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Forensic Low Secure Patients Pornography Use Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will support patients detained on low secure forensic wards to access pornography in line with least restrictive practise. This will be completed with consideration of risks to staff and patients, as well as ethical considerations on the use of pornography.

Policy Commitment

- Complete a risk formulation for each patient requesting pornography on the Forensic low secure unit to determine individual appropriateness to access pornography
- Support patients to purchase ethical and legal pornography in line with their individual formulation
- Review pornography brought onto the unit to assess for unethical, illegal, and risk-related content
- To co-produce a care plan with patients for appropriate use and storage or pornographic material
- Monitor the impact of pornography being brought onto the unit
- Take action if pornography on the unit is suspected to be causing or at risk of causing harm
- To review and update the policy with any updates in research evidence, changes in legislation, and/or changes in the nature of pornography (for example, increasing use of artificial intelligence in pornography creation).

Supporting Procedures and Written Control Documents

This Policy and the *supporting procedures* describe the following with regard to pornography use by patients as part of low secure services.

- Access to pornography on Maple Ward, Low secure services by inpatients on a case by case basis.
- Permitted and non-permitted content of pornography.
- Case by case risk assessment procedures.
- Monitoring of pornography impact.

Other supporting documents are:

- *Low secure services television policy*
- *Maple ward operational policy*

Scope

This policy applies to all our staff in Forensic Low Secure Services including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EQIA) has not been completed as this policy will apply to all service users on the low secure ward, and access will be assessed on a case-by-case basis.

Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed as this policy does not directly relate to health.
Policy Approved by	Mental Health Clinical Board Controlled Document Oversight Group
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health Clinical Board Controlled Document Oversight Group
Accountable Executive or Clinical Board Director	Rachel Dix
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	25/10/2025	April 2026	*New Document*

Forensic Low Secure Patients Pornography Use Policy

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Contents

Forensic Low Secure Patients Pornography Use Policy Background

*The term "patient" will be used throughout the to refer to the individuals on the low secure unit. This was decided by asking each individual in the ward cohort, as well as staffs, preferred term ("patient", "client" or "service user"). Out of the 13 patients, 11 were approached (two were off the ward), five identified the term "patient", five identified "client", and one did not wish to respond. The consensus of staff was for the term "patient".

1. What laws does the policy base its decision on?

1.1. Mental Health Act (1983)

1.1.1. The overarching principles that guide the MHA are least restrictive option and maximising independence, empowerment and involvement, respect and dignity, purpose and effectiveness, and efficiency and equity.

1.1.2. Within the least restrictive principle stipulates:

- Avoiding 'blanket' or 'global' restrictions without clear justification.
- Least restrictive of the persons rights and freedom of action.

1.1.3. This act quotes lawfulness includes compliance with the Human Rights Act (1988) and Equality Act (2010).

1.2. Human Rights Act (1988) stipulates ensuring full enjoyment of a person's human rights of life.

1.2.1. At the 2019 World Congress of Sexual Health, it was declared that "sexual pleasure is a fundamental part of sexual rights as a matter of human rights," and governments were urged to promote sexual pleasure because of its importance to global public health.

1.2.2. It was reported it is healthy to masturbate, and that sex promotes better sleep, less stress, and more happiness, and that "our bodies thrive on the chemicals released during orgasm, so a healthy sex life is indeed part of a healthy body."

2. What is this policy about?

2.1. The policy is in the interest of the patient's rights under MHA and HRA.

2.2. It is outlining the access to pornography for forensic low secure patients by which restrictive practices within the service may deprive them. Statistics released from the Welsh government indicated forensic psychiatry had the highest proportion of resident patients residing in hospital for over 2 years (36%). Unless subject to licence/probation restrictions, these patients would have access to pornographic material if within the community.

2.3. Welsh statistics has shown that approximately 50% of the general adult population have experienced at least on Adverse Childhood Experience (ACE), 13.5% reporting four or more and 7% experiencing sexual trauma (Hughes et al., 2018). A Welsh prison survey indicated that 46% of the population had 4 or more ACEs and 18% experiencing sexual trauma (Ford et al., 2019). The policy encompasses the Trauma-Informed Care (TIC) model and practices. Implementing this "realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation.' (SAMHSA 2014a p. 9).

2.4. It defines principles and guidance on how the decision process should be made when considering access to pornographic material.

