***“I feel that if I didn’t come to it anymore, maybe I would go back to my old ways and I don't want that to happen”.***

***Adapted Sex Offender Treatment Programmes: Views of Service Users with Autism Spectrum Disorders.***

## Introduction

Most individuals with autism spectrum disorders (ASD) do not display criminal behaviours. Yet, it has been suggested that the clinical features of ASD (e.g. atypical social communication and interaction styles, difficulties with theory of mind and empathy, inflexibility of thought and repetitive interests) have the potential to leave an individual vulnerable to committing offences, including sexual crimes (e.g. Allely et al., 2015; Allen *et al*., 2008; Dein & Woodbury Smith, 2010). This has been illustrated in a handful of case studies (Milton, Duggan, Latham, Egan & Tantum, 2002; Griffin-Shelley, 2010; also see Melvin et al., 2017) and it has been hypothesised that these features may also result in barriers to treatment, particularly in programmes for sexual offenders. Sexual offending treatment is typically delivered in groups and includes therapeutic objectives to increase victim empathy and address cognitive distortions to reduce ‘pro-offence thinking styles’ and attitudes conducive to offending (Bontna & Andrews, ; SOTSEC-ID, 2010; GLM, ) . While many have supposed the ASD phenotype as challenging within treatment programmes, this has not been subjected to rigorous empirical investigation (Allely & Creaby-Attwood, 2016; Higgs & Carter, 2015; Murphy, 2010a).

Recognition of ASD has improved and the prevalence rate of 4 in 10,000 in the 1970s (Rutter, 2005), is considerably less than the 1.1% estimated in the UK today (Brugha et al., 2012). ASD is a developmental disorder (DD) that can occur with and without a co-morbid intellectual disability (ID) and co-morbidity rates vary across samples and populations, for example, a Western Australian cohort study found 5.1 in every thousand children with an ASD, and 3.8/1000 with ID and an ASD (Bourke et al., 2016). The Brugha et al., (2012) survey identified 35.4% and 31% of adults with mild to severe intellectual disabilities living in private households and communal residences with co-occurring ASD.

Variation in impairments in cognitive abilities, as well as social and adaptive functioning in ASD, produces a wide range of clinical presentations, and individuals with ASD that require social or health care support can be found within intellectual and/or developmental disability (IDD) populations as well as offending and mental health populations. Reported prevalence rates of ASD within these populations can be much higher than in the community. For example, within forensic or psychiatric populations, estimates of ASD including those with an ID, range between 1.5% and 30% (Alexander et al., 2011; Hare, 1999; Scragg & Shah, 1994). As such, autistic sex offenders have typically been included within studies of IDD and/or mentally disordered offenders, rather than identified as a distinct population (SOTSEC-ID, 2010; Søderstrøm, 2005).

Group cognitive behavioural therapy (CBT) has been considered best practice in sexual offending treatment for some years (Marshall, Fernandez & Serran, 2003; Lösel & Schmucker, 2005). Programmes are available both for individuals with intellectual and developmental disabilities (IDD) and those without, in mental health and forensic settings from community and secure services, as well as in prisons and via probation services (Marshall, 1996; Lindsay et al., 1998; Rose et al., 2002).

Findings regarding recidivism rates following CBT treatment for sexual offenders (both IDD and non-IDD) are inconsistent, with some studies finding very small or no effects (see Schmucker & Lösel, 2008 and Mews, Di Bella & Purver, 2017 for a ten-year review of NOMS programmes). It is important to point out that these inconsistencies may be the result of methodological issues e.g. the difficulties of randomised controlled trials and appropriate comparison samples, rather than the efficacy of the treatment itself (Dennis et al. 2012; Duggan and Dennis, 2014; Hanson et al., 2009; Marshall & Marshall, 2007; Mews, Di Bella & Purver, 2017; Sturgeon et al., 2018).

Despite reported inconsistencies, recidivism rates of sexual offending are generally lower than non-sexual recidivism (Hanson & Bussière, 1998), however it should be noted that there is wide recognition of persistent under-reporting of sexual abuse/assault (Davies & Leitenburg, 1987; Furby et al., 1989), including in those with ID (Murphy, 2007).

There is conflicting evidence as to whether sexual recidivism rates are higher amongst ID populations compared to non-ID however this may be a consequence of increased rates of supervision, either from previous offending or for other health and/or social care needs, plus a potentially higher propensity to be apprehended due to victim selection or modus operandi i.e. more likely to impulsive/opportunistic rather than elaborate and complex in planning (Leam & Lindsay, 2010).

