Guerriero, 2009) and has been shown to impact on other aspects of the male physique. Androgens impact not only the testicles but also the immune system, cardiovascular system, musculoskeletal system and impact on an individual's mood and cognition (Bain, 2007). Jordan et al. (2011) outline how testosterone has been shown to be related to all four aspects of the four-component model put forward by Redouté et al. (2000), discussed in section 2.2.2 below.

Dihydrotestosterone (DHT) is another androgen which also has a role in maintaining sexual function. Whilst the production of testosterone is predominantly due to the testes, DHT levels are lower and are produced via tissues (Bancroft, 2009). DHT is the main androgen responsible for the development of genital tissue. Whilst DHT has been shown to impact erectile functioning in the same way as testosterone, the evidence base is lacking, meaning it is not possible to determine whether a deficiency in DHT can explain erectile dysfunction (Corona et al., 2016).

Neurotransmitters Dopamine and Serotonin have also been shown to have a role in sexual arousal. Dopamine has been shown to decrease the release of prolactin, a hormone that has been shown to reduce sexual arousal. Testosterone has been shown to assist in releasing dopamine, increasing the sensitivity of receptors (Hull et al., 2004). Whilst dopamine in associated with appetitive

behaviours such as sex, sleep, hunger and thirst, serotonin has an inhibitory effect on these behaviours. Using medications that increase serotonin production leads to decreased arousal and delayed ejaculation (Grubin, 2018). Kafka (2003) outlined how serotonin has an inhibitory effect on sexual behaviour in primates and rats, whilst dopamine increases sexual behaviour. Due to the inhibitory effect on sexual behaviours, selective serotonin reuptake inhibitors (SSRIs) are used to reduce levels of sexual arousal in males experiencing PSA (Thibaut et al., 2020). The use of SSRIs in managing PSA is discussed in more detail throughout the literature review.

Peptides have also been shown to influence male sexual arousal. The main peptides shown to influence sexual arousal are oxytocin and melanocortins (Bancroft, 2009). Neuropeptides influence sexual arousal and behaviours by acting on the spinal cord, and hypothalamic nuclei (Argiolas & Melis, 2013). Whilst most of the research is limited to studies in animals, a few studies evidence the influence of peptides in male sexual arousal. Oxytocin has a clear role in female reproduction through its role in milk production and uterine contractions. In relation to males, the role is less clear (Bancroft, 2005; Corona et al., 2016). Animal studies have however shown how sexual cues lead to the stimulation of oxytocin, leading to intercourse (Argiolas & Melis, 2013). In humans, a randomised controlled trial (RCT) provided evidence that oxytocin did not impact levels of sexual arousal but did increase the perceived attractiveness of the partner (Scheele et al., 2013). Despite this, the evidence for the use of oxytocin to improve levels of sexual dysfunction in males in unclear (Corona et al., 2016). The peptides melanocortins have also been shown to increase erectile functioning in males, initially indicating that treatment with melanocortin analogues may be suitable for males with erectile dysfunction (Molinoff et al., 2003). However, subsequent RCTs provided evidence that treatment with melanocortin analogues would not be suitable due to the associated side effects, including nausea and increased blood pressure (Ückert et al., 2014).

2.2.2 Models of male sexual arousal

As outlined above, there are a number of biological underpinnings that are involved when considering male sexual arousal. In order to understand what the author has termed PSA, it is important to consider the theoretical models put forward to explain male sexual arousal, to gain an understanding of when aspects of sexual arousal may become problematic for the individual. Several attempts at explaining sexual arousal have been made over the years in the form of theoretical models. Whilst the various models may also explain female sexual arousal, for this thesis, the models have been explored in terms of male sexual arousal. It has been suggested that sexual response can be seen as a complex process whereby an individual experiences subjective

sexual desire, including sexual fantasies and thoughts leading to an increased interest in engaging in sexual activities (Meston & Frohlich, 2000). The experience of sexual desire leads to physiological changes, whereby the body prepares itself for sexual activity through increasing blood flow to genitalia and penile erection (Pfaus & Scepkowski, 2005). The process of arousal involves interactions between cognitive processing, emotional states and physiological changes, which influence the process by either increasing or decreasing arousal (Bancroft, 2002). Despite this, many of the theoretical models explore sexual arousal from a biological perspective, whilst not considering the subjective nature of arousal (Janssen, 2011). Nevertheless, they have aided the understanding of sexual arousal as outlined below.

Human sexual behaviour was initially described by Kinsey et al. (1948). Their work was an in-depth case history study using data from over 12,000 participants. The work of Kinsey et al. (1948) was influential in defining the excessive number of total sexual outlets and was used by Kafka (1997) when determining hypersexuality. Masters and Johnson (1966) however, were the first to put forward a model of sexual arousal based on empirical evidence of observing over 10,000 sexual acts. Their model proposed four stages of sexual response: excitation, plateau, orgasm and resolution (EPOR). During the excitation phase, sexual stimuli led to an increase in arousal, which for the male results in an erection. The plateau stage refers to the period following excitement before the male is able to reach ejaculation. Typically, following orgasm, males cannot reach climax for a period of time (Wylie, 2022). This period has been referred to by the authors as the resolution stage. Whilst the model describes the changes in genital and extragenital response when engaging in sexual activities, it is not without weaknesses as psychological aspects are absent and subjective experiences of arousal are not explored (Janssen, 2011, Levin, 2008). Additionally, the model was criticised for ethical reasons due to the process by which sexual acts were observed (Wylie, 2022). Regardless, the model was highly influential in gaining an understanding of sexual arousal at the time it was proposed.

Building on the model proposed by Masters and Johnson (1966), Kaplan (1979) suggested that desire was a critical stage to be included, prior to excitation. Previously, this was a criticism of the model as it was recognised that ordinarily, individuals do not become aroused without first entering into a stage of sexual desire (Levin & Riley, 2007). Sexual desire causes the individual to seek out sexual activity, which may involve engaging in fantasies and sexual behaviours (Darjee & Quinn, 2020). Robinson (1976) argued that the “plateau” stage was not named correctly. Rather than a plateau, it was a stage of increased excitement to reach the height of orgasm and therefore still

part of the excitation phase (Robinson, 1976). For the revised model, the “plateau” stage was removed, and the stage of “desire” was added. The model became the DEOR model and was widely accepted. Criticisms of the model occurred when it was recognised that females do not often experience sexual desire spontaneously, although this was recognised in males (Michael et al., 1994). Additionally, as with Masters and Johnson (1966), the model assumes that each stage will occur linearly. Basson (2000) argued that sexual arousal should be seen as occurring in a circular fashion, and in relation to females, should include aspects of psychological excitement. However, in relation to male sexual arousal, evidence suggests that linear models are better suited, with only 5.4% of males resounding with circular models (Giraldi et al., 2014).

A more detailed model of male sexual arousal was put forward by Barlow (1986), who wished to gain an understanding of sexual dysfunction. Barlow (1986) considered how cognitive and emotional responses impact on sexual arousal. Based on empirical evidence, the model illustrates how anxiety affects sexual arousal differently in sexually functional and dysfunctional men. Anxiety was shown to increase sexual arousal in sexually functional men but decrease arousal in males with sexual dysfunction. A negative feedback loop ensures that sexual dysfunction is maintained in sexually dysfunctional males, arising from the anxieties of poor performance from previous experiences. A positive feedback loop however would reduce the likelihood of sexual dysfunction leaving males in a better position to experience sexual arousal. The model assists in understanding issues with sexual functioning, such as erectile dysfunction, by focusing on the attentional aspect. The model outlines how males who have a fear of sexual performance are more likely to experience difficulties with erection than males without such anxieties (Barlow, 1986).

Influenced by Barlow (1986) and building on the theoretical model of sexual arousal proposed by Bancroft (1999), Bancroft and Janssen (2000; Bancroft et al., 2009) developed the dual-control model. Bancroft (1999) proposed that the Central Nervous System (CNS) contains excitatory and inhibitory mechanisms, which have a ‘dual control’ impact on managing levels of sexual arousal. The premise of which suggests that individuals with high inhibitory mechanisms may experience problems with sexual dysfunction, such as erectile dysfunction. Individuals with low inhibitory mechanisms were more likely to engage in high levels of risky sexual behaviour. The dual control model, influenced by neurobiology, suggests that individuals vary in their tendency for sexual inhibition and excitation. As with the theoretical model proposed by Bancroft (1999), individuals with low levels of sexual inhibition were more likely to take risks regarding sexual behaviour, and those with high levels of sexual inhibition may encounter problems such as erectile dysfunction.

Janssen et al. (2002) developed the Sexual Inhibition/Sexual Excitation Scale to measure levels of sexual excitation and inhibition in individuals. Following factor analysis, three factors were established. One excitation factor, 'sexual excitation' and two for inhibition, a 'fear of performance failure' and a 'fear of performance consequences'. The scale demonstrated good test-retest reliability and moderate correlations when compared with similar scales (Janssen et al., 2002). When considering males with PSA, research suggests that males with hypersexuality will score higher for sexual excitation and lower for sexual inhibition (Winters et al., 2010).

Whilst an individual has the ability to recognise feelings of sexual arousal in themselves, recognising sexual arousal in others is not straightforward (Sachs, 2007). As indicated by Janssen (2011), the available literature is ambiguous in relation to both what is observed, and what is felt in a state of arousal. Correlations between physiological and self-report measures of sexual arousal have been shown in male samples to a substantial level (Chivers et al., 2010). Evidence also shows that physiological responses and self-reported, subjective experiences of sexual arousal do not always correspond. It is evident that men can experience arousal without an erection being present, and vice versa.

Van Lankveld and Van den Hout (2004) tested the effects of distraction on subjective sexual arousal and physiological responses. In their study, sexually functional and sexually dysfunctional men were exposed to erotic stimuli whilst being subjected to distraction stimuli in the form of audio recordings of random digit pairs. The results showed that whilst physiological arousal, in the form of an erection, was reduced, levels of subjective arousal were not. Janssen et al. (2009) also provided further evidence to support the difference between subjective and physiological arousal. Homosexual and heterosexual males were exposed to sexual scenes depending on their sexual preferences. The scenes included non-threatening sexual scenes and videos depicting coercive sexual acts. The study showed correlations between physiological responses and self-report levels of sexual arousal were low. When viewing the video, some males experienced an erection whilst reporting no subjective feelings of arousal (Janssen et al., 2009).

Additionally, males have reported feelings of arousal when visiting strip clubs without experiencing an erection (Janssen et al., 2008). In attempts to clarify sexual arousal, Sachs (2000; 2007) suggests that in order to assume a state of sexual arousal in males, consideration should be given to whether an erection is present and whether or not the erection is in response to a sexual context. Sachs (2007) suggests that where an erection is present, but the sexual context is absent, sexual arousal

should not be assumed, such as in the case of nocturnal erections. Sachs (2007) suggests that using this criterion in determining arousal in males should limit the ambiguity and restrict the assumption of sexual arousal.

One of the first models to consider both physiological and subjective responses was put forward by Redouté et al. (2000; Stoléru et al., 1999). The study used data from nine heterosexual males without sexual dysfunction to create a model of sexual arousal. Participants viewed several video clips depicting, neutral, humorous and sexual scenes. Data collected included brain imaging via Positron Emission Tomography PET, penile tumescence measurements, heart rate, blood pressure and self-reported levels of sexual arousal. The authors proposed a four-factor model of sexual arousal, which includes cognitive, motivational, physiological, and emotional components. All components involved multiple regions of the brain which work together to process sexual arousal. The cognitive aspect is processed by the right orbitofrontal cortex. This component assesses the stimuli and determines whether it is deemed sexual. The motivational aspect occurs within the caudal anterior cingulate gyrus and nucleus accumbens. This aspect determines the behaviour undertaken to attain the sexual goal. The emotional component is processed in the anterior cingulate gyrus and is where the individual experiences the pleasures associated with sexual arousal. Finally, the physiological component is where changes in the body occur, such as erection, as a result of arousal. This component is processed by the posterior hypothalamus, the primary somatosensory cortex and the secondary somatosensory area. The model demonstrates the importance of taking a multifaceted approach to understanding sexual arousal. Rather than simply seeking to understand sexual arousal from a biological perspective, instead a biopsychosocial approach should be used, taking into consideration sexual, cognitive and emotional aspects to fully understand sexual arousal (Nimbi et al., 2018). The following section of the literature review will now discuss problematic aspects of sexual arousal.

2.3 Problematic sexual arousal

Problematic sexual arousal (PSA) is an area of research into sexual offending that has received much more attention in recent years. The terminology used to refer to the subject is diverse, and there has been little consensus on definitions. Researchers have used various terms over the years to describe a loss of control over sexual urges, fantasies and behaviours. The literature for example refers to terms such as sexual compulsivity (Kalichman et al., 1994), nymphomania and satyriasis (Rinehart & McCabe, 1997), hypersexual desire (Kafka, 1997, 2003, 2013), hypersexuality (Kaplan & Krueger, 2010), sex addiction (Carnes, 2001) and compulsive sexual behaviour (Miner et al., 2007;

Muench et al., 2007; Morgenstern et al., 2011). Whilst many attempts have been made over the years to provide a uniform definition, to date many of the terms are still used interchangeably. For this thesis, the author has chosen to use the term PSA. This term has been chosen as PSA can refer to two distinct categories: it may refer to problematic sexual interests, such as an interest in paraphilic behaviour or it may refer to problematic levels of sexual arousal, specifically excessive levels of sexual arousal. The author has chosen this term in an attempt to cover both aspects of PSA, problematic sexual interests and problematic levels of sexual arousal. For ease of understanding, these problematic sexual interests and levels of sexual arousal are as outlined by HMPPS (2021) in their criteria for the referral of MMPSA. Therefore, the term PSA is used to encompass individuals who experience sexual preoccupation, individuals who experience hypersexuality, those who rely on using sexual activity to manage their low mood and anxiety, and those who have difficulties controlling deviant sexual fantasies that have not been addressed through psychological interventions and cause distress. The individual may experience only one of these aspects to be classed as experiencing PSA, or a combination. The following section will discuss these two aspects in more detail.

2.3.1 Problematic sexual interests

Problematic sexual interests can include a wide range of sexual interests or behaviours, many of which are deemed socially unacceptable and may be labelled as deviant or paraphilic. The term paraphilia is described by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) as persistent and intense sexual behaviours and interests outside the remit of sexual activities that would usually occur within physically mature, consensual sexual relationships. Paraphilias may include a preference for anomalous sexual activities, such as engaging in whipping or spanking. Alternatively, the individual may prefer anomalous sexual targets, for example, animals, children or corpses (American Psychiatric Association, 2013). In order for a paraphilia to be defined as a paraphilic disorder, the DSM-5 outlines that the paraphilia must cause impairment or distress to the individual concerned as the satisfaction of the paraphilia may cause a risk of harm to others or personal harm (American Psychiatric Association, 2013). Currently, the DSM-5 recognises nine paraphilic disorders, which include: Fetishistic Disorder, Paedophilic Disorder, Transvestic Disorder, Sexual Sadism Disorder, Sexual Masochism Disorder, Frotteuristic Disorder, Voyeuristic Disorder, Exhibitionist Disorder and Specified Paraphilic Disorder (American Psychiatric Association, 2013). A diagnosis of a Paraphilic Disorder is usually avoided in adolescents to avoid stigmatisation and, as a general rule, is reserved for adults (Seto et al., 2014). However, according to the DSM-5, the paraphilia would need to be recognised as a paraphilic disorder for an individual to receive clinical intervention (American Psychiatric Association, 2013). This may lead to

problems should an individual require treatment for a paraphilic interest, many individuals may experience barriers in accessing treatment without a diagnosis of a paraphilic disorder.

Rather than being based on scientific evidence, the behaviours classed as anomalous, and paraphilic are influenced by historical, cultural and political factors (Balon, 2013). As a result, the definitions are subject to change over time (Joyal, 2014). Homosexuality, for instance, was classified as a mental disorder by the DSM-11 until 1973 (American Psychiatric Association, 1968). In the UK, homosexuality was classed as an illegal act until the introduction of the Sexual Offences Act 1967 (UK Parliament, 2022). Joyal (2014) outlines how for example, masturbation is not permitted in some religions, and anal sex was previously illegal.

Joyal (2014) suggests that problematic sexual interests should not be restricted to paraphilic sexual interests as defined by the DSM-5. The DSM-5 criterion for a paraphilic disorder requires the presence of distress as a result of the paraphilia. Joyal (2014) indicates that distress may also be present in an individual with a non-paraphilic interest and that should the need for the interest to be paraphilic be removed this may lead to more individuals seeking help. This would be especially important for individuals with aspects of PSA, such as hypersexuality and sexual preoccupation. For these individuals, their engagement in sexual activity and sexual thoughts need not be paraphilic, however, the overwhelming engagement in sexual thoughts and activities can become all encompassing, impacting the individual's daily life and causing distress (Dickenson et al., 2018).

Whilst paraphilias are commonly shown in forensic and psychiatric settings (Seto et al., 2014), several studies have attempted to establish the prevalence of paraphilic sexual interests in the general population. Joyal and Carpentier (2017) used a sample of 1040 individuals in the general population. Their findings indicate that almost half of the sample held at least one paraphilic sexual interest, with one third having engaged in paraphilic behaviours at least once. The results are also supported by Bartova et al. (2021), who showed that 13.6% of females and 31.3% confessed to having one paraphilic preference, with 15.5% of males and 13.6% having more than one. For Joyal and Carpentier (2017), voyeurism was the most prevalent paraphilic interest, with 46.3% indicating a desire and 34.5% indicating they had engaged in the activity. This was followed by fetishism, with 44.5% expressing an interest and 26.3% indicating engagement, extended exhibitionism (30.6% desire, 30.1% engagement), frotteurism (26.7 desire, 26.1% engagement) and finally, masochism (23.8% desire, 19.2% engagement). For males, higher rates of desire and engagement were indicated for voyeurism and frotteurism, whereas masochism was significantly higher for females.

Results were similar for Bartova et al. (2021), who found voyeurism to be the most prevalent paraphilia, followed by frotteurism and fetishism. As a result of the findings of their study, Joyal and Carpentier (2017) suggest that voyeurism, frotteurism, fetishism and masochism are neither unusual (15.9%) nor rare (less than 2.3%) and therefore should not be classed as nomophilic as defined in the DSM-5.

Further studies have also examined the prevalence of problematic sexual interest in the community. Långström and Seto (2006) studied the prevalence of voyeuristic and exhibitionist disorder in a randomly selected sample of 2,450 Swedish residents. Result showed that 7.7% of the sample reported engaging in at least one incident of voyeuristic behaviour and becoming sexually aroused. Additionally, 3.1% of the sample reported sexual arousal for exhibitionistic behaviour by exposing their genitals to a stranger. The results of this study also indicate that both voyeuristic and exhibitionist behaviours were positively associated with being male, again supporting the evidence above. Seto et al. (2015) undertook a self-report survey to assess sexual behaviours and interests using a Swedish sample of 1,978 males aged between 17 and 20. The survey showed that 4.2% of the sample admitted to viewing pornography involving a child. Almost half the sample suggested that they would not reject the idea of engaging in sexual activity with a child if they were sure this would not be discovered and result in punishment. Similarly, findings by Alanko et al. (2013) reported that 3% of their sample indicated a sexual interest in children, whilst 0.3% admitted to sexual behaviour.

Interestingly, the International Statistical Classification of Diseases and Health Related Problems (ICD-11) (WHO, 2018), which came into effect in May 2019, has changed substantially since the previous version, the ICD-10. The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) identified that since the release of the ICD-10, 25 years previously, there has been a significant change in social attitude and improvements in research concerning Disorders of Sexual Preference in addition to Gender Identity Disorders, sexual development and sexual dysfunctions (Reed et al., 2016). Whilst it is not within the scope of this chapter to discuss changes made in relation to Gender Identity Disorder, sexual dysfunctions and sexual development, in terms of Disorders of Sexual Preference, recommendations by the WGSDSH led to significant changes, including the renaming of the category to Paraphilic Disorders.

The WGSDSH considered several principles when determining whether or not specific patterns of sexual behaviour and arousal should be classified as mental disorders, outlined by Cochran et al.

(2014). The first concerns the use of the ICD as a global tool for defining treatment needs. For Paraphilic Disorders it is necessary, from the WHO's perspective, to be able to distinguish between private behaviours. A distinction between behaviours for which treatment is either not required and has limited impact on public health, and those behaviours that impact public health and indicate a need for intervention of the health services. Previously, dressing for sexual excitement in clothes of the opposite sex was classed by ICD-10 as paraphilic, however, this no longer meets the requirement necessary to impact public health (Krueger et al., 2017). The second principle recognises a difference between the presence of a mental disorder and emotional responses to aspects of life. An individual may present with a need for clinical intervention without being recognised as having a disorder (Cochran et al., 2014). The current ICD-11 recognises that there is no need to diagnose an individual with a disorder to qualify for clinical intervention (Krueger et al., 2017). The final principle recognises the need for the presence of personal dysfunction, as a result of the behaviour, to be present in order for the behaviour to be classified as a disorder. This is important as many stressors may influence behaviour that are not caused by an underlying mental disorder (Cochran et al., 2014).

The renaming of the previously known disorders of sexual preference category to Paraphilic Disorders was an attempt by the WGSDSH to encapsulate better the content of atypical sexual interest meeting the requirements for a mental disorder (Krueger et al., 2017). The diagnostic criteria for a Paraphilic Disorder in the ICD-11, as recommended by the WGSDSH, states that there must be anomalous sexual arousal that is persistent and intense. The WGSDSH also recommends that in order to meet the principle of impacting public health, atypical arousal should involve those who cannot consent, for example a child or an animal whereby the individual has acted on the arousal or is under distress as a result of the arousal (Krueger et al., 2017). Should the arousal not involve those with the inability to consent or involve solitary activities, then atypical arousal may be classed as a Paraphilic Disorder if there is a risk of harm, death or injury or if there is significant distress experienced as a result of the arousal (Krueger et al., 2017). As a result of the new diagnostic criteria, categories of Sadomasochism, Fetishism, and Fetishistic Transvestism are no longer classed as Paraphilic Disorders by the ICD-11. Exhibitionistic Disorder, Frotteuristic Disorder, Paedophilic Disorder, Voyeuristic Disorder and Coercive Sexual Sadism Disorder have been included, in addition to Paraphilic Disorder involving solitary behaviour or consenting adults and Other Paraphilic Disorder involving non-consenting adults (WHO, 2018).

It is recognised that not all paraphilias are illegal to act on, and there is no direct link between paraphilic sexual interests and sexual offending. Of course, paraphilias such as rape and child sexual contact are illegal. Paraphilias which involve non-consenting individuals, such as exhibitionism and voyeurism are also illegal. However, paraphilias, such as sadomasochism, involving other consenting adults, are not (Seto, 2019). Many individuals who commit sexual offences do not meet the criteria to be classed as having a paraphilia. In addition to this, there are individuals classed as paraphilic who have never gone on to offend (Seto, 2019). In relation to child sex offences, Seto (2008) estimates that only 50% to 60% of individuals who commit sexual offences against children are classed as having paedophilia.

2.3.2 Problematic levels of arousal

Not all aspects of PSA are deviant or paraphilic. One aspect of PSA that needs not be paraphilic is problematic levels of sexual arousal. As with problematic sexual interests, problematic levels of sexual arousal can also be separated into two categories: levels of sexual arousal that are too low and levels of sexual arousal that are too high. Hyposexual desire relates to individuals with low levels of sexual arousal and interest in sex. For individuals with a low sex drive, this may lead to problems in maintaining healthy sexual functioning and maintaining relationships, which in turn may cause distress (Kafka, 2003).

At the opposite end of the spectrum, some individuals may consider their interest in sex excessive. It is recognised that a high sex drive need not be problematic nor indicative of sexual offending for all individuals (Seto, 2019). It is apparent that some individuals' high sex drive can be met through consenting relationships with other adults. However, others may become so preoccupied with their sexual thoughts that they cannot perform or concentrate on daily tasks (Marshall et al., 2006). Kafka (2003) indicates that individuals who spend more than an hour each day engaging in sexual thoughts and fantasies can be classed as having sexual preoccupation. Mann et al. (2010, p. 198) have defined sexual preoccupation as an "abnormally intense interest in sex that dominates psychological functioning". For individuals with PSA, many will experience intrusive and uncontrollable sexual thoughts. The intensity of these sexual thoughts leaves the individual with a lack of headspace, meaning they cannot process emotions effectively (Lievesley et al., 2014). Individuals with sexual preoccupation may also have unrealistic expectations in relation to healthy sexual relationships as a result of the amount of time they spend engaged in sexual fantasies and pornography use (Egan & Parmar, 2013).

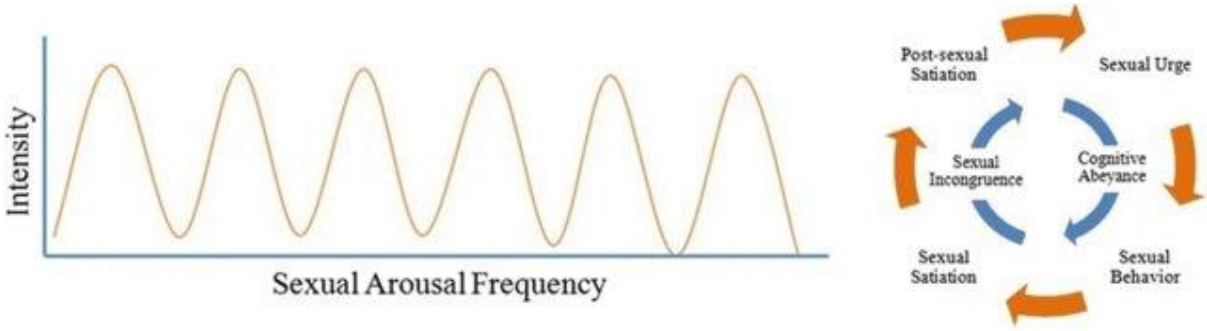
Sexual preoccupation is a significant predictor of risk of reoffending for individuals who have been convicted of sexual offences (Hanson & Morton-Bourgon, 2005; Hanson & Harris, 2000). As a result of their intense and intrusive sexual thoughts and urges, individuals with sexual preoccupation often need to engage in a high number of sexual outlets to find relief. This high engagement in sexual activities has been referred to in the literature as hypersexuality or hypersexual desire (Kafka, 1997). Hypersexuality is more prevalent in males than in females (Erez et al., 2014). In the general population, it is estimated that 3-6% of individuals experience excessive levels of sexual arousal (Odlaug et al., 2013). For those with excessive arousal, individuals may engage in masturbation so frequently that they cause injuries to their own genitals (Winder et al., 2014a). In order to satisfy their sexual urges, individuals with sexual preoccupation may find themselves engaging in sexual activities that are paraphilic or socially unacceptable (Saleh & Berlin, 2004). Whilst individuals may experience shame as a result of engaging in potentially risky sexual activities, Walton et al. (2017a) suggest that for individuals with PSA, negative emotions will be dismissed once a new sexual urge is experienced.

Seto (2019) indicates that high sex drive is an intrinsic motivator in sexual behaviour that, when present, increases the risk of sexual offending. Whilst often individuals with a high sex drive are able to meet their needs through conventional sexual activities, sexual preoccupation increases the risk of the individual overcoming inhibitions and engaging in deviant sexual behaviours such as non-consensual sexual activities. Paraphilias are often driven by high levels of sexual desire, as well as anti-social and problematic sexual interests (Kafka, 2003). Whilst it is clear that there is some overlap between aspects of PSA such as sexual preoccupation and hypersexuality, in order to separate the two, it has been suggested that sexual preoccupation refers to the amount of time an individual may spend engaging in fantasies and thoughts of sexual activity and hypersexuality may be seen as the resulting behaviour (Winder et al., 2014a).

Whilst the models explored in section 2.2.1 above have been put forward in attempts to explain sexual arousal, to date, there is only one model that explores hypersexual behaviour. The "sexhaviour cycle of hypersexuality" was put forward by Walton et al. (2017a). A visual representation of the model is provided in Figure 1 below. The model proposes that hypersexual behaviour occurs in four stages, which the authors have labelled sexual urges, sexual behaviour, sexual satiation and post sexual satiation. In essence, the individual experiences a sexual urge, which increases sexual arousal leading to an act of sexual behaviour being performed. For individuals with hypersexuality, the engagement in sexual acts may involve the engagement in acts

which include paraphilic behaviours due to their inability to control their sexual urges. Following engagement in the sexual act, the individual experiences sexual satiation when the sexual urge has been met. This then leads to a period of post sexual satiation whereby the levels of sexual arousal are reduced. Whilst the individual may experience feelings of shame from engaging in deviant sexual acts, the feelings are reduced when a new sexual urge is experienced, causing the individual to recommence the cycle.

Figure 1. The Sexhaviour cycle of hypersexuality (Walton et al., 2017a).



2.4 Measures of problematic sexual arousal

As outlined above, no one, generally accepted definition of PSA exists. As a result of this, measures of PSA are varied and wide ranging. The first attempt to create an operational measure of PSA was put forward by Kafka (1997). Using data from sexuality surveys, Kafka (1997) suggested that for an individual to be classed as having hypersexual desire, the individual must engage in a minimum of seven total sexual outlets (TSO) per week. The individual must be over the age of 15 and must repeatedly engage in this high frequency of TSO for six months or more. To be classed as having hypersexual desire, Kafka (2010) also indicates that the individual must become distressed as a result of the frequent engagement in activity and that the behaviour must not be a result of any medical condition.

It is recognised that engagement in seven TSO per week may be a conservative number when concerning individuals with high sexual drives who do not engage in deviant activities to fulfil their needs (Wakefield, 2012). In order to quantify the number of TSO for his measure of PSA, Kafka (1997) used evidence from Kinsey et al. (1948) which suggested that 7.6% of males between adolescence and 30 had greater than 7 TSO per week. It is accepted that a high frequency of engagement with sexual activities, at greater than 7 TSO per week, does not necessarily indicate a pathological condition. However, Kafka (1997) explains that it has the potential to increase the risk of the behaviour becoming pathological as a result of the persistent, frequent engagement in sexual activities. This is similar to how an individual who regularly consumes six or more alcoholic drinks

per day, would be at a greater risk of becoming reliant on alcohol than an individual who does not drink regularly. Kafka (2003) clarifies that an individual with hypersexual desire may be classed as having Hypersexual Disorder (HD) when sexual preoccupation is also present, and the individual is experiencing distress as a result of their sexual thoughts and behaviours.

The diagnostic criteria for HD were proposed to the American Psychiatric Association be included in the DSM-5 by the Work Group on Sexual and Gender Identity Disorders (Kafka, 2010). However, despite evidence illustrating the criteria's reliability and validity, the proposal was rejected (Reid & Kafka, 2014). Currently, HD is not recognised as a sexual disorder by the DSM-5. The proposed diagnostic criteria are displayed in Table 1 below.

Table 1. Kafka (2010 p.379) Proposed diagnostic criteria for Hypersexual Disorder

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviours in association with 3 or more of the following 5 criteria:
A1. Time consumed by sexual fantasies, urges or behaviours repetitively interferes with other important (non-sexual) goals, activities and obligations.
A2. Repetitively engaging in sexual fantasies, urges or behaviours in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
A3. Repetitively engaging in sexual fantasies, urges or behaviours in response to stressful life events.
A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviours.
A5. Repetitively engaging in sexual behaviours while disregarding the risk for physical or emotional harm to self or others.
B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies,
urges or behaviours.
C. These sexual fantasies, urges or behaviours are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication)
Specify if:
Masturbation
Pornography
Sexual Behaviour with Consenting Adults
Cybersex
Telephone Sex
Strip Clubs

Other:

The American Psychiatric Association rejected the proposal for two main reasons. There were concerns regarding the possibility of misuse of a diagnosis of HD in the forensic and legal community. Wakefield (2012) criticised the criteria by suggesting it could lead to 'false positives' whereby normally high levels of sexual drive could be diagnosed as a mental disorder, opening up the possibility of abuse in forensic settings. Reid and Kafka (2014) however argue that those who rely on mental disorders as a defence for their offending often result in longer prison sentences. No evidence was provided that those diagnosed with a paraphilia would receive a shorter sentence. Kafka (2014) also provides evidence to show that in individuals serving custodial sentences, a diagnosis of HD would only occur in 1.8% of the population and would not therefore have a significant impact on those being assessed for court ordered institutionalisation as a result of mental illness.

The diagnostic criteria were also rejected on the basis that there was a lack of evidence that the suggested criteria offered a distinct clinical diagnosis (Kafka, 2014). Moser (2011) argues that rather than being a disorder, hypersexual behaviour should be seen as an impact of other underlying disorders and that naming a disorder after the resulting behaviour would lead to diagnostic errors. Moser (2011) further suggests that engaging in pleasurable activities, despite a risk of harm, could be likened to individuals engaging in risky activities such as mountain climbing, which would, therefore, be indicative of a mental disorder. Kafka (2014) explains how the criteria were redesigned to ensure that 80% of the factors to be met in order, over a period of six months to receive a diagnosis, setting a stringent threshold. However, despite evidence suggesting that the diagnostic criteria are reliable and valid (Reid et al., 2012a), Reid and Kafka (2014) suggest that further research is required for HD to be categorised as a mental disorder.

Whilst not currently recognised as a disorder in DSM-5. The International Classification of Diseases (ICD-11) now classifies compulsive sexual behaviour as a disorder, labelled Compulsive Sexual Behaviour Disorder (CSBD; WHO, 2023). The ICD-11 defined CSBD as being an impulse control disorder whereby the individual is persistently unable to control their sexual urges and impulses. This results in persistent, repetitive sexual behaviours, regardless of negative consequences over a period of six months or longer. The frequent engagement in sexual activities causes significant distress to the individual in terms of social, occupational, personal, and other areas of daily functioning. The ICD-11 outlines that distress in terms of morality would not be sufficient to meet

the criteria. The inclusion of CSBD as a disorder was welcomed as it is anticipated that there will be an improvement in accessing treatment and an increased interest in further research (Lew-Starowicz & Coleman, 2022). The classification of CSBD as a disorder also allows for tailored pharmacological intervention, taking into consideration the various aspects of sexuality such as sexual activities being used as a coping mechanism, compulsivity, and excessive libido (Landgren et al., 2022).

A diverse range of measures have been developed by researchers in order to evaluate and assess levels of PSA. There must be tools to effectively measure levels of PSA to enable researchers and clinicians to identify a need for treatment and assess the effectiveness of treatment (Akerman, 2008; Akerman, 2010; Akerman & Beech, 2012). Womack et al. (2013) asserts that the type of measures available for measuring PSA can be organised into two main categories: self-report measures, which can be further categorised into those that assess the symptoms associated with PSA and those that measure the consequences experienced as a result of PSA; and clinical interviews. A thorough assessment of PSA should incorporate a combination of clinical interviews, self-report measure of symptoms and self-report measure of consequences (Womack et al., 2013).

Clinical interviews involve a trained practitioner undertaking an assessment with the individual to assess both symptoms and consequences experienced as a result of PSA. There are numerous strengths in this type of measure, as the practitioner can ask probing questions in order to encourage the individual to expand on their experiences (Womack et al., 2013). Additionally, clinical interviews are more objective than information obtained via self-report scales (Böthe et al., 2019a). However, this method may not be suitable for all individuals as some may not be comfortable verbally expressing their experiences concerning sensitive and personal information (Womack et al., 2013). Clinical interviews are also time consuming and cannot provide detailed information on each criterion (Böthe et al., 2019a).

Self-report scales can be used quickly and help obtain a broad overview of PSA (Böthe et al., 2019a). One of the earliest attempts at measuring the symptoms of sexual compulsivity and sexual preoccupation was provided by Kalichman et al. (1994) and the Sexual Compulsivity Scale (SCS). The SCS is a self-report scale containing ten statements and asks participants to rate how closely the statement resembles themselves on a four-point Likert scale, with a score of 4 being ‘very much like me’ and 1 ‘not at all like me’. Kalichman et al. (1994) provided the internal consistency of the scale using a sample of 106 sexually active, homosexual men. Kalichman and Rompa (2001) found

the reliability of the scale in a sample of HIV positive males and females. In relation to men, reliability was shown to have a Cronbach's alpha score of .89 and .92 for females. Winder et al (2014b) have also shown the scale's reliability in a sample of men serving custodial sentences for sexual offences with a Cronbach alpha score of .83.

Reid et al. (2012b) developed a self-report measure of the consequences associated with PSA in their Hypersexual Behaviour Consequences Scale (HBCS). The HBCS was developed to coincide with the diagnostic criteria of HD provided by Kafka (2010) using a combination of interviews and self-report measures. An individual may experience a wide range of consequences as a result of their engagement in sexual activities. The scale was developed taking consequences in relation to criminal activities, finances, employment, relationships, emotional wellbeing and physical and mental health into consideration. The scale consists of 22 statements, of which participants are asked to consider the extent to which each of the statements relates to themselves on a 5-point Likert scale. Each of the statements are scored from 1 (hasn't happened and it unlikely to happen) and 5 (has happened several times) (Reid et al., 2012b). Koós et al. (2021) used exploratory and confirmatory factor analysis with a non-clinical sample of 16,935 participants and showed the scale to be reliable and valid.

Montgomery-Graham (2017) conducted a systematic review of PSA self-report measures. The review identified six scales with the most empirical validation for HD. The scales include: the Sexual Compulsivity Scale (SCS) (Kalichman et al., 1994), The Compulsive Sexual Behaviour Inventory (CSBI) (Coleman et al., 2001), the Hypersexual Behaviour Inventory (HBI) (Reid et al., 2011), the Hypersexual Disorder Screening Inventory (HDSI) (Reid et al., 2012b), the Sexual Addiction Screening Test (Carnes, 1983), and the Sexual Addiction Screening Test-Revised (SAST-R) (Nelson & Oehlert, 2008). Montgomery-Graham (2017) used a rating framework developed by Hunsley and Mash (2008) to evaluate the psychometric adequacy of each of the scales. Hunsley and Mash (2008) suggest that to achieve a highly recommended rating, the scale must receive a good or excellent rating in most psychometric categories. The categories include norms, internal consistency, interrater reliability, test re-test reliability, content validity, construct validity, validity generalisation, treatment sensitivity and clinical utility. The review concluded that the scale HDSI was the best measure of HD when using the criteria provided by Hunsley and Mash (2008). Montgomery-Graham (2017) is clear, however, that the HDSI was the only scale to achieve a rating of excellent on any of the psychometric properties. The HDSI achieved a rating of excellent in

relation to inter-rater reliability and internal consistency and that validity would be a more important property to consider when assessing HD.

2.5 Comorbidity and wellbeing

The development of tools to enable levels of PSA to be assessed in individuals is welcomed, as PSA is detrimental to the individual's life and wellbeing due to the consequences of the associated behaviours. Individuals may experience problems in their relationships as a result of one partner being sexually demanding (Paunovic & Hallberg, 2014). The engagement in risky sexual activities, in attempts to alleviate sexual urges, can lead to sexually transmitted diseases being contracted (Yoon et al., 2016). The individual may experience problems with employment as a result of their engagement in sexual activities (Koós et al., 2021; Paunovic & Hallberg, 2014), which may also result in financial problems (Reid et al., 2012a).

In addition to the consequences experienced as a result of sexual activities, there is a high prevalence of mental health issues among individuals with sexual convictions. Eher et al. (2019) found that in their sample of 1250 individuals with sexual convictions, 92.9% had been diagnosed with mental health issues, with many being diagnosed with multiple disorders. Individuals with sexual convictions are four times more likely than the general population to be assessed as having an Axis 1 DSM disorder (Långström & Grann, 2007). Henshaw et al. (2018) found that trauma disorders were the most prevalent of those receiving a psychiatric diagnosis, mood disorders were the next most common, followed by substance misuse, personality, and paraphilic disorders.

PSA in the form of hypersexuality and sexual preoccupation, have been shown to have high levels of comorbidity with disorders with obsessional components. Raymond et al. (2003) suggested that PSA should be considered part of the compulsive/impulsive spectrum due to the high comorbidity with other psychiatric problems. CSBD is currently classified as an impulse control disorder by the ICD-11 (WHO, 2018). Böthe et al. (2019b) have suggested that Attention Deficit Hyperactivity Disorder should be assessed in males with hypersexuality and excessive pornography usage as a comorbid disorder due to the high levels of comorbidity. Fuss et al. (2019) also illustrate how compulsive sexual behaviour has comorbidity with Obsessive Compulsive Disorder. In their samples of individuals with Obsessive Compulsive Disorder, Intermittent Explosive Disorder was the most common comorbid disorder. CSBD was the second, with 23% of the male sample experiencing CSBD. Many individuals with PSA also experience anxiety and depression (Walton et al., 2017b).

The links between hypersexuality and mental health problems are not only apparent in individuals with sexual convictions: but have also been shown to be present in non-offending community-based samples. Långström and Hanson (2006) used a sample of members of the general population in Sweden. They estimated that hypersexuality is present in 12% of men, whilst in females, the figure is lower at 6.8%. Black (2000) estimates that 6% of all adults in the USA are affected by compulsive sexual activity. Långström and Hanson (2006) concluded that whilst those engaging in high levels of intercourse with a regular sexual partner exhibit few problems, it was those engaged in impersonal activities such as excessive masturbation who experienced undesirable health and mental health concerns.

It is recognised that many individuals do not commit offences (Akerman & Beech, 2012). However, for some individuals, PSA can lead them to engage in risky behaviours, that may cause them to commit illegal acts. Addressing emotional wellbeing is extremely important when considering the risk of reoffending of any kind especially when treating those at risk of offending sexually. Hanson and Harris (2000) performed a study of recidivism among individuals with sexual convictions. The study used interviews with offender managers and notes taken from the period leading up to the reoffending. Hanson and Harris (2000) identified that acute dynamic risk factors were important in predicting recidivism. Recidivists were likely to have shown a rapid decrease in mood or an increase in anger immediately prior to reoffending. Anger was shown to be one of the best three predictors of recidivism. In addition, recidivists were also more likely to have engaged with supervision and treatment to a lesser extent than non-recidivists. Howells et al. (2004) suggest that this lack of cooperation and disengagement could be associated with negative mood. The effective treatment of PSA is essential when considering the above evidence regarding reducing the risk of offending and improving wellbeing. The following section will discuss the currently available treatment methods for individuals with sexual convictions.

2.6 Treating problematic sexual arousal

2.6.1 Risk Assessment and Treatment of Individuals with Convictions

Currently, in the UK, risk assessments are undertaken on individuals with convictions in line with guidance from the Risk-Need-Responsivity Model (RNR). The RNR was originally developed in 1990 by Andrews et al. (1990). The model has been expanded upon on a number of occasions (Andrews et al., 2006; Andrews and Bonta, 2010; Bonta & Andrews, 2007) and is now recognised worldwide as the most influential method of assessing risk and addressing the treatment needs of individuals

with convictions (Gov, 2020). The model is based on three core principles: the *risk principle*, whereby the likelihood of reoffending determines the level of treatment provided. Whilst previously, the assessment of risk was based on professional judgement, risk assessments should now be undertaken using approved risk assessment instruments. The *need principle*, whereby criminogenic needs are identified and addressed through treatment, and the *responsivity principle*, which aims to tailor the intervention to the individual's personal strengths and ability to respond to treatment (Bonta & Andrews, 2007). Treatment of individuals with sexual convictions have been shown to be effective when applying the RNR model (Schmucker & Lösel, 2015).

The RNR identifies seven dynamic risk factors, and the static risk factor of criminal history. The dynamic risk factors identified as being important in determining the likelihood of an individual remaining offence-free are antisocial personality patterns, pro-criminal attitudes, social supports for crime, substance abuse, family relationships, school/work and prosocial recreational activities (Gov, 2020). The model also identifies four non-criminogenic needs that reduce the likelihood of reoffending. These include the self-esteem of the individual, any feelings of distress the individual may be experiencing, the physical health of the individual, and any experiences of mental health disorder (Bonta & Andrews, 2007).

The RNR model suggests that by identifying the individual's criminogenic need, the likelihood of reoffending is reduced by addressing the needs successfully. An individual with a peer group of individuals with pro-criminal attitudes, for example, would be encouraged to distance themselves from their peers and develop ties with non-offending individuals. Evidence suggests that treatment interventions based on addressing criminogenic need are the most effective at reducing recidivism for both sexual and other kinds of offences (Hanson et al., 2009).

Ward and Stewart (2003) have criticised the RNR for the way risk assessment prioritises the community's safety over the wellbeing of the individual with a conviction. Ward and Stewart (2003) suggested that, especially for individuals with sexual convictions, rather than simply focusing on risk factors, the assessment and treatment should focus on promoting wellbeing and enhancing the lives of the individual. The authors suggest that simply focusing on risk factors does not provide the individual with enough incentive to obtain their human needs through non-offending. Instead, the individual's strengths should be focused on, meaning they are more capable of meeting their needs through prosocial methods and reducing the likelihood of reoffending.

More recently, it has been argued that many risk-assessment tools, designed for assessing risk in those with sexual offences, focus solely on risk and individual deficits, creating difficulties in providing effective treatment (Willis et al., 2020). Simply focusing on risk may create pessimistic views for those working with individuals with convictions, which could cause an over prediction of risk (Miller, 2006). It is now accepted that there should be a balance when aiming to reduce the risk of reoffending and increase the wellbeing of the individual with the conviction. Protective factors should also be incorporated in risk assessment tools (Hanson, 2009).

2.6.2 Psychological Interventions

Currently, in the UK, the most popular method of treatment is through psychological intervention delivered via cognitive behavioural, group-based treatments, which are the most effective and robust method when compared with other psychosocial approaches (Lösel & Schumucker, 2005). Previously, this was delivered via the Core Sex Offender Treatment Programme (SOTP) (Mews et al., 2017). There were several programmes available to which the individuals were allocated, according to their level of risk of harm and reoffending. These programmes include the Core SOTP, Rolling and Extended SOTP, Better Lives Booster and Healthy Sexual Functioning Programme (MOJ, 2013). In addition to this, there are programmes aimed at PCSOs classified as intellectually disabled (ID) known as Becoming New Me, New Me Coping and Living as New Me (MOJ, 2013).

A number of meta-analysis studies evaluate the effectiveness of psychological treatment programmes. Hanson et al. (2002) undertook a meta-analysis using data from 43 studies. They found that the rate of recidivism was lower in the treatment group (12.3%) than the untreated comparison group (16.8%). Findings were similar for Lösel and Schumucker (2005), with recidivism rates of 12% for the treated groups compared to 24% of the comparison group. However, these differences were altered when considering the sizes of the group, meaning that recidivism at 11% was the same across both groups. They did however highlight that when comparing the mean rate of sexual recidivism, the difference between the treatment group and control group was 11.1% and 17.5% respectively, which indicates a reduction of 37% but made it clear that they had included both psychological and medical treatment in this calculation. Fisher et al. (2000) found that those who had successfully reduced their pro-offending attitudes through the treatment and maintained their relapse prevention skills nine months after treatment indicating positive results in support of the SOTP. The community based SOTP was reviewed by Mandeville-Norden et al. (2008).

Significant, positive treatment effects were found for all participants who had received treatment via the programme (Mandeville-Norden et al., 2008).

A recent review into the effectiveness of offence specific, psychological interventions was performed by Gannon et al. (2019). Evidence of treatment effectiveness was found, with a reduction in recidivism for all treatment programmes. In relation to sexual offence treatment programmes, recidivism of a sexual nature was reduced by 32.6%, non-offence specific recidivism was also significantly reduced (Gannon et al., 2019). Treatment programmes were shown to be most effective when qualified psychologists were involved, and regular supervision was received by the treatment facilitators (Gannon et al., 2019).

Despite the positive findings of the studies outlined above, not all evidence has supported the previous Core SOTP. A Cochrane review conducted by Dennis et al. (2012) suggested that the evidence of the effectiveness of SOTP was weak. Others have argued that findings by Gannon et al. (2019) should be treated with caution as the rigour employed by the authors was lower than the standards set by Schumucker and Lösel (2017) (Ramsay et al., 2020). An evaluation undertaken by Mews et al. (2017) led to changes in the programmes currently being delivered in the UK. The review found, contrary to previous research, that completion of the Core SOTP had little impact on reducing reoffending and in relation to sexual and child image reoffending rates, increased the likelihood of reoffending (Mews et al., 2017). Unfortunately, it was not possible to include the impact of PSA on treatment effectiveness in the SOTP review by Mews et al. (2017) as individuals with PSA were not identified in the review. The review concluded that in relation to child image reoffending, completion of the Core SOTP increased the likelihood of reoffending (Mews et al., 2017). Individuals accessing child imagery via the internet have been shown to be more compulsive than those who commit contact sexual offences (Marshall et al., 2012). Therefore, it is possible that this kind of offending and levels of compulsivity, impacted the results of the review. Following the review, new programmes, Horizon and Kaizen, were introduced to replace the Core SOTP (NACRO, 2018). As with the Core SOTP, individuals are allocated to the programmes according to their level of risk. Horizon is tailored towards individuals who pose a medium risk of reoffending, whilst those posing a high or very high risk of reoffending are allocated to Kaizen (McCarten et al., 2018). The Becoming New Me SOTP has been replaced by the New Me Strengths (NMS) and Becoming New Me Plus (BNM+) (Ramsay et al., 2020).

The new wave of psychological interventions, Horizon and Kaizen, are based on principles outlined in the Risk Need and Responsivity Model (RNR) (Andrews & Bonta, 2013). This ensures that the programmes are evidence informed. A number of changes in programme content have been applied. Schumucker and Lösel (2017) had previously shown individual focused interventions had a more significant benefit than those that delivered group content. The new programmes have more one-to-one sessions, and both Kaizen and BNM+ have materials that can be tailored to the individual (Ramsay et al., 2020). Whilst previously, denial was seen to be a factor that prevented participation in treatment programmes, the new programmes are available to all who are motivated to work on aspects of their lives, regardless of admittance of guilt or innocence (Ramsay et al., 2020).

2.6.3 Pharmacological Interventions

As PSA is recognised as a risk factor in reoffending (Hanson & Harris, 2000; Mann et al., 2010). The effective treatment of PSA is essential. Individuals with sexual convictions and PSA are disadvantaged in terms of the effectiveness of traditional psychological treatment methods. As a result of their intrusive sexual thoughts, individuals with PSA are often unable to concentrate on psychological treatment programmes sufficiently (Akerman, 2008; Marshall et al., 2006; Winder et al., 2014b; Winder et al., 2018). As they are unable to concentrate on the psychological interventions, they do not benefit by learning the skills that are taught to prevent them from committing further offences and managing their wellbeing. The new programmes Horizon and Kaizen are suitable for individuals who deny they have committed an offence, an aspect which previously meant they were not suitable for treatment (Klapilova et al., 2019). Sexual preoccupation is not addressed by these programmes (Winder et al., 2018).

In order to improve the effectiveness of treatment in those identified as sexually preoccupied or hypersexual, medication to manage problematic sexual arousal (MMPSA) can be a valuable addition to treatment. Pharmacological treatment assists in controlling sexual behaviours and urges, relieving the individual of the burden of intrusive thoughts, and making the individual more susceptible to treatment (Winder et al., 2014a). Lievesley et al. (2014) asserted that medicated individuals reported being more able to deal with feelings of anger and distress and found an increased ability to manage their emotions. The headspace offered to them due to the reduction of sexual thoughts enabled the individual to process thoughts and emotions that they had previously been unable to do. For individuals with problematic sexual arousal and sexual

preoccupation, a combination of psychological treatment and pharmacological intervention is an effective treatment (Guay, 2009).

The benefits of MMPSA in improving mood disorders and anxiety are significant, as feelings of distress have been associated with recidivism and highlighted as an acute dynamic risk factor (Hanson & Harris, 2000). Hanson and Harris (2001) suggest that the methods by which the individual regulates their emotion can impact whether or not the individual is likely to reoffend. It is evident that for some, their overwhelming sexual urges are so strong that they feel it is their right to act on them (Hanson et al., 1994). It is anticipated that the use of medication to reduce these sexual urges, combined with psychological interventions to assist in developing healthy sexual attitudes and effective coping skills, would be beneficial in assisting in reducing reoffending on release.

2.6.3.1 Types of medication

2.6.3.1.1 Selective Serotonin Reuptake Inhibitors (SSRIs)

Various medications have been used to reduce problematic sexual arousal, including amphetamines, lithium, antipsychotics, and anticonvulsants, however, the efficacy of such medications is inconsistent (Thibaut et al., 2020). Currently, in UK prison establishments, pharmacological treatment of problematic sexual arousal can be separated into two main medication types: Selective Serotonin Reuptake Inhibitors (SSRIs) and hormonal therapy medications.

SSRIs are more commonly used to treat depression but have also proven to be successful in treating problematic levels of sexual arousal (Thibaut et al., 2020). SSRIs work to increase the levels of serotonin available in the neuronal synapse. SSRIs achieve this by blocking the reuptake of serotonin in the pre-synaptic membrane. Whilst usually being taken back to the pre-synaptic membrane that released it, blocking the reuptake in serotonin results in the presence of serotonin in the synapse remaining for longer periods of time (Schloss & Williams, 1998). Auto receptors can then signal the presence of too much serotonin, meaning that the production of serotonin is initially reduced. This reduction in the production of serotonin is transitory and, after a couple of weeks, there is a reduction in the efficiency of the auto receptors at alerting to the presence of serotonin. Following this, the production of serotonin is no longer reduced, and as a result of the SSRIs blocking the reuptake, this in turn, leads to an increase in the levels of serotonin present in the synapse (Sibille & Lewis, 2006).

Whilst SSRIs are not currently recognised by the NICE (2015) guidelines as a treatment for problematic sexual arousal, they are being used 'off-label' to treat problematic levels of sexual arousal (Winder et al., 2018). Whilst it is unclear how SSRIs reduce problematic sexual arousal, evidence suggests that a side effect of the use of SSRIs is a reduction in levels of sexual arousal, with 60% to 70% of individuals reporting a reduction in libido and delayed ejaculation (Montejo et al., 2001). SSRIs have also been shown to decrease intrusive sexual thoughts (Adi et al., 2002). As outlined in section 2.2.2 above, serotonin has been shown to have an inhibitory impact on appetitive behaviours such as sleep, sex and appetite, whilst dopamine increases such behaviours (Grubin, 2018). Physiologically, the increase in levels of serotonin levels increases the inhibition of sexual behaviour through the use of SSRIs (Pfaus, 2009). The increase in serotonin has been shown to reduce erections and the likelihood of ejaculation. Additionally, psychological theories of how SSRIs reduce arousal have been offered by Meston and Frohlich (2000), who suggest that testosterone mediated dopamine release controls motivation, thereby reducing arousal.

Further theories as to the effectiveness of SSRIs in reducing arousal have also been provided. The repetitive nature and high frequency of engagement in sexual activity in individuals with sexual preoccupation has been characterised in relation to obsession and compulsion disorders. Bradford (1999) provides evidence that SSRIs may work on the psychological aspect of desire. SSRIs are effective in treating compulsive behaviours such as Obsessive-Compulsive Disorder (Hollander, 1998; Bloch et al., 2010). SSRIs also effectively reduce comorbidities associated with problematic sexual arousal and paraphilias, such as depression (Adi et al., 2002). The effective treatment of comorbidities also has the potential to reduce the likelihood of further offending, as they have been identified as risk factors for future offending (Hill et al., 2003). However, the evidence of the effectiveness of SSRIs in treating problematic sexual arousal is growing, leaving some to suggest that they should be classified as an antilibidinal medication (Winder et al., 2014b).

There are side effects associated with using SSRIs, many of which are mild and will cease as the body becomes familiar with the medication. Common side effects include nausea, diarrhoea, feelings of anxiety, loss of appetite, a loss of libido, difficulty achieving orgasm and sleeping problems (NHS, 2022a). Less frequent side effects include hallucinations, confusion, difficulty urinating and bruising easily (NHS, 2022a). Serotonin Syndrome is a less common but serious side effect of SSRIs that may occur if serotonin levels become excessive. Symptoms of Serotonin

Syndrome require medical attention and may include seizures, becoming unconscious and a body temperature above 38C (NHS, 2022a).

2.6.3.1.2 Hormone Therapy Medications

The second type of medication currently used in the UK to manage PSA are hormonal therapy medications. Hormonal therapy medications come in two main types. The first are gonadotropin-releasing hormone agonists (GnRH), for example, Triptorelin. The second form of hormonal therapy medication are anti-androgens such as Cyproterone Acetate (CPA). Both types of medication can lower the androgen testosterone, the primary hormone for male sexuality. Testosterone is responsible for sexual thoughts, desires, motivations, maintaining erection, enabling spermatogenesis and ejaculation (Jordan et al., 2011). A reduction in testosterone to 30-40% of normal levels causes a significant reduction in sexual arousal (Bancroft, 1989). Hormonal therapy medications effectively reduce arousal as they reduce testosterone to the threshold level. Once an individual chooses to cease medication use, levels of testosterone return to pre-medication levels, unlike surgical castration (Thibaut et al., 2020). Whilst surgical castration is still performed in some countries on males voluntarily, the reversible nature of hormonal therapy medications means that it is a more attractive option that does not involve physical mutilation (Grubin, 2018).

Anti-androgen medications, such as CPA, bind to the androgen receptor, which blocks the reuptake and metabolism of testosterone, leading to a reduction of the hormone (Thibaut et al., 2020). GnRH agonists work differently to reduce levels of testosterone. The agonists stimulate the pituitary gland to release luteinising hormone (LH). This causes a temporary increase in testosterone levels. However, the release of LH is then reduced, and approximately 3 weeks later, testosterone deprivation occurs (Van Poppel et al., 2008). Unfortunately, there are several side effects associated with the medications, such as weight gain, shortness of breath, headaches, and gynaecomastia (Czerny & Briken, 2002; Grubin, 2008). The NICE guidelines recognise hormonal therapy medications as an appropriate treatment for problematic levels of sexual arousal (NICE, 2015).

The link between sexual arousal and testosterone has been illustrated in section 2.2.2 above. The link between testosterone and sexual offending however is unclear. Giotakos et al. (2004) compared 57 individuals with a conviction for rape to a control group. Their study showed increased levels of testosterone, DHT and luteinising hormones in those convicted of rape than in the control group. Levels of serotonin were also lower in those with a rape conviction than the control group.

Kruger et al. (2019) have provided evidence that individuals who commit sexual offences against children presented with increased prenatal androgen exposure when compared with a control group and individuals with paedophilia who have not offended. Their study indicates that testosterone abnormalities in early brain development may be associated with offending behaviour. Additionally, high levels of testosterone have been associated with violent sexual offending and recidivism. However, this was only apparent in those who did not complete psychological interventions (Studer et al., 2005). Grubin (2018) therefore suggests that it is not simply enough to lower testosterone levels with medication and that psychological interventions should also be used to treat the cause of sexual offending.

2.7 Medication guidelines

Guidelines in relation to the prescribing of medication to individuals with problematic levels of sexual arousal have been provided by Thibaut, et al. (2020) and the World Federation of Societies of Biological Psychiatry (WFSBP). The guidelines are tailored to offer a response in accordance with the risk of the individual concerned and the intensity and severity of the paraphilias. Initially, treatment may be possible with the use of psychological interventions alone. Should an individual require pharmacological intervention, treatment should initially begin with SSRIs. The treatment may then be increased with the addition of hormonal therapy medications depending on the risk of the individual and the intensity of their sexual urges. The guidelines cover five levels of treatment, which are outlined below in Table 2.

Table 2. Adapted from "The World Federation of Societies of Biological Psychiatry (WFSBP) 2020 guidelines for the pharmacological treatment of paraphilic disorders." By Thibaut et al., 2020, The World Journal of Biological Psychiatry, 21(6), p61.

- Level 1 – Psychological intervention should be provided for all. If available, CBT is the preferred intervention.
- Level 2 – For individuals who pose a low risk of sexual violence who have not received a satisfactory response to level 1, treatment can be increased by including pharmacological interventions. SSRIs are recommended at a dose of 40mg per day.
- Level 3 - Individuals posing a moderate risk of sexual violence who have failed to respond to level 2. To substantially reduce sexual fantasies, behaviours and compulsions, a low dose of anti-androgen, 50-200 mg/day, in addition to psychotherapy.
- Level 4 – This level is for individuals who pose a moderate to high risk of sexual violence and those who failed to respond to the level 3 treatment. For these individuals, GnRH

agonists may be used, in addition to psychotherapy, in order to achieve, almost complete suppression of sexual fantasies and urges.

- Level 5 - Aims to completely suppress sexual activity and desire for those with the most severe paraphilic disorder. Level 5 may also be used for those who have failed to respond to treatment at level 4. For these individuals, anti-androgen therapy is suggested as an addition to treatment with GnRH agonists. SSRIs may also be introduced if necessary.

2.8 Evidence of the effectiveness of pharmacological interventions

There is a growing evidence base for the effectiveness of pharmacological interventions in treating PSA however, the need for more robust trials, such as a randomised control trial for the use of SSRIs, is recognised (Adi et al., 2002; Khan et al., 2015) Evidence of the effectiveness of both types of medication will be discussed here in turn.

2.8.1 Effectiveness of hormonal therapy medications

The most recent Cochrane Review into the effectiveness of pharmacological interventions in treating PSA was performed by Khan et al. (2015). Their review included seven studies, many of which were published over 20 years ago. Participants in the studies reviewed were all male, and the majority had received convictions for sexual offences ranging from non-contact sexual offences such as exhibitionism to penetrative offences such as rape. Of the studies reviewed, one was performed in Australia, two in the UK and the remainder used Canadian samples.

Of the seven studies reviewed, one compared the use of antipsychotic medications, benperidol and chlorpromazine (Tennant et al., 1974). The remaining six studies used anti-androgen medications such as cyproterone acetate (CPA), ethinylestradiol (EO) and medroxyprogesterone acetate (MPA) (Bancroft et al., 1974; Cooper, 1981; Bradford & Pawlack, 1993; Langevin et al., 1979; Hucker et al., 1988; and McConaghy et al., 1988). At the time of the review, the authors found no evidence of studies using GnRH agonists or SSRIs.