3. Definitions

3.1. ***Pornography*** – *Material deemed sexual, given the context, that has the primary intention of sexually arousing the consumer, and is produced and distributed with the consent of all persons involved" (Ashton, McDonald, & Kirkman, 2019, p. 163).*

- *The content of pornography included 'genitals', 'clear images of nudity', 'masturbation', 'oral sex', 'anal sex', 'vaginal intercourse', 'genitals', and 'people having sex'. It was described using terms such as 'sexual', 'explicit', 'graphic', 'erotic', and 'pleasurable'. Format was described generally as 'material', 'media', 'entertainment', 'depictions', or 'communication' and more specifically as printed material, pictures, videos, internet material, media, written text, and audio. In one paper, content was specified as being either 'professionally produced' or 'user generated' (Peter and Valkenburg 2016).*

3.2. ***Pornographic*** *– of such a nature that it must reasonably be assumed to have been produced solely or principally for the purpose of sexual arousal" (Part 5 of the Criminal Justice and Immigration Act 2008 under section 63.)*

3.3. ***Image*** *– (a) a moving or still image (produced by any means); or (b) data (stored by any means) which is capable of conversion into an image within paragraph*

3.4. ***Obscene*** *- ordinary meaning ("repulsive", "filthy", "loathsome" or "lewd"), distinct from that provided for by the statutory terms of the Obscene Publications Act 1959: Anderson [1972] 1 QB 304.*

3.5. ***Sexually explicit material*** *– refers to textual, visual, or audio materials that typically intends to arouse the viewer and depicts sexual activities and (arouses) genitals in unconcealed ways, usually with close-ups on oral, anal, and vaginal penetration.*

3.6. ***Sexual arousal*** *– an emotional state (Geer et al., 1992) instigated by processing of sexual stimuli internally (e.g., fantasy) or externally (e.g., tactile, visual). It involves the interacting of components such as physiological changes, emotional expression, and motivated behaviour (Frijda, 1986). The experience is an appraisal of the dynamic combination of*

psychological (e.g., emotion, cognition, perception), and generalised and sex-specific physiological arousal responses.

3.7. ***Device*** *– an object or machine that has been invented for a particular purpose. A machine for example a phone or computer that can be connected to the internet to stream music (Cambridge Dictionary) or view pornography.*

4. What is legal to create in terms of sexually explicit material

4.1. *Where (as found in the person's possession) an image forms part of a series of images, the question whether the image is of such a nature as is mentioned in subsection (3.2) is to be determined by reference to—*

- *the image itself, and*
- *(if the series of images is such as to be capable of providing a context for the image)*
- *the context in which it occurs in the series of images.*

4.1.1. *For example, where*

- *an image forms an integral part of a narrative constituted by a series of images, and*
- *having regard to those images as a whole, they are not of such a nature that they must reasonably be assumed to have been produced solely or principally for the purpose of sexual arousal,*

4.1.2.*The image may, by virtue of being part of that narrative, be found not to be pornographic, even though it might have been found to be pornographic if taken by itself.*

4.2. *Legal definition of "**Extreme pornographic image**" found in Part 5 of the Criminal Justice and Immigration Act 2008 under section 63.*

4.2.1. *An extreme pornographic image is an image which meets four criteria. It is:*

- *Pornographic and*
- *Grossly offensive, disgusting or otherwise of an obscene character, and*
- *Portrays in an explicit and realistic way any of the following:*
  - *An act which threatens a person's life, or*
  - *An act which results, or is likely to result, in serious injury to a person's anus, breasts or genitals, or*
  - *An act which involves sexual interference with a human corpse (necrophilia), or*
  - *A person performing an act of intercourse or oral sex with an animal (whether dead or alive) (bestiality), or*
  - *An act which involves the non-consensual penetration of a person's vagina, anus or mouth by another with the other person's penis or part of the other person's body or anything else (rape or assault by penetration)*
- *And, a reasonable person looking at the image would think that the persons or animals were real.*

4.3. *Any pornography, visual or written, which depicts a child, under the age of 18, is illegal.*

5. The ethics of legal pornography consumption

5.1 There has been much debate around the ethics of legal pornography consumption. Concerns have included the suggestion that observing harmful practices in pornography could lead to imitation; that it can be considered degrading to women in particular and promotes male dominance; and that the sex industry can indicate sexual enslavement of women (Smith & Cree, 2014). However, although modern day slavery is a real concern linked to the production and therefore consumption of pornography, to say that all pornography fits this definition is considered to be a radical view. Although representative of some experiences, it is not representative of the feelings of all sex workers. As noted by Tremblay (2021), "several of my respondents emphasised that they had chosen to do this work and did not feel that

the sex industry was more or less exploitative than any other type of work within a capitalist system".