Adaptations for sexual offending treatment for those with ID include a larger emphasis on sex education and relationships, legal and illegal behaviours, and a simplified cognitive model. They continue to address victim empathy, cognitive distortions and include a relapse prevent plan. Adapted programmes are designed for those with a mild to moderate impairment in cognitive functioning, typically with an IQ ranging between 55 to 80, contain less information per session, increased repetition of content and higher use of visual aids.

Supporting evidence for the implementation such adaptations has been shown in numerous studies for offenders with ID (Heaton & Murphy, 2010; Lambrick & Glaser, 2004; Lindsay et al., 1998; SOTSEC-ID, 2010), however their appropriateness and effect for autistic sexual offenders is yet to be determined. It is important to consider that adaptations to sexual offender treatment programmes for those with ID have not been developed specifically for offenders with co-occurring ASD. As such, the clinical features of ASD coupled with an ID may create a more complex profile and potentially limit the impact of any adaptations to treatment.

For example, a trial of an adapted sex offender treatment programme for men with IDD found ASD to be associated with increased likelihood of recidivism (Murphy et al., 2007; SOTSEC-ID, 2010; Heaton & Murphy, 2013). It should be noted that the authors of these studies advise caution in interpreting this finding due to the small sample sizes and because the participants with ASD were more likely to commit non-contact offences. Some evidence has shown higher recidivism rates for non-contact offences compared to contact offences (e.g. Mair & Stephens, 1994). However, a number of clinical case studies of sexual offenders have also suggested poor treatment outcomes for those with ASD, and have illustrated particular challenges to therapy in relation to cognitive inflexibility and victim empathy (Griffin-Shelley, 2010; Murphy, 2010b), as well as continued displays of sexual offending behaviours following treatment (Ray, Marks & Bray-Garretson, 2004; Kohn et al., 1998) and challenges in delivering traditional group CBT programmes due to social interaction difficulties (Milton et al., 2002; Murphy, 2010b).

Recidivism and re-offending rates are the primary measure of treatment effect but nevertheless service user involvement and opinion has become a key driver in UK health and social care policy (Attree et al. 2011; NHS England, 2015; Omeni et al., 2014). Relatively few studies have examined service user views of sexual offender treatment. Some interviews with participants have been completed alongside quantitative outcome measures that assess treatment objectives or evaluate risk (e.g. Blagden, Winder & Hames, 2016; Hanson et al., 2004; Large & Thomas, 2011; Hays et al., 2007; Sinclair, 2011; Courtney & Rose, 2004). It is possible that men with ASD participated in these studies, but it remains unclear. Unlike other areas of research, such as diagnosis, services and therapy, self-advocacy and human rights, being a victim of crime and being imprisoned where service users have been interviewed about their experiences (Allely, 2015; Huws et al., 2008; Nora et al., 2016; Petri et al., 2017; Richardson et al., 2016), , the views of men with ASD have not been sought or identified specifically in relation to sexual offending treatment. This study was therefore designed to capture the views and experiences of men with ASD with a history of sexual offending who had received treatment.

## Aims of Study:

The aims of this study were to gather the collective views and experiences of men with ASD who have completed an adapted CBT sex offender treatment programme and to explore their views about whether treatment was helpful in reducing risk of re-offending.

In addition to collating the men’s experiences and views, the study also sought to consider whether the features of ASD are a vulnerability to effective participation within treatment programmes.

**METHOD**

## Design:

As the study was exploring the use of adapted sex offender treatment programmes for individuals with ASD, eligible participants were anticipated to have co-morbid intellectual disabilities (including the mild-borderline range), and be in receipt of, or known to, community learning disability services. Purposeful sampling was therefore utilised due to the specific niche of the target population and constraints relating to time and resources, but also to ensure that the sample was able to effectively take part in the interviews. Eligible men were required to: (a) have the capacity to consent, (b) be over eighteen years old, (c) have a diagnosis of ASD (either from an assessment or through clinician opinion) or meet the cut-off threshold for an ASD from the Autism Diagnostic Observation Schedule. Second Edition. (ADOS-2) (Rutter et al., 2012), and (d) have completed a CBT sex offender treatment programme.

Semi-structured interviews were used to allow participants the freedom to recount their narratives and give opinions, whilst providing some direction about the challenges to treatment in relation to difficulties with empathy and cognitive rigidity. It was also felt that some guidance and structure to the interview would be beneficial to those anxious about social situations and/or unfamiliar people.

## Participants:

Eighteen men with ASD were identified by services and invited to take part. Fourteen returned consent forms, but one failed to attend his interview and did not respond to attempts to re-schedule. The service provider stated that this participant wished to withdraw from the study and all information for this individual was destroyed. Therefore, thirteen men with ASD who had completed an adapted sex offender treatment programme participated in the study and were interviewed by the first author.