There were encouraging findings in the reduction of physiological arousal for the studies that used CPA (Bancroft et al., 1974; Cooper, 1981; Bradford & Pawlack, 1993). MPA was shown to be effective in reducing testosterone (McConaghy et al., 1988) but was also associated with significant side effects, which could explain why compliance rates were low (Hucker et al., 1988; Langevin et al. (1979). The authors concluded that the limitations, lack of follow up and short duration of the

small number of studies reviewed, did not produce firm evidence to support the use of pharmacological interventions to treat individuals with sexual convictions. The authors suggested that the lack of a recent RCT was concerning, and that further research was required to support the use of pharmacological interventions.

A summary of the findings of the studies reviewed by Khan et al. (2015) can be seen in Table 3 below.

Table 3. Summary of studies reviewed by Khan et al. (2015)

Authors	**Design**	**Medication Type**	**Results**
Bancroft et al. (1974)	Cross-over design	Compared the use of CPA and EO with that of a placebo.	When compared with the placebo, both medications achieved significant reductions in sexual activity. There was no significant difference in effectiveness between the medications.
Bradford and Pawlack (1993)	Cross-over design 19 outpatient volunteers	Compared the use of CPA with a placebo	The use of CPA showed a significant reduction in sexual fantasies and activities.
Cooper (1981)	Cross-over design Community – 9 participants	Compared the use of CPA with a placebo	The use of CPA showed a significant reduction in both levels of sexual arousal and sexual outlets.
Hucker et al. (1988)	Parallel design	Compared MPA with a placebo.	Despite the use of MPA being instructed by the Courts, all participants ceased the use of medication.
Langevin et al. (1979)	Parallel design	Compared the use of MPA alongside assertiveness training and assertiveness training alone.	The use of medication caused significant side effects with all participants ceasing the use of MPA.
McConaghy et al. (1988)	Parallel design	Compared imaginal desensitisation alongside the use of MPA and without medication.	MPA was shown to be effective in reducing testosterone. In a two year follow up, all participants who had

			received a combination of MPA and imaginal desensitisation remained free of conviction.
Tennant et al. (1974)	Cross-over design Secure Psychiatric Unit	Compared the use of antipsychotic medications; benperidol and chlorpromazine.	Chlorpromazine was not shown to be effective in reducing libido, whilst benperidol had a small effect.

Since the most recent Cochrane review by Khan et al. (2015), Turner and Briken (2018) have undertaken a systematic review of hormonal therapy medications for men who have committed, or, are at risk of committing sexual offences. The review by Turner and Briken (2018) covers studies conducted in a variety of countries including; Korea (Ahn et al., 2013; Koo et al., 2014; Park et al., 2014), Germany (Amelung et al., 2012; Beier et al., 2010; Briken et al., 2004; Briken et al., 2009; Bussmann & Finger, 2009; Jordan et al., 2014; Mayrhofer et al., 2016; Schiffer et al., 2009; Turner et al., 2013; Voß et al., 2016) Switzerland (Habermeyer et al., 2012), France (Moulier et al., 2012), USA (Fosdick & Mohiuddin, 2016; Saleh, 2005; Saleh et al., 2004; Schober et al., 2005) , Canada, (Gallo et al., 2017), UK (Ho et al., 2012), Netherlands (Hoogeveen & Van der Veer, 2008; Polak & Nijman, 2005) and Belgium (Huygh et al., 2015). Their review concluded that whilst GnRH agonists are more effective in treating PSA than anti-androgen medications, as a result of the significant side effects associated with the medication, the use should be restricted to individuals who are the highest risk of committing sexual offences. This is consistent with the recommended guidelines published by Thibaut et al. (2020).

Additionally, Culos et al. (2024) performed a systematic review of pharmacological interventions to treat paraphilias. Their review was international and covered 28 studies from a variety of countries including the United States, Europe, Brazil and Hong Kong. In relation to hormonal therapy medications, their review included nine studies that had used anti-androgen medications (Amelung et al., 2012; Bradford & Pawlack, 1993; Boons et al., 2020; Cooper & Cernovsky, 1994; Kiersch, 1990; Kravitz et al., 1995; Krueger et al., 2006; Lehne & Money, 2000; Meyer et al, 1992). The review also included ten studies that had used GnRH agonsists (Choi et al., 2018; Dickey, 1992; 2002; Habermeyer et al., 2012; Landgren et al., 2020; Landgren et al., 2022; Rösler & Whitton, 1998; Rousseau et al., 1990; Saleh, 2005; Schiffer et al., 2009). Culos et al. (2024) concluded that there was supportive evidence for the use of anti-androgen medications and GnRH agonists in treating

paraphilias, when combined with psychological interventions. However, as a result of the side effects caused by the medications, the individuals require careful monitoring.

In relation to evidence of effectiveness provided by Randomised Controlled Trials (RCT), Landgren et al. (2020) performed a double-blind, RCT. The RCT aimed to ascertain the effectiveness of GnRH agonists in reducing the risk of committing offences in individuals with Paedophilic Disorder. The results showed that the GnRH agonist, Degralix, significantly reduced the composite risk scores for paedophilic disorder and sexual preoccupation at two weeks and ten weeks post-medication when compared to the placebo group. There was no significant difference in scores, however for self-rated risk, low empathy, impaired self-regulation or quality of life. The study showed promising evidence for using Degralix as a treatment intervention due to the rapid reduction in risk of offending at two weeks post medication. However, a methodological limitation of the study is the reliance on self-report measures and short follow-up periods. In addition, there are adverse consequences associated with the use of GnRH agonists, meaning that the use of the medication for treating individuals with sexual convictions is limited.

2.8.2 Effectiveness of treatment with SSRIs

Adi et al. (2002) performed a systematic review of the effectiveness of SSRIs as a treatment intervention for individuals with sexual convictions. Their review included nine studies, all conducted in America, which showed some reduction in sexual arousal following treatment with SSRIs. However, the authors suggest that the length of studies and subjective nature of the scales used meant that the methodological quality of the results were not robust enough to provide sufficient evidence for the use of SSRIs as a treatment intervention. A summary of the studies reviewed is provided in Table 4 below.

Table 4. A summary of the studies reviewed by Adi et al. (2002)

Authors	**Medication**	**Results**
Bradford (1995)	Sertraline	Found a reduction in masturbation, fantasy, obsession and sexual obsession.
Coleman et al. (1992)	Fluoxetine	Improvements for depression, obsession and compulsion.
Fedoroff (1995)	Fluoxetine and psychotherapy	49/51 participants reported no paraphilic interest

Greenberg et al. (1996)	Fluoxetine and Sertraline	SSRIs reduced the severity of sexual fantasies but no difference between the type of SSRI was found.
Kafka and Prentky (1992)	Fluoxetine	Found a significant reduction in sexual activities and depression.
Kafka (1994)	Sertraline and Fluoxetine	70.8% of participants reported a significant reduction in TSO and time spent thinking about sex.
Kafka and Hennen (2000)	Fluoxetine, Sertraline, Paroxetine, Fluvoxamine	Found a significant decrease in TSO.
Perilstein et al. (1991)	Fluoxetine	All participants (*n*=3) reported improvements in relation to the frequency of masturbation and fantasies.
Stein et al. (1992)	Fluoxetine	23% of participants reported changes in fantasies.

More recently, Culos et al. (2024) undertook a systematic review of pharmacological interventions for individuals with paraphilias. Their review included interventions with both SSRIs and hormonal therapy medications. In relation to treatment with SSRIs, the authors identified seven studies for review. The review showed that SSRIs were successful in reducing the intensity of fantasies in three of the studies reviewed (Abouesh and Clayton, 1999; Chow & Choy 2002). The review also showed SSRIs were successful in suppressing deviant thoughts and behaviours (Emmanuel et al., 1991), reducing sexual urges (Saleh & Berlin, 2004), and improving impulse control (Perilstein et al., 1991). In Baltieri & De Andrade (2009) however (*N* = 2), for one participant the use of SSRIs produced no decrease in sexual fantasies. For the second participant, a reduction in fantasies was only achieved when combing SSRIs with MPA. Results for Shiwach & Prosser (1998) found fluoxetine to be ineffective in reducing sexual fantasies. Their review is however limited to a small number of participants (*n* = 10) across seven studies, all of which were undertaken 20 years ago.

Whilst currently there has been no RCT of SSRIs conducted on males with sexual convictions, Borgogna et al. (2024) undertook a systematic review of medication used to treat Compulsive Sexual Behaviour Disorder (CSBD) Their review identified two RCTs that had used SSRIs as an intervention. Wainberg et al. (2006) performed a double-blind RCT using the SSRI citalopram with a sample of males who have sex with males. Whilst there was no significant difference between the treatment and placebo group in relation to the primary outcome, the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS-CSB), there was a significant reduction in the time spent using pornography, masturbation and sex drive for individuals prescribed citalopram. Only sexually

adverse side effects, such as delayed ejaculation, were reported by those who had been prescribed citalopram, suggesting that SSRIs may be safer to use than GnRH analogues in terms of negative side effects. Lew-Starowicz et al. (2022) also conducted a RCT with males seeking help for Compulsive Sexual Behaviour Disorder (CSBD). During their RCT, individuals were randomly allocated to either the SSRI paroxetine, the opioid antagonist naltrexone or a placebo. Results showed that both naltrexone and the SSRI paroxetine were safe to use in the treatment of CSBD, however, self-reported data on improvements in CSBD were no different when compared with the placebo. Further, robust evidence is needed to support the use of SSRIs in treating PSA, in the form of a double-blind RCT (Adi et al., 2002; Borgogna et al., 2024).

2.8.3 UK Based Research by the Sexual Offences Crime and Misconduct Research Unit (SOCAMRU): National long-term evaluation of MMPSA

In 2007, MMPSA was introduced into prisons in England and Wales (Home Office, 2007). As outlined in Chapter 1, individuals may be referred for medication if they are experiencing aspects of PSA outlined by HMPPS (2021). A referral for MMPSA can be made if the individual is experiencing one or more of the following; sexual preoccupation, hypersexuality, using sex as a way of dealing with anxiety and low mood, and experiencing deviant sexual fantasies that are difficult to control and have not been addressed through psychological interventions. Since 2010, members of the SOCAMRU, based at NTU, have been undertaking a mixed-methods, national long-term evaluation of the effectiveness of MMPSA. This was the first evaluation of the effectiveness of MMPSA in UK prison systems. The evaluation assessed the effectiveness of anti-androgen medications and SSRIs in managing problematic sexual arousal and improving wellbeing, in sexual compulsive individuals convicted of a sexual offence. During the evaluation, several research studies have been undertaken with individuals serving custodial sentences at HMP Whatton. The results of the various studies undertaken to date are promising.

A preliminary evaluation of the effectiveness of MMPSA was undertaken by Winder et al. (2014b). The study used a sample of 64 males who had been prescribed SSRIs and anti-androgens. The results showed that three months post-medication, levels of sexual compulsivity, sexual preoccupation and hypersexuality were significantly lower than pre-medication. The findings of this study show that the impact of both SSRIs and anti-androgens were similar in their levels of effectiveness, indicating the possibility that SSRIs could be classed as antilibidinal in nature.

A number of case studies were undertaken by Winder et al. (2014a). The findings of which suggest that the experience of taking MMPSA is very individual. All four individuals in the study experienced a different treatment journey. Whilst some individuals may take the medication and experience a reduction in PSA, others require frequent prescription adjustments, whether this is an increase of the dosage or medication type. Others may begin to take the medication and then choose to stop. It is important to remember that the use of MMPSA is entirely voluntary and is, therefore the decision of the individual being prescribed the medication. When individuals continued the medications, lower levels of PSA were shown. However, whilst some individuals welcome the reduction of PSA as they found their ability to become easily aroused embarrassing, others reported missing the medication to allow them to masturbate. Decisions to stop the medication also included self-reported side effects such as disturbed sleep. The results indicate that individuals need to discover which dosage or combination of medications are most suitable if they intend to continue the use of MMPSA.

As well as studies undertaken with individuals taking MMPSA, studies have been performed with professionals working with the individuals. Lievesley et al. (2014) conducted qualitative studies with individuals prescribed MMPSA and therapists involved with the individuals to gain an understanding of their experiences. Whilst the individuals prescribed the medication reported reductions in PSA, concerns were raised regarding what this would mean for future relationships, and as in Winder et al. (2014a), concerns in relation to side effects of the medication. For the therapists working with the medicated individuals, concerns were raised as to whether or not they would continue the use of MMPSA following release. The therapists felt that the individual may not appreciate the importance of continuing their medication to manage their risk and may choose to stop the medication due to the side effects.

Probation staff managing individuals who had been prescribed MMPSA were also interviewed by Elliott et al. (2017). The findings of the study were concerning in that Probation staff indicated a lack of knowledge about the medication. Many reported they were unaware that individuals on their caseload had been prescribed MMPSA, unless the individual informed them personally. The study highlights the need for greater communication between departments in the prison system.

A further review of the individuals prescribed MMPSA was conducted by Winder et al. (2018). This study used a sample of 100 males who had received medication, 75 of which had been prescribed SSRIs (72 fluoxetine, three paroxetine), 16 had been prescribed anti-androgen medications

(Cyproterone Acetate, CPA) and two had received GnRH agonists (Triptorelin). The results showed that all medications were effective in reducing PSA one month after medication. PSA continued to decline after three and six months. For those medicated with SSRIs, the reduction then began to level off but continued with the use of anti-androgen medications. The evidence suggests that MMPSA is effective in reducing PSA but that further research is required to compare the findings with that of a control group and also with individuals in the community.

Winder et al. (2024) extended the research by comparing the individuals prescribed MMPSA with a non-matched comparison group. The use of MMPSA was shown to be effective with both SSRIs and AAs, reducing levels of sexual compulsivity significantly. No reduction in sexual compulsivity was shown in the non-medicated comparison group. The study provides further evidence of the effectiveness of SSRIs in reducing levels of PSA, which is beneficial as SSRIs have fewer side effects and cost considerably less than AAs to provide to patients. Whilst the results are promising, there is still the need for a Randomised Controlled Trial of the effectiveness of SSRIs which is currently awaiting commencement by Winder et al. (in prep).

2.9 The transition from custody to community

As outlined above, the available literature regarding the effectiveness of MMPSA has been undertaken using custodial samples. How effective MMPSA will be for individuals residing in the community is not yet known. The literature indicates that the transition into the community following a custodial sentence is an inherently difficult period for many individuals. The first six months, post-release is where an individual is most at risk of being arrested (Hanson et al. 2018; Langan & Levin, 2002;). The Ministry of Justice report reoffending rates for all individuals released from custodial sentences in the UK. The figures are based on a 12-month period, with an additional six months provided to allow for convictions to be proven. In the January to March 2020 bulletin, 40.3% of adults released from custodial sentences had reoffended within a 12-month period (MOJ, 2022). Individuals who had been released from custodial sentences for sexual offences however, represented the lowest reoffending rates of all those reconvicted, with only 11.8% committing a further offence within 12 months (MOJ, 2022). However, despite the relatively low reoffending rates, individuals with sexual convictions are often subjected to intensive licence conditions, which can hinder the individual's ability to reintegrate into the community successfully (Mann et al., 2021). This is as a result of the prioritisation of risk management in order to protect the public from harm, as adopted by the current UK Criminal Justice System (Dealey, 2020; Deering, 2011).

Traditionally, researchers seeking to understand criminal behaviour sought to understand the reasons behind why an individual would commit offences. Desistance theories, on the other hand, seek to discover why an individual chooses to live an offence free life. It has been suggested that desistance is still a relatively misunderstood concept (Cooley & Sample, 2018). The literature evidences that there is much disagreement in terms of what is meant by true desistance or whether an individual is simply having a break from offending (Maruna et al., 2004). Hanson (2018) argues that the risk of reoffending for individuals with sexual convictions is often overestimated. He suggests that the majority of individuals with sexual convictions who have lived in the community offence-free for a period of 10 years would no longer be considered to be at risk of reoffending and can be classed as having passed the desistance threshold. Hanson et al. (2018) provided evidence to show that after a period of 10-15 years, the risk of reoffending sexually is reduced to that of an individual who may have a record of offending non-sexually. Desistance is usually defined as the process whereby an individual makes the change from habitual offending to the complete cessation of criminal activity (Maruna, 2001; Harris 2014).

Perhaps the earliest attempt at explaining desistance was provided by Hirschi (1969) and the Social Control Theory. Hirschi (1969) argued that seeking to explain why individuals commit offences was a fundamental flaw in theories seeking to explain criminal behaviour. Hirschi (1969) suggested that all individuals have the capacity to behave in a criminal manner and instead queried what is different about those who choose not to offend. Hirschi (1969) suggested that prosocial bonds, in the form of people, institutions and values, are what prevent an individual from committing offences when the opportunity arises. Social bonds are suggested to come in four forms, the first of which is attachment. Those who have strong feelings of attachment to their relationships and institutions will have higher levels of social control out of not wishing to disappoint those whom they are close to. Commitment is the second bond, and as with attachment, how committed an individual is to the relationships and institutions will reduce the likelihood of offending through fear of losing the bond. Involvement is the third bond, Hirschi (1969) suggests that those who spend their time engaged in prosocial activities will ultimately have less time to engage in illegal activities and will therefore be less likely to commit offences. The final bond comes in the form of belief and how much an individual values law-abiding behaviours and attitudes. Should these bonds remain strong, an individual is likely to desist from offending. However, once these bonds begin to break, the risk of offending increases. Sampson and Laub (2005) also advocate the importance of social controls in their life course theory of desistance. The authors argue that reoffending rates will often decline over an individual's life course and suggest that this is as a result of the social bonds the individual will make to their significant others and employment.

Other theories of desistance seek to explain the eventual cessation of offending through internal processes. Individuals may undergo a conscious decision to change the course of their lives. Giordano et al. (2002) suggest that there are numerous cognitive transformations that an individual will go through in order to achieve desistance. A motivation to change is not enough to achieve desistance. They must also have the opportunity to cease offending and a belief in their new identity as a non-offending individual. Maruna (2001) also suggests that acceptance of a new identity is important in the desistance process. However, this is particularly challenging for individuals with convictions who want to prove they have stopped offending. Individuals with convictions are often seen as risky by others, despite a cessation in offending, as innocence is difficult to prove. The lack of belief that the individual can change can lead some to live up to the label and be detrimental to their efforts to remain offence-free (Maruna et al., 2004). In order to accept their new identity, an individual with convictions will undergo an acceptance that their previous acts do not define them, and they are a good individual who has previously made bad choices (Maruna, 2001). Farmer et al. (2015) suggest that for an individual to be successful in achieving disistance, both aspects of desistance theory must be present. This includes changes to thought patterns in terms of making prosocial choices and also a change in the individual's circumstances to make desistance possible (Farmer et al., 2015).

Planning for reintegration has been shown to be important in reducing the likelihood of reoffending following release (Willis & Grace, 2009). Successful transition to the community from custody and achieving disistance are most likely to be possible when protective factors are in place (Harris & Levenson, 2021). However, when considering individuals with sexual convictions, the transition period into the community may be more difficult than those who have committed other kinds of offences (Grossi, 2017). This is as a result of the numerous restrictions that are often placed on those with sexual convictions following release.

De Vries Robbè et al. (2015, p.18) have suggested that protective factors should be defined as encompassing "… social, interpersonal, and environmental factors as well as psychological and behavioural features". In essence, a protective factor for individuals with sexual offences would be factors associated with a reduced risk of further offences (Willis et al., 2020). Risk factors, however, are factors associated with an increase in risk of offending (Heffernan & Ward, 2019). Protective factors, as with risk factors, can be both static and dynamic and should not be inferred simply as the lack of a risk factor but instead should represent a strength (De Vries Robbè et al., 2015). Risk

and protective factors may also coexist, for example, relationships can be both protective and risk factors (De Vries Robbè et al., 2015). Whilst supportive relationships could encourage the individual to cease offending, relationships with those with pro-criminal attitudes on the other hand, could support further offending. It is apparent throughout the literature that a number of factors, when present, protect the individual from being at risk of offending and assist in smoothing the transition from custody to the community.

Relationships have been evidenced as influential in determining the likelihood of an individual committing offences. Family relationships are identified as a criminogenic risk factor in the RNR model, as are relationships with offence-supportive peers (Bonta & Andrews, 2017). Relationships with parents were highlighted by Marshall and Marshall (2000). In their theory of sexual offending, individuals with poor relationships with their parents are at a greater risk of being a victim of sexual abuse. For individuals with poor family connections, masturbation then becomes used as a coping mechanism, which is common for individuals with sexual preoccupation and sexual compulsivity (Cortoni & Marshall, 2001). Marshall and Marshall (2000) suggest that frequent masturbation causes sexual fantasies to become deviant, which when coupled with opportunity, puts the individual at risk of committing sexual offences. De Vries Robbè et al., (2015) also identify a lack of intimate adult relationships and negative social networks as being risk factors in sexual offending.

On the other hand, supportive relationships have been shown to be important protective factors in encouraging desistance and ensuring a smooth transition into the community (De Vries Robbè et al., 2015; Sampson & Laub, 2005). Individuals with sexual convictions who have supportive relationships are less likely to reoffend than those without (Kruttschnitt et al., 2000). For individuals subject to licence conditions as a result of their sexual offending, the possibility of reforming prosocial bonds such as ties to family and friends may be reduced significantly. Whilst for many, the release into the community may be a time for individuals to return to their family home and be reunited with loved ones, others may experience isolation (Bailey & Klein, 2018; Fox, 2017). Individuals subject to a residency requirement, for example, may be prohibited from returning to their home address and may be required to live alone in an area that is unfamiliar to them (Levenson & Cotter, 2005a, Levenson & Hern, 2007). Individuals with sexual convictions are often ostracised from society as a result of their sexual offending. Often members of the public do not wish for individuals with sexual convictions to be reintegrated into their community. Landlords may be more reluctant to rent properties to individuals with sexual offences against children (Evans & Porter, 2015). Additionally, the families of those who have been convicted of sexual offences have

experienced threats and damage to property due to their association with the individual with the conviction (Levenson & Cotter 2005b). Individuals with a sexual conviction may therefore face additional barriers for reforming positive, prosocial relationships, which are a recognised protective factor in desistance (Bailey & Klein, 2018). Indeed, one of the biggest fears faced by individuals serving custodial sentences is the lack of social support they may receive following release (Winters et al., 2017).

Experiencing PSA has been shown to impact the quality of relationships. The attachment style of an individual has been shown to influence the success of supportive relationships (Marchand, 2004). Individuals with hypersexuality experience more insecure attachment styles, such as anxious and avoidant relationship attachments (Faisandier et al., 2012; Zapf et al., 2008). Insecure attachment styles are detrimental to the quality of relationships however, it is unclear whether the attachment style leads to PSA in the form of hypersexuality or vice versa (Zapf et al., 2008). Additionally, the inability to manage sexual urges and behaviours leads to conflicts in relationships and causes distress for both the individual and those close to them (Reid et al., 2010). Individuals with PSA have also been shown to put themselves at risk of sexual infection as a result of engaging in frequent, casual sexual activities (Yoon et al., 2016). As PSA has been shown to be detrimental to relationships, maintaining supportive relationships in the community may be particularly difficult for such individuals if they cannot manage their PSA successfully.

Goal-directed living has been identified as an important factor in desistance (De Vries Robbé et al., 2015). This can include factors such as having meaningful employment and using leisure time constructively (Sampson & Laub, 2017). Support for this protective factor is also shown in the RNR as having meaningful employment, education and pro-social activities are identified as being important in assessing the risk of reoffending (Andrews & Bonta, 2010). Unemployment has been shown to be a risk factor for offending (Hanson & Harris, 2000). Individuals with sexual convictions who are engaged in employment have been shown to have lower recidivism rates than those who are unemployed (Kruttschnitt et al., 2000). For individuals with sexual convictions, restrictions may be placed on them that prohibit them from returning to their previous employment or field in which they previously worked (Evans & Porter, 2015). This increases the chances of financial hardship and reduces the bonds to institutions, which has been shown to be a protective factor in encouraging desistance (Hirschi, 1969; Sampson & Laub, 2005).

Experiencing PSA may be additionally detrimental to employment opportunities. Individuals with PSA have been shown to lose employment as a result of their hypersexual behaviour (Reid et al., 2010). The expense of using sex workers can lead to financial difficulties, and some have used company funds to finance this, leading to job loss and legal consequences (Cantor et al., 2013). The successful management of PSA would therefore assist in increasing the individual's employment opportunities.

An individual's wellbeing has also been shown to be an important factor when enabling the transition from custody to community. Bonta and Andrews (2007) identify that mental health, self-esteem and feelings of distress are key factors in reducing the likelihood of reoffending. Individuals with mental health problems are at a higher risk of reoffending (Baillargeon et al., 2010). Research shows that an individual recently released from custody encounters many difficulties, such as an inability to rebuild bonds with family members (Levenson & Hern, 2007), difficulties in finding housing (Evans et al., 2019) and employment. All of this can take a toll on the individual's mental wellbeing. Pratt et al. (2006) showed that individuals recently released from custodial sentences were 13 times more likely to commit suicide when compared to the general population, with 21% occurring within the first month of release. Many individuals who have been released following a conviction for a sexual offence experience lower wellbeing due to feelings of shame of their offending (Bailey & Klein, 2018). Often, individuals with sexual convictions are threatened as a result of their previous offending and experience damage to property. Living in fear of vigilantism may increase stress experienced by the individual with the sexual conviction, leading to the deterioration of wellbeing (Cubellis et al., 2019). As a result of this, how well an individual can manage their emotions may be important in the transition process in terms of managing sexual preoccupation and achieving desistance.

In addition to the difficulties faced by those with sexual convictions, as outlined above, living with PSA has been shown to further reduce levels of wellbeing. Individuals experiencing PSA often experience feelings of shame and guilt as a result of their inability to manage their sexual thoughts (Garcia & Thibaut, 2010; Reid, 2010). The knowledge that the individual's sexual interest is deviant impacts on their levels of self-esteem and self-worth particularly as they did not choose to have deviant sexual attractions (Blagden et al., 2018). The low feelings of self-worth may make it difficult to interact with others, leading to feelings of isolation, which further lowers levels of wellbeing.

PSA in the form of sexual compulsivity and preoccupation also has high levels of comorbidity with psychological disorders with obsessional components, demonstrating that PSA could be argued to be compulsive/impulsive (Raymond et al., 2003). Individuals with sexual compulsivity have been shown to experience paraphilic disorders, substance misuse disorders, phobic disorders, anxiety, and depression (Black et al., 1997; Kafka & Hennen, 2002; Schultz et al., 2014). An inability to regulate emotions effectively can lead some individuals to use sexual activities as a coping mechanism (Marshall & Marshall, 2000; Cortoni & Marshall, 2001). Sexual activities may be used as a way of reducing negative emotions (Reid et al., 2008). However, this may then leave the individual engaged in a vicious circle, as the relief from sexual activities can be short lived, causing the individual to engage in further sexual activities and reinforcing sexual compulsivity (Lew-Starowicz et al., 2020; Miltenberger, 2008; Reid, 2010).

Wellbeing is also associated with a risk of reoffending. Self-regulation problems are a recognised risk factor in reoffending (Hanson et al., 2007). Individuals are likely to engage in sexual activity when depressed, anxious and stressed (Bancroft & Vukadinovic, 2004). Many individuals who have reoffended sexually have reported a negative mood state in the time period before committing offences (Hanson & Harris, 2000). SSRIs have been shown to be effective in improving wellbeing and reducing PSA in individuals in custodial settings (Winder et al., 2018). Should individuals be able to access SSRIs in the community to assist with their wellbeing, this may also assist them in remaining offence free.

2.10 Conclusion

The current chapter has provided an overview of the literature relating to PSA, the impact this has on wellbeing and risk of offending, and how the use of MMPSA may be used to assist individuals in having a better quality of life. The chapter has also given an outline of the literature relating to risk factors that are specifically related to the transition period of an individual being released from a custodial sentence and reintegrated back into the community.

Whilst there is evidence of the effectiveness of MMPSA being used in custodial sentences, in the UK, little is known about the effectiveness or availability of MMPSA in the community. As a result, the thesis has been designed in an attempt to gain a further understanding of the use of MMPSA in the community. The thesis therefore aims (1) to illustrate how risk factors associated with the release from custodial sentences may be improved with the use of MMPSA, (2) to gain an understanding of the experiences of individuals seeking help for PSA in the community, (3) to gain

an understanding of the views and experiences of GPs who may be asked to prescribe MMPSA to individuals with PSA in the community. The subsequent chapter will provide an outline of the methodological framework used to address the research aims.

3 Methodology

3.1 Introduction

The following chapter outlines the chosen methodological approach for the research project which forms this thesis and discusses the rationale behind the design. This research programme comprises three studies, which were introduced in Chapter 1, the order of which is outlined again at the beginning of this chapter as a reminder to the reader. A discussion of research philosophy and how this has informed the chosen mixed methods approach will follow. The chapter will discuss the issues with ensuring the validity of the research design. The ethical considerations which formed part of the design of the research project will then be discussed. Following this, information in relation to participant recruitment, sample size and data collection will be introduced before moving on to discuss the chosen methods of analysis and the rationale behind these. A summary of the design of each of the three studies is included at the end of the chapter.

3.2 The empirical studies

3.2.1 Study one

Study one is a quantitative study designed to demonstrate the characteristics of individuals with PSA. The study aimed to illustrate how individuals with PSA present both pre and post intervention with MMPSA. It was felt that study one would be an important starting point for the research studies as the study provides an illustration of the impact PSA has on wellbeing and protective personality facets. Study one uses secondary data collected during the national long-term evaluation undertaken by member of SOCAMRU. The findings of the national, long-term evaluation are outlined in detail in Chapter 2, section 2.8.3. Although the study uses secondary data, the analysis of the data provided in study one has not been undertaken in any previous research studies undertaken by members of SOCAMRU. This ensures the study brings a unique contribution to knowledge.

The analysis is undertaken in two parts. In the first part, t tests were used to compare across samples. The research sample were compared against previously published samples to show how individuals with PSA compare pre-intervention with MMPSA and then at three and six-months post intervention with MMPSA. The second part of the analysis focuses on exploring relationships between PSA, as measured by the SCS (Kalichman et al., 1994); anxiety and depression, as measured by the HADS (Zigmond & Snaith, 1983); emotion regulation, responsible industry, enduring relationships and purposefulness as measured by the SIPP-118 (Andrea et al., 2007). Initially, a path

analysis to explore the relationship between variables. A Gaussian Graphical Model (GGM) is then used to further explore the data to check for any strong relationships among the variables. The study aimed to demonstrate how factors identified in the literature for ensuring desistance from offending, are impacted by PSA. The study also demonstrates how the use of MMPSA lowers PSA, anxiety and depression to levels consistent with non-offending samples, ensuring the individual is in a similar place to those without PSA, leaving them better prepared to achieve desistance. The study illustrates the importance of individuals being able to obtain MMPSA in the community.

3.2.2 Study Two

Study two is a qualitative study. The study was designed to gain an understanding of the experiences of individual living with PSA in the community. The study also aimed to gain an understanding of how individuals with PSA experience help-seeking in the community. It was felt that this was an important aspect of the study as if individuals have not been prescribed the medication in custody it was important to understand their experiences of seeking help when they had not previously been on the MMSA pathway. Additionally, to date, no research has been conducted with individuals who are on the MMSA pathway following their release from custody. The study helped to illustrate the experiences of individuals seeking help for PSA in the community. The study follows on from study one to demonstrate the challenges individuals face when living with PSA in the community. Thematic analysis was chosen as the analytical method.

3.2.3 Study three

The final empirical study sought to gain an understanding of the views and experiences of GPs prescribing MMPSA in primary care. Whilst the medication is initiated by a psychiatrist in custodial settings, in the UK, an individual will need to be referred to a psychiatrist via their GP. It was therefore felt to be important to gain knowledge of how a GP would deal with a consultation if someone asked for help with their PSA and whether they would be able to deal with this in primary care or seek advice from a specialist. The study is qualitative and thematic analysis was chosen as the analytical method. The study follows on from study two, which demonstrates the challenges individuals face in seeking help for PSA in the community. Study three highlights the barriers faced by GPs in treating PSA in primary care and presents recommendations to help improve interventions available for individuals in the community.

3.3 Research Philosophy

The research project has been designed following consideration of research philosophy literature and the paradigms that inform research. Paradigms, a term first coined by Thomas Khun (1970), refer to the collective beliefs and values in relation to research. These collective belief systems have the ability to guide the researcher in terms of how they conduct their investigations through their selection of research questions, methods of data collection and interpretation of the data collected (Morgan, 2007). The term paradigm is also often referred to in the literature as worldview, which would refer to how we think of the world and how we make sense of it (Patton, 2002). They are also referred to in the literature as 'theoretical frameworks', or 'sociological theories' (Cooper, 2008). Creswell and Plano Clark (2011) highlight how worldviews of research are informed by five main elements which influence how a researcher will carry out their investigations. Each of these philosophical elements will vary slightly depending on the worldview of the individual researcher. These elements of research refer to the ontology, or nature of reality of the research; how the researcher will gain knowledge, which is known as the epistemology; how the research will be performed, the methodology; the axiology of research, or the importance of values; and the rhetoric, which relates to the language of research.

When designing a research project, it is important to be clear on the aims of the research and what it will be possible to discover. In order to achieve this, a researcher will adopt an epistemological position (Willig, 2008). Epistemology is the way in which we acquire knowledge and what is defined as acceptable knowledge (Tuli, 2010). The way in which an individual acquires knowledge has been debated over time as to whether this is achieved through inductive reasoning, known as empiricism, or through deductive reasoning, known as rationalism. In more recent years, new philosophical positions have appeared and been debated in social science research (Walliman, 2006). The two epistemological positions which inform this research project come under the umbrella terms of positivism and interpretivism. The divide between these two positions will now be discussed further.

Positivism is an epistemological position associated with quantitative research. Positivists argue that any social science research should be objective and treated in the same way in which a scientist would investigate phenomena (Johnson & Onwuegbuzie, 2004). Positivism has been defined by Kirk and Miller (1986, p.14), and assumes that 'the external world itself determines absolutely the one and only correct view that can be taken of it, independent of the process or circumstances of viewing'. Positivist philosophy uses scientific methods in order to reduce the subjective influence

of the researcher as it assumes there is an objective reality which can be discovered through research (Van Griensven et al., 2014). Positivism should be unbiased and without influence from the researcher (Willig, 2008).

For interpretivists, the nature of reality, or ontology, is a different position to that of a positivist. Interpretivism maintains that the way in which we view the world is influenced by our own beliefs and experiences (Walliman, 2006). The way in which one individual experienced an event may be totally different to how another individual experiences the same event. For interpretivists, there is no single reality which can be measured, instead research produces only that which the researcher is able to interpret as their understood reality (Alexander et al., 2008). One branch of interpretivism is that of constructivism. Constructivism is a philosophical position favoured by qualitative researchers and rejects positivism. Constructivism uses the subjective and individual experiences of the participants to form meaning and understanding of specific phenomena (Creswell & Plano Clark, 2011; Young & Collin, 2004). Whilst positivism assumes that the world can be viewed directly, constructivism assumes that the world can only be understood by the construction of the mind (Young & Collin, 2004).

During the 1970s and 80s, social science research underwent a period often referred to as the paradigm debate, or paradigm wars, whereby researchers debated whether qualitative and quantitative methods could be mixed as a result of the differing philosophical positions of the two paradigms (Creswell & Plano Clark, 2011). Howe (1988) suggested that whilst many purist qualitative and quantitative researchers would be, what he labels, advocates of the 'incompatibility thesis', Howe argued that there was a need for a move towards the 'compatibility thesis'. The compatibility thesis, as suggested by Howe (1988) supports the notion that there are benefits in combining different methods. Schwandt (2000) also considers that there is no need for researchers to make allegiances with only one paradigm, either positivism or constructivism. Schwandt (2000) states that research is interpretive, and the different types of methods available are important for enhancing understanding in relation to the phenomena studied. This point is also raised by Willig (2008) who suggests that, despite the influence of positivism being present for a number of years, in contemporary research, there are few researchers who would today classify themselves as a pure positivist. It is now accepted that 'pure' positivism is not possible as all research will have elements of influence from the researcher, observations are selective as are descriptions (Willig, 2008). The idea that research can be purely objective is not possible as the researcher will always have some influence over the research.

It is now considered that the debate between qualitative and quantitative methods can be counterproductive in the development of social science research (Onwuegbuzie & Leech, 2005). Both qualitative and quantitative research have their own benefits and many researchers agree that there are positives in combining different methods (Alexander et al., 2008). Greene et al. (2001) identify that researchers are now aware that the complexities of the social phenomena can be better understood through the use of a variety of different methods, rather than restricting the research to just one method. The combination of methods also allows for the weaknesses found in both quantitative and qualitative methods, to be compensated for (Kelle, 2006). Ultimately, the option to combine methods has the ability to lead to superior findings as a result of the eclectic nature of the research methods (Johnson & Onwuegbuzie, 2004). Mixed methods research is now viewed as an influential research approach, along with qualitative and quantitative research (Bryman, 2006; Johnson et al., 2007).

The various purposes of combining methods have been outlined by Greene et al. (1989) who developed a theoretical framework to identify five reasons a mixed methods approach may be utilised. The five purposes they defined were: triangulation, complementarity, development, initiation and expansion. When combining methods for the purpose of triangulation, a researcher would use a multiple methods approach in order to converge and corroborate results. Should a researcher be interested in the purpose of complementarity, they would use multiple methods in order to gain a better understanding of the differing aspects of the phenomena under investigation. The purpose of complementarity allows for the illustration and elaboration of the results through the use of different methods. Should a researcher be interested in the purpose of development, the results of one method would be used to inform the choice of the second method, this is often used in order to create or develop research instruments (Alexander et al., 2008). The purpose of initiation is used when the results from the use of one method leads to questions which can by answered with further investigation through the use of a second method. The final purpose defined by Greene et al. (1989) is that of expansion, whereby different methods are used in order to extend the investigation.

A mixed methods approach has been chosen for the research project as it was felt that the combination of quantitative and qualitative methods would allow the aims of the research to be explored at a greater depth, than through the use of one method alone. Newman et al. (1998) highlight how the use of both qualitative and quantitative methods allow for a greater

understanding of the phenomena under investigation to be obtained, and this was felt to be important for this research project. Greene et al. (2001) explain how a better understanding can be achieved by enhancing the credibility of findings, by achieving more comprehensive findings, by providing more thoughtful understandings and increasing values and diversity. The purpose of mixing methods in this research project, as defined by Greene et al. (1989) was to achieve both triangulation and complementarity.

It is suggested, in the literature, that the use of a mixed methods design should be determined by the research question, rather than simply the epistemological and methodological positions (Kelle, 2006). The research questions for this research project are two-fold. The research aimed to evaluate the effectiveness of MMPSA in reducing problematic sexual arousal and improve well-being, but in addition to this, sought to gain an understanding of the individuals' experiences of living with PSA in the community. The two strands to the research aim were not possible to achieve through one method alone. In order to measure the effectiveness of the medication, quantitative methods were chosen. Unfortunately, as a result of the Covid-19 pandemic, secondary data were used for this study. Participants who took part of the national long-term evaluation of the effectiveness of MMPSA completed questionnaires in custody to measure their levels of sexual arousal and well-being at three-monthly intervals. The statistical data collected from the long-term evaluation was used to measure changes in the effects of MMPSA over time. Protective factors were identified from the literature that were deemed to be important in encouraging desistance following release into the community. Data were analysed to ascertain how the use of medication impacted on the participants levels of anxiety and depression and protective personality facets. The use of quantitative methods allows for the results to be generalised to similar samples.

As indicated by Crossan (2013) it is not possible to explore an individuals' feelings and experiences through a positivist approach. One of the research aims of this project however is to gain an understanding of the lived experiences of the individuals who have problematic sexual arousal and how their use of MMPSA has impacted on this. It was felt that a quantitative approach alone would not be of benefit to this type of research question and therefore qualitative methods were chosen for study two order to achieve complementarity. Qualitative methods were also chosen for study one which aimed to gain an understanding of GPs views and experiences of treating PSA in primary care. The use of qualitative methods allowed the participants to give a detailed account of their personal experiences which quantitative measures alone would not have achieved, thereby enabling another layer of the phenomena to be investigated. Giving participants a voice to discuss

their lived experiences of PSA and the use of MMPSA in the community enabled a further dimension to be added to the statistical data obtained through the completion of questionnaires.

The combination of both qualitative and quantitative methods allows for triangulation of the results, which was felt to be an important aspect of the research aims. Triangulation may be undertaken by a researcher using two or more different methods in order to gain a better understanding of the phenomena under investigation (Alexander et al., 2008). Campbell and Fiske (1959) were the first to introduce triangulation. In their paper, the authors discuss establishing discriminate and convergent validity through the use of a multitrait multimethod matrix. In order to establish the validity of instrument measures, multiple methods were used to evaluate multiple traits concomitantly. The authors then used correlational analysis in order to establish the independence of the traits and methods.

The use of triangulation is particularly important when gaining an understanding of a subject in which little is already known. In relation to the use of MMPSA, there is little research which has focused on individuals who have been prescribed MMPSA and are living in the community. Triangulation was therefore an important aspect of the research project in order to gain a better understanding of the effectiveness of the medication in reducing arousal and managing the well-being of the individual. It was felt that through using quantitative methods in order to measure levels of sexual arousal and well-being, in addition to conducting qualitative interviews in order to assess the experiences of those using the medication, that the triangulation of the results would allow for more robust findings. In a perfect case of triangulation, the comparison of the quantitative data with the qualitative data allows for validation of the findings through convergence of the results (Creswell & Plano Clark, 2011). It is recognised however that in reality, research does not always conform and there are occasions where qualitative and quantitative data provide conflicting results.

Mathison (1988) suggests that the use of triangulation provides a rich and detailed account of the phenomena under investigation, and that rather than being used as a mechanism to ensure validity, the focus should be on the researcher to find understanding in the phenomena under investigation. Mathison (1988) outlines three outcomes that may occur as a result of using triangulation, the first of which is convergence of the results which is the most common assumption of the use of triangulation and is discussed above. Mathison (1988) highlights that there are two other possible outcomes of triangulation, inconsistency is the first of these whereby there is no clear evidence of

which claim is valid as the data offers alternative propositions. The final outcome is contradiction, whereby the results. Are not only inconsistent but also contradictory. As a result of these three possible outcomes, Mathison (1988) argues that the process of triangulation provides the researcher with evidence to make more informed explanations of the subject under investigation.

For the research questions and aims of this research project, both the chosen qualitative and quantitative research methods were given equal importance. Alexander et al. (2008) indicated when this is the case, the research usually aims to understand more of the problem in question through complementarity. As a result of the above, in order to carry out the research process, a convergent parallel design was chosen. A convergent parallel design aims to gain an understanding of the research problem through the comparison of results from different methods of data collection (Creswell & Plano Clark, 2011). In this design, as both qualitative and quantitative data is given equal importance, there is the ability to collect the data concurrently, as the results of the quantitative study do not determine the design of the qualitative study, as in sequential studies for example. Following the concurrent data collection, data is then analysed separately and merged following the final analysis of results (Fetters et al., 2013).

As a result of the overarching research aims, and methodological design, the worldview or paradigm that has been chosen to inform this research project is that of pragmatism. Pragmatism is the recommended philosophical position for a research design utilising mixed methods research and aims to achieve the best chance of answering research aims efficiently through combining approaches to research (Johnson & Onwuegbuzie, 2004). The use of pragmatism as a philosophical position moves away from a focus on whether research should be either objective or subjective and instead has a focus on what works (Creswell & Plano Clarke, 2011). The differences between the paradigms become less important (Alexander et al., 2008). Tashakkori and Teddlie (2003) indicate that it is the research question and how best to address this which is most important and that in doing so, the need to align with either positivism or constructivism can be moved away from. A pragmatic approach to the use of a combination of research methods allows this to happen and allows for flexibility in the design.

3.4 Ensuring the validity of the research design

When designing a research project, an important aspect to consider is whether or not the researcher can have confidence in the research findings. In order to achieve this, the quality or validity of the measures and methods chosen, need to be assessed. Even when taking pragmatism

as the overarching paradigm, the methods of validation used for each method are incredibly different (Yardley & Bishop, 2017). As quantitative and qualitative research methods often come from opposing epistemological positions, the concepts by which this is measured also vary. For quantitative methods, the ways in which the validity of research are ensured is covered at length in the literature and there is a general consensus in the standard criteria. Confidence in quantitative methods is measured by four criteria which are, internal validity, external validity, objectivity and reliability (Anney, 2014). For quantitative research, reliability relates to the consistency of a psychological measure in different settings and time scales, whilst validity would indicate the researcher could be confident that the measure used, measures that which is intended (Howitt & Cramer, 2011). In an experimental design, a research project would have external validity if the sample is representative of the population, and internal validity if the results occurred as a result of the difference between how the two groups were treated (Howell, 2013). Objectivity for quantitative research methods, refers to the basic premise of positivism, in that the research should be free from influence from the researcher to allow for unbiased findings (Payne & Payne, 2004).

As a result of the different epistemological positions in relation to quantitative and qualitative research, the way in which the validity of qualitative research can be measured has been debated. Traditional methods of ensuring validity in quantitative research are based on positivist assumptions and are therefore not suitable for measuring the quality of qualitative research (Salner, 1989). This has led to the criticism of qualitative research as qualitative results cannot be relied on without ensuring the production of consistently valid results (Maxwell, 1992). Whilst quantitative researchers are concerned with the reliability and validity of research, for qualitative researchers, Creswell and Plano Clarke (2011) suggest that there is more of a focus on validity than reliability. Onwuegbuzie and Burke Johnson (2006) suggest that in relation to mixed methods research in particular, when speaking of measures of validity, this refers to the quality of the research and how defensible the findings are, rather than the definition given above in relation to quantitative research. Onwuegbuzie and Burke Johnson (2006) indicate that in order to avoid confusion with the validity criteria as favoured by quantitative researcher, for many qualitative researchers, the term validity has been replaced by trustworthiness.

In order to ensure the validity of qualitative research, a number of researchers have attempted to produce criteria for which the validity of research can be measured. It is noted that as a result of all the varying measures by which the validity of qualitative research can be measured, it is often difficult to decide on the appropriate measure (Creswell & Plano Clark, 2011). Lincoln and Guba

(1985), in perhaps one of the earliest of these attempts, developed what they labelled the 'trustworthiness criteria'. Lincoln and Guba (1985) proposed that the 'trustworthiness criteria' could be used in qualitative research as a direct alternative to the criteria used by quantitative researchers. The trustworthiness criteria proposed by Lincoln and Guba (1985) consists of four principles: credibility, transferability, dependability and confirmability. Credibility is offered as an alternative to internal validity, transferability replaces external validity, dependability is an alternative for reliability and confirmability is the alternative to objectivity.

The trustworthiness criterion however is not the only available measure for ensuring validity in qualitative research. Maxwell (1992) suggested that the criteria offered by Lincoln and Guba (1985) denied that the scientific paradigm was relevant to qualitative research. Maxwell proposed that instead, the validity of qualitative research should be measured by descriptive validity, interpretative validity, theoretical validity, evaluative validity and generalisability. In relation to generalisability, Maxwell (1992) suggests that this can be differentiated between internal and external generalisability. Internal generalisability would mean the results apply within a particular group, and external generalisability to be applied beyond the group (Onwuegbuzie & Burke Johnson, 2006).

Another particularly useful measure for ensuring validity in qualitative research has been provided by Elliott et al. (1999). Elliott et al. (1999) sought to build on previous literature in relation to the validity of qualitative research and proposed a set of, what they labelled, Evolving Guidelines, for use in reviewing qualitative research. Elliott et al. (1999) were keen to establish that the Evolving Guidelines were not intended to be used rigidly in order to avoid restricting creativity in rich qualitative research. This has led to praise in their approach by authors such as Smith (2003) and Willig (2008). The Evolving Guidelines provided by Elliott et al. (1999) contain seven guidelines which are applicable to both qualitative and quantitative research. These include, ensuring the scientific purpose and context is explicit, the use of appropriate methods, a respect for participants, specification of methods, appropriate discussion, clarity of presentation and a contribution to knowledge.

Elliott et al. (1999) also set out seven guidelines which are specific to qualitative research. The first of these they label *owning one's perspective*. Elliott et al. (1999) indicated that in qualitative research, researchers should make clear their theoretical orientations and values, this assists the reader in interpreting the data. The second guideline is *situating the sample,* by describing the

sample used readers of the research are able to assess to which group of individuals the results will be relevant to. The third guideline is *grounding in examples,* through the use of extracts from the data, the reader is able to understand the researchers' interpretation of the data. *Providing credibility checks* is the fourth guideline and this can be achieved using a variety of methods such as triangulation and checking understanding. *Coherence* is achieved through the understanding being presented to form a story, framework or structure, for the subject. *Accomplishing general vs specific research tasks,* is the sixth guideline proposed. The author should make clear the purpose of the research whether this is to gain an understanding of a specific case or a general understanding of the subject. The final guideline is *resonating with readers,* the reader should be able to feel that the way the research is presented is an accurate representation of the subject matter.

The final method for ensuring validity in qualitative research that will be discussed here is proposed by Yardley (2000; 2008). Yardley (2000; 2008) suggests that in order to ensure quality in qualitative research, the measures can be split into three main categories or principles. The first principle suggested by Yardley (2000; 2008) is that of sensitivity to context. Sensitivity to context could be achieved in various ways. A researcher would need to have an awareness of the relevant literature in order to achieve sensitivity to a theoretical context for example. The researcher could show sensitivity to the data collected, through the use of extracts of the responses given by the participants (Smith, 2003). Sensitivity to the socio-cultural context is another which could reveal sensitivity to context, whereby the researcher shows an understanding of the cultural norms associate with the population being studied. Sensitivity to the social context is another aspect which should be considered. Yardley (2000) indicates that the is the relationship between the researcher and the participant themselves is extremely important. Yardley (2000) highlights the importance in qualitative methods of giving the participant a voice which can assist in achieving a greater balance of power between the participant and the researcher. Through the use of open-ended questions, the participant receives the opportunity to provide their personal perspectives and experiences, and to discuss subjects which are of importance to themselves (Wilkinson et al., 2004).

Commitment, rigour, transparency and coherence is the second principle outlined by Yardley (2000, 2008). Yardley (2000) suggests that this is a broad principle which is usually associated with techniques used in all methods of data collection and research. Smith (2003) indicates that commitment can be shown by the researcher having considerable experience of using the chosen research method. Yardley (2000) suggests that commitment can be demonstrated not only through

experience of the methods used but also through immersion in the subject area and data collected. Rigour is concerned with the thoroughness of the collected data and resulting analysis. Yardley (2008) suggests that rigour is achieved through personal commitment of the researcher in demonstrating thorough engagement with participants and subsequent data collection, knowledge of methodologies and theoretical understanding.

Coherence refers to the study as a whole and Yardley (2008) suggests that this is achieved by the arguments used for choosing the design of the research project in order to answer the chosen research questions. The researcher therefore needs to demonstrate competence in the theoretical backgrounds of the methodologies in order to ensure that the design and approach chosen is compatible. Transparency relates to how well readers of the research can understand exactly how the research was carried out and how the data was analysed. The reader should be able to understand how the interpretation was arrived at (Yardley, 2017). This is supported by the cohesive argument mentioned above, but it is also important to show how the analysis was performed so the reader can understand how the data was interpreted. The final principle outlined by Yardley (2000, 2008) in that of, impact and importance, this is often the deciding factor in whether or not the research should be undertaken. Yardley (2000) suggests that research must have an impact on others' actions and beliefs. This impact can be achieved by having theoretical implications or practical implications which can be applied to assist real life situations.

Smith (2003) particularly praises the work of Elliott et al. (1999) and Yardley (2000) as he suggests that the criteria provided are able to be applied to any area of psychology. Smith (2003) indicates how the criteria provided by Yardley (2000) offers broad principles which can be flexibly applied in order to evaluate the quality of qualitative research. It is the approaches offered by both Elliott et al. (1999) and Yardley (2000, 2008) that informs the basis of this thesis.

3.5 Ethical considerations

In order to appropriately guide the research, prior to any data collection, ethical approval was sought from Nottingham Trent University (NTU), the National Health Service (NHS) via the Health Research Authority (HRA), and Her Majesty's Prison and Probation Service (HMPPS). The application for ethical approval to NTU was approved without the need for amendments on 16.09.2019. Further requests for information were made by both HMPPS and HRA. Replies were sent to both relevant Research Ethics Committees to address these concerns and obtain a favourable ethical

opinion. HMPPS granted a favourable ethical opinion on 03.03.2020. A favourable ethical opinion was received from the HRA on 28.05.2020.

Unfortunately, the World Health Organisation announced Covid-19 as a global pandemic on 12.03.2020. This meant that in person data collection was no longer possible. Further applications were made to allow data to be collected remotely on 13.07.2020, the details of which are outlined in-depth in Chapter 7. A favourable opinion for remote data collected was granted by NTU on 21.07.2020. HMPPS provided a favourable ethical opinion for remote data collection on 26.04.2021.

The British Psychological Society provide a code of ethics which all psychological researchers must abide by and adhere to. The ethical code is guided by four principles; respect, competence, responsibility and integrity (BPS, 2018). These four principles were considered when designing the research project and adhered to throughout. As with all research involving the participation of individuals, especially the sensitive nature of the subject matter regarding individuals with sexual convictions, a number of possible ethical concerns were considered and the appropriate management of these was put in place. The main ethical concerns which arose as a result of the research aims are outlined below.

3.5.1 Confidentiality and anonymity

The first principle in the British Psychological Society (BPS, 2018) code of ethics is that of respect. Respect for individuals is a fundamental principle in psychological research and researchers value the worth of individuals and take care to ensure that this is reflected in the research process (BPS, 2018). In order to adhere to this principle, the issue of confidentiality was considered throughout the research design, before, during and after data collection. Due to the nature of the subject matter and the participants involved in the research, the data collected are extremely sensitive and care was taken to ensure that only the author and members of the supervision team had access to the data. Care was taken to ensure that all personal data, which included names, ages and any other details which may identify participants were stored securely on NTUDataStore separate to any raw data. Only the author and members of the supervisory team were able to access the folders containing identifying and raw data with permissions being granted by IT. All raw data were identifiable only by an identification (ID) number, which allowed for the data to remain anonymous. Participants were made aware that any reports written would only contain anonymous information and that they would not be identified in the report. The responsible way in which the data was stored was in accordance with the third principle of the British Psychological Society code of ethics,

that of responsibility (BPS, 2018). All psychological researchers need to ensure they maintain professional accountability and managing data responsibly and maintaining confidentiality fits with this value.

When undertaking sensitive research such as research with individuals with sexual convictions there may be a need to breach confidentiality in order to protect individuals from harm. The fourth principle of the ethical code is that of integrity. Whilst ensuring the research is conducted ethically, care should be taken to ensure professional boundaries are maintained and that any misconduct is addressed (BPS, 2018). As a result of this, participants were made aware prior to data collection that anything they told the researcher during the interviews would remain confidential unless they informed the researcher that they were harming themselves or that someone else was being harmed. Participants were also made aware that should they disclose an offence for which they had not yet been convicted, or that they had been a victim of, that this would not remain confidential. It was also made clear that should they tell the researcher about anything that may give the researcher concern that they were putting themselves, or others, in danger that this would not remain confidential. In relation to study two, participants were nine individuals experiencing PSA, five of which had sexual convictions. If anything had been disclosed during interview which gave cause for concern this would have been passed on to the relevant agency, however nothing of concern was raised.

This ethical dilemma is discussed by Cowburn (2005) who explains that, especially in qualitative research, the researcher is likely to spend a number of hours with the participant. Whilst this is positive as a good working relationship enables a rapport to be built which fosters an environment where information is shared freely, this may also leave the participant open to unintended disclosures. Care must be taken to ensure that professional boundaries are maintained between the researcher and participant in accordance with fourth principle of psychological research, integrity (BPS, 2018). Previous research has criticised close relationships as creating false friendships, which can leave the participant vulnerable in terms of sharing information they would not have shared otherwise (Kvale, 2006). Cowburn (2005) explains that there is a difficult balance in creating a relationship with the participant which will foster an environment whereby the participants feel comfortable enough to provide unconstrained responses on the subject matter whilst at the same time ensuring that there is no collusion. Should information be disclosed during interview in relation to previous offences for which the individual has not been convicted, this potentially leaves victims at risk of further harm, if the information is not shared with the

appropriate agencies (Cowburn, 2005). As a result of this, participants were reminded of the caveat to the promise of confidentiality at the beginning of each meeting. Participants were reminded of this again at any point they mentioned anything during the interview which gave cause for concern.

3.5.2 Consent

In accordance with the guidance of the British Psychological Society (2017) informed consent was voluntarily obtained from each of the participants before they took part in the research. The issue of consent comes under the first principle of the British Psychological Society code of ethics, the principle of respect for individuals (BPS, 2018). Obtaining informed consent can only be achieved when the research participant is able to fully understand their involvement in the research project and is able to make an informed decision about whether or not they wish to take part (Syse, 2000). Obtaining informed consent is particularly important when researching vulnerable populations. When using participants who have been convicted of offences, it is important that the participant understands that taking part in the research will have no impact, either positive or negative, on the sentence they have received (Crane et al., 2013). It is also important to ensure that the participant does not feel in any way coerced into take part in the research, a factor identified as subject to abuse when undertaking research with those serving custodial and non-custodial sentences (Edens et al., 2011).

In order to ensure understanding, prior to the research taking place all participants were provided with a detailed information sheet which outlined what would be expected of them should they agree to take part in the research. This was also discussed verbally by the principal investigator to avoid any problems with reading ability. Participants were made aware of what would happen with the data collected and reminded of their right to withdraw from the research. All participants were also made aware that they would receive no financial benefit, or favourable treatment should they be subject to licence conditions, as a result of taking part in the research. A consent form was provided to each of the participants and was signed prior to any data being collected.

3.5.3 Risk of harm to participants

Due to the nature of the research, there was the potential that participants may become distressed by reflecting on previous behaviours, experiences and feelings. As outlined by Cowburn (2010), research with individuals with sexual convictions can bring about feelings of distress as a result of reliving experiences and behaviours. In relation to the qualitative studies, there was the potential that participants may be uncomfortable answering questions about their private feelings and

thoughts. In order to manage any possibility of the emotional harm however, the principal investigator was alert to the behaviour of participants and would offer the opportunity of a break if there were any signs of distress. This use of personal skills in being alert to the needs of the participant, is in accordance with the second principle of ethical research, that of competence (BPS, 2018). At the beginning of each meeting, participants were reminded that they could stop the meeting or interview at any time, for any reason, and there would be no adverse consequences if they chose to do so. In accordance with the first and third ethical principles of respect and responsibility, the welfare of participants was considered throughout the research and compassionate care was taken (BPS, 2018). Participants were provided with a debrief sheet which signposted them to the appropriate organisation should they need assistance after experiencing any negative thoughts.

The risk of harm to participants due to the nature of questions to be asked during the research was a point which was of significant concern to the HRA. During the original ethics application, the HRA raised concerns particularly in relation to the My Private Interests (MPI) scale which was intended for use in the originally designed study one of the research project. The MPI is a scale that was designed for use as an assessment of sexual interests for individuals who are undergoing the accredited Sex Offender Treatment Programme and was originally developed to better include those who have intellectual disability (Farren & Barnett, 2014). The scale includes 54 true or false statements in relation to a variety of sexual interests. The HRA REC highlighted concerns that some questions on the scale, for example, question 22, “I would like to have sex with a dead body”, might increase the risk of offending posed by the participant. The HRA requested further clarification that reading such statements to individuals who had previously offended sexually, and were now no longer in custody, would not cause them to engage in the behaviours highlighted in the statements and go on to commit further offences.

In order to alleviate the concerns of the HRA REC a search for literature in relation to the risk of administering the MPI was undertaken. Whilst there was a paucity of research into the risk of administering the MPI in particular, it was possible to provide evidence in relation to suicide which may alleviate the concerns raised in relation to engaging in thoughts and behaviours as a result of asking about the subject. Blades et al., (2018) performed a meta-analysis in order to assess the risks and benefits of asking research participants about suicide as a result of concerns raised that this may increase suicidal thoughts and behaviour. The authors reviewed 18 studies, both peer-reviewed and unpublished and results showed that the risk of suicide was not increased through

asking participants about it and indicated that it may be associated with small benefits. In the research reviewed by the authors, as a result of exposure to suicidal content, suicidal ideation was reduced, and participants showed a lower likelihood of engaging in suicidal behaviour. Unfortunately, the HRA felt that some of the statements would increase the likelihood of participants committing further offences. In order to reduce this perceived risk of harm, and to ensure ethical approval was granted, the scale was removed.

3.5.4 Risk of harm to the researcher

Research into sensitive topics has the potential to leave the researcher involved at a risk of emotional harm, especially when conducting in depth qualitative research (Mallon & Elliott, 2019). Lee and Lee (2012) identified three possible types of threat when conducting research which involves asking questions about an individual's private life. Lee and Lee (2012) indicated that the risks involved contained, an 'inclusive threat', whereby the research relates to sensitive, potentially distressing and private matters, a threat which they refer to as 'sanction' which relates to information which may reveal deviance. The third type of threat discussed is when researching a subject which could relate to social conflict, the authors refer to this type of threat as a 'political threat'. Research into individuals with sexual convictions is clearly a sensitive topic which could leave the researcher at risk of the first two type of threats outlined by Lee and Lee (2012) and potentially at risk of the third type.

