Literature Review:

Maladaptive Psychosocial Development as a Mediator between Adverse Childhood Experiences and Sexual Offending in Adolescence: A Review

Empirical Paper:

Understanding Their Story: Investigating the Narratives of Persons with Sexual Offence Histories and Adverse Childhood Experiences

Submitted by Eleanor Hall, to the University of Exeter

as a thesis for the degree of Doctor of Clinical Psychology, March 2022

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature: 

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

SYSTEMATIC LITERATURE REVIEW

Maladaptive Psychosocial Development as a Mediator between Adverse Childhood Experiences and Sexual Offending in Adolescence: A Review

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Abstract

The literature suggests that many adolescents with sexual offence histories (AWSOHs) have experienced adversity in their childhood which significantly impacted their psychosocial development. This review sought to systematically appraise the literature of 3 major data bases to explore to what extent maladaptive psychosocial development mediates the relationship between adverse childhood experiences and sexual offending in adolescents. Studies that met criteria were assessed for quality, summarised and critically evaluated; 10 papers were included for the final review. Three key findings were that emotion dysregulation (anxiety and depression), attachment (insecure) and development of offence-themed fantasies mediate the relationship between childhood adversity and sexual offending in adolescence. Some papers were able to demonstrate whether and to what extent these variables mediate the relationship. Due to the methodological weaknesses of some studies, however, it is unclear how and to what extent the factors discussed in their papers mediate the relationship. The authors of the studies make suggestions for how the link could be mediated; these are evaluated in this review. The findings are discussed in the context of attachment theory and the stages of psychosocial development. The review is consistent with previous literature proposing etiological causes for sexual offending and pathways to offending. Implications for clinical practice include considerations for risk assessment, preventative measures in school and health environments and treatment options for adolescents. Future directions could include completing a qualitative review to add to this quantitative review and improving on previous methodology to make firmer conclusions.

Keywords: Aversity, trauma, psychosocial, development, sexual offending, adolescence

Introduction

Adversity and Trauma

Trauma is defined as "one of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (American Psychological Association, 2011, pp.271). This can be through witnessing or direct experience (American Psychological Association, 2000; Levenson, 2014). Psychosocial stressors are not captured within the current definition of trauma. Adverse childhood experiences (ACEs) encapsulate a wider subset of traumas and adversities, including emotional, physical or sexual abuse, familial mental illness, substance misuse, emotional and physical neglect, witnessed domestic violence, separation, divorce or incarceration (Felitti et al., 1998; The Centers for Disease Control and Prevention, 2020).

According to a large-scale survey in the UK, approximately 47% of respondents had experienced at least one ACE (Bellis et al., 2014). It is suggested current definitions and measurements of adversity in childhood are inconsistent (McLaughlin, 2016). A definition of adversity needs to capture its subjective nature and how different people may view and be affected by the same experience in different ways. McLaughlin (2016) proposes the following definition: "experiences that are likely to require significant adaptation by an average child and that represent a deviation from the expectable environment" (McLaughlin, 2016, p. 363).

There is a breadth of evidence demonstrating the link between ACEs and offending in adolescence; however, the number of papers that focus on sexual offending outcomes is relatively sparse. A study investigating adversity in a sample of 322 adolescents with a sexual offence history (AWSOHs) found 66.5% had experienced adversity in childhood, with 9% having experienced multiple forms (Barra et al., 2018). This research was conducted in Swiss cantons and may not be generalisable to other parts of the world. Hall et al. (2018) found

much greater instances, with 76% of their sample of 120 AWSOHs from the USA experiencing four or more adversities. This indicates AWSOHs have experienced significant adversity in childhood, the effects of which require exploration.

Maladaptive Psychosocial Development

The lasting effects of exposure to trauma and adversity are well documented in the literature (Anda et al., 2010; Felitti et al., 1998). A number of outcomes have been observed in people who have experienced adversity in childhood, including depression, poor health and substance abuse (Felitti et al., 1998). It is suggested that adversity and trauma elicit a toxic stress response (Shonkoff et al., 2012). This affects the brain and nervous system development as the stress response become heightened, prolonged, triggered more easily and is more difficult to bring under control (Teicher & Samson, 2016; van der Kolk, 2003). This increases the risk of physical and mental health problems later in life (Nelson et al., 2020).

Psychosocial development has been defined in a number of ways. According to Lewis (2020), it can be defined as the way in which the individual interacts with the demands placed on them by society and how well this meshes with their individual need. The stages of psychosocial development theory proposes eight stages of development throughout a person's life wherein bio-psycho-social factors interact to result in positive or negative outcomes (Erikson, 1963). If the person is successful at each stage, accomplishing goals and resolving internal conflict, this supports development of core beliefs in relation to the self and others and progression to the next stage. Failure to do this can result in negative core beliefs, unresolved conflict and remaining stuck in a developmental stage as the individual grows older (Orenstein & Lewis, 2020).

Erikson's theory was analysed and critiqued by Franz and White (1985) who claimed the theory does not incorporate concepts of attachment and intimacy very well due to the focus on identity issues. It is also suggested that Erikson used an ambiguous writing style and

used different terms for identity interchangeably – formation, development, consolidation – with little explanation for what each meant (Hoare, 2002). He also did not define age ranges for his stages of development (Waterman, 1993), making subjective interpretation inevitable. Erikson's writing also come from a period of time where adolescence was arguably much different from today (Sokol, 2009). The development of technology, adolescents going to university rather than straight from school to employment and changes to a woman's role (in the home versus going to work) are but a few examples of societal change and so applying the model today requires careful consideration of these differences.

Interestingly, Erikson provided comment in the early 60s regarding his thoughts on the potential challenges modern technologies may have on attainment or diffusion of identity (Erikson, 1963). Kay (2018) discusses the impact of the internet on psychosocial development in relation to Erikson's theory. He discusses how the internet may foster loneliness, isolation and depression and prevent children and adolescents from successfully meeting Erikson's stages of development (Kay, 2018; Morahan-Martin & Schumacher, 2003; Sanders et al., 2000). A pertinent consideration when considering the internet habits of adolescents today.

There has been extensive investigation regarding the links between adversity in childhood and how this affects psychosocial development in non-offending populations. The literature indicates that ACEs can affect emotion regulation, cognitive development, interpersonal difficulties, coping skills and mental health problems including PTSD, depression and suicidality (Escueta et al., 2014; Herzog & Schmahl, 2018; Sachs-Ericsson et al., 2016).

AWSOHs often display maladaptive psychosocial development in their behaviour and ability to engage with and cope with the world around them. Hunter and colleagues found AWSOHs in the USA demonstrated problems with self-esteem, self-efficacy, social

competency, mood, hostile masculinity, paedophilic interests, ideas of self and the way others view them, loneliness and dependency on adults (Hunter et al., 2003; Hunter et al., 2004; Hunter et al., 2009).

Theories of Sexual Offending in Adolescents

There are several theories presented in the literature which attempt to explain why some adolescents sexually offend. One suggestion is that attachment theory has relevance within the context of AWSOHs. It is suggested that AWSOHs have greater numbers of parent-child separation, resulting in increased loneliness and insecure attachment styles that persist as the child grows older (Kobayashi et al., 1995; Miner et al., 2016). This results in difficulties establishing and maintaining intimate relationships in adolescence and young adulthood (Goodrow & Lim, 1998) which is a known risk factor in sexual offending (Hanson & Morton-Bourgon, 2004). Insecure attachment has been demonstrated to result in problems with emotion dysregulation and callousness in AWSOHs (Yoder et al., 2020). Attachment theory in the context of AWSOHs is limited as it does not account for why only some individuals with insecure attachments go on to sexually offend, indicating it accounts for a small proportion of the relationship.

Another theory cited is social learning theory, wherein behaviour is observed, memorised and re-enacted by children (Bandura, 1973). It has been suggested that AWSOHs may fixate on their own experiences of sexual abuse and recreate the experience by offending against others (Ryan, 1989). This is a controversial theory of sexual offending in adolescence and there has been inconsistent findings and evidence to both support and dispute this theory. Gwartney-Gibbs et al. (1987) collected questionnaire data from 289 students and found individuals with personal experiences of sexual aggression were more likely to keep sexually aggressive peer groups and commit sexually coercive behaviour. They cited a social learning mechanism to explain this link. Another study, however, found that when comparing

adolescents who had been sexually victimised, there was no difference in experience of this abuse between AWSOHs and non-offending adolescents (Skuse et al., 1998). This contradicts the victim to victimiser hypothesis at the core of social learning theory in relation to adolescent sexual offending. The latter study was, however, limited by a small sample size. Skuse et al. (1998) did find that exposure to familial violence was a predictor of offending.

It could be argued this theory is limited in its explanation of the link between ACEs, trauma and offending. The theory posits that sexual offending is re-enacting previously experienced sexual violence; however, this does not account for the large proportions of AWSOHs who have only experienced non-sexual trauma and adversity but go on to sexually offend. Given Skuse et al. (1998) found other types of adversity predicted later offending in adolescents, this suggests a precedent for a theory that encapsulates a wider range of ACEs than social learning theory permits.

Summary, Rationale and Review Question

Previous literature has demonstrated that the vast majority of AWSOHs have experienced adversity and trauma in their childhood (Hall et al., 2018). The evidence base also suggests that AWSOHs demonstrate maladaptive psychosocial development which has implications for their offending behaviour. Given the prevalence of ACEs and maladaptive psychosocial development there may be an interaction or a correlation between the two which contribute to offending behaviour in AWSOHs. To the author's knowledge there are no systematic literature reviews that consider how different types of maladaptive psychosocial development may mediate the relationship between experienced ACEs and sexual offending behaviour. This is an important gap to address as there may be commonality between papers that have examined the link between the two, which may indicate a novel theory of sexual offending in adolescence. It could also identify a specific range of risk factors to consider not only in risk assessment and preventative work for adolescents, but also in treatment post-

offence for AWSOHs while they are still developing into young adults. This review aims to answer the following:

To what extent does maladaptive psychosocial development mediate the relationship between adverse childhood experiences and sexual offending in adolescents?

Method

Search Strategy and Data Screening

This review followed the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines and checklist (Page et al., 2021). In October 2021, the following databases were searched: OVID medline, PsycArticles and Web of Science. Retrieved papers were systematically screened using selected PECOS criteria (Population, Exposure, Comparator, Outcome, Study Design) outlined in table 1. The review focused on the psychosocial development of adolescents who have a history of sexual offending, thus studies who recruited adults and children under 10 were excluded. Given the additional complexity for later comparison of studies, and the unlikelihood of papers having participants who are 'other' genders outside of male and female or non-binary, these were excluded. This review set out to explore the impact of ACEs on an individual's development and offending behaviour, therefore studies that did not directly measure ACEs, or used a comparison group who had not experienced ACEs, were removed. Measures of ACEs included trauma, abuse and neglect as well as any factors relevant to the original ACEs study, for example divorce, as outlined in the ACE Questionnaire (Felitti et al., 1998). Similarly, papers that did not directly measure psychosocial development were excluded. Typical measures of development included the Multidimensional Assessment of Sex and Aggression (MASA; Knight & Cerce, 1999). This paper aimed to examine mediating quantifiable factors, therefore qualitative and qualitative majority mixed methods studies were not included.

Table 1

Inclusion and Exclusion Criteria for Systematic Literature Review Studies

PECOS	Inclusion Criteria	Exclusion Criteria
	Male and female	**Other gender or non-binary**
Population	**Adolescents age 10-19**	**Adults over 19; Children under 10**
	Perpetrators of sexual offences (either convicted or self-disclosed)	**Perpetrators of non-sexual offences (either convicted or self-disclosed)**
Exposure	**Measurement of adversity completed**	**No measurement of adversity**
Comparator	**No comparison group/ comparison group of non-sexual offenders or non-offenders who have experienced adversity/ AWSOHs who have not experienced adversity**	**Comparison group non-sexual offenders who have not experienced adversity**
Outcome	**Measurements of psychosocial development outcomes completed with participants**	**No measurement of psychosocial development outcomes**
	Correlational or causal-comparative/ quasi-experimental research	**Descriptive or experimental research**
Study Design	**Quantitative research**	**Qualitative research**
	Mixed methods where the majority of the data is quantitative	**Mixed methods where the majority of the data is qualitative**
	Published in English	Published in non-English language only

	Published 1998 or later	Published earlier than 1998
	Peer reviewed research	Non-peer reviewed research
	Primary research	Book reviews, books, commentaries, literature reviews, theoretical or methodological discussions, policy documents

In accordance with the Cochrane Handbook (Higgins & Thomas, 2019) an initial scope was conducted wherein key concepts, terms and relevant synonyms were explored to develop search terms. Relevant terms within each key concept were combined using the OR Boolean operator, and each key concept was combined using the AND Boolean operator. Truncation was used for spelling and word ending variators e.g. behavio* for behaviour/behavior and sex* offend* for sex/sexual offender/offending. Searches were conducted within titles and abstracts only. Search terms used can be viewed in table 2.