5.2 Efforts should be made to ensure that pornography acquired meets ethical standards and does not adversely contribute to the exploitation of women, or indeed any of the performers depicted. McKee et al (2023) outline six criteria for identifying pornography that can be considered to support healthy sexual development. These criteria are:

5.3 A negotiation of consent onscreen (e.g. open communication, explicit statement of sexual desire, respect of boundaries)

5.4 Depictions of safe sex (e.g. condom use, dams, lube)

5.5 Ethical production

5.6 A focus on pleasure for all participants

5.7 A variety of sexual practices (not just penis in vagina intercourse)

5.8 A variety of body types, genders, and races.

5.9 With particular attention paid to the idea of "ethical production", the following themes were noted: ethical creators are paid for their labour, indicating that it may be more likely that ethical pornography must be paid for and free to consume pornography may have a higher chance of being unethical in production. In addition to fair pay, ethical pornography includes attention to consent, and safe working conditions, which may be considered within points 1 and 2.

5.10 When assessing requested pornographic material, assessors will therefore consider these criteria with information available from the materials provided. Any materials that indicate a lack of consent, lack of pleasure, or clearly unsafe practices will not be permitted, even if this is believed to be role play.

5.11 Sexual preferences will be respected and service users will not be restricted to materials that show "a variety of sexual practices" nor "a variety of body types, genders, and races" in favour of their preference. This is also with consideration of practicalities: that many pornographic materials are created with a specific sexual preference in mind and do not focus on variety due to the intention to please a specific audience. This may result in pornography being less representational and educational, but not unethical. Equally, it is possible that safe practices could have been achieved without use of measures such as condoms. On balance, if it is determined to be overly difficult to obtain pornography with consistent condom usage, this may not be required if practices appear to be safe overall.

5.12 Additionally, all individuals who access pornography will be provided with information about these criteria when their request is initially granted. This will be in the form of a verbal discussion with a psychologist or other practitioner who feels able to have this discussion, and a leaflet detailing these criteria to keep with their pornography supplies. It will be emphasised to individuals that there is a chance that they have historically and may again view pornography that has been unethically produced, and a summary of the harm that this can cause.

5.13 For individuals specifically seeking out ethical pornography, websites including **https://www.feministpornawards.com/** and https://ethical.porn/ review and feature ethically produced pornography.

6 **Use of pornography and mental health**

7 Research has shown access to sexually violent material is associated with increased sexual and non-sexual aggression. A recent meta-analysis on pornography and sexual aggression found no association between non-violent pornography and sexual aggression. Population studies suggested increased availability of pornography is associated with reduced sexual aggression.

8 When permitting access to pornographic material, the clinical MDT should consider the individualised risk formulation. A clear understanding of the patients offending history including sexual offending or sexually harmful behaviours should be held by the team before any decision making takes place. This should incorporate knowledge of TIC model and practices and awareness of patients ACEs, particularly the any sexual trauma due to chances of dissociation.

9 Patients should not be accessing pornography without a risk formulation in place.

10 Patients who have a history of sexual offending or sexually harmful behaviours should have a comprehensive sexual violence assessment to obtain a clear formulation, identification of risks, appropriate treatment, supervision and management plans if necessary.

11 The judgement of access to pornographic material should be made on a case-by-case basis. The clinical team should consider the individual benefits with the potential for pornography use leading to increased sexual preoccupation and increased sexualised risk. In addition, the possible re-traumatisation of sexual trauma through the exposure to sexually explicit material.

12 Factors of consideration which could result in a decline of access to pornographic materials include:

13 Existing attitudes that support or condone sexual violence.

14 Sexual preoccupation.

15 Materials directly linked to current offence or offending history.

16 Current or recent sexual disinhibition or sexual aggression.

17 Incidents of accessing without permission, trading or sharing pornographic material.

18 A lack of understanding about the nature of risk due as a result of limited information.

19 Access to pornographic material in video format (e.g. DVDs) should be in conjunction with the developed TV policy for low secure patients.

Forensic Low Secure Patients Pornography Use Policy Procedure

20 **A summary of the procedure**

20.1 Access to pornographic materials within low secure ward will be considered on an individual basis by the MDT and will be dependent on the individual formulation of risk.

20.2 Any sexually explicit material is deemed a restricted item within the low secure service. Patients do not have an automatic right to access such items while residing on the ward.

20.3 Materials considered extreme, obscene, violent, offensive and/or illegal in any form (written, digital, video or computerised) are banned in the service. If such materials are found police should be notified for involvement.

20.4 The need for such material to assist in sexual expression and gratification is not assumed and not guaranteed. The availability within the community does not mean the material is acceptable to have on the ward.