When undertaking research with individuals with sexual convictions, the researcher is often exposed to distressing content, which could include details of the offence committed, a history of abuse and a distressing account of the experiences of custody (Blagden & Pemberton, 2010). As a result of this, there was the potential that the principal investigator may become distressed as a result of exposure to the sensitive information being discussed. Mallon and Elliott (2019) indicate however, that researchers felt the risk of emotional harm was reduced by the focus on professionalism. The second ethical principle of the BPS (2018) guidance also suggests the importance of competence and professional skills when carrying out research. The principal investigator has experience of working with individuals with sexual convictions through previous employment as an offender manager for the Probation Service and therefore the risk was reduced. However, in order to combat the possibility of this, the principal investigator had the support of the supervisory team throughout. All members of the supervisory team are experienced in doing research with individuals with sexual convictions and are familiar with the risks associated with this.

Following interviews, the principal investigator was invited to debrief with colleagues. Support was also available from Nottingham Trent University Counselling Service.

The risk of physical harm to the researcher was also considered. In order to reduce the level of risk of physical harm appointments were arranged in suitable, risk assessed buildings. As a result of the Covid-19 pandemic, many interviews were completed using the online video conferencing software, Microsoft Teams. Interviews were also conducted over the telephone. These methods of remote data collection removed the risk of physical harm to the researcher. In relation to study two, where interviews were undertaken face to face, appointments took place at the Safer Living Centre, which is a facility which offers support to individuals with sexual convictions. By arranging appointments at this location, the researcher was able to inform staff members of her whereabouts in the building, was often covered by CCTV and had access to a panic alarm. Care was taken to ensure the researcher always sat closest to the door and was aware of her exits. In addition to this, the researcher was alert to the participants demeanour and would offer breaks should the participants appear to be experiencing discomfort or becoming agitated.

3.6 Recruitment of participants

Study one uses secondary data, collected as part of the national, long-term evaluation of MMPSA undertaken by Professor Winder and the research team. As such, all participants were originally recruited for the evaluation. The process for referral to the pathway, and subsequent recruitment to the national, long-term evaluation has been provided in section 1.1 of this thesis. Between the start on the evaluation in 2010 and March 2019, 183 individuals were recruited to the long-term evaluation. For the purpose of study one, data from a total of 85 participants were analysed. This was due to data cleaning. A total of 99 participants recruited for the evaluation were removed from the original data set as they had not completed Sexual Compulsivity Scale (SCS; Kalichman et al., 1994) after the initial baseline collection. They had also not completed the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983) or the Severity Indices of Personality Problems – 118 (SIPP-118; Andrea et al., 2007).

The recruitment for participants for studies two and three focus on specific populations and therefore a purposive sampling technique was used. For study two, volunteer sampling methods were used. The study was advertised by a poster that was placed in the Safer Living Centre, a service for individuals with sexual convictions. Three participants were recruited from the Safer Living Centre. Whilst the Safer Living Centre has close links with researchers at NTU, the principal

investigator is not known to the Safer Living Centre. This meant that she had not met the participants previously as she is not involved in any research being undertaken there. Study two was also advertised on social media and on a forum for people with problematic sexual interests, with six participants recruited this way. A total of 9 participants were recruited for the study. Volunteer and snowball sampling methods were used in study three to recruit a sample of 8 GPs. This was done by advertising the study on the social media platform Twitter. As studies two and three are qualitative studies, small sample sizes are acceptable. Reflexive thematic analysis was used for these and as outlined by Braun and Clarke (2021) it was felt that a rich data set had been obtained for both studies with the samples obtained.

3.7 Data collection

As the research project used a mixed methods design, the methods of data collection differed. Study one was the quantitative study and is discussed in brief here as this will be discussed in more detail in Chapter 6 which is dedicated to this study. The two remaining studies were qualitative studies which used the same methods of data collection and as a result of this will be discussed in more detail in this chapter.

3.7.1 Psychometric scales

In relation to study one, secondary data was used. This was due to the restrictions placed on HMPPS research as a result of the Covid-19 pandemic which were not lifted until 22.06.22 (Gov, 2022). The secondary data were data collected as part of the long-term evaluation of MMPSA undertaken by Professor Belinda Winder. A favourable ethical opinion, allowing myself to analyse the data was provided by NTU on 02.12.2021 (WINDER 2021/415 (amendment to 2018/10, 2017/49, 2010/34). During the long-term evaluation, data were collected from participants voluntarily using MMPSA at three monthly intervals through the completion of psychometric scales. The scales used were the Sexual Compulsivity Scale (SCS), Hospital Anxiety and Depression Scale (HADS), the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), My Private Interests (MPI) and the Severity Indices of Personality Problems -118 (SIPP-118). These scales were completed with participants at baseline (pre-medication) and then again at three monthly intervals, for as long as the participant remained in the study. Study one used data collected via the SCS, HADS and SIPP-118 for the analysis. In study one, data were analysed at baseline (pre-medication), three months post-medication and six months post-medication (n = 85). Although the study uses secondary data, the data have not been analysed previously in the same way as study one, ensuring the contributions of the study are unique. As the focus of this chapter is concerned with the methodological approach to the thesis, the information in relation to each of these scales is discussed in more detail in Chapter 4 of the thesis which relates to the first of the empirical studies, study one.

3.7.2 Semi-Structured Interviews

Semi-structured interviews were used for studies two and three. Semi-structured interviews are undertaken by using a collection of questions already decided upon by the researcher. Semi-structured interviews usually involve up to 12 questions with a number of prompts or probes for each question (Rowley, 2012). In semi-structured interviews, the researcher has the freedom to ask the questions in any order, or ask new questions depending on points raised by the participant (Runswick-Cole, 2011). This enables a degree of flexibility which the researcher can adapt to suit each participant taking into consideration their understanding and allow for the possibility that participants may provide answers that respond to questions intended to be asked later on in the schedule (Fielding & Thomas, 2008). The decision to use semi-structured interviews was taken as it was felt this would allow rich, detailed data to be obtained. Unstructured interviews for example may have made it difficult for the researcher to obtain the relevant information in the time frame available. The use of an unstructured interview may also have made the analysis more difficult as the transcripts could have had too much variation (Rowley, 2012). The research design involves a specific research question and therefore an exploratory method of data collection was not necessary. A structured interview schedule was also decided against as they are often used in order create quantitative data (Runswick-Cole, 2011). The flexible nature of the semi-structured interview makes it particularly useful when researching topics where there is little known on the subject matter (Fielding & Thomas, 2008). The use of MMPSA in the community has not previously been evaluated and there is little evidence of the effectiveness of the medication outside of a custodial setting. The aim of study two was to gain an understanding of the lived experiences of individuals with problematic levels of arousal and their use of medication. Study three aimed to gain views of GPs in using MMPSA as a treatment method for individuals living with PSA. As a result of this, semi-structured interviews were chosen as the appropriate method of data collection.

Prior to the research being carried out, two interview schedules were produced. The first interview schedule was designed for study two and could be adapted depending on whether the participant had gained treatment for their PSA or not. If the participant had been prescribed medication, the interview schedule could be adapted to consider whether the participant was using medication, had stopped the medication entirely or was on a journey which meant they were changing the use of medication regularly. The changes in the use of medication could be for a variety of reasons including dosage changes or side effects. The second interview schedule was designed for use in study three, which was designed to gain an understanding of the views and experiences of GPs in prescribing MMPSA to individuals with problematic levels of sexual arousal and sexual compulsivity.

The interview schedules were designed following consideration of qualitative research literature. In order to establish an initial rapport with participants, the start of the interview schedule consisted of broad, opening questions and was filtered down to the more sensitive questions (Willig, 2008). Building a rapport with participants is important as this enables the participant to feel comfortable in responding to the questions, allowing a rich account of their personal experiences to be obtained (McGrath et al., 2019). Due to the sensitive subject matter it was important to ensure participants were comfortable to avoid any feelings of distress which could have arisen had the matter not been dealt with professionally. This is an important aspect of carrying out ethically sound research in that care is taken to ensure the safety of participants (BPS, 2018). The use of semi-structured interview schedules allowed for probing and further questioning of participants in encouragement to the responses provided (Fielding & Thomas, 2008). This is particularly useful if a participant was nervous and allows the researcher to provide gentle encouragement that what the participant has to say is of interest.

During the interviews, all data was recorded using an encrypted dictaphone. Participants were informed that the interviews would be recorded and consent to record was obtained prior to the commencement of the interview. The recording of interviews is advised as opposed to note taking as this avoids the possibility of the loss of data as a result of being distracted by writing the notes and also helps to reduce the length of time the interview takes (Fielding & Thomas, 2008). When interviews were undertaken remotely, using Microsoft Teams, no video recordings were taken to protect the participant's anonymity. Following the interviews, all data collected was transcribed verbatim. Verbatim transcription of the data is advised in order to ensure that when the analysis is being undertaken, the entire data set is available and nothing important is lost (Fielding & Thomas, 2008). Patton (2014) advises that verbatim transcription is essential when conducting qualitative analysis.

3.8 Methods of analysis

Study one is the only study in the research project which uses quantitative methods. Secondary data were used which had been collected through the use of questionnaires at three monthly intervals in order to evaluate the changes in the effects of MMPSA on reducing problematic sexual arousal and improving well-being over time. As this is the only study which uses quantitative methods, details of the methods of analysis are discussed further in Chapter 4, which is dedicated

to this study. The remainder of this section discusses the qualitative methods of analysis and the rationale behind this.

For studies two and three, thematic analysis was chosen as the most appropriate approach in terms of analysis in order to best address the research aims. Other methods of analysis were considered before deciding on thematic analysis, including Grounded Theory (GT) and Interpretive Phenomenological Analysis (IPA). The literature indicates that Grounded Theory is a particularly useful method of analysis when there is little known on the subject (Morse, 1994). The ultimate aim of GT is to produce a theory in order to gain an understanding of the phenomena under investigation. Rather than taking a deductive approach as favoured by positivists and quantitative methods, GT takes an inductive approach. Instead of attempting to test a hypothesis, inductive research begins with the social phenomena under investigation and attempts, through the use of exploratory research, to create a theory from the data in order to explain social life (Hodkinson, 2008). The main aim of the qualitative studies was to gain an understanding of the experiences of individuals living with PSA in the community. The research aimed to gain an understanding of the experiences of seeking help for PSA from healthcare practitioners, and the experiences of GPs in treating PSA. It was felt that GT, whilst not without its merits, was not the most suitable method of analysis for this research question.

IPA was also considered as a possible method of analysis when designing the research project. IPA was first introduced by Smith (1996). IPA is a particularly useful method of analysis when attempting to gain an understanding of the lived experiences of individuals, as the main aim is to gain an understanding of how individuals make sense of the world, both personally and socially (Smith & Osborne, 2003). Whilst this is the aim of the qualitative studies which make up this thesis IPA is informed by numerous philosophical positions including hermeneutics, idiography and phenomenology (Shinebourne, 2011). The overarching paradigm of this thesis is that of pragmatism which is as a result of the mixed methods design. Thematic analysis allows for theoretical freedom which means it can be used as an approach in many designs (Braun & Clarke, 2006). As a result of this, thematic analysis was chosen as this method of analysis allows for a greater degree of flexibility.

Thematic analysis is a method used to identify themes across the data in order to gain meaning and understanding of shared experiences of participants (Braun & Clarke, 2006; Braun & Clarke, 2012; Braun et al., 2023). Thematic analysis has previously been criticised as a method with authors

suggesting that the coding and identification of themes is a common tool in qualitative analysis, rather than a standalone approach (Boyatzis, 1998; Ryan & Bernard, 2000). The flexible nature of the approach has also been criticised and characterised as 'anything goes' (Antaki et al., 2002). Braun and Clarke (2006) however argued that thematic analysis should be seen as a method in its own right. This has been supported by others, including Nowell et al. (2017).

Braun and Clarke (2006) sought to rectify some of the criticisms previously associated with thematic analysis by creating a more sophisticated system for carrying out the analysis. Braun and Clarke (2006) suggested that the researcher should undertake six steps in order to perform a comprehensive analysis of the data. Each of these will now be discussed.

Familiarisation

The first step which should be undertaken is familiarisation of the data. The authors suggest that this is key and that the more familiar a researcher is with the data, the more efficient the analysis. In order to achieve this all interviews should be undertaken by the researcher to increase familiarity from the start. In addition to this, the researcher should undertake the transcription of the data themselves. This means that the researcher will be in a better position from the start of the project as they become immersed in the data collected. Through making notes of aspects of the data which cause interest as the transcription occurs, this will lead to the initial codes becoming generated as in the next step.

Initial coding generation.

The second step in thematic analysis is the initial coding generation. Braun and Clarke (2006) suggest that coding should be systematically performed, each line of the data at a time. Making notes of aspects of the data which seem particularly interesting or important will lead to themes to start to emerge. In this particular case, coding used a data led approach, where the codes were determined by the data, rather than being theory driven.

Identify themes

The next stage in the analysis process is when the researcher begins to group together the separate codings to create overarching themes or patterns in the data. It is through this process that the data set will become more meaningful as the themes begin to make sense of the data.

Review themes

In order to undertake a successful analysis, a researcher will need to review the theme on a number of occasions. The themes should have data to support them and may need to be redefined if data does not fit appropriately. The themes may also need to be split, or sub themes may need to be created.

Theme definition

Following the review of the themes, the researcher moves on to the stage of defining them and this may be conducted a number of times in order to ensure accuracy.

Report writing

This is the final stage of the analysis and allows the researcher a further opportunity to reflect on their findings and the data collected. Extracts from the data are used to illustrate the findings and backed up by previous literature in the discussion.

Each of the above points were considered when conducting studies two, three and four.

3.9 Conclusion

The above chapter has highlighted the research methods that have informed the design and data collection of this thesis. The research philosophy has been presented in order to provide a rationale for the research design. The considerations given to ethical concerns have also been discussed, along with the steps taken to ensure the research was conducted in line with guidance by the British Psychological Society. In addition to this, the steps taken to ensure the appropriate sample were recruited, and the appropriate sample size, have been introduced along with the rationale behind the chosen methods. An introduction to each of the empirical studies was provided earlier in Chapter 1. These will now be discussed at length in the following chapters.

4 Study One – A quantitative analysis of the characteristics of individuals with problematic sexual arousal.

4.1 Introduction

Chapter 2 highlights how MMPSA benefits individuals with PSA serving custodial sentences. MMPSA assists in reducing problematic levels of arousal and improving wellbeing (Thibaut et al., 2020; Winder et al., 2018). However, due to a paucity of available research, it remains unclear how effective the medication will be for these individuals following their release into the community. The current chapter aims to explore the potential effects of living with PSA in the community and how this may impact an individual should they not be able to access the medication. This is an important starting point of the thesis and is followed by Chapter 5, which highlights the difficulties faced by individuals when seeking help for PSA in the community, and the barriers to obtaining treatment. Additionally, Chapter 6 illustrates the problems faced by GPs in prescribing MMPSA to individuals in the community.

Individuals with sexual convictions have been shown to experience difficulties reintegrating into the community following release from a custodial sentence (Allan et al., 2023). This period of reintegration may be particularly difficult for individuals with sexual convictions and PSA. Whilst a number of protective factors have been shown to improve successful reintegration and encourage desistance, these have been shown to be negatively impacted by PSA. Factors that have been shown to be important include; having supportive relationships (Sampson & Laub, 1997, 2005; De Vries Robbè et al., 2015), spending free time engaged in prosocial activities such as employment (Andrews & Bonta, 2010; Sampson & Laub, 2017), and higher levels of wellbeing (Andrews & Bonta, 2007).

PSA has been shown to be detrimental to the first of these protective factors, that of supportive relationships (Paunovic & Hallberg, 2014). The inability to control sexual urges, thoughts and behaviours leads to distress and diminished functioning in many aspects of life, including personal and professional relationships (World Health Organisation, 2019). Koós et al. (2021) found relationship problems to be one of the four main types of negative consequences of hypersexuality, along with work related problems, risky behaviour and personal problems. Individuals with higher levels of sexual compulsivity have been shown to have lower levels of relationship quality, along with an increased risk of contracting sexual infections as a result of the frequent engagement in risky, sexual activities (Starks et al., 2013; Yoon et al., 2016).

Relationship quality has also been shown to be important in mediating compulsive pornography consumption. Compulsive pornography consumption refers to the perceived inability to control the use of pornography (Grubbs et al., 2015). Perceived lower relationship quality is associated with individuals feeling unable to control their use of pornography (Daspe et al., 2018). For individuals with PSA, it is possible that treating excessive levels of arousal with the use of MMPSA may assist in improving the quality of relationships. Thus, potentially strengthening this protective factor for the individual.

In relation to the protective factor of spending free time meaningfully, individuals with sexual convictions often encounter difficulties when seeking employment (Brown et al., 2007). Individuals with sexual convictions and PSA however may face additional challenges to those with sexual convictions that do not experience PSA. Koós et al. (2021) highlighted how individuals with hypersexuality often experienced work-related problems as a result of their frequent engagement in sexual behaviours. Job loss has been shown to be a negative consequence of PSA (Reid & Woolley, 2006, Reid et al., 2011). Should the individual be unable to get their sexual urges and behaviour under control, this may increase the likelihood of having problems with employment. Treating PSA with MMPSA following release, may assist the individual in managing their PSA. This could increase the possibility of successful reintegration by enabling the individual to engage in employment and make constructive use of leisure time.

Increased wellbeing has been shown to be important in increasing desistance (Lievesley & Harper, 2022). PSA however has been shown to be detrimental to an individuals' wellbeing (Winder et al., 2019). Individuals with PSA have been shown to experience high levels of anxiety and depression (Walton et al., 2017b). Reid (2010) showed that individuals with PSA experienced significantly higher negative, and significantly lower positive emotions when compared with controls. An inability to manage wellbeing effectively can lead some individuals to use sex as a coping mechanism, further increasing the risk of reoffending (Levenson et al., 2018). Additionally, it is recognised that some sexual offences are committed following a negative mood state (Hanson & Harris, 2000). As PSA has been associated with lower levels of wellbeing it is important for those who experience PSA to be able to manage it effectively following release.

It is recognised that not all individuals with PSA will wish to continue the use of MMPSA following release, every treatment journey is individual to the person. Some wish to stop medication when they feel it is no longer necessary, or they may require regular changes to the medication type and/or dose (Winder at al., 2014a). For those who wish to continue to use of MMPSA, the ability to access the medication on release is particularly important. Lowering PSA with the use of MMPSA may assist in increasing the outlined protective factors, leaving the individual in a better position to cope following release. The current chapter therefore aims to illustrate the impact the use of MMPSA can have on levels of PSA and how this relates to protective factors relevant to community reintegration, and for individuals with PSA residing in the community, to live offence free lives. Data collected as part of the long-term evaluation of MMPSA in custodial settings are used to achieve this aim.

4.1.1 Analysis One: Comparison of males with PSA with other male populations

The analysis for the present study was undertaken in two sections, the first of which aimed to describe a sample of individuals with PSA and how they presented both pre and post medication to answer the following research questions:

1. How do levels of sexual preoccupation and sexual compulsivity in males with a sexual conviction and PSA compared to those (i) in the general population (male student sample), (ii) with other males convicted of a sexual offence who do not experience PSA?

   It is hypothesised that the research sample will display significantly higher levels of sexual compulsivity pre-medication than (i) those in the general population, and (ii) males convicted of a sexual offence without PSA. It is also hypothesised that levels of sexual compulsivity will reduce in the research sample after three months of the use of MMPSA to show similar levels to (i) those in the general population, and (ii) males convicted of a sexual offence without PSA and will be further reduced following six months' intervention with MMPSA.

2. How do levels of anxiety and depression in males with a sexual conviction identified as suitable for MMPSA compare to those in the (i) in the general population, (ii) with male prisoners not convicted of a sexual offence, (iii) with males convicted of sexual offences who do not have PSA.

It is hypothesised that the research sample will display significantly higher levels of anxiety and depression pre-medication than (i) those in the general population, (ii) male prisoners without a sexual conviction and (iii) males convicted of a sexual offence who do not have PSA. It is also hypothesised that levels of anxiety and depression will reduce in the research sample after six months of the use of MMPSA to show similar levels to (i) those in the general population, (ii) male prisoners without a sexual conviction and (iii) males with a sexual conviction who do not have PSA.

4.1.2 Analysis Two: Exploring the relationships between levels of sexual compulsivity, anxiety, depression, emotion regulation, enduring relationships, responsible industry and purposefulness

As outlined in section 2.9 of the literature review and section 4.1 above, there are a number of protective factors that are deemed to support individuals, following their release from custody. These factors are also important in supporting individuals in the community to remain offence free. When present, these factors have been shown to assist individuals in successfully reintegrating into the community and achieving desistance. These protective factors are; having supportive relationships (De Vries Robbè et al., 2015; Sampson & Laub, 2005), goal-directed living or spending free time meaningfully (De Vries Robbé et al., 2015; Sampson & Laub, 2017), and positive wellbeing (Leivesley & Harper, 2022). Additionally, all these protective factors have been shown to be negatively impacted by living with and experiencing PSA (Koós et al. 2021; Paunovic & Hallberg, 2014; Winder et al., 2019). In an attempt to explore the relationship between PSA, wellbeing and protective personality facets, a path analysis was performed. The model uses personality facets from the Severity Indices of Personality Problems (SIPP-18; Andrea et al., 2007) associated with the protective factors outlined above. The chosen personality facets are; emotion regulation (to represent an aspect of wellbeing), purposefulness and responsible industry (to represent spending free time meaningfully) and enduring relationships (to represent the importance of relationships). The relationship of these personality facets, with sexual preoccupation and hypersexuality, as measured by the Sexual Compulsivity Scale (SCS; Kalichman et al., 2004) and aspects of wellbeing as measured by the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith 1983) were explored.

The analysis was performed at baseline, to illustrate how the individual presents without the intervention of MMPSA. The model explored the relationship between sexual compulsivity and wellbeing and how this impacted on the protective personality facets. As outlined above, PSA has

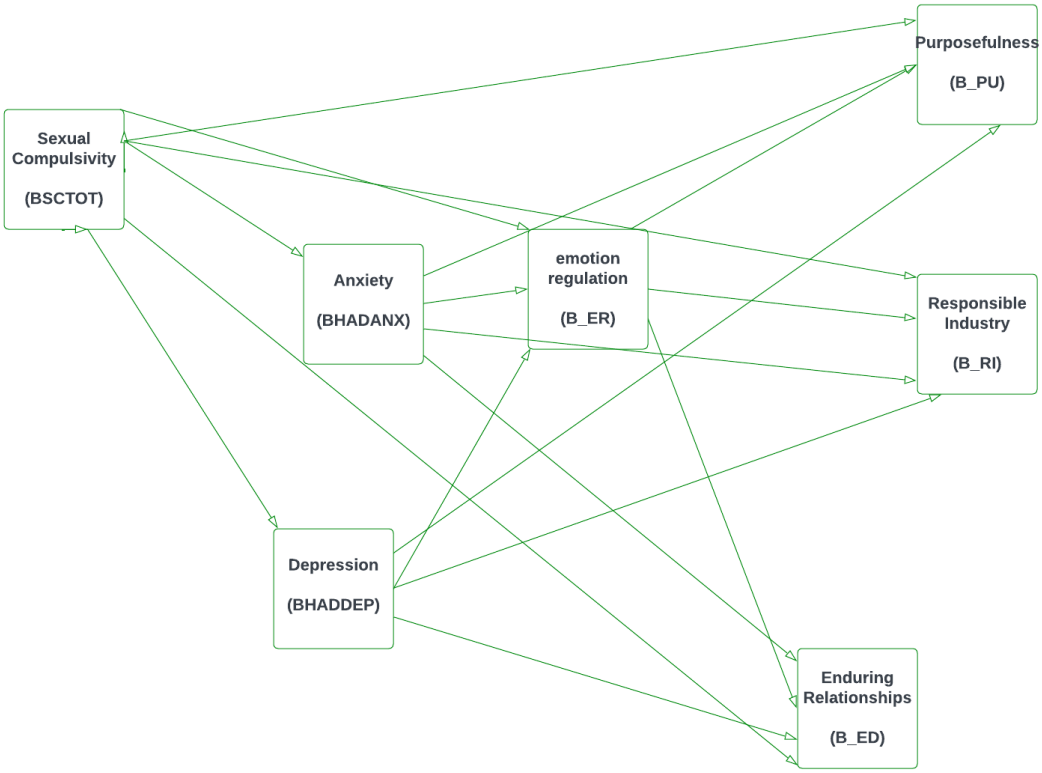
been shown to negatively impact levels of wellbeing. As a result of this, the model was designed with anxiety, depression and emotion regulation as mediating variables in an attempt to explore how levels of wellbeing impact the relationship between sexual compulsivity and the personality facets purposefulness, enduring relationships and responsible industry. The direct relationship between sexual compulsivity and each of the variables is also explored.

There are three hypotheses:

1. As sexual compulsivity has been shown to negatively impact wellbeing (Winder et al., 2019), relationships (Klein et al., 2015) and employment (Koós et al., 2021) it is anticipated that the model will show that sexual compulsivity will have a negative relationship with each of the protective personality facets chosen from the SIPP-118.
2. It is also anticipated that emotion regulation, an aspect of wellbeing, will have a positive relationship with the personality facets; responsible industry, purposefulness and enduring relationships.
3. As PSA has been shown to impact on levels of wellbeing it is anticipated that there will be a positive relationship between levels of anxiety and depression as measured by the HADS and sexual compulsivity as measured by the SCS.

An illustration of the Path Diagram explored is provided in figure 2 below.

Figure 2: Illustration of Path analysis model.



4.2 Method

4.2.1 Participants

The study uses secondary data, collected for the long-term evaluation of the effectiveness of MMPSA in managing arousal in custodial settings. As outlined in section 3.6 of this thesis, although data were available from the long-term evaluation for 183 individuals, for this study data were analysed for 85 participants. These 85 participants were chosen for analysis as they had completed the SCS (Kalichman et al., 1994), HADS (Zigmond & Snaith, 1983) and the SIPP-188 (Andrea et al., 2007). Further details of the measures used is provided in section 4.2.2 below. Data were analysed for a total of 85 male participants aged between 24 and 77 (M = 46.56, SD = 13.26), currently serving custodial sentences. Ethnicity data were available for 76 participants, all of whom were White British. All participants had been identified as being a suitable candidate for the prescription of MMPSA as a result of their PSA.

Individuals may be considered for referral for pharmacological interventions in the form of MMPSA should they meet one or more of the following criteria as outlined by HMPPS (2021).

- Sexual preoccupation
- Hypersexuality
- Using sex as a way of dealing with emotions such as anxiety and low mood
- Experiencing deviant sexual fantasies that are difficult to control and cause distress to the individual.

Of the 85 participants, 75 had been prescribed Selective Serotonin Reuptake Inhibitors (SSRIs), 72 of which had been prescribed fluoxetine, 2 had received paroxetine and 1 had been prescribed sertraline. The remaining 10 individuals had been prescribed anti-androgen medication in the form of cyproterone acetate (CPA). For most of the analysis, individuals on both types of medication are combined as only 10 participants had been prescribed anti-androgen medication. However, when comparing levels of anxiety and depression in the research sample with other samples, the data was split between medication type. This was to investigate whether the difference in medication type, SSRIs and anti-androgens, had an impact on anxiety and depression.

4.2.2 Measures

4.2.2.1 Sexual Compulsivity Scale (SCS)

The sexual compulsivity scale (SCS), designed by Kalichman et al. (1994) is a self-report measure designed to measure an individual's propensity to sexual compulsivity and hypersexuality. The scale consists of 10 statements, such as 'my sexual appetite has got in the way of my relationships' and 'I think about sex more than I would like to', to be rated on a 4 point Likert scale from 1 (not at all like me) to 4 (very much like me). For the present study, total scores were used with higher scores indicating higher levels of sexual compulsivity. The scale items were adapted from items from a self-help booklet designed for people with sexual addictions (Comp Care, 1987). Kalichman et al. (1994) found the scale to be reliable in a sample of sexually active homosexual men with a Cronbach alpha of .89. The scale was also found to be reliable with a female sample, with Cronbach alpha of .92 (Kalichman & Rompa, 2001). For the current study, the Cronbach alpha was .93.

Total scores for the SCS range between a minimum of 10 and a maximum of 40. For individuals with sexual convictions, scores of 15 and above are indicative of PSA requiring intervention with MMPSA. This score has been recommended by the consulting psychiatrist on the MMPSA programme. The score is based on findings of the long-term evaluation of MMPSA (Winder et al., 2014b; Winder et al., 2018).

4.2.2.2 Hospital Anxiety and Depression Scale (HADS)

The Hospital Anxiety and Depression Scale (HADS) was designed by Zigmond and Snaith (1983) to measure anxiety and depression. The self-report questionnaire contains fourteen statements, seven relating to anxiety and seven relating to depression. Example statements from the anxiety scale include 'I feel tense or 'wound' up' and 'worrying thoughts go through my mind'. For the depression scale statements include 'I look forward with enjoyment to things' and 'I feel cheerful'. Individuals are asked to consider the reply that closest represent how they have been feeling over the last week. The statements are scored from 0-3. The scores are totalled for each subscale following completion of the statements, with minimum and maximum scores being 0 and 21. A score of 7 and under indicating no problems, a score of 8-10 would suggest a borderline case, and 11+ defined as a case (Zigmond & Snaith, 1983). The scale has been shown to be reliable across a number of samples with a review confirming a mean Cronbach alpha of .83 for the anxiety subscale (HADS-A) and .82 for the depression subscale (HADS-D; Bjelland et al., 2002). In the current sample, Cronbach's alpha scores were .78 for HADS-A and .70 for HADS-D.

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

The Severity Indices of Personality Problems – 118 (SIPP-118) is a self-report measure of (mal)adaptive personality functioning designed by Andrea et al. (2007). The questionnaire contains 118 statements that individuals are asked to consider how much they agree with the statement based on the last three months. Scores are rated on a 4 point Likert scale from 1 (fully disagree), to 4 (fully agree) with high scores being indicative of higher adaptive functioning. The survey contains statements such as 'I can cope very well with disappointments' and 'it is hard for me to really enjoy doing things'. The statements relate to 16 facets of adaptive personality categorised into five domains; Self-control (emotion regulation, effortful control, stable self-image, self-reflective functioning, aggression regulation), Responsibility (responsible industry, trustworthiness), Social concordance (cooperation, respect), relational capacities (intimacy, enduring relationships, feeling recognised) and identity integration (enjoyment, purposefulness, frustration tolerance, self-respect). The facets of personality were decided upon following consultation with various experts. The facets were shown to be reliable with a Cronbach's alpha of .70 (Andrea et al., 2007). For the current sample, Cronbach's alpha was .96.

4.2.3 Ethical Considerations

Ethical approval was sought via Nottingham Tent University (NTU), Her Majesty's Prison and Probation Service (HMPPS) National Research Centre (NRC) and the Health Research Authority (HRA). Permission was provided by the Governor at HMP Whatton for data to be collected on site for the national long-term evaluation. The current study used the data collected as part of the evaluation as secondary data. Permission was granted by NTU for the data collected to be analysed for the purpose of this study, reference: WINDER 2021/415 (amendment to 2018/10, 2017/49, 2010/34).

4.3 Analysis and Results

4.3.1 Analysis One: Comparison of males with PSA with other male populations

In order to illustrate the relevant characteristics of individuals assessed as being suitable for the use of MMPSA, a series of one sample t tests were performed for the scales SCS and HADS and were compared against community scale norms and other relevant samples. In relation to the SCS, the research sample was compared against a male student sample and a sample of males with sexual convictions who were not assessed as requiring the use of MMPSA (Day et al unpublished manuscript). When comparing the HADS, the research sample was compared against the general population (Breeman et al. 2015) using males aged 45-49 as this was closest to the research sample; a sample of male prisoners without sexual convictions (McMurran and Christopher 2009) and a sample of males with sexual convictions (Robertson et al., 2020). All t tests were performed at baseline (pre-medication) to highlight the typical characteristics of the sample before they were prescribed MMPSA and then again after 3 and 6 months of use of MMPSA. Although the study uses secondary data, this is the first time the data has been compared with other research samples, ensuring the contributions are unique.

4.3.1.1 Sexual Compulsivity Scale

In order to illustrate levels of sexual compulsivity in the research sample, one sample t tests were performed comparing with data previously collected on two samples, a male student sample (Day et al., unpublished manuscript) and a sample of males with sexual convictions who were not using MMPSA (Day et al., unpublished manuscript). A summary of the results is provided in Table 5 below. Pre intervention with MMPSA, results showed that the research sample had significantly higher levels of sexual compulsivity than the male student sample and individuals with sexual convictions who were not assessed as requiring MMPSA. At three months post intervention with MMPSA levels of sexual compulsivity remained significantly higher in the research sample when compared with

the male student sample and individuals with sexual convictions who did not require MMPSA. After six months intervention with MMPSA, levels of sexual compulsivity had reduced in the research sample with the mean score resembling that of the male student and individuals with sexual convictions without PSA and there was no significant difference with either sample. A summary of the results is shown in Table 5 below.

Table 5 Comparing levels of sexual compulsivity in the research sample with individuals with sexual convictions and a male student sample.

Sample	**Baseline *M* *(SD)***	**3m MMPSA *M* *(SD)***	**6m MMPSA *M* *(SD)***	**T test baseline**	T test 3m	T test 6m
Research Sample	26.56 (7.31)	18.26 (8.09)	15.40 (6.40)			
Male student sample	15 (5.1)			$t(84) = 14.69$, $p < 0.001$	$t(76) = 3.54$, $p = 0.001$	$t(57) = .472$, $p = .291$
Individuals with sexual conviction	14.5 (6.2)			$t(84) = 15.23$, $p < 0.001$	$t(76) = 4.08$, $p = < 0.001$	$t(57) = 1.07$, $p = .291$

4.3.1.2 The Hospital Anxiety and Depression Scale

In order to explore levels of anxiety and depression in the research sample, a series of one sample t tests were performed using data collected for participants who had been identified as being suitable for the use of MMPSA. The baseline measurement was analysed to ascertain the levels of anxiety and depression premedication. This was compared against normative data in the general population, for males in the age group 45-49 years, (Breeman et al., 2015). Comparisons were also made with a male sample of prisoners without sexual convictions (McMurran and Christopher, 2009) and a sample of males with sexual convictions obtained by Robertson et al., (2020). A summary of the results is shown in Tables 6 and 7 below.

Results showed that pre-medication individuals with PSA were significantly more anxious than those in the general population, male prisoners without sexual convictions and males with sexual convictions. At three months post medication, the research sample were significantly more anxious than the general population, however there was no significant difference when compared to the sample of male prisoners without sexual convictions. When compared with males with sexual convictions the research sample were significantly less anxious after three months use of MMPSA. Following six months use of MMPSA, for the current research sample, there was no longer a significant difference in levels of anxiety when comparing the research sample with the general population and adult men in prison who did not have a sexual conviction. The research sample were significantly less anxious however than the sample of males with sexual convictions following six months' use of MMPSA.

In relation to depression, results showed that pre-medication the research sample were significantly more depressed than the general population, male prisoners without sexual convictions and males with sexual convictions. At three and six-months post intervention with MMPSA, there was no significant difference in depression between the research sample, the general population and male prisoners without sexual convictions. Following the use of MMPSA for three and six months, the research sample were significantly less depressed than the sample of males with sexual convictions.

Table 6. Comparing levels of anxiety in the research sample with the general population, male prisoners without sexual convictions and males with sexual convictions.

Sample	Anxiety					
	M (SD)			**baseline**	**3m**	**6m**
	baseline	3m	6m			
Research Sample	10.28 (4.21)	7.13 (4.25)	6.71 (3.75)			
General population	5.85 (4.21)			*t* (83) = 9.64, *p* = < 0.001**	*t*(75) = 2.63, *p* = .010*	*t*(57) = 1.74, *p* = .087
Male prisoners without sexual convictions	6.49 (4.15)			*t* (83) = 8.25, *p* = < 0.001**	*t*(75) = 1.32, *p* = .192	*t*(57) = .441, *p* = .661
Males with sexual convictions	8.73 (4.53)			*t*(83) = 3.38, *p* = .001**	*t*(75) = -3.28 *p* = .002*	*t*(57) = -4.11, *p* = <.001**

Note * $p < .05$, ** $p < .001$

Table 7. Comparing levels of depression in the research sample with the general population, male prisoners without sexual convictions and males with sexual convictions.

Sample	Depression					
	M (SD)			**baseline**	**3m**	**6m**
	baseline	3m	6m			
Research Sample	6.67 (3.75)	4.24 (3.12)	4.45 (3.15)			
General population	5.85 (4.21)			*t*(83) = 6.41, *p* = <0.001**	*t*(75) = .521, *p* = .604	*t*(57) = .964, *p* = .339
Male prisoners without sexual convictions	6.49 (4.15)			*t*(83) = 4.41, *p* = <0.001**	*t*(75) = -1.77, *p* = .081	*t*(57) = -1.02, *p* = .312
Males with sexual convictions	8.73 (4.53)			*t*(83) = 2.70, *p* = .008*	*t*(75) = -3.72, *p* = <.001**	*t*(57) = -2.72, *p* = .009*

Note * $p < .05$, ** $p < .001$

As SSRIs are an antidepressant designed to reduce anxiety and depression (BNF, 2022). In an attempt to assess whether anti-androgens also impacted on levels of anxiety and depression, the analysis was performed again splitting the sample by medication type. The number of participants using the different medication types is outlined in Table 8 below. On occasions where only one participant was using the medication, they could not be included in the analysis. As a result of this, all types of SSRI; Fluoxetine, Paroxetine and Sertraline have been merged together and the data file split between SSRIs and CPA.

Table 8. Number of participants on types of medication at baseline, three months and six months.

Medication Type	Baseline	Three Months	Six Months
Fluoxetine	71	65	50
Paroxetine	2	2	1
Sertraline	1	1	1
CPA	10	8	6

4.3.1.2.1 Comparison with males in the general population aged between 45 and 49 (Breeman et al., 2015).

A summary of the results of this analysis is provided in Table 9 & 10 below. When compared with the general population sample (Breeman et al., 2015), members of the research sample who had been prescribed SSRIs at baseline were significantly more depressed than the general population. There was no significant difference however for those who had been prescribed the anti-androgen, CPA. Individuals prescribed both groups of medication were significantly more anxious than the general population at baseline. Following three months of intervention with both types of medication, there was no significant difference between the research sample and the general population in relation depression. The research sample were however significantly more anxious than the general population after three months intervention with SSRIs. There was no significant difference between the research sample and general population sample for those who had been prescribed CPA. After six months intervention with MMPSA, there was no significant difference in levels of anxiety or depression when compared to the general population (Breeman et al., 2015) for either SSRIs or CPA.

4.3.1.2.2 Comparison with male prisoners without sexual convictions (McMurran & Christopher, 2009).

A summary of results is shown in Table 9 and 10 below. When compared with the sample of male prisoners without sexual convictions (McMurran and Christopher, 2009), at baseline, individuals

who had been prescribed SSRIs were significantly more depressed than male prisoners without sexual convictions, but there was no significant difference between the ten individuals who had been prescribed CPA. In relation to anxiety at baseline, both groups were significantly more anxious than the sample of male prisoners without sexual convictions. Following three months intervention with both types of medication, there was no significant difference in relation to anxiety or depression when compared to male prisoners without sexual convictions.

4.3.1.2.3 Comparison with males with sexual convictions (Robertson et al., 2020).

As shown in Tables 9 and 10 below, in relation to the sample of males with sexual convictions (Robertson et al., 2020) at baseline, those who had been prescribed SSRIs were significantly more depressed than males with sexual convictions but there was no significant difference between those who had been prescribed CPA. Those who had been prescribed SSRIs and CPA were significantly more anxious at baseline than males with sexual convictions. Following three months intervention with MMPSA, those who had been prescribed SSRIs and CPA were significantly less depressed than males with sexual convictions. Those who had been prescribed Fluoxetine were also significantly less anxious than males with sexual convictions, but there was no significant difference between those prescribed CPA. Levels of anxiety and depression were further reduced following 6 months use of SSRIs so the research sample were significantly less anxious and depressed than males with sexual convictions but there was no significant difference between the sample obtained by Robertson et al., (2020) and those prescribed CPA. It is important to note however that the number of participants who had been prescribed the anti-androgen medication, CPA, is small (n = 10) and therefore the interpretations are made cautiously.

Table 9. Mean and Standard Deviations of Anxiety and Depression by medication type for the research sample.

	Anxiety *M* (*SD*)			**Depression *M* (*SD*)**		
	Baseline	**3 months**	**6 months**	**Baseline**	**3 months**	**6 months**
SSRIs	10.02 (4.30)	6.88 (4.16)	6.44 (3.70)	6.74 (3.69)	4.32 (3.20)	4.42 (3.26)
CPA	12.20 (3.05)	9.25 (4.71)	9.00 (3.68)	6.20 (4.39)	3.50 (2.45)	4.67 (2.16)

Table 10. Comparing levels of anxiety and depression in the research sample with the general population, male prisoners without sexual convictions and males with sexual convictions based on medication type.

	Anxiety				Depression			
	M (SD)	**baseline**	**3m**	**6m**	***M (SD)***	**baseline**	**3m**	**6m**
General Population	5.85 (4.21)				4.05 (4.02)			
SSRIs		*t* (73) = 8.37, *p* = < 0.001**	*t* (67) = 2.05, *p* = .045*	*t* (51) = 1.16, *p* = .253		*t* (73) = 6.74, *p* = < 0.001**	*t* (67) = .7.05, *p* = < .483	*t* (51) = .826, *p* = .413
CPA		*t* (9) = 6.59, *p* = < 0.001**	*t* (7) = 2.04, *p* = .081	*t* (5) = 2.09, *p* = .091		*t* (9) = 1.55, *p* = .156	*t* (7) = -.635, *p* = < .546	*t* (5) = .669, *p* = .516
Male prisoners without sexual convictions	6.49 (4.15)				4.87 (3.07)			
SSRIs		*t*(73) = 7.08, *p* = < 0.001**	*t*(67) = .778, *p* = .439	*t*(51) = -.093, *p* = .926		*t* (73) = 4.36, *p* = < 0.001**	*t* (67) = -1.41, *p* = .163	*t*(51) = -.990, *p* = .327
CPA		*t*(9) = 5.93, *p* = < 0.001**	*t* (7) = 1.66, *p* = .142	*t* (5) = 1.67, *p* = .156		*t* (9) = .958, *p* = .363	*t* (7) = -1.58, *p* = .158	*t* (5) = -.231, *p* = .827

Males with sexual convictions	8.73 (4.53)				5.57 (3.47)			
SSRIs		$t(73) = 2.60$, $p = .011$**	$t(67) = -3.66$, $p = <.001$**	$t(51) = -4.46$, $p = <.001$**		$t(73) = 2.73$, $p = .008$**	$t(67) = -3.22$, $p = .002$**	$t(51) = -2.51$, $p = .014$**
CPA		$t(9) = 3.60$, $p = .006$**	$t(7) = .312$, $p = .764$	$t(5) = .179$, $p = .865$		$t(9) = .454$, $p = .661$	$t(7) = -2.39$, $p = .048$*	$t(5) = -1.02$, $p = .353$

Note ** = $p < .001$, * = $p < .05$

4.3.2 Analysis Two: Exploring the relationships between levels of sexual compulsivity, anxiety, depression, emotion regulation, enduring relationships, responsible industry and purposefulness

Initially, a Path Analysis was performed to explore the relationship between levels of sexual compulsivity, as measured by the SCS scale (Kalichman et al., 1994), wellbeing and protective personality facets which may assist individuals in achieving desistance in the community. As PSA has been shown to negatively impact these protective factors, the analysis was performed as baseline to establish how the individual presents without medication. As a result of the literature reviewed in section 2.9 of this thesis, in relation to risk of offending and protective factors, a number of personality facets were chosen from the SIPP-118 (Andrea et al., 2007). In order to represent the importance of supportive, pro-social relationships, enduring relationships was chosen. Goal directed living is represented by responsible industry and purposefulness. The importance of wellbeing is represented by the facet of the self-control domain, emotion regulation. Anxiety and Depression as measured by the HADS (Zigmond and Snaith, 1983) was also included to represent wellbeing. As outlined earlier, the study uses secondary data collected during the national long-term evaluation. However, this is the first time a path analysis has been undertaken using this data, ensuring the unique contribution of the findings. A summary of the descriptive statistics and correlations is shown in Table 11 below.

In relation to levels of sexual compulsivity, scores were high for the research sample pre-medication. This is to be expected as all members of the sample had been assessed as suitable for the use of MMPSA due to their high levels of sexual compulsivity. For individuals with sexual convictions, a score of 15 and above would indicate a need for intervention with MMPSA for individuals with sexual convictions (Winder et al., 2024). The research sample therefore score highly for sexual compulsivity (M = 26.49, SD=7.32).

The research sample presented with higher levels of anxiety than depression. According to Zigmond & Snaith (1983), scores between 8 and 10 represent a borderline case. Over 11 would indicate an abnormal case. The research sample therefore present as a borderline case for anxiety (M = 10.29, SD = 4.22) but show normal levels of depression (M = 6.68, SD = 3.76).

In relation to the personality facets chosen from the SIPP-118, the current sample scores outlined in Table 11 show maladaptive functioning for each of the facets. As outlined earlier, the present study uses secondary data obtained as part of the long-term evaluation of MMPSA. These scores have been shown to be significantly lower than when compared to samples in the general population as illustrated in Winder et al. (in prep).

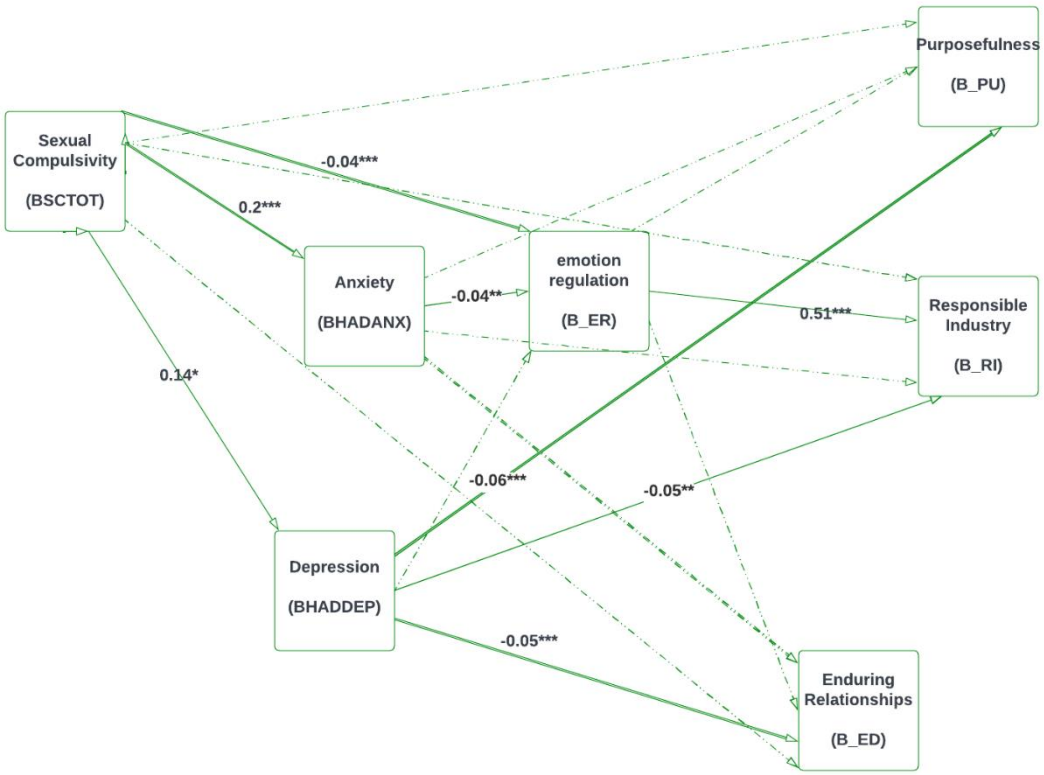
Table 11. Descriptive Statistics and Summary of Pearson Correlations

	Mean	Standard deviation	Sexual Compulsivity	Anxiety	Depression	Emotion Regulation	Purposefulness	Responsible Industry	Enduring Relationships
Sexual Compulsivity	26.49	7.32	.						
Anxiety	10.29	4.22	.340**	.					
Depression	6.68	3.76	.264*	.568**	.				
Emotion Regulation	2.42	0.69	-.551**	-.457**	-.353**	.			
Purposefulness	2.75	0.63	-.375**	-.366**	-.457**	.349**	.		
Responsible Industry	2.75	0.67	-.394**	-.249*	-.372**	.589**	.452**	.	
Enduring Relationships	2.45	0.59	-.270*	-.386**	-.459**	.339**	.412**	.286**	.

The analysis of the correlations illustrates that the data shows the relationships as predicted in the hypotheses. Levels of sexual compulsivity are significantly negatively correlated with each of the protective personality facets chosen (emotion regulation, purposefulness, responsible industry and enduring relationships). This shows that higher levels of sexual compulsivity are related to lower personality functioning. Sexual compulsivity is also significantly, positively correlated with elements of poor mental health (anxiety and depression), indicating higher levels of sexual compulsivity are associated with lower mental wellbeing.

Unfortunately, despite being an overidentified model (*df* = 4) the model did not show a good fit of the data (Chi-Square = 0.000, CFI = 0.805, TLI = -0.023, RMSEA = 0.315, SRMR = 0.120). Notwithstanding, an illustration of the path diagram produced has been included for illustration purposes in Figure 3 below. For ease of understanding, only the significant standardized path coefficients are illustrated (***p <.001, **p >.001 p<.005, *p<.005).

Figure 3: Path Analysis Diagram exploring the relationship between sexual compulsivity, anxiety, depression, emotion regulation, enduring relationships, purposefulness and responsible industry.



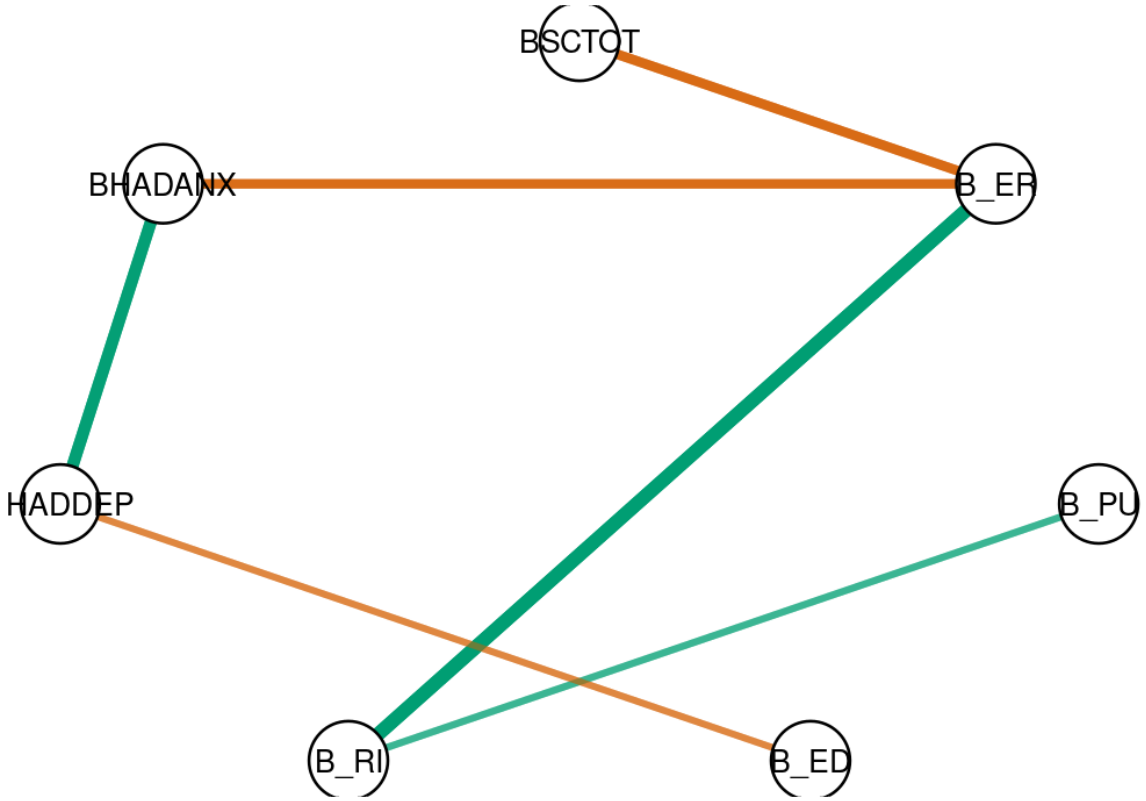
The model shows that levels of sexual compulsivity in individuals with PSA, before intervention with MMPSA, has a significant, negative relationship with emotion regulation, a protective personality facet of wellbeing. The model also shows a significant, positive relationship with aspects of poor wellbeing, anxiety and depression. This indicates that as sexual compulsivity increases, the ability to manage emotions decreases. This also shows that levels of anxiety and depression increase with levels of sexual compulsivity. The model shows a stronger relationship between sexual compulsivity and anxiety than depression. This is not surprising as the research sample presented with higher levels of anxiety than depression, as outlined above.

The model did not however show a significant direct relationship between sexual compulsivity and the protective personality facets; purposefulness, responsible industry and enduring relationships. Sexual compulsivity and anxiety show a significant negative relationship with emotion regulation. Sexual compulsivity, anxiety and emotion regulation have a significant, positive relationship with responsible industry. This could indicate that appropriate levels of emotion regulation assist in increasing responsibility. The model also showed that sexual compulsivity had significant, negative indirect relationships with purposefulness, responsible industry and enduring relationships when mediated by depression. Suggesting that sexual compulsivity and depression lead to more maladaptive personality functioning in terms of spending free time meaningfully and maintaining supportive relationships.

In an attempt to explore whether any strong patterns had been missed through the path analysis, further exploratory work was undertaken in the form of a Gaussian Graphical Model. Gaussian Graphical Modelling is a useful exploratory tool when considering how different variables relate to each other (Bhushan et al., 2019). Gaussian Graphical Models can be used to explore the partial correlations between pairs of variables, whilst controlling for all other variables in the network, reducing the risk of encountering misleading relationships (Bhushan et al., 2019; Epskamp et al., 2017). In a Gaussian Graphical Model, the variables are represented by circles, referred to as nodes, and the relationship between the variables are presented with lines known as edges (Epskamp et al., 2018). The strength of the relationship is illustrated by the thickness of the line, with thicker lines representing stronger relationships (Bhushan et al., 2019). The direction of the relationship is represented by the colour of the lines. Positive partial correlation coefficients are typically represented by green lines, whilst negative relationships are depicted by orange lines Bhushan et al., 2019). Thus, each edge shows the unique relationship between a pair of variables over and

above and contribution shared with other variables in the model. Figure 4 below shows the output of the Gaussian Graphical Model.

Figure 4: Gaussian Graphical Model



Note: BSCTOT = sexual compulsivity, B_ER = emotion regulation, BHADANX = anxiety, HADDEP = depression, B_RI = responsible industry, B_PU = purposefulness and B_ED = enduring relationships.

In Gaussian Graphical Modelling, no edges are presented between nodes when the partial correlation is not significantly different from zero (Epskamp et al., 2018). As shown in Figure 4, despite what was expected to be found from reviewing the literature and the links between PSA and protective factors, sexual compulsivity only has a significant negative relationship with emotion regulation. This relationship indicates that higher levels of sexual compulsivity are associated with lower levels of emotion regulation. Emotion regulation had a significant negative relationship with anxiety, indicating that higher levels of anxiety are associated with lower levels of emotion regulation. Emotion regulation had a significant, positive relationship with responsible industry, indicating higher levels of emotion regulation are associated with higher levels of responsible industry. Responsible industry also had a significant positive relationship with purposefulness, although this relationship was weaker than the relationship between emotion regulation and

responsible industry. Perhaps unsurprisingly, anxiety and depression had a significant, positive relationship, indicating higher levels of anxiety and related to higher levels of depression. Depression only had a significant negative relationship with enduring relationships, suggesting that higher levels of depression may negatively impact on relationships. The results of the significant relationships are summarised in Table 12 below.

Table 12: Posterior mean, standard deviation and credible intervals of the Gaussian Graphical Model

Relationship	Posterior *M*	Posterior *SD*	Lower CI	Upper CI
BSCTOT – B_ER	-0.324	0.101	-0.509	-0.114
B_ER – BHADANX	-0.315	0.101	-0.502	-0.103
BHADDEP-BHADANX	0.401	0.096	0.201	0.571
B_ED--BHADDEP	-0.229	0.107	-0.433	-0.011
B_ER--B_RI	0.458	0.090	0.269	0.618
B_PU--B_RI	0.237	0.106	0.024	0.437

4.4 Discussion

4.4.1 Analysis One: Comparison of males with PSA with other male populations

Analysis one aimed to describe the research sample to illustrate difficulties they may have following release and how the use of MMPSA may help. To achieve this, levels of sexual compulsivity, anxiety and depression in the research sample were explored and compared to individuals in the general population, and other relevant research samples. This was in an attempt to illustrate how the research sample present with and without medication and how this may impact them should they be unable to obtain MMPSA following their release from custody. The results for analysis one support the hypotheses that individuals assessed as suitable for the use of MMPSA, pre-medication,

will be significantly more anxious, significantly more depressed, and have significantly higher levels of sexual compulsivity than those in the general population and other relevant samples.

In relation to sexual compulsivity, the results showed that there remained a significant difference in levels of sexual compulsivity until the research sample had been using MMPSA for a period of 6 months, illustrating the importance of this sample being able to obtain MMPSA following release. As sexual compulsivity is a recognised risk factor in reoffending (Van den Berg, 2020), should the research sample be unable to obtain MMPSA in the community, it is possible that their levels of sexual preoccupation and compulsivity will increase, meaning they will be at a higher risk of committing further offences. However, after six months intervention with MMPSA, sexual compulsivity levels are reduced so that they resemble that of individuals with sexual convictions without PSA and the male student sample. Through lowering levels of sexual compulsivity and preoccupation to that which resembles those in the general population, this will leave the individual in a better position to engage with their licence requirements following release, reducing the risk of reoffending.

In relation to anxiety and depression, pre intervention with MMPSA the research sample showed significantly higher levels of anxiety and depression than the general population, male prisoners without sexual convictions and males with sexual convictions. Three months post MMPSA levels of depression had reduced so there was no significant difference between the general population and male prisoners without sexual convictions, and the research sample was significantly less depressed than males with sexual convictions. This was also shown at six months post MMPSA. Levels of anxiety were reduced at three months post MMPSA so there was no significant difference between the research sample and male prisoners without sexual convictions. The research sample were significantly more anxious than the general population however, and significantly less anxious than males with sexual convictions. Following six months intervention with MMPSA, levels of anxiety had reduced in the research sample so there was no longer a significant difference when compared with the general population and male prisoners without sexual convictions and were significantly less anxious than males with sexual convictions.

Lowering levels of anxiety and depression with the use of MMPSA may assist the individual in coping better following release. As a result of licence conditions placed on individuals with a sexual conviction, the individuals may experience isolation and feelings of shame of their offending (Bailey & Klein, 2018). Many individuals are unable to return to their home address and rebuild

relationships with family members (Levenson & Hern, 2007), causing them to live in an area with which they are not familiar (Levenson & Cotter, 2005a). They may also struggle to gain meaningful employment as a result of their licence conditions (Evans & Porter, 2015) and receive threats from members of the public who become aware of their offence (Cubellis et al., 2019). All these factors can be detrimental to an individuals' wellbeing, however the evidence that MMPSA reduces levels of anxiety and depression may mean that they are in a better position to cope with the likely challenges they will face following release.

The analysis was performed a second time by splitting the sample by medication type. This was in an attempt to investigate whether anti-androgen medications had a similar effect in lowering levels of anxiety and depression. The results showed that SSRIs had a greater impact in lowering levels of anxiety and depression when compared with the various samples. The use of CPA however did show that in relation to depression, the research sample were significantly less depressed than males with sexual convictions who were not assessed for PSA, following three months use of the medication. The number of participants prescribed CPA was small (n = 10) and therefore analyses are to be interpreted with caution. Intervention with CPA is recommended for those who have received no benefits from the 40-60mg dose of SSRIs (Thibaut et al., 2020). It was therefore not possible to obtain a larger sample size of individuals prescribed CPA. However, this could be evidence that the lowering of sexual compulsivity and preoccupation has a direct impact on the individual's levels of wellbeing, as sexual preoccupation and compulsivity has been shown to be detrimental to wellbeing (Winder et al., 2019). As well-being is associated with a risk of reoffending (Andrews & Bonta, 2007), and a negative mood state has been reported prior to offending by those who have reoffended sexually (Hanson & Harris, 2000), this illustrates the importance of the research sample being able to access MMPSA in the community should they wish to do so.

The lack of long-term studies of effectiveness in relation to treating PSA with SSRIs, means that there is currently no guidance as to the length of time pharmacological intervention with SSRIs should be (Adie et al., 2002). In relation to hormonal therapy medications however studies have shown that once an individual cease the use of medications, problematic sexual interests and behaviours are likely to return. Schober et al. (2005) illustrated that when the use of medication was switched to a placebo, paraphilic behaviours recommenced within two months. Fosdick and Mohiuddin (2016) showed how when treatment with GnRH agonists stopped, the autistic patient restarted the sexual abuse of their sibling immediately. For individuals who require hormone

therapy medications, such as GnRH agonists to manage their arousal, it is possible that the treatment may be required for a lifetime (Thibaut et al., 2020).