Table 2

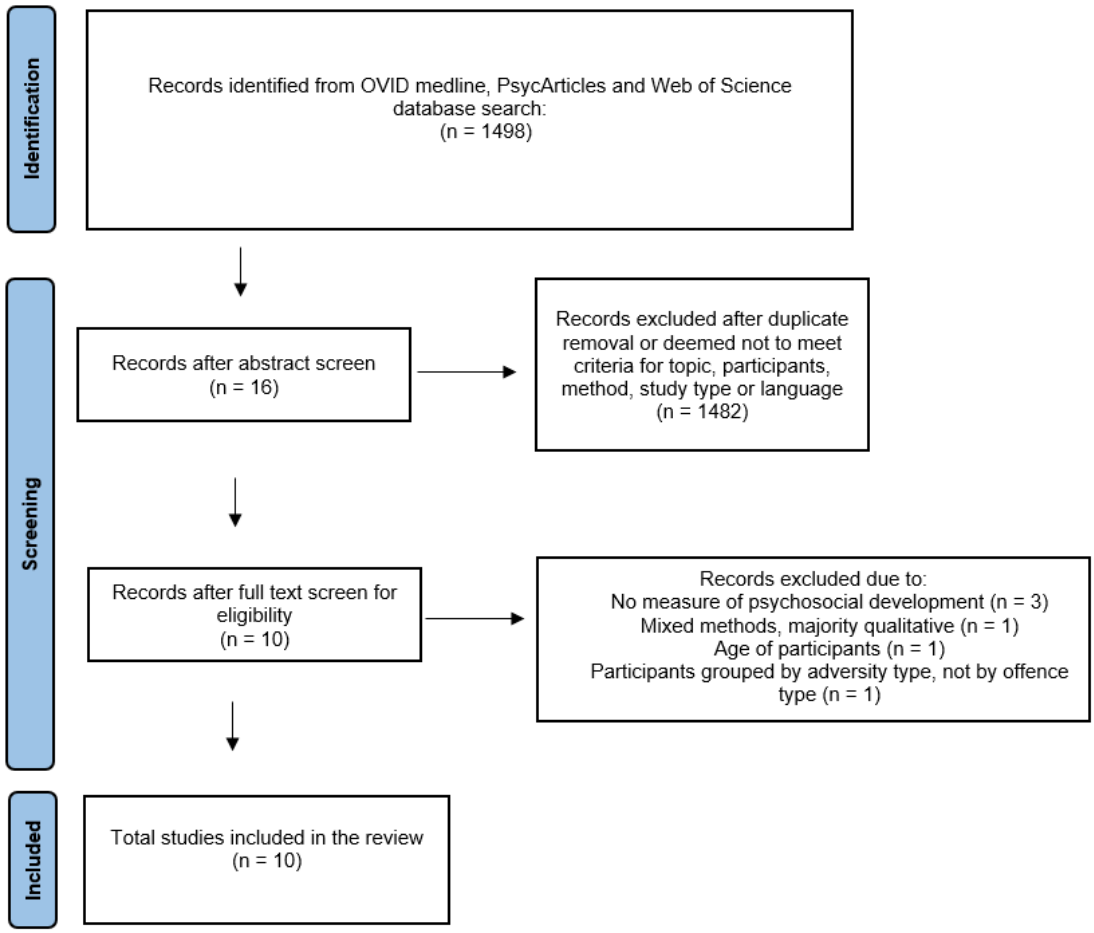
Search Terms for Systematic Review

Search Terms
Adverse childhood experiences OR ACE* OR psychological OR emotional OR sexual OR substance OR abuse OR trauma OR violence OR stress* OR maltreatment OR neglect OR criminal behavio* OR incarceration OR imprisonment OR separation OR divorce
AND
Maladaptive OR dysfunctional OR psychosocial OR cognition* OR development
AND
Sex* offend*

The initial search yielded 1498 papers (see figure 1). Duplicates were removed and titles and abstracts were examined. Studies deemed not to meet PECOS criteria were also removed. 16 papers were deemed appropriate for full text screening. An independent reviewer reviewed 6 of the studies at full text screening stage and there was an 83% inter-rater reliability with regards to a yes/no decision for inclusion. This prompted a discussion regarding the inclusion of mixed methods design, where the vast majority of the data is quantitative. After discussion we agreed there was no rationale to exclude this paper and thus the PECOS criteria were amended to reflect this. Reference lists of all included papers were screened for relevant studies missed by the search as recommended by NICE guidelines (2012). A total of 10 studies were included for review.

Figure 1

Flowchart Demonstrating Record Screening and Selection for Review



Data Extraction and Quality Appraisal

The data from the 10 studies were evaluated using the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (EPHPP: Jackson & Waters, 2005; see Appendix A). Each paper was evaluated with regards to study design, confounders, selection bias, blinding, data collection method and withdrawals and the overall quality assigned a strong, moderate or weak rating (Armijo-Olivo et al., 2012; see Appendix B). The quality of three papers were assessed by an independent reviewer who agreed with all original ratings giving 100% inter-rater reliability.

Results

A summary of the eligible studies can be viewed in table 3, followed by an in-depth examination and critique.

Table 3

Summary of Eligible Papers for the Review

Authors	Population	Design	Measures	Comparator	Outcomes and Key Findings	EPHPP Rating
1. Daversa & Knight (2007)	Male AWSOHs (USA) *N* = 329	Structural Equation Modelling	Multidimensional Assessment of Sex and Aggression administered	None	Four pathways to offending: 1) emotional and physical abuse → psychopathy (β = .73, *p* < .01) and sexual fantasy (β = .40, *p* < .001) → sexual fantasy (child), offences against children (β = .47, *p* < .001) 2) emotional and physical abuse → sexual inadequacy (β = .93, *p* < .05), sexual fantasy (β = .46, *p* < .001) → sexual fantasy (child), offences against children (β = .29, *p* < .01) 3) emotional and physical abuse → sexual inadequacy (β = .93, *p* < .05) → sexual fantasy (child), offences against	WEAK

					children (β = .29, *p* < .01) 4) sexual abuse → offences against children (β = .21, *p* < .01) **SEXUAL FANTASIES AS A MEDIATOR**	
2. Fanniff & Kimonis (2014)	AWSOHs (gender not specified) (USA) *N* = 108	Descriptive	Childhood Trauma Questionnaire administered	Adolescent offenders (non-sexual offences, gender not specified) *N* = 119	AWSOHs scored higher for sexual (*d* = .84) and emotional abuse history (*d* = .33). Emotional and physical abuse were not predictors of offending when sexual abuse was controlled for (Hosmer and Lemeshow χ^2 = 9.97, df = 8, *p* = .267). Mechanisms for the links are discussed. They also displayed higher anxiety (*d* = .49), non-significant differences in maternal attachment, fewer consensual sexual partners (*d* = –.67), fewer antisocial traits, more delinquent peers than comparator group. **EMOTION DSYREGULATION AS A MEDIATOR**	MODERATE

3. Grabell & Knight (2009)	Male AWSOHs (USA) *N* = 193	Structural Equation Modelling and Path Analysis	Multidimensional Assessment of Sex and Aggression administered	None	A relationship between experiencing abuse and sexual fantasy in AWSOHs, moderated by age abuse occurred: 3-7 age range was the only predictor (standardized β = .20, $p < .02$). Mechanisms for the links are discussed. **SEXUAL FANTASIES AS A MEDIATOR**	WEAK
4. Hummel et al. (2000)	Male AWSOHs (Germany) *N = 16*	Descriptive	Comprehensive item sheet covering developmental, sociodemographic, personal and behavioural data administered to parents, subject and social services Semi-structured interview Further information obtained from medical, social care records	Male AWSOHs without abuse history *N* = 20	Experiencing loss of one or both parents before age 14 (contingency coefficient: .402; $p < .05$), in combination with experiencing sexual abuse, impacted on attachment, primary school development and social development (contingency coefficient .302, $p > .05$) in AWSOHs. **ATTACHMENT AS A MEDIATOR**	WEAK

5. Hunter et al. (2004)	Male AWSOHs (USA) *N* = 182	Structural Equation Modelling	Social History Questionnaire administered	None	Exposure to violence against women predicted deficits in psychosocial development (β = .20, $p < .05$) which predicted offending behaviour (β = .22, $p < .05$). **EMOTION DYSREGULATION AS A MEDIATOR**	WEAK
6. Hunter et al. (2009)	Male AWSOHs (USA) *N* = 256	Structural Equation Modelling and Path Analysis	Social History Questionnaire administered	None	Sexual deviance pathway: mediated by psychosocial deficits (low self-esteem and mood disturbance; R^2 = .10). Physical and sexual victimisation and early exposure to violent and pornographic stimulus → hostile masculinity (β = .18, $p < .05$). and paedophilic interests in AWSOHs (β = .22, $p < .05$). **EMOTION DYSREGULATION AS A MEDIATOR**	WEAK
7.	Male AWSOHs (USA)	Multivariate Analysis and Structural	Social History Questionnaire administered	None	AWSOHs with pre-pubescent victims and a history of physical abuse and/or witnessing abuse	WEAK

Hunter et al. (2003)	*N* = 182	Equation Modelling	against women demonstrate greater psychosocial deficits (ideas of self and the way others view them, anxiety and depression, loneliness, dependency on adults, preference for the company of young children; β = .20, *p* < .05) than AWSOHs with pubescent victims. Less likely to use drugs, alcohol and weapons in offences. Victims of non-coercive sexual offences with adult male non-relatives influenced the offence characteristics of the AWSOHs. Consideration of heritable psychosocial deficits in AWSOHs. Psychosocial deficits mediate the link between adversity and offending: deficits in self-esteem, self-efficacy and social competency (β = .22, *p* < .05). **EMOTION DYSREGULATION AS A MEDIATOR**

8. Johnson & Knight (2000)	Male AWSOHs (USA) *N* = 122	Path Analysis	Multidimensional Assessment of Sex and Aggression administered	None	Pathways to offending: physical, sexual and alcohol abuse in childhood → peer aggression (β = .19, $p < .05$; β = .41, $p < .001$) and alcohol abuse in adolescence (β = .26, p < .01; β = .49, $p < .001$). → sexual compulsivity (β = .21, $p < .05$; β = .26, $p < .01$), hyper masculinity (β = .25, $p < .05$). β = .36, $p < .001$) → misogynistic fantasies (β = .20, $p < .05$; β = .51, $p < .001$) → sexually coercive behaviour (β = .34, $p < .01$). $R^2 = .33$. **SEXUAL FANTASIES AS A MEDIATOR**	WEAK
9. Miner et al. (2010)	Male AWSOHs (USA) *N* = 156	Descriptive	Interview Computerized survey consisting of questions from: the Denver Youth Survey, Cynicism Scale of the Minnesota Multiphasic Personality Inventory–Adolescent version, Multidimensional Inventory of	Adolescent offenders (non-sexual offences) N = 122	Anxious attachment styles have an indirect effect on sexual offending. Anxiety around and isolation from women through rejection may mean some AWSOHs may try to meet their attachment needs and seek out intimacy through offending against children. **ATTACHMENT AS A MEDIATOR**	MODERATE

			Development, Sex and Aggression (short version) Review of institutional and clinical records			
10. Netland & Miner (2012)	Male AWSOHs (USA) *N = 208*	Descriptive	Multidimensional Inventory of Development, Sex, and Aggression administered Review of institutional files	Adolescent offenders (non-sexual offences) *N* = 125	AWSOHs had less grandiosity ($F = 8.13$, $p = .000$), lower self-worth and higher empathy levels ($F = 5.55$, $p = .001$) than adolescent non-sexual offenders. No differences in psychopathy traits. AWSOHs experienced more maternal psychiatric issues ($\chi^2 = 11.59$, $p = .009$) and drug use ($\chi^2 = 8.05$, $p = .045$) which may affect attachment style. **ATTACHMENT AS A MEDIATOR**	MODERATE

Participants

Nine out of ten papers in this literature review specify they assessed male AWSOHs. Faniff and Kimonis (2014) do not specify the gender of their participants, referring to participants as “juveniles” or “delinquents”. This is an unusual omission, however they do allude to participants being male by referencing how one measure used had been shown to have internal consistency in previous research with male adolescent offenders. Nine of the ten studies were conducted in the USA. Study #4 was conducted in Germany. In all ten of the studies, AWSOHs were defined as having committed “contact” or “hands on” offences involving a physical victim, therefore AWSOHs where the offence was “non-contact”, for example viewing of illegal imagery, are not represented in this review. Paper #4 assessed participants’ IQ using a German version of the WAIS, finding no significant differences between AWSOHs with and without adversity. Only paper #2 stated that individuals with a diagnosis of an intellectual disability were screened out; the presence or absence of intellectual disabilities in the sample is not mentioned in the other papers. Each of the papers that reported the diversity of their participants demonstrated a range of ethnicities represented, including but not restricted to: Black, White, Hispanic, Latinx, Indigenous People of Northern America, Asian American and individuals who define themselves as ‘mixed race’ (the papers sometimes refer to these groups using different language, for example Caucasian and Native American).

In eight of ten papers the participants’ age range was between 12 – 19 years. Indeed, the World Health Organisation (WHO, 2022) defines adolescence as spanning ages 10 – 19. In Daversa and Knight’s (2007) study, 6% of their participant group were aged between 18 and 22. They justify including these individuals by stating that, due to the small proportion of older participants, their sample should be “considered to be within the developmental boundaries of adolescence and under the legal and responsible age of adulthood” (Daversa &

Knight, 2007, pp. 1315). The authors do not specify how they concluded this, given the legal age of adulthood in the USA, where the study was conducted is 18 (Cornell Law, 2020) and adolescence is defined by WHO as up to 19 years (WHO, 2022). They propose such a small proportion of their population would not be enough to skew the data. Grabell and Knight (2009) use the same age range 11 – 22, however do not give the same caveat for justifying inclusion of a small proportion of individuals over 19.

Papers #1, #3, #5, #6, #7 and #8 received a "weak" rating for study design using the EPHPP Quality Assessment Tool (Jackson & Waters, 2005). This was in part due to the study not having a control or comparator group. Papers #2, #9 and #10 used a comparator group of adolescents with non-sexual offence histories, to compare the adversity, development and behavioural outcomes of the two groups. Having a comparator strengthened these studies and the authors' ability to draw conclusions for how developmental pathways from adversity to sexual offending may differ from other types of offending.