20.5 If access is granted, a care plan will be created and patients will be able to access their materials on a request only basis.

21 **How is a decision made to allow an individual to access sexually explicit materials?**

10.1 The decision-making process is considered by the multidisciplinary team and is specific to each individual.

21.1 All patients have a comprehensive psychological formulation assessing their risk. This is completed by the psychology team with input from the patient. The formulation provides a clear understanding of the individuals offending history, including violent and sexual risk.

21.2 The formulation and decision-making process will integrate awareness of the TIC model and practices, and ACEs. TIC encourages work with survivors of trauma to prioritise victim wellbeing, healing is promoted, and re-traumatisation is reduced (Elliott et al., 2005; SAMHSA, 2014). “The impact of trauma-related dissociation can also be observed in online sexual behaviours.” (Wéry et al., 2019, pg. 8). Research suggests offline and online sexual behaviours may significantly vary and dissociation may play a crucial part in establishing differences between these for individuals exposed to trauma as a child (Chaney & Dew, 2003; Schimmenti & Caretti, 2010, Schimmenti & Caretti, 2017).

21.3 This formulation and understanding will aid the multidisciplinary team decision on access to sexually explicit materials.

21.4 This decision should be held within an appropriate amount of time allowing for each individual within the MDT to express their opinion on the individual and access. This should not be a brief discussion.

21.5 The patient should be included in these discussions where possible.

21.6 Multi-disciplinary team members will be offered reflective practise sessions to discuss decision making processes in this area. Space will be provided to discuss and support with discomfort around the provision of pornographic materials, as it is acknowledged that not all staff members will be comfortable with this.

22 Permitted materials and access

22.1 Reasonable access

22.1.1 Patients will have access to pornographic material on their own volition.

22.1.2 Patients must be able to purchase pornography themselves, either whilst on section 17 leave, or online, and must not ask staff members or other patients to purchase this for them on their behalf.

22.1.3 Patients must use the material within their own bedrooms and follow appropriate steps to ensure their privacy and dignity.

22.1.4 If it is deemed the patient is accessing pornography frequently and this is having an impact upon other areas of their rehabilitation, or causing them harm, a further MDT discussion should be had to care plan use along with the patient. Alongside this a discussion should be held with the patient on an individual basis to understand the frequency and intensity of use and what this means for them.

22.2 Legal material

22.2.1 Legal material is accessible after the MDT is in agreement and has been reviewed by the team.

22.2.2 The material can be in narrative format (e.g., books and magazines with or without pictures) or video format for which they have purchased (DVDs). The latter will only be permitted if the individual patient has access to a suitable TV and DVD player in their bedroom. There will be no access to internet website based pornography.

22.3 Illegal material

22.3.1 Access to illegal material within the low secure service is prohibited, therefore no decision needs to be considered by the MDT.

22.3.2 If illegal material is found it should be confiscated and police should be contacted.

22.4 Any materials deemed sexually explicit, pornographic or rated 18 must be reviewed by the clinical team.

22.5 Patients may request access to pornographic material through high street shops and may be allowed to purchase through internet sites if supervised or reviewed by the clinical team.

22.6 Patients are not permitted to obtain material which includes sexual images of children, sexual violence or sexualised human-animal contact. This includes graphic or cartoon type narrative/images/videos, real or composite narrative/photography/ videos. Note should be taken to mainstream films which could include inappropriate content and possibly rated 15 which could contain material detrimental to individual patients. Any material which is cause for concern should be raised and discussed with the clinical MDT.

22.7 The following are also prohibited:

22.7.1 Copied or pirated DVDs.

22.7.2 TV channels requiring subscription or pay per view.

22.7.3 Videos or DVDs not certificated or above 18 without clinical MDT review.

22.7.4 Pornographic material fetishising uniformed professions, such as nurses or police.

22.8 The clinical team can choose to prohibit material when sufficient concern is held relating to sexual/violent content (may be influenced by the individualised formulation of the patient).

23 How will a care plan be produced?

23.1 The decision is considered by the MDT. If access to pornography is considered safe and reasonable, care planning will commence.

23.2 A member of the MDT, alongside the patient, will update the patient's care plan to incorporate the use of pornographic material on PARIS.

23.3 A contract will be developed and read through with patient to ensure understanding of the agreement. This includes any individualised restrictions on the content of the material, where they can use the material, where the material will be stored, prohibition of sharing with other peers, consequences of breaking the contract with the immediate confiscation of the material. Prior to any access or purchasing the patient must show comprehension of the contract and provide a signature. Revisiting the contract on a regular 2/3 monthly basis may be required to encourage retention of the agreement.