In the current study, the sample were predominantly prescribed SSRIs. Evidence from this sample illustrates that with the use of MMPSA, for individuals with PSA, sexual compulsivity and preoccupation, anxiety and depression, are lowered to levels similar to those in the general population after six months of pharmacological intervention. This evidences that their risk of offending may be no higher than those in the general population. Unfortunately, should individuals with PSA be unable to obtain MMPSA following release, their risk of reoffending may increase. However, specifically in relation to the use of SSRIs, further research into the long-term effectiveness is required.

4.4.2 Analysis Two: Exploring relationships between levels of sexual compulsivity, anxiety, depression, emotion regulation, enduring relationships, responsible industry and purposefulness.

Analysis two aimed to explore the relationship between variables identified as protective factors following release from custody, with sexual compulsivity and wellbeing. In order to achieve this, path analysis was chosen. A model was designed exploring the direct relationship between levels of sexual compulsivity, anxiety, depression, emotion regulation, enduring relationships, responsible industry and purposefulness. The model also explored the mediating effects of anxiety, depression and enduring relationships, between sexual compulsivity and protective facets; enduring relationships, responsible industry and purposefulness. Unfortunately, the model did not provide a good fit of the data with neither of the fit indices being met. Therefore, neither of the hypotheses were supported.

An exploration of the correlation coefficients however did partially support the hypothesis as the relationships were all in the predicted direction. Sexual compulsivity had a positive significant relationship with both anxiety and depression. This was expected as individuals with sexual compulsivity have been shown to experience lower levels of wellbeing (Reid et al., 2008; Winder et al., 2019). As illustrated above, the current research sample presented with borderline cases of anxiety. Anxiety has been shown to be associated with PSA, with individuals classified as having Compulsive Sexual Behaviour Disorder experiencing higher levels of anxiety when compared to those without (Scanavino et al., 2019). Individuals with PSA have also been shown to have

significantly higher levels of depression than control groups (Scanavino et al., 2018). This is further supported by the results of analysis one which showed that the research sample were significantly more depressed pre-medication than males in the general population (Breeman et al., 2015), male prisoners without sexual convictions (McMurran & Christopher, 2009) and males with sexual convictions who do not have PSA (Robertson et al., 2020).

The correlation coefficients also showed that sexual compulsivity had a significant negative relationship with each of the personality facets; emotion regulation, enduring relationships, responsible industry and purposefulness. As outlined in the introduction, individuals with PSA have been shown to experience problems with relationships (Yoon et al., 2016), employment (Reid et al., 2011) and wellbeing (Walton et al., 2017). Findings from Chapter 5 also outline the problems individuals with PSA face. Participants in Chapter 5 explained how their PSA led them to become isolated with some unable to work. Participants also explained how they were fearful of forming relationships as that would mean revealing their PSA to others. This leads to feelings of self-hatred and suicidal thoughts. An inability to manage emotions effectively has been further illustrated in individuals with PSA. Cashwell et al. (2016) explored emotion regulation amongst students with and without sexual addiction. Those classified as being addicted to sex displayed more difficulties in managing emotions than students who did not meet the classification for sex addiction.

The path analysis model did not show a good fit of the data and therefore it is not possible to say that the relationships exist. However, when exploring the path diagram, significant relationships were shown in relation to sexual compulsivity, anxiety, depression and emotion regulation as also shown in the correlation coefficients. Significant indirect negative relationships were also shown for purposefulness, responsible industry and enduring relationship when sexual compulsivity was mediated by depression. Individuals with PSA have been shown to exhibit higher levels of depression than the general population (Yen et al., 2007). Depression has also been shown to be associated with relationships, with individuals in poor quality relationships more likely to experience depression (Whisman et al., 2021). As a result of the literature reviewed, a negative relationship of enduring relationships and sexual compulsivity was expected. In relation to responsible industry and purposefulness, depression has been shown to negatively impact how productive individuals can be (Rasool et al., 2019). Whilst employment has been shown to be a protective factor in depression (van de Noordt et al., 2014), individuals with depression often encounter problems engaging with employment (Rayner et al., 2016). A negative relationship

between sexual compulsivity, responsible industry and purposefulness, when mediated by depression was anticipated.

A significant positive relationship was also found for responsible industry when sexual compulsivity was mediated by anxiety and emotion regulation. This indicates how having effective emotion regulation is important in mediating the relationship between sexual compulsivity, anxiety and responsible industry. Increased emotion regulation has been shown to be important in reducing addictive behaviours (Cavicchioli et al., 2020) and therefore could be a protective factor in relation to sexual compulsivity. Interventions that encourage emotion regulation have been advised for the treatment of PSA (Adams & Robinson, 2001) as sexual activities are often used as a way of relieving negative mood states (Cashwell et al., 2017). Reducing engagement in addictive behaviours could possibly leave the individual to act more responsibly. Emotion regulation therefore deserves further investigation in relation to PSA.

In an attempt to explore whether any strong relationships between the variables had been missed through the path analysis, a Gaussian Graphical Model was created, as presented in Figure 4. The Gaussian Graphical Model explored partial correlations between pairs of variables and presented a network between the variables, whilst controlling for other variables in the network (Bhushan et al., 2019; Epskamp et al., 2017). Initially, for this study, it was hypothesised that sexual compulsivity would have a negative relationship with the protective personality facets; emotion regulation, enduring relationships, responsible industry and purposefulness. It was also hypothesised that sexual compulsivity would have a positive relationship with anxiety and depression and that emotion regulation would have a positive relationship with the personality facets; responsible industry, purposefulness and enduring relationships. The Gaussian Graphical Model however, only presented a significant negative relationship between sexual compulsivity and emotion regulation. It should be noted that this is a unique effect of the Gaussian Graphical Model, which reduces the risk of spurious relationships being encountered (Bhushan et al., 2019) Again, this highlights the importance of further exploring the relationship between PSA and emotion regulation and using interventions that encourage the management of emotion regulation when treating individuals experiencing PSA (Adams & Robinson, 2001).

Emotion regulation had a significant, negative relationship with anxiety. This is consistent with previous findings that have shown how an increase in emotion regulation skills can lead to a reduction in the severity of symptoms of anxiety (Wirtz et al., 2014). Emotion regulation also had a

significant positive relationship with responsible industry, and responsible industry had a significant positive relationship with purposefulness. Schneider et al. (2018) demonstrated how maladaptive, emotion dysregulation was associated with a decrease in goal directed living and an increase in levels of anxiety. Through supporting individuals with PSA to manage their emotion regulation effectively, this could enable them to better manage their levels of sexual compulsivity, anxiety and engage more efficiently with pro-social activities such as employment.

Anxiety had a significant, positive relationship with depression. This is unsurprising as evidence suggests the two are comorbid and often experienced by individuals concurrently (Kalin, 2020), with estimates suggesting 45.7% of individuals experiencing depression will also experience at least one type of anxiety disorder in their lifetime (Kessler et al., 2015). Additionally, depression had a significant, negative relationship with enduring relationships. Supportive relationships have been shown to be a protective factor in reducing levels of depression (Pettorruso et al., 2023; Santini et al., 2015). Conversely, relationship problems can be a risk factor for depression with evidence suggesting Individuals experiencing problems in intimate relationships are at a higher risk of developing depression (Whisman et al., 2021). Based on this, should an individual be in a position to manage their levels of wellbeing, in the form of depression, they could encounter and engage in more supportive relationships, potentially enabling them to live better lives.

4.4.3 Strengths and Limitations

The analyses undertaken as part of analysis one, provide evidence on the effectiveness of MMPSA in reducing levels of sexual compulsivity and preoccupation, anxiety and depression. All of which may assist the individual in coping with the transition from custody to the community. The analysis has also shown that CPA impacts on reducing depression in individuals with PSA, despite the medication not being an antidepressant. This shows how by lowering levels of PSA an individuals' wellbeing is improved. This is important as it illustrates how the use of MMPSA can assist individuals with PSA serving custodial sentences, which may also be the case when they are released into the community.

Analysis two attempted to show how protective personality facets may be impacted by sexual compulsivity. This was in an attempt to illustrate the barriers an individual with PSA who is unable to manage this with medication in the community may face. The model unfortunately did not provide a good fit of the data meaning it is difficult to make inferences. The model used data for 84 participants and 24 parameters. The recommended guidance of sample size for path analysis is for

10 times the number of parameters (Kline, 1991). This is a limitation of the study. However, the relationships of the variables as illustrated by the correlation analysis showed the predicted relationships hypothesised from reviewing the literature. In an attempt to strengthen this, the Gaussian Graphical Model was used as an exploratory tool to investigate the strength of these relationships further. Future research could investigate further the relationship between sexual compulsivity and protective factors. It is possible that should a larger sample size be obtained the model may fit the data. Additionally, secondary data was used and therefore the protective factors were explored using data collected from the SIPP-118. It is possible that there are better methods of assessing the protective factors, such as through semi-structured interviews with the individual with PSA to gain an in depth understanding of their support network and lifestyle. The collection of reconviction data would also be important in measuring the effectiveness of the protective factors following release from custody.

4.5 Conclusion

The current chapter aimed to provide an illustration of the characteristics of individuals with PSA before intervention with MMPSA. The study also aimed to demonstrate how the use of MMPSA impacts levels of sexual compulsivity, anxiety, depression and personality functioning. Although secondary data was used and it is not possible to gain a true understanding of how these levels may change once the individual is released into the community, it at least provides an overview of how an individual with PSA typically presents prior to intervention with MMPSA and how these aspects may be affected following release, and for individuals with PSA who have not received a custodial sentence. As MMPSA has been shown to reduce the above risk factors, accessing the medication in the community could increase the chances of the individual achieving desistance following release and living a fulfilled life. The availability of MMPSA in the community would also assist individuals in the community who need help with their PSA, prior to coming into contact with the CJS.

5 Study Two – "Infinite torment": A thematic analysis of the experiences of individuals seeking help for problematic sexual arousal in the community.

5.1 Introduction

As outlined in Chapter 2, little is known in relation to the availability or effectiveness of MMPSA in the community. Chapter 6 below, outlines the challenges and barriers faced by GPs in prescribing MMPSA in primary care. However, there is currently a dearth of literature illustrating the experiences of individuals seeking help for PSA and seeking to obtain MMPSA in the community. Formal help-seeking behaviour has been described as a process by Cornally and McCarthy (2011) whereby an individual recognises they have a problem they are unable to solve themselves and decide to seek help from a healthcare practitioner. Informal help-seeking can also involve seeking help from family, friends and the internet (Yousaf et al., 2015).

The literature indicates that males are much less likely than females to seek help for physical and psychological health problems (Galdas et al., 2005; McCusker & Galupo, 2011; Sagar-Ouriaghli et al., 2019). Men are also more reluctant to seek informal help for any problems they encounter in life (Addis & Mahalik, 2003). A systematic review of the literature revealed that the main barriers to help-seeking amongst males were poor communication with health care, embarrassment, fear and difficulties expressing emotions (Yousaf et al., 2015). In relation to help-seeking for mental health problems, men have also been shown to be more impacted by stigma than woman with many believing they will be criticised or seen as a failure for seeking help (Vogel et al., 2007). Men are often influenced by self-reliance and a belief that they should be able to deal with their problems themselves (Johnson et al., 2012).

The stigma associated with deviant sexual interests has also been shown to be a barrier to help-seeking (Jahnke, 2018). Levenson et al. (2017) conducted a study with individuals convicted of sexual offences to ascertain barriers to help-seeking and found that only 20% had attempted to talk to someone about their sexual interests before they committed an offence. One of the main reasons they had not attempted to seek help was due to the shame and stigma attached to having deviant sexual interests as well as their own confusion about such feelings. Additionally, it was shown that fear of legal and social consequences of admitting to their interests, affordability and availability of relevant treatment were also barriers faced by the individual when seeking help. The findings were further supported by Levenson and Grady (2019), who showed that in their sample

of Minor Attracted Persons (MAP), less than half of individuals seeking help from a professional had found the experience useful. Barriers to help-seeking included a fear of judgement and the consequences of disclosing their interest. Difficulties in accessing a knowledgeable practitioner and financial constraints were also identified as barriers to seeking help.

As outlined in Chapter 2, not all individuals with PSA experience deviant sexual interests. For some, their PSA can become problematic when engaging in a high level of legal sexual activities, for example, excessive pornography use. Evidence suggests that individuals interested in seeking help for excessive pornography use were 9.5 times more likely to experience high levels of hypersexuality compared with those who did not wish to seek treatment (Kraus et al., 2016). Unfortunately, many individuals who have sought help from healthcare practitioners for excessive pornography use have had negative experiences, reducing the likelihood of further help-seeking and increasing feelings of shame (Sniewski & Farvid, 2020).

Most treatment for those with deviant sexual interests is only available after an offence has been committed and the person has been apprehended by police and convicted by the courts. Access to the MMSA pathway in the UK is currently only available to individuals once the individual has received a custodial sentence. Additionally, access to the pathway is only possible if they are serving their sentence in one of the eight prison sites, outlined in Chapter 1, where the medication is available. Should treatment be available prior to offending, this would potentially reduce the risk of harm to the public and lead to a decrease in the number of victims. The availability of help prior to offending would also lead to a better quality of life for the person with deviant sexual interests (Levenson et al., 2017).

At present, there is little available literature to show the experiences of individuals seeking help for PSA in the form of accessing MMPSA. Due to this, the present study was designed to gain an understanding of the experiences of individuals seeking help for PSA in the community, with a particular focus on those seeking to obtain MMPSA to assist them in managing their levels of arousal. As the study aims to gain an understanding of the shared experience of individuals seeking help for PSA, individuals who personally felt they were experiencing PSA and needed help with this were recruited. This was regardless of whether they had already received a conviction or been previously assessed by a health care practitioner as having PSA. Individuals were recruited from the UK, USA and Mexico in an attempt to illustrate the shared experience of living with PSA. It is hoped that the following study will gain further information on this subject and provide evidence to

ascertain the extent of the problem and highlight any barriers to seeking help. This could lead to the barriers being addressed in order to make the process easier for individuals to gain help for their problematic sexual arousal before they commit an offence, thus preventing harm to victims.

The research aimed to cover the following research aims:

1. To explore the experiences of individuals living with PSA and seeking help to assist them in managing their problematic sexual thoughts and urges.
2. To explore the experience of individuals who had sought help and the effectiveness of treatment in improving their wellbeing.

5.2 Method

5.2.1 Design

The study used a qualitative design utilising semi-structured interviews to gain an understanding of the experiences of individuals seeking help for PSA in the community. There is little available literature exploring this topic, and following on from the findings on study one, it was felt important to gain further knowledge on how individuals experience help-seeking for sensitive, often taboo, subjects from healthcare practitioners. An inductive, data-driven, approach was chosen to understand the experiences of those seeking help in the community.

5.2.2 Ethics

The study received ethical approval from Nottingham Trent University (Ref: Marshall 2021/158 (amendment to 2020/304, 2020/245, 2020/202, 2019/179) in accordance with British Psychological Society Guidelines. As participants were recruited online and via a poster in the Safer Living Centre, there was no need to obtain approval from the NRC. Prior to data collection, in order to protect anonymity, all participants were allocated an identity number known only to participants, the author, and members of the supervisory team. Participants were issued with a Participant Information Sheet (Appendix 1) and provided written consent via Microsoft Forms. This was to enable data to be collected both remotely and face-to-face. All copies of the consent were stored on NTU DataStore in a separate folder to any raw data. Following the interview, participants were debriefed, thanked for taking part, and provided with telephone numbers for helplines should they feel distressed as a result of the interview.

5.2.3 Sampling, Participants and Recruitment

As the study required a specific population, the study used volunteer sampling methods. A poster was displayed in the Safer Living Centre so that users of the service had the opportunity to make enquiries if the project was of interest. The study was also advertised on an online forum for individuals with problematic sexual interests and on Twitter. As participation was voluntary, there was no monetary incentive offered for taking part, however, participants were informed that their contribution would add knowledge to the field, which may assist in better treatment services for individuals with PSA becoming available in future. Contact details of potential participants were provided to the author, who discussed the study with each individual to ensure they understood what the study entailed and had the opportunity to ask questions prior to providing consent.

Participants were male (*n* = 8) and non-binary (*n* = 1) who had sought help for PSA via healthcare providers. Participants were aged between 24 and 76, *M* = 47.77, *SD* = 18.34 and were British (*n* = 6), American (*n* = 2) and Mexican (*n* = 1). Four participants had previously been convicted of a sexual offence including, exhibitionism, making attempts to contact a minor and sexual assault. Five participants had no sexual convictions. As the study was undertaken by recruiting participants on a voluntary basis, independent of the NRC, it was not possible to obtain details of the participants PNC and therefore the information in relation to convictions is based on the participants disclosures. Table 13 below provides a summary of the participants

Table 13. A summary of participants

Participant ID	**Nationality**	**Declared sexual convictions**	Declared previous use of MMPSA	Type of MMPSA used
1	British	Yes	Yes	SSRIs
2	British	Yes	Yes	SSRIs
3	American	No	No	N/A
4	British	Yes	Yes	SSRIs
5	British	Yes	Yes	SSRIs
6	British	No	No	N/A
7	Mexican	No	No	N/A
8	American	No	Yes	SSRIs
9	British	No	Yes	SSRIs and anti-androgens

5.2.4 Data Collection

Qualitative data were collected through semi-structured interviews. A total of nine interviews were conducted, lasting between 1 and 2 hours with *M* = 01:25:06, *SD* = 00:22:01. Two of the interviews were conducted face to face, five were conducted over Microsoft Teams and two were completed over the telephone. In all interviews, only the author and the participants were present. All interviews were recorded using a password protected dictaphone.

In order to develop the interview schedule (Appendix 2), the existing literature was reviewed in depth. Questions were formed taking account of the research question. Members of the supervisory team reviewed the interview schedule to take account of their knowledge of collecting qualitative data. The interview was divided into nine sections, with various sections applying to different participants. The first section covered basic demographic information and the participant's relationship and experiences with their GP or healthcare provider. The interview moved on to discuss the individual's background in seeking help for their problematic sexual arousal and how they came to realise they needed help. The following sections discussed their experiences of seeking help from their GP or healthcare provider, the treatments that were offered and how effective the treatment was. If the participant had been offered medication to treat their PSA, this was discussed with the participants and any effects of the medication, positive or negative. The final two sections discussed any help offered during custody and whether this had continued in the community which did not always apply to participants as a number had no experience of custody and four had no convictions.

5.2.5 Reliability and validity

The author transcribed all data to ensure familiarity with the data. The steps taken to ensure the reliability and validity of the research have been addressed in Chapter 3.

5.2.6 Data analysis

Data were analysed using reflective thematic analysis as proposed by Braun and Clarke (2021), informed by a phenomenological perspective. A phenomenological perspective was chosen to inform the analysis in order to gain an understanding of the subjective experiences of individuals seeking help for PSA. Data were coded using Microsoft Word and the researcher spent time grouping the codes to generate themes in the data. Full details of the steps taken during the analytical procedure can be found in Chapter 3, which outlines the process in detail.

5.3 Results

Three dominant themes were identified from the data as outlined in Table 14 below.

Table 14: Table of superordinate and subordinate themes

Superordinate theme	Subordinate theme
Infinite torment	Living in hell
	The beast within
	The hidden self
	Controlled by arousal
Facing the music to fall on deaf ears	Revealing the hidden self
	Feeling unheard
Quietening the beast	Turning down the volume
	Reconciling with the self

5.3.1 Superordinate theme 1: "Infinite torment"

The superordinate theme illustrates how the unwanted sexual thoughts were compared to being possessed. Four subordinate themes were apparent within the superordinate theme, "Infinite torment". Participants described how living with problematic sexual thoughts was like living in hell. The shame and guilt experienced as a result of these thoughts leads to self-hatred and a desire to be free from their own mind and destroy aspects of themselves. Participants did not see this as a part of their identity rather that it was a beast inside of them. Experiencing the thoughts ate away at their emotions, leaving them unable to interact with others as they tried to keep that aspect of themselves hidden. Participants also described that, rather than being in control of their sexual urges, they were controlled by the urges themselves.

5.3.1.1 Subordinate theme 1.1: Living in hell

This subtheme illustrates how the participants were tormented by their unwanted sexual thoughts. Sitting with thoughts that were out of their control caused the participants significant distress as they were unable to escape from their own mind.

Extract 1

> P2 - Yeah it, it worried me a lot it was like I, I really don't know how to how to deal with this, it's uncomfortable. Erm, these are not thoughts I want. I, I don't feel I should be having these. I feel guilty about it. And so it was, it was really quite a, a distressing place to be.
>
> (P2; lines 89-92)

This extract illustrates the sentiments of all participants of their unwelcome sexual thoughts and feelings. As with subtheme 1.4 below Participant 2 explains that experiencing these thoughts is outside of his control. The participant has difficulty reconciling these thoughts with their self-identity with the statement, 'these are not the thoughts I want'. It is recognised that deviant sexual interests are not something the individual chooses to have (Lehmann et al., 2021). Participant 2 has an awareness that what he desires is not something that would be classed as acceptable to society with his admittance of feeling guilty. PSA is characterised by unwanted, intrusive sexual thoughts that cause distress to the individual (Kaplan & Krueger, 2010). Experiencing these sexual thoughts causes shame, impacting on their identity, as they feel they are not the person they should be (Lazarus, 2006).

Extract 2

> P7 - Well, let's, it was really difficult not only in my personal life, my, was my college life and my, and my, my work life also because I was distracted all the time, I was wondering. I was obsessing, I was somewhere else. I wasn't, I wasn't at the place I needed to be at the moment, so it was, it was hard. I remember most days at college I would just cry every time I could be alone, so, it was hard.
>
> (P7; lines 99-103)

Living with intrusive sexual thoughts permeates all aspects of the individuals lives. The impact of this means they are unable to focus on anything else. This is consistent with the definition of sexual preoccupation provided by Mann et al. (2010, p.198) which outlines how living with the sexual thoughts "dominates psychological functioning". As a result of his thoughts, Participant 7 is not present, he is "somewhere else". This indicates that the obsessions have taken over, almost like an out-of-body experience. He is chained to his sexual thoughts and cannot escape them as further illustrated by Participant 9 below.

Extract 3

> P9 – Hell on earth. Absolute, like being in, like being in, like being in hell, like 24 hours a day, like not dying to go to hell and like it was just like being in hell. So infinite torment. It wasn't just the physical torment. The physical torment was bad enough. But it bought with it, mental torment, emotional torment. I just can't. It was awful.
>
> (P9; lines 211-214)

This extract from Participant 9 illustrates the constant suffering experienced when living with problematic sexual thoughts. He describes feeling permanently tormented in all aspects of life from which there is no escape. He struggles to articulate the feeling into words with his expression, "I just can't". Individuals with sexual convictions describe the constant nature of sexual thoughts they cannot escape from (Lievesley et al., 2014). However, it is not only those with sexual convictions that need assistance with PSA. Individuals seeking help for PSA without convictions have reported feeling tormented by their sexual thoughts and fantasies (Darjee & Quinn, 2020), highlighting a need for intervention outside of the Criminal Justice System.

5.3.1.2 Subordinate theme 1.2: The beast within

The participants struggled to identify with the aspect of themselves that caused their problematic sexual thoughts, as illustrated in the subtheme below. This aspect of themselves is not seen to be a part of them. Instead, it is another being, something that needs to be destroyed in order for them to be free from their PSA. By distancing themselves from this aspect of them, they are able to reduce feelings of culpability.

Extract 4

> P9 - I wasn't loving at all. I had no emotion whatsoever. I was just turning into a monster. I wasn't, and I didn't want to be that kind of person. I felt like something was possessing me.
>
> (P9; lines 1074-1076)

This extract illustrates the unwanted essence of sexual arousal. For Participant 9, the all-consuming nature of his sexual thoughts took away his self-identity. The sexual thoughts and urges became so intense that they ate away at emotions within him, leaving him, as he terms, "a monster", void of

human emotion. He has become desensitised to anything outside of his arousal. His description of feeling possessed further illustrates how sexual thoughts and urges took away his essence of being and indicates a lack of control. The unwelcome nature of these thoughts is reiterated by Participant 5; “I don’t like these feelings. I don’t want to be this person”. Participants felt that their sexual thoughts were defining their identity, as in Blagden et al. (2018), and turning them into “a monster” they could not reconcile with.

Extract 5

> P1 – Ah, well, it's been the worst thing in my life really because I can't, because, I think, if I think of all the, like all the different individual problems it's caused me.
>
> (P1; lines 202-203)

This extract from Participant 1 illustrates the element of distancing the ideal version of themselves from the “beast within”. Participant 1 refers to this aspect of himself as “it”. By labelling this as “it” the participant is able to present the thoughts and behaviours as an entity separate from himself, an othering. It is the “it” that has caused him the problems he has experienced, rather than any actions taken by himself evidencing minimisation. Distancing from their sexual interests and behaviours is a tactic reported in those with sexual convictions, especially in relation to the use of child pornography (Quayle & Taylor, 2002; Winder & Gough, 2010). Through the act of “distancing” individuals are able to remove themselves from the behaviour and create a more positive identity for themselves.

Extract 6

> P5 – (deep sigh) that would be impossible to explain how I used to feel about myself. Erm, hate……, hate……., not real, not human, not proper. I actually used to hate myself. I would class myself, looking back, I was very lucky I didn’t go into self-harm.
>
> (P5; lines 205-207)

This extract illustrates how participants felt after engaging in sexual activities to relieve the urges. Here, Participant 5 is reflecting back on a period of his life when he was offending sexually against children. The participant struggles to vocalise the level of self-hatred experienced, indicated by his

sigh, repetition and pauses. Participants became so removed from their self-identity that they no longer felt human. While Participant 5 states he did not go on to self-harm, the extract illustrates the wish to destroy the self to obliterate that aspect of his personality. Emotional distress and suicidal thoughts have been shown to be prevalent in individuals with problematic sexual interests (Cohen at al., 2018). Experiencing these thoughts bring about feelings of shame, anger, guilt and despair (Lawrence & Willis, 2021), leading to self-hatred and a wish to self-mutilate (Stevens & Wood, 2019). The willingness to destroy the self is highlighted further by Participant 6 who states, "I want to die because I'm a paedophile" and in extract 7 below.

Extract 7

> P9 - I felt like I was a monster. I didn't wanna be, that's not who I wanted to be. I felt like my real nature was asexual. But it felt like there was a beast in me and it was scary, it was like, it was like a boss battle and I had to destroy it, or it would destroy me. And I, I didn't want to become that person.
>
> (P9; lines 1078-1081)

Participant 9 clearly illustrates the desire to obliterate the aspect of himself which he identifies as ruining his life. Participant 9 does not recognise this arousal as part of himself but instead, something that needed to be removed from him. By becoming a eunuch and physically removing his genitalia, he feels he will remove his sexual desire, therefore reducing his sexual thoughts and solving his problems. Research has shown that for those who wish to receive an amputation, they felt they had been given a new lease of life following the removal of the limb (First, 2004). For Participant 9, the removal of his genitalia saved his life.

5.3.1.3 Subordinate theme 1.3: The hidden self

The thoughts and knowledge of what they were experiencing caused the participants to withdraw from others. By avoiding interacting with others, they felt able to keep this aspect of themselves hidden. Unfortunately, this led to further problems of being left alone with their thoughts.

Extract 8

> P7 - Umm well, not really. There were the same because I tried to keep myself Umm. I, I want to say isolated, but I tried to, not get too, too close to anyone because well let's say

that I don't like that feeling of being vulnerable to someone, that, I don't know It just doesn't make me feel good about.

(P7; lines 282-285)

This extract shows how the knowledge of what they felt inside acted as a barrier to communicating with others. Participant 7 is describing his relationships with family and peers. By remaining distanced from others, participants felt they could keep the unwanted nature of themselves hidden from others. Becoming closer to others may cause them to reveal aspects of their identity they could not accept in themselves.

Extract 9

P9 - No, I wasn't able to work. I couldn't be around people, full stop, because that thing was happening all the time. I could feel it down there and it was in me, and I was a monster and I just couldn't be around people in the same room, I couldn't look them in the eye. I just had to be on my own all the time, like 24 hours a day I'd be alone. I wasn't house bound, I was room bound.

(P9; lines 256-260)

The feelings of Participant 7 are also highlighted by Participant 9, who becomes caged in his room to avoid interactions with others. Echoing back to extract 5 in subordinate theme 1.2 above the participant is distancing himself from this aspect of himself. He refers to the arousal as "that thing". That thing was inside of him, and it is that thing which he needs to keep hidden. The persistent nature of arousal meant that the only way he could control it was to remove himself entirely from other people. Not being able to look people in the eye indicates a desire to keep his identity hidden out of fear of others becoming aware of what he was feeling.

Extract 10

P4 – Erm, it's still always in the back of my mind, what people will, you know, whether I'm going to accidently let it slip out, you know.

(P4; lines 570-571)

Keeping PSA hidden is something the participants were living with on a daily basis, meaning it was difficult to relate to others. The participants had difficulties creating meaningful relationships with others as they were fearful of letting the mask slip. The aspect of themselves they wished to hide was constantly gnawing away at them.

Extract 11

> P2 - it's, it's kind of difficult to start making new friendships when you are already in a position of knowing you, you've got a guilty, unpleasant secret that you're going to be very reluctant to divulge, but at the same time, people can't really get to know you as an entire person unless you're honest with all of yourself.
>
> (P2; lines 120-124)

As with Participant 4, Participant 5 finds it difficult to open up to new people in order to build relationships. He is weighing up the process of allowing people to know the real him while wanting to hide that aspect of himself. Whilst others have previously tried to distance themselves from that aspect of themselves by othering, Participant 2 outlines that "people can't really get to know you as an entire person" without acknowledging that aspect of himself. This highlights the tensions in the data between the not wanting to accept that aspect as their identity but realising it is a part of them.

A willingness to hide sexual interests that are not accepted has been explained by Meyer (2003) and the Minority Stress Theory to explain discrimination as a result of sexual interests. The theory was initially developed in order to understand the stigma associated with same sex relationships. Historically, homosexuals needed to hide their sexual interests from others to avoid stigma (Pachankis, 2007). As a result of the negative views of society and the shame experienced, individuals seek to keep their PSA hidden by withdrawing (Reid et al., 2009). Unfortunately, this can lead to an increased risk of isolation, increasing the possibility of offending behaviour (Cantor & McPhail, 2016; Jhanke & Hoyer, 2013). The suppression of sexual interests is detrimental to individual wellbeing and is not effective in diminishing sexual interests (Stevens & Wood, 2019).

5.3.1.4 Subordinate theme 1.4: Controlled by arousal

The subordinate theme outlines the participants' inability to take control of their sexual urges. The participants do not reconcile "the beast within" as part of their identity, making it difficult to control. Instead, the sexual urges are controlling them and the way they live their lives.

Extract 12

> P4 – Erm, my head was all, erm, my head was all mixed up and I wanted to obviously, all I wanted to do was like, well I'm sorry to put it so bluntly, but I was just wanting to have sex with anyone. So, I was like, well I wouldn't say it was hard all the time but a lot of the time, I could just be walking down the street and all of a sudden, I would just get those feelings just for no apparent reason.
>
> (P4; lines 265-269)

This extract illustrates the impact PSA has on an individual on a day to day basis. For Participant 4, it is the sexual act itself that is important, rather than who it takes place with. Impersonal sexual activities, such as numerous meaningless sexual partners, have been shown to be the most problematic for individuals with PSA (Långström & Hanson, 2006). As Participant 4 outlines, he is unable to control when the feelings of arousal happen. These feelings can appear out of nowhere when going about his daily life.

Extract 13

> P9 – Because lust is like a volcano. It it could erupt anytime. You don't know when it's gonna come. You could be alright one minute and then it erupts.
>
> (P9; lines 1396-1396)

The uncontrollable nature of PSA is reiterated by Participant 9. His illustration of a volcano that could erupt at any time shows how unmanageable the arousal is. The inability to control sexual urges can cause difficulties for individuals with PSA in relation to employment (Reid et al., 2009) and relationships (Klein et al., 2015).

Extract 14

P5 - I'd drive ten miles just to look at girls' pants, it was a bit of an obsession and I started thinking, this is not right.

(P5; lines 67-68)

Participants also discussed how their activities were governed by their sexual urges. The participants would go to extreme lengths to meet their sexual urges, often to the detriment of other daily tasks. This is further illustrated by Participants 1 and 3 below.

Extract 15

P1 – No, not really no, I think it's just, it's just, it was just a complete drain on your time, so you just don't get anything else done, and I and I realised that, that it was, you know, that everything else, you know, ah, you know, sometimes when I've had too many er energy drinks or I erm, have a glass of whiskey every night. But I could stop any of those.

(P1; lines 183-186)

This extract illustrates how the engagement in sexual activities began taking over the participants' lives. Whilst the participant indicates he has control over other "vices" such as drinking alcohol or energy drinks, he is unable to control his use of pornography. This is reiterated by Participant 3 below.

Extract 16

P3 – whether it was like, oh I wanted to go to the gym after work, or like I wanted to wake up early and have like a good, morning routine and instead I was just rushing out the door to catch the bus because I had been in a like a porn in the morning. Erm, so yeah, it became, it became frequent, but also not so much the frequency that was an issue but also just like when I would do it. Erm, so very avoidant behaviour, very like procras… like erm, a fuel for like procrastination so that's kind of like how it was problematic for me.

(P3; lines 136-141)

This extract illustrates how the frequency of engaging in sexual activities accelerates to the point where it becomes problematic as it begins impacting on the participant's daily life. Participant 3 has an awareness of what he should be doing in order to improve his life by engaging in productive, healthy activities such as going to gym. Participant 3 refers to his porn use as "a fuel for procrastination". This avoidance behaviour is clearly problematic, indicating that internally, he does not wish to be productive. Males with sexual compulsivity have been shown to use more avoidant coping mechanisms, which may be indicative of individuals using pornography as a way of avoiding daily tasks (Wetterneck et al., 2012). Avoidance has also been shown by Rimmer and Holt (2023, p.13), with participants reporting the use of pornography as "An avoidance of what I should be really sorting out about myself".

5.3.2 Superordinate theme 2: Facing the music to fall on deaf ears

The superordinate theme illustrates the process the individuals went to in order to gain help for their PSA. The participants discuss the fear of admitting their sexual interests to healthcare practitioners due to shame, embarrassment and a fear of being reported to the police. Once they managed to overcome this fear, many participants felt they were not taken seriously by the person they sought help from and experienced frustration when services were often unaware of how to help them.

5.3.2.1 Subordinate theme 2.1: Revealing the hidden self.

In order to gain help for PSA, participants had to disclose an element of themselves they had gone to great lengths to keep hidden, linking back to subordinate theme 1.3, 'keeping the beast hidden'. As they had spent so long attempting to hide this aspect of themselves, revealing this part of their identity was a complex process. Admitting they had PSA, which may involve deviant sexual interests and behaviours, opened the individual up to the stigma associated with PSA. However, once revealed, participants indicated feeling relieved. Having their secret out in the open made them feel more able to cope and less of a risk to others.

Participants outlined the risks involved with revealing their sexual interests as outlined in extracts 17 and 18 below.

Extract 17

P5 - But some people, oh he's a dirty sex offender, let's go and put stones through his windows, telling the neighbours so they don't talk to you anymore, or what have you.

(P5; lines 746-748)

Extract 18

P8 - So they did not ever file any charges or prosecute me. They were clear. But it did create a lot of backlash. People hated on us. They threatened our lives. Our neighbours found out, our church banished us from all the churches in (place name). And now in (place name), part of (place name). Umm. And that that's been very hard on my wife.

(P8; lines 265-268)

These extracts highlight the real risk of vigilante action that comes when the community become aware that they are living near an individual with a sexual offence. There is much stigma associated with deviant sexual interests, especially in the community (Jhanke et al., 2015). Individuals often experience threats and damage to their properties (Levenson & Cotter, 2005b). This stigma often extends to family members, children and associates of the person with deviant sexual interests (Cubellis et al., 2019). The fear of being ostracised illustrates how people with PSA experience difficulty when admitting their interests.

Extract 19

P3 – This is terrifying, erm, initially disclosing something that, you know, this is an area I didn't talk about to, to anyone. So yeah, it was really, really scary, yeah.

(P3; lines 228-229)

Participants outlined how revealing the secret nature of their sexual thoughts and behaviours was difficult to voice. Participants struggled to accept PSA as part of their identity and went to great lengths to keep this aspect of themselves hidden, as illustrated in subordinate theme 1.3 above. Participant 3 sexual outlet was through the use of excessive pornography consumption. The secret nature of problematic pornography was highlighted by Sniewski and Farvid (2020). For participants in their study, the first time they had admitted to using pornography was during the interview with

the researcher. In the present study, removing the mask and voicing this hidden and unwanted aspect of themselves to a stranger brought about feelings of fear, as illustrated further below.

Extract 20

> P6 – Erm but with the GP. Yeah. Like I didn't know what the response would be. I didn't know whether it would be kind of like a phone call to the police or. Because, like, obviously like there was never a point where I thought I was a risk to anyone, but it's more just, you know, would a GP agree with that? So it was, I wouldn't have done it if I felt like I had any other sort of option. Because like I, at the time, I really did, it was, yeah, I was very suicidal.
>
> (P6; lines 370-374)

The participants expressed the dichotomy they faced when revealing the nature of their sexual interests. Participants knew they needed help for the PSA but were conscious this may cause them problems with the Criminal Justice System. This is often a barrier shown to reduce help-seeking for individuals before offending (Piché et al., 2018). For many, this step was taken as a last resort. For Participant 6, when he considers the alternative, he identifies he has no other option.

There is much uncertainty around whether there is a need to report an individual who admits to having deviant sexual interests. As outlined in Chapter 6, GPs are governed by the General Medical Council and are obliged to disclose information if they assess there is a risk of serious harm (General Medical Council, 2021). The GPs participants in Chapter 6 outline the balancing act they need to undertake when assisting patients with problematic sexual interests and balancing the patient's needs with those of the general public. A recent study of social work students revealed that over half the sample would report an individual to the police if they labelled themselves a paedophile (Walker et al., 2022). StopSo, however, a UK-based organisation designed to provide therapy for individuals with problematic sexual interests, are against reporting to outside agencies in order to provide the individual with help (Christiansen & Martinez-Dettamanti, 2018).

Extract 21

> P2 - Yeah, I'm already in trouble now, it's not going to get any worse. So, you know, It's, it's not dangerous to disclose anymore because the damage is already done. So that's kind of

opened the door if you like. But now I can, I can go and seek help, although as I say, I wasn't really sure what help that would be.

(P2; lines 172-175)

For others, the ability to reveal this nature of themselves was only possible of coming into contact with the Criminal Justice System. For Participant 2, the fear was removed once he had been arrested for offending. The aspect of himself had already been revealed, and he was no longer at risk of it being exposed. The stigma associated with PSA has been shown to be a barrier in relation to help-seeking (Blagden et al., 2018). In previous samples, only 20% of individuals with problematic sexual interests had sought help prior to conviction (Levenson et al., 2017). Had Participant 2 felt able to request help prior to offending, this may have enabled him to get his PSA under control. By having help available prior to individuals with PSA coming into contact with the Criminal Justice System, this would reduce the likelihood of offending and lead to a reduction in victims of sexual abuse.

Extract 22

P5 - It took a lot, a lot of courage, I must have drove by the surgery ten, fifteen times before I actually went in, and then sat in the car. And then when you go in you think, ok, this is it, this is it.

(P5; lines 83-85)

Participants recounted the steps they took to build the courage to ask a healthcare professional for help. Whilst in extract 20 of this subordinate theme this was as a last resort, before they harmed themselves, others knew they had to take action as they may harm others. Participant 5 outlines the back and forth his mind is taking with his account of driving past the surgery, then entering the surgery, before going back to the car. When he finally enters the surgery, he is full of hope that his problems will be solved as he has finally taken the first step to seeking help.

Once participants were able to reveal their PSA, many experienced a feeling of relief, as illustrated below.

Extract 23

P2 - It was, it was a mixture of things. I mean, it was, it was pretty devastating to be arrested and slammed in a police cell for over 12 hours. That's not a fun experience. I wasn't able to contact anybody so, and I had been on my way to work at the time so I couldn't even let them know. I'm not coming. Sorry. And that was, that was pretty devastating. But there was an element of, of relief as well in that, well it's out now, you know, so whatever's gonna happen, it's gonna happen.

(P2; lines 229-234)

For Participant 2, his hidden identity was revealed when he was arrested for offending. For him, the timing was not his choice. The hidden aspect of himself may have remained sequestered from others had his actions not been brought to the attention of the authorities. However, the arrest became a turning point in his life. As he outlines, having his PSA exposed to others brought about feelings of acceptance and relief. Now his secret was out in the open he was free to seek help, as he was already facing a sentence.

Extract 24

P8 - I'm the last one who's going to abuse the child. Since I've come out, publicly, everybody's got eyes on me. So I'm not gonna do anything.

(P8; lines 514-516)

Participants also felt that once they were no longer trying to hide their sexual interests or behaviours, their risk of offending was reduced. As Participant 8 states, having the world aware of his interests means his is not going to offend. He is no longer hiding a secret. As illustrated in extract 18, Participant 8 has experienced difficulties with reactions from others since revealing his sexual interests. He also finds some relief as he feels he is less likely to act on his interests than if he was still hiding a secret. It is recognised that individuals may not have control over their sexual interests but are in control of whether they act on their sexual attractions (Levenson et al., 2020). A number of individuals identify as 'virtuous paedophiles' and choose not to act on their attractions as they are aware of the harm they would cause should they do so (Cohen et al., 2018). Whilst many minor attracted persons choose to keep their interests hidden, Participant 8 feels that revealing this nature of himself assists in controlling the likelihood of him acting on his sexual interests.

5.3.2.2 Subordinate theme 2.2: Feeling unheard

This subordinate theme illustrates the frustrations experienced by participants when seeking help. Participants felt they were not offered the help they required and often felt unheard or not taken seriously.

Extract 25

> P1 - Somewhere, Uh, it was quite near here but it was a, a sort of Psychologist thing. And he decided that I didn't have a problem so, so that was, that was a bit frustrating at the time. Because I thought well, I know I do, but I can't really, obviously haven't talked properly or whatever or made it clear enough.
>
> (P1; lines 539-542)

Participants discussed how they were unable to articulate the nature of their PSA to others in order to get the help they needed. Whilst this may be the case, it may also have been the case that the psychologist in question did not specialise in the area of PSA and may not have fully understood the extent of the problem. Often healthcare professional feel sexual issues should be reserved for specialists (Gott et al., 2004) and feel unprepared to treat patients appropriately due to lack of confidence (O'Connor et al., 2019).

Extract 26

> P6 - But I got the impression he didn't think I really had those thoughts or because. Sort of, what I used the term paedophile, which I think in a lot of people's minds is like a criminal thing. Which like I, I know, like people sort of sort of moved more towards MAP now which I mean, I have mixed feelings about it, but like erm at the time, like it wasn't really a thing, so I just, yeah, used the word paedophile. And that was a he, he kept using air quotes whenever he said it. And I was trying to explain like no like this, no like this is, this isn't just sort of something that I've sort of made up or like, I'm worried that I might have those thoughts, like I definitely have those thoughts.
>
> (P6; lines 494-501)

Again, this extract illustrates the difficulties participants had in expressing their experiences to healthcare professionals. Participant 5 noticed as he grew older, the age of the people he was attracted to remained young. Having lived with this for a number of years he sought help from his healthcare practitioner but felt unheard. Participant 5 did not feel the heath care professional was taking his interests seriously and felt almost belittled by the use of air quotes. For the participants, having taken such a long time to reveal this aspect of themselves to others, being listened to with understanding is important to encourage further help-seeking behaviours (Quinn et al., 2018).

Extract 27

> P9 - Yeah, and they would say, come of it, you're a bloke, what bloke doesn't like sex. And the main reaction from the doctor, from the psychiatrist was that was that it was a mental illness and I shouldn't want to be free from persistent sexual arousal. And that wanting to be free from it was the mental illness. And they say, you know, you're a man. You should be having sex. You should be having sexual thoughts. And I'm like, no, not, all the time. And they said no, the mental illness is thinking that you shouldn't be like that. I was like that's crazy.
>
> (P9; lines 87-92)

This extract illustrates the difficulties participants had in finding healthcare professionals with an understanding of excessive levels of sexual arousal experienced by those with PSA. It appears that people with low levels of sexual arousal are more likely to seek help for their sexual health than those with excessive arousal (Heiden-Rootes et al., 2017). As outlined in Chapter 6, many healthcare professionals have a limited experience of assisting those with PSA and may not appreciate the extent of the difficulties faced by the person. Participant 9 feels that he is struggling to have his voice heard and is not being understood.

Extract 28

> P5 - And when I went in and I was talking to her I said erm, I fancy young girls. I'm not really interested in an adult, sexual relationships. I'm only interested in young girls. Adult ones don't bother me in the slightest, I don't, I'm not bothered. And she said, ooh this fella, and I thought which fella? Oh, this friend of yours. I said, no I'm talking about me. Yes but, pretend it's a friend. And I thought well, I can't try to talk about it like that because my

> friends wouldn't do things like that. It ended with me actually walking out of the surgery, because she wouldn't listen to me, she wouldn't pay attention. She wouldn't listen to what I wanted to say, she wanted to do it through a third party, you know, let's talk about somebody else. Dr (name) her name was, and I ended up walking out with nothing but a red face, shame, embarrassment and when I got to the car, tears. It had took a hell of a lot of courage to go in the first place.
>
> (P5; lines 71-81)

Here, Participant 5 is describing an exchange with his GP whereby they wanted to discuss the issue as if this was happening to someone else. It is not known why the exchange was undertaken in this way, but it is possible that the GP may have felt more comfortable dealing with the conversation as if it was not the person in front of her. Evidence suggests that GPs often find it difficult to discuss sexual issues and depersonalisation assists them in discussing the matter discreetly, without referring to the individual directly (Kelder et al., 2022). It is also possible the conversation was directed this way to enable the participant to voice their concerns without opening himself up to safeguarding issues. For Participant 5 however, having built up the courage to reveal this aspect of himself, to have to pretend this was not his own personal problem caused frustration. The participants had taken a long time to admit they needed help, and this caused more negative feelings when the help was not received as expected.

Extract 29

> P4 - I was at the point where I said to my psychiatrist, have I literally got to do something before you lot will listen, because I knew I wasn't right in the head. And then, I don't it don't make an excuse (Researcher's name) but it, just to make my point you see. And then all I got, off him, when I next saw him after I'd been arrested was, "well what did you go and do that for?"
>
> (P4; lines 219-223)

This extract clearly illustrates the frustrations experienced by participants. Participant 4 had been working with a psychiatrist at the time of his offence and whilst he says he is not making excuses, blames the perceived lack of support for his offending. This enables him to remove the responsibility from himself. Individuals with sexual convictions have been shown to deflect

responsibility through denial and minimisation. This enables them to present a moral identity (Blagden et al., 2014). However, the participant in clearly frustrated that he did not receive the help he sought prior to his offence being committed which is further illustrated in extract 30 below.

Extract 30

> P8 - Yeah. Now another one that actually came from my own list when we moved to (place name), I contacted a woman in a community near us to us and she was busy, so she referred me to her whatever, assistant and I went once and it was great. I thought it was great. She was very helpful and understanding, but she called me the next week and said so I can't help you. I said well why is that? Well, you haven't abused anybody. Great, you want me to go out and screw a little girl so I can get help? That I didn't say. But that's what I thought.
>
> (P8; lines 598-603)

Feelings of a lack of support are also echoed by Participant 8 and was common for many. There is a distinct lack of help for people with PSA prior to them becoming involved in the CJS. This was frustrating for participants as many were seeking help as they did not wish to act on their urges and cause harm to others. Primary interventions have been developed to allow individuals to seek help prior to offending (Christiansen & Martinex-Dettamanti, 2018). However, for most help, only becomes available following conviction. Additionally, those who manage to admit to themselves that they need help and spend time searching for someone to help them, to be then told they cannot be helped is frustrating for individuals and may lead some to cease help-seeking as they feel their efforts are futile (Levenson et al., 2017).

5.3.3 Superordinate theme 3: Quietening the beast

The theme shows the various ways the participants were able to reduce their levels of PSA to manageable levels. Whilst some had used medication to reduce their problematic sexual thoughts and arousal, others had favoured psychological interventions. Ultimately, recognising that their sexual thoughts did not need to define them, enabled participants to reconcile this aspect of themselves and live with their PSA.

5.3.3.1 Subordinate theme 3.1: Turning down the volume

Participants discussed their reasoning behind choosing medication to manage their PSA and their experiences of using the medication.

Extract 31

> P3 – Then I felt that some of my urges were going towards things that were potentially, could lead to like illegal things, especially online. Like illicit, illegal pornography, and it just scared the hell out of me. And erm, that's when I was like, you know, I've talked to my therapist about medication.
>
> (P3; lines 113-116)

Participants explained that they were afraid of their interests escalating. Research has illustrated how, for individuals with problematic pornography usage, an escalation in the severity of content is common (Hanseder & Dantas, 2023). For Participant 3, his realisation that his interests could possibly enter the realm of illegal pornography caused him to admit he needed further assistance in the form of medication.

Extract 32

> P6 – So, I asked specifically about erm, kind of help for sort of depression and then also, you know, like any kind of medication, for libido because I thought. At the time, I thought if I didn't have, like, a sex drive, that would be easier to deal with.
>
> (P6; lines 313-315)

This extract from Participant 6 was common for most participants. They wished to be free from their excessive levels of arousal to enable them to live a better life. Participant 6 was not sure whether he was depressed as a result of his excessive arousal or his deviant sexual interests. Evidence suggests that people with PSA often have poorer mental wellbeing than others, and this is particularly higher among those with a sexual interest in children (Savoie et al., 2021).

Extract 33

P2 – Once I'd started the medication, initially it was like, well, this might have been a mistake. This is, this is harder than before I started it. But I'd been warned that there could be a transition period. And so I thought OK, well, let's, let's not jump too soon. Let's give it chance. And after a couple of weeks. Yeah, it was definitely easier than before the medication.

(P2; lines 892-896)

For those who had been given the opportunity to use medication in the form of SSRIs, many reported that there was an adjustment period for the first couple of weeks. For Participant 2, initially, his levels of arousal increased when he began using the medication. The NHS (2022b) highlight how SSRIs often take up to two weeks to start improving an individual's symptoms, with people sometimes feeling worse when they initially start the treatment. The participants had to persevere through this initial period in order to reap the benefits of the medication.

Extract 34

P8 - Uh, yes, it helped both with the anxiety and the libido. It's just nice to turn down the volume a bit.

(P8; lines 418-419)

Once participants had gone through the adjustment period of the medication, they outlined the benefits. Participant 8 describes this as "turning down the volume". This indicates that the constant intrusive sexual thoughts had been reduced, allowing him to think more clearly. This is consistent with the findings of Lievesley et al. (2014) where participants reported experiencing more "headspace" as a result of the reduction of intrusive sexual thoughts.

Not all participants experienced the effects of the medication in the same way however, as outlined in extract 35 and 36 below.

Extract 35

P1 - I did, erm, yeah, I got that fluoxetine and then erm, and tried that for a while, but it just it just made me not feel very, it didn't really make me feel very well and wasn't really stopping the, the urge to act out. I was just, difficult to have sex.

(P1; lines 550-552)

Extract 36

P8 - You know, we're adults here, so my wife and I still had a good sex life. It didn't destroy my ability to enjoy a sexual relationship.

(P8; lines 421-422)

The extracts from Participant 1 and 8 show the tensions within the data and illustrate how treating PSA is an individual process. What may work for one person may not necessarily work for others. Participants 1 and 8 had both been prescribed fluoxetine. Whilst Participant 8 reported being able to enjoy a healthy sex life with his wife, for Participant 1, the medication removed the healthy sexual behaviours but did not assist him to reduce his problematic behaviours. Clearly, in cases such as this, alternative treatments are important as the point of MMPSA is not to diminish sexual behaviours entirely but to reduce the problematic sexual behaviours allowing individuals to pursue a healthy sex life (Winder et al., 2018).

Extract 37

P9 - Ohh you've no idea. And when I first tried the anti-androgens like, you know, injected myself in my bottom or whatever it was like, chucking a bucket of water on a raging fire and I, I've had drugs in the past, you know, LSD and marijuana. Nothing compared to the what the Depo Prevara did. It was like for the first time I could look women in the eyes without being ashamed

(P9; lines 158-162)

Participant 9 is the only participant in the sample who had used anti-androgen medication to manage his PSA. After being refused anti-androgens by the NHS, he took the risk to order the medication online and had it imported from India. As he outlines, the medication had the ability to extinguish levels of arousal, which he compared to a raging fire. Linking back to subtheme 1.3, by

reducing the extent of arousal, this opened up the ability of him to look women in the eye. He was no longer fearful of them noticing the beast within him as it had been stifled by the medication.

Depo Provera is an anti-androgen medication used a number of years ago to treat individuals with sexual compulsions. Individuals who have been prescribed anti-androgen medications have previously reported "for the first time in my life (of sexual awareness and preoccupation of over 35 years) I am at peace sexually" (Robinson & Valcour, 1995 p.284). More recently, anti-androgen therapy has been provided to individuals in the form of Medroxyprogesterone acetate (MPA) and Cyproterone Acetate (CPA) (Thibaut et al., 2020). CPA has been shown to reduce sexual arousal and the amount of sexual activities (Lippi & van Staden, 2017). MPA has been shown to be effective in reducing PSA when combined with psychological interventions (Maletzky et al., 2006). However, there is a lack of recent studies into the effectiveness of MPA and CPA (Turner & Briken, 2021).

5.3.3.2 Subordinate theme 3.2: Reconciling with the self

This subordinate theme illustrates the acceptance process the participants underwent in order to live with their PSA. The participants learned coping skills in order to manage their arousal. Reconciling the problematic thoughts as a part of themselves but recognising they did not need to action the thoughts helped the participants to live more meaningful lives.

Extract 38

> P2 - Yes, it, it did help. But more it, it, it was when I got to the light bulb moment of OK, I need to accept that these, these thoughts aren't gonna go away, and instead of trying to battle with them, I need to just let them be basically and you know I can, I can have the thought, acknowledge the thought and not do anything with it.
>
> (P2; lines 551-554)

Participants experienced a turning point in their thinking when learning to manage their PSA. Accepting that the problematic thoughts were likely to always be there but knowing they did not need to act on them was comforting to the participants. Rather than fighting with the thoughts, they were able to acknowledge them as is further illustrated in extract 39 below.

Extract 39

P8- I, I do. Yes. So as I interpret it, as I understand mindfulness, I acknowledge the feeling. Yes, I'm attracted to this little girl. And instead of trying to fight it, I let it, shall we say, float away, naturally, float down the river. You know, arousal doesn't last more than 4 minutes unless you, unless you're on Viagra, and need to call the doctor, so the joke goes, but anyway.

(P8; lines 188-192)

This extract illustrates how the participants manage their PSA. Acknowledging the feelings but being that they do not need to act on them assisted the participants in living offence-free. This was also helpful for participants in Blagden et al. (2018). Mindfulness and meditation are effective in helping individuals manage problematic sexual thoughts and behaviours. Individuals have reported more feelings of calm and reduced feelings of shame when replacing problematic pornography use with mindfulness and meditation (Sniewski & Farvid, 2019).

Extract 40

P5 – Yes because it gives you a lot of information, gives you a lot of things you can do on your thinking skills. Think about something before you do it, don't act on impulse. I used to act on impulse. Not nastily. There's several different items on the, I've forgotten what they're all called, but they still stick with you, not all the while. You know, like you're walking down the street, see a young girl, sitting on the floor, flashing her knickers. And I can think, I can turn around and walk back, you don't have to walk by them.

(P5; lines 572-577)

The participants also outlined the various coping skills they had learned in order to manage their PSA. For Participant 5, the skills he has learned through engagement with psychological interventions have been invaluable in changing his behaviours. As he outlines, he now has an awareness that he has options. He is able to recognise a situation that puts him at risk of reoffending and take action to remove himself. Participant 5 goes on to say, "I do get the feeling, I get the feeling several times a week, and they last two or three seconds, and then it's gone. Because I have to do something about it". He has accepted that the urges are still going to happen, but he has the ability now to distract himself by undertaking different activities.

Extract 41

> P7 - So that's, so that way we could focus on that. But not on how to. Let's say how to get rid of it or how to illuminate or delete or anything like that, but instead of, how to live with it and how to, how, I was more than that. How I was, it was just a part of me, and it wasn't the whole of me was just a part of myself. And she helped me focus on other aspects of my life on other things, like erm finding, hobbies finding what my talents are, finding the positive aspects of my personality and my life, so I didn't focus only on my attractions. I could be, try to live in a better way.
>
> (P7; lines 173-179)

This extract illuminates the importance of the individual accepting PSA as a part of them. Rather than battling with "the beast within", learning to live with it enabled the participants to live better lives. Participants had spent such a long time trying to hide and destroy this aspect of themselves, it became all-consuming, resulting in withdrawal and poor mental wellbeing. Accepting that PSA is only one aspect of themselves, realising they are not defined by it and focusing on their positive qualities helped participants live in harmony with their sexual interests. Such shifts in identity have been shown to encourage desistance from offending (Göbbels et al., 2012).

In order to facilitate desistance, acceptance has been shown to be an attainable intervention goal in managing problematic sexual thoughts and behaviours (Sniewski & Farvid, 2019). Previously, participants have reported, "The goal is to accept your attraction and yourself … as long as I don't have sexual contact with a child, I won't feel bad" (Stevens & Wood, 2019, p.975). This acceptance process relates to Acceptance and Commitment Therapy (ACT) principles. ACT is a psychological intervention which aims to encourage psychological flexibility. Hayes et al. (2006, p.8) have defined psychological flexibility as "the ability to contact the present moment more fully as a conscious human being and to change or persist in behaviour when doing so serves valued ends". When using ACT, individuals are required to have an awareness of their thoughts and achieve presence in the moment. Individuals are encouraged to accept the thought, but then move into a state of diffusion whereby they accept that the thought is not a reality. Individuals are then encouraged to take actions in relation to their values (Hocken, 2018). As illustrated above, all participants appear to go through this process by accepting their problematic sexual thoughts and taking alternative actions.

As a result of accepting the nature of their thoughts, participants were able to respond appropriately and not feel controlled by their interests, as illustrated further in extract 42 below.

Extract 42

> P8 - Well, you don't rape your secretary, do you? you're sexually attracted to other women? Well, so you can control your attraction just because you're attracted to somebody doesn't mean you're out of control.
>
> (P8; lines 490-493)

This extract illustrates how the participants began to acknowledge that their "deviant" sexual interests did not need to control them. Participant 8 outlines how paraphilic interests work in the same way as normophilic interests. Participants were able to recognise that just because they had an attraction, they did not need to act on it. This enabled them to take back control over their sexual interests.

Extract 43

> P9 - You know, now I'm, now I'm the person I wanted to be and it's not. And it's not an issue. And I can, I can you know, look women in the eyes and I can, I can help people.
>
> (P9; lines 988-990)

The final extract illustrates the importance of the transformation process the participants underwent in order to reconcile the self and live with their PSA. Whilst many had different journeys in terms of using medication and psychological interventions, ultimately, learning to live with PSA in a healthy way enabled participants to be who they wanted to be. Being able to look people in the eyes is taken for granted by many. For participants with PSA, no longer having to withdraw as a result of their PSA gave them a new lease of life.

5.4 Discussion

The study aimed to gain an understanding of the experiences of individuals living with and seeking help for PSA in the community. The use of qualitative semi-structured interviews allowed

participants to discuss their experiences at length, which enabled an in-depth data set to be obtained. Following data analysis, three superordinate themes were developed to encapsulate the data. The first superordinate theme, “I was turning into a monster”, illustrates the experiences of individuals living with PSA and how this impacts their daily lives. The second superordinate theme, “Facing the music to fall on deaf ears”, outlines the challenges participants faced in admitting to themselves and others that they needed help. It also highlights the frustrations participants encountered when seeking help for PSA. The final superordinate theme, “Quietening the beast”, demonstrates the process through which individuals were able to manage their PSA and reconcile this aspect of themselves as part of their identity in order to live with it in harmony.

The superordinate theme “I was turning into a monster” gives a clear illustration of the problematic nature of PSA. Participants compared living with PSA to “living in hell”. They were chained to their sexual thoughts with nowhere to escape. PSA is characterised by unwanted and intrusive sexual thoughts (Krueger & Kaplan, 2001) that have been shown to take over the mind at a detriment to everything else (Mann et al., 2010). Experiencing these thoughts brought about feelings of guilt and shame. This caused feelings of self-hatred, which is common among individuals with problematic sexual thoughts (Tewksbury, 2012). Participants also expressed a willingness to self-harm. Evidence suggests that individuals with convictions of a sexual nature are more likely than those without sexual convictions to self-harm (Zohng et al., 2021). Feelings of self-hatred and a willingness to self-harm have also been shown in non-offending individuals with problematic sexual interests (Stevens & Wood, 2019). This indicates that perhaps it is the nature of the thoughts that lead to self-hatred, rather than a knowledge of harm caused to victims.

As a result of the hatred participants had for their PSA, they struggled to reconcile this aspect of themselves with their identity. Participants demonstrated distancing from their PSA by referring to it as an entity separate to themselves. Distancing has been shown to be a common technique in those with sexual convictions and enables the individuals to relieve themselves of culpability (Winder & Gough, 2010). Additionally, participants fought hard to keep this aspect of themselves hidden from others by withdrawing from society. Individuals reported being unable to get close to others for fear of being rejected should they discover their PSA consistent with findings of Blagden et al. (2018) and Jhanke et al. (2015). Withdrawal however leads to increased isolation which in turn increases the risk of sexual offending (Cantor & McPhail, 2016).

Participants explained that their levels of arousal were controlling aspects of their daily lives. Whilst they felt able to control other "vices", such as the use of alcohol, sexual arousal was out of their control. Participants explained that the urges would occur for no apparent reason. This meant they were unable to engage in daily tasks as they were engaged in sexual activities. The inability to control PSA leads to many problems in terms of relationships and employment (Reid et al., 2010), finances (Cantor et al., 2013), and health (Yoon et al., 2016). The theme demonstrates the distressing nature of PSA and indicates a need for effective intervention to support those living with such thoughts.