Measures

Papers #1, #3 and #8 used the Multidimensional Assessment of Sex and Aggression (MASA; Knight & Cerce, 1999) to measure exposure to adversity and/or trauma and subsequent development. Assessment items included a comprehensive developmental history, psycho, social and behavioural domains, drug and alcohol history and items pertaining to sexual thoughts and behaviours. Scales within the MASA have been demonstrated to have internal consistency and good test-retest reliability (Knight et al., 1994).

Paper #9 used a survey consisting of subsets from: the Denver Youth Survey, the Cynicism Scale of the Minnesota Multiphasic Personality Inventory–Adolescent version and the Multidimensional Inventory of Development, Sex and Aggression (Butcher, 2010; Huizinga et al., 1994; MIDSA Clinical Manual, 2011). Domains measured included: self-esteem, perceived and peer isolation, cynicism, masculine adequacy, anxiety with women,

sexual compulsivity, sexual preoccupation, hypersexuality and sociosexuality. All scales used demonstrated at least adequate internal consistency, with many scoring good or excellent (Miner et al., 2010). Childhood, family and peer relationships were assessed via interview based on the history of attachments interview (Bartholomew & Horowitz, 1991). Participants' clinical and institutional records were also reviewed. Paper #10 used subscales from the MIDSA, assessing for: grandiosity, impulsivity. lack of empathy, interpersonally exploitative behaviour and risk-taking (Knight, 2004). Institutional records were reviewed to evaluate parental dysfunction.

Papers #5, #6 and #7 used what the authors describe as a social history questionnaire measuring developmental experiences in childhood, aggression and criminal behaviour. The questionnaire had good internal consistency. Developmental outcomes were assessed scales from the literature, domains included: hostile masculinity, egotistical masculinity, psychopathic and paedophilic attitudes and psychosocial deficits including anxiety, depression, withdrawal and self-esteem (Hunter et al., 2003; Hunter et al., 2004; Hunter et al., 2009).

Paper #2 used the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1997) to measure early maltreatment. The authors assessed development using The Parental Bonding Instrument (PBI; Parker et al., 1979) and a number of other scales assessing: loneliness/social isolation, anxiety, self-esteem, delinquency, peer delinquency, callous-unemotional traits and sensation-seeking (Fanniff & Kimonis, 2014). All scales used had good validity, reliability and internal consistency.

Paper #4 described using a comprehensive item sheet to measure developmental history and abnormal behaviour in childhood and adolescence. Information sources included parents, the participant, social services and medical records. Information regarding experiences of sexual abuse was obtained via interview. Socio-economic status was assessed

through paternal occupation. The authors did not report whether their item sheet had been assessed for reliability, validity or internal consistency; a weakness of the methodology.

Key Findings

All papers included in this review consider psychosocial development outcomes within the context of the relationship between exposure to adversity and offending. Each paper considers the causal relationships between adversity, development and offending. Some of the papers further assess to what extent the variance of the relationship is accounted for or mediated by the particular developmental outcome. Some papers only appraise the incidence of certain outcomes and make suggestions on how they may mediate the link. Although a vast number of psychosocial development outcomes were appraised, there was commonality between the papers, and three key variables emerged.

Emotion Dysregulation

One feature cited was development of emotion dysregulation, in particular anxiety and depression. Papers #2, #5, #6 and #7 discuss how AWSOHs demonstrate high anxiety levels, higher than their non-sexual offending counterparts. Paper #2 does not indicate to what extent anxiety may mediate the relationship, just that AWSOHs report greater anxiety than youth convicted of non-sexual crimes. They do not indicate to what extent anxiety mediates the relationship.

Papers #5, #6 and #7 investigate to what proportion emotion dysregulation mediates the relationship between adversity and sexual offending. Papers #5 and #6 use structural equation modelling to assess the relationship. Papers #5 and #7 found the relationship between exposure to abuse of females and sexually offending against children was mediated by a factor they termed “psychosocial deficits” which included measures of anxiety and depression. The proportion of variance accounted for was not very high. Paper #6 found the relationship between exposure to pornography, physical abuse and hostile masculinity

leading to paedophilia and offending was mediated by anxiety and depression. Again, the proportion of variance was small and lower than the authors predicted.

Attachment

Papers #2, #4 #9 and #10 consider attachment as a mediator. In paper #4, the authors make assumptions that loss of a parent before age 14 would lead to attachment disorders, thus mediating the relationship between this adversity and offending in AWSOHs. As they did not directly measure attachment, their conclusions are hypothetical.

Papers #9 and #10 conducted analysis of variance to assess their data. Both studies found high exposure to dysfunctional relationships and dynamics (paper #10 cites maternal psychiatric problems and substance misuse specifically) within the families and high anxious attachment in AWSOHs. They suggest that anxious attachment mediates the link between the family environment and offending behaviour, but this is not supported by the data as there was no analysis of variance or path analysis conducted to explore the links.

Paper #2 assessed attachment but found no significant differences between AWSOHs and adolescents with non-sexual offence histories. Both groups displayed disturbances in attachment, and both groups reported experiencing adversities. These factors were analysed independently, however, and the authors did not explore to what extent attachment may have mediated the relationship for AWSOHs specifically.

Sexual Fantasies

Papers #1, #3 and #8 suggest that development of offence fantasies have a mediating role in the link between adversity and offending. In paper #1, the authors completed a path analysis from sexual, physical and emotional abuse and caregiver instability to sexual offences against child victims. They found development of sexual fantasies mediated the relationship between physical and sexual abuse and offending. They found strong, significant, direct mediation effects of fantasies between being a victim of sexual abuse and offending.

They also found strong significant mediating effects of fantasy, in combination with development of psychopathy in the relationship between being a victim of physical abuse and offending.

Using path analysis, paper #3 found that when sexual abuse is experienced between the ages of three and seven sexual fantasy mediated the relationship between this abuse and perpetration of sexual offences. The effect size for this was small. For other age groups of experienced abuse (between naught and 17), no significant mediating effects of fantasy were found.

Paper #8, using path analysis, found that development of misogynistic fantasies mediated the relationship between sexual and physical abuse, and childhood alcohol abuse and sexual coercive behaviour in adolescence. They found fantasy shared a mediation role with peer aggression and alcohol abuse in teen years. They found fantasies accounted for a significant proportion of the variance in most cases, however there were also some direct relationships between sexual abuse and coercive behaviour without fantasy playing a mediating role. These were less significant and had a smaller effect size.

Discussion

This review set out to explore whether maladaptive psychosocial development mediates the relationship between exposure to early trauma and adversity and later sexual offending behaviour in adolescents. The key findings suggest that the relationship between early adversity and sexual offending is mediated, at least in part, by specific psychosocial development outcomes in adolescence: emotion dysregulation, attachment and fantasising behaviours. This adds to the current evidence as it demonstrates a potential interaction of unique risk factors that result in sexual offending in adolescence. Thus, starting to explore why some adolescents who experience these adversities and development outcomes go on to offend and some do not.

The suggested links proposed by the papers in this review appear to be supported by current theoretical models of development, especially in relation to offending. The findings in this review are consistent with the wider literature base that exposure to early adversity and trauma can have a severe impact on a child's ability to regulate their emotions resulting in anxiety and depression (Felitti et al., 1998; Nelson et al., 2020). Current theories suggest early adversity causes a child's threat response to be affected, in that physiological mechanisms in the brain and body are triggered more readily, sustained for longer periods of time and are more difficult to manage and return to baseline (Teicher & Samson, 2016; van der Kolk, 2003).

In paper #5, Hunter et al., (2004) suggest that low self-esteem linked to anxiety and depression mediates the relationship between adversity and offending; they suggest sexual offending becomes compensatory due to this as AWSOHs lack the skill and confidence to compete with other males for a sexual partner. In paper #2, the authors suggest exposure to adversity impacts on a child's ability to self-regulate which can manifest as anxiety, and that AWSOHs are more anxious overall (Fanniff & Kimonis, 2014).

Ward and Siegert (2002) propose an etiological role for emotion dysregulation in the pathway to sexual offending. They suggest that emotion dysregulation plays a role in a person's ability to cope under times of stress, and in combination with other contributing factors, individuals may use sexual offending as a way to soothe when they have no other strategies. This could be pertinent for adolescents whose increased thoughts and impulses about sex often intersect with challenges emotionally and hormonally (Marshall & Barbaree, 1990).

It is likely that these challenges begin to manifest during the industry vs inferiority conflict cited in Erikson's (1963) psychosocial stages of development wherein social and academic demands begin to increase as a child gets older and failure to cope leads to feelings

of inferiority. This stage of development likely interacts with some children's difficulties with emotional regulation, resulting in their developing into an adolescent who feels inferior to their peers and unable to cope with stressors.

Linked to emotion dysregulation, a number of papers in this review found attachment plays a role in the pathway from adversity to offending. In tandem with difficulties coping with stressors, a child with adverse experiences is more likely to develop an insecure attachment style (Thomson & Jaque, 2017). Within the context of AWSOHs it is proposed that development of an insecure attachment style can result in difficulties with social interaction and connectedness with peers and wanted romantic partners (Felizzi, 2015). This is supported by attachment theories that suggest attachments formed in early childhood are repeated during adolescence and adulthood (Fraley & Roisman, 2019; Hazen & Shaver, 1987).

In paper #9, the authors propose that anxious attachment patterns affect psychosexual development in relating to women and feeling isolated from others. They suggest anxious attachment can result in low self-worth, a need for intimacy and a fear of rejection or being unable to form a romantic attachment which results in offending behaviour in AWSOHs, especially offences against children (Miner et al., 2010). In paper #10, the authors provide further exploration of how adversity could contribute to an anxious attachment style. They suggest that maternal dysfunction, in particular substance misuse and mental health problems, could contribute to an anxious pattern as they are less attuned and available to meet the needs of their child (Netland & Miner, 2012).

In paper #4, Hummel et al. (2000) also suggest a role for attachment within this context. They propose that disrupted attachment from loss of a parent before age 14 can make adolescents more susceptible to sexual abuse, which can affect the AWSOHs sense of self and others, impacting on social connectedness and development.

Attachment as a lens to understand developmental causes of sexual offending has been extensively covered in the evidence base (Baker et al., 2006; Whitaker et al., 2008). Anxiously attached individuals commonly display hypervigilance for fear of losing their relationships and can display obsessive tendencies and try to control others (Honari & Saremi, 2015). The papers reviewed suggest that because of these behavioural patterns anxiously attached children display, they can go on to struggle to form meaningful relationships with others, resulting in feelings of loneliness and intense fear of rejection (Miner et al., 2010; Netland & Miner, 2012). Anxious attachment could disrupt the adolescence and young adulthood stages of psychosocial development, leaving the child feeling isolated and having a weak sense of self (Erikson, 1963). It is proposed that sexual offending behaviour can occur in adolescence either through seeking out individuals who are powerless and less likely to reject (offences against younger children) or through coercive or aggressive means (offences against peers).

Either as a direct result of experiencing abuse and adversity, or being unable to form romantic relationships with peers, some children may fantasise about abuse or offending scenarios, which can continue into adolescence (Daversa & Knight, 2007; Grabell & Knight, 2009; Johnson & Knight, 2000). In paper #1, the authors propose a path from abuse to development of feeling inadequate physically, sexually and as a ‘man’ which can lead to a preoccupation with sex and entertaining offence fantasies (Daversa & Knight, 2007). In paper #3, Grabell and Knight (2009) suggest a sensitive period of age three to seven wherein sexual abuse can predict the onset of unhealthy and illegal sexual fantasy. They propose that disrupted development in this age range because of sexual abuse can cause the individual to struggle with impulsivity and inhibition control later in life, thus making sexually coercive behaviour more likely. The authors suggest their findings differ to that of Burton et al. (2002) who found that sustained sexual abuse correlated more to later perpetration than sensitive age

periods. The findings of both studies propose a potential combination of age of onset and duration of abuse are important contributors to sexual offence attitudes and behaviours.

This links to Erikson's stages of psychosocial development and it could be proposed that fantasies, in some cases, are a direct outcome of a child struggling to develop a sense of self-worth and competence that they can achieve their goals (Erikson, 1963).

This is especially pertinent given the key role fantasising has in the four preconditions model (Finkelhor, 1984). The model suggests fantasising in combination with masturbating about these fantasies can trigger a pathway to offending, when masturbation becomes unsatisfactory, and individuals seek to play out their fantasies in the real world. The model suggests once masturbation to fantasies becomes mundane, and the individual has developed cognitive distortions to justify offending to themselves, this combination can significantly increase the likelihood of sexual offending.

Clinical Implications

The main clinical implications from this review are regarding treatment options for AWSOHs and preventative measures for at risk adolescents. There are considerations for exploring these specific risk factors in risk assessment and increasing awareness of all multi-disciplinary mental health clinicians that adolescents who have experienced adversity and demonstrate problems with emotion dysregulation, attachment and sexual fantasies could be at increased risk of sexual offending. While not all adolescents with this background who demonstrate problems in their development will offend, clinicians might consider this as additional complexity within their formulations and appraise an individual's situation through a trauma informed lens (Levenson, 2014) to shape potential interventions.