23.4 Any breaches of the care plan/contract for accessing pornographic material (e.g., purchasing material without consent, lending, trading or selling material to other patients, using materials in communal areas) should result in a review of their access to such material. Continued breaches should result in the clinical MDT removing the material.

23.5 All material must be analysed by psychiatry or psychology to ensure it is appropriate within that individual's formulation and legal.

23.6 Any observations or concerns of increased sexual preoccupation or isolated behaviours in relation to the use of the pornographic material should be raised with the clinical MDT for consideration and review. Individual conversation should be held with the patient exploring this. A plan should be developed accordingly.

24 **Storage and access of pornographic materials**

24.1 Pornographic material must be kept in patients secure lockers within the ward office to ensure use can be monitored, and to reduce lending and trading. Sharing the material with other patients is prohibited and should be clearly stated to the patient. Materials will be kept in a large envelope/folder so that they can be discreetly carried to the client's bedroom.

24.2 Patients must ask a member of staff to access their pornographic material. This can be any member of staff and is not limited to the nurse in charge in the event that a patient wishes to ask a male staff member. However, staff members must be aware of the patient's specific pornography care plan and check with the nurse in charge if they are unsure whether they should permit access.

24.3 When an agreement has happened for a patient to access pornographic material a care plan should be developed and agreed with by the patient clearly stating access and storage.

24.4 Patients must return pornographic materials to the ward office within an agreed time frame. This may vary based on individual care plans but will generally be recommended to be within two hours of first accessing materials.

24.5 Pornographic materials may destabilise patients' mental health or lead to increase in risk, particularly those with sexual offending history. It is important these materials are kept securely to prevent other individuals accessing them. Therefore, materials must be held in the ward office where other patients cannot access them and stored in a discrete manner.

24.6 Pornographic material must be used in the patient's private bedroom with suitable measures taken to ensure both the patient's dignity and staff members wellbeing when conducting observations is maintained. This includes, but is not limited to, closing

curtains/blinds so that activities are not visible through windows (including door observation windows); and using headphones if DVDs are used. Patients must commit to using their materials quietly.

24.7 Breaching their own pornographic material care plan would result in a review by the clinical MDT. Behaviours include, sharing, lending, trading, or selling materials to those without access, use in communal areas and purchasing material without consent. Repeated accidental or apparent accidental indecent exposure could also be considered a breach on an individual basis, e.g. if a patient orchestrates use of materials at a time they are aware that staff members will be carrying out observations of them. If breaches are made, the MDT will consider revoking access.

25 **Monitoring the impact of access to materials**

25.1 Any instances of sexually inappropriate behaviours (e.g., sexualised comments or sexual preoccupation) should be clearly documented by staff on Paris and a Datix to be completed if required.

25.2 Patients will not be limited on the frequency of accessing materials, but a frequency monitoring chart may be put in place if it is felt that use is becoming excessive and/or interfering with rehabilitation, e.g. choosing to use pornographic materials rather than attend scheduled sessions.

25.3 Ward staff members permitting access to pornographic materials should be vigilant for patterns emerging in use, e.g. immediately following sessions with particular staff members. Guidelines for what to observe for will be shared with ward staff.

25.4 When concerns are raised due to impact of accessing pornographic material, the clinical MDT should review the individual patient's access.

25.5 Any instances of sexual offending or assaultive behaviour should lead to immediate revocation of the patients access to pornographic material. It should be documented on PARIS and a Datix completed. A safeguarding referral should be made if required. It should be reported to the police and investigated.

25.6 Clinical MDT should review individual patients access when a significant deterioration in mental health/state is observed.

25.7 Clinical team should continually implement knowledge of the TIC model and practices, and ACEs. If concerns are raised due to possible re-traumatisation from childhood sexual trauma (e.g., dissociation), a review of access should be considered.

26 Review of policy

26.1 The policy will be reviewed by a review of DATIX reports and Paris entries relevant to the use of pornographic material by patients on Maple Ward. If patterns of incidents are observed between patients that are felt to be in relation to the policy implementation as opposed to individual formulation and risk, the policy will be reviewed.

26.2 This policy will be reviewed to reflect any changes in guidance or legislation around pornography use in the UK. As a maximum it will be reviewed three years after the date of approval.

27 **Who is accountable for the enforcement of the policy?**

27.1 The clinical MDT is accountable for the enforcement of the policy.

27.2 Full understanding of what the policy entails is required by all staff before involvement in the decision process.

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