The second superordinate theme illustrated the process the participants underwent in order to seek help for their PSA. As participants had spent most of their lives keeping their PSA hidden from others, admitting these feelings to healthcare professionals was a difficult process. Once they had built up the courage to ask for help, many felt that they were not understood by the professional or perhaps did not like the advice they received. It is evident in the literature that males find it harder than females to seek health related help (Sagar-Ouriaghli et al., 2019). Males are also more likely to fear stigma associated with seeking help (Vogel et al., 2007). For individuals with PSA, this is made particularly difficult due to the embarrassment and stigma of admitting to problematic sexual interests and behaviours (Jahnke, 2018). As a result of this, it is vital that once the individual feels in a position to gain help, that help is provided. If the appropriate help is not available, this may lead to further reductions in help-seeking (Sniewski & Farvid, 2020).

The final superordinate theme demonstrates how individuals were able to "quiet" the beast within them. For many this was achieved with the help of medication. Whilst initially participants went through a period of adjustment as their bodies adapted to the medication, they then began to experience reduced levels of sexual arousal. Participants explained how the medication enabled them to "turn down the volume", leaving them with more headspace to concentrate on other aspects of their lives, consistent with findings of Lievesley et al. (2014). The medication was more effective for some than others however, illustrating that the journey of medication is an individual process as described in Winder et al. (2014a). Whilst only one participant in the present sample had used anti-androgen medications, this proved to be extremely effective in reducing levels of sexual arousal. Whilst anti-androgens are effective in treating PSA (NICE, 2015), they are associated with more severe side effects than SSRIs (Grubin, 2008).

Participants discussed the “light bulb” moment that enabled them to change their thinking. Accepting that they would experience problematic sexual thoughts, but they did not need to act on them, was a part of them was a major step in their recovery. Previously they had spent their time battling with this aspect of themselves and attempting to hide it from others. The acceptance of their PSA enabled participants to become at peace and focus more on the positive aspects of their identity. Whilst no participants reported being treated with ACT, the process by which participant achieved this resonates with methods recommended in ACT.

In order to achieve psychological flexibility, ACT outlines six key stages: contact with the present moment, acceptance, defusion, self as context, committed action and values (Hayes et al., 2006). For participants in the current study, mindfulness was used to achieve contact with the present moment. Acceptance occurs when the participants accept that problematic sexual thoughts may always be a part of their lives. The purpose of ACT is to recognise that avoidance of problematic thoughts may be detrimental to wellbeing (Hayes et al., 2012). Ceasing to avoid their thoughts and accepting them may lead to more effective solutions to the problem (Walton & Hocken, 2019). Cognitive defusion allows the participants to accept that their sexual thoughts are simply thoughts. By increasing their skills in defusion, participants are able to decrease the likelihood of them acting on their sexual thoughts (Hocken, 2018). Self as context allowed the participants to accept that their sexual thoughts do not define them. They may experience problematic sexual thoughts, but thoughts pass. This shift in self-identity has been shown to decrease the likelihood of offending (Maruna, 2004). Committed action and values are the final stages of ACT. Individuals undergoing ACT are encouraged to take actions that reflect their personal values (Hayes et al., 2006). Participants in the present study outline how they have learned skills to distract themselves by undertaking productive activities rather than engaging with sexual thoughts.

There is currently little research available that has used ACT with individuals with sexual convictions. However, ACT has been posited to be effective in treating those with convictions for intimate partner violence (Berta & Zarling, 2019). A Randomised Controlled Trial (RCT) compared the use of ACT with the Duluth Model in a sample of individuals with convictions for intimate partner violence. The RCT provided evidence in support of the use of ACT. Those treated with ACT showed significant reductions in violent offending when compared with those treated with the Duluth Model (Zarling & Russell, 2022). An RCT has also been undertaken to assess the effectiveness of ACT with problematic pornography use. Those allocated to treatment with ACT reported a 93% reduction in pornography usage when compared to the control group (Crosby & Twohig, 2016). This

evidence, along with the findings of the present study suggest that ACT may be an effective treatment for individuals with PSA.

5.4.1 Strengths, limitations and suggestions for future research

The present study provides a unique contribution to knowledge through its investigation of the experiences of individuals living with and seeking help for PSA in the community. The study has provided a detailed account of the challenges individuals face in their daily lives as a result of their PSA. The study also provides an in-depth understanding of the efforts needed to gain help for PSA and the experiences of this. As a result of remote data collection, it was possible to recruit participants from a variety of countries. Participants were recruited from the United Kingdom, United States of America and Mexico. This enabled a rich data set to be obtained and allowed shared experiences to be explored regardless of the participants' nationality.

The recruitment of participants outside of the UK may also have been a limitation of the study. The procedure for accessing health care varies across each country. Whilst participants in the UK initially sought help from the GP, participants in the USA and Mexico sought help directly from therapists they had found online. Despite this, the study enabled an exploration of the experiences of help-seeking. Future research may wish to specify the healthcare practitioner to assess commonalities across each type of profession. Additionally, whilst all participants were seeking help for their PSA, not all participants wished to access medication to manage their sexual arousal. Future research may seek to recruit solely participants who are seeking to access medication to gain a deeper understanding of the challenges and barriers faced in obtaining medication for PSA.

The present study did not aim to assess the effectiveness of ACT in treating PSA. However, from the data obtained it became apparent that ACT appeared to be an overarching theme in the data. By accepting their problematic sexual thoughts and taking actions not to act on them, participants learned to live with their PSA. To date, there is limited evidence in relation to the use of ACT and problematic sexual behaviours (Walton & Hocken, 2019). The evidence provided in the present study suggests that this is a treatment intervention worthy of further investigation amongst similar samples.

5.4.2 Recommendations

The study has illustrated the difficulties individuals with PSA face in the community, particularly prior to conviction. Should more help be available for individuals with PSA prior to coming into contact with the Criminal Justice System, this would help to improve the lives of the individual with PSA and prevent harm to potential victims.

5.4.2.1 Increasing availability of help prior to conviction.

The findings of the study have illustrated the fear many participants experience in seeking help for PSA. Participants were fearful that if they revealed their problematic sexual interests, they would be reported to the authorities. As a result of this, many participants failed to seek help until after conviction. Additionally, for those that did seek help, many were told there was nothing that could be done for them as they had not committed offences. A belief held by some healthcare practitioners that aspects of PSA should only be dealt with by the Criminal Justice System.

Increasing the availability of services prior to conviction would have an impact on rates of sexual offending. Relieving the fear of reporting requirements would also increase the likelihood of individuals with PSA seeking help and reducing the chance of offending. Whilst primary interventions are available, often participants had struggled to find the appropriate service when needed. Increasing awareness of primary services would assist individuals with PSA in gaining the help they need, without fear of reprisals.

5.4.2.2 Increased awareness for healthcare professionals

The study outlined the frustrations of the participants when attempting to gain the help they needed. For someone with PSA, seeking help may be a last resort with many experiencing suicidal thoughts. Having built up the courage to ask for help to then not received the required help could lead to a reduction of help seeking and increase the risk of offending (Jahnke et al., 2015; Levenson et al., 2017). By increasing awareness of PSA amongst healthcare professionals, this will leave them feeling better prepared when encountering such a case. As outlined in Chapter 6, the creation of a shared care pathway would enable healthcare practitioners to signpost individuals with PSA to the appropriate service.

5.4.2.3 Availability of MMPSA in the community

The study illustrated the difficulties participants faced in obtaining MMPSA in the community, particularly in the case of anti-androgen medication. Should the shared care pathway recommended in Chapter 6 come into fruition, this would enable GPs to refer individuals with PSA to the correct specialist in order to obtain medication. This would reduce the likelihood of

individuals with PSA obtaining medications online. Individuals would then be properly monitored by trained medical practitioners in relation to dosage and side effects.

5.5 Conclusion

The present study has provided a detailed exploration of the lived experiences of individuals with PSA. The chapter has highlighted the difficulties faced by individuals as a result of PSA and the impact this has on their wellbeing. The research has also shown the ability to gain help for PSA in the community can be challenging, as outlined in Chapter 6, many GPs do not feel confident treating individuals without the support of a specialist. This can be frustrating for those seeking help, as they may not feel they are being supported, especially prior to offending. When able to obtain medication to manage their arousal, most participants felt this was beneficial. However ultimately, being able to reconcile their sexual thoughts, as simply thoughts, enabled to participants to take back control and lead a meaningful life.

6 Study Three – Prescribing MMPSA in primary care. A thematic analysis.

6.1 Introduction

It is estimated that 52% of males experience sexual problems (Chen et al., 2019). Erectile dysfunction is the most commonly reported sexual problem, with 3-76.5% of males experiencing the issue globally (Kessler et al., 2019). Most people consider their GP the most appropriate point of contact for sexual health issues (Hinchcliff et al., 2018). Despite this, many individuals experiencing problems with their sexual health are reluctant to seek help from their GPs (Alarcão et al., 2012). When seeking help, as discussing sexual problems is a sensitive topic, patients can be reluctant to articulate sexual problems in their appointments (Porst et al., 2007). To put patients at ease, GPs can routinely ask questions relating to sexual health indicating to the patient that it is appropriate to have discussions about sexual issues in primary care (Ramanathan & Redelman, 2020). The confidence of the GP in recognising the necessity of initiating conversations regarding sexual issues is, therefore, essential (Manninen et al., 2021).

There are many practical barriers faced by GPs in the management of sexual dysfunction in primary care. These include a lack of time in consultations and a lack of secondary care services to refer the patient to (Dyer & dasNair, 2012). A lack of training and knowledge of sexual dysfunction is common, hindering treatment opportunities (Manninen et al., 2021). Gott et al. (2004, p.432) use the term 'can of worms' to illustrate the difficulties faced by health workers in primary care due to time constraints and the complexity and sensitivity of sexual issues. GPs also experienced barriers when discussing sexual issues with people of different genders, non-heterosexual individuals, older individuals and individuals of black and ethnic minorities (Gessner et al., 2020; Gott et al., 2004). Language barriers also impact the discussion of sensitive topics with the patient leading to decreased patient satisfaction, however the use of translation services can assist with this (Al Shamsi et al., 2020).

The most frequent indications GPs encounter appear to be reduced sexual arousal, such as erectile dysfunction, premature ejaculation and vaginismus (Aschka et al., 2001; Heiden-Rootes et al., 2017). Consequently, GPs do not often encounter individuals seeking help with levels of sexual arousal that are out of control, which may create additional barriers for treating PSA in primary care. The use of MMPSA is intended for use with a specific group of individuals experiencing excessively high levels of sexual arousal. MMPSA has been used to treat PSA in custodial settings

since 2007 (Home Office, 2007). In the community however, GPs have limited experience of prescribing MMPSA to patients, and may lack confidence (Grubin, 2018). The level of experience may vary between areas due to the localisation of treatment governed by CCGs.

Individuals currently using MMPSA in custody have voiced concerns regarding obtaining the prescription following release (Lievesley et al., 2014). At present, in the UK prison system, prescribing of the medications is initiated by the prison psychiatrist. Whilst community-based GPs are permitted to prescribe SSRIs, should an individual require treatment with hormonal medications they will need to be assessed by a psychiatrist as suitable (Thibaut et al., 2020). In the community, for an individual to gain access to a psychiatrist in secondary care, often they will often need to be referred to a psychiatrist by their GP in primary care (NHS, 2022c). The practicalities of prescribing MMPSA in the community with individuals with PSA have not yet been explored. The current study aims to bridge this gap by gaining an understanding of the experiences of GPs prescribing MMPSA to individuals with PSA. As a result of the limited research undertaken with GPs regarding the use of MMPSA in the community, it was important to understand the challenges that GPs face in helping patients who suffer from problematic sexual arousal.

6.2 Method

6.2.1 Design and Analytical Process

The study uses qualitative methods to gain an in-depth understanding of the experiences of GPs who may be asked to prescribe MMPSA to individuals with problematic levels of sexual arousal in the community. Full details have been outlined in the methodology chapter, Chapter 3.

6.2.2 Ethics

The study received a favourable ethical opinion from Nottingham Trent University (Marshall 2020/202 - 2019/179).

6.2.3 Recruitment and sampling

Recruitment was via the social media site Twitter. Potential participants who contacted the author were provided with the Participant Information Sheet (see Appendix 3). An interview was arranged if participants expressed a willingness to participate in the study. A total of 14 GPs expressed an interest in participating in the research. Six GPs chose not to be interviewed after consideration. Reasons for not wishing to participate included not having time to attend for an interview and not wishing to discuss medications they felt were outside their area of prescribing.

6.2.4 Participants

A total sample of eight participants were recruited and interviewed. All participants (*n* = 8) were qualified GPs. Age ranged between 30-46 (*M* = 36.63, *Sd* = 5.60). Participants were *n* = 3 males (2 White British, 1 Pakistan), *n* = 5 females (4 White British, 1 African).

6.2.5 Data Collection

As a result of the Covid-19 pandemic, all interviews were conducted remotely. Semi-structured interviews were conducted over the Microsoft Teams video conferencing application and recorded using a password-protected dictaphone. Eight interviews were undertaken lasting 27-54 minutes (*M*= 39:07, *SD*=11:12). All interviews were undertaken with only the participant and author present.

The interview schedule (Appendix 4) was developed following consultation of the existing literature. Key points were identified, and questions were formed. The interview schedule was then discussed and revised with members of the supervisory team in order to include their knowledge of undertaking qualitative research. The interview covered four main topic areas: demographic information questions and their experiences as a GP in treating sexual issues; the treatment of sexual preoccupation and hypersexual behaviour and how this would be approached in general practice. The final section addressed the different types of medication currently used in the UK to treat PSA, Anti-androgens and Selective Serotonin Reuptake Inhibitors (SSRIs). The GPs' experiences of prescribing the medications was also discussed.

6.2.6 Data analysis

An inductive, data-driven, thematic analysis was conducted on the data in accordance with guidance provided by Braun and Clarke (2023). Full details of the steps taken to perform the analysis have been provided in Chapter 3 of this thesis.

6.3 Results

Two dominant themes were identified from the dataset, as outlined in Table 15 below.

Table 15. Table of superordinate and subordinate themes

Superordinate theme	Subordinate theme
The balancing act	Juggling conversations
	Juggling risk and the individual as a person

The problematic prescribing of MMPSA	It's a rare scenario and I would be outside my comfort zone
	The perils of 'off label' prescribing
	The oversight of secondary care is required
	The creation of a structured care pathway

6.3.1 Superordinate theme 1: A balancing act.

This theme reflected the balancing act that GPs needed to engage in when dealing with problematic sexual interests and behaviours in primary care. The GPs showed they were juggling several factors when managing conversations relating to sensitive issues. The GPs wished to support the patient and create an environment in which the patient felt comfortable in opening up and discussing sensitive information. At the same time, the GPs were conscious that they had to balance the patient's needs and confidentiality with the potential risk of harm. Participants were also aware of the potential of personal bias and the need to balance this professionally by not letting bias influence their risk assessments.

6.3.1.1 Subordinate theme 1.1: Juggling conversations

This subordinate theme highlights the difficulties the GPs perceived in relation to consultations regarding PSA for both themselves and patients. The GPs engaged in a juggling act between encouraging the patients to discuss sensitive issues and managing their workload and time allocated to each patient. When dealing with this kind of consultation, GPs also have to juggle any personal bias they may experience in having sometimes difficult conversations with individuals with PSA.

Extract 1

> So, a lot of the time, I'm a sort of firm believer in the doctor has to be part of the medication, the doctor is the drug. Actually seeing, and talking through, and having the opportunity to listen to their experiences is really important for patients and they feel obviously meeting a professional and talking about that is really important.
>
> (P7; lines 64-68).

The participants highlighted the importance of communication. This extract illustrates the significance Participant 7 places on effective communication between the GP and patient. Participant 7 explains how giving the patients a voice to discuss their experiences can be therapeutic for the patient. Simply having someone to hear them can be healing in itself. Whilst the participants wished to give the patients a place to discuss their problematic sexual interests and behaviours, the GP also needs to be aware of the risk the patient may pose to the public and themselves. This causes a balancing act for the GP in that they need to consider the risk assessment whilst balancing their care for the patient and encouraging them to discuss their difficulties.

Participant 7 also highlights how important the role of the GP is in the treatment process as the 'doctor is the drug'. Here, Participant 7 suggests that treatment begins with talking to one's GP. The role of the doctor as the treatment could mean that the treatment will only be as effective as the individual skills of the GP in opening up the conversation. Research suggests that GPs are unlikely to initiate conversations about sexual health (Schaller et al., 2020). Patients may be reluctant to have these conversations, so a more proactive approach by the GP in initiating conversations would assist (Gott & Hinchcliff, 2003). Being listened to and having a GP who is willing to spend time with them is particularly appreciated by marginalised groups, such as those with convictions (Quinn et al., 2018). However, for a doctor that is unaware of how to deal with problems such as problematic sexual arousal or unhealthy sexual thoughts, this could cause difficulties in treating the patient efficiently.

Extract 2

> I can't say I have, erm, I have had, like we said earlier, I've had the complete opposite where people have not had any interest in sex, or they have a lack of libido but I've not had anybody coming to me saying that they think about it too much, or are preoccupied with it. But I guess it's possibly never a thing that I would usually ask patients, because I wouldn't really know what to do with the answers. So, it might be me, maybe not having those conversations with them, or not making them feel comfortable.
>
> (P3; lines 45-50).

This notion was typical of all participants when discussing whether or not anyone had approached them for help with problematic sexual arousal. All GPs had experience of individuals asking for help with low or reduced libido but not with excessive arousal. Evidence from Schloegl et al. (2017)

suggests that GPs are much more confident in treating sexual dysfunctions such as low levels of arousal compared to paraphilias due to the medical training they receive. As a result, the GPs needed to balance their limited experience of the subject with encouraging the patient to disclose their difficulties. This extract illustrates how the subject may be avoided out of fear of opening up difficult conversations. This is particularly difficult when considering discussion regarding problematic sexual interest and behaviours. The GP needs to gain information from the patient to help but may find aspects of the topic difficult to hear. Gott and Hinchcliff (2003) suggest that GPs should take a proactive approach to encourage conversations. However, should the GPs start asking questions about sexual arousal that they do not feel confident to treat, this could lead to them being out of depth in the consultation.

Extract 3

> It's quite difficult because they don't often come in with it, it's usually something that we talk about as a side and I've got 10 minutes and not a lot of time to cover, a lot of things, so sometimes it's something that you erm, you broach once and then you kind of sow the seed and you might write some notes on it on the computer so then the next time they pop in it sort of jogs your memory and you sort of think, I might just mention that again, so.
>
> (P2; lines 248-253).

Disclosing sensitive topics may not always be easy for the patient, as Participant 2 describes above. Patients may be reluctant to discuss their sexual health with their practitioners (Malta et al., 2020). Sensitive topics are often mentioned as a symptom or inconvenience rather than being bought up as the main reason for the appointment (Manninen et al., 2021).

The GPs indicate the difficulties of delving into the issue in depth with the time available and are often only able to scratch the surface. The process often occurs over a series of consultations by the GP initially planting the seed in the patient's mind. By mentioning the subject, this leaves the patient with something to think about, potentially making it easier to discuss on the next visit. This ongoing series of appointments also assists with the time limitations of consultations. By recording the issue, the GP is also in a position to remember to open up the discussion again. The use of the word 'might', however, indicates that this is not always the case. Should the next consultation be equally as short on time, the GP may not have a chance to open up the lines of discussion again. Instead, they may need to simply focus on the issue the patient is presenting with, rather than the

peripheral issues. This illustrates the juggling act of time management the GPs need to engage in. GPs are required to balance the time required to discuss sensitive topics such as sexual interests with the patient whilst also balancing the time frame they are allocated for each consultation.

Extract 4

> We've certainly got plenty of experience of children, you know, having been sexually abused. But, for the most part, the people that have been accused, I'm just thinking of a recent example going through the courts, that come and speak to us, come from like 'I can't believe this is happening to me, I'm completely innocent, I'm really depressed, erm you know, I've become suicidal because of the accusations'. While it's going through court and sometimes further down the line, a lot of, it can take a while before people will willingly admit to you that they have been accused or even convicted of those charges. Erm, there will be a lot of hesitancy and it will sometimes take a few consultations before that will come out so, yeah. I can't think of any examples of when someone openly admitted to it and said can you help me. It's been much more along the lines of it's not true, I'm really depressed, what can you offer me?
>
> (P8; lines 150-158).

The above extract further illustrates the pitfalls encountered with the disclosure of problematic sexual arousal. The participant recalls occasions when individuals accused of committing sexual offences are reluctant to seek help for the possible illegal sexual interests and excessive sexual arousal. The extract illustrates how often individuals are unwilling to admit to wrongdoing. This can create tension where the individual could be seeking help prior to committing offences. Clearly, there are occasions where individuals are wrongfully accused, and the author does not wish to suggest that all individuals who are accused are guilty. However, as with many people who know they have done something wrong, denial and minimisation are common in those who have committed sexual offences at all stages of the criminal justice process (Dietz, 2020). The aspect of denial means that patients will struggle to seek help but may seek help for the associated issues, such as depression, which may only be one symptom of a more complex problem. The GPs felt that patients may find it difficult to disclose such sensitive issues, and, as with extract 3 above, this often takes a number of consultations before the patient is willing to speak to them about the issue.

Extract 5

> I think, initially I'd be wanting to really kind of understand, try and sort of develop a rapport with somebody so that they would then trust me and then remind them about confidentiality, unless I thought someone was going to be a serious risk. Try and sort of just get them to open up as much as possible about erm, you know, when it all started, how it's all kind of come about, what sort of effect it's having on them. I think I would, you know, my main thing would be to get as much information from the patient as possible.
>
> (P5; lines 63-68)

Once the patient has arrived at the point where they are willing to seek help, there may still be difficulties in encouraging them to open up. Statements showed the GPs had an understanding that, creating an environment where the patient felt comfortable enough to discuss the sensitive problems they were facing, was important in order to get the patient talking. As can be seen in this extract, the GPs need to establish communication in order to get to the root of the problems the patient is facing. In order to gain an understanding of the patient's experiences, creating an element of trust is important to achieve this. Patient centred communication, showing empathy, reassurance and a genuine interest in the patients' concerns, has been shown to increase patient satisfaction (Little et al., 2001; Venetis et al., 2009). However, there is some ambivalence in relation to opening up the lines of communication. As illustrated in this extract, Participant 5 is clear that she will remind the patient about the confidential nature of the appointment, which is only superseded by the risk of harm (Slowther, 2010). She indicates she would remind the patient about the confidential nature of the consultation, but only if she did not feel they were a risk. The extract shows the conflict in balancing encouraging the patient to open, but at the same time, being conscious that the patient may disclose something of concern, which could lead to safeguarding obligations being triggered.

Developing a rapport and generating trust is important as this can create an environment where the patient feels more relaxed and able to disclose sensitive information to their GP. Should the individual not feel comfortable opening up, it is unlikely that they will be willing to disclose quite sensitive information in the 10-minute appointment available to the GP and patient. In relation to individuals with a sexual conviction, the World Federation of Societies of Biological Psychiatry (WFSBP) highlights that a trusting relationship between the patient and healthcare practitioner is vital in order to decrease the likelihood of offending and provide treatment for the individual (Thibaut et al., 2020).

Extract 6

> and erm, if somebody tells you that they're having, erm, sexual preoccupation, you know there may be an element of judgement that comes with that but I think I would be really mindful not to let that show and to really kind of encourage that person to open up to me and be mindful that the reason they feel like that is very kind of complex and they don't want to be feeling like that. It's a problem to them and that, you know, they're quite a vulnerable person because of it, erm, and that they really need help, and just to try and kind of erm come to some kind of management plan with them really. Treat them with empathy and erm, yeah.
>
> (P5; lines 114-121).

The GPs indicated that they would be aware of possible personal bias that could be associated with hearing someone disclose something as sensitive as experiencing PSA. The extract illustrates that although the GPs were conscious that this is something they may feel, they would use their professional role to ensure the patient did not feel any judgement. This involves the GP juggling their personal and professional roles. The GPs wished to encourage help-seeking behaviour by enabling the patient to disclose their experiences. Participant 5 recognises that the unwanted feelings are causing the patient discomfort, and this is why they have reached out to her for help. She will be sensitive in how she treats the patient and will involve them in coming to a decision as to the best way to assist in treating them. This was encouraging as previous research has shown an unwillingness of some organisations to work with individuals who may have sexual convictions (Jahnke, 2018; Lasher & Stinson, 2017). This also highlights the importance of not showing any personal judgement as without this, the likelihood of help-seeking would be reduced. Evidence suggests that when patients feel judged, this reduces the likelihood of further help-seeking (Levenson & Grady, 2019).

Extract 7

> I've dealt with people who have been rapists, who've physically abused children, who have murdered people, erm, you know so the whole, the kind of, the psychological impact on me is kind of secondary really. I hope I'm aware of, you know, the impact of it, am I aware of some of the biases I probably have? Have I, given that I'm now a Dad to an eight-year-old if someone was talking about committing offences against children, or physical violence

against children, I would find that difficult, but I would deal with that in my professional job.

(P1; lines 55-61).

Participant 1 discusses his experiences of working with patients who have committed various offences, although not treating them for anything specific to offending. He initially indicates that the impact of the uncomfortable disclosures on himself is not his primary concern. He goes on to question whether he is aware of his own personal bias and discusses how this impacts him as a father. For him, being a father and hearing disclosures of harm caused to children would be hard, and he may feel personally affected by listening to difficult conversations and again shows how the GPs need to juggle their professional and personal roles. Pre-judgement of patients has been shown to impact on the effectiveness of patient care (Monks et al., 2012). However, although he questions his personal bias, he uses his professional role as a protective barrier. He separates his role as a father and a GP. His role as a GP would be able to handle the sensitive topic. The consideration of personal bias is also outlined in subordinate the theme below.

6.3.1.2 Subordinate theme 1.2: Juggling risk and the individual as a person

This subordinate theme outlines the juggling acts the GPs need to undertake when assessing individuals with PSA. The data showed that juggling the needs of the individual with safeguarding obligations was something all GPs were conscious of. The GPs discussed the internal battle they would experience when weighing up the needs of the individual patient and safeguarding obligations.

It became apparent throughout the interviews that whether a GP would have an awareness of whether or not an individual had been convicted of sexual offences was unclear. Some indicated that this information would be readily available to them on computer systems but when questioned further, it was understood that this is only if the patient disclosed their offending. Others stated that they would be aware if a patient had been in custody but would not be aware of the offence unless the patient disclosed it, or they had been contacted by the police. Whilst those in specialist services may have an awareness of an individual's offending history, GPs are not always provided with this information (Quinn et al., 2018). This unawareness of convictions is not restricted to those with sexual convictions but occurs with all kinds of offending. In cases of domestic violence, for example, the knowledge of offending could be particularly useful to a GP, as they are in a prime

position to deal with the wealth of mental and physical health problems associated with it. However, if the police do not inform the surgery, the GPs are often unaware that their patients have experienced it. As patients are often reluctant to discuss aspects of domestic violence, this leaves the GP unable to assist (Pitt et al., 2020).

The possible awareness of a conviction and the management of risk was something that represented an internal battle in the GPs' assessment of the individual.

Extract 8

> Erm, this comes up a lot as an ethical discussion in General Practice, erm, in reality it doesn't come up very often. Erm, I suppose in the same way that we deal with, with anyone. You deal with the person in front of you, you are mindful of the legality of it. Erm, and, you know your care for the person in front of you is paramount really, unless it is superseded by any professional or legal obligations that you've got.
>
> (P1; lines 51-55).

This extract represents the internal battle which was common with all participants. The GP states that the assessment of the individual, regardless of the knowledge of convictions, would be the same. As he outlines, the care of the patient in front of you is the most important aspect. However, he goes on to say that this is only unless something else becomes more important. For example, GPs are obligated to disclose information if required by law and in cases where failure to disclose could cause a risk of serious harm or death to others (General Medical Council, 2021). The extract shows the internal conflict as he is almost weighing up his thoughts with his statements. He would deal with the individual in front of him but at the same time is mindful of the legality. The care for the individual is the most important aspect, but only until safeguarding obligations become more important.

Extract 9

> I think so yes, I mean, um. I think, if they had a sexual conviction then I would obviously, that would be in my mind and I would be more alert to the fact that this could spill over into, erm, you know, criminal convictions, so, the threshold for treating or referring.

(P2; lines 291-294)

The above extract shows how having an awareness of the patients' previous convictions could possibly heighten the concerns they may have about the individual. The knowledge of the conviction would increase vigilance when undertaking risk assessments, which may influence their decision making in terms of treating the individuals themselves or seeking specialist input.

The GPs' views differed in terms of how much the knowledge of a criminal conviction would influence their thinking on the possibility of the patient committing further offences.

Extract 10

> I think you would always think, I know it's probably biased and judgemental but anybody who has had a previous conviction I am always going to be thinking a bit more of safeguarding and are they potentially a risk to themselves and to other people. And I think if they've already been convicted of doing something in the past, erm, then you think that it is more likely that they might offend again.
>
> (P3; lines 123-127).

This extract shows that the knowledge of a sexual conviction may result in personal bias and judgements. Participant 3 indicates that although it may be considered judgemental, safeguarding concerns would be high when undertaking a risk assessment. For her, the idea that past behaviour predicts future behaviour would be a concern and the priority would be for the safety of the individual and the public.

Extract 11

> Yeah, it's obviously important to know if they've had erm convictions, erm but just because somebody has had convictions in the past doesn't mean that they, they're more necessarily like to, in the, now. Erm, and just because someone hasn't had any convictions doesn't mean that they're kind of like a lower risk necessarily. I think I would just try and assess the situation as it presents to me at that time. Obviously, it is important to know the previous history, but I would try not to let that affect my judgement at that time.

(P5; lines 166-172).

This extract, on the other hand, shows how the GP approaches the situation differently. She acknowledges that the fact that someone has previously offended does not necessarily make them any more of a risk of offending than someone without convictions. Although this participant deems the knowledge of previous behaviour to be important, she will try to assess the individual based on the current circumstances and not let the knowledge of the patient's past influence her decision making.

The possible risk of the patient causing harm or committing offences was obviously something that influenced the decision of whether or not to alert the police to the potential risk of the individual.

Extract 12

> Erm, if they were saying look, I think I'm going to commit a crime, then I think I'd probably have no choice but to do so but, I think it depends on the level doesn't it, the level of risk. Erm, yeah and I guess, erm, if they're saying, because a lot of people will have thoughts won't they but won't act on those thoughts, but like people having suicidal thoughts, or the signs but won't necessarily act on them. You know if someone, it looks like they may well act on those thoughts, and there seems to be some action, intent and plans there to do those actions then I think I would have no choice but to do so.

(P4; lines 176-182)

This extract illustrates the thought processes involved when considering whether or not the GP would need to alert the police. If someone disclosed that they were having sexual thoughts that were out of control, the GP discusses the internal risk assessment that would be taking place on whether or not alerting the police would be necessary. Whilst all GPs indicated that it was rare an individual would ask them for help with PSA, they were able to use transferrable skills they had developed when treating more general indications. Thus, Participant 4 compares this to risk assessments that would be undertaken when considering whether an individual would be likely to act on suicidal thoughts. As he outlines, there is a balance in assessing whether the thoughts are simply thoughts, or whether there is an action plan in place to enable the individual to act upon these thoughts. His states that he would have no choice, should the assessment led him to consider

that action may be taken, showing a possible reluctance to involve legal authorities such as the police but recognising the necessity should he feel that an offence is imminent, as obligated by the General Medical Council. The reluctance to involve police is also mentioned by Participant 6.

Extract 13

> The question now is, I would speak to the safeguarding lead in my GP surgery. Because this is, this is, the risk is high, and then get some advice about do I need to speak to adult and child safeguarding? Is there any need to speak to the police? But then I fear stigmatising the patient because they've come to me for help, and they are telling me they are, feeling, so, honesty from the patient to know, is any child at risk, have they gone after any child, because then we will be dealing with a case of rape or, what's going on here. So, it depends on the honesty and my ability to tease out that information, from the patient. Based on the information I get I will be speaking to either the safeguarding or the police. Yeah.
>
> (P6; lines 156-160).

Again, this extract illustrates the weighing-up thought processes the GPs undertake when considering breaching patient confidentiality and alerting the police. Participant 6 is conflicted between wanting to do what is best for the patient and also managing any potential risk that they may face to the public. She questions whether there is a need to inform the police but then iterates her fears in pushing the patient away as they have come to her for help with their problematic sexual thoughts. For her, the aspect of help-seeking behaviour from the patient shows a desire to not act on these thoughts but to gain assistance in managing these. The GP also shows that it is her skills in communication which are important to gain the relevant information in order to undertake her risk assessment effectively. Depending on the outcome of the risk assessment will determine which of the relevant authorities will be alerted to the potential risk of the individual.

The recognition of this desire to assist the individual rather than simply alert the police is important. As was raised by the GPs in the subtheme above, individuals may fear seeking assistance with problematic sexual arousal out of fear that they would be at risk of legal consequences (Levenson et al., 2017). Research suggests that those who seek help and are then reported, for reasons of caution, can be left feeling betrayed and less likely to seek help in future (Levenson & Grady, 2019). Despite the fears of help-seeking of those with problematic sexual arousal, there is a range of literature which shows reporting of safeguarding is lower than might previously have been thought.

Talsma et al., (2015) asserted in their study of Swedish GPs, the likelihood of reporting suspected child abuse cases was quite low, 50% of their sample had never reported cases of suspected child abuse to child protection services, and only 3 GPs of the 77 who completed the questionnaire had ever reported suspected cases to the police. The interviews showed that the GPs had a desire to assist the individual whilst using their professional judgement to alert the relevant authorities appropriately. This could encourage those with problematic sexual arousal to seek help rather than feel they will be judged and reported to the police for asking for help.

Should a patient disclose information to the GP that they felt needed to be passed on to the police or to Safeguarding, the way this was handled was highlighted by participants as being extremely important. Honesty with the patient was seen to be important in relation to the assessment of risk and the possibility of breaching confidentiality. Patient confidentiality is an important aspect of the doctor and patient relationship (Baird, 2008). However, there are occasions where the GP is obligated to breach patient confidentiality, when a person may be at significant risk of harm or when required to breach confidentiality by law (Slowther, 2010; General Medical Council, 2021).

The maintenance of honesty and handling of the breach in confidentiality is described as “dicey” by Participant 6. A GP/patient relationship is built on trust. By alerting the patient to the possibility that the GP may need to breach confidentiality, if they feel the patient is a risk to themselves or others, this could assist in avoiding problems later and prevent a breakdown in the GP/patient relationship. Informing the patient that their confidentiality may be breached is recommended by the General Medical Council (2021) unless it is unsafe, not practicable or appropriate. The importance of handling the breach of confidentiality well is described in detail by Participant 2.

Extract 14

> So, erm, you would tell the patient about that because, I always like to erm, you’d have to sort of tell them that if they were having thoughts about children or having thoughts about maybe assaulting somebody, then if you think a crime might be committed then you have to alert the safeguarding lead…It’s very difficult, because we had a really horrible case erm, where we had a suicide, because of erm, it’s, basically, the, there was a guy who was seeing another woman and he had step-children, in the relationship. He had hit them, erm, but you know, so they had gone to school the two children and they said about this, this had happened. The school had reported it and then Social Services got involved, and they told

him that they were investigating child abuse. But they weren't allowed, you're not allowed to tell somebody if you're investigating it, what type of child abuse it is.

E – Right ok,

P2 – So he assumed that they had said about sexual abuse, when they hadn't, they said about physical abuse, that they had alleged about sexual abuse when that hadn't happened, and he was so traumatised by it that he committed suicide.

(P2; lines 301-318).

Here, Participant 2 outlines what could happen with a miscommunication when referring cases to safeguarding. A referral was made in relation to one of her patients by the school of his stepchildren. As a result of the lack of knowledge of the reasons why the case had been referred to safeguarding, the man took his own life. This is illustrative of the minefield that GPs face when dealing with sensitive topics such as PSA and may explain the reluctance of some to open up such discussions as outlined in subordinate theme 1.1. Clearly, breaching confidentiality is a sensitive task that needs to be handled with care. Should the discussions involved in alerting the relevant authorities not be handled correctly, this could lead to further complications as outlined in the extract above. Informed consent procedures should be adhered to ensure transparency (Levenson et al., 2020).

6.3.2 Superordinate theme 2: The problematic prescribing of MMPSA

This theme highlights the lack of confidence that GPs have in treating PSA appropriately in primary care. The GPs indicated that whilst the treatment of problematic sexual arousal was possible in primary care, they would need input from a specialist in order to manage this confidently. Excessively high levels of sexual arousal are not the usual sexual issues that present at a GP surgery. The most common sexual issues encountered by GPs are associated with low levels of arousal such as erectile dysfunction and premature ejaculation (Moreira et al., 2008). As a result of this, GPs did not feel comfortable dealing with patients with excessive arousal and potentially deviant sexual interests, alone. The creation of a pathway for PSA and a Shared Care Agreement between the GP and psychiatrist in secondary care would increase the GP's confidence in being able to provide effective treatment in primary care.

6.3.2.1 Subordinate theme 2.1: It's a rare scenario and I would be outside my comfort zone.

All participant GPs highlighted that it was very rare for a patient to approach them for help with problematic sexual thoughts, and admitted they were neither experienced nor confident in treating such patients.

Extract 15

> Erm, well I've obviously treated things like erectile dysfunction, erm, but, erm, I think some of the issues, sort of, that you are getting at, the sort of hypersexual sort of problems about people having I guess, high sex drives, or paedophilia that kind of thing, very, very little, as a GP. Erm, it's not something I come across routinely.
>
> (P4; lines 11-14)

This extract was representative of all participants. The participant GPs explained that the most common sexual issue they encountered from men was erectile dysfunction. GPs were rarely approached by male patients because of an overly high sex drive or atypical sexual interests. While the participant GPs asserted they would use their skills to take a history from the patient and gain an understanding of the presenting problem, they were not confident they could do this effectively since they encountered the problem so infrequently.

Extract 16

> Err, well obviously, literally, err, what is the problem? Are they thinking about anything in particular, is it particular thoughts, is it, you know, is it with children? Is it adult type thoughts? Err is it something that's occupying them all the time? Is it interfering with their day to day life? Is it affecting their job? Their social life? Their sexual life? All those sorts of things, to try and work out is it a minor thing or is it a genuine problem that is affecting someone's day to day life. I think that would be the key thing to work out. It's a rare, it's a very rare scenario, I've been a GP 8 years and it's not common I get someone coming in telling me these sorts of problems so, err, I imagine it's much more common than I see. So, I can only assume that lots of people just don't seek help for these issues.
>
> (P4; Lines 41-49).

This extract illustrates the processes the GPs would use to take a history from the patient. Participant 4 tries to come up with the various questions he would ask the patient in order to establish the extent of the problem. He reiterates how infrequently this is encountered in general practice. This causes him to question why it is not something he has experience of. He recognises that there must be individuals in the community experiencing problematic sexual thoughts and excessive arousal and that possibly they are failing to seek help.

As a result of the rare nature of the consultation, the GPs indicated that they may feel less confident in treating the patient and would feel uncomfortable taking on sole responsibility of treatment.

Extract 17

> Er, I think I would feel fine in terms of, you know, having a chat with them and asking about them. I think I would feel a little bit out of my depths in terms of, I wouldn't really, apart from just guessing really, I wouldn't really know what specific questions I should be asking. And, erm, you know what is important when somebody is preoccupied erm, with sexual thoughts. I think I would be ok at making a risk assessment but, just because it's, it's not something we've ever been taught about, or ever had training on, I would find it quite difficult to erm, do it sort of confidently.
>
> (P3; lines 57-63).

Whilst the GPs have confidence in their ability to communicate with patients, they were less confident in their ability to thoroughly assess and diagnose PSA. Participant 3 recognises she will be using 'guess work' indicating a lack of knowledge in relation to PSA. This lack of knowledge means she would not be confident that she is asking the right questions in order to make a thorough assessment. In extract 13 above, Participant 4 queries whether individuals are failing to seek help for PSA. Participant 3 however, queries whether she would be asking the right questions in order to gain an understanding of the presenting issue. There is some uncertainty in terms of whether individuals are failing to seek help, or are questions not being raised to uncover the issue. As with the subtheme 1.1, the ability of the GP to encourage conversations is important to enable the patient to open up to sensitive topics. Should the GPs feel better equipped to engage in conversations in relation to PSA, this could lead to a greater increase in patient disclosure.

In order to increase confidence in assisting individuals with problematic sexual arousal, the GPs explained that they would require specialist involvement.

Extract 18

> This is not erm, this is certainly not generic and I, in GP land of course, as soon as they get into kind of super specialised areas, that's where we are generalists, by nature. We're not specialists by nature, and so I think almost certainly we'd need, we'd need erm, somebody with a bigger hat than us.
>
> (P7; lines 427-430).

As outlined by Participant 7, should an individual ask their GP for help, the GP may be unable to assist the patient, due to the niche nature of PSA, without help from outside services. As Participant 7 identifies, more complex issues require additional expertise or a 'bigger hat'. This illustrates the potential problems faced by patients seeking help for PSA. Research shows that many individuals with PSA are fearful of seeking help (Levenson et al., 2017). However, most individuals seeking help with sexual issues would contact their GP in the first instance (Hinchcliff, et al., 2020). For an individual who has summoned up the courage to make an appointment with their GP, to be told they are unable to assist them, may reduce the likelihood of help seeking continuing. How a GP manages the intervening period between the consultation and gaining specialist advice would therefore be important.

Extract 19

> I, I don't know the science behind medications being used to control erm, sexual erm, being preoccupied with sexual thoughts. I don't know. I would have thought to be more of like, erm cognitive behavioural therapy, as well as counselling, and psychotherapy. That's what I would have thought. I don't know of any medications and I am willing to learn, yes. So, I don't know.
>
> (P6; lines 194-198)

The extract was common for all GP participants when asked their thoughts on the use of MMPSA. As PSA was not something they encountered regularly, their knowledge was limited in terms of the types of medication that may be used to treat excessive arousal and sexual preoccupation and how this would assist in reducing problematic levels of sexual arousal. Throughout the interviews, a lack of understanding of how to treat PSA was apparent, again highlighting the need for specialist intervention. For all GP participants, their initial thoughts of a treatment methods were to favour non-medical interventions, such as CBT. They were however open to learning more about the medications which would enable them to prescribe for this indication.

6.3.2.2 Subordinate theme 2.2: The perils of 'off label' prescribing

GP participants were far more confident in prescribing SSRIs, than anti-androgen medications, due to their familiarity with the drug. There were concerns raised however in relation to prescribing the medication 'off label'. The NICE (2022) guidelines lists sexual dysfunction as a side effect of fluoxetine, however hypersexuality is not listed as an unlicensed use. The General Medical Council (2021) permits prescribing for unlicensed use, where it is necessary based on the needs of the patient. Provided they could justify their decision making to prescribe SSRIs, most GP participants were confident that they would be able to do so, however the views varied between GPs meaning the ability to access SSRIs in the community for PSA would be dependent on the GP.

Extract 20

> I mean we prescribe them all the time and I would have no problem prescribing them. It would just depend on whether there were different dosages or whether erm, sort of different monitoring for patients, obviously not using them for the antianxiety, antidepressant side of it. If we were using it just for sexual preoccupation, yeah, if there's different ways of monitoring it, then I would want to know about it, but otherwise I would feel confident because we use them all the time.
>
> (P3; lines 243-248)

All GP participants were familiar with prescribing SSRIs for mental health problems which increased their confidence in prescribing the medication. However, when prescribing for PSA the GPs indicated that they would require further information as this is not an indication that they are familiar with.

Extract 21

> Yeah, I think personally as a GP, I don't think all GPs would, because I think they would say, oh hang on a minute, this is not licenced, I've not been trained in how to do this, I'm not going to do it. But personally, I'd say well hang on a minute, if they're, if they're quite stable, it's a safe, cheap, effective medication, fine, I'll just continue the prescription with some monitoring. But clearly, if they weren't stable, I would need to ask for a referral, get some advice from someone else. I think I would personally, would do that.
>
> (P4; lines 288-293).

This extract from Participant 4 illustrates how if a patient presented to him and stated they had been previously prescribed SSRIs in custody, he would consider continuing the prescription. He is aware that different GPs may have different views, but he would assess the situation as it presents at the time. The GP has an awareness of the side effects and risks associated with the use if SSRIs. As a result of this, he would be happy to continue the prescription, providing the patient is stable. If on the other hand, he had concerns in relation to the risk the patient posed to himself and others, he would need to seek specialist involvement to get further advice on how to proceed.

Extract 22

> In medicine, whoever provides the prescription, has to satisfy themselves that they have covered all the risks and benefits otherwise you're kind of, you are legally responsible for every unintended consequence of that medication. So, you would have to be a specialist in order to prescribe it. Even if it's a drug that you're familiar with but you are using it for a different reason. Take an SSRI for example, we prescribe them all the time for people with mental health problems, we wouldn't prescribe it for sexual deviance because its off licence, it's an off licence use and therefore as a doctor you would take all of the inherent risks with that. And I, I wouldn't want to go to Court if something happened with medication that I'd prescribed because you're erased from like a register.
>
> (P1; lines 132-140).

In contrast to Participant 4 however, Participant 1 was very reluctant to prescribe an SSRI for PSA particularly as the medication is being used 'off label'. As outlined by the General Medical Council

(2021), all GPs are responsible for all prescriptions that they authorise. Participant 1 is fearful that should there be problems with the medication, this could open up legal consequences for himself that he does not want to become involved in. For him, the risk of losing his employment is too great to consider the use of a medication off label. The two very different viewpoints of Participant 1 and Participant 4 highlight the ambiguities that currently exist in relation to treating PSA. A patient may have a very different experience depending on the standpoint of the GP the individual seeks help from.

The prescribing of medications 'off-label' evoked different levels of concerns for the GP participants throughout the data. The GPs described the different processes they would use in order to justify the use of medication 'off label' with some noting that they would need to seek specialist input in order to increase their confidence that they were justified in such a use. The General Medical Council (2021) states that whilst medicines should be prescribed for the purpose of which they are licenced, prescribing off label is permitted when it is required to meet the patient's needs.

Extract 23

> So, prescribing off licence we do do, but it's, it has to be something that's done widespread. For, you know, like for example, amitriptyline is an old-fashioned antidepressant that we now use for neuropathic pain. So, like, we've been doing that for 10, 15, 20 years actually……But it's been done historically so it's not, you know, erm. So, I'm trying to think what else I use but the main ones are the sort of anti-epileptic. So, it depends on the history of it. So, if it's quite a new thing, then, then, I wouldn't feel comfortable doing it, no. So, I think it's, again, if it's somebody who's erm, you know having sexual sort of deviant thoughts then I would want to get the patient referred for that.
>
> (P2; lines 462-486)

This extract shows how the use of medication off label is quite common in general practice provided there is a history of the medication being used for a particular indication. If there is a precedent of the medication being used for different indications to that which they are licenced for, this increases the confidence of the GP in using the drug. The precedent acts like a security blanket to ensure the GP feels confident they are making the right decisions. The knowledge that GPs before them, have used the medication with positive results, assists them in prescribing confidently. In this extract however, as Participant 2 has no experience in prescribing SSRIs to manage PSA, she would

not feel comfortable in prescribing the medication without the oversight of a specialist. The extract shows the tensions within the data, that whilst prescribing off label is common, it would depend on the individual GP as to whether they would prescribe for PSA.

Extract 24

> We go by the BNF and a lot of, we GPs, we cannot, we have to be very careful about prescribing. All our prescriptions are scrutinised, everything is scrutinised. They have data about everything that we prescribe yeah. And if we do something random, off label, we've got to justify that in the notes, I've got to write a justification. I've read this research paper, I actually quote the whole research paper, in the medical records, say, this is what I've read, this is used for this purpose and I'm going to trial it and monitor this patient. So long as you've got a full plan and you've justified in properly yes. But obviously you can't make, you can't pluck it out of thin air. Today, I think SSRIs are good for you (laughing), let's give it a whirl, you can't do that.
>
> (P7; lines 638-646).

This extract again illustrates the differing views of the participants in how open they were to prescribing SSRIs off label to manage PSA. Participant 7 outlines the steps he would need to take to justify prescribing a medication off label. The importance of justifying decisions is outlined by the General Medical Council (2021). For Participant 7, by ensuring his decision is defensible with the use of research papers justifies the use of the medication off label. So long as he could evidence his decision making to justify the prescription, he would be happy to prescribe the medication. Should more evidence become available so that PSA is included in the British National Formulary (BNF) as an unlicensed use, this would increase the confidence of the GP in prescribing SSRIs to manage excessive sexual arousal. The inclusion of SSRIs in the BNF would reduce the complications of prescribing SSRIs 'off label'.

6.3.2.3 Subordinate theme 2.3: The oversight of secondary care is required.

In relation to hormonal therapy medications such as gonadotropin-releasing hormone (GnRH) agonists, GPs are restricted in how these are prescribed. Participants highlighted that they need a shared care agreement with a specialist in secondary care in order to be authorised to prescribe the medication. The shared care agreement provides GPs with a step by step process that they can

follow methodically and confidently. The oversight of the specialist increases confidence, making the GP more comfortable in dealing with issues that are not frequently encountered.

Hormonal therapy medications come under two main types; GnRH agonists and anti-androgens, such as Cyproterone Acetate (CPA). Whilst both medications are currently recognised as a pharmacological treatment method for PSA in the NICE Guidelines (NICE, 2015) the GPs would require the oversight of a specialist to prescribe them.

Extract 25

> Not confident, no, because I would need that diagnosis to be made that this is, obsession, and that would have to be made by a psychiatrist, because we are so, erm, we are so, governed or policed in general practice, you need to stick to what you are permitted to do. So, until I had that letter from a consultant psychiatrist saying, we have made this diagnosis, and yes we agree that the patient should be started on this, then I can say fine, we are happy to go ahead with that.
>
> (P6; 279-284)

Perhaps due to infrequency of which the GPs encountered individuals with PSA, the GPs were not confident in making the diagnosis of PSA themselves. Instead, they would require oversight of a psychiatrist. Unlike SSRIs, when considering the use of hormonal therapy medications, all GPs indicated that they would first need the patient to be referred to secondary care. The GPs are restricted in terms of the types of drugs they are permitted to prescribe. GnRH agonists for example, fall into red light medication, as outlined by Nottinghamshire Area Prescribing Committee (NHS, 2021). However, should a specialist instigate the prescribing, this would mean the GP would be able to work alongside them. This would then enable the prescription to be managed in primary care.

Extract 26

> Yeah, potentially, but the problem you've got is that when they come out of custody, they're not going to go, hopefully, to those psychiatrists again so there's no comeback. So, if there was a problem, who would I go to, to get help? So shared care means that if there is a problem you would then go back to the initiating clinician. I would imagine that SSRIs,

absolutely fine, we could carry on prescribing those, but androgen blockers, that's probably going to have to go back to the community mental health team. So, I would imagine that, what would tend to happen if somebody had a, if somebody in custody had a specialist problem and they were being discharged and they were moving from area so they were in prison somewhere up north and they were coming down south, the consultant would then refer them to the local team and they would take over their care.

(P2; lines 419-428)

Many individuals with PSA may have been prescribed hormonal-therapy medications whilst serving a custodial sentence. These individuals may then approach their GP on release asking for the prescription to be continued. The extract illustrates how the GPs would have difficulties prescribing medications, such as anti-androgens, that have been initiated by a psychiatrist in custody. The GPs would require the medication to be transferred to a community psychiatrist in order for them to be in a position to continue the medication. Unfortunately, continuity of health care is often poor during the transition between custody and the community (Vail et al., 2017). There is often an inconsistent approach and individuals may be released into hostels, in areas they have not resided in previously. This creates difficulties in obtaining access to healthcare with many individuals who have recently been released into the community experiencing problems accessing medication and community health services (Binswanger et al., 2011). The extract highlights the difficulties encountered by those who have had prescriptions initiated in custody. Participant 2, as with Participant 4 above, suggests that it would be more straightforward to continue the prescription for those who have been prescribed SSRIs.

Extract 27

So, I mean a lot of these anti-androgens, I mean some of them are injections. Erm, so the one for prostate cancer is an injection, which we would do every few, every 12 weeks. Erm, and so that is a separate funded service for General Practice, so we get additional payment for doing that. Erm, because obviously we have to administer the injection, we've got to monitor them for the side effects and things, so that's not core General Practice work so there's a separate sort of funding for that. And I think that, you know, if we were doing something similar, for sort of this situation there would need to be some additional funding and also guidance and training to do that. Erm, so, I think to just do it with no funding and zero training would be very difficult.

(P4; lines 234-242)

Here Participant 4 is describing the process for providing anti-androgen injections for individuals with prostate cancer. The extract highlights the difficulties in managing more specialist treatments in Primary Care. Prescribing anti-androgens can be managed in Primary Care however the GPs receive a separate funding for the providing the treatment. As a result of already limited time available to GPs, additional funding would be necessary to enable them to provide the service.

When considering the cost of medication types currently used to manage PSA a twelve-month supply of SSRIs would cost £289. A twelve-month supply of anti-androgens is estimate at £376, with GnRH agonists costing £992 (NICE, 2015). Hormonal therapy medications are also associated with more serious side effects such as weight gain, shortness of breath, headaches and gynaecomastia (Czerny & Briken, 2002; Grubin 2008). As a result of the more serious side effects and monitoring requirements involved managing a prescription of hormonal therapy medications would be much more involved than a prescription of SSRIs meaning that a separate service would need be created.

Extract 28

> So… I would only be confident in prescribing it probably if we had like a, sometimes we get a shared care protocol. So often between us as doctors and maybe the mental health team, particularly in children we get it a lot. Where we'll do a shared protocol where we'll continue the prescribing, we'll do the checks but because it's not something we personally started, that you know, they kind of take ownership and they're the people that review the medications and whether or not they want to make changes to it, but we're the ones who prescribe it, but without something like that, definitely at the moment I wouldn't feel confident at all.

(P3; lines 206-213)

This extract was common for GPs when considering the use of hormonal therapy medications to manage PSA. GPs are not able to initiate prescriptions for anti-androgen medication. Whilst they would be confident to manage the prescription in the form of shared care, they would need to

oversight of a specialist from secondary care to assist individuals with this type of medication. The creation of a shared care pathway would assist with this.

6.3.2.4 Superordinate theme 2.4: The creation of a structured care pathway

In order to ensure the shared care agreement could be obtained easily, the GPs outlined that a pathway would need to be created. The creation of this pathway could increase the possibility of PSA being managed effectively in Primary Care.

Extract 29

> Yeah, if nothing else, that's going to be a useful thing, yeah, it's going to need to have a bit more structure to it rather than just turning up at your GP practice, I don't think many GPs would be willing to just take that on without any extra guidance.
>
> (P5; lines 330-332)

Most GPs felt that the use of MMPSA could be a useful treatment option for individuals with PSA. However, there is some reluctance to become involved. The GPs would need more information and guidance provided for them to be able to do so in primary care. The creation of a pathway and oversight of a specialist would help to diminish this reluctance.

Extract 30

> And so pathways have been developed for lots of major medical problems and now for even super specialised problems and so that helps us as GPs because you are able to do it in the ten minutes. You can send them to the right place, by email, in the ten minutes. It helps us.
>
> (P7; lines 516-519).

The creation of a pathway would assist the GPs when dealing with the specialist nature of PSA. In addition to increasing confidence, the pathway would help to streamline the process meaning it would be simpler to assist the patient in the limited time available in a GP consultation.

Extract 31

> Yeah, yeah there would need to be a pathway, so a lot of these specialised medications have some kind of pathway. So, there will be like a protocol about how to prescribe them, how to monitor them and all those kinds of things. So, if there's a clear pathway involved, I think it would become much easier for a GP to do.
>
> (P4; lines 257-260).

Should there be a pathway for prescribing MMPSA, the GPs would have clear guidance available to them. This would make treating PSA in primary care easier and could lead to more GPs being willing to offer MMPSA as a treatment method for individuals with PSA.

Extract 32

> Gender dysphoria is a very good example of this. So, gender dysphoria, twenty years ago, it just wasn't dealt with very well at all. It was, you know, they come in and you'd be theoretically thinking about whether you needed to refer them to the gender dysphoria clinic. Which at that time there were only four in the whole country, and now there's a huge number, a huge number, more than twenty, yeah, centres in the country where you'd refer these patients for maybe gender reassignment, and this kind of therapy. And there's a pathway for it now, so there's a single, one referral form that you fill in, that can be done in that ten minutes (laughing), you can do it in the ten minutes, and then you refer the patient to that pathway yeah. And if we had a similar kind of thing for this kind of area, psychosexual counselling and psychosexual problems, then at least, the erm, the person at the end would then have the ability to a head up about what's happening but he would then be able to navigate that patient to the right kind of therapy that they need, either CBT, or seeing a psychiatrist, or seeing a counsellor, you know, it could be anything. But that's a, what you call a senior point of access to that service.
>
> (P7; line 489-502).

The extract illustrates precedents in creating pathways and treatment avenues. Using gender dysphoria as an example, Participant 7 highlights how this kind of pathway has been created before. As he explains, in the beginning, the treatment of gender dysphoria was an unknown entity. However, through developments in research, the process for treating is now more streamlined. GPs now have the knowledge of specialists available to assist the patient and where to find them. This assists the GPs in dealing with the consultation in the limited time available to them. Should a

similar process be undertaken for individuals requiring MMPSA to manage PSA, this would increase the confidence of GPs in treating PSA in primary care.

6.4 Discussion

The chapter aimed to gain an understanding of the views and experiences of eight GPs on the use of MMPSA as a treatment method when treating individuals with PSA. Semi-structured interviews with the participants, allowed for an in depth exploration of the views and experiences of the GPs on the use of MMPSA to treat PSA. Following thematic analysis, two main superordinate themes were unpicked from the data. The first superordinate theme illustrates the 'balancing act' that is experienced by GPs when treating sensitive issues such as patients with PSA. The second superordinate theme, 'the problematic prescribing of MMPSA' outlines the barriers faced by GPs and potential solutions to enable the GPs to treat PSA in primary care confidently. The first superordinate theme, the juggling endeavour, contains two subordinate themes, 'encouraging conversations' and 'juggling risk and the needs of the individual'. The first subordinate theme 'encouraging conversations' illustrates the difficulties GPs encounter when encouraging patients to open up about sensitive issues with the restrictions placed on GPs in primary care.

The GPs in the current study expressed the difficulties encountered on encouraging conversations on sexual issues due to the ten minutes allocated for GP appointments. The short amount of time available in a GP appointment means that the complex nature of sexual issues is often difficult to deal with in the limited time frame (Schlogle et al., 2016). Patients may be reluctant to initiate conversations regarding their sexual issues, (Malta et al., 2020) they may feel embarrassed to discuss the issue (Vik & Brekke, 2017) and many patients prefer their GP to take a proactive approach in broaching the subject (Gott & Hinchcliff, 2003). In the present study, the GPs indicated that they may not feel confident initiating conversations about sexual issues and may experience feelings of discomfort when the patient raised the issue in the consultation. Aa a result of the infrequency a consultation involving PSA occurred, the lack of knowledge of how to approach the consultation led the GPs to feel out of their depth. Previous research suggests that GPs may be reluctant to raise subjects such as sexual issues with patients (Schaller et al., 2020). This can be for a variety of reasons, such as feeling embarrassed, a lack of knowledge and a fear of being unable to treat the issue (Hinchcliff et al., 2005), and a lack of services to refer the patient to (Dyer & DasNair, 2012).

PSA may include both excessive levels of sexual arousal and problematic sexual interests, some of which may be paraphilic. Encouraging conversations around such subject matters, has the risk of the patient disclosing aspects of their PSA that may be quite shocking and distressing, to both the patient and the GP. For an individual to have reached the stage where they are able to reach out and ask for help, for what is often an embarrassing personal problem, the way this is handled by the GPs is very important. The GP participants in the present study, recognised however, the importance of encouraging GP and patient communication. Through developing a rapport and building a relationship with the patient, this can encourage the patient to open up, even though it is sometimes necessary to build this rapport over a number of consultations. The GPs had an awareness that they may feel judgement depending on the nature of the sexual interest being disclosed. They were however confident that their professional role would not be affected by any personal bias and that they would ensure the patient would not feel judgement. This is encouraging as the importance of a trusting relationship between the patient and healthcare practitioner is recognised as being a protective factor in reducing the likelihood of reoffending and engagement with treatment (Thibaut et al., 2020).

Juggling conversations also links with the difficulties highlighted in the second subordinate theme 'juggling risk and the needs of the individual'. Whilst the GPs would like to use their skills to encourage the patient to open up, this bought about further problems in the actions that would need to take place should the patient disclose behaviours that put the patient themselves, or other individuals at risk. Juggling risk and the individual as a person was something all GPs recognised as important. Views differed in terms of whether the knowledge of a patient's sexual conviction would impact on the way they undertake their risk assessment of the individual. Whilst some GPs felt that they would assess the individual in the same way as anyone else and did not feel it would impact on their assessment (P1 and P5), others felt that the awareness of previous offending would cause them to be more vigilant when carrying out an assessment as they may be fearful of further offences being committed (P2 and P3).

The second superordinate theme illustrates the lack of confidence GPs currently have in treating PSA in primary care. The theme also highlights the processes that would need to be put in place in order to increase confidence in treating PSA. Subtheme 2.1 'It's a rare scenario and I would be outside of my comfort zone', illustrates how as a result of the infrequent nature of which the GPs encountered patients with PSA, they would be out of their comfort zone in treating the issue. As with subtheme 1.1 'encouraging conversations', the GPs were confident that they would be able to

obtain a sexual history from the patient, using transferrable skills. However, when treating PSA all GPs felt that they would benefit from specialist oversight in order to treat the indication confidently.