The findings of this review suggest a greater need to implement treatment for AWSOHs with a focus on exploring their life and experienced adversity and trauma. The papers in this review report that many AWSOHs have experienced trauma (for example

emotional, physical and sexual abuse) and their lived adversity (for example mothers with psychiatric and drug abuse issues) could mean they received little support during those times. Treatment could work to help resolve and process these experiences. Suggested approaches that AWSOHs could access to process their trauma are Eye Movement Desensitisation and Reprocessing Therapy, Narrative Therapy and Cognitive Behavioural Therapy (Hassija & Cloitre, 2015; Shapiro & Maxfield, 2002; Wamser- Nanney et al., 2016). Once they have been able to piece together their experiences and make sense of them, an AWSOH could be supported using, for example Cognitive Analytic Therapy approaches, to consider how their adverse experiences impacted on their psychosocial development and offending behaviour. They could be supported to change the way they relate to themselves and others and develop psychosocial skills and other coping strategies which could be protective against further offending. Clinical psychologists could be offered training in using these approaches with AWSOHs and services could be redesigned to allow clinicians to offer more individual therapeutic sessions to support their clients.

The psychosocial impact of adversity and trauma suggests a precedent for preventative measures for at risk adolescents, creating a point of intervention to reduce the risk of offending. Interventions could be implemented by clinicians as part of engagement with mental health services, but for adolescents that do not seek support for such services, clinicians could provide consultation to schools. They could provide education and consultation for teachers, whilst also supporting them to implement similar interventions in an education setting that is more likely to reach adolescents who do not wish to engage with mental health services. This provides evidence to support development of more initiatives like the Tackling Crime Together approach (Catch 22, 2019) which promote addressing crime prevention and intervention in the community.

Points of intervention could include supporting adolescents to counter isolation, develop social skills, feel more competent in social interactions and foster friendships and peer affiliations. Building up the self-worth, self-esteem and coping skills of at-risk adolescents with identified adversity would be important. Given the identification of alcohol abuse as a risk factor, increased education, assessment and support for adolescent alcohol abuse needs to be considered. Systemically, there could be opportunities for increasing familial support and fostering warmth in the family environment. Finally, clinicians could increase their awareness, and consider in their formulation, the impact of emotion dysregulation, anxiety, depression and PTSD increasing the risk of sexual offending in some adolescents demonstrating other vulnerabilities and adversities highlighted in this review.

Strengths, Limitations and Future Directions

A strength of this review is that it considers the developmental consequences of adolescents experiencing adversity and trauma. A limitation of previous literature in this topic area is that they appraise the number of adverse experiences and traumas experienced, or the psychosocial outcomes for AWSOHs, but in isolation. This review considers both and the theoretical links between the two, thus adding to and strengthening the evidence base for potential causes of sexual offending in adolescence.

A limitation of this review is that it is only able to make partial conclusions regarding to what extent maladaptive psychosocial development mediates the relationship between adverse childhood experiences and sexual offending in adolescents due to methodological issues in many of the studies. A strength is that papers #1, #3, #5, #6, #7 and #8 use structural equation modelling and path analysis to demonstrate what proportion of the variance can be explained by certain psychosocial development outcomes within the relationship between adversity and offending. All the other papers, however, examined adversity, development and offending in isolation, and then made tentative suggestions for links. Though intuitive,

making assumptions and suggestions does not directly evidence how their studies' psychosocial development outcomes are mediating the relationship which results in weak conclusions and makes it difficult to conclude causal relationships.

Other limitations of this review are that the method of choosing specific search terms in a literature review could mean studies that used atypical language to title their paper could have been missed. For example, "delinquents" was found to be a common term during the review, but this was not part of the search criteria.

Finally, a limitation of this review is all participants were male, and nine of ten papers were from the USA. It is possible that male or male majority cohorts are unavoidable, given the proportion of sexual offences committed by females is approximately 2.2% (Cortoni et al., 2017). A USA sample results in problems with the generalisability of the findings of these studies, especially as the criminal justice system differs so substantially from other countries. For example, the USA has approximately 629 prisoners per 100,000 population whereas the UK only has 132 per 100,000 (World Prison Brief, Institute for Crime & Justice Policy Research, 2022). It is documented that the USA has a disproportionate number of black and minority individuals from low socio-economic backgrounds who are imprisoned (Wildeman & Wang, 2017), indicating the potential for USA based studies to be idiosyncratic and not applicable to other contexts and countries.

Future research in this area could include a systematic literature review that considers relevant qualitative literature, given this review only appraised quantitative studies. This could illuminate findings missed in this review. Further studies could expand on the findings of this review. AWSOHs could be interviewed to explore views of their adversity and how they feel it has impacted on their life, and whether they feel it contributed to their offending behaviour. Similarly, interviews could be conducted with parents and clinicians working with AWSOHs for their experiences of the way the AWSOHs have developed from their

adversity. Further studies could consider what is protective, and why not all individuals that experience the adversity and psychosocial development outlined in this review go on to sexually offend. Data from securely attached AWSOHs could be examined to explore what other mediating factors might be present.

Conclusion

This literature review aimed to systematically review the evidence base to explore to what extent maladaptive psychosocial development mediates the relationship between adverse childhood experiences and later going on to sexually offend in adolescence. Key findings were that emotion dysregulation, attachment and development of offence fantasies appear to mediate the relationship for AWSOHs who have experienced adversity to some extent. Firm conclusions could not be made due to several methodological issues within the papers. Attachment theory and Erikson's psychosocial stages of development are posited to play a role in these links. The findings of this study provide support for existing pathway theories of sexual offending in adolescence.

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Appendix A

EPHPP Tool

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP
Effective Public Health Practice Project

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify _____
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

Final decision of both reviewers (circle one):

1 STRONG
2 MODERATE
3 WEAK

Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended. Mixed methods studies can be quality assessed using this tool with the quantitative component of the study.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)
An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A study that uses observations at multiple time points before and after an intervention (the 'interruption'). The design attempts to detect whether the intervention has had an effect significantly greater than any underlying trend over time.
Exclusion: Studies that do not have a clearly defined point in time when the intervention occurred and at least three data points before and three after the intervention

Other:
One time surveys or interviews

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

Score **NOT APPLICABLE** if the study was a one-time interview or survey where there was not follow-up data reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Component Ratings of Study:

For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS

Good: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Fair: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).

Poor: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) DESIGN

Good: will be assigned to those articles that described RCTs and CCTs.

Fair: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: will be assigned to those that used any other method or did not state the method used.

C) CONFOUNDERS

Good: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1).

Fair: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2).

Poor: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

D) BLINDING

Good: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and** the study participants are not aware of the research question (Q2 is 2).

Fair: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2).

Poor: The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1); **or** blinding is not described (Q1 is 3 and Q2 is 3).

E) DATA COLLECTION METHODS

Good: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

Fair: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

Poor: The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:

Good: will be assigned when the follow-up rate is 80% or greater (Q1 is 1 and Q2 is 1).

Fair: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q1 is 4 or Q2 is 5.

Poor: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q1 is No or Q2 is 4).

Not Applicable: if Q1 is 4 or Q2 is 5.

Appendix B

EPHPP Component Ratings

Paper #	EPHPP Component Rating						
	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawals and Drop-Outs	Overall Rating
1	Weak	Weak	Strong	Strong	Strong	Moderate	Weak
2	Weak	Moderate	Strong	Strong	Strong	Moderate	Moderate
3	Weak	Weak	Strong	Strong	Strong	Moderate	Weak
4	Moderate	Moderate	Strong	Strong	Weak	Moderate	Weak
5	Weak	Weak	Strong	Strong	Weak	Moderate	Weak
6	Weak	Weak	Strong	Strong	Weak	Moderate	Weak
7	Weak	Weak	Strong	Strong	Weak	Moderate	Weak
8	Weak	Weak	Strong	Strong	Strong	Moderate	Weak
9	Weak	Moderate	Strong	Strong	Strong	Moderate	Moderate
10	Weak	Moderate	Strong	Strong	Strong	Moderate	Moderate

Appendix C

Copy of Instructions for Authors for Sexual Abuse Journal

https://journals.sagepub.com/author-instructions/SAX

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Understanding Their Story: Investigating the Narratives of Persons with Sexual Offence Histories and Adverse Childhood Experiences

Trainee Name:	**Eleanor Hall**
Primary Research Supervisor:	**Dr Janet Smithson**, Senior Lecturer
Secondary Research Supervisor:	**Dr Alicia Smith**, Clinical Psychologist
Target Journal:	Sexual Abuse
Word Count:	8265 words (excluding abstract, headings, references, appendices)

Submitted in partial fulfilment of requirements for the Doctorate Degree in Clinical Psychology, University of Exeter

Abstract

The evidence base suggests many persons with sexual offence histories (PWSOHs) have experienced adversity in their childhood. This study sought to explore the narratives of these individuals and how they believe adversity impacted on their offending behaviour. 12 men in the community who had childhood adversity, a sexual offence history and treatment within the prison and probation service volunteered to share their story. Key narratives elicited included: experiences of relationships, the absence of gendered socialisation, the internal struggle, the problem with current treatment and wider attitudes and moral issues. This analysis provides support for the developmental psychopathological perspective that suggests adversity and trauma directly impacts psychosocial and psychosexual development, creating a catalyst for later offending behaviour. Clinical implications include a need for change in societal attitudes to improve access to preventative support for at risk individuals, improved 1:1 therapy access for PWSOHs and a need for a trauma informed approach in prisons and probation. Strengths, limitations and future directions are considered. Future directions include conducting similar interviews in a prison population to explore contrasts and comparisons to the narratives from this study.

Keywords: narratives, childhood, adversity, trauma, sexual offence histories

Introduction

Childhood Trauma and Adversity

The DSM-5 defines trauma as "one of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (American Psychological Association, 2011, pp.271). A person can experience trauma through witnessing or direct experience of the event (American Psychological Association, 2000; Levenson, 2014). The long-term harmful impact of trauma has been extensively studied (Anda et al., 2010; Felitti et al., 1998) and can be observed across bio-psycho-social outcomes including alcohol and drug abuse, depression and poor health (Felitti et al., 1998). Experienced trauma also has implications for brain and nervous system development, in particular an individual's stress response and ability to cope with stress (Teicher & Samson, 2016; van der Kolk, 2003).

The DSM-5 does not include psychosocial stressors within its definition of trauma. Experience of stressors like divorce or parental mental health problems are not deemed to pose an immediate threat and are not included. Adverse Childhood Experiences (ACEs) is a term that encapsulates both trauma and psychosocial stressors. ACEs can be defined as: experiences resulting in emotional, physical or sexual abuse, emotional and physical neglect, witnessed domestic violence, substance misuse, familial mental illness, separation, divorce or incarceration (Felitti et al., 1998; The Centers for Disease Control and Prevention, 2020). This definition is limited. McLaughlin (2016) argues that definitions and measurements of childhood adversity are inconsistent, proposing an alternative definition of childhood adversity: "experiences that are likely to require significant adaptation by an average child and that represent a deviation from the expectable environment" (McLaughlin, 2016, p. 363). This indicates the subjective nature of adversity and how a person may come to understand their childhood experience(s) as adverse through reflection on how they were shaped by their

environment. With this broader definition, any experience could be described as adverse if the person finds meaning in remembering it that way. Despite the complexities of defining ACEs, as a concept it has proved beneficial when exploring the impact of ACEs on mental health throughout the lifespan, as well as within an offending context (Felitti et al., 1998; Levenson et al., 2016).

It is recognised that persons with sexual offence histories (PWSOHs) have more ACEs compared to the general population (Levenson et al., 2016; Reavis et al., 2013; Strickland, 2008). It is estimated there are approximately 850,000 PWSOHs in the UK (National Crime Agency, 2020). In a comparison study, 31% of PWSOHs had experienced sexual abuse compared to 3% in a control sample (Groth & Burgess, 1979). Another study found 45.7% of 679 PWSOHs sampled reported having 4 or more ACEs, with sexual abuse being one of the most prevalent (Levenson et al., 2016).

A meta-analysis comparing data from 1,037 PWSOHs and 1,762 offenders (non-sexual) found higher rates of experienced sexual abuse in PWSOH (Jespersen et al., 2009). There was no significant difference in rates of physical abuse between groups. Another study found only 4% of the PWSOHs sampled had experienced sexual abuse (Leach et al., 2016). This study benefitted from a prospective design, however used official records of abuse and offending rates. Potentially the true prevalence was under-represented given how common the disparity is between officially recorded and self-reported adversity (Pinto & Maia, 2013).

The literature suggests ACEs are linked to bio-psycho-social outcomes that may have a direct implication in later offending behaviour. Felitti et al. (1998) argue that there is a relationship between number of ACEs and subsequent depression, anxiety and issues managing anger. The authors suggest that individuals with more ACEs may use sex as a coping mechanism due to the immediate physical and psychological gratification it provides.

A Proposed Pathway from ACEs to Sexual Offending

A developmental psychopathological perspective can be applied to examine the link between ACEs and subsequent offending behaviour (Levenson & Socia, 2016). Rutter and Srouf (2000) propose that through affective and cognitive processes, individuals attach meaning to their experiences and adapt their behaviour as a result. An environment of adversity could mean that adaptive coping and functioning skills are not learned in childhood and adolescence (Cicchetti & Banny, 2014). Adversity may impact on a variety of psychosocial and psychosexual processes, thus creating a cumulative effect of maladaptive development (Masten & Cicchetti, 2010). Given that children who experience one ACE are likely to go on to experience more, this cumulative effect could be especially pernicious (Dong et al., 2004). Levenson and Socia (2016) suggest that adverse environments can result in maladaptive cognitive schema development and emotion dysregulation, while other literature suggests that problematic internalising and externalising behaviours are a common outcome of ACEs (Zaremba & Keiley, 2011).

There is evidence to suggest that PWSOHs demonstrate maladaptive psychosocial development, for example distorted schemas regarding relationships (Chakhssi et al., 2013); depression, anxiety, dysregulated affect, challenging peer interactions and offending behaviour (Zaremba & Keiley, 2011). This is pertinent given the high figures of PWSOHs with ACEs (Levinson et al., 2016).

Historical and Current Treatment for PWSOHs

Launched in 1992 by Her Majesty's Prisons in England and Wales, the Sex Offenders Treatment Programme (SOTP; Mews et al., 2017) was the main treatment option for PWSOHs until 2017. SOTP was replaced by the Horizon course after an impact evaluation of SOTP conducted by Mews et al. (2017) found that "core SOTP in prisons is generally associated with little or no changes in sexual and non-sexual reoffending" (p.4). Horizon is a shorter course that can be accessed by both PWSOHs who maintain their innocence or admit

their guilt (Wilkinson & Powis, 2019). Horizon promotes the Good Lives Model (Ward & Maruna, 2007) and promotes "strengths based and future focussed" approaches (Wilkinson & Powis, 2019, p. 3). The Good Lives Model suggests that PWSOHs lack the ability to achieve wanted outcomes in their life, and offending occurs when it is the only strategy they have to achieve such an outcome, for example offending to fulfil some form of romantic relationship (Ward & Maruna, 2007). The model aims for PWSOHs to build on existing strengths to develop skills to live an offence free life (Ward & Maruna, 2007).

Feedback from staff and PWSOHs on Horizon was mainly positive with reports of skill building and quality of life improvement (Wilkinson & Powis, 2019). Concerns included the lack of opportunity for individual support for group members and inconsistencies in whether to disclose offences, making the course less specific to sexual offences (Her Majesty's Inspectorate of Probation, 2019; Wilkinson & Powis, 2019). It could be argued that current treatment options focus on attempting to reduce reoffending without explicitly addressing mental health problems. For example, the effects of trauma and PTSD on sexual beliefs, attitudes and behaviours about relationships and intimacy. Not addressing potential drivers for offending could mean any change is short-term or superficial.

Group-based treatment options typically follow a "one size fits all" approach that is unlikely to meet the needs of such a diverse group of people (Levinson, 2014). Treatment may also have the potential to be retraumatising, for example, listening to abuse perpetration similar to experienced abuse, which may result in PWSOHs reverting to old coping strategies directly implicated in their offending (Levinson, 2014).

A New Treatment Approach?

Previous literature argues that supporting PWSOHs to process and resolve their trauma and adversity should be essential in the process of treatment and rehabilitation (Levenson, 2014; Levenson et al., 2016; McMackin et al., 2002). In particular, the

relationship between trauma and adversity to the development of a PWSOH's values, assumptions and attitudes (Levenson, 2014). Current treatment options somewhat address psychosocial development and encourage skill building, but do not consider how trauma and adversity may be at the root. Exploring dysfunctional coping strategies and how PWSOHs and experienced adversity meet their emotional needs and relate to others is crucial in understanding and restructuring how they interact with others and the world around them (Levinson, 2014).

Previous studies have quantified ACEs in PWSOHs through questionnaire data (Levinson et al., 2016) or interviewed clinicians on what a new treatment option could include (McMackin et al., 2002). Furthermore, much of the current research has been conducted in the USA and may not be applicable to a UK setting and population. McMackin et al. (2002) propose that "a study using direct assessment techniques of the offenders themselves would strengthen the evidence" (p. 38).

Studies interviewing adolescents and adults with offending histories regarding their ACEs have found that individuals are able to discuss their past in detail and demonstrate reflexivity (Dixon et al., 2005; Haapasalo & Kankkonen, 1997; Paton et al., 2009). The authors of these studies suggest links between early experience and current mental health issues and behaviour. There is a need for qualitative research to explore these links in PWSOHs to establish common themes, patterns and experiences that could be explored and targeted in treatment. Current treatment is future focussed and largely does not address PWSOHs backgrounds that shaped their attitudes, values and behaviour. Qualitative research that demonstrates how instrumental childhood adversity was in the offending behaviour of PWSOHs could set a precedence for incorporating understanding and processing of this adversity into treatment.

The Role of the Individual's Story and Narrative Approaches

Previous studies have quantified ACEs in PWSOHs, but these are limited to retrospective data which lacks depth and detail. I aim to capture the narratives of PWSOHs who have experienced ACEs and explore their story of how these relate to their offending.

To my knowledge, there are no narrative studies analysing the stories of PWSOH who now live in the community. It is important to understand how PWSOHs construct their narratives of ACEs and later offending as this could inform development of trauma informed treatment that utilises aspects of narrative therapy. Treatment could support PWSOHs to explore how their childhood experiences link to their offending, process and resolve these experiences and re-construct new narratives to support living an offence free life. This could include exploring how ACEs may have influenced development of maladaptive schemas, attitudes, coping strategies and behaviours, which could all be targeted as points of change in treatment. The narratives may also indicate what could be considered 'early warning signs' or interactions of specific experiences and risk factors in children. Clinical psychologists could have an active role across child mental health settings to help identify and formulate a child's experience to inform evidence-based intervention to change attitudes, values, build skills and promote self-esteem to change a child's developmental trajectory and actively prevent future offending. Finally, the PWSOHs will be asked about their experiences of the current treatment models, with a view to informing how future models could be improved directly from PWSOH feedback.

My narrative research questions are thus:

What are the narratives of adverse childhood experiences (ACEs) from persons with sexual offence histories?

How do persons with sexual offence histories use these narratives to partially or fully explain why they later committed a sexual offence?

Method

Research Approach

Epistemological (social) constructionism is the idea that a person's knowledge is constructed rather than based in fact (Smith, 2016). It suggests that we construct meaning through social context and subjective interaction with the world (Doan, 1997). Social constructionism accepts that there are inherited genetic influences, however it chooses to focus on how individuals develop knowledge through sharing all that is psychological with others in their society (Galbin, 2014). It is rooted in social mechanisms, rather than focussing on the individual (Andrews, 2012).

Social constructionism is the foundation of many narrative approaches. They are rooted in the notion that experience and identity is communicated and understood through use of narratives which construct a life story (Smith, 2016). Narratives actively attribute meaning and order to subjective experience so that individuals may construct a sense of themselves, making them far more than simply passive story telling (Doan, 1997; Smith, 2016). Narrative approaches explore how a person's understanding and interpretation of their life story shaped who they are, and their narrative does not have to be centred in absolute truth (Riessman, 2004; Smith, 2016).

I took a social constructionism approach in this paper and assumed that maladaptive learning occurs through interaction and social context. In a therapeutic setting, damaging dominant narratives for a PWSOH can be challenged by the therapist in order to support re-constructing and re-author their life to one that aligns with their values (Nylund & Nylund, 2003). A social constructionist approach also allows for PWSOHs to identify adversity not

currently encapsulated by current definitions, allowing for new understandings of what a person may consider an adverse and impactful experience.

Autobiographical Narratives

Data for this study was collected using an autobiographical narrative approach (Schütze, 2016). Participants discussed their life story within the context of ACEs and offending through narrative interview. This approach elicits an individual's social and psychological experiences to explore how their values and attitudes may have developed over time (Svašek & Domecka, 2012). This method can provide a space for individuals to discuss and reflect on the difficult aspects of their life (Svašek & Domecka, 2012) and is a suitable approach for discussing adversity. A narrative approach was taken as it allows for the life story to be shared and how it was told and unfolded can be analysed. This can illuminate how an individual learns and develops and how they make sense of why they went on to offend. Other approaches were considered but not used. For example, Interpretative Phenomenological Analysis (IPA) was not used as I was not looking to explore specific phenomenon or experience of one particular event; rather, I required an approach that would allow for storytelling around multiple experiences across the lifespan, and understanding how participants relate their various life experiences to each other. Similarly, Thematic Analysis would have been a possible approach, but I wanted to focus on the longer-term sense-making by participants of their childhood experiences, with an emphasis primarily on individual life histories rather than on common themes.

Schütze's method has been utilised in research with forensic populations, demonstrating the method can facilitate exploration of how a person's identity forms, and support re-evaluation of life choices which can promote rehabilitation (Szczepanik & Siebert, 2016).

Reflexive Journalling

I was conscious that my pre-existing perspectives, thoughts and feelings could influence data analysis (Smythe & Murray, 2000). Throughout data collection and subsequent analysis, I kept a journal to consider my thoughts, biases and assumptions and explore their impact on this research (Appendix H; Smythe & Murray, 2000). This was important given the nature of the topic, likelihood of experiencing distress hearing the stories and how my perceptions of the PWSOHs and what I am open to talking about in this piece may be affected by wider societal and media influences.

Ethical Considerations

Ethical approval was granted by the School of Psychology Ethics Committee, Exeter University (see Appendix A). The DClinPsy Programme paid for all research expenses. Informed consent (Schuck, 1994) was acquired through providing information sheets (see Appendix B) and giving participants opportunities to ask questions before providing consent. I was aware that the interview topic may cause distress (Legerski & Bunnell, 2010) and that PWSOHs are often ostracised from society resulting in less access to support networks (Blagden & Pemberton, 2010). After the interview a mood measure briefly assessed how the participant felt. I used an affect elevating exercise and informal discussion to allow the participants to re-establish psychological distance from their narratives of adversity and return their mood to baseline. The participants were continually reminded they could pause the interview or withdraw completely at any point. They were also signposted to support services in their debrief.

I used my clinical judgement to continually assess whether the participants' narratives indicated a current risk of harm to themselves, to others or from others and planned to call 999, 111 or write to their GP (see Appendix G) depending on severity and imminence of risk. A measure assessed the impact of the study on their mood (see interview method). I planned

to call if a participant shared they were at risk of harming themselves or others or at risk from others.

Participants

Participants were recruited via an independent charity for individuals with criminal convictions, who agreed to send my research poster to their members. 33 men and women responded, however only men continued to express their interest once they received more information. A total of 12 men who met criteria volunteered to share their story. All had self-reported ACEs, been convicted or cautioned for a sexual offence and had accessed a form of treatment in the last 15 years. All were living in the community having served their sentence/s.

During recruitment potential participants were told they would not have to share any details of their offence. This was done to encourage individuals who may be reluctant to share this information to take part. Also, this research focusses on a person's life story leading up to offending, and thus knowing the offence characteristics was not necessary. Each of the men who took part did, however, go into brief detail about their offences with nine reporting 'non-contact' internet-based offences and three reporting 'contact' offences which involved physical victims. Pseudonyms are used throughout, and all identifiable information has been removed.

Interview Method

Once informed consent was obtained, interviews were arranged via Zoom, an encrypted video conferencing platform. Face-to-face interviews were not possible due to COVID-19, however, Zoom made interviews with participants who lived across the UK more accessible. I checked the men were in a private and quiet space to talk before commencing the interview (Seitz, 2016).

Prior to data collection, I conducted a pilot interview with a volunteer who did not meet study criteria. The volunteer fed back that he felt the questions were clear, reasonable, and made sense. He noted the mood exercises felt appropriate. The interviews followed Kaźmierska's (2004) five phases (table 1).

Table 1

Phases of Autobiographical Interview (Kaźmierska, 2004)

Phases	**Features**
Initial	Not recorded Informal discussions Build trust and rapport
Stimulating a Narration	Ask initial question relevant to research aims Emphasise interest in narrator's story
Main Story	Narrator tells life story Interviewer listens and does not interrupt Non-verbal cues of encouragement for the narrator to continue their story are permitted Interviewer may take notes
Additional Enquiry	Interviewer is confident narrator has finished their story Clarification and theoretical questions posited to narrator
Closing	Not recorded Informal conversation re-established Interviewer and narrator may discuss disparate views

Informal discussions and collection of demographic information was conducted before recording started to establish rapport (see Appendix D). I listened to the narrative question response without interrupting or speaking, only giving non-verbal encouragement where appropriate (Kaźmierska, 2004) until they had finished their narrative (Jovchelovitch & Bauer, 2000). I followed up to clarify aspects of their story, ask relevant theoretical questions and explore experiences of treatment. After recording, I closed with informal

discussion and completed a Positive Affect Negative Affect Schedule (PANAS: Watson et al., 1988) to evaluate their mood. Each participant was invited to tell me about a time they had acted in line with their values and been their best self as a mood lifting exercise.

The men were provided with a debrief which included signposting to support services (Appendix F). They were later offered their transcript to review for accuracy of representation, and all who responded stated they were happy with their transcript.

Method of Analysis

I transcribed the data verbatim and firstly summarised each story, noting the structure of each. I then used Gibbs' (2018, table 2) phases of narrative analysis to analyse each story at the macro and micro level, identifying themes across narratives.

Table 2

Phases of Narrative Analysis (Gibbs, 2018)

Phase of Analysis	**Details**
Familiarise transcript	Read transcript multiple times, familiarise content and structure
Identify themes	Identify events, experiences, accounts, explanations, excuses, interactions, chronology, subjects, plot and imagery
Summarise	Prepare a short, written summary of key features
Thematic and structural points	Examine themes and transitions between themes, where themes feature within the narrative/ life story
Contradictions and omissions	Examine contradictions in content, mood and evaluation. Examine omissions in the narrative
Sub-plots	Identify embedded sub-plots and how they may or may not link to the overall narrative
Other features	Identify emotive language, metaphors, imagery, discussion of feelings, specific word use

Code themes; coding frame	Develop a coding frame incorporating identified themes
Connect to the literature	Make links between the narrative analysis and existing theory and literature
Comparisons	Compare and contrast narrative analysis of each interview

Once the chosen narrative themes were established, I asked participants to provide their opinions and interpretations, given how user consultation can improve content and clinical relevance of research findings (Trivedi & Wykes, 2002). User consultation further allowed each participant to have a voice in the analysis. It facilitated exploration of any discrepancies in interpretation between the participant and myself (Smythe & Murray, 2000). I also consulted tentative themes and narratives with my peer cohort and incorporated their views.