Subthemes 2.2, 'the perils of off label prescribing' and subtheme 2.3 'the oversight or secondary care is required' illustrate the restrictions placed on GPs when prescribing medications. GPs are often restricted from prescribing medications such as GnRH agonists in primary care. The Nottinghamshire Area Prescribing Committee categorises these medications as red light, meaning the prescription would need to be initiated in secondary care (NHS, 2021). Should an individual present to a GP with PSA that could not be managed with SSRIs, the GPs would need to refer the patient to a psychiatrist. However, the GPs were confident that should the prescription be instigated by a psychiatrist, they would be able to manage the prescription with a shared care agreement. Shared care agreements can be put in place when the specialist involved in initiating the prescription deems the patient to be stable, this then allows the GP to share the care of the patient, with advice from the specialist in terms on monitoring and reviewing the prescription (NHS, 2018).

In relation to SSRIs, as stated previously, treating PSA is not a licensed use of the medication. The GPs explained how the prescribing of medications 'off-label' is not a factor which concerns them, provided there is a precedent of prescribing the medication for the indication. However, all precedents must begin somewhere. The GPs explained how when individuals had been prescribed SSRIs for the recommended indications, such as anxiety and depression, it was common for patients to then seek help for a lack of libido. Sexual dysfunction is a side effect of the medication recognised by the BNF (NICE, 2022), which all GPs are aware of. Despite this, most would be reluctant to prescribe the medication, without the patient also exhibiting symptoms of anxiety and/or depression. Should the BNF list PSA as an unlicensed use for SSRIs the GPs would be more confident in prescribing the medication for that indication.

The subordinate theme 2.4 'the creation of a structured care pathway' highlights the need for a streamlined process to be put in place in the form of a pathway. By having a clear pathway and process for GPs to follow, this would enable GPs to feel confident in their decision making. The oversight of secondary care and the use of shared care agreements would again increase confidence of the GPs in treating PSA. As the indication is not something with which they are familiar, having the oversight of a specialist, from whom to seek advice when unsure, enables the GP to be secure in their decision making. The oversight of a specialist also removes the barriers

outlined in the subordinate theme 'juggling conversations'. Should the GP have a specialist from who to seek advice, this would also increase their confidence in initiating the difficult conversations. The creation of pathways is a common occurrence in health care and assists both the GP and the patient. When implemented properly, a care pathway can provide a blending of the cares of management and professionals (Whittle & Hewison, 2007). A pathway is a tool used in clinical practice to enable GPs to keep up to date with the most recent medical evidence (Toy et al., 2018). The imposition of such a pathway would also remove the barriers associated with prescribing restricted medication such as hormonal therapy medications, and prescribing SSRIs off label.

6.4.1 Strengths and Limitations

To the author's knowledge, the study is the first of its kind to undertake qualitative research into the views and experiences of GPs in treating individuals with PSA. As a result of this, the research brings a unique contribution to knowledge. It is hoped that the research will increase awareness of the problems faced by individuals when seeking help for PSA and increase the knowledge of GPs who may be approached by such individuals for help. The themes have informed recommendations that if implemented in primary care, could have important implications for the treatment of individuals with PSA in the community, regardless of whether they have committed sexual offences. The prevention of sexual abuse is a globally important issue which assists in reducing the number of victims and the financial costs of offences (Knack et al., 2019). Quaternary prevention assists with desistance and aims to achieve long-term avoidance of harm and successful community reintegration (McCarten & Kemshall, 2023). Currently, MMPSA is predominantly used in custodial settings, with individuals who have been convicted of sexual offences. By increasing the availability of MMPSA in the community, this could enable individuals to seek help from their GP, prior to committing offences and therefore reducing the number of sexual offences.

There are a number of strengths of the study resulting from the trustworthiness criteria employed throughout the research. The findings are grounded in examples to ensure transparency of the data and enable the reader to understand how the interpretation was derived (Yardley, 2017). The sample is clearly situated throughout the research to ensure the reader is aware of the population of which the results are applicable to (Elliott et al., 1999). The research also has practical implications which could impact on the future of treatment availability in primary care, meeting the impact criteria of Yardley (2000).

The study used qualitative methods in the form of semi-structured interviews to collect data. The use of semi-structured interviews allowed a rich and detailed data set to be obtained. Whilst the length of the interviews was under 60 minutes, all questions were answered at length by participants. However, the study is not without limitations. As a result of the voluntary nature of the recruitment of participants, only participants who had a genuine interest in the study were recruited. A number of potential participants were approached, however, many turned down the opportunity to take part in the study as they felt that using MMPSA to treat individuals with PSA was not something that they would become involved in. Due to this, the participants who were recruited were all open minded in relation to the potential use of MMPSA and had an interest in research in general. This means that the results are not generalisable to the wider population, as a result of the skewed sample size. Furthermore, of the eight participants recruited, none had experienced a consultation where an individual had requested medication for PSA in the form of excessive sexual arousal. The participants in the study therefore were not reflecting on direct experiences but were instead using their experiences as a GP to ascertain how they would approach such a consultation. In addition to this, although the sample was small, the sample was predominantly female, whilst the research focused on the treatment of male patients. This may also have skewed attitudes in treating males with PSA. Future qualitative research could be done to include those GPs who do not feel that it is their role to treat individuals with PSA to gain a wider understanding of the differing views. Additionally, a future qualitative research study will be undertaken with GPs who have had experience of prescribing medication to individuals with PSA.

6.4.2 Recommendations

The findings from the study have illustrated that the treatment of PSA in primary care would be possible. However, in order for GPs to treat PSA in primary care confidently, they would require additional training, the oversight of a specialist and the imposition of a structured care pathway.

6.4.2.1 Additional Training for GPs

All GPs indicated that as PSA was not a general indication that they encountered regularly, they had limited knowledge of how to treat the condition. In order to increase awareness of PSA and the difficulties experienced by individuals who live with high levels of sexual arousal, additional training should be provided. Furthering their knowledge, would assist the GPs to increase their confidence in assessing the individual for PSA. Training and support would ensure the GPs feel more able to instigate conversations in relation to sensitive issues. Instead of fearing they were opening an unknown ‘can of worms’ as reported by Gott et al (2004), the GPs will feel better equipped to deal

with wherever the conversation may lead. Additional training would increase the confidence of the GPs in managing the balance between treating the individual patient and managing any risks they may pose as a result of PSA.

6.4.2.2 A Structured Care Pathway

The oversight of a specialist in secondary care would enable the GPs to be better equipped to treat PSA in primary care. Through the creation of a care pathway, the GPs will have an awareness of where and to whom the patient should be referred, which would be possible in the ten-minute appointment offered in GP consultations. Similar to when dealing with sensitive and specialist issues such as gender dysphoria, a single contact point would be provided to GPs. This would be a specialist with knowledge of PSA who would be able to advise and support the GPs.

Specialist oversight would also assist GPs with the prescribing of hormonal therapy medications. Currently, hormonal therapy medications are restricted and many need to be prescribed initially in secondary care. Should a care pathway be created, with a single point of contact for individuals with PSA, prescribing of these kinds of medications would become straight forward. Once the prescription has been initiated, the GPs would be in a position to monitor side effects and administer the prescription. Should the patient need any tweaks to the prescription, the GP would have a specialist they could contact to seek advice as to how to manage changes in medication.

6.4.2.3 Prescribing SSRIs

Whilst the evidence base for SSRIs to be used for their antilibidinal properties is growing, the research findings should be provided directly to GPs. Further training should also be provided to GPs to increase the awareness of the effective use of SSRIs in reducing arousal. SSRIs are not currently recognised as antilibidinal medications in the BNF. Should the BNF recognise the unlicensed use of SSRIs to treat PSA, this would assist the GPs in feeling comfortable that they were justified in prescribing the medication.

6.4.3 Conclusion

The chapter sought to gain an understanding of the views and experiences of GPs in treating PSA in Primary Care. The research highlights the gaps currently in primary care which mean this particular subset of patients are difficult to treat. In the UK alone, it is estimated that 3 to 6% of individuals in the general population experiences PSA in the form of sexual preoccupation and excessive sexual

arousal (Kuzma & Black, 2008; Coleman, 1992). Whilst it is recognised that not all individuals with PSA are at risk of committing offences, the experiences of PSA can be damaging to their well-being which is a recognised risk factor in sexual offending (Heffernan & Ward, 2015). Improvements in the treatment methods available to treat PSA will therefore be beneficial to individuals.

7 General Discussion and Conclusion

This programme of research was designed to gain an understanding of the use of MMPSA in the community. As outlined in Chapter 1, the voluntary use of MMPSA was initially introduced into UK prisons in 2007. The long-term evaluation of the effectiveness of MMPSA in custodial settings undertaken by Winder et al. began in 2010. However, more research needed to be undertaken to evaluate the effectiveness of MMPSA in community settings. Whilst initially the research was designed to continue this evaluation in the community, the impact of the Covid-19 pandemic and the inability to undertake research with individuals subject to supervision by HMPPS led to the redesign of the studies.

As most research into the effectiveness of MMPSA has been undertaken in custodial settings, it was still the intention that the current research project would aim to gain an understanding of the use of medication in the community, despite the difficulties encountered as a result of the pandemic. Chapter 1 outlines the aims of the thesis, of which there were three primary research aims, with research questions attached to each aim:

1. To illustrate the characteristics of those living with PSA and how the use of MMSA assists in improving levels of wellbeing and sexual compulsivity.
    a. How do levels of sexual preoccupation and sexual compulsivity in males with a sexual conviction identified as suitable for MMPSA compare to those (i) in the general population, (ii) with other males convicted of a sexual offence and (iii) with other relevant clinical groups?
    b. How do levels of anxiety and depression in males with a sexual conviction identified as suitable for MMPSA compare to those in the (i) in the general population, (ii) with males convicted of a sexual offence, (iii) with other relevant clinical groups?
    c. Are levels of good mental wellbeing, relationship capacities, and spending free time meaningfully associated with lower levels of sexual compulsivity?

2. To gain an understanding of experiences of those living with and seeking help for PSA in the community.
    a. How was your experience of living with PSA on a daily basis?
    b. How was the experience of seeking help with problematic sexual arousal from your healthcare practitioner?
    c. How effective was the treatment in improving your wellbeing and day to day life?

3. To gain an understanding of the experience of community-based GPs in treating individuals with PSA and their views of the use of MMSA to manage excessive levels of sexual arousal.
    a. What are your views on prescribing MMPSA as a treatment method for individuals with problematic sexual arousal?
    b. What are your experiences of prescribing medication as a treatment method for individuals with problematic sexual arousal?
    c. Are there any barriers to prescribing MMPSA in primary care?

The final chapter provides a synthesis of the findings from each of the empirical studies and explains how the research aims were met. A critical review of the studies is included, highlighting the strengths and limitations of the research project. The chapter also includes a discussion of the implications of the findings, recommendations for practice and suggestions for future research.

7.1 Contributions of the thesis

Three empirical studies were designed in order to achieve the research aims. The details of the studies are outlined in Chapter 1. The first empirical study, Chapter 4, was designed to address the first research aim. The study illustrates the impact of MMPSA in reducing levels of PSA, anxiety and depression in a custodial sample. The study provides tentative evidence to illustrate how reducing PSA assists in improving wellbeing, as individuals prescribed the anti-androgen medication CPA exhibited lower levels of anxiety and depression following intervention with MMPSA. The sample of individuals prescribed CPA was small (n = 10) and therefore the results are interpreted cautiously. Study one also provides a unique contribution to knowledge by using path analysis to explore the relationship between PSA and factors that have been shown to encourage desistance. Anxiety, depression and emotion regulation were used as mediating variables to explore the relationship between SCS, responsible industry, purposefulness and enduring relationships. To the authors knowledge, this is the first attempt to explore the relationship between PSA and protective factors through the use of path analysis. The study demonstrates how the use of MMPSA is effective in increasing wellbeing and demonstrates the importance of ensuring individuals in the community are able to access the medication should they wish to do so.

The second empirical study, Chapter 5, was designed to address the second research aim. The study provides a unique contribution to knowledge by exploring the experiences of individuals seeking help for PSA in the community. The study uses participants with and without convictions to illustrate the help that is available without the intervention of the Criminal Justice System. The

findings of the study illustrate the challenges faced by individuals living with PSA in the community. The participants discussed how they went to great lengths to keep this aspect of themselves hidden from other and how living with PSA impacts their wellbeing. The study also shows the challenges faced by individuals on their help-seeking journey with many making a number of help-seeking attempts before finding help that allowed them to manage their PSA successfully.

The final empirical study, Chapter 6, was designed in order to address the final research aim. The study aimed to discover how UK based GPs would approach a situation where an individual had sought help for PSA, and the possibilities of prescribing medication to assist with this. The study brings an original contribution to knowledge as it is the first study to explore the possibility of treating PSA in primary care from the views of professionals working in the field. The results demonstrate how when an individual is able to seek help for PSA in the community there are still challenges faced by GPs in treating PSA in primary care. These include the uncertainty of prescribing SSRIs for an unlicensed use and the restrictions involved in prescribing hormonal therapy medications.

The three empirical studies have produced informed recommendations for practice outlined later in the chapter. Should the recommendations be implemented, this would assist in managing PSA in the community. PSA has been shown to be a risk factor in sexual offending (Thornton, 2013). The effective management of PSA would lead to the reduction of sexual offending in individuals with PSA. Should help for PSA be available in the community, it would assist those with PSA to access help before coming into contact with the criminal justice system. Ultimately, this would lead to a reduction in the number of victims of sexual offences. The findings of the three empirical chapters are synthesised below.

7.1.1 Living with PSA

The findings from the three empirical studies have highlighted the journey on which an individual embarks when seeking to address their PSA in the community. Study two provided an in-depth illustration of how living with PSA impacts an individual's daily life, addressing the second research aim. The superordinate theme "infinite torment" explored the challenges the individuals faced due to living with PSA. As outlined in Chapter 2, PSA is characterised by unwanted, intrusive sexual thoughts that cause distress to the individual experiencing them (Kafka, 2010; Kaplan & Kreuger, 2010). Individuals with PSA are unable to escape from the constant nature of their sexual thoughts (Lievesley et al., 2014). The participants described how they were trapped with their sexual

thoughts, from which there was no escape. Participants were unable to concentrate on aspects of their daily life and felt tormented by their arousal.

The unwanted nature of the sexual thoughts caused the participants to question their identity. As with the findings of Blagden et al. (2018) the findings from study two show how the individuals felt defined by their thoughts, which brought about feelings of shame. The individuals began to question their self-worth as a result of the shame caused by the feelings, which meant they were not the person they believed they should be (Lazarus, 2006). The thoughts led to feelings of self-hatred and a desire to self-harm which is common amongst those with problematic sexual interests (Nielsen et al., 2022). In attempts to protect their perceived identity, the participants distanced themselves from the sexual thoughts, seeing them as a separate entity as illustrated by the subordinate theme "the beast within". Distancing is often used among those with sexual convictions to reduce the culpability felt by the individual (Winder & Gough, 2010). This enables the individual to create a more positive identity for themselves. However, not accepting that the thoughts are a part of their identity leaves the individual unable to undertake the work necessary to manage their thoughts. Simply trying to suppress sexual interests and behaviours has been shown to be detrimental to wellbeing and is not effective in diminishing problematic interests (Stevens & Wood, 2019).

The findings from study one support those of study two by further illustrating the distressing nature of living with PSA, supporting the findings of study two. Pre-medication with MMPSA, individuals with PSA exhibited significantly higher levels of sexual preoccupation than male student samples and males with sexual convictions without PSA (Day et al., unpublished manuscript). Additionally, individuals with PSA displayed significantly higher levels of anxiety and depression when compared with the general population (Breeman et al., 2015), male prisoners without sexual convictions (McMurran & Christopher, 2009) and males with sexual convictions (Robertson et al., 2020). The data collected for study one were from a sample of individuals serving a custodial sentence for a sexual offence which may have impacted the participants' levels of wellbeing. Custody has been shown to be detrimental to wellbeing. For example, individuals serving custodial sentences have been shown to be at a greater risk of suicidal thoughts, and suicide attempts than those in the general population (Favril, 2021). Suicide rates of men serving custodial sentences are 4 times higher than men in the community (Fazel et al., 2017). However, the findings from study two suggest that living with PSA is distressing in itself, regardless of whether the individual is in custody or the community.

Study one has also illustrated how PSA may impact an individual following release from custody, should they not be able to manage their PSA effectively in the community. Chapter 4 outlines protective factors that have been shown to assist a person in achieving desistance and improving the transition period from custody into the community. Individuals with sexual convictions often face challenges following release from custodial sentences making it difficult to reintegrate into the community (Allen et al., 2023). Unfortunately, individuals with PSA are likely to face more barriers during this transition period than those without. A number of protective factors have been shown to assist individuals during this transition period. These include good wellbeing (Andrews & Bonta, 2007), spending free time meaningfully in prosocial activities (Sampson & Laub, 2017) and having supportive, prosocial relationships (De Vries Robbè et al., 2015). As outlined in Chapter 4, PSA has been shown to impact all three protective factors negatively.

In order to explore the relationship between PSA and protective factors further, a path analysis model was designed. Secondary data were used for study one, collected while participants were serving custodial sentences. The path analysis was undertaken using data collected pre-intervention with MMPSA to demonstrate how an individual with PSA presents before intervention with medication. The model measured levels of sexual compulsivity and sexual preoccupation as measured by the Sexual Compulsivity Scale (SCS; Kalichman et al., 1994) to represent levels of PSA. Scores obtained from the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) were to represent aspects of wellbeing, along with emotion regulation obtained via the Severity Indices of Personality Problems (SIPP-18; Andrea et al., 2007). The variables chosen to represent wellbeing were used as mediating variables, as PSA has been shown to negatively impact wellbeing. Also chosen for the model were personality facets from the SIPP-18, enduring relationships, to represent the importance of supportive relationships, responsible industry and purposefulness, to represent the protective factor spending free time meaningfully.

As was expected, the sample demonstrated high levels of sexual compulsivity and preoccupation, as all members of the sample had been assessed as suitable for intervention with MMPSA due to their PSA. In relation to wellbeing, the sample displayed high levels of anxiety, with the mean score obtained meaning the participants demonstrated a borderline case for anxiety but normal levels of depression (Zigmond & Snaith, 1983). The sample also demonstrated maladaptive functioning for each of the chosen facets, enduring relations, responsible industry, purposefulness and enduring relationships.

Unfortunately, despite being an over-identified model, the model did not demonstrate a good fit of the data. However, the analysis of the coefficients demonstrated that, as predicted, levels of PSA were negatively correlated with each of the protective personality facets, emotion regulation, responsible industry, purposefulness and enduring relationships, demonstrating that higher levels of PSA are associated with lower levels of personality functioning. This is consistent with findings of Winder et al. (2017) who provide evidence that maladaptive personality functioning is frequently found in individuals with PSA (Winder et al., 2017).

PSA was also positively correlated with poor indicators of mental wellbeing, anxiety and depression. This is consistent with previous studies that have shown that individuals with PSA have significantly higher levels of depression when compared to control groups (Scanavino et al., 2018). Levels of anxiety have also been shown to be significantly higher in individuals with PSA, than those without (Scanavino et al., 2019). The correlations illustrate that PSA would negatively impact protective factors, thereby leaving an individual who is unable to manage their PSA effectively with additional challenges following release from a custodial sentence.

7.1.2 The quest for help with PSA

The findings from study two have illustrated the help-seeking process an individual with PSA must undertake in order to gain help for their problematic sexual thoughts and behaviours. Requesting help for sexual arousal is a complex process for individuals with PSA. As shown in Chapter 5, individuals go to great lengths to keep their problematic sexual interests and behaviours hidden from others. The desire to keep their PSA hidden caused the participants in study two to become withdrawn and isolated. Participants explained how they became "room bound" and feared getting close to others in case they revealed the problematic nature of their sexual thoughts. Problematic sexual interests are associated with stigma (Jhanke et al., 2015). This stigma is not only reserved for the individual but has also been shown to extend to those close to them (Cubellis et al., 2019). Participants in study two explain how themselves and family members were ostracised from the community, receiving threats to their lives on discovery of their problematic sexual interests. The ostracism and threats can occur despite individuals having no convictions for sexual offences. Consequently, for individuals with PSA, revealing this aspect of themselves to gain help for their arousal is challenging. Many feared they would be reported to the authorities and, therefore, felt unable to ask for help before their arrest, a recognised barrier in help-seeking (Levenson et al., 2017; Piché et al., 2018).

Once the individual with PSA begins to seek help for their unwanted sexual thoughts, many feel they are not offered the help they need. The findings from study two illustrate the process whereby the individual is "facing the music to fall on deaf ears", highlighting the need of increased training for healthcare professionals in treating PSA. The participants outlined how it had taken courage for them to take steps to ask for help, with some participants explaining how they had driven past the surgery numerous times before finally entering. Revealing the hidden aspect of themselves took courage; often, they felt they were not taken seriously by their healthcare practitioners. In order to encourage help-seeking, being listened to emphatically is vital (Quinn et al., 2018). For individuals who have struggled to reveal this aspect of themselves, to feel unheard is difficult for the individual. When participants did not receive the help they anticipated, this reduced the likelihood of further help-seeking (Levenson et al., 2017). Additionally, many were unable to find the help they required prior to conviction, causing further frustrations. Should the availability of help before conviction be increased, this would enable individuals to manage their PSA without coming into contact with the Criminal Justice System. Ultimately this would be beneficial in reducing the number of victims of sexual offences.

The findings from study three assist in illuminating the help-seeking stage of the individual's journey. The GPs recruited for study three outline the difficult balancing act required when dealing with sensitive issues such as problematic sexual interests and behaviours. GPs must balance their care for the patient with the potential risk the patient may pose to the public. They are also restricted in Primary Care by the allocation of ten minutes per patient to manage their workload. When discussing sensitive topics such as PSA, it may take the patient longer to feel confident to broach the subject with their GP (Malta et al., 2020). The participants in study three outlined how they would use their skills to build a rapport and trust with the individual to encourage the conversations. A relationship between the individual with PSA and the healthcare practitioner has been shown to be imperative when treating individuals with deviant sexual interests and paraphilias to ensure a good standard of care (Thibaut et al., 2020). For GPs however, this can be difficult, as should they feel the individual is a risk of harm, they are duty-bound to breach confidentiality (Slowther, 2010).

The findings from study three also highlighted the various challenges the GPs experience when prescribing MMPSA in primary care. Whilst the findings have shown that this would be possible in some instances, the creation of a shared care pathway is necessary to enable GPs to do this

confidently. The views in relation to prescribing SSRIs "off label" varied between the GP participants, which could indicate that the effective treatment would depend on the individual GP. In order to solve this, the inclusion of SSRIs in the BNF would enable GPs to prescribe SSRIs for the treatment of PSA without a fear of repercussions for using the medication for an indication for which it is not licenced.

7.1.3 The impact of MMPSA

The findings of the thesis have provided qualitative and quantitative evidence of the effectiveness of MMPSA in reducing levels of sexual arousal and improving wellbeing. Study one has illustrated how, in custodial samples, the use of SSRIs and anti-androgen medications reduce levels of sexual compulsivity. Pre-intervention with MMPSA, the sample displayed significantly higher levels of sexual compulsivity when compared with a male student sample, and a sample of males with sexual convictions (Day et al., unpublished manuscript). At three months post-intervention with MMPSA, the sample displayed significantly higher levels of sexual compulsivity than both samples obtained by Day et al. (unpublished manuscript). However, after six months of intervention with medication, there was no significant difference between the samples. The findings illustrate that MMPSA is effective in reducing levels of sexual compulsivity so that individuals with PSA exhibit the same levels of sexual compulsivity as those without PSA. This is important because this demonstrates that with the use of medication, PSA can be effectively reduced to levels that represent those without PSA.

Study one also provides evidence of the effectiveness of MMPSA in improving levels of wellbeing among individuals with PSA. Levels of anxiety and depression in the research sample were compared to three samples: individuals in the general population (Breeman et al., 2015), male prisoners without sexual convictions (McMurran & Christopher, 2009) and males with sexual convictions (Robertson et al., 2020). Pre-medication, the research sample displayed significantly higher levels of anxiety and depression when compared with the three samples. When looking at levels of anxiety, following three months of intervention with MMPSA, the research sample displayed significantly higher levels of anxiety than those in the general population. However, there was no significant difference when compared with males in prison who did not have sexual convictions but significantly lower levels of anxiety when compared to males with sexual convictions. Following six months of intervention with MMPSA, levels of anxiety had reduced so there was no longer a significant difference when compared with the general population and males in prison without sexual convictions. The research sample displayed significantly lower levels of

anxiety when compared with males with sexual convictions following six months of intervention with MMPSA.

Levels of depression were also lowered with the use of MMPSA. Whilst premedication the research sample had significantly higher levels of depression than the three samples, following three and six-months of intervention with MMPSA, there was no significant difference between the research sample, the general population and males in prison without sexual convictions. When compared with males with sexual convictions, the research sample displayed significantly lower levels of depression following three and six-months intervention with MMPSA.

The findings of study two have also illustrated the effectiveness of MMPSA in assisting individuals in managing their PSA. SSRIs have side effects and often individuals may feel worse once they commence treatment, however the medication begins to improve the individuals symptoms after two weeks use of the medication (NHS, 2022b). The participants explained how although initially, there was a period of adjustment in getting used to the medication, they were aware this may happen and began feeling the benefits following two weeks use of the medication. Once they had gone through the period of adjustment, the participants began to notice their levels of anxiety and arousal reducing. Participant 8 explains how "it's just nice to turn down the volume a bit". This is consistent with the findings of Lievesley et al. (2014) as participants have previously reported having more "headspace" due to the reduction of problematic sexual thoughts.

The positive impact of the medication in reducing sexual arousal is also reiterated by Participant 9. The use of anti-androgen medication had such an impact on the participant that he explains, "It was like for the first time I could look women in the eyes without being ashamed". As outlined above, individuals with PSA often become withdrawn as a result of their need to keep their PSA hidden from others. The use of anti-androgen medication reduced his levels of sexual arousal, meaning he no longer felt the need to keep it hidden from others. Similar findings in relation to the effectiveness of anti-androgen medication in reducing arousal have also been shown by Robinson & Valcour (1995), Lippi and van Staden (2017) and Maletzky et al. (2006). More recent studies into the effectiveness of anti-androgens however are lacking (Turner & Briken, 2021).

Although the medication helped to reduce the problematic sexual thoughts, Participant 8 was still able to maintain a sexual relationship with his wife. The purpose of MMPSA is to enable individuals

to seek “healthy” sexual relationships whilst diminishing problematic sexual behaviours (Winder et al., 2018). Enabling individuals to manage their PSA but still achieve healthy sexual functioning is consistent with the Good Lives Model (GLM) proposed by Ward and Stewart (2003). The GLM suggests that in order to enable the individual to live a prosocial life, the focus of treatment should be on increasing wellbeing. The findings of study two and three have illustrated how the use of MMPSA positively impacts the individual’s wellbeing. The ability to maintain healthy sexual relationships will further improve the quality of life for the individual, meaning they are less likely to seek to satisfy their sexual urges through antisocial means.

7.1.4 Reconciling with the self

The results of study two have shown that not all individuals will wish to use medication to manage their PSA. Participant 1 explains how when he used SSRIs, rather than preventing him from using pornography, the behaviour that was problematic for him the medication impacted his ability to have sex. As outlined in Chapter 1, the introduction, the use of MMPSA is voluntary and it is recommended to be used in addition to psychological interventions, as these enable the individuals to develop the appropriate coping skills (Home Office, 2007).

The findings of study two have illustrated the importance of the individuals coming to terms with their problematic sexual interests. Rather than attempting to battle with the deviant thoughts, the participants came to the realisation that they may experience problematic sexual thoughts, but they were in control of their decision as to whether to act on them. As with findings from Blagden et al. (2018), the participants were able to use mindfulness techniques in order to acknowledge their problematic sexual thoughts. An illustration of how this happens is provided by Participant 8, who explains, “And instead of trying to fight it, I let it, shall we say, float away, naturally, float down the river”. The use of mindfulness techniques has been shown to reduce feelings of shame in individuals who use the technique to manage the problematic use of pornography (Sniewski & Farvid, 2019).

The importance of accepting problematic thoughts as just one aspect of themselves is highlighted in study two. Previously, participants had tried to hide from others, leading to withdrawal, isolation and thoughts of self-harm. By recognising that problematic sexual thoughts need not define them, the participants were able to focus on positive aspects of themselves. This allowed the participants to make shifts in their perceived identity, which has been shown to encourage desistance (Göbbels et al., 2012). Acceptance has been shown to be an intervention goal to assist in facilitating

desistance (Sniewski & Farvid, 2019). Through accepting the problematic thoughts, the participants were then able to better control them and learn appropriate coping mechanisms, taking back the control of the PSA.

7.2 Implications and recommendations for practice

7.2.1.1 Reduce stigma to encourage help-seeking prior to conviction.

The findings of study two, in particular, have illustrated the fear that many individuals face when seeking help for problematic sexual interests and behaviours. For some participants in study two, they only felt able to seek help after they had been arrested for committing offences and there was no possibility of them being reported to the Criminal Justice System. Others only felt able to seek help as the alternative was suicide. Reducing the stigma and encouraging help-seeking before coming into contact with the Criminal Justice System would enable more individuals to access the help they need and reduce the likelihood of offending.

Study three has given an insight into how a GP would deal with consultations where individuals seek help for PSA. As outlined in Chapter 6, GPs are obligated to report concerns of risk of serious harm (General Medical Council, 2021). However, the GPs are also mindful that individuals may be experiencing thoughts but are not likely to act on them. Consultations of this nature need not lead to the individual being reported to the police. The GPs undertake a risk assessment and have a desire to help the patient without unnecessarily alerting the authorities. Increasing the availability of information to those with PSA and encouraging help-seeking behaviour would enable more individuals to seek help prior to coming into contact with the Criminal Justice System, reducing the number of victims of sexual offences.

7.2.1.2 Additional training for General Practitioners

The findings of study three highlighted how consultations relating to PSA are encountered infrequently in primary care. It is possible that this is due to the fear of seeking help expressed by participants in study two. Should this fear be reduced and individuals with PSA encouraged to seek help prior to conviction, this type of consultation may be encountered more frequently in primary care. To assist with this, additional training should be provided the GPs. Increasing the knowledge base of GPs in recognising the signs of PSA would increase the confidence of the GPs in treating the indication. This would also increase the confidence of GPs in balancing the needs of the patient with the risk they may pose to society, reducing the need for unnecessary reporting.

7.2.1.3 The creation of a structured care pathway

Studies two and three explored the possibility of obtaining MMPSA in the community. Study three provided an in-depth understanding of the views and experiences of GPs and their ability to prescribe MMPSA. Additionally, study two explored the lived experiences of those seeking help for PSA in the community. The findings from study three highlighted the need for a structured care pathway. The GPs in study three outlined the barriers they face in treating PSA in primary care. GPs are limited in the time they are given to deal with consultations. The creation of a care pathway would enable GPs to effectively deal with consultations relating to PSA. The pathway would enable the GPs to refer the patient to the appropriate specialist in the time allocated. This would benefit the patient as they would be offered the care, they require without feeling as though no one is able to help them. The findings from study two illustrate how often individuals with PSA seek help and are then faced with practitioners who are unable to help them. This leads to frustration for the individual seeking help and has been shown to lead to a reduction in help-seeking behaviour.

The findings of Chapter 6 have illustrated a need for more throughcare for individuals prescribed MMSA in custody. As outlined in Chapter 1, there is a lack of understanding of whether MMPSA is the responsibility of the Criminal Justice System, primary or secondary care (Vollm et al., 2019). For an individual who has been prescribed anti-androgen medication whilst in custody, the findings of study three outline the difficulties the individual may face in obtaining this prescription in the community. GPs are restricted when prescribing anti-androgen medications. The findings of study three highlight that there is some reluctance to take on additional work that would be required in prescribing MMPSA. The creation of a structured care pathway would remove this reluctance as a specialist in secondary care would support the GPs.

7.2.1.4 More evidence for the use of SSRIs

The findings of study three have illustrated the need for more evidence in relation to the prescribing of SSRIs 'off label'. Whilst the GPs were confident in their ability to prescribe SSRIs and monitor the side effects in their patients, views were mixed as to whether they would feel confident prescribing SSRIs for PSA as the medication is not licenced for that use. Should excessive arousal be stated as a use for SSRIs in the BNF, GPs would be able to prescribe them in primary care. Adi et al. (2002) outlined the need for a double-blind RCT to support the use of SSRIs to treat individuals with PSA. A double-blind RCT was undertaken by Wainberg et al. (2006) to assess the effectiveness of SSRIs in a sample of males who have sex with males. The results showed that there were significant

reductions in libido, masturbation and use of pornography following treatment with the SSRI citalopram. To date, no RCT has been performed to evaluate the effectiveness of SSRIs in reducing arousal in individuals with PSA. An RCT is in the process of being designed by Professor Winder and colleagues. Should evidence be provided from the RCT that SSRIs are effective in reducing sexual arousal and improving wellbeing, this would assist in allowing the BNF to recognise the reduction of arousal as a licenced use for SSRIs.

7.3 Strengths, limitations and suggestions for future research

Despite the number of necessary redesigns as a result of various hurdles outlined below, the thesis demonstrates a number of key strengths. Study one enabled the characteristics of individuals with PSA to be explored and comparisons to be made with individuals without PSA. The study provides evidence of the effectiveness of MMPSA in reducing levels of sexual preoccupation and compulsivity, anxiety and depression. Additionally, the study showed that the anti-androgen medication CPA was effective in reducing levels of depression. As CPA is not designed to lower levels of depression, the study provides evidence that by lowering levels of PSA, wellbeing improves. Study one also attempted to explore how protective characteristics relate to sexual compulsivity and preoccupation. Although the model did not provide a good fit of the data, this provides a basis for future research.

Study two provided a unique contribution to knowledge by undertaking an in-depth exploration of how living with PSA is experienced by the individual. The study also provided insight into the help-seeking experiences and individual journeys the participants went on in order to live comfortably with PSA. Participants were recruited, regardless of whether they had convictions, to provide an insight into those who require help with PSA but who have not come into contact with the Criminal Justice System. Due to remote data collection, the study recruited individuals from the UK, USA and Mexico. This enabled a rich data set to be obtained, exploring the shared experiences of individuals living with PSA in the community, regardless of their nationality.

Study three provides a unique contribution to knowledge as it is the first known study to undertake research with GPs regarding the use of MMPSA. The study enabled an insight into the barriers and challenges that may be faced by GPs when prescribing MMPSA and identified recommendations, that if implicated, will improve the treatment interventions available for individuals with PSA.

The studies are not without limitations. Unfortunately, due to the impact of Covid-19, it was not possible to continue the evaluation with the participants in the research sample following their release from custody as was originally intended. Prisons were not permitting face-to-face research and therefore no researcher presence was permitted on site. This meant that a number of participants were released from custody, without knowledge of the research team, meaning locating released individuals was no longer possible. As a result of this, study three used secondary data already collected on the sample during their custodial sentence, in an attempt to highlight their characteristics pre and post intervention with medication. This was in an attempt to predict the types of problems individuals with PSA would experience following release, should they be unable to obtain MMPSA in the community. Ideally, the psychometric scales would have been completed with the individual following their release, and again at three, and six-month time periods. However, the analysis has been performed at intervals on data previously collected whilst they were in custody. Unfortunately, it is not yet known whether there would be a difference in the effects of the medication in custody and in the community. Future research could continue the evaluation of individuals using MMPSA, following their release into the community to evaluate the effectiveness of MMPSA in a less restrictive environment in order to gain a more accurate picture of whether MMPSA assists in managing PSA in the community.

In relation to study two, participants were recruited via a poster in the Safer Living Centre, a service that provides support for individuals with problematic sexual interests and behaviours. The study was also advertised on the social media platform Twitter and a forum for individuals with problematic sexual interests. As a result of this, participants were recruited from the UK, the USA and Mexico. Whilst this is a strength of the study, as it enabled the shared experiences of individuals with PSA to be explored, it is also a weakness of the study. The way in which an individual access health care varies between countries. In the UK for example, an individual with initially seek help from their GP. The individuals in the USA and Mexico sought help directly from specialist therapists they had found online. Future research could recruit individuals only if they had sought help from PSA from their GP. Additionally, not all participants in study two had wished to obtain MMPSA. Whilst the study did enable an exploration of help-seeking for PSA and the methods by which individuals were able to manage this, future research could be undertaken to look specifically at those who had sought access to MMPSA.

In relation to study three, GPs were recruited voluntarily via social media. This potentially skewed the sample as only individuals with an interest in research were recruited. Initially 14 individuals

indicated an interest in the research project, eight were interviewed. Whilst many GPs were not interviewed as they did not have the time to commit to the project, others chose not to be interviewed as they did not wish to discuss the possibility of prescribing MMPSA as this was not their area of expertise and they would not be permitted to prescribe the medication in primary care. Due to this, the participants who were interviewed were all open-minded to the possibility of prescribing the medication. Had it been possible to interview those who did not wish to become involved in prescribing MMPSA, the results would have been more inclusive of the different views. Additionally, the sample was predominantly female. As the research was exploring PSA in males, this also may have impacted on the findings. Future research could be undertaken in order to gain an insight into the views and opinions of those who do not feel it is their remit to treat PSA.

7.4 Personal Reflections

Undertaking a PhD has been described as a journey (Miller & Brimicombe, 2010, p.409), a "rollercoaster" (Morrison-Saunders et al., 2010, p.2) and a "rite of passage" (Amran & Ibrahim, 2011, p.528). The PhD process is often challenging with the researcher experiencing barriers and personal challenges throughout. For mature students such as myself, there may be additional challenges in terms of maintaining a balance between raising children and undertaking the PhD. Reflecting on the research process is recommended for continuing professional development. Reflective practice is recommended by the BPS Guidelines for anyone working in psychology. The following section of the thesis will discuss certain aspects of the research process including challenges and triumphs.

7.4.1 Conducting research with vulnerable populations

The participants in studies one and two are classed as vulnerable populations. Whilst secondary data was used for study one, I contributed to the collection of data for the long-term custodial evaluation of MMSA during my time as a PhD researcher. I would regularly support the research associates employed to work on the long-term evaluation when risk issues meant the participants were not to be seen by a lone female. In relation to study two, whilst not all participants had convictions for sexual offences, those without were still disclosing problematic sexual interests which would leave them feeling exposed and vulnerable.

Working with vulnerable populations, such as those with sexual convictions, can be challenging. The nature of the conversations means the researcher is often exposed to quite distressing content.

I had experience of working with individuals with convictions prior to embarking on the PhD as a result of my previous employment as an offender manager for the Probation Service. My role as a researcher however was quite different to that of an offender manager as it was not my responsibility to manage risk, but to alert the appropriate authorities should the need arise. During the researcher process this was not required but was something I was aware of throughout.

Although on occasions the conversation in relation to problematic sexual interests and behaviours was challenging, it was also very rewarding. Often, individuals with sexual convictions are isolated, for a number of reasons that have been discussed throughout the thesis. Many of the participants expressed their thanks at being given the opportunity to share their experiences. Undertaking the research and presenting the findings was also very rewarding. Ultimately, if better treatment options are available for individuals with problematic sexual interests and behaviours, prior to offending, this will lead to a reduction in the number of victims of sexual offences. To have the knowledge that I have contributed to the reduction of offending is fulfilling and something of which I am proud.

7.4.2 Challenges as a result of the pandemic

The PhD and research process began in October 2018 with a final submission date of 30th September 2022. As stated earlier in the thesis, in order to complete the research project in accordance with BPS guidelines, ethical approval was sought from NTU, HMPPS and HRA. Ethical approval was granted by NTU on 16/09/2019. Initial applications for ethical approval were made to HRA on 14/11/2019 and HMPPS on 15/11/2019. HMPPS granted ethical approval on 03/03/2020 and HRA approval was given 28/05/2020.

Unfortunately, on 12th March 2020, the World Health Organisation (WHO) announced Covid-19 as a pandemic (World Health Organisation, 2020). This had a considerable impact on the way research was conducted around the world. NTU protocols were amended to state that face to face data collection was no longer approved. Access to prisons was not permitted and this was in relation to both staff and visitors. In order to make attempts to work around the pandemic, an application was made to NTU and HMPPS to allow for remote data collection on 13/07/2020. No amended application was made to HRA for remote data collection as HRA were not involved in the recruitment of participants and did not include research on NHS sites. Therefore, the favourable opinion granted by the HRA remained acceptable. NTU approved remote data collection on 21/07/2020.

Following the application HMPPS to amend ethics, made on 13/07/2020, HMPPS responded on 24/09/2020 stating that the NRC had now started taking applications to restart research projects and that new guidance had been created to align with the Framework for Prison Regimes and Services and the Probation Roadmap to Recovery Documents. Consideration was given to both these documents and a further application was submitted to HMPPS on 16/10/2020 taking into account the new guidance. This was followed up on 11/11/2020 with a request for a timescale as to how long the amendments were likely to take as I was unable to make progress on three of my studies until ethical permission had been obtained. A reply was received on 07/12/2020 from the NRC, apologising for the delay and stating that they were consulting with internal colleagues and hoped to be in touch with a response within the next week. No response was received and therefore I contacted the NRC on 21/12/2020 requesting a further update. Remote data collection was approved by HMPPS on 26.04.2021. This resulted in a considerable delay in data collection as had the pandemic not been announced in March 2020, data collection would have been underway by May 2020.

During the pandemic, progress was made on Chapter 6, study three as this study did not require HMPPS approval. Once HMPPS approval had been granted, work began on the originally designed three studies requiring HMPPS approval. Originally, the three studies had been designed as follows;

1. A quantitative study designed to measure the effectiveness of MMPSA in individuals recently released from a custodial sentence. The study mimics research undertaken by SOCAMRU in the custodial settings and continues the evaluation following the individual's release from their custodial sentence. All participants were intended to be recruited from a bank of individuals who had already given consent to take part in the evaluation whilst serving their custodial sentence.
2. A qualitative study designed to gain an in-depth understanding of the experiences of individuals who continued to use MMPSA on their release from custody.
3. A qualitative study designed to gain an understanding of the reasons why individuals may choose to stop taking medication. All participants were intended to be recruited from the sample used for study one who had chosen to cease the use of medication.

In order to make progress with the originally designed studies remotely, access to the HMPPS software Offender Assessment System (OASys) was required. All three studies were designed to use participants who had taken part in the long-term evaluation of MMPSA undertaken by Prof Winder. Permission had previously been provided by a large number of potential participants for

their Probation Officer to be contacted following their release from custody (so I could contact them for future research post-release). The original design outlined that participants would be recruited from this pool of individuals who had taken part in the custodial evaluation, by contacting their Probation Officer following release.

Prior to the pandemic, two research associates were based at HMP Whatton. These research associates maintained the database of participants taking part in the MMSA evaluation. When participants were released from custody, a record of which area they moved to and the contact details for their supervising officer was recorded. As a consequence of the pandemic, no one was permitted to conduct any research in UK prisons from 24.03.2020. This meant there was no record of which participants had been released from prison, or to which probation area they had been released to. However, in anticipation of HMPPS approvals, I managed to obtain use of a prison laptop, which enabled me to start looking at the release locations of potential participants. On obtaining the laptop, it was noticed that the level of access provided by HMP Whatton only allowed individuals currently serving custodial sentences to be found on the system. The levels of access did not allow for those who had been released from prison to be located. In order to enable recruitment of individuals for studies one, two and three during the pandemic, enquiries were made as to the possibility of obtaining access to OASys which covered those in the community. Should the relevant access be obtained, it would have been possible, in theory, to locate participants via OASys and make contact with their Probation Officer. Enquiries as to how to gain the levels of access of OASys to view those the community commenced on 11.02.2021.

On 26.04.2021 a Data Protection Impact Assessment (DPIA) was allocated to me for completion. This was a legal requirement of the Ministry of Justice to ensure the processing of OASys data was compliant with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. The DPIA needed to be completed to allow me to obtain access to OASys in the community. The DPIA was completed, after consultation with Jane Bonnell, the Data Protection Officer at NTU and was submitted on 27.05.2021. The DPIA was reviewed and authorised by the HMPPS Data Privacy Team on 30.06.2021. The DPIA was reviewed by the Ministry of Justice on 13.09.2021 and approved; consequently, access to OASys was provided to me on 14.09.2021.

Unfortunately, on 07.10.2021 access to my prison IT account was deleted. There does not seem to be a particular reason for this, but it is likely to have been because I was unable to enter prison (like every other researcher) and my IT access was suspended for security reasons. As a result of the

time spent trying to gain access to OASys in the community and the limited time left on the PhD, a decision was made in supervision on 18.10.21 that if progress was not possible by November 2021 alternatives to studies one, two and three would have to be sought. At this stage, I continued making attempts to reconnect the prison laptop as I was still hopeful that I would eventually be able to access the database I needed. I was simultaneously working on alternatives for the three studies in case access was delayed. I was still regularly contacting the Prison IT department to recreate my account. On 29.11.2021 it was established that the laptop would need to be returned to HMP Whatton to be reconfigured (HMPPS had updated all prison laptops and a complete reset was needed for the laptop, and the reset needed to be completed by the IT dept within HMP Whatton). On 14.12.21 I attended HMP Whatton to attempt to reconfigure the laptop. Unfortunately, this was not successful, and a decision was made that the originally designed studies were no longer possible.

Although the originally intended research project was not possible, I am proud of the progress I have made as a PhD researcher. I have shown that I am resilient and have the ability to rethink the design of my studies to reach the intended aims of my research. I feel I have grown considerably as a researcher and have increased my skills in both qualitative and quantitative research. I have enjoyed undertaking the interviews with participants. Coming from a background in probation, I had experience of working with individuals with sexual convictions. However, conducting interviews as a researcher was a position new to myself. I learned that I was able to move away from the interviewing methods used as an offender manager and step into my role as researcher. I thought this may be difficult, but I enjoyed the process.

7.5 Conclusion

The thesis has explored various aspects of PSA and the avenues for treating PSA in the community. A detailed exploration of how individuals experience living with PSA and the impact this has on their wellbeing has been provided in Chapter 5. The findings from study two presented in Chapter 5 have outlined the need for PSA to be treated effectively in the community, preferably prior to conviction through the use of prevention. The potential challenges for treating PSA with MMPSA in the community have been explored with potential solutions outlined. The use of MMPSA has been shown to be effective in custodial samples, the findings from study two have provided additional evidence that those who use MMPSA in the community have found the medication to be helpful.

The programme of research has provided important recommendations for practice in an attempt to improve the interventions available for individuals with PSA. By reducing the stigma surrounding individuals with problematic sexual interests and encouraging help-seeking, individuals will be more likely to access help before committing offences. Enabling individuals with problematic sexual interests and behaviours to seek help will assist in preventing victims of sexual offences. Recommendations have also been made to improve the treatment of PSA in the community. Additional training for GPs to recognise the signs of PSA will be beneficial in increasing the confidence of GPs in treating PSA effectively. The creation of a structured care pathway would also improve the efficiency of the treatment of PSA and increase the availability of anti-androgen medications in the community. Finally, more evidence for the use of SSRIs as an anti-libidinal medication would enable more GPs to prescribe the medication to treat PSA. While further research to evidence the effectiveness of MMPSA in community is still required, the thesis has illustrated the benefits MMPSA can bring to the lives of those with PSA.

References

Abouesh, A., & Clayton, A. (1999). Compulsive voyeurism and exhibitionism: A clinical response to paroxetine. *Archives of Sexual Behavior*, *28*, 23-30. https://doi.org/10.1023/A:1018737504537

Adams, K. M., & Robinson, D. W. (2001). Shame reduction, affect regulation, & sexual boundary development: essential building blocks of sexual addiction treatment. Sexual Addiction & Compulsivity, 8, 23–44. doi:10. 1080/107201601750259455.

Adi, Y., Ashcroft, D., Browne, K., Beech, A., Fry-Smith, A., & Hyde, C. (2002). Clinical effectiveness and cost-consequences of selective serotonin reuptake inhibitors in the treatment of sex offenders. *Health Techno Assess 6*, 1-66. https://doi.org/10.3310/hta6280

Addis, M., E. & Mahalik, J., R. (2003). Men, masculinities, and the contexts of seeking help. *American Psychologist, 58*(1), 5-14. https://doi.org/10.1037/14594-031

Ahn, J., Shim, G., Lee, J., Lee, J., Lee, T., & Roh, I. (2013). Preliminary study of effect of leuprolide acetate treatment on sexual fantasy of sex offenders. *The Korean Journal of Laboratory Medicine*, *37*(3), 139-144. https://doi.org/10.7580/kjlm.2013.37.3.139

Akerman, G. (2008). The development of a fantasy modification programme for a prison-based therapeutic community. *International Journal of Therapeutic Communities,* 108-188. https://doi.org/10.53841/bpsfu.2009.1.98.16

Akerman, G. (2010). Undertaking therapy at HMP Grendon with men who have committed sexual offences. In E. Sullivan and R. Shuker (Eds.), *Grendon and the Emergence of Forensic Therapeutic Communities: Developments in Research and Practice,* (171 – 182). Chichester, UK: Wiley. https://doi.org/10.1002/9780470661444.ch10

Akerman, G., & Beech, A. (2012). A systematic review of measures of deviant sexual interest and arousal. *Psychiatry, Psychology and Law, 19*, 118-143. https://doi.org/10.1080/13218719.2010.547161

Alanko, K., Salo, B., Mokros, A., & Santtila, P. (2013). Evidence for heritability of adult men's sexual interest in youth under age 16 from a population-based extended twin design. *Journal of Sexual Medicine, 10*(4), 1090-1099. https://doi.org/10.1111/jsm.12067

Alarcão, V., Ribeiro, S., Miranda, F. L., Carreira, M., Dias, T., e Costa, J. G., & Galvão-Teles, A. (2012). General practitioners' knowledge, attitudes, beliefs, and practices in the management of sexual dysfunction—results of the Portuguese SEXOS study. *The journal of sexual medicine*, *9*(10), 2508-2515. DOI: 10.1111/j.1743-6109.2012.02870.x

Alexander, V. D., Thomas, H., Cronin, A., Fielding, J., & Moran-Ellis, J. (2008). Mixed Methods. In Gilbert, N. (eds.), *Researching Social Life* (3rd ed, 5-21). London, England: Sage.

Allan, C., Winters, G. M., Grydehøj, R. F., Jeglic, E. L., & Calkins, C. (2023). Perspectives of reentry and desistance: a comparison of individuals convicted of general and sexual offenses. *Journal of Offender Rehabilitation*, 1-22. https://doi.org/10.1080/10509674.2022.2158983

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: a systematic review. *Oman medical journal*, *35*(2), e122. doi: 10.5001/omj.2020.40

Amelung, T., Kuhle, L. F., Konrad, A., Pauls, A., & Beier, K. M. (2012). Androgen deprivation therapy of self-identifying, help-seeking pedophiles in the Dunkelfeld. *International Journal of Law and Psychiatry*, *35*(3), 176-184. https://doi.org/10.1016/j.ijlp.2012.02.005

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM – 5,* (5th Ed). Arlington, VA: American Psychiatric Publishing.

Amran, N. N., & Ibrahim, R. (2012). Academic rites of passage: reflection on a PhD journey. *Procedia-Social and Behavioral Sciences*, *59*, 528-534. https://doi.org/10.1016/j.sbspro.2012.09.310

Andrea, H., Verheul, R., Berghout, C., Dolan, C., van der Kroft, P., Bateman, A., ... & van Busschbach, J. (2007). *Measuring the core components of maladaptive personality: Severity Indices of Personality Problems (SIPP-118)* (No. Report 005).

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, *16*(1), 39. https://doi.org/10.1037/a0018362

Andrews, D. A., & Bonta, J. (2013). *The psychology of criminal conduct.* (6th ed.). Newark, NJ: Lexis-Nexis/Anderson. https://doi.org/10.4324/9781315721279

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal justice and Behavior*, *17*(1), 19-52. https://doi.org/10.1177/0093854890017001004

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & delinquency*, *52*(1), 7-27. https://doi.org/10.1177/0011128705281756

Anney, V. N. (2014). Ensuring the quality of findings in qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Education Research and Policy Studies, 5*(2), 272-281.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2002). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online, 1,* Retrieved 10/06/2020 from http://www.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-paper.html

Argiolas, A., & Melis, M. R. (2013). Neuropeptides and central control of sexual behaviour from the past to the present: a review. *Progress in neurobiology*, *108*, 80-107. https://doi.org/10.1016/j.pneurobio.2013.06.006

Aschka, C., Himmel, W., Ittner, E., & Kochen, M. M. (2001). Sexual problems of male patients in family practice. *The Journal of Family Practice, 50*(09), 773-778.

Bailey, D. J., & Klein, J. L. (2018). Ashamed and alone: Comparing offender and family member experiences with the sex offender registry. *Criminal Justice Review*, *43*(4), 440-457. https://doi.org/10.1177/0734016818756486

Baillargeon, J., Penn, J. V., Knight, K., Harzke, A. J., Baillargeon, G., & Becker, E. A. (2010). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*, 367-374. https://doi.org/10.1007/s10488-009-0252-9

Bain, J. (2007). The many faces of testosterone. *Clinical interventions in aging*, *2*(4), 567-576. DOI: 10.2147/cia.s1417

Baird, G. (2008). Confidentiality: What everyone should know, or rather, shouldn't. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 58*(547), 131-133. https://doi.org/10.3399/bjgp08x277131

Balon, R. (2013). Controversies in the diagnosis and treatment of paraphilias. *Journal of Sex & Marital Therapy*, *39*(1), 7-20. https://doi.org/10.1080/0092623x.2012.709219

Baltieri, D., & de Andrade, A. (2009). Treatment of paraphilic sexual offenders in Brazil: issues and controversies. *International Journal of Forensic Mental Health*, *8*(3), 218-223. https://doi.org/10.1080/14999010903362369

Bancroft, J. (1999). Central inhibition of sexual response in the male: A theoretical perspective. *Neuroscience & Biobehavioral Reviews*, *23*(6), 763-784. https://doi.org/10.1016/S0149-7634(99)00019-6

Bancroft, J. (1989). *Human sexuality and its problems* (2nd ed.). Edinburgh: Churchill Livingstone.

Bancroft, J. (2002). Biological factors in human sexuality. *Journal of sex Research*, *39*(1), 15-21. https://doi.org/10.1080/00224490209552114

Bancroft, J. (2003). Androgens and sexual function in men and women. In *Androgens in health and disease* (pp. 259-290). Humana Press, Totowa, NJ. https://doi.org/10.1385/1-59259-388-7:259

Bancroft, J. (2005). The endocrinology of sexual arousal. *Journal of endocrinology*, *186*(3), 411-427. https://doi.org/10.1677/joe.1.06233

Bancroft, J. (2009). *Human sexuality and its problems* (3rd ed.). Elsevier Health Sciences

Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The dual control model: Current status and future directions. *Journal of sex research*, *46*(2-3), 121-142. https://doi.org/10.1080/00224490902747222

Bancroft, J., & Janssen, E. (2000). The dual control model of male sexual response: A theoretical approach to centrally mediated erectile dysfunction. *Neuroscience & Biobehavioral Reviews*, *24*(5), 571-579. https://doi.org/10.1016/S0149-7634(00)00024-5

Bancroft, J., Tennett, G., Loucas, K., and Cass, J. (1974). The control of deviant sexual behaviour by drugs. 1. Behavioural changes following oestrogens and anti-androgens. *Bristish Journal of Psychiatry, 125*(1), 310-315. https://doi.org/10.1192/bjp.125.3.310

Bancroft, J. & Vukadinovic, Z. (2004). Sexual addiction, sexual compulsivity, sexual impulsivity, or what? Toward a theoretical model. *The Journal of Sex Research, 41*(3), 225-234. https://doi.org/10.1080/00224490409552230

Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. *Journal of Consulting and Clinical Psychology, 54*(2), 140-148. https://doi.org/10.1037/0022-006x.54.2.140

Bártová, K., Androvičová, R., Krejčová, L., Weiss, P., & Klapilová, K. (2021). The prevalence of paraphilic interests in the Czech population: Preference, arousal, the use of pornography, fantasy, and behavior. *The Journal of Sex Research*, *58*(1), 86-96. https://doi.org/10.1080/00224499.2019.1707468

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex &Marital Therapy*, *26*(1), 51-65. DOI: 10.1080/009262300278641

Beier, K. M., Amelung, T., & Pauls, A. (2010). Antiandrogene therapie als teil der prävention von sexuellem kindesmissbrauch im Dunkelfeld. *Forensische Psychiatrie, Psychologie, Kriminologie*. https://doi.org/10.1007/s11757-010-0076-1

Berta, M., & Zarling, A. (2019). A preliminary examination of an acceptance and commitment therapy-based program for incarcerated domestic violence offenders. *Violence and victims*, *34*(2), 213-228. DOI: 10.1891/0886-6708.VV-D-17-00106

Bhushan, N., Mohnert, F., Sloot, D., Jans, L., Albers, C., & Steg, L. (2019). Using a Gaussian graphical model to explore relationships between items and variables in environmental psychology research. *Frontiers in psychology*, *10*, 1050. https://doi.org/10.3389/fpsyg.2019.01050

Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). "From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates. *International journal of law and psychiatry*, *34*(4), 249-255. https://doi.org/10.1016/j.ijlp.2011.07.002

Bjelland, I., Dahl, A. A., Haug, T. T., & Neckelmann, D. (2002). The validity of the Hospital Anxiety and Depression Scale: an updated literature review. *Journal of psychosomatic research*, *52*(2), 69-77. https://doi.org/10.1016/S0022-3999(01)00296-3

Black, D. W., Kehrberg, L. L. D., Flumerfelt, D. L., & Schlosser, S. S. (1997). Characteristics of 36 subjects reporting compulsive sexual behaviour. *The American Journal of Psychiatry, 154*(2), 243-249. https://doi.org/10.1176/ajp.154.2.243

Blades, C. A., Stritzke, W. G. K., Page, A. C., & Brown, J. D. (2018). The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide related content. *Clinical Psychology Review, 64*, 1-12. https://doi.org/10.1016/j.cpr.2018.07.001

Blagden, N. J., Mann, R., Webster, S., Lee, R., & Williams, F. (2018). "It's not something I chose you know": Making sense of pedophiles' sexual interest in children and the impact on their psychosexual identity. *Sexual Abuse*, *30*(6), 728-754. https://doi.org/10.1177/1079063217697132

Blagden, N., & Pemberton, S. (2010). The challenge in conducting qualitative research with convicted sex offenders. *The Howard Journal of Criminal Justice, 49*(3), 269-281. https://doi.org/10.1111/j.1468-2311.2010.00615.x

Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2014). Making sense of denial in sexual offenders: A qualitative phenomenological and repertory grid analysis. *Journal of interpersonal violence*, *29*(9), 1698-1731. https://doi.org/10.1177/0886260513511530

Bloch, M. H., McGuire, J., Landeros-Weisenberger, A., Leckman, J. F., & Pittenger, C. (2010). Meta-analysis of the dose-response relationship of SSRI in obsessive compulsive disorder. *Molecular Psychiatry, 15,* 850-855. https://doi.org/10.1038/mp.2009.50

BNF (2022). Antidepressant Drugs. https://bnf.nice.org.uk/treatment-summaries/antidepressant-drugs/. Retrieved 30.09.2022.

Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, *6*(1), 1-22. https://doi.org/10.4324/9780203962176-9

Bonta, J. and Andrews, D.A. (2017) *The Psychology of Criminal Conduct* (6th edn), New York, NY: Routledge.

Boons, L., Jeandarme, I., & Vervaeke, G. (2021). Androgen deprivation therapy in pedophilic disorder: exploring the physical, psychological, and sexual effects from a patient's

perspective. *The Journal of Sexual Medicine*, *18*(2), 353-362. https://doi.org/10.1016/j.jsxm.2020.12.001

Borgermans, L., Vrijhoef, B., Vandevoorde, J., De Maeseneer, J., Vansintejan, J., & Devroey. D. (2013). Relevance of Hypersexual Disorder to family medicine and primary care as a complex multidimensional chronic disease construct. *International Journal of Family Medicine, 2013*(2013), 1-5. https://doi.org/10.1155/2013/519265

Borgogna, N. C., Owen, T., Johnson, D., & Kraus, S. W. (2024). No magic pill: A systematic review of the pharmacological treatments for compulsive sexual behavior disorder. *The Journal of Sex Research*, *61*(9), 1328-1341. https://doi.org/10.1080/00224499.2023.2282619

Bőthe, B., Koós, M., Tóth-Király, I., Orosz, G., & Demetrovics, Z. (2019b). Investigating the associations of adult ADHD symptoms, hypersexuality, and problematic pornography use among men and women on a largescale, non-clinical sample. *The Journal of Sexual Medicine*, *16*(4), 489-499. https://doi.org/10.1016/j.jsxm.2019.01.312

Bőthe, B., Kovács, M., Tóth-Király, I., Reid, R. C., Griffiths, M. D., Orosz, G., & Demetrovics, Z. (2019a). The psychometric properties of the hypersexual behavior inventory using a large-scale nonclinical sample. *The Journal of Sex Research*, *56*(2), 180-190. https://doi.org/10.1080/00224499.2018.1494262

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Sage

BPS (2017). Practice Guidelines (*Third ed).*

BPS (2018). Code of ethics and conduct. Retrieved 13.04.20 from https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct

Bradford, J. (1995). An open pilot study of sertraline in the treatment of outpatients with paedophilia. Paper presented at the 1995 American Psychiatric Association, Miami, Florida.