Analysis

To analyse the data, I explored the pertinent narratives that emerged from the stories of the 12 men. A vast array were shared in the interviews, however, there will not be space to explore all stories shared within this paper. To select quotes I developed initial story summaries for each interview (Gibbs, 2018). I aimed to explore accounts which focussed on developmental explanations of behaviour that were novel or infrequent in the existing literature. I decided to explore humanistic and compassionate stories, to challenge current public perceptions of PWSOHs. Pertinent comparison and contrasting narratives to explore further both at a macro and micro level of detail were then identified. Key narratives I focussed on are summarised in table 3.

Table 3

Key Narratives

Narrative	Participants who shared this narrative
Experiencing Parental Relationships	Adam, Ethan, Frank, Henry
The Absence of Gender Socialisation	Adam, Brad, Frank
The Internal Struggle	Charlie, Dean, Ethan, Frank, Gary, Henry, Ian, Jack
The Problem with Current Treatment	Brad, Charlie, Frank, Henry, Kieran, Liam
Wider Attitudes and Moral Issues	Adam, Brad, Ian, Jack, Kieran

Experiencing Parental Relationships

Many of the men interviewed began telling their life story through situating themselves within the family; sharing early experiences of their parents' marriage. Frank's narrative began with this aspect of his childhood: "my parents had a very sort of volatile marriage very, very unhappy marriage and that rubbed off on me a lot… it was quite disturbing as a small child to kind of the antagonism I witnessed there". Frank grounded his story in an environment of volatility and coldness between two caregivers that he should have experienced as loving each other.

Although Frank spoke of not noticing the impact of this at the time, with retrospect he talks about how "it just set a very bad example to me early on, on what a loving relationship is or should be" and the impact on his confidence to seek a romantic partner. Frank discussed how his internalised model of a relationship was constructed on witnessing his parents' interactions: "it set a bad, a very bad model damaging model model for me" (sic). He grew up to believe that men and women want different things from life and are ultimately incompatible. He thought "balanced passionate" versions of coupledom in the media would not be achievable for him as he was never taught how to communicate and enter into a loving relationship by his parents. He said: "they just like didn't know how to pass it on to me how to give me the model of good communication and because of their own problems". Frank

identified difficulties connecting with people which impacted his ability to make friends, find love and alleviate "crucifying loneliness". Frank demonstrated a deep reflection of his experiences, possibly highlighting a level of knowledge obtained from accessing private counselling. Frank believed his trajectory towards was rooted in an internalised idea of romantic relationships. He set the scene that he began life situated within conflict with the absence of observing or learning about warmth, love and affection within romantic couples.

Adam and Henry shared similar narratives to Frank, grounding their story in their experience of parent relationships. Adam recalled: "my parents argued a lot and I can't ever remember a time when they showed one another affection, theirs was a relationship that didn't have a lot of love in it, and I think that's subconsciously that caused a lot of problems." Henry also conceptualised his parents as being "at war" verbally and physically.

Frank's narrative then moved on, talking about rushing into an unsatisfying relationship as he was desperate to find love and connection. Frank discussed entering into marriage with his first romantic attachment as his, "earlier life experiences had kind of made me desperate to get this thing sorted and to get hitched". Frank added: "really from the beginning of that I suppose I had doubts that I was really with the person I would want to be with … the marriage pretty soon became sort of frustrating and non-sexual and my obsessions with sort of sex and fantasising about it just became more intense sort of using it as a means of escape in the marriage". Frank sought sexual gratification from other sources as he could not find it in his marriage; developing an addiction to pornography: "I was taking myself out of reality and living in the Internet and using that to fuel my increasing obsession with sex and my imagined inadequacy erm… you become desensitised it becomes boring, and I needed it to become more kind of experimental, darker and taboo".

Ethan shared similar experiences, describing marrying "for the wrong reasons…there was an opportunity to have a family, start a family and I'd married for that reason, and not for

love". It could be that Ethan was seeking to start a new family to replace of his own "dysfunctional" and "abusive" family experiences, to create the loving and warm environment he never had.

The Absence of Gender Socialisation

Within his life narrative, Brad mentioned the impact of attending an all-boys school. This was interesting given attendance at a same sex school is not something I would have considered a possible adverse experience, having attended one myself. He situated this experience within the context of his mother's controlling behaviour on his social life. Brad talked about how, "exposure on a day-to-day basis at school was zero to girls of my age" while his ability to meet with girls outside of school was "monitored by Mum". The word "exposure" indicated that even passive exposure to girls could have helped, even if it was not direct interaction.

Brad also spoke of his mother saying to him, "you'll never leave me, for, you know, for another girl" and making him feel guilty for seeking a teenage romantic relationship "the one time I did do it, I got really kind of guilted and shouted". Brad's narrative suggests he was held back from the transition all adolescents go through of fleeing the nest. He missed out on experiences his peers were having both socially and sexually.

Brad directly implicated this to later offending: "I thought I was owed it, I thought I'd missed out on it. I thought I'd I hadn't had those relationships" (sic). Missing out on relationships because of external factors, his schooling and his mother, Brad used the word "owed" to signal an inevitability to his actions. To be owed something can mean automatically justifying actions to getting what is owed to you. Justification of action is a necessary feature in offending.

Brad specifically chose to focus on his single sex schooling and conceptualised it as an adversity that he believed directly impacted on his offending. He demarcated how his

development of skills navigating gender roles, maturity and attracting a partner were implicated, as well as his sense of the relationships he was entitled to. Brad's narrative continued in this sense, as he talked about how this absence of gender socialisation led to an obsession with sex: "I was a sex addict, but my addiction wasn't necessarily sex my addiction was trying to feel better about myself". It seems as though Brad was not able to develop self-esteem within the context of being desired by girls as a teenager because he was never around girls. When Brad did eventually mix with women he said: "I kind of measured my own worth on … sexual conquest really and attention from females".

Adam and Frank shared a narrative similar to Brad's, regarding all-boys schools: "I had no experience of dealing with large numbers of kids… let alone with girls, I was very shy…and that's always made forming relationships very difficult. I've never been any good at the dating game" (Adam); "I'm convinced it is very, very bad very bad for me to have gone to a single sex school … just kind of made the opposite sex seem even more mysterious and more intimidating… when then I did get into situations to actually meet any of them it was even more difficult… the pain, I felt from the communication problems and unable to socially integrate, especially with girls from an early age" (Frank). The absence of gendered socialisation for these men seemed to directly impact their psychosexual development. They did not get the chance to develop an understanding of navigating interactions with the opposite sex and learn successful approaches to dating. This seemed to build up the narrative that relationships with women were impossible to achieve, resulting in fantasising and an obsession with sex and obtaining a sexual partner whilst feeling inadequate.

The Internal Struggle

Narratives regarding the impact of adversity on mental health was a common feature with half of the men citing depression and/or anxiety as significant in their life story. Charlie

spoke about, “it was just a feeling of worthlessness, it was a feeling of what’s the point… it makes you depressed, it makes you feel alone”.

Jack’s narrative featured heavily on his battles with mental health and internal struggle: “I wasn't diagnosed with my depression until I was 30 but I know I had it years before that”. Jack said, “I didn't [have a Dad] I became very introverted in my early years between the ages of seven and nine, suffered from deep depression and anger … I got angry and started to withdraw within myself”. Jack indicated a lack of skills to cope with losing his father, possibly rooted in perpetual bereavement after not attending the funeral: “I never got to say goodbye”. Jack’s tendency to internalise distress started very young: “I didn't cry but came out in a rash”. You could argue crying signals distress and need for comfort to others, and at an early age Jack may have suppressed this and pushed those feeling inwardly.

Jack’s narrative regarding his offending appeared to be directly linked to his introversion, “it was an escape out of the feelings that I felt… by releasing all these endorphins and all these other chemicals, it made me feel better”. Dealing with things internally, using pornography, Jack became desensitised, “things didn’t seem to satisfy, I found I was looking at stronger and stronger materials… afterwards I would feel overwhelming shame and found it hard to forgive myself”.

Dean detailed an internal struggle and rooted his narrative in being a victim of a paedophile ring during childhood. This remained secret, “nobody knew, I didn't tell anyone my my parents didn't know, my brother didn't know” (sic) and so Dean was never supported to process what happened. Dean was threatened by his abusers who convinced him he was “going to get into a lot of trouble” if he told anyone. This happened approximately 50 years ago, when little opportunities to speak up and seek support were probably available. Trying to move on from the trauma, Dean suppressed those memories, using metaphor to describe this: “I shut it away in a bottom drawer or something and it stayed there for a very long time”.

Dean lived for many years without thinking about his abuse, however eventually distressing life events meant the “little devils were let out of the bottom drawer” resulting in an “emotional maelstrom”. Dean believed stressful life events caused his trauma to resurface in “flashbacks” and “nightmares”. Dean offered: “I think that it was a form of escapism into a bubble. I had escaped from everything that was impacting on me then…I think there was also the perhaps a need to almost revisit what had happened… did this really happen, am I remembering correctly”. Dean talked about how confusing and distressing flashbacks and nightmares of his abuse were. He spoke about how viewing indecent images could have been both an attempt to escape the negative feelings he was experiencing and to try to validate whether his memories actually happened.

This narrative featured in many of the life stories. Gary spoke about his abuse and “the trauma cycle… [which] led to quite bad feelings of self-worth”. Ian remembered: “I just had no way of coping with it… part of my private behaviours are engaging in some form of self-harming… I continued with my private sexual fantasy world… regressing to a boy… I feel as though I deserve it, you know, as though I deserve that pain and punishment for some reason, because I should have fought back and I didn’t, so I deserve what I get”. Ethan noted, “I wasn't brave enough, my triggers were I wasn't brave enough to address situations… bottling it up getting depressed”.

The Problem with Current Treatment

Almost all the men critiqued the current treatment methods and models. A feature of Henry’s narrative was his certainty his childhood sexual abuse directly impacted on his later offences: “When I’m offending what I’m doing I’m getting really sort of angry I’m getting angry at the people that abused me… this is what I’m doing, this is what you wanted me to do so I’m doing it now, are you happy now”.

During his time completing treatment in prison, he shared: “I mean actually it made me feel a bit worse because some of the people that one of the sort of groups that I would do they were there for abusing kids… I tried to explain to them on two different courses, I did about what had happened to me when I was younger and it’s all about that but then they shut me down [saying] you can't make yourself a victim”. You could argue treatment was retraumatising for Henry who listened to group members detailing similar offences he was a victim of. Henry spoke of being placed into the “offender” category without appreciating he was both a victim and a perpetrator. Henry’s felt his own abuse history was discounted as irrelevant and an attempt to excuse his behaviour: “no it didn’t really help me at all”.

In light of his experiences, Henry remarked that, “instead of having a one size fits all approach, which is what they did used to do, they ought to try to individualise a bit more”. He commented that the approach needs to “treat people as individuals, and not try and group everybody together and treat everybody the same way”. Henry remarked that a lot of his experience of treatment was not relevant to him, as it focussed on “power and control” which he did not connect with. He noted that an individualised approach could allow PWSOHs to explore the root cause and develop understanding relevant to their story and give specific skills to avoid reoffending. Henry remarked that, “the facilitators always used to think that all the people that have committed sex offences it didn't matter, what sort of it didn’t matter which particular sex offence it was… it were very generic”. Henry implied that courses cannot treat a group of people with diverse offences in the same way.

Henry was offered brief 1:1 counselling in prison, the only one of the 12 men offered this option. He said how beneficial this was for rehabilitation, but it was cut short upon his release: “she acknowledged me and she gave me a platform just as you have, you know to actually you know talk about what had happened to me”.

Liam and Kieran shared similar narratives regarding treatment. Kieran shared, “being in a group of people, some of whom had committed offences that were quite similar to the ones I had been a victim of… it was really you know doing more harm than good”. He added, “it was… a well-polished series of lies, mitigations, manipulation… to give the impression the false impression of progress… they were learning from people that were more experienced as to how to get away with it next time…although sex offending has one of the lowest re-offending rates of any sort of category of offence… I believe that to be representative of people becoming better at it”. Liam noted, “I firmly believe that there is a reason why a person becomes a sex offender… if you spent time working with them and really digging into the history, I think that the mind can change the brain”.

Wider Attitudes and Moral Issues

Several men commented on the attitudes of others towards them; much of Ian’s story focussed on experiences after his caution. When explaining the impact of adversity on his behaviour, social care told him: “[there were] people who’d experienced much worse in their lives and didn't go around doing what I’d done… there was no excuse for that, and what I’d told them was basically a load of rubbish and that it didn't it didn't count for my behaviour”. Ian experienced professionals conflating explanation with excuses: “they all decided that I was a pretty bad person”.

Ian continued, “that was the first time that I’d ever revealed the truth and it was thrown back in my face as being inconsequential, you can see it's hardly surprising I didn't reach out for help”. Ian emphasised how current societal attitudes of blame and villainising PWSOHs actively prevented him from seeking support before offending.

Kieran also talked in depth about current attitudes seeing sexual offending as a moral issue is actively discouraging seeking help before offending: “the more we moralise about it, the less people are going to get help before it happens… if the person who’s sexually

attracted to kids actually feels like they have a phone number or that they can tell someone and they're not going to end up becoming marginalised and stigmatised as a result… if there's early intervention, it can prevent victims".