Bradford, J. M. W. (1999). The paraphilias, obsessive compulsive spectrum disorder, and the treatment of sexually deviant behaviour. *Psychiatric Quarterly*, *70*, 209-219. https://doi.org/10.1023/A:1022099026059

Bradford, J., & Pawlak, A. (1993). Effects of cyproterone acetate on sexual arousal patterns of paedophiles. *Archives of Sexual Behaviour, 22*(6), 629-641. https://doi.org/10.1007/bf01543305

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In Cooper, H. (Ed.), The Handbook of Research Methods in Psychology. (57-71). American Psychological Association.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, *18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., Clarke, V., Hayfield, N., Davey, L., & Jenkinson, E. (2023). Doing reflexive thematic analysis. In *Supporting Research in Counselling and Psychotherapy: Qualitative, Quantitative, and Mixed Methods Research* (pp. 19-38). Cham: Springer International Publishing. https://doi.org/10.1007/978-3-031-13942-0_2

Breeman, S., Cotton, S., Fielding, S., & Jones, G. T. (2015). Normative data for the hospital anxiety and depression scale. *Quality of Life Research*, *24*, 391-398. https://doi.org/10.1007/s11136-014-0763-z

Briken, P., Hill, A., & Berner, W. (2004). A Relapse in Pedophilic Sex Offending and Subsequent Suicide Attempt During Luteinizing Hormone–Releasing Hormone Treatment. *J Clin Psychiatry*, *65*(10), 1429.

Briken, P., Welzel, K., Habermann, N., Hill, A., & Berner, W. (2009). Antiandrogenic pharmacotherapy of sexual offenders and home leave steps in the forensic psychiatric hospital Berlin. *Psychiatrische Praxis*, *36*(5), 232-237. https://doi.org/10.1055/s-0028-1090221

Brown, K., Spencer, J., & Deakin, J. (2007). The reintegration of sex offenders: Barriers and opportunities for employment. *The Howard Journal of Criminal Justice*, *46*(1), 32-42. https://doi.org/10.1111/j.1468-2311.2007.00452.x

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done?. *Qualitative research*, *6*(1), 97-113. https://doi.org/10.1177/14687941060588

Bussmann, H., & Finger, P. (2009). Die Durchführung antiandrogener Behandlung von Sexualstraftätern im Berliner Maßregelvollzug. *Forensische Psychiatrie, Psychologie, Kriminologie*, *2*(3), 129-140. 10.1007/s11757-009-0127-7

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminate validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56*(2), 81-105. https://doi.org/10.1037/h0046016

Cantor, J. M., Klein, C., Lykins, A., Rullo, J. E., Thaler, L., & Walling, B. R. (2013). A treatment-oriented typology of self-identified hypersexuality referrals. *Archives of Sexual Behavior*, *42*, 883-893. DOI 10.1007/s10508-013-0085-1

Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedo- philes. Current Sexual Health Reports, 8(3), 121–128. https://doi.org/10.1007/s11930-016-0076-z

Carnes P. (1983). Out of the shadows: understanding sexual addition. Center City, MN: Hazeldon Publishing.

Carnes, P. J. (2001). Cybersex, courtship and escalating arousal: Factors in addictive sexual desire. *Sexual Addiction and Compulsivity, 8*(1), 45-78.

Cashwell, C.S., Giordano, A.L., King, K. (2017). Emotion Regulation and Sex Addiction among College Students. *International Journal of Mental Health Addiction* **15**, 16–27. https://doi.org/10.1007/s11469-016-9646-6

Cavicchioli, M., Ramella, P., Vassena, G., Simone, G., Prudenziati, F., Sirtori, F., Movalli, M., & Maffei, C. (2020). Dialectical behaviour therapy skills training for the treatment of addictive behaviours among individuals with alcohol use disorder: the effect of emotion regulation and experiential avoidance. *The American journal of drug and alcohol abuse*, *46*(3), 368-384. https://doi.org/10.1080/00952990.2020.1712411

Chen, L., Shi, G. R., Huang, D. D., Li, Y., Ma, C. C., Shi, M., ... & Shi, G. J. (2019). Male sexual dysfunction: A review of literature on its pathological mechanisms, potential risk factors, and herbal drug intervention. *Biomedicine & Pharmacotherapy*, *112*, 108585. https://doi.org/10.1016/j.biopha.2019.01.046

Chivers, M. L., Seto, M. C., Lalumiere, M. L., Laan, E., & Grimbos, T. (2010). Agreement of self-reported and genital measures of sexual arousal in men and woman: A meta-analysis. *Archives of Sexual Behaviour, 39*(1), 5-56. https://doi.org/10.1007/s10508-009-9556-9

Choi, J. H., Lee, J. W., Lee, J. K., Jang, S., Yoo, M., Lee, D. B., ... & Lim, M. H. (2018). Therapeutic Effects of Leuprorelin (Leuprolide Acetate) in Sexual Offenders with Paraphilia. *Journal of Korean Medical Science*, *33*(37), e231-e231. https://doi.org/10.3346/jkms.2018.33.e231

Chow, E. W., & Choy, A. L. (2002). Clinical characteristics and treatment response to SSRI in a female pedophile. *Archives of Sexual Behavior*, *31*, 211-215. https://doi.org/10.1023/A:1014795321404

Christiansen, C., & Martinez-Dettamanti, M. (2018). Prevention in action: Exploring prevention initiatives and current practices. In Lievesley, R., Hocken, K., Elliott, H., Winder, B., Blagden, N., and Banyard, P. (Eds.), *Sexual crime and prevention*, (pp. 27-56). Palgrave. https://doi.org/10.1007/978-3-319-98243-4

Cochran, S., Drescher, J., Kismodi, E., Giami, A., Garcia-Moreno, C., Atalla, E., Marais, A., Meloni Vieira, E., & Reed, G. (2014). Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11). *Bulletin of the World Health Organisation, 92*(9), 672-679.

Cochran, J. C., Toman, E. L., Shields, R. T., & Mears, D. P. (2021). A uniquely punitive turn? Sex offenders and the persistence of punitive sanctioning. *Journal of Research in Crime and Delinquency*, *58*(1), 74-118. https://doi.org/10.1177/0022427820941172

Cohen, L., Ndukwe, N., Yaseen, Z., & Galynker, I. (2018). Comparison of self-identified minor-attracted persons who have and have not successfully refrained from sexual activity with children. *Journal of Sex & Marital Therapy*, *44*(3), 217-230. https://doi.org/10.1080/0092623X.2017.1377129

Coleman, E. (1992). Is your patient suffering from compulsive sexual behaviour? *Psychiatric Annals 22*(6), 320-325.

Coleman, E., Cesnick, J., Moore, A., and Dwyer, S. (1992). An exploratory study of the role of psychotropic medications in the treatment of sex offenders. *Journal of Offender Rehabilitation, 18,*(3-4) 75-88. https://doi.org/10.1300/J076v18n03_08

Coleman, E., Miner, M., Ohlerking, F., & Raymond, N. (2001). Compulsive Sexual Behavior Inventory: A preliminary study of reliability and validity. *Journal of sex & marital therapy*, *27*(4), 325-332. https://doi.org/10.1080/009262301317081070

Cooley, B. N., & Sample, L. L. (2018). The difference between desistance from sexual offending and not reoffending. *Journal of crime and justice*, *41*(5), 483-503. https://doi.org/10.1080/0735648X.2018.1479286

Cooper, A. (1981). A placebo-controlled trial of the anti-androgen cyproterone acetate in deviant hypersexuality. *Comprehensive Psychiatry, 22*(5), 458-465. https://doi.org/10.1016/0010-440X(81)90034-1

Cooper, G. (2008). Conceptualising social life. In Gilbert, N. (eds.), *Researching Social Life* (3rd ed, 5-21). London, England: Sage.

Cooper, A. J., & Cernovsky, Z. Z. (1994). Comparison of cyproterone acetate (CPA) and leuprolide acetate (LHRH agonist) in a chronic pedophile: a clinical case study. *Biological Psychiatry*. https://doi.org/10.1016/0006-3223(94)90609-2

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International Journal of Nursing Practice, 17*(3), 280-288. https://doi.org/10.1111/j.1440-172X.2011.01936.x

Corona, G., & Maggi, M. (2010). The role of testosterone in erectile dysfunction. *Nature Reviews Urology*, *7*(1), 46-56.

Cortoni, F., & Marshall, W. L. (2001). Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *13*, 27-43. https://doi.org/10.1023/A:1009562312658

Cowburn, M. (2005). Confidentiality and public protection: Ethical dilemmas in qualitative research with adult male sex offenders. *Journal of Sexual Agression, 11*(1), 49-63. https://doi.org/10.1080/13552600512331298284

Crane, C. A., Hawes, S. L., Mandel D., & Easton, C. J. (2013). Informed consent: An ethical issue in conducting research with male partner violent offenders. *Ethics and Behaviour, 23*(6), 477-488. https://doi.org/10.1080/10508422.2013.804795

Cresswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Los Angeles, CA; London: Sage.

Crossan, F. (2013). Research philosophy: towards an understanding. *Nurse Researcher (through 2013), 11*(1), 46-55. https://doi.org/10.7748/nr2003.10.11.1.46.c5914

Cubellis, M. A., Evans, D. N., & Fera, A. G. (2019). Sex offender stigma: An exploration of vigilantism against sex offenders. *Deviant Behavior*, *40*(2), 225-239. https://doi.org/10.1080/01639625.2017.1420459

Culos, C., Di Grazia, M., & Meneguzzo, P. (2024). Pharmacological Interventions in Paraphilic Disorders: Systematic Review and Insights. *Journal of Clinical Medicine*, *13*(6), 1524. https://doi.org/10.3390/jcm13061524

Czerny, J.P., Briken, B.W. (2002). Antihormonal treatment of paraphilic patients in German forensic psychiatric clinics. *Eur Psychiatry. 17*(2):104–106. https://doi.org/10.1016/S0924-9338(02)00635-1

Darjee, R., & Quinn, A. (2020). Pharmacological treatment of sexual offenders. *The Wiley Handbook of What Works with Sexual Offenders: Contemporary Perspectives in Theory, Assessment, Treatment, and Prevention*, 217-245. https://doi.org/10.1002/9781119439325.ch13

Daspe, M. È., Vaillancourt-Morel, M. P., Lussier, Y., Sabourin, S., & Ferron, A. (2018). When pornography use feels out of control: The moderation effect of relationship and sexual satisfaction. *Journal of Sex & Marital Therapy*, *44*(4), 343-353. DOI: 10.1080/0092623X.2017.1405301

Dealey, J. (2020). Responding to sexual offending in a risk society: a review of policy and changes in approach to work with perpetrators of sexual offending by the probation service in England and Wales. *British Journal of Community Justice*, *16*(2/3), 46-63.

Deering J (2011) *Probation Practice and the New Penology: Practitioner Reflections*. London: Routledge.

del Busto, E., & Harlow, M. C. (2011). American sexual offender castration treatment and legislation. *International perspectives on the assessment and treatment of sexual offenders: Theory, practice, and research*, 543-571.

Dennis, J. A., Khan, O., Ferriter, M., Huband, N., Powney, M., & Duggan, C. (2012). Psychological interventions for adults who have sexually offended or are at risk of offending. *Cochrane Database of Systematic Reviews,* (12). https://doi.org/10.1002/14651858.cd007507.pub2

De Vries Robbé, M., Mann, R. E., Maruna, S., & Thornton, D. (2015). An exploration of protective factors supporting desistance from sexual offending. *Sexual Abuse*, *27*(1), 16-33. https://doi.org/10.1177/1079063214547582

Dickenson, J. A., Gleason, N., Coleman, E., & Miner, M. H. (2018). Prevalence of distress associated with difficulty controlling sexual urges, feelings, and behaviors in the United States. *JAMA network open*, *1*(7), e184468-e184468.

Dickey, R. (1992). The management of a case of treatment-resistant paraphilia with a long-acting LHRH agonist. *The Canadian Journal of Psychiatry*, *37*(8), 567-569. https://doi.org/10.1177/07067437920370080

Dickey, R. (2002). Case report: The management of bone demineralization associated with long-term treatment of multiple paraphilias with long-acting LHRH agonists. *Journal of Sex &Marital Therapy*, *28*(3), 207-210. https://doi.org/10.1080/009262302760328244

Dietz, P. (2020). Denial and minimisation among sex offenders. *Behavioural Sciences & The Law, 38*(6), 571-585. https://doi.org/10.1002/bsl.2493

Dyer, K., & dasNair, R. (2012). Why don't health professionals talk about sex? *Journal of Sexual Medicine, 10*(11), 2658-2670. https://doi.org/10.1111/j.1743-6109.2012.02856.x

Edens, J. F., Epstein, M., Stiles, P. G., Poythress, N. G. (2011), Voluntary consent in correctional settings: Do offenders feel coerced to participate in research? *Behavioural Sciences and the Law, 29*(6), 771-795. https://doi.org/10.1002/bsl.1014

Egan, V., & Parmar, R. (2013). Dirty habits? Online pornography use, personality, obsessionality, and compulsivity. *Journal of sex & marital therapy*, *39*(5), 394-409.

Eher, R., Rettenberger, M., & Turner, D. (2019). The prevalence of mental disorders in incarcerated contact sexual offenders. *Acta Psychiatrica Scandinavica*, *139*(6), 572-581. https://doi.org/10.1111/acps.13024

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229. https://doi.org/10.1108/jfp-09-2017-0036

Elliott, H., Winder, B., Manby, E., Edwards, H., and Lievesley, R. (2017). "I kind of found out by accident": probation staff experiences of pharmacological treatment for sexual preoccupation and hypersexuality. *The Journal of Forensic Practice, 20*(1), 20-31.

Emmanuel, N. P., Lydiard, R. B., & Ballenger, J. C. (1991). Fluoxetine treatment of voyeurism. https://doi.org/10.1176/ajp.148.7.950a

Erez, G., Pilver, C. E., & Potenza, M. N. (2014). Gender-related differences in the associations between sexual impulsivity and psychiatric disorders. *Journal of psychiatric research*, *55*, 117–125. https://doi.org/10.1016/j.jpsychires.2014.04.009

Epskamp, S. (2017). Discussion: The road ahead. In *Net- work psychometrics*, 237–248. Retrieved from http:// sachaepskamp.com/dissertation/Discussion.pdf.

Epskamp, S., Waldorp, L. J., Mõttus, R., & Borsboom, D. (2018). The Gaussian graphical model in cross-sectional and time-series data. *Multivariate behavioral research*, *53*(4), 453-480. https://doi.org/10.1080/00273171.2018.1454823

Evans, D. N., Blount-Hill, K. L., & Cubellis, M. A. (2019). Examining housing discrimination across race, gender and felony history. *Housing Studies*, *34*(5), 761-778. https://doi.org/10.1080/02673037.2018.1478069

Evans, D. N., & Porter, J. R. (2015). Criminal History and Landlord Rental Decisions: A New York Quasi- Experimental Study. *Journal of Experimental Criminology, 11*(1):21–42. doi:10.1007/s11292-014-9217-4.

Faisandier, K. M., Taylor, J. E., & Salisbury, R. M. (2012). What does attachment have to do with out-of-control sexual behaviour? New Zealand Journal of Psychology, 41, 19–29.

Farmer, M., McAlinden, A. M., & Maruna, S. (2015). Understanding desistance from sexual offending: A thematic review of research findings. *Probation Journal*, *62*(4), 320-335. https://doi.org/10.1177/0264550515600545

Farren, L. & Barnett, G. (2014). Measuring offence related sexual interests in convicted sexual offenders: An initial test of the reliability and validity or a self-report scale. *Analytic Summary,* National Offender Management Service.

Favril, L. (2021). Epidemiology, risk factors, and prevention of suicidal thoughts and behaviour in prisons: a literature review. *Psychologica Belgica*, *61*(1), 341. doi: 10.5334/pb.1072

Fazel, S., Ramesh, T., & Hawton, K. (2017). Suicide in prisons: an international study of prevalence and contributory factors. Lancet Psychiatry, 4(12), 946–952. DOI: 10.1016/S2215-0366(17)30430-3

Fedoroff, J. (1995). Anti-androgen vs serotonergic medications in the treatment of sex offenders: A preliminary compliance study. *Canadian Journal of Human Sexuality, 4,* 111-123.

Fetters, M. D., Curry, L. A. & Creswell, J. W. (2013). Achieving integration in mixed methods designs – principles and practices. *Health Services Research, 48*(6 pt 2), 2134-2156. https://doi.org/10.1111/1475-6773.12117

Fielding, N. & Thomas, H. (2008). Qualitative interviewing. In Gilbert, N. (eds.), *Researching Social Life* (3rd ed, 5-21). London, England: Sage.

First, M. B. (2005). Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder. *Psychological medicine*, *35*(6), 919-928. https://doi.org/10.1017/S0033291704003320

Fisher, D., Beech, A., & Browne, K. (2000). The effectiveness of relapse prevention training in a group of incarcerated child molesters. *Psychology, Crime and Law*, *6*(3), 181-195. https://doi.org/10.1080/10683160008409803

Fosdick, C., & Mohiuddin, S. (2016). Case report: resolution of severe sexual aggression in a developmentally disabled adolescent during leuprolide acetate use. *Journal of autism and developmental disorders*, *46*(6), 2267-2269. https://doi.org/10.1007/s10803-016-2739-z

Fox, K. J. (2017). Contextualizing the policy and pragmatics of reintegrating sex offenders. *Sexual Abuse*, *29*(1), 28-50. https://doi.org/10.1177/1079063215574711

Fuss, J., Briken, P., Stein, D. J., & Lochner, C. (2019). Compulsive sexual behaviour disorder in obsessive–compulsive disorder: Prevalence and associated comorbidity. *Journal of Behavioral Addictions*, *8*(2), 242-248. https://doi.org/10.1556/2006.8.2019.23

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of advanced nursing*, *49*(6), 616-623. https://doi.org/10.1111/j.1365-2648.2004.03331.x

Gallo, A., Abracen, J., Looman, J., Jeglic, E., & Dickey, R. (2019). The use of leuprolide acetate in the management of high-risk sex offenders. *Sexual Abuse*, *31*(8), 930-951. https://doi.org/10.1177/1079063218791176

Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical psychology review*, *73*, 101752. https://doi.org/10.1016/j.cpr.2019.101752

Garcia, F. D., & Thibaut, F. (2010). Sexual addictions. *The American journal of drug and alcohol abuse*, *36*(5), 254-260. https://doi.org/10.3109/00952990.2010.503823

General Medical Council. (2021). Confidentiality, disclosing patients' personal information: A framework. Retrived from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/disclosing-patients-personal-information-a-framework#paragraph-17 accessed 10.06.2021.

Gessner, M., Bishop, M. D., Martos, A., Wilson, B. D., & Russell, S. T. (2020). Sexual minority people's perspectives of sexual health care: Understanding minority stress in sexual health settings. *Sexuality Research and Social Policy*, *17*, 607-618. https://doi.org/10.1007/s13178-019-00418-9

Giordano, P. C., Cernkovich, S. A., & Rudolph, J. L. (2002). Gender, crime, and desistance: Toward a theory of cognitive transformation. *American journal of sociology*, *107*(4), 990-1064. https://doi.org/10.1086/343191

Giotakos O, Markianos M, Vaidakis N, Christodoulou GN. (2004). Sex hormones and biogenic amine turnover of sex offenders in relation to their temperament and character dimensions. Psychiatry Res 127:185–93. https://doi.org/10.1016/j.psychres.2003.06.003

Giraldi, A., Kristensen, E., & Sand, M. (2015). Endorsement of models describing sexual response of men and women with a sexual partner: an online survey in a population sample of Danish adults ages 20-65 years. *The journal of sexual medicine*, 12 1, 116-28. https://doi.org/10.1111/jsm.12720.

Göbbels, S., Ward, T., & Willis, G. M. (2012). An integrative theory of desistance from sex offending. *Aggression and Violent Behavior*, *17*(5), 453-462. https://doi.org/10.1016/j.avb.2012.06.003

Gott, M., & Hinchliff, S. (2003). Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. *Family Practice, 20*(6), 690-695. https://doi.org/10.1093/fampra/cmg612

Gott, M., Galena, E., Hinchcliff, S., & Elford, H. (2004). "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21*(5), 528-536. https://doi.org/10.1093/fampra/cmh509

Gov. (2020). *The Risk-Need-Responsivity Model.* https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/models-and-principles/the-rnr-model/

Gov. (2022, June 22). *Living with Covid-19: prisons and youth custody settings.* Gov https://www.gov.uk/government/publications/living-with-covid-19-prisons-and-youth-custody-settings

Grant Weinandy, J. T., Lee, B., Hoagland, K. C., Grubbs, J. B., & Bőthe, B. (2023). Anxiety and compulsive sexual behavior disorder: A systematic review. *The Journal of Sex Research*, *60*(4), 545-557. DOI: 10.1080/00224499.2022.2066616

Greenberg, D. M., Bradford, J. M., Curry, S., and O'Rourke, A. (1996). A comparison of treatment of paraphilias with three serotonin reuptake inhibitors: A retrospective study. *Journal of the American Academy of Psychiatry and the Law Online*, *24*(4), 525-532.

Greene, J. C., Caracelli, V. J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11*(3), 255-274.

Greene, J. C., Benjamin, L., & Goodyear, L. (2001). The merits of mixing methods in evaluation. *Evaluation, 7*(1), 25-44. https://doi.org/10.1177/13563890122209504

Grossi, L. M. (2017). Sexual offenders, violent offenders, and community reentry: Challenges and treatment considerations. Aggression and Violent Behavior, 34, 59–67. https://doi.org/10.1016/j.avb.2017.04.005

Grubbs, J. B., Volk, F., Exline, J. J., & Pargament, K. I. (2015). Internet pornography use: Perceived addiction, psychological distress, and the validation of a brief measure. *Journal of Sex & Marital Therapy*, *41*(1), 83–106. doi:10.1080/0092623X.2013.842192

Grubin, D. (2018). The pharmacological treatment of sex offenders. *The Wiley Blackwell handbook of forensic neuroscience*, *1*, 703-723. https://doi.org/10.1016/j.sexol.2011.02.003

Guay, D. (2009). Drug treatment of paraphilic and nonparaphilic sexual disorders. *Clinical Therapeutics, 31*, 1-31. https://doi.org/10.1016/j.clinthera.2009.01.009

Guerriero, G. (2009). Vertebrate sex steroid receptors: evolution, ligands, and neurodistribution. *Annals of the New York Academy of Sciences*, *1163*(1), 154-168.

Habermeyer, B., Händel, N., Lemoine, P., Klarhöfer, M., Seifritz, E., Dittmann, V., & Graf, M. (2012). LH-RH agonists modulate amygdala response to visual sexual stimulation: A single case fMRI study in pedophilia. *Neurocase*, *18*(6), 489-495. https://doi.org/10.1080/13554794.2011.627346

Hanseder, S., & Dantas, J. A. (2023). Males' Lived Experience with Self-Perceived Pornography Addiction: A Qualitative Study of Problematic Porn Use. *International Journal of Environmental Research and Public Health*, *20*(2), 1497. https://doi.org/10.3390/ijerph20021497

Hanson, R. K. (2009). The psychological assessment of risk for crime and violence. *Canadian Psychology/Psychologie canadienne*, *50*(3), 172. https://doi.org/10.1037/a0015726

Hanson, R. K. (2018). Long-term recidivism studies show that desistance is the norm. *Criminal Justice and Behavior*, *45*(9), 1340-1346. https://doi.org/10.1177/0093854818793382

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). A meta-analysis of the effectiveness of treatment for sexual offenders: Risk, need, and responsivity. *User Report*, *1*.

Hanson, R. K., Gordon, A., Harris, A. J., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A journal of research and treatment*, *14*, 169-194. https://doi.org/10.1023/A:1014624315814

Hanson, K., Gizzarelli, R., & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. *Criminal justice and behavior*, *21*(2), 187-202. https://doi.org/10.1177/0093854894021002001

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexual offence recidivism. *Criminal Justice and Behaviour, 27*(1), 6 – 35. https://doi.org/10.4135/9781452229454.n23

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of consulting and clinical psychology, 73*, 1154-1163. https://doi.org/10.4324/9781351161565-5

Hanson, K., Harris, A. J. R., Helmus, L., & Thornton, D. (2014). High-risk sex offenders may not be high risk forever. *Journal of Interpersonal Violence*, *29*(15), 2792-2813. https://doi.org/10.1177/0886260514526062

Hanson, R. K., Harris, A. J., Letourneau, E., Helmus, L. M., & Thornton, D. (2018). Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law*, *24*(1), 48. https://doi.org/10.1037/law0000135

Hanson, R. K., Harris, A. J., Scott, T. L., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (Vol. 5, No. 6). Ottawa, Ontario: Public Safety Canada.

Harris, D. A., & Levenson, J. (2021). Life on "the list" is a life lived in fear: Post-conviction traumatic stress in men convicted of sexual offenses. *International journal of offender therapy and comparative criminology*, *65*(6-7), 763-789. https://doi.org/10.1177/0306624X20952397

Harris, A. J., & Socia, K. M. (2016). What's in a name? Evaluating the effects of the "sex offender" label on public opinions and beliefs. *Sexual Abuse: A Journal of Research and Treatment, 28*(7), 660-678. https://doi.org/10.1177/1079063214564391

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour research and therapy*, *44*(1), 1-25. https://doi.org/10.1016/j.brat.2005.06.006Get rights and content

Heffernen, R., & Ward, T. (2015). The conceptualisation of dynamic risk factors in child sex offenders: An agency model. *Aggression and Violent Behaviour, 24,* 250 -260. https://doi.org/10.1016/j.avb.2015.07.001

Heffernan, R., & Ward, T. (2019). Dynamic risk factors, protective factors and value-laden practices. *Psychiatry, Psychology and Law*, *26*(2), 312-328.https://doi.org/10.1080/13218719.2018.1506721

Heiden-Rootes, K. M., Salas, J., Gebauer, S., Witthaus, M., Scherrer, J., McDaniel, K., & Carver, D. (2017). Sexual dysfunction in primary care: An exploratory descriptive analysis of medical record diagnoses. *Journal of Sexual Medicine, 14*(11), 1318-1326. https://doi.org/10.1016/j.jsxm.2017.09.014

Henshaw, M., Ogloff, J. R., & Clough, J. A. (2018). Demographic, mental health, and offending characteristics of online child exploitation material offenders: A comparison with contact-only and dual sexual offenders. *Behavioral sciences & the law*, *36*(2), 198-215. https://doi.org/10.1002/bsl.2337

Hill, A., Briken, P., Kraus, C., Strohm, K., and Berner, W. (2003). Differential pharmacological treatment of paraphilias and sex offenders. *International Journal of Offender Therapy and Comparative Criminology, 47*, 407-421. https://doi.org/10.1177/0306624X03253847

Hinchliff, S., Carvalheira, A. A., Štulhofer, A., Janssen, E., Hald, G. M., & Træen, B. (2020). Seeking help for sexual difficulties: findings from a study with older adults in four European countries. *European Journal of Ageing*, *17*(2), 185–195. https://doi.org/10.1007/s10433-019-00536-8

Hinchliff, S., Gott, M., & Galena, E. (2005). 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health & social care in the community*, *13*(4), 345-353. https://doi.org/10.1111/j.1365-2524.2005.00566.x

Hinchliff, S., Lewis, R., Wellings, K., Datta, J., & Mitchell, K. (2021). Pathways to help-seeking for sexual difficulties in older adults: qualitative findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Age and ageing*, *50*(2), 546-553.

Hinchliff, S., Tetley, J., Lee, D., & Nazroo, J. (2018). Older adults' experiences of sexual difficulties: Qualitative findings from the English Longitudinal Study on Ageing (ELSA). *The Journal of Sex Research*, *55*(2), 152-163. https://doi.org/10.1080/00224499.2016.1269308

Hirschi, T. (1969). Key idea: Hirschi's social bond/social control theory. *Key Ideas in Criminology and Criminal Justice,(1969)*, 55-69. https://doi.org/10.4135/9781483388045.n5

HMPPS (2008). *Psychiatric assessment for sexual offenders: Interventions group.* London:HMPPS.

HMPPS (2021, September 9). *The HMPPS Approach to the management and rehabilitation of people convicted of sexual offences.* GOV. https://www.gov.uk/government/publications/the-hmpps-approach-to-the-management-and-rehabilitation-of-people-convicted-of-sexual-offences

Ho, D. K., Kottalgi, G., Ross, C. C., Romero-Ulceray, J., & Das, M. (2012). Treatment with triptorelin in mentally disordered sex offenders: experience from a maximum-security hospital. *Journal of clinical psychopharmacology*, *32*(5), 739-740. DOI: 10.1097/JCP.0b013e318266c6f5

Hocken, K. (2018). Safer living foundation: The aurora project. In Lievesley, R., Hocken, K., Elliott, H., Winder, B., Blagden, N., and Banyard, P. (Eds.), *Sexual crime and prevention*, (pp. 83-109). Palgrave. https://doi.org/10.1007/978-3-319-98243-4

Hodkinson, P. (2008). Grounded Theory and inductive research. In N. Gilbert (Ed.), *Researching Social Life* (3rd ed., 80-100). Sage

Hollander, E. (1998). Treatment of obsessive-compulsive spectrum disorders with SSRIs. *The British Journal of Psychiatry, 35,* 7-12. https://doi.org/10.1192/S0007125000297845

Home Office (2007). Review for the protection of children from sex offenders. London: Home Office.

Hoogeveen, J., & Van der Veer, E. (2008). Side effects of pharmacotherapy on bone with long-acting gonadorelin agonist triptorelin for paraphilia. *The journal of sexual medicine*, *5*(3), 626-630. DOI: 10.1111/j.1743-6109.2007.00642.x

Howe, K. R. (1988). Against the quantitative-qualitative incompatibility thesis or dogmas die hard. *Educational researcher*, *17*(8), 10-16. https://doi.org/10.3102/0013189x017008010

Howell, D. C. (2013). *Statistical Methods for Psychology* (8th ed..). Wadsworth Cengage Learning.

Howells, K., Day, A., & Wright, S. (2004). Affect, emotions and sex offending. *Psychology, Crime and Law, 10*(2), 179-195. https://doi.org/10.1080/10683160310001609988

Howitt, D., & Cramer, D. (2011). *Introduction to Research Methods in Psychology* (3rd Ed..). Essex: Pearson Education Limited.

Hucker, S., Langevin, R., & Bain, J. (1988). A double-blind trial of sex drive reducing medication in pedophiles. *Annals of Sex Research*, *1*, 227-242. https://doi.org/10.1007/BF00852799

Hull, E. M., Muschamp, J. W., & Sato, S. (2004). Dopamine and serotonin: influences on male sexual behavior. *Physiology & behavior*, *83*(2), 291-307.

Hunsley, J., & Mash, E. J. (Eds.). (2008). *A guide to assessments that work*. Oxford University Press.

Huygh, J., Verhaegen, A., Goethals, K., Cosyns, P., De Block, C., & Van Gaal, L. (2015). Prolonged flare-up of testosterone after administration of a gonadotrophin agonist to a sex offender: an under-recognized risk. *Crim. Behav. & Mental Health*, *25*, 226. DOI:10.1002/cbm.1945

Jahnke, S. (2018). The stigma of paedophilia: Clinical and forensic implications. *European Psychologist, 23*(2), 144-153. https://doi.org/10.1027/1016-9040/a000325

Jahnke, S., & Hoyer, J. (2013). Stigmatization of people with pedophilia: A blind spot in stigma research. *International Journal of Sexual Health*, *25*(3), 169-184. https://doi.org/10.1080/19317611.2013.795921

Jahnke, S., Imhoff, R., & Hoyer, J. (2015). Stigmatization of people with pedophilia: Two comparative surveys. *Archives of sexual behavior*, *44*, 21-34. https://doi.org/10.1007/s10508-014-0312-4

Janssen, E. (2011). Sexual arousal in men: A review and conceptual analysis. *Hormones and Behaviour, 59*(5), 708-716. https://doi.org/10.1016/j.yhbeh.2011.03.004

Janssen, E., Goodrich, D., Petrocelli, J. V., & Bancroft, J. (2009). Psychophysiological response patterns and risky sexual behaviour in heterosexual and homosexual men. *Archives of Sexual Behaviour*, *38*(4), 538-550. https://doi.org/10.1007/s10508-008-9432-z

Janssen, E., McBride, K. R., Yarber, W., Hill, B. J., & Butler, S. M. (2008). Factors that influence sexual arousal in men: A focus group study. *Archives of Sexual behavior*, *37*, 252-265. https://doi.org/10.1007/s10508-007-9245-5

Janssen, E., Vorst, H., Finn, P., & Bancroft, J. (2002). The Sexual Inhibition (SIS) and Sexual Excitation (SES) Scales: I. Measuring sexual inhibition and excitation proneness in men. *Journal of sex research*, *39*(2), 114-126. https://doi.org/10.1080/00224490209552130

Johnson, J. L., Oliffe, J. L., Kelly, M. T., Galdas, P., & Ogrodniczuk, J. S. (2012). Men's discourses of help-seeking in the context of depression. *Sociology of health & illness*, *34*(3), 345-361. https://doi.org/10.1111/j.1467-9566.2011.01372.x

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, *33*(7), 14-26. https://doi.org/10.3102/0013189X033007014

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research*, *1*(2), 112-133. https://doi.org/10.1177/1558689806298224

Jordan, K., Fromberger, P., Laubinger, H., Dechent, P., & Müller, J. L. (2014). Changed processing of visual sexual stimuli under GnRH-therapy–a single case study in pedophilia using eye tracking and fMRI. *BMC psychiatry*, *14*, 1-13.

Jordan, K., Fromberger, P., Stolpmann, G., & Müller, J. L. (2011). The role of testosterone in sexuality and paraphilia—A neurobiological approach. Part I: Testosterone and sexuality. *The journal of sexual medicine*, *8*(11), 2993-3007. https://doi.org/10.1111/j.1743-6109.2011.02394.x

Joyal, C. C. (2014). How anomalous are paraphilic interests? *Archives of Sexual Behaviour, 43*(7)*,* 1241-1243

Joyal, C. C, & Carpentier, J. (2017). The prevalence of paraphilic interests and behaviours in the general population: A provincial survey. *The Journal of Sex Research, 54*(2), 161-171.

Kafka, M. (1994). Sertraline pharmacotherapy for paraphilias and paraphilia related disorders: An open trial. *Annals of Clinical Psychiatry, 6*(3), 189-195. https://doi.org/10.3109/10401239409149003

Kafka, M. (1997). Hypersexual desire in males: An operational definition and clinical implications for males with paraphilias and paraphilia-related disorders. *Archives of sexual behaviour*, *25*, 505-526.

Kafka, M. (2003). Sex offending and sexual appetite: The clinical and theoretical relevance of hypersexual desire. *International Journal of Offender Therapy and Comparative Criminology, 47*, 439-451.

Kafka, M. (2010). Hypersexual Disorder: A proposed diagnosis for DSM-V. *Archives of Sexual Behaviour, 39*(2), 377 – 400.

Kafka, M. P. (2013). The development and evolution of the criteria for a newly proposed diagnosis for DSM-5: Hypersexual Disorder. *Sexual Addiction and Compulsivity, 20*(1-2), 19-26.

Kafka, M. P. (2014). What happened to hypersexual disorder?. *Archives of sexual behavior*, *43*(7), 1259-1261. https://doi.org/10.1007/s10508-014-0326-y

Kafka, M., and Prentky, R. (1992). Fluoxetine treatment of nonparaphilic sexual addictions and paraphilias in men. *Journal of Clinical Psychiatry, 53*(10)*,* 351-358.

Kafka, M., & Hennan, J. (2000). Psychostimulant augmentation during treatment with selective serotonin reuptake inhibitors in men with paraphilias and paraphilia related disorders. *The Journal of Clinical Psychiatry, 61*(9), 664-670.

Kafka, M., & Hennen, J. (2002). A DSM-IV Axis 1 comorbidity study of males (n = 120) with paraphilias and paraphilia-related disorders. *Sexual Abuse: A Journal of Research and Treatment, 14*(4), 349 - 366. https://doi.org/10.1023/A:1020007004436

Kalichman, S., Johnson, J., Adair, V., Rompa, D., Multhauf, K., & Kelly, J. (1994). Sexual sensation seeking: Scale development and predicting AIDS-risk behaviour among homosexually active men. *Journal of Personality Assessment, 62*, 385-397. https://doi.org/10.1207/s15327752jpa6203_1

Kalichman, S. C., & Rompa, D. (2001). The Sexual Compulsivity Scale: Further development and use with HIV-positive persons. *Journal of personality assessment*, *76*(3), 379-395. https://doi.org/10.1207/s15327752jpa7603_02

Kalin, N. H. (2020). The critical relationship between anxiety and depression. *American Journal of Psychiatry*, *177*(5), 365-367. doi: 10.1176/appi.ajp.2020.20030305

Kaplan, H. S. (1979). *Disorders of sexual desire*. New York: Simon and Schuster.

Kaplan, M., & Krueger, R. (2010). Diagnosis, assessment and treatment of hypersexuality. *Journal of Sex Research, 47*, 181-198. https://doi.org/10.1080/00224491003592863

Kelder, I., Sneijder, P., Klarenbeek, A., & Laan, E. (2022). Communication practices in conversations about sexual health in medical healthcare settings: A systematic review. *Patient Education and Counseling*, *105*(4), 858-868. https://doi.org/10.1016/j.pec.2021.07.049

Kelle, U. (2006). Combining qualitative and quantitative methods in research practice: Purposes and advantages. *Qualitative Research in Psychology, 3*(4), 293-311. https://doi.org/10.1177/1478088706070839

Kessler, A., Sollie, S., Challacombe, B., Briggs, K., & Van Hemelrijck, M. (2019). The global prevalence of erectile dysfunction: a review. *BJU international*, *124*(4), 587-599. https://doi.org/10.1111/bju.14813

Kessler, R. C., Sampson, N. A., Berglund, P., Gruber, M. J., Al-Hamzawi, A., Andrade, L., ... & Wilcox, M. A. (2015). Anxious and non-anxious major depressive disorder in the World Health Organization World Mental Health Surveys. *Epidemiology and psychiatric sciences*, *24*(3), 210-226. https://doi.org/10.1017/S2045796015000189

Khan, O., Ferriter, M., Huband, N., Powney, M. J., Dennis, J. A., & Duggan, C. (2015). Pharmacological interventions for those who have sexually offended or are at risk of

offending. *Cochrane Database of Systematic Reviews*, (2). https://doi.org/10.1002/14651858.CD007989.pub2

Khun, S.T. (1970) *The Structure of Scientific Revolution* (2nd edn), Chicago, University of Chicago Press.

Kiersch, T. A. (1990). Treatment of sex offenders with Depo-Provera. *Journal of the American Academy of Psychiatry and the Law Online*, *18*(2), 179-187.

Kinsey, A. C., Pomery, W. B., & Martin, C. E. (1948). Kinsey scale. *Personality and Social Psychology Bulletin*.

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research* (Vol. 1). Sage. https://doi.org/10.4135/9781412985659.n2

Klapilova, K., Demidova, L. Y., Elliott, H., Flinton, C. A., Weiss, P., & Fedoroff, J. P. (2019). Psychological treatment of problematic sexual interests: cross-country comparison. *International Review of Psychiatry, 31*(2), 169-180. https://doi.org/10.1080/09540261.2019.1591353

Klein, V., Jurin, T., Briken, P., & Štulhofer, A. (2015). Erectile dysfunction, boredom, and hypersexuality among coupled men from two European countries. *The journal of sexual medicine*, *12*(11), 2160-2167. https://doi.org/10.1111/jsm.13019

Kline, R. B. (1991). Latent variable path analysis in clinical research: A beginner's tour guide. *Journal of clinical psychology*, *47*(4), 471-484. https://doi.org/10.1002/1097-4679(199107)47:4<471::AID-JCLP2270470402>3.0.CO;2-O

Knack, N., Winder, B., Murphy, L., & Fedoroff, J. P. (2019). Primary and secondary prevention of child sexual abuse. *International review of psychiatry*, *31*(2), 181-194.https://doi.org/10.1080/09540261.2018.1541872

Koo, K. C., Ahn, J. H., Hong, S. J., Lee, J. W., & Chung, B. H. (2014). Effects of chemical castration on sex offenders in relation to the kinetics of serum testosterone recovery: implications for dosing schedule. *The Journal of Sexual Medicine*, *11*(5), 1316-1324. https://doi.org/10.1111/jsm.12492

Koós, M., Bőthe, B., Orosz, G., Potenza, M. N., Reid, R. C., & Demetrovics, Z. (2021). The negative consequences of hypersexuality: Revisiting the factor structure of the Hypersexual Behavior Consequences Scale and its correlates in a large, non-clinical sample. *Addictive Behaviors Reports*, *13*, 100321. https://doi.org/10.1016/j.abrep.2020.100321

Kraus, S. W., Martino, S., & Potenza, M. N. (2016). Clinical characteristics of men interested in seeking treatment for use of pornography. *Journal of Behavioural Addictions*, *5*(2), 169-178. https://doi.org/10.1556/2006.5.2016.036

Kravitz, H. M., Haywood, T. W., Kelly, J., Wahlstrom, C., Liles, S., & Cavanaugh, J. L. (1995). Medroxyprogesterone treatment for paraphiliacs. *Journal of the American Academy of Psychiatry and the Law Online*, *23*(1), 19-33. https://doi.org/10.1016/0091-3057(93)90419-t

Krueger, R. B., Hembree, W., & Hill, M. (2006). Prescription of medroxyprogesterone acetate to a patient with pedophilia, resulting in Cushing's syndrome and adrenal insufficiency. *Sexual abuse: a journal of research and treatment*, *18*, 227-228. https://doi.org/10.1007/s11194-006-9012-5

Krueger, R. B., & Kaplan, M. S. (2001). Depot-leuprolide acetate for treatment of paraphilias: a report of twelve cases. *Archives of Sexual Behavior*, *30*, 409-422. https://doi.org/10.1023/A:1010213432606

Krueger, R., Reed, G., First, M., Marais, A., Kismodi, E., & Briken, P. (2017). Proposals for Paraphilic Disorders in the International Classification of Diseases and Related Health Problems, eleventh revision (ICD-11). *Archives of Sexual Behaviour, 46*(5), 1529-1545.

Kruger, T. H., Sinke, C., Kneer, J., Tenbergen, G., Khan, A. Q., Burkert, A., ... & Frieling, H. (2019). Child sexual offenders show prenatal and epigenetic alterations of the androgen system. *Translational Psychiatry*, *9*(1), 28. https://doi.org/10.1038/s41398-018-0326-0

Kruttschnitt, C., Uggen, C., & Shelton, K. (2000). Predictors of desistance among sex offenders: The interaction of formal and informal social controls. *Justice Quarterly*, *17*(1), 61-87. https://doi.org/10.1080/07418820000094481

Kuhn, T. S. (1970). *The structure of scientific revolutions,* (2nd ed.). Chicago: University of Chicago Press.

Kuzma, J. M. and Black, D. W. (2008). Epidemiology, prevalence and natural history of compulsive sexual behavior. *Psychiatric Clinics of North America*, 31: 603–611. https://doi.org/10.1016/j.psc.2008.06.005

Kvale, S. (2006). Dominance through interviews and dialogues. *Qualitative Inquiry, 12*(3)*,* 480-500. https://doi.org/10.1177/1077800406286235

Landgren, V., Malki, K., Bottai, M., Arver, S., & Rahm, C. (2020). Effect of gonadotropin-releasing hormone antagonist on risk of committing child sexual abuse in men with pedophilic disorder: a randomized clinical trial. *JAMA psychiatry*, *77*(9), 897-905. doi:10.1001/jamapsychiatry.2020.0440

Landgren, V., Savard, J., Dhejne, C., Jokinen, J., Arver, S., Seto, M. C., & Rahm, C. (2022). Pharmacological Treatment for Pedophilic Disorder and Compulsive Sexual Behavior Disorder: A Review. *Drugs*, 1-19. https://doi.org/10.1007/s40265-022-01696-1

Langan, P. A., & Levin, D. J. (2002). *Recidivism of prisoners released in 1994*. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://doi.org/10.1525/fsr.2002.15.1.58

Langevin, R., Paitich, D., Hucker, S., Newman, S., Ramsay, G., Pope, S., ... & Anderson, C. (1979). The effect of assertiveness training, provera and sex of therapist in the treatment of genital exhibitionism. *Journal of Behavior Therapy and Experimental Psychiatry*, *10*(4), 275-282. https://doi.org/10.1016/0005-7916(79)90002-8

Långström, N., & Grann, M. (2007). Severe mental illness and risk of sexual offending in men: a case-control study based on Swedish national registers. *J Clin Psychiatry*, *68*(4), 588-596. https://doi.org/10.4088/jcp.v68n0415

Långström, N., & Hanson, K. (2006). High rates of sexual behaviour in the general population: Correlates and predictors, *35*(1), 37-52. https://doi.org/10.1007/s10508-006-8993-y

Långström, N., & Seto, M. C. (2006). Exhibitionistic and voyeuristic behaviour in a Swedish national population survey, *Archives of Sexual Behaviour, 35*, 427-453. https://doi.org/10.1007/s10508-006-9042-6

Lasher, M. P., & Stinson, J. D. (2017). Adults with pedophilic interests in the United States: Current practices and suggestions for future policy and research. *Archives of sexual behavior*, *46*, 659-670. https://doi.org/10.1007/s10508-016-0822-3

Lawrence, A. L., & Willis, G. M. (2021). Understanding and challenging stigma associated with sexual interest in children: A systematic review. *International Journal of Sexual Health*, *33*(2), 144-162. https://doi.org/10.1080/19317611.2020.1865498

Lazarus, R. S. (2006). Emotions and interpersonal relationships: Toward person-centered conceptualization of emotions and coping. Journal of Personality, 74(1), 9–46. https://doi.org/10.1111/j.1467-6494.2005.00368.x

Lee, Y., & Lee, R. M. (2012). Methodological research on sensitive topics: A decade review. *Bulletin of Sociological Methodology, 114,* 35-49. https://doi.org/10.1177/0759106312437139

Lehmann, R. J. B., Schmidt, A. F., & Jahnke, S. (2020). Stigmatization of paraphilias and psychological conditions linked to sexual offending. Journal of Sex Research, 58(4), 438–447. https://doi.org/10.1080/00224499.2020.1754748

Lehne, G. K., & Money, J. (2000). The first case of paraphilia treated with Depo-Provera: 40-year outcome. *Journal of Sex Education and Therapy*, *25*(4), 213-220. https://doi.org/10.1080/01614576.2000.11074353

Levenson, J. S., Brannon, Y. N., Fortney, T., & Baker, J. (2007). Public perceptions about sex offenders and community protection policies. *Analyses of Social Issues and Public Policy, 7*(1), 1-25.

Levenson, J. S., & Cotter, L. P. (2005a). The impact of sex offender residence restrictions: 1,000 feet from danger or one step from absurd?. *International Journal of Offender Therapy and Comparative Criminology*, *49*(2), 168-178. https://doi.org/10.1177/0306624X04271304

Levenson, J. S., & Cotter, L. P. (2005b). The effect of Megan's law on sex offender reintegration. *Journal of Contemporary Criminal Justice, 21*(1), 49–66. doi:10.1177/1043986204271676

Levenson, J., S. & Grady, M. D. (2019). Preventing sexual abuse: Perspectives of minor attracted persons about seeking help. *Sexual Abuse, 31*(8), 991-1013. https://doi.org/10.1177/1079063218797713

Levenson, J. S., Grady, M. D., & Morin, J. W. (2020). Beyond the 'ick factor": Counselling non-offending persons with paedophilia. *Clinical Social Work Journal, 48*(4), 380-388. https://doi.org/10.1007/s10615-019-00712-4

Levenson, J. S., & Hern, A. L. (2007). Sex offender residence restrictions: Unintended consequences and community reentry. Justice Research and Policy, 9(1), 59–73. doi:10.3818/JRP.9.1.2007.59

Levenson, J. S., Willis, G. M., & Prescott, D. (2018). Incorporating principles of trauma-informed care into evidence-based sex offending treatment. *New frontiers in offender treatment* (pp 171-188). Springer, Cham. https://doi.org/10.1007/978-3-030-01030-0_9

Levenson, J. S., Willis, G. M., & Prescott, D. S. (2020). Evidence-based practice and the role of trauma-informed care in sex offending treatment. *Sexual crime and trauma*, 197-224. https://doi.org/10.1007/978-3-030-49068-3_8

Levenson, J.S., Willis, G. M., & Vicencio, C. P. (2017). Obstacles to help-seeking for sexual offenders: Implications for prevention of sexual abuse. *Journal of Child Sexual Abuse, 26*(2), 99-120. https://doi.org/10.1080/10538712.2016.1276116

Levin, R. J. (2008). Critically revisiting aspects of the human sexual response cycle of Masters and Johnson: Correcting errors and suggesting modifications. *Sexual and Relationship Therapy*, *23*(4), 393-399. https://doi.org/10.1080/14681990802488816

Levin, R., & Riley, A. (2007). The physiology of human sexual function. *Psychiatry*, *6*(3), 90-94. https://doi.org/10.1016/j.mppsy.2007.01.004

Lew-Starowicz, M., & Coleman, E. (2022). Mental and sexual health perspectives of the International Classification of Diseases (ICD-11) Compulsive Sexual Behavior Disorder: Commentary to the debate:"Behavioral addictions in the ICD-11". *Journal of Behavioral Addictions*, *11*(2), 226-229. https://doi.org/10.1556/2006.2022.00032

Lew-Starowicz, M., Draps, M., Kowalewska, E., Obarska, K., Kraus, S. W., & Gola, M. (2022). Tolerability and efficacy of paroxetine and naltrex- one for treatment of compulsive sexual behaviour disorder. *World Psychiatry*, *21*(3), 468–469. https://doi.org/10.1002/WPS.21026

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, 25*(3), 262-287. https://doi.org/10.1080/14789949.2014.909867

Lievesley, R., & Harper, C. A. (2022). Applying desistance principles to improve wellbeing and prevent child sexual abuse among minor-attracted persons. *Journal of sexual aggression*, *28*(1), 1-14. https://doi.org/10.1080/13552600.2021.1883754

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry,* Sage.

Lippi, G., & van Staden, P. J. (2017). The use of cyproterone acetate in a forensic psychiatric cohort of male sex offenders and its associations with sexual activity and sexual functioning. *South African Journal of Psychiatry*, 23(1), 1–8. https://doi.org/10.4102/sajpsychiatry.v23i0.982

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K., & Payne, S. (2001). Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ, 323*(7318), 908-911. https://doi.org/10.1136/bmj.323.7318.908

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology, 1*(1), 117-146. https://doi.org/10.1007/s11292-004-6466-7

Lowe, G., & Willis, G. (2020). "Sex offender" versus "person": the influence of labels on willingness to volunteer with people who have sexually abused. *Sexual Abuse*, *32*(5), 591-613. https://doi.org/10.1177/1079063219841904

Lussier, P., McCuish, E., Chouinard Thivierge, S., & Frechette, J. (2023b). A meta-analysis of trends in general, sexual, and violent recidivism among youth with histories of sex offending. *Trauma, Violence, & Abuse*, 1-19. https://doi.org/10.1177/152483802211376

Lussier, P., McCuish, E., Proulx, J., Chouinard Thivierge, S., & Frechette, J. (2023a). The sexual recidivism drop in Canada: A meta-analysis of sex offender recidivism rates over an 80-year period. *Criminology & Public Policy*, *22*(1), 125-160. https://doi.org/10.1111/1745-9133.12611

Maletzky, B., M., Tolan, A., & McFarland, B. (2006). The Oregon depo-Provera programme: A fine year follow up. *Sexual Abuse, 18*(3), 303-316. https:// doi.org/10.1007/s11194-006-9021-4

Mallon, S., & Elliott, I. (2019). The emotional risks of turning stories into data: An exploration of the experiences of qualitative researchers working on sensitive topics. *Societies (Basel Switzerland) 9*(3), 62-78. https://doi.org/10.3390/soc9030062

Malta, S., Temple-Smith, M., Bickerstaffe, A., Bourchier, L., & Hocking, J. (2020). 'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care. *Australasian Journal on Ageing, 39 Suppl 1*(s1), 40-48. https://doi.org/10.1111/ajag.12762

Mandeville-Norden, R., Beech, A., & Hayes, E. (2008). Examining the effectiveness of a UK community-based sexual offender treatment programme for child abusers. *Psychology, Crime & Law*, *14*(6), 493-512. https://doi.org/10.1080/10683160801948907

Mann, N., Devendran, P. N., & Lundrigan, S. (2021). 'You're never really free': Understanding the barriers to desistance for registered sexual offenders in the community. *Criminology & Criminal Justice*, *21*(2), 206-223. https://doi.org/10.1177/1748895819853861

Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse, 22*(2), 191-217. https://doi.org/10.1177/1079063210366039

Manninen, S. M., Kero, K., Perkonoja, K., Vahlberg, T., & Polo-Kantola, P. (2021). General practitioners' self-reported competence in the management of sexual health issues–a web-based questionnaire study from Finland. *Scandinavian journal of primary health care*, *39*(3), 279-287. https://doi.org/10.1080/02813432.2021.1934983

Marchand, J. F. (2004). Husbands' and wives' marital quality: The role of adult attachment orientations, depressive symptoms, and conflict resolution behaviours. *Attachment & Human Development, 6*, 99–112. https://doi.org/10.1080/14616730310001659575

Marshall, W. L., & Marshall, L. E. (2000). The origins of sexual offending. *Trauma, Violence, & Abuse*, *1*(3), 250-263. https://doi.org/10.1177/1524838000001003003

Marshall, L. E., O'Brien, M. D., Marshall, W., Booth, B., & Davis, A. (2012). Obsessive-compulsive disorder, social phobia, and loneliness in incarcerated internet child pornography offenders. Sexual Addiction & Compulsivity, 19(1-2), 41–52. https://doi.org/10.1080/10720162.2012.665291 Actions

Marshall, W. L., Marshall, L. E & Serran, G.A. (2006). Strategies in the treatment of paraphilias: A critical review. *Annual Review of Sex Research, 17*(1), 162-182. https://doi.org/10.1080/10532528.2006.10559841

Maruna, S. (2001) Making Good: How Ex-convicts Reform and Rebuild their Lives. Washington, DC: American Psychological Association. https://doi.org/10.1037/10430-000

Maruna, S., LeBel, T. P., Mitchell, N., & Naples, M. (2004). Pygmalion in the reintegration process: desistance from crime through the looking glass. Psychology, Crime & Law, 10, 271–281. https://doi.org/10.1080/10683160410001662762

Masters, W., & Johnson, V. E. (1966). *Human Sexual Response.* New York: Little, Brown and Company.

Mathison, S. (1988). Why triangulate? *Educational researcher*, *17*(2), 13-17. https://doi.org/10.3102/0013189X017002013

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, *62*(3), 279-300. https://doi.org/10.17763/haer.62.3.8323320856251826

Mayrhofer, G., Wegner, D., & Voß, T. (2016). Urolithiasis in the long-term GnRH agonist treatment of patients with paraphilia: 3 case studies. *Aktuelle Urologie*, *47*(6), 487-490. https://doi.org/10.1055/s-0042-112999

McAlinden, A. M. (2012). The governance of sexual offending across Europe: Penal policies, political economies and the institutionalization of risk. *Punishment & Society*, *14*(2), 166-192. https://doi.org/10.1177/1462474511435573

McCartan, K., Hoggett, J., & Kemshall, H. (2018). Risk Assessment and Management of Individual's Convicted of a Sexual Offence in the UK.

McCartan, K., & Kemshall, H. (2023). Incorporating quaternary prevention: Understanding the full scope of public health practices in sexual abuse prevention. *International Journal of Offender Therapy and Comparative Criminology*, *67*(2-3), 224-246. https://doi.org/10.1177/0306624X211049204

McConaghy, N., Blaszczynski, A., & Kidson, W. (1988). Treatment of sex offenders with imaginal desensitization and/or medroxyprogesterone. *Acta Psychiatrica Scandinavica*, *77*(2), 199-206. https://doi.org/10.1111/j.1600-0447.1988.tb05101.x

McCusker, M. G., & Galupo, M. P. (2011). The impact of men seeking help for depression on perceptions of masculine and feminine characteristics. *Psychology of Men & Masculinity*, *12*(3), 275. https://doi.org/10.1037/a0021071

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical Teacher,* *41*(9), 1002-1006. https://doi.org/10.1080/0142159X.2018.1497149

McMurran, M., & Christopher, G. (2009). Social problem solving, anxiety, and depression in adult male prisoners. *Legal and Criminological Psychology*, *14*(1), 101-107. https://doi.org/10.1348/135532507X267031

Meston, C. M., & Frohlich, P. F. (2000). The neurobiology of sexual function. *Archives of General Psychiatry*, *57*(11), 1012-1030. doi:10.1001/archpsyc.57.11.1012

Mews, A., Di Bella, L., Purver, M. (2017). *Impact evaluation of the prison-based core sex offender treatment programme.* London: Ministry of Justice.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, W. J., Cole, C., & Emory, E. (1992). Depo provera treatment for sex offending behavior: An evaluation of outcome. *Journal of the American Academy of Psychiatry and the Law Online*, *20*(3), 249-259. https://doi.org/10.1016/0006-3223(92)90592-n

Michael, R. T., Gagnon, J. H., Lauman, E. O., & Kolata, G. (1994). *Sex in America: A definitive survey*. London: Little, Brown.

Miller, H. A. (2006). A dynamic assessment of offender risk, needs, and strengths in a sample of pre-release general offenders. *Behavioral sciences & the law*, *24*(6), 767-782. https://doi.org/10.1002/bsl.728

Miller, N. & Brimicombe, A. (2010). Mapping research journeys across complex terrain with heavy baggage. *Studies in Continuing Education*, 26 (3): 405-417. https://doi.org/10.1080/0158037042000265962

Miltenberger, R. G. (2008). Behavior modification: Principles and procedures (4th ed.). Belmont, CA: Thomson.

Miner, M., Coleman, E., Center, B., Ross, M., & Rosser, S. (2007). The compulsive sexual behaviour inventory: Psychometric properties. *Archives of Sexual Behaviour, 36*(4), 579-587.

MOJ (2013, May). New sex offender treatment programmes. https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=web&cd=&ved=0CDcQw7AJahcKEwi49638v76BAxUAAAAAHQAAAAAQAw&url=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F259044%2Fsex-offender-treatment-programmes.doc&psig=AOvVaw3_n3TnEWIzVtkWpuur8Zmt&ust=1695481781175972&opi=89978449

MOJ (2022, March). Proven reoffending statistics quarterly bulletin, January to March 2020. https://www.gov.uk/government/statistics/proven-reoffending-statistics-january-to-march-2020

Molinoff, P. B., Shadiack, A. M., Earle, D., Diamond, L. E., & Quon, C. Y. (2003). PT-141: A melanocortin agonist for the treatment of sexual dysfunction. *Annals of the New York Academy of Sciences*, *994*(1), 96-102. https://doi.org/10.1111/j.1749-6632.2003.tb03167.x

Monks, R., Topping, A., & Newell, R. (2013). The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: a grounded theory study. *Journal of advanced nursing*, *69*(4), 935-946. https://doi.org/10.1111/j.1365-2648.2012.06088.x

Montgomery-Graham, S. (2017). Conceptualization and assessment of hypersexual disorder: A systematic review of the literature. *Sexual Medicine Reviews*, *5*(2), 146-162. https://doi.org/10.1016/j.sxmr.2016.11.001

Montejo, A., Llorca, G., Izquierdo, J., and Rico-Villademoros, F. (2001). Incidence of sexual dysfunction associated with antidepressant agents: A prospective multicentre study of 1022 outpatients. *Journal of Clinical Psychiatry, 62*(1), 10-21.

Moreira, E. D., Glasser, D. B., Nicolosi, A., Duarte, F. G., Gingell, C., & CSSAB Investigators' Group. (2008). Sexual problems and help-seeking behaviour in adults in the United Kingdom and

continental Europe. *BJU International, 101*(8), 1005-1011. https://doi.org/10.1111/j.1464-410X.2008.07453.x

Morgan, D. L. (2007). Paradigms lost and pragmatism regained. Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research, 1*(1), 48-76. https://doi.org/10.1177/2345678906292462

Morgenstern, J., Muench, F., O'Leary, A., Wainberg, M., Parson, J., Hollander, E., Blain, L., & Irwin, T. (2011). Non-paraphilic compulsive sexual behaviour and psychiatric co-morbidities in gay and bi-sexual men. *Sexual Addiction and Compulsivity, 18*, 114-134.

Morrison-Saunders, A., Moore, S.A., Hughes, M., & Newsome, D. (2010). Coming to terms with research practice: Riding the emotional rollercoaster of doctoral research studies. In M. Walker, & P. Thomson (Eds.), *The Routledge Doctoral Supervisor's Companion: Supporting effective research in Education and the Social Sciences* (pp. 206-218). London: Routledge.

Morse, J. M. (1994). Emerging from the data: The cognitive processes of analysis in qualitative inquiry. In Morse, J. M. (Ed..). *Qualitative Research Methods.* Newbury Park: Sage.

Moser, C. (2011). Hypersexual Disorder: Just More Muddled Thinking. *Arch Sex Behav* **40**, 227–229. https://doi.org/10.1007/s10508-010-9690-4

Moulier, V., Fonteille, V., Pélégrini-Issac, M., Cordier, B., Baron-Laforêt, S., Boriasse, E., ... & Stoléru, S. (2012). A pilot study of the effects of gonadotropin-releasing hormone agonist therapy on brain activation pattern in a man with pedophilia. *International Journal of Offender Therapy and Comparative Criminology*, *56*(1), 50-60. https://doi.org/10.1177/0306624X10392191

Muench, F., Morgenstern, J., Hollander, E., Irwin, T., O'Leary, A., Parsons, J., Wainberg, M., & Lai, B. (2007). The consequences of compulsive sexual behaviour: The preliminary reliability and validity of the compulsive sexual behaviour consequences scale. *Sexual Addiction and Compulsivity, 14*, 207-220.