Kieran summarised by saying, "this is far more pervasive than anyone realises… it is preventable with education… with de-stigmatisation". Kieran emphasised the importance of preventative measures which can only be achieved if attitudes shift toward PWSOHs or people who are worried about their thoughts and behaviours. Reducing this stigma may encourage help-seeking before offending.

Discussion

This study explored the narratives of PWSOHs, their experienced adversity, how they believe adversity impacted their later offending behaviour and experiences of treatment within the criminal justice system. 12 men shared their stories, eliciting key narratives regarding experiencing parental relationships, the absence of gender socialisation and the internal struggle. Other key narratives explored the problem with current treatment, wider attitudes and moral issues.

Social learning theory (SLT) suggests that behaviour can be learned, internalised and enacted by children via observing others (Bandura, 1973). This can be observed in children's experiences of their parents' relationship (Mihalic & Elliott, 1997). SLT could theoretically explain the processes described by the men when talking of their parents setting bad examples and their interactions "rubbing off" on them. Similar narratives from PWSOHs have been elicited in the evidence base (Davids et al., 2015; Harrati et al., 2018). The witnessing of volatile and unhappy relationships perhaps set a precedent for experiencing later relationships which were unfulfilling and volatile. SLT is limited, however, as it does not account for the complex interplay of other factors, or why most people have these experiences without the same outcomes as PWSOHs (Johnson & Bradbury, 2015).

Learning gender roles and behaviours within society is achieved through socialisation (Bem, 1981) which is informed by identity theory (Tajfel & Turner, 1979). Identity theory suggests that identities are developed and shaped through repeated exposure to situations, across contexts that provide a platform for an individual to develop a range of characteristics to meet the needs of their interpersonal relationships (Stryker, 1968; VandenBos, 2015). Identity theory is relevant to the concept of narratives, as it is suggested that creating and telling one's life story is essential within the development of a narrative identity (McLean et al., 2007). Narratives allow a person to define their identity, based on their unique interactions with their environment. An experience only they can convey as they experienced it (McAdams & Pals, 2006). Many of the men in this study described being denied access to such situations, for example attending a single sex school and/or not being allowed to mix with girls outside of school. It could be argued that gender socialisation was disrupted, hence they went on to struggle to initiate and maintain adult romantic relationships. They did not have the opportunity to explore and find their gender identity within the context of socialisation with others.

Most literature uses quantitative data to explore pathways to offending. This narrative approach provided depth and richness to how these pathways might form at the individual level; detailing a complex interaction of factors and experiences that result in maladaptive outcomes. My analysis identified two areas of adversity not included in current definitions of ACEs: parental relationship problems not meeting domestic violence criterion and gender socialisation disruption. Social constructionist perspectives argue that ACEs can rarely be reduced to a single definition. Any experience unique to the individual could potentially be an ACE if the person made sense of those experiences in that way (Smith, 2016). Thus, narrowing definitions of ACE's is limiting and could mean important data is missing from existing quantitative ACE literature regarding PWSOHs.

This study provides support for existing literature regarding the developmental psychopathological perspective in which adversity in childhood affects biopsychosocial development (Cicchetti & Banny, 2014; Levenson & Socia, 2016; Rutter & Srouf, 2000). Most of the men interviewed detailed persistent mental health problems, low self-worth and the tendency to internalise or "bottle up" distress and emotions because they had never developed the skills to cope with stress.

Throughout this research I kept a reflexive journal (see Appendix H). Experience working in forensic settings and current interest in this area may have led to some desensitisation to the topic. I try to see all PWSOHs as a person first, try to humanise them within my own thinking and try to be mindful to the influence of societal attitudes that all PWSOHs are "monsters". I was struck by my mixed feelings to their narratives, holding both anger at their actions but also intense sadness for their childhood. Without excusing what they did, I got the sense that some people are dealt very difficult hands in life and felt injustice about this. I cannot ignore all the complexities that make them who they are.

I found it interesting that I did not often have to prompt participants to consider developmental pathways. I imagined wrongly that men would struggle to be reflective or would conceal information from me. Given the minimal prompting needed, this allowed me the freedom to explore parts of their narratives which were more unique and less covered in the literature.

I found myself in agreement with much of what my participants had to say, which surprised me. Especially with regards to increasing availability to have services to go to before the point of offending, for example if you are worried about the thoughts you are having. I learned about myself that I probably do implicitly hold some of the stigma held in society about PWSOHs, for example still wondering how someone can go so far as to actually commit the offence – what type of person does that make them? I tried to take as

neutral a stance as possible throughout my questioning and keep an open mind when my participants shared their thoughts, even if I did not personally agree with them.

I also wondered if my question regarding the person's experiences of treatment effectiveness was leading and resulted in answers that were what my participants thought I wanted to hear. I wondered if the 'effectiveness' element was leading to more polarised answers. If I were to ask a similar question in future I think I would ask, 'what were your experiences of treatment' which is less likely to signal to my participants what I am looking for.

This research had made me think more deeply about the important difference between understanding why someone has done something without that meaning it absolves them of wrongdoing. I have taken this distinction and used it when working therapeutically with victims of sexual abuse to help them process their experiences, find closure and understand why it happened but without taking away the impact it had on them or excusing the perpetrator's actions.

Clinical Implications

This research supports a call for trauma and adversity informed approaches in forensic settings (Levenson, 2014; Levenson et al., 2016; McMackin et al., 2002). This approach could be facilitated by clinical psychologists working in these settings, establishing and maintaining a trauma informed approach within multi-disciplinary meetings, and offering treatment options and consultation to staff in how to facilitate a trauma informed environment. Suggestions for a trauma informed approach include providing safety, reconstruction of experience and re-establishing and reconnecting with loved ones (Herman, 1998). Staff teams could be supported to formulate the reasons their patients may have offended, considering the complex factors that affect their development and thus promote compassion and improve working relationships.

This research adds to the current literature regarding the importance of recognition and early intervention for children experiencing adversity and trauma. Not only for professionals identifying trauma by providing space for a child to disclose and safeguarding them, but through intervention and consultation across mental health settings for children. This research identified risk factors such as experiences of relationship, introversion and restricted exposure to other genders that clinical psychologists may need to consider in their formulations and interventions for at risk persons. Identifying and treating risks early may change the trajectory of someone's life to prevent offending and protect potential victims.

The potential impact education and de-stigmatisation could have for PWSOHs was highlighted, given the pervasive nature of current attitudes that PWSOHs are "evil", irredeemable and undeserving of help (Gavin, 2005). This research aims to demonstrate that offending behaviour is often rooted in a complex set of circumstances where a person's development is affected. Clinical psychologists could have an important role in advocating for commissioning of services set up for "at risk" persons who are worried about their thoughts, fantasies or intentions. Stop It Now! run by The Lucy Faithfull Foundation provides this, however, is one of only a few charities within the UK. There is a gap in this kind of service provision in prison, probation and healthcare services that the general public are aware of and can easily access without fear of labelling and stigmatisation. The Lucy Faithfull Foundation is one charity that is limited in scale and could not possibly meet the needs of the estimated 850,000 PWSOHs in the UK (National Crime Agency, 2020).

This study indicates some value in generic group programmes currently offered, however there is also a need for 1:1 therapy for PWSOHs. 10 of the 12 men who took part had accessed some form of private therapy which had given greater understanding of their narratives. Some men noted that their narratives were confusing, difficult to make sense of and too tough to talk about prior to accessing 1:1 therapy. Given how important narratives

appear to be in this context, narrative therapy could be considered a potential treatment option. Narrative therapy has been utilised with victims of sexual offences (Countryman-Roswurm & DiLollo, 2017; Kress et al., 2008). To my knowledge there is almost no offer of narrative therapy to PWSOHs to explore and process their trauma and adversity. Treatment models for PWSOHs focus almost solely on skill building to reduce re-offending without consideration of how their past may be impacting their ability to develop and maintain such skills (Ward & Maruna, 2007).

Private therapy is self-funded and a clear economic barrier to accessing psychological therapy for many PWSOHs. There are likely difficulties in self-motivation to access private therapy given the challenges men have in seeking support independently (Bilsker et al., 2018). Integration of 1:1 therapy from clinical psychologists within forensic settings could overcome these barriers, with research like this study demonstrating to commissioners that early aversity needs to be addressed for PWOSH.

Strengths, Limitations and Future Directions

This paper allows individuals who are often vilified and ostracised by society to have a voice, share their story and explain the circumstances surrounding their offending behaviour, taking into account their own adversity. Many of the men felt this research was important and wished to take part because they are rarely given a platform to speak about these issues. Examining the links between adversity and offending has illuminated new insights which can inform treatment options to work towards successful rehabilitation and reintegration for these individuals. A strength of this study is that some of the men's narratives were explored in depth, however future papers using this data are warranted to present the narratives of some of the other men not featured as heavily.

The COVID-19 pandemic restrictions meant my original plan to interview prisoners became unviable and so I moved to a community sample, which meant this study does not

incorporate the voice of individuals currently accessing treatment programmes. It could be argued persons with 'contact' offence histories were also not represented well as most of the men who took part were convicted of internet-based offences. A future narrative study with a prison and/or probation sample would expand on the narratives explored in this study, including people with a wider variety of offences at different stages of rehabilitation. Female and non-binary voices were also not part of this research, likely due to the disproportionate number of male PWSOH (Cortoni et al., 2017). Participants of other genders would provide a different gendered lens. Finally, 10 of the men who took part had accessed privately funded therapy after their prison/probation treatment. It could be that therapy substantially increased their ability to reflect and find meaning in their experiences. This research did not adequately represent individuals who cannot afford private therapy. A future prison-based study would negate this limitation.

From my journalling, I explored my prior assumptions, knowledge and position and how these affected the questions I chose to ask. My prior knowledge of the developmental psychopathological perspective (Cicchetti & Banny, 2014; Levenson & Socia, 2016; Rutter & Srouf, 2000) likely steered my focus to coping skills and stress. My questioning could have signalled to participants what I was anticipating hearing, and they may have agreed with me to meet my expectations rather than because it was part of their narrative. If I were to conduct similar research in the future, I would utilise a second interviewer who could bring different knowledge and experience in the context of working with PWSOHs. We could conduct reflective practice to challenge potential bias and prior assumptions which might shape the questions and interpretations made.

Conclusion

For this study, I explored the narratives of PWSOHs who have experienced adversity in childhood and how they used those narratives to partially or fully explain why they later

committed a sexual offence. Key narratives raised by participants were experiences of relationships, the absence of gender socialisation, the internal struggle, the problem with current treatment and wider attitudes and moral issues. These provided qualitative detail to the current evidence base demonstrating the number of adversities PWSOHs have experienced, allowing the individuals to share their story and inform how to improve preventative measures and post-offence treatment.

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Appendix A

Ethics Approval

ethics@exeter.ac.uk

Mon 08/02/2021 10:35

To: Hall, Eleanor

Cc: Smithson, Janet

Dear Eleanor Hall,

Application ID: eCLESPsy002037 v5.1

Title: Understanding Their Story: An Investigation into the Narratives of Adverse Childhood Experiences and Offending Behaviours of Convicted Sex Offenders and Implications for Treatment.

Your e-Ethics application has been reviewed by the CLES Psychology Ethics Committee.

The outcome of the decision is: Favourable

Potential Outcomes

Favourable: The application has been granted ethical approval by the Committee. The application will be flagged as Closed in the system. To view it again, please select 'view completed'.

Favourable, with conditions: The application has been granted ethical approval by the Committee conditional on certain conditions being met. Please log in to your application (click 'view completed') to view these conditions in the Comments tab. You do not need to resubmit.

Provisional: You have not been granted ethical approval. The application needs to be amended in light of the Committee's comments and re-submitted for Ethical review.

Unfavourable: You have not been granted ethical approval. The application has been rejected by the Committee. The application needs to be amended in light of the Committee's comments and resubmitted / or you need to complete a new application.

Please view your application here and respond to comments as required. You can download your outcome letter by clicking on the 'PDF' button on your eEthics Dashboard.

If you have any queries please contact the CLES Psychology Ethics Chair:

Nick Moberly

n.j.moberly@exeter.ac.uk

Kind regards,

CLES Psychology Ethics

Appendix B

Participant Information Sheet

Title of Project: Understanding Their Story: An Investigation into the Narratives of Adverse Childhood Experiences and Offending Behaviours of Convicted Sex Offenders and Implications for Treatment.

Researcher name: Ellie Hall

Invitation and brief summary:
The following research project investigating the narratives of adverse childhood experiences (ACEs) and links to offending behaviour in individuals who have committed a sexual offence. Please take time to consider the information carefully and to discuss it with family or friends if you wish, or to ask the researcher questions.

Purpose of the research:
The aim of this research is to understand the life stories of individuals who have experienced early life adversity and later committed a sexual offence. We also want to understand whether these early experiences are linked to later offending behaviour. We are also interested in participants' experiences of SOTP. This research is investigating whether the current treatment options for sex offenders can be developed to include trauma informed care principles.

Why have I been approached?
We are currently hoping to recruit up to 12 male and female participants who are over 18. Participants will need to have ACEs that they are willing to discuss in an interview. Participants will also have committed a sexual offence against another person and completed SOTP in the last 5 years.

What would taking part involve?
Taking part in this study will involve completing an interview that lasts approximately 1 hour. The interview will be face to face in the Mood Disorders Centre, Exeter University. Should this not be possible due to social distancing restrictions or you are unable to travel to Exeter, the interview can be conducted via a video conferencing platform e.g. Skype. You will be asked about your early experiences, whether these have had an impact on your offending behaviour and your experiences of SOTP. **You will not be asked to discuss your offence/s in detail if you do not want to.** This is a research interview and not a therapeutic session.
Taking part in this study will also include providing the researcher with demographic information such as your age and how long has passed since you committed your last offence. You will also be asked to complete a questionnaire that assesses your mood.

What are the possible benefits of taking part?
Information you provide in your interview may help to develop a new trauma informed treatment option for sex offenders with ACEs. Incorporation of new treatment options has the potential to improve treatment outcomes and thus re-offending rates.

What are the possible disadvantages and risks of taking part?
This study asks participants to discuss potentially distressing past experiences. We encourage you to have someone in mind you can telephone for support should you need it during or after the interview. Should the researcher deem there is a risk of injury to yourself or others as a result of the interview, or a disclosure of previously unknown offending is made, confidentiality may need to be breached in order to ensure safety of all those involved.

What will happen if I don't want to carry on with the study?

Should you wish you can pause or stop the interview at any time without giving a reason. Your participation in this study is completely voluntary and you can withdraw from the study at any time. If you wish to do so your data will be destroyed.

How will my information be kept confidential?
The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk or at www.exeter.ac.uk/dataprotection

Your interview will be recorded and transcribed for analysis purposes. All information will be kept in accordance with GDPR and the Data Protection Act (1998) on a password protected computer. Your information will remain confidential and your details will be kept anonymous. Only members of the research team will have access to the data. Once your interview has been transcribed and analysed you will be contacted for consultation.

What will happen to the results of this study?
The results of this study will be reported within the empirical paper section of the doctoral thesis of the main researcher. The thesis will aim to be published within a relevant peer reviewed journal. The results of this study may also be presented at a relevant conference event.

Who is organising and funding this study?
This research is funded by the Clinical Psychology Doctorate Programme, Exeter University. The project is being conducted by Ellie Hall, Trainee Clinical Psychologist at the University of Exeter, under the supervision of Dr Janet Smithson, Senior Lecturer, University of Exeter.

Who has reviewed this study?
This project has been reviewed by the Research Ethics Committee at the University of Exeter (Reference Number XXX).

Further information and contact details
For further information and/or to take part please contact Ellie Hall. Should you wish to complain about any aspect of the project, please contact Dr Janet Smithson or Gail Seymour.

Ellie Hall
Trainee Clinical Psychologist
eh650@exeter.ac.uk

Dr Janet Smithson
Senior Lecturer in Psychology
j.smithson@exeter.ac.uk

Gail Seymour
Research Ethics and Governance Manager
g.m.seymour@exeter.ac.uk

Thank you for your interest in this project.

Appendix C

Consent Form

Participant Identification Number:

Title of Project: **Understanding Their Story: An Investigation into the Narratives of Adverse Childhood Experiences and Offending Behaviours of Convicted Sex Offenders and Implications for Treatment.**

Name of Researcher: Ellie Hall

Please initial box

1. I confirm that I have read the information sheet dated XXX (version no XXX) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

3. I understand that relevant sections of the data collected during the study, may be looked at by members of the research team where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I am aware that if the interviewer considers there to be a risk to self or others, a disclosure of previously unknown offending is made, then the confidentiality of the interview may be breached to ensure the safety of everyone involved. ☐

5. I understand that taking part involves anonymised interview transcripts to be used for the purposes of

   a doctoral research paper write up ☐

   publishing findings in a peer reviewed journal ☐

   presentation at a relevant conference ☐

6. I agree to take part in the above project. ☐

Name of Participant	Date	Signature
Name of researcher taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher/project file

Appendix D

Interview Schedule

Demographic Questions (to be asked prior to the interview commencing)

1. What is your name?
2. What is your age?
3. What is your gender?
4. What is your current location?
5. What are your GP details?
6. How many years have passed since your most recent offence?
7. How many years have passed since you completed a treatment programme?
8. How many years since you were released from prison/ hospital?
9. Have you received any therapy to process your early experiences**?**

Main Question

1. Can you tell me about your early life experiences of adversity, whether these have had an impact on your life and whether you believe these contributed to why you offended**?**

Clarification Questions

1. Are there any inconsistencies or omissions to explore?

Additional Enquiry Questions

1. Can you tell me about your experiences of completing a treatment programme/s for people who have been convicted of a sexual offence?
2. How effective do you think it/they was/were for you? This Q affected by social desirability? Show you are rehabilitated?
3. How effective are the current treatment options in the UK, in your opinion?
4. What could be different about them to improve them?

Appendix E

Positive Affect Negative Affect Schedule

We now want to investigate whether time of day affects mood. This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you feel this way **RIGHT NOW.** Use the following scale to record your answers.

1	2	3	4	5
Very slightly	A little	Moderately or not at all	Quite a bit	Extremely

..... interested	..... irritable
..... distressed	..... alert
..... excited	..... ashamed
..... upset	..... inspired
..... strong	..... nervous
..... guilty	..... determined
..... scared	..... attentive
..... hostile	..... jittery
..... enthusiastic	..... active
..... proud	..... afraid

Appendix F

Debrief Form

Thank you very much for taking part in this study.

The aim of this research is to understand the early experiences of individuals who have committed a sexual offence. Namely, to understand their early life adversities or exposure to trauma and understand whether there are any links between these experiences and later offending behaviour. We are also investigating individuals feelings and opinions about the current treatment option in the UK – SOTP. We are aiming to understand individual's stories in order to inform potential trauma informed treatment approaches. We are also considering how trauma informed treatment may fit with the current SOTP model, or whether an entirely new treatment model should be developed.

Previous research indicates mixed treatment outcomes for individuals who have committed sexual offences and there are calls from a number of researchers and clinicians for a new approach. There is a rising belief that trauma informed treatment will be beneficial due to the high number of individuals who commit sexual offences having experienced trauma and/or adversity in their lives. We aim to add to this literature by understanding the stories of the individuals who would benefit from such treatment in order to further suggest what approaches could be taken within the treatment model itself.

Your interview recordings and any transcriptions of your interview will be held securely in line with the Data Protection Act (1998). Any personal identifiable information such as your name will be removed and replaced by a code or pseudonym. You have the right to withdraw your data at any point by contacting Ellie Hall, Trainee Clinical Psychologist.

If you would like more information regarding sources of support, please see the following contact details:

Circles UK

Website: www.circles-uk.org.uk Tel: 0118 950 0068

StopSO UK

Website: www.stopso.org.uk Tel: 07473 299883

Samaritans

Tel: 116 123

If you have any questions about this research please contact Ellie Hall or Dr Janet Smithson:

Ellie Hall
Trainee Clinical Psychologist
University of Exeter
eh650@exeter.ac.uk

Dr Janet Smithson
Senior Lecturer in Psychology
University of Exeter
j.smithson@exeter.ac.uk

Appendix G

Example Letter to GP

Dear Dr XXX,

I am writing to express my concerns regarding the current mental health status of one of your patients [NAME & DoB]. I am a Trainee Clinical Psychologist from Exeter University who is currently conducting research with convicted sex offenders. Part of this research involves exploring the offender's adverse childhood experiences. As part of the informed consent process [NAME] was made aware that I may need to break confidentiality if I had concerns about their mental health or risk of suicide and they provided their GP details for this purpose.

During our interview [NAME] told me [INSERT WHAT THE PARTICIPANT SAID REGARDING THEIR MENTAL HEALTH AND/OR SUICIDALITY].

In light of this, I felt [NAME] needed to be brought to your attention as I am concerned [NAME] may be at high risk of hurting themselves and/or attempting suicide. I would be grateful if you could arrange an appointment with [NAME] to explore options for support.

Yours Sincerely,

Ellie Hall

Trainee Clinical Psychologist

Exeter University

Appendix H

Extracts from Reflexive Journal

Excerpt 1

I felt really sad listening to this account today. The amount of sadness I felt surprised me as it was held in tandem with the anger that I felt for the victims of this person's offences. I think I need to be careful to hold a balance of compassion without making excuses for what he did and hope this comes through in my questioning. Excuses? No. Explanations? Yes. I am interested in how 'grey' the area becomes. This is no longer a question of this person did a bad thing and therefore they are a bad person, there's so much more complexity to it. I don't think this is a viewpoint shared by much of the general public who, in my experience, think about this issue in a very black and white way. I have been told "they should be locked up and you should throw away the key". Who does this benefit? The system doesn't work like that, and the vast majority of these individuals will re-enter society. What will be the cost if we do nothing to help them and just punish them in prison? What are the true clinical implications here?

Excerpt 2

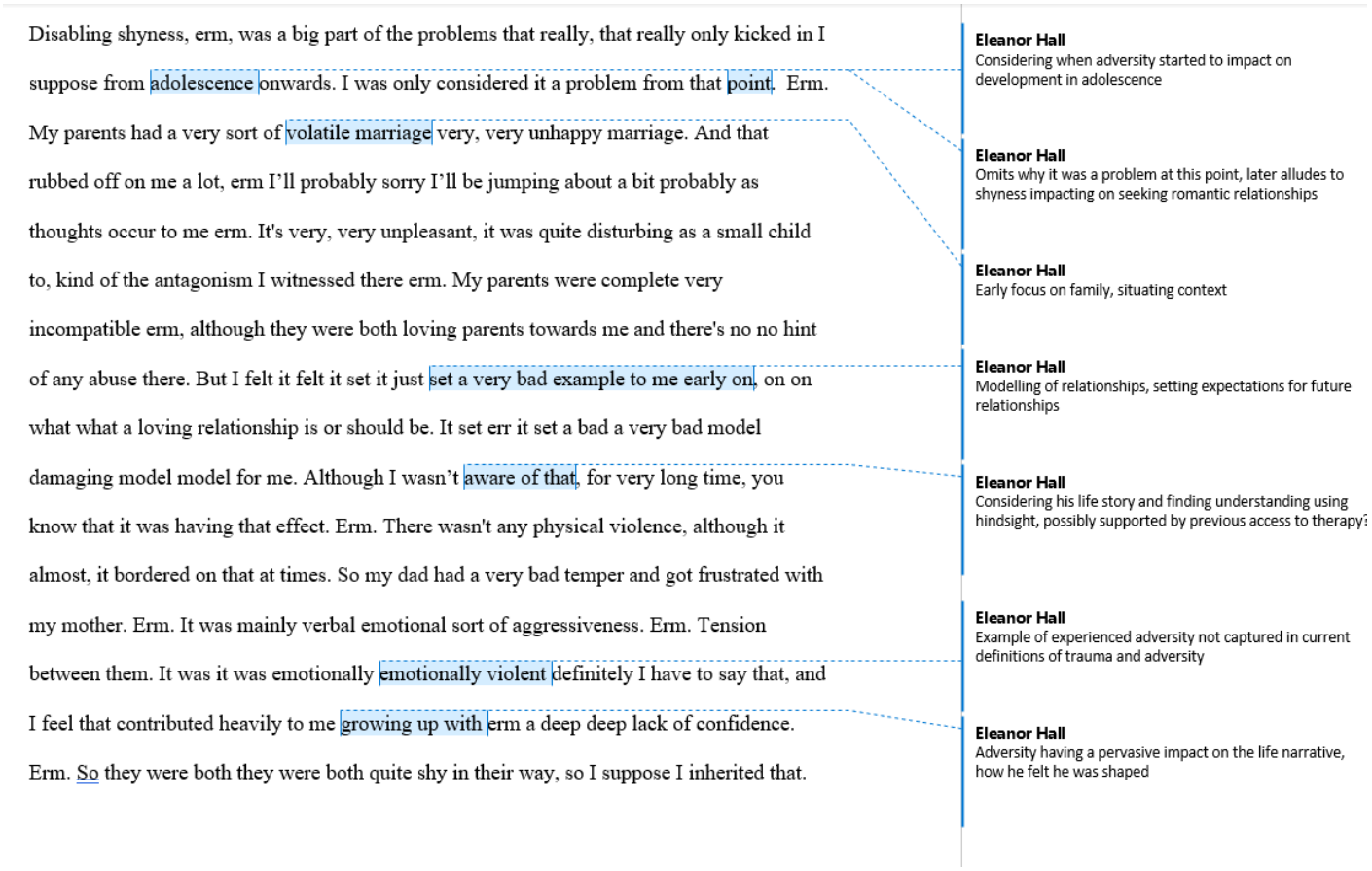
I'm wondering if my knowledge around the complexity and factors that are more likely to result in a person offending is influencing the questions I'm asking in the 'clarifications and omissions' section. Am I leading them? Would they agree with me because of my assumed position of power as 'the professional'? I'm not sure. I don't think so to some extent because many of the men have said particular questions don't fit within their narrative, but it is hard to tell.

Excerpt 3

Feeling very upset again. This man has had his life ruined by the aftermath of his actions. I'm not even sure what he did was illegal, immoral perhaps, but illegal? There aren't any victims here. He has been completely villainised by services and society. What has come from this except reducing a man to feeling everyone would be better off if he ended his life? I'm sure his wife and children have suffered too and continue to do so. This research feels so important now to communicate their story. This man's adversity had massive implications in his later behaviour. I can't even call it offending because it wasn't. More needs to be done to show others that this behaviour doesn't just come from nowhere because they are 'bad' people. To truly help both at risk persons who haven't offended yet, and persons who have an offence history, we need to understand what is going on here and where professionals and society can step in. This is so important in preventing more victims. This message really needs to come through in the research.

Appendix I

Narrative Analysis Extract



Appendix J

Dissemination Statement

I will submit this research to the journal Sexual Abuse for publication. I will also aim to present my findings at a relevant conference such as the annual New Directions in Sex Offender Practice conference hosted by Forensic Psychology Practice Limited. Finally, I will provide a copy of this research to each of the men who took part in this study.

Appendix K

Copy of Instructions for Authors for Sexual Abuse Journal

https://journals.sagepub.com/author-instructions/SAX