Nacro (2018). *Interventions for Perpetrators of Child Sexual Exploitation.* Retrived 18/02/2019 from https://www.csacentre.org.uk/csa-centre-prod/assets/File/CSE%20perpetrators%204%20-%20Interventions%20for%20perpetrators%20of%20CSE.pdf

Nelson, K. G., & Oehlert, M. E. (2008). Psychometric exploration of the Sexual Addiction Screening Test in veterans. *Sexual Addiction & Compulsivity*, *15*(1), 39-58. https://doi.org/10.1080/10720160701876609

Newman, I., Benz, C. R., & Ridenour, C. S. (1998). *Qualitative quantitative research methodology: Exploring the interactive continuum.* SIU Press.

NHS (2018, March). Responsibility for prescribing between Primary and Secondary/Tertiary Care. https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

NHS (2021, September). Nottinghamshire Area Prescribing Committee. https://www.nottinghamshireformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.03.04.02

NHS (2022a, December). Side effects – Selective Serotonin Reuptake Inhibitors (SSRIs). https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/ssri-antidepressants/side-effects/

NHS (2022b, February). Common questions about fluoxetine. https://www.nhs.uk/medicines/fluoxetine-prozac/common-questions-about-fluoxetine/

NHS (2022c, June). Psychiatry. https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/psychiatry/

NICE (2015, September). *Hypersexuality: Fluoxetine.* Retrieved 25/10/2018 from https://www.nice.org.uk/advice/esuom46/chapter/Key-points-from-the-evidence

NICE (2022, February). Fluoxetine. https://bnf.nice.org.uk/drug/fluoxetine.html#sideEffects

Nielsen, M. H., Aaskov, L., & Larsen, J. E. (2022). When virtuous paedophiles meet online: A sociological study of a paedophile community. *Sexualities*, *25*(5-6), 598-614. https://doi.org/10.1037/sah0000317

Nimbi, F. M., Tripodi, F., Rossi, R., & Simonelli, C. (2018). Testing a conceptual model for men's sexual desire referring to automatic thoughts, emotions, sexual function, and sexism. *The Journal of Sexual Medicine*, *15*(11), 1518-1526. https://doi.org/10.1016/j.jsxm.2018.09.008

Nowell, L. S., Morris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1-13. https://doi.org/10.1177/1609406917733847

O'Connor, S. R., Connaghan, J., Maguire, R., Kotronoulas, G., Flannagan, C., Jain, S., ... & McCaughan, E. (2019). Healthcare professional perceived barriers and facilitators to discussing sexual wellbeing with patients after diagnosis of chronic illness: A mixed-methods evidence synthesis. *Patient education and counseling*, *102*(5), 850-863.https://doi.org/10. 1016/j.pec.2018.12.015

Odlaug, B. L., Lust, K., Schreiber, L. R., Christenson, G., Derbyshire, K., Harvanko, A., Golden, D., & Grant, J. E. (2013). Compulsive sexual behavior in young adults. *Annals of Clinical Psychiatry*, *25*(3), 193-200.

Onwuegbuzie, A. J. & Burke Johnson, R. (2006). The validity issue in mixed research. *Research in the Schools*, 13(1), 48-63.

Onwuegbuzie, A. J., & Leech, N. L. (2005). On becoming a pragmatic researcher: The importance of combining quantitative and qualitative methodologies. *International Journal of Social Research Methodology*, 8(5), 375-387. https://doi.org/10.1080/13645570500402447

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological bulletin*, *133*(2), 328. https://doi.org/10.1037/0033-2909.133.2.328

Park, W. S., Kim, K. M., Jung, Y. W., & Lim, M. H. (2014). A case of mental retardation with paraphilia treated with depot leuprorelin. *Journal of Korean medical science*, *29*(9), 1320-1324. https://doi.org/10.3346/jkms.2014.29.9.1320

Patton, M. Q (2002). *Qualitative research and evaluation methods.* 3rd ed. Thousand Oaks, Sage.

Patton, M. Q. (2014). *Qualitative research and evaluation methods: Integrating theory and practices.* Sage.

Paunovic, N., & Hallberg, J. (2014) Conceptualisation of hypersexual disorder with the behavioural-cognitive inhibition theory. *Psychology, 5*, 151-159. https://doi.org/10.4236/psych.2014.52024

Payne, G. & Payne, J. (2004). Objectivity. In Payne, G. & Payne, J. *Sage Key Concepts: Key Concepts in Social Research.* (pp.153-157). London: Sage. https://doi.org/10.4135/9781849209397.n32

Perilstein, R., Lipper, S., and Friedman, L. (1991). Three cases of paraphilias responsive to fluoxetine treatment. *The Journal of Clinical Psychiatry, 52,* 169-170.

Pettorruso, M., Collevecchio, R., Zoratto, F., Collacchi, B., Boffa, M., Santorelli, M., Clerici, M., Martinotti, G., & Borgi, M. (2023). Social connection and depression: an umbrella review of meta-analyses assessing the magnitude of risk and protection. *European Psychiatry*, 66, S415 - S416. https://doi.org/10.1192/j.eurpsy.2023.896.

Pfaus, J. G. (2009). Pathways of sexual desire. *The journal of sexual medicine*, *6*(6), 1506-1533. https://doi.org/10.1111/j.1743-6109.2009.01309.x

Pfaus, J. G., & Scepkowski, L. A. (2005). The biological basis for libido. *Current Sexual Health Reports, 2*(2), 95-100. https://doi.org/10.1007/s11930-005-0010-2

Piché, L., Mathesius, J., Lussier, P., & Schweighofer, A. (2018). Preventative services for sexual offenders. *Sexual Abuse, 30*(1), 63-81. https://doi.org/10.1177/1079063216630749

Pitt, K., Dheensa, S., Feder, G., Johnson, E., Man, M-S., Roy, J., Williamson, E., & Szilassy, E. (2020). Sharing reports about domestic violence and abuse with general practitioners: A qualitative interview study. *BMC Family Practice, 21*(1) 117. https://doi.org/10.1186/s12875-020-01171-4

Polak, M. A., & Nijman, H. (2005). Pharmacological treatment of sexually aggressive forensic psychiatric patients. *Psychology, Crime & Law*, *11*(4), 457-465. https://doi.org/10.1080/10683160500256669

Porst, H., Montorsi, F., Rosen, R. C., Gaynor, L., Grupe, S., & Alexander, J. (2007). The Premature Ejaculation Prevalence and Attitudes (PEPA) survey: prevalence, comorbidities, and professional help-seeking. *European urology*, *51*(3), 816-824. https://doi.org/10.1016/j.eururo.2006.07.004

Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: a population-based cohort study. *The Lancet*, *368*(9530), 119-123. https://doi.org/10.1016/S0140-6736(06)69002-8

Quayle, E., & Taylor, M. (2002). Child pornography and the Internet: Perpetuating a cycle of abuse. *Deviant behavior*, *23*(4), 331-361. https://doi.org/10.1080/01639620290086413

Quinn, C., Denman, K., Smithson, P., Owens, C., Sheaff, R., Campbell, J., ... & Byng, R. (2018). General practitioner contributions to achieving sustained healthcare for offenders: a qualitative study. *BMC family practice*, *19*(1), 1-7. https://doi.org/10.1186/s12875-018-0708-7

Ramanathan, V., & Redelman, M. (2020). Sexual dysfunctions and sex therapy: The role of a general practitioner. *Australian Journal of General Practice*, *49*(7), 412-415.

Ramsay, L., Carter, A. J., & Walton, J. S. (2020). Contemporary programmes designed for the tertiary prevention of recidivism by people convicted of a sexual offence: A review and the UK perspective. *The Wiley Handbook of What Work with Sexual Offenders: Contemporary Perspectives in Theory, Assessment, Treatment and Prevention,* 185-199. https://doi.org/10.1002/9781119439325.ch11

Rasool, S. F., Maqbool, R., Samma, M., Zhao, Y., & Anjum, A. (2019). Positioning depression as a critical factor in creating a toxic workplace environment for diminishing worker productivity. *Sustainability*, *11*(9), 2589. doi:10.3390/su11092589

Raymond, N., Coleman, E., & Miner, M. (2003). Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behaviour. *Comprehensive Psychiatry, 44*(5), 370-380. https://doi.org/10.1016/s0010-440x(03)00110-x

Rayner, L., Hotopf, M., Petkova, H., Matcham, F., Simpson, A., & McCracken, L. M. (2016). Depression in patients with chronic pain attending a specialised pain treatment centre: prevalence and impact on health care costs. *Pain*, *157*(7), 1472. doi: 10.1097/j.pain.0000000000000542

Redouté, J., Stoléru, S., Grégoire, M. C., Costes, N., Cinotti, L., Lavenne, F., Le Bars, D., Forest, M. G., & Pujol, J. F. (2000). Brain processing of visual sexual stimuli in human males. *Human brain mapping*, *11*(3), 162-177. https://doi.org/10.1002/10970193(200011)11:3<162::AID-HBM30>3.0.CO;2-A

Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., ... & Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World psychiatry*, *15*(3), 205-221. https://doi.org/10.1002/wps.20354

Reid, R. C. (2010). Differentiating emotions in a sample of men in treatment for hypersexual behaviour. *Journal of Social Work Practice in the Addictions, 10*(2), 197-213. https://doi.org/10.1080/15332561003769369

Reid, R. C., Carpenter, B. N., Hook, J. N., Garos, S., Manning, J. C., Gilliland, R., Cooper, E. B., McKittrick, H., Davtian, M., & Fong, T. (2012a). Report of findings in a DSM-5 field trial for hypersexual disorder. *The journal of sexual medicine*, *9*(11), 2868-2877. DOI: 10.1111/j.1743-6109.2012.02936.x

Reid, R. C., Carpenter, B. N., & Lloyd, T. Q. (2009). Assessing psychological symptom patterns of patients seeking help for hypersexual behavior. *Sexual and Relationship Therapy*, *24*(1), 47-63. https://doi.org/10.1080/14681990802702141

Reid, R. C., Carpenter, B. N., Spackman, M., & Willes, D. L. (2008). Alexithymia, emotional instability, and vulnerability to stress proneness in patients seeking help for hypersexual behavior. *Journal of Sex and Marital Therapy, 34*(2), 133–149. https://doi.org/ 10.1080/00926230701636197

Reid, R. C., Garos, S., Carpenter, B. N., & Coleman, E. (2011). A surprising finding related to executive control in a patient sample of hypersexual men. *The journal of sexual medicine*, *8*(8), 2227-2236. https://doi.org/10.1111/j.1743-6109.2011.02314.x

Reid, R. C., Garos, S., & Fong, T. (2012b). Psychometric development of the hypersexual behavior consequences scale. *Journal of Behavioral Addictions*, *1*(3), 115-122. https://doi.org/10.1556/jba.1.2012.001

Reid, R. C., Harper, J. M., & Anderson, E. H. (2009). Coping strategies used by hypersexual patients to defend against the painful effects of shame. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *16*(2), 125-138. https://doi.org/10.1002/cpp.609

Reid, R. C., Karim, R., McCrory, E., & Carpenter, B. N. (2010). Self-reported differences on measures of executive function and hypersexual behaviour in a patient and community sample of men. *International Journal of Neuroscience*, *120*(2), 120-127. https://doi.org/10.3109/00207450903165577

Reid, R. C., & Kafka, M. P. (2014). Controversies about hypersexual disorder and the DSM-5. *Current Sexual Health Reports*, *6*, 259-264. https://doi.org/10.1007/s11930-014-0031-9

Reid, R. C., & Woolley, S. R. (2006). Using emotionally focused therapy for couples to resolve attachment ruptures created by hypersexual behaviour. *Sexual Addiction and Compulsivity, 13*(2-3), 219-239. https://doi.org/10.1080/10720160600870786

Rimer, J. R., & Holt, K. (2023). "It was in Control of Me": Notions of Addiction and Online Child Sexual Exploitation Material Offending. *Sexual Abuse*, *35*(1), 3-30. https://doi.org/10.1177/10790632211070797

Rinehart, N., & McCabe, M. (1997). Hypersexuality: Psychopathology or normal variant of sexuality. *Sexual and Marital Therapy, 12*, 45-60. https://doi.org/10.1080/02674659708408201

Robertson, T. M., Magyar-Russell, G. M., & Piedmont, R. L. (2020). Let him who is without sin cast the first stone: Religious struggle among persons convicted of sexually offending. *Religions*, *11*(11), 546. https://doi.org/10.3390/rel11110546

Robinson, P. (1976). *The modernization of sex*. London: Elek.

Robinson, T., & Valcour, F. (1995). The use of depo-provera in the treatment of child molesters and sexually compulsive males. *Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention*, *2*(4), 277-294. https://doi.org/10.1080/10720169508400089

Rösler, A., & Witztum, E. (1998). Treatment of men with paraphilia with a long-acting analogue of gonadotropin-releasing hormone. *New England Journal of Medicine*, *338*(7), 416-422. DOI: 10.1056/NEJM199802123380702

Rousseau, L., Couture, M., Dupont, A., Labrie, F., & Couture, N. (1990). Effect of combined androgen blockade with an LHRH agonist and flutamide in one severe case of male exhibitionism. https://doi.org/10.1177/070674379003500412

Rowley, J. (2012). Conducting research interviews. *Management Research Review, 35*(3/4), 260-271.

Runswick-Cole, K. (2011). Interviewing. In Banister, P., Bunn, G., Burman, E., Daniel, J., Duckett, P., Goodley, D., Lawthom, R., Parker, I., Runswick-Cole, K., Sixsmith, J., Smailes, S., Tindall, C., & Whelan, P. (Eds.), *Qualitative Methods in Psychology: A Research Guide.* (2nd Ed. Pp.88-100). Open University Press.

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Dezin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 769-902). Sage.

Sachs, B. (2000). Contextual approaches to the physiology and classification of erectile function, erectile dysfunction, and sexual arousal. *Neuroscience and Biobehavioural Reviews, 24,* 541-560 https://doi.org/10.1016/S0149-7634(00)00022-1

Sachs, B. (2007). A contextual definition of male sexual arousal. *Hormones and Behaviour, 51*(5), 569-578. https://doi.org/10.1016/j.yhbeh.2007.03.011

Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. S. (2019). Improving mental health service utilization among men: a systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American journal of men's health*, *13*(3), 1557988319857009. https://doi.org/10.1177/1557988319857009

Saleh, F. (2005). A hypersexual paraphilic patient treated with leuprolide acetate: a single case report. *Journal of Sex & Marital Therapy*, *31*(5), 433-444. https://doi.org/10.1080/00926230591006782

Saleh, F., & Berlin, F. (2004). Sex hormones, neurotransmitters, and psychopharmacological treatments in men with paraphilic disorders. *Journal of Child Sexual Abuse, 12*, 233-253. https://doi.org/10.1300/J070v12n03_09

Saleh, F. M., Niel, T., & Fishman, M. J. (2004). Treatment of paraphilia in young adults with leuprolide acetate: a preliminary case report series. *Journal of forensic sciences*, *49*(6), JFS2003035-6. https://doi.org/10.1520/JFS2003035

Salner, M. (1989). Validity in human science research. In *Nordic Postgraduate Research Course: The Question of Validity in Qualitative Research in the Social Sciences, Aug, 1988, Bergby Gaard, Sweden*. Studentlitteratur.

Sampson, R. J., & Laub, J. H. (1997). A life-course theory of cumulative disadvantage and the stability of delinquency. *Developmental theories of crime and delinquency*, *7*, 133-161.

Sampson, R. J., & Laub, J. H. (2005). A life-course view of the development of crime. *The Annals of the American Academy of Political and Social Science*, *602*(1), 12-45. https://doi.org/10.4324/9781315094908-13

Sampson, R. J., & Laub, J. H. (2017). A general age-graded theory of crime: Lessons learned and the future of life-course criminology. In *Integrated developmental and life-course theories of offending* (pp. 165-182). Routledge. https://doi.org/10.4324/9780203788431-7

Santini, Z., Koyanagi, A., Tyrovolas, S., Mason, C., & Haro, J. (2015). The association between social relationships and depression: a systematic review.. *Journal of affective disorders*, 175, 53-65 . https://doi.org/10.1016/j.jad.2014.12.049.

Savoie, V., Quayle, E., & Flynn, E. (2021). Prevalence and correlates of individuals with sexual interest in children: A systematic review. *Child Abuse & Neglect*, *115*, 105005. https://doi.org/10.1016/j.chiabu.2021.105005

Scanavino, M. D., Ventuneac, A., Abdo, C. H., Tavares, H., Amaral, M. L., Messina, B., ... & Parsons, J. T. (2018). Sexual compulsivity, anxiety, depression, and sexual risk behavior among treatment-seeking men in São Paulo, Brazil. *Brazilian Journal of Psychiatry*, *40*, 424-431. https://doi.org/10.1590/1516-4446-2017-2476

Scanavino, M. D. T., Ventuneac, A., Caramelli, B., Naufal, L., Santos Filho, C. S. D., Nisida, I. V. V., Amaral, M. L. S., Vieira, J. C., & Parsons, J. T. (2019). Cardiovascular and psychopathological factors among non-sexually compulsive, sexually compulsive, and hypersexual individuals in Sao Paulo, Brazil. *Psychology, Health and Medicine*, *25* (1), 121–129. https://doi.org/10.1080/13548506.2019.1687916

Schaller, S., Traeen, B., & Lundin Kvalem, I. (2020). Barriers and facilitating factors in help-seeking: A qualitative study on how older adults experience talking about sexual issues with healthcare personnel. *International Journal of Sexual Health, 32*(2), 65-80. https://doi.org/10.1080/19317611.2020.1745348

Scheele, D., Wille, A., Kendrick, K. M., Stoffel-Wagner, B., Becker, B., Güntürkün, O., Maier, W., & Hurlemann, R. (2013). Oxytocin enhances brain reward system responses in men viewing the face of their female partner. *Proceedings of the National Academy of Sciences*, *110*(50), 20308-20313. https://doi.org/10.1073/pnas.1314190110

Schiffer, B., Gizewski, E., & Kruger, T. (2009). Reduced neuronal responsiveness to visual sexual stimuli in a pedophile treated with a long-acting LH-RH agonist. *The Journal of Sexual Medicine*, *6*(3), 892-894. https://doi.org/10.1111/j.1743-6109.2008.01094.x

Schloegl, I., Köhn, F. M., Dinkel, A., Schulwitz, H., Gschwend, J. E., Bosinski, H. A. G., & Herkommer, K. (2016). Education in sexual medicine – a nationwide study among German urologists/andrologists and urology residents. *Andrologia, 49*(2), e12611. https://doi.org/10.1111/and.12611

Schloss, P., & Williams, D. C. (1998). The serotonin transporter: a primary target for antidepressant drugs. *Journal of psychopharmacology*, *12*(2), 115-121. https://doi.org/10.1177/026988119801200201

Schober, J. M., Kuhn, P. J., Kovacs, P. G., Earle, J. H., Byrne, P. M., & Fries, R. A. (2005). Leuprolide acetate suppresses pedophilic urges and arousability. *Archives of Sexual Behavior*, *34*(6), 691-705. https://doi.org/10.1007/s10508-005-7929-2

Schmucker, M., & Lösel, F. (2015). The effects of sexual offender treatment on recidivism: An international meta-analysis of sound quality evaluations. Journal of Experimental Criminology, 11, 597-630. https://doi.org/10.1007/s11292-015-9241-z

Schmucker, M., & Lösel, F. (2017). Sexual offender treatment for reducing recidivism among convicted sex offenders: a systematic review and meta-analysis. *Campbell Systematic Reviews*, *13*(1), 1-75. https://doi.org/10.4073/csr.2017.8

Schneider, R. L., Arch, J. J., Landy, L. N., & Hankin, B. L. (2018). The longitudinal effect of emotion regulation strategies on anxiety levels in children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, *47*(6), 978-991. https://doi.org/10.1080/15374416.2016.1157757

Schultz, K., Hook, J. N., Davis, D. E., Penberthy, J. K., & Reid, R. C. (2014). Nonparaphilic hypersexual behavior and depressive symptoms: A meta-analytic review of the literature. *Journal of sex & marital therapy*, *40*(6), 477-487. https://doi.org/10.1080/0092623X.2013.772551

Schwandt, T. (2000). Three epistemological stances for qualitative inquiry. In N. K. Denzin & Y.S. Lincoln (Eds.). *Handbook of Qualitative Research* (2nd Ed..). (189-213). Thousand Oaks: Sage.

Scott, C. L., & Holmberg, T. (2003). Castration of sex offenders: prisoners' rights versus public safety. *Journal of the American Academy of Psychiatry and the Law Online*, *31*(4), 502-509.

Seto, M. C. (2008). *Pedophilia and sexual offending against children: Theory, assessment, and intervention.* American Psychological Association. https://doi.org/10.1037/11639-000

Seto, M. C., Kingston, D. A., & Bourget, D. (2014). Assessment of the paraphilias. *Psychiatric Clinics of North America, 37*(2), 149-161. https://doi.org/10.1016/j.psc.2014.03.001

Seto, M.C., Hermann, C. A., Kjellgren, C., Priebe, G., Svedin, C. G., Långström, N. (2015). Viewing child pornography: Prevalence and correlates in a representative community sample of young Swedish men. *Archives of Sexual Behaviour, 44*(1), 67-79. https://doi.org/10.1007/s10508-013-0244-4

Seto, M. C. (2019). The motivation-facilitation model of sexual offending. *Sexual Abuse, 31*(1), 3-24. https://doi.org/10.1177/1079063217720919

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis, 22*(1), 16-31.

Shiwach, R. S., & Prosser, J. (1998). Treatment of an unusual case of masochism. *Journal of Sex & Marital Therapy*, *24*(4), 303-307. https://doi.org/10.1080/00926239808403965

Sibille, E., & Lewis, D. A. (2006). SERT-ainly involved in depression, but when? *American Journal of Psychiatry*, *163*(1), 8-11. https://doi.org/10.1176/appi.ajp.163.1.8

Slowther, A. (2010). Confidentiality in primary care: Ethical and legal considerations. *InnovAiT, 3*(12), 753-759. https://doi.org/10.1093/innovait/inq096

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*(2), 261-271. https://doi.org/10.1080/08870449608400256

Smith, J. A. (2003). Validity and qualitative psychology. In J. A. Smith (ed.), *Qualitative psychology: A practical guide to research methods* (232-235). Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (ed.), *Qualitative psychology: A practical guide to research methods* (53-80). Sage

Sniewski, L., & Farvid, P. (2019). Abstinence or acceptance? A case series of men's experiences with an intervention addressing self-perceived problematic pornography use. *Sexual Addiction & Compulsivity*, *26*(3-4), 191-210. https://doi.org/10.1080/10720162.2019.1645058

Sniewski, L., & Farvid, P. (2020). Hidden in shame: Heterosexual men's experiences of self-perceived problematic pornography use. *Psychology of Men and Masculinities, 21*(2), 201-212. https://doi.org/10.1037/men0000232

Starks, T. J., Grov, C., & Parsons, J. T. (2013). Sexual compulsivity and interpersonal functioning: Sexual relationship quality and sexual health in gay relationships. *Health Psychology, 32*(10), 1047-1056. https://doi.org/10.1037/a0030648

Stein, D., Hollander, E., Anthony, D., Schneier, F., Fallon, B., Liebowitz, M., and Klein, D. (1992). Serotonergic medications for sexual obsessions, sexual addictions and paraphilias. *The Journal of Clinical Psychiatry, 53*(8), 267-271.

Stevens, E., & Wood, J. (2019). "I despise myself for thinking about them." A thematic analysis of the mental health implications and employed coping mechanisms of self-reported non-offending minor attracted persons. *Journal of child sexual abuse*, *28*(8), 968-989. https://doi.org/10.1080/10538712.2019.1657539

Stoleru, S., Gregoire, M. C., Gerard, D., Decety, J., Lafarge, E., Cinotti, L., ... & Comar, D. (1999). Neuroanatomical correlates of visually evoked sexual arousal in human males. *Archives of sexual behavior*, *28*, 1-21. https://doi.org/10.1023/A:1018733420467

Studer, L. H., Aylwin, A. S., & Reddon, J. R. (2005). Testosterone, sexual offense recidivism, and treatment effect among adult male sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 171-181. https://doi.org/10.1007/s11194-005-4603-0

Syse, A. (2000). Norway: valid (as opposed to informed) consent. *The Lancet*, *356*(9238), 1347-1348. https://doi.org/10.1016/S0140-6736(00)02828-2

Talsma, M., Bengtsson Boström, K., & Östberg, A. L. (2015). Facing suspected child abuse – what keeps Swedish general practitioners from reporting to child protection services? *Scandinavian Journal of Primary Health Care, 33*(1), 21-26. https://doi.org/10.3109/02813432.2015.1001941

Tashakkori, A., & Teddlie, C. (2003). Issues and dilemmas in teaching research methods courses in social and behavioural sciences: US perspective. *International journal of social research methodology*, *6*(1), 61-77. https://doi.org/10.1080/13645570305055

Tennent G, Bancroft J, Cass J. (1974). The control of deviant sexual behavior by drugs: a double-blind controlled study of benperidol, chlorpromazine, and placebo. *Archives of Sexual Behaviour* 3(3):261-71.

Tewksbury, R. (2012). Stigmatization of sex offenders. *Deviant Behavior*, *33*(8), 606-623. https://doi.org/10.1080/01639625.2011.636690

Thibaut, F., Cosyns, P., Fedoroff, J. P., Briken, P., Goethals, K., Bradford, J. M., & WFSBP Task Force on Paraphilias. (2020). The World Federation of Societies of Biological Psychiatry (WFSBP) 2020 guidelines for the pharmacological treatment of paraphilic disorders. *The World Journal of Biological Psychiatry*, *21*(6), 412-490. https://doi.org/10.1080/15622975.2020.1744723

Thornton, D. (2013). Implication of our developing understanding of risk and protective factors in the treatment of adult male sex offenders. *International Journal of Behavioural Consultation and Therapy, 8*(3-4), 62-65. https://doi.org/10.1037/h0100985

Toy, J. M., Drechsler, A., & Waters, R. C. (2018). Clinical pathways for primary care: current use, interest and perceived usability. *Journal of the American Medical Informatics Association*, *25*(7), 901-906. https://doi.org/10.1093/jamia/ocy010

Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences, 6*(1), 97-108. **DOI:**10.4314/ejesc.v6i1.65384

Turner, D., Basdekis-Jozsa, R., & Briken, P. (2013). Prescription of testosterone-lowering medications for sex offender treatment in German forensic-psychiatric institutions. *The journal of sexual medicine*, *10*(2), 570-578. https://doi.org/10.1111/j.1743-6109.2012.02958.x

Turner, D., & Briken, P. (2018). Treatment of paraphilic disorders in sexual offenders or men with a risk of sexual offending with luteinizing hormone-releasing hormone agonists: an updated systematic review. *The journal of sexual medicine*, *15*(1), 77-93. https://doi.org/10.1016/j.jsxm.2017.11.013

Turner, D., & Briken, P. (2021). Pharmacological treatment for individuals with paraphilic disorders or at risk for sexual offending. In C. A. Leam (Eds.), *Sexual deviance: Understanding and*

managing deviant sexual interests and paraphilic disorders (p.282-294). John Wiley & Sons. DOI:10.1002/9781119771401

Turner, D., Petermann, J., Harrison, K., Krueger, R., & Briken, P. (2019). Pharmacological treatment of patients with paraphilic disorders and risk of sexual offending: An international perspective. *The World Journal of Biological Psychiatry*. https://doi.org/10.1080/15622975.2017.1395069

Vail, W. L., Niyogi, A., Henderson, N., & Wennerstrom, A. (2017). Bringing it all back home: Understanding the medical difficulties encountered by newly released prisoners in New Orleans, Louisiana–A qualitative study. *Health & social care in the community*, *25*(4), 1448-1458. https://doi.org/10.1111/hsc.12445

Van den Berg, J. W., Smid, W., Kossakowski, J. J., van Beek, D., Borsboom, D., Janssen, E., & Gijs, L. (2020). The application of network analysis to dynamic risk factors in adult male sex offenders. *Clinical Psychological Science*, *8*(3), 539-554. https://doi.org/10.1177/2167702620901720

Van der Noordt, M., IJzelenberg, H., Droomers, M., & Proper, K. I. (2014). Health effects of employment: a systematic review of prospective studies. *Occupational and environmental medicine*, *71*(10), 730-736. doi:10.1136/oemed- 2013-101891

Van Griensven, H., Moore, A. P., & Hall, V. (2014). Mixed methods research – The best of both worlds? *Manual Therapy 19*(5), 367-371. https://doi.org/10.1016/j.math.2014.05.005

Van Lankveld, J. J. D. M., and Van Den Hout, M. A. (2004). Increasing neutral distraction inhibits genital but not subjective sexual arousal of sexually functional and dysfunctional men. *Archive of Sexual Behaviour, 33*(6), 549-558.

Van Poppel, H., & Nilsson, S. (2008). Testosterone surge: rationale for gonadotropin-releasing hormone blockers?. *Urology*, *71*(6), 1001-1006. https://doi.org/10.1016/j.urology.2007.12.070

Veening, J. G., De Jong, T. R., Waldinger, M. D., Korte, S. M., & Olivier, B. (2015). The role of oxytocin in male and female reproductive behavior. *European journal of pharmacology*, *753*, 209-228. https://doi.org/10.1016/j.ejphar.2014.07.045

Venetis, M. K., Robinson, J. D., Turkiewicz, K. L., & Allen, M. (2009). An evidence base for patient-centered cancer care: a meta-analysis of studies of observed communication between cancer specialists and their patients. *Patient education and counseling*, *77*(3), 379-383. https://doi.org/10.1016/j.pec.2009.09.015

Vik, A., & Brekke, M. (2017). Do patients consult their GP for sexual concerns? A cross sectional explorative study. *Scandinavian Journal of Primary Health Care, 35*(4), 373-378. https://doi.org/10.1080/02813432.2017.1398934

Voß, T., Klemke, K., Schneider-Njepel, V., & Kröber, H. L. (2016). When yes, for how long?–Duration of antiandrogenic treatment of sexual offenders with paraphilic disorders: Clinical experiences from treatment-free trials in forensic aftercare practice. *Forensische Psychiatrie, Psychologie, Kriminologie*, *10*, 21-31. https://doi.org/10.1007/s11757-015-0346-z

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counselling: The mediating roles of self-stigma and attitudes toward counselling. *Journal of counselling psychology*, *54*(1), 40. https://doi.org/10.1037/0022-0167.54.1.40

Vollm, B., Craissati, J., Grubin, D., & Skett, S. (2019). Learning from research: Adapting interventions for sexual offending to improve outcomes. *Criminal Behaviour and Mental Health: CBMH, 29*(4), 227-238. https://doi.org/10.1002/cbm.2122

Wainberg, M. L., Muench, F., Morgenstern, J., Hollander, E., Irwin, T. W., Parsons, J. T., ... & O'Leary, A. (2006). A double-blind study of citalopram versus placebo in the treatment of compulsive sexual behaviors in gay and bisexual men. *Journal of Clinical Psychiatry*, *67*(12), 1968-1973. https://doi.org/10.4088/jcp.v67n1218

Wakefield, J. C. (2012). The DSM-5's proposed new categories of sexual disorder: The problem of false positives in sexual diagnosis. *Clinical Social Work Journal*, *40*(2), 213-223. https://doi.org/10.1007/s10615-011-0353-2

Walker, A., Butters, R. P., & Nichols, E. (2022). "I would report it even if they have not committed anything": Social service students' attitudes toward minor-attracted people. *Sexual Abuse*, *34*(1), 52-77. https://doi.org/10.1177/1079063221993480

Walliman, N. S. R. (2006). *Social Research Methods* (2nd Ed..). Los Angeles: SAGE. https://doi.org/10.4135/9781849209939

Walton, M. T., Cantor, J. M., Bhullar, N., & Lykins, A. D. (2017a). Hypersexuality: A critical review and introduction to the "sexhavior cycle". *Archives of Sexual Behavior*, *46*(8), 2231-2251. https://doi.org/10.1007/s10508-017-0991-8

Walton, M. T., Cantor, J. M., & Lykins, A. D. (2017b). An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. *Archives of sexual behavior*, *46*(3), 721-733. https://doi.org/10.1007/s10508-015-0606-1

Walton, J., & Hocken, K. (2019). Compassion and acceptance as interventions for paraphilic disorders and sexual offending behaviour . In G. Akerman , D. Perkins , & R. Bartels (Eds.), Assessing and managing deviant sexual interest and arousal .

Ward, T., & Stewart, C. (2003). The treatment of sex offenders: risk management and good lives. *Professional Psychology: Research and Practice, 34*, 353-360. https://doi.org/10.1037/0735-7028.34.4.353

Wetterneck, C. T., Burgess, A. J., Short, M. B., Smith, A. H., & Cervantes, M. E. (2012). The role of sexual compulsivity, impulsivity, and experiential avoidance in internet pornography use. *The Psychological Record*, *62*, 3-18. https://doi.org/10.1007/BF03395783

Whisman, M. A., Sbarra, D. A., & Beach, S. R. H. (2021). Intimate relationships and depression: Searching for causation in the sea of association. *Annual Review of Clinical Psychology*, *17*(1), 233–258. https://doi.org/10.1146/ annurev-clinpsy-081219-103323

Whittle, C., & Hewison, A. (2007). Integrated care pathways: pathways to change in health care?. *Journal of health organization and management*, *21*(3), 297-306.

Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative data collection: interviews and focus groups. In D. Marks, & L. Yardley (Eds.). *Research Methods for Clinical and Health Psychology* (pp. 39-55). SAGE Publications. https://doi.org/10.4135/9781849209793.n3

Willig, C. (2008). *Introducing Qualitative Research,* (2nd Ed.). Berkshire, England: Oxford University Press.

Willis, G. M. (2018). Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology. *Psychology, Crime & Law*, *24*(7), 727-743. https://doi.org/10.1080/1068316X.2017.1421640

Willis, G. M., & Grace, R. C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior*, *36*(5), 494-512. https://doi.org/10.1177/0093854809332874

Willis, G. M., Kelley, S. M., & Thornton, D. (2020). Are protective factors valid constructs? Interrater reliability and construct validity of proposed protective factors against sexual reoffending. *Criminal Justice and Behavior*, *47*(11), 1448-1467. https://doi.org/10.1177/0093854820941039

Willis, G. M., Levenson, J. S., & Ward, T. (2010). Desistance and attitudes towards sex offenders: Facilitation or hindrance?. *Journal of family violence*, *25*, 545-556. https://doi.org/10.1007/s10896-010-9314-8

Winder, B., Blagden, N., Underwood, M., & Penford, E. (2021, April 12). *Challenges and successes in setting up and running a community centre providing post-prison support for people convicted of a sexual offence* [Conference presentation]. New Directions in Sexual Offender Practice, University of Birmingham, Birmingham, United Kingdom

Winder, B., Faulkner, J., Lievesley, R., Elliott, H., & Norman, C. (2017). The management of hypersexuality in men and women.

Winder, B., Fedoroff, J. P., Grubin, D., Klapilová, K., Kamenskov, M., Tucker, D., ... & Vvedensky, G. E. (2019). The pharmacologic treatment of problematic sexual interests, paraphilic disorders, and sexual preoccupation in adult men who have committed a sexual offence. *International Review of Psychiatry*, *31*(2), 159-168. https://doi.org/10.1080/09540261.2019.1577223

Winder, B., & Gough, B. (2010). "I never touched anybody—that's my defence": A qualitative analysis of internet sex offender accounts. *Journal of sexual aggression*, *16*(2), 125-141. https://doi.org/10.1080/13552600903503383

Winder, B., Lievesley, R., Elliott, H. J., Norman, C., & Kaul, A. (2014a). 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: Wiley.

Winder, B., Lievesley, R., Kaul, A., Elliott, H. J., Thorne, K., & Hocken, K. (2014b). Preliminary evaluation of the use of pharmacological treatment with convicted sexual offenders experiencing high levels of sexual preoccupation, hypersexuality and/or sexual compulsivity. *The Journal of Forensic Psychiatry & Psychology*, *25*, 176-194. https://doi.org/10.1080/14789949.2014.903504

Winder, B., Lievesley, R., Elliott, H., Hocken, K., Faulkner, J., Norman, C., and Kaul, A. (2018). Evaluation of the use of pharmacological treatment with prisoners experiencing high

levels of hypersexual disorder. *The Journal of Forensic Psychiatry and Psychology, 29*, 53-71. https://doi.org/10.1080/14789949.2017.1337801

Winder, B., Norman, C., Hamilton, J., Cass, S., Lambert, A., Tovey, L., Hocken, K., Marshall, E., Hamilton, L., Antoniadis, Z., & Kaul, A. (2024). Evaluation of selective-serotonin reuptake inhibitors and anti-androgens to manage sexual compulsivity in individuals serving a custodial sentence for a sexual offence. *The Journal of Forensic Psychiatry & Psychology*, 1-36. https://doi.org/10.1080/14789949.2024.2338917

Winters, J., Christoff, K., & Gorzalka, B. B. (2010). Dysregulated sexuality and high sexual desire: Distinct constructs? Archives of Sexual Behavior, 39, 1029–1043. doi:10.1007/s10508-009-9591-6.

Winters, G. M., Jeglic, E. L., Calkins, C., & Blasko, B. L. (2017). Sex offender legislation and social control: An examination of sex offenders' expectations prior to release. Criminal Justice Studies, 30(2), 202–222. doi:10.1080/1478601X.2017.1299894

Wirtz, C. M., Hofmann, S. G., Riper, H., & Berking, M. (2014). Emotion regulation predicts anxiety over a five-year interval: A cross-lagged panel analysis. *Depression and anxiety*, *31*(1), 87-95. https://doi.org/10.1002/da.22198

Womack, S. D., Hook, J. N., Ramos, M., Davis, D. E., & Pemberthy, J. K. (2013). Measuring hypersexual behaviour. *Sexual Addiction & Compulsivity, 20*(1-2), 65-78. https://doi.org/10.1080/10720162.2013.768126

World Health Organisation (WHO). (2018, April). *ICD-11 (Mortality and Morbidity Statistics) 6C72 Compulsive Sexual Behaviour Disorder.* https://icd.who.int/dev11/l-m/en#/http://id.who.int/icd/entity/1630268048

World Health Organisation (WHO). (2020). *WHO announces Covid-19 outbreak a pandemic*. Retrieved 03/09/2020 from https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/who-announces-covid-19-outbreak-a-pandemic

World Health Organisation (WHO). (2023, July 18). *ICD-11 for mortality and morbidity statistics (version: 01/2023), 6C72 compulsive sexual behaviour disorder.* ICD. https://icd.who.int/browse11/l-m/en#/http%253A%252F%252Fid.who.int%252Ficd%252Fentity%252F1630268048

Wylie, K. (2022). Masters & Johnson–their unique contribution to sexology. *BJPsych Advances*, *28*(3), 163-165. https://doi.org/10.1192/bja.2021.53

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (2nd ed., 257-272).

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology, 12*(3), 295-296. https://doi.org/10.1080/17439760.2016.1262624

Yardley, L. & Bishop, F. L. (2017). Mixing qualitative and quantitative methods: A pragmatic approach. In W. S. Roger & C. Willig (Eds.), *The Sage Handbook of Qualitative Research in Psychology,* 398-414, Sage. https://doi.org/10.4135/9781526405555.n24

Yen, J. Y., Ko, C. H., Yen, C. F., Wu, H. Y., & Yang, M. J. (2007). The comorbid psychiatric symptoms of Internet addiction: attention deficit and hyperactivity disorder (ADHD), depression, social phobia, and hostility. *Journal of adolescent health*, *41*(1), 93-98.https://doi.org/10.1016/j.jadohealth.2007.02.002

Yoon, I., Houang, S., Hirshfield, S., & Downing, M. (2016). Compulsive sexual behaviour and HIV/STI risk: A review of current literature. *Current Addiction Reports, 3*, 387-399. https://doi.org/10.1007/s40429-016-0121-z

Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behaviour, 64*(3), 373-388. https://doi.org/10.1016/j.jvb.2003.12.005

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review, 9*(2), 264-276.https://doi.org/10.1080/17437199.2013.840954

Zapf, J. L., Greiner, J., & Carroll, J. (2008). Attachment styles and male sex addiction. *Sexual Addiction and Compulsivity, 15*(2), 158-175. https://doi.org/10.1080/10720160802035832

Zarling, A., & Russell, D. (2022). A randomized clinical trial of acceptance and commitment therapy and the Duluth Model classes for men court-mandated to a domestic violence program. *Journal of Consulting and Clinical Psychology, 90*(4), 326–338. https://doi.org/10.1037/ccp0000722

Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., & Fazel, S. (2021). Risk factors for suicide in prisons: A systematic review and meta-analysis. *The Lancet Public Health, 6,* 164-174. https://doi.org/10.1016/S2468-2667(20)30233-4.

Zigmond, A. S., & Snaith, R. P. (1983). The hospital anxiety and depression scale. *Acta psychiatrica scandinavica*, *67*(6), 361-370. https://doi.org/10.1111/j.1600-0447.1983.tb09716.x

Appendices

7.6 Appendix 1. Study two Participant Information Sheet

PARTICIPANT INFORMATION SHEET

An evaluation of the effectiveness of medication to manage problematic sexual arousal (MMPSA) in reducing problematic sexual compulsivity and improving well-being in individuals in the community.

Invitation and Summary

You have been asked to take part in a research project which is looking at the effectiveness of medication to manage problematic sexual arousal (MMPSA).

The decision to take part in the research is up to you. If you take part in the research you will not receive anything and if you do not want to take part, you will not lose anything.

Your decision to take part or not to take part will not affect any treatment or medication, nor will it affect your supervision on licence if that applies to you.

In this research study we will use information that you give us during the interview. Only members of the research team will know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will follow all privacy rules.

At the end of the study we will save some of the data in case we need to check it **AND/OR** for future research.

We will make sure no-one can work out who you are from the reports we write.
The below information tells you more about this.

What is the research about?

We are looking at how medication is used to treat sexual thoughts, urges and behaviours. We are looking at the experiences of people who have tried to get help for problematic sexual arousal and whether they have been able to get access to the medication from their GP. We will be looking at whether you were able to get access to the medication, any other treatments offered to you, and how easy/difficult this was.

We will also be looking at what it is like for people taking the medication – whether it works, whether there are any side effects and how people feel about taking it. We will be looking at any changes over time and any differences between taking the medication in custody and the community, if this applies to you.

What would you be asked to do?

Interviews

If you take part in the study, you will be asked to take part in an interview to discuss your experience of getting access to the medication and any other treatment offered to you. We will also ask about taking the medication. This will be one interview however further interviews may be requested depending on if we run out of time – and as long as you are willing to meet with us again.

The interview will take place online via a video conferencing application such as Microsoft Teams or over the telephone if you prefer. We would ask that you arrange the talk for a time when you can be alone in a quiet room and are unlikely to be interrupted. The researcher will do the same. If the interview has started, and you wish to have a break or stop the interview, you are very welcome to do that.

If you do not have access to the technology to take part in an online interview, then arrangements can be made for you to attend the Corbett Centre and access technology there. The interviews will last about 1-2 hours each.

In these interviews, we will talk a little bit about you and how you came to realise you needed help with your problematic sexual arousal. We will talk about how you tried to gain help for this and your experiences of asking for help.

We will talk about the help offered to you, and what type of treatment this was, counselling, support and medication for example. We will talk about whether you decided to take up the offer of treatment, if any treatment was offered to you. If no treatment, or help, was offered we will talk about this and how this made you feel.

If you did take up the offer of treatment, we will talk about how effective the treatment was and your experiences of this. We are interested to know how you feel since you have started any treatment offered to you and whether you think this has helped you or not.

If you were prescribed medication, we will talk about how you feel since you have started taking medication and whether or not you feel this has helped. We will also talk about how easy or difficult it was for you to get the medication.

There are no right or wrong answers, we are just trying to understand your experiences of getting help for your levels of arousal.

The interview will be recorded on a dictaphone so that we can remember what was said.

What happens if I do not want to take part anymore?

If for any reason you wish to stop the interview, you will be able to do so with no questions or consequences. If, after talking to us, you change your mind and decide you no longer want to take part in the research that is no problem. Please let us know **up to a month after your interview** and we shall remove all your data.

What happens to the information you give to me?

All information about you will be kept in a database that only the research team have access to. The information is stored and used for research purposes and long-term evaluation of the effectiveness of medication to manage problematic sexual arousal and may be shared anonymously with other researchers in future.

People who do not need to know who you are will not be able to see your name or contact details. We will keep all information about you safe and secure. We will abide by the Data Protection Act 2018.

What we talk about will be kept private unless:

- **You tell me that you want to harm yourself**
- **You tell me that someone else is at risk of being harmed**
- **You tell me information about an offence which you have not been convicted for (like the name of a victim and when the offence happened)**
- **You tell me about a non-convicted offence(s) which you have been a victim of and have not previously disclosed**
- **You tell me about anything that may put yourself or others in danger**

If you mention any of these things to me, I will have to pass the information on to the police, or your Probation Officer if you are currently under supervision.

After an interview, I will listen to the recorded tape and write down everything that we said. I will use a number instead of your name and any people or places that you talk about will be changed. The information about you and any notes I make will be stored on a secure drive provided by Nottingham Trent University. Only I and other members of the research team will have access to these or know that you are taking part.

The tape recordings will also be stored on a secure drive, in a separate folder to any personal details. A transcriber may have access to the audio files to assist with transcribing the interviews. A confidentiality agreement will be signed by the transcriber to ensure the security of data.

When the research has finished, the tape recordings will be deleted.

The data from this research may be presented in published papers, presentations, conference presentations or reports. These will not mention you by name and nobody will be able to tell you took part in the research.

Some of the information we collect and things that you say to me will be included in the report, but nobody will know it was you. Sometimes the reports may use direct quotes, no one will know that it is you that has said this as it will just show a number.

What are the possible benefits of taking part?

There are no personal benefits to you in taking part in the research. The research will provide evidence of the effectiveness of MMPSA which could lead to better treatment being available for individuals with problematic sexual arousal.

What are the possible disadvantages of taking part?

It is hoped that there are no disadvantages to taking part. Appointments will be arranged at a time and place suitable to yourself. You will be reimbursed any travel fares.

Who do I contact if I want to make a complaint?

If you have any complaints about how you have been treated please contact Dr Duncan Guest (Head of Psychology at Nottingham Trent University) by email duncan.guest@ntu.ac.uk.
You can find out more about how we use your information by sending an email to dpo@ntu.ac.uk

Extra support

If you feel upset after the interview, perhaps because of some of the things you talked about, please do get some help.

The information Hub- a charity that provide self-help information on a range of issues that people with criminal convictions may face e.g. personal relationships, disclosing criminal records

- *Website- https://hub.unlock.org.uk/important-links/*

Please remember you can also contact Samaritans – Samaritans have a free phone line that is available 24/7 so you are able to call at anytime if you feel down or just need to talk to someone.

- *Website- https://www.samaritans.org/*
- Helpline- 116 123

CALM (Campaign Against Living Miserably)- They provide help on specific issues and are available to access if you are feeling down, need someone to talk to or are looking to find further information and support

- *Website- https://www.thecalmzone.net/*
- *Helpline- 0800 58 58 58*

7.7 Appendix 2. Study two Interview Schedule

Interview Schedule

Seeking help from GP for PSA

Consent Guide

a. Introductions, followed by discussion of consent, background information to the research and explanation of the ways in which research will be used.
b. Discuss anonymity and that no personal/identifying information will be used in final write up of report.
c. Ensure participants understand that should they disclose harm to themselves, others, or any crimes for which they have not been prosecuted, that this information will not be confidential and will be passed on to the relevant agencies.
d. Ensure agreement to record interview and the above prior to interview commencing.

Personal Info

- How would you describe your gender?
- How old are you?
- What is your nationality?

Background to visiting your General Practitioner (GP) in general

- In general, how often do you go and see your GP?
- How do you feel normally about arranging to go and see your GP?
    - Nervous/Apprehensive
    - Not concerned
- In general, what would it usually take for you to go and see your GP?
    - Do you go regularly?
    - How ill do you need to be before you make an appointment to see your GP?
- How would you describe your relationship with your GP?
    - Do you often see the same GP?
    - How important is this to you?
    - Is your GP male/female? Does this matter to you?
        - Would you have any concerns seeing a GP of the opposite/same gender?

Background to seeking help

- Thinking back to before you went to see your GP, could you tell me how would you describe your sexual thoughts and urges?
- Can you tell me a little bit about how/when you realised you were struggling with your sexual thoughts and urges?
    - How did this develop?

    - What was happening in your life at the time you realised you may have problematic sexual thoughts and urges?
    - How did this impact on how you felt about yourself?
- Can you explain what it is like living with problematic sexual thoughts and urges?
    - How does this affect you day to day?
- How do you feel your problematic sexual thoughts affect your relationships?
    - Do you feel that your problematic sexual thoughts affect how you interact with others?
- How do you feel that living with problematic sexual thoughts affect how you make sense of the world?
- Remind them this question may not apply to them. Have you ever been convicted of a sexual offence?
    - Could you talk to me about what led to the offence?
    - How did this make you feel?
    - Could you tell me what sentence you received?

Treatment offered by GP

- Can you talk to me about how you came to decide to ask your GP for help with your sexual arousal?
    - Prompts
    - Particular incident?
    - Feeling distressed?
    - Someone mentioned you might need help?
- How did you feel about approaching your GP for help?
    - Nervous
    - Motivated
- Can you tell me about what happened when you asked your GP for help with your sexual arousal?
- What was your experience of the appointment?
    - How did the consultation make you feel supported/encouraged/comfortable?
- What type of treatment options did your GP discuss with you?
- How did you feel about the options available?
- What treatment options did you decide to try?
- Were you aware of the medication when you asked your GP for help?

If not medication

- What was your experience of the treatment?
- Is there anything else you would have liked to be available to you?
- Can you tell me a little bit about how the treatment affects/affected you?
    - Prompts:
    - How has the treatment affected your problematic sexual thoughts?
    - Are there any downsides to the treatment
- How do you feel the treatment has impacted on your well-being?
    - Prompts:
    - Improved, positive effect,

    - Negative effect,
    - In what way?
- How is your experience of living with problematic sexual thoughts once you began the treatment?
    - How do you feel the treatment has affected you on a day to day basis?
    - How has the treatment affected your ability to manage your sexual thoughts?
- Some individuals have found that once their sexual thoughts have been reduced, this gives them more time to think about other things. Is this something you experienced?
- If so, what did you do with this?
    - Was this positive or negative?
    - Did you find yourself thinking more about previous offences? If applicable

- How has the treatment affected your relationships?
    - Do you feel like the treatment has affected how you interact with others? In what way?
    - How would you describe your levels of sexuality, healthy sexual functioning?
        - How important is this to you?
        - Has the treatment assisted with this?
    - How much does having a healthy sexual relationship matter to you?
        - Has this been a problem in the past?
    - Has the treatment assisted you in maintaining/creating healthy relationships?
        - How important is this to you?
- How do you feel the treatment has impacted on your behaviour?

Referral for medication, type of medication, continued or not (if prescribed)

- Can you tell me a little bit about when/why you were referred for medication?
- What was your experience of the referral process?
        - Any difficulties in obtaining medication?
- Can you tell me a little bit about the medication you were prescribed?
        - What medication are you/were you taking?
        - How long have you been taking the medication for?
        - How often/what dosage?
        - Have you needed many changes to the dosage/medication type? Can you tell me about this?
- Have you had any breaks in the medication?
- Do you ever miss days when taking the medication?
        - Why do you miss days?
- Are you still using the medication?
        - If No – complete ceased questions (section 6)

Effects of medication (If prescribed)

- Can you tell me a little bit about how the medication affects/affected you?
    - How has the medication affected your problematic sexual thoughts?
- How do you feel the medication has impacted on your well-being?
    - Prompts:
    - Improved, positive effect,
    - Negative effect,
    - In what way?
- Some individuals have found that the medication reduced their sexual thoughts, giving them more time to think about other things. Is this something you experienced?
- If so, what did you do with this?
    - Was this positive or negative?
    - Did you find yourself thinking more about previous offences?
- How is your experience of living with problematic sexual thoughts once you began the use of medication?
    - How do you feel the medication has affected you on a day to day basis?
    - How has the medication affected your ability to manage your sexual thoughts?
- How has the use of medication affected your relationships?
    - Do you feel like the medication has affected how you interact with others? In what way?
    - How would you describe your levels of sexuality, healthy sexual functioning?
        - How important is this to you?
        - Has the medication assisted with this?
    - How much does having a healthy sexual relationship matter to you?
        - Has this been a problem in the past?
    - Has the medication assisted you in maintaining/creating healthy relationships?
        - How important is this to you?
- How do you feel the medication has impacted on your behaviour?
    - Prompts:
    - Positive/negative changes in behaviour
- Do you feel like the medication has improved your engagement on supervision, programmes, licence? If applicable.
- Can you describe any negative side effects of the medication you may have experienced?
- Can you describe any down sides to taking the medication you may have experienced?
- Has you OM discussed your use of medication with you? If applicable
- Was the medication mentioned by the parole board? If received custodial sentence

If ever prescribed medication in custody - Custody vs Community

- How was the prescription managed from release until now?
    - Was it a smooth process?
    - Have you experienced any difficulties in obtaining the prescription?
- How is your experience of living with problematic sexual thoughts since your release from custody?
    - How has the use of medication affected your experience of living with problematic sexual thoughts on a day to day basis?
    - What is your experience of managing your problematic sexual thoughts now you are in the community?

    - Are there any differences in how you manage your problematic sexual thoughts in the community to in custody?
- How would you describe your relationships with others since your release?
    - How are your interactions with others?
    - Do you feel as though the medication has assisted you in maintaining relationships since your release?
- Do you think there has been any difference in the effects of medication since being released in the community?
    - Have you needed any changes in the type or dosage of the medication?
    - How motivated are you to take the medication?
    - How in control of managing your problematic sexual thoughts do you feel?
- Do you feel the medication has any other benefits?
    - Has it improved your ability to concentrate on treatment programmes?
- How would you describe the support available in relation to taking your medication?
    - Do you get as much support in the community? Would you say the support more or less than in custody?

Ceased use of MMPSA in Community

- Can I ask when you stopped using the medication?
- Could you tell me a little bit about why you decided to stop using the medication?
    - Changes in effectiveness, issues with prescription, personal choice, no longer needed.
- How are you managing your problematic sexual thoughts whilst in the community?
- Have you noticed any changes in your well-being since you stopped the use of medication?
- How would you describe your relationships since you have stopped the use of medication?
- Do you have any plans to restart the medication?

7.8 Appendix 3. Study three Participant Information Sheet

Information sheet – before the research

You have been asked if you would like to take part in a research study.

What is the research about?

The Sexual Offences Crime and Misconduct Research Unit (SOCAMRU) are undertaking a long-term evaluation of the effectiveness of medication to manage problematic sexual arousal. The research aims to improve treatment interventions for individuals with sexual convictions. A selection of research papers already published on the subject have been provided for you to read at your leisure.

For the current research, we are interested in gaining the opinions of General Practitioners who may be asked to prescribe the medication in order to get a better of understanding of the use of medication from professionals working in the field. To date, no research has focused on General Practitioners' opinions and we are hoping that this will be valuable contribution to the evidence base.

What would you be asked to do?

Interviews

If you take part in the study, you will be asked to take part in an interview to discuss your thoughts on, or experiences of, prescribing the medication and your views on this as a treatment method for individuals with sexual convictions. This will be one interview however further interviews may be requested depending on if we run out of time – and as long as you are willing to meet with us again.

The interviews will be undertaken remotely, this will be done through a video conferencing application such as Microsoft Teams/Skype for business or over the telephone if you prefer. This is for your convenience and to reduce the level of commitment required by yourself. The interviews will last about 30 minutes each, or longer depending on your availability. They will be recorded on a dictaphone.

You may stop the interviews at any time to have a break or if you decide you no longer want to take part. In these interviews, we will talk a little bit about you and your experience as a General Practitioner. We will also discuss your knowledge and experiences of the use of medication to treat problematic arousal and your opinions on this.

What happens if I do not want to take part anymore?

You can stop the interviews at any time.

You can say that you do not want to take part in the research at any time.

If you change your mind and decide you no longer wish to take part in the research, you have 1 month (4 weeks) after the interview or assessment to let me know.

All the notes I have made will be destroyed and the tape recordings will be deleted.

There will be no adverse consequences if you decide this.

What happens to the information you give to me?

All information about you will be kept in a database that only the research team have access to. The information is stored and used for research purposes and long-term evaluation of the effectiveness of medication to manage problematic sexual arousal.

After the interview, I will listen to the recorded tape and write down everything that we said. I will use an identification number to refer to you and any people or places that you talk about will not be named. The tape recordings, information about you and any notes I make will be stored on a secure drive provided by Nottingham Trent University. Only I and other members of the research team will have access to these or know that you are taking part.

When the research has finished, the tape recordings will be deleted.

The data from this research may be presented in published papers, presentations, conference presentations or reports. These will not mention you by name and nobody will be able to tell you took part in the research.

Some of the information we collect and things that you say to me will be included in the report, but nobody will know it was you.

Who do I contact if I want to make a complaint?

If you have any complaints about how you have been treated please contact Professor Belinda Winder or Dr Phil Banyard (Head of Psychology at Nottingham Trent University) by email Belinda.Winder@ntu.ac.uk Phil.Banyard@ntu.ac.uk. You can find out more about how we use your information by sending an email to dpo@ntu.ac.uk

7.9 Appendix 4. Study three Interview Schedule

Interview Schedule

MMPSA

Consent Guide

e. Introductions, followed by discussion of consent, background information to the research and explanation of the ways in which research will be used.
f. Discuss anonymity and that no personal/identifying information will be used in final write up of report.
g. Ensure participants understand that should they disclose harm to themselves, others, or any crimes for which they have not been prosecuted, that this information will not be confidential and will be passed on to the relevant agencies.
h. Ensure agreement to record interview and the above prior to interview commencing.

Personal Info

- How would you describe your gender?
- How old are you?

Experience as a GP

- Can you tell me a little bit about your experiences as a General Practitioner in treating individuals with sexual issues?
    - What is the usual type of sexual problem people come to you with?
        - Prompts:
        - Excessive sexual arousal
        - Lack of sexual arousal
        - Help with STDs

Treating sexual preoccupation in general

- In this next section we will talk a little about sexual preoccupation. Individuals with sexual preoccupation will experience intrusive and uncontrollable sexual thoughts which interfere with their day to day life and how they regulate their emotions. The term sexual preoccupation has been defined by Mann, Hanson and Thornton (2010, pp198) as "an abnormally intense interest in sex that dominates psychological functioning".
- Could I ask, if someone came to see you as they were struggling to control their sexual thoughts, how would you deal with this?
        - Prompts:
        - Too many sexual thoughts, cannot think about anything else
        - Deviant thoughts, eg, an attraction to children

        - Feeling they may commit an offence
        - Affecting their relationships
        - Making them depressed/stressed as thinking about sex all the time
    - What questions would you ask?
    - What would or could you offer as support?
    - Have you had experience of this?
    - How would/did you feel about the consultation?
- If you felt someone needed treatment as their sexual thoughts were out of control, how confident would you be in offering treatment?
    - How would you go about this?
    - Would you feel confident prescribing medication?
    - What type of medication would you prescribe?
    - If not confident in prescribing medication, how would you treat this?

Treating hypersexual behaviour

- Individuals may be classed as hypersexual if they need to engage in excessive amounts of sexual activity. Have you had patients approach you as they were engaging excessive amounts of sex?
- Have you had patients approach you as they were using sex workers frequently and this was interfering with their life?
- Have you had patients approach you as their need to engage in too much sex was affecting their relationships/daily life/employment?
- Have you had patients who you felt were under pressure to have excessive amounts of sex? For example, any partners needing treatment due to ailments as a result of excessive sex.

Medication to treat individuals with sexual convictions

- Could I ask, if the individual presented with sexual preoccupation but also had convictions for sexual offences, would this be assessed in the same way as an individual who did not have sexual convictions?

- If an individual came to you and informed you that they were struggling with deviant sexual thoughts in that they were attracted to children for example, and needed assistance in managing their thoughts, how would you deal with this?
    - Would you feel comfortable in offering treatment?
    - Would you take any actions that may involve reporting to the police?
    - Have you ever had to do this?

- How would you feel if an individual with sexual convictions presented to you and asked you for help as they felt they may commit a further sexual offence as a result of their sexual thoughts?
    - Would you feel comfortable in offering treatment?
    - Would you take any actions that may involve reporting to the police?
    - Have you ever had to do this?

- Do you feel that the use of medication to manage sexual preoccupation is an appropriate treatment strategy for individuals with sexual convictions?
    - What other options would you consider appropriate?
    - What usual actions would you take?
- Have you had any experience of prescribing medication to individuals with sexual convictions who have sexual preoccupation? If so, have you noticed any changes in the individuals that you prescribed the medication to?
    - Did you notice any changes in their well-being?

Prescribing antiandrogens

- How confident would you be in prescribing antiandrogens to an individual to manage their sexual preoccupation?
- How confident would you be in assisting the individual to manage the side effects of the medication?

The 'off label' use of SSRIs

- SSRIs are currently being used 'off label' as a method to treat sexual preoccupation as a common side effect of SSRIs in a reduction in libido and they have also been shown to be effective in the treatment of obsessive/compulsive disorders, which sexual preoccupation is often associated with.
- Do you feel there are benefits to using SSRIs to manage sexual preoccupation?
- Would you feel comfortable prescribing SSRIs to treat sexual preoccupation?
- Do you feel that there are any problems with prescribing medication 'off label'?
- What are your thoughts on the use of SSRIs to manage sexual preoccupation?