The demographics of the service users are found in Table 1 and are comparable to other samples of individuals with IDD who display offending behaviours in relation to age, offending behaviour, referral to community or secure provision, legal status, involvement with the criminal justice system, co-morbid psychiatric diagnoses, histories of adverse childhood events and other problem behaviours such as aggression and substance abuse (e.g. Langdon et al. 2013; Sinclair, 2011; Lindsay et al., 2014; Carson et al., 2010, 2014).

All men in the study were in receipt of support from learning disabilities services. The mean age of the sample was 38 years and 3 months (SD: 11 years and 1 month) and, where available (n=9), the mean full-scale IQ score was 71 (SD=9.5, range=57-85). Seven of the men interviewed were living in the community and six were detained under the Mental Health Act (1983) in locked rehabilitation wards or low and medium secure services.

The men had various ASD diagnoses which were not always consistent with diagnostic protocols (e.g. a diagnosis of Asperger’s Syndrome alongside an IQ score below 70). A higher number than would be anticipated had diagnoses of atypical autism (n=4) and one man was diagnosed with Social Communication Disorder on his records but there was agreement by three of his clinicians of his having an ASD.

During recruitment, it was recognised that some men had a diagnosis of ASD but no record of an assessment or formal diagnosis was recorded. For these participants (n=3)[[1]](#footnote-2), The Autism Diagnostic Observation Schedule (ADOS-2) (Lord et al., 2012) was completed by the primary author as part of the screening process. All of those assessed met the cut-off threshold for an ASD.

As would be expected from a sample recruited through learning disability services, the men presented with various psychiatric co-morbidities (Table 1), and as such co-morbid diagnoses did not constitute an exclusion criterion.

A range of sexual offending behaviours were displayed within the sample (Table 2). Many of the men had long histories of sexually abusive behaviours and typically offended against women, children and vulnerable peers. Ten of the men had received convictions and been placed on the sex offenders’ register and three had received custodial sentences. The men also displayed other antisocial or risky behaviours, with many receiving convictions for these behaviours (more so than the sexual offending behaviours). The presence of additional problem behaviours is consistent with other studies of IDD offending populations (Lindsay et al., 2009; Wheeler et al., 2009).

### Adapted Sex Offender Treatment Programmes:

The average number of treatment groups completed by the men was two, with each group lasting approximately one year, with one session a week. The men completed ‘closed’ treatment programmes (i.e. once the groups had started they were closed to new members and members were required to commit to the group, with a limited number of absences allowed). Not all sexual offending treatment programmes are organised in this way, for example, some have a rolling programme, open admissions to avoid delays to starting treatment (e.g. Large & Thomas, 2011), however the men interviewed in this study all undertook treatment in a closed group. One service user reported to have completed a group six times, however the average remains at two if this outlier is removed. The majority of the men interviewed had completed the SOTSEC-ID programme (SOTSEC-ID, 2010) or a prison/probation programme such as the adapted Sex Offender Treatment Programme ( adapted SOTP) (Williams, Wakelin & Webster, 2007) or Becoming New Me (Williams & Mann, 2010). It was not possible to ascertain which group all of the men completed, nor the number of sessions attended as for some it had been some time since they had completed the treatment group, or this information had been lost during transition between services and was not in their clinical file. From the self-reported data generated during interviews, the size of the groups attended ranged between three and ten men. Many of the service users were in receipt of, or had previously received, individual therapy (n=10). This was often related to sexual behaviours but also other areas of the men’s life such as anxiety or transition.

Four men continued to display sexual offending behaviours since completing their first treatment programme, including sexual assault or possession of child abuse images, and a further six displayed ‘risky’ or concerning behaviours which were seen as precursors to previous offences by their clinical teams, such as stalking and ‘watching’ behaviours, or sexually inappropriate behaviours whilst using the telephone (e.g. masturbating during calls to customer services help lines).

[Insert Tables 1 and 2 here]

## Measures:

### Demographic information

Information about the service user’s history, offending behaviour and living status was gathered using a personal data sheet completed by staff (Tables 1 and 2).

### The Interviews

The interview schedule (obtainable from the primary author) consisted of questions addressing: *What the individual remembered from the group; what they thought of the group including aspects they found challenging, helpful, or missing?; how they found taking part in a group; if the group has helped them from re-offending?; how they have managed any behaviours or risks since completing the group (e.g. attending maintenance groups, etc.).*

The schedule was developed from previous research interviewing sexual offenders with IDD (e.g. Hays et al. 2007; Sinclair, 2011) and revised in line with the study’s research aims to explore/identify any issues specific to those with ASD, e.g. regarding module content such as the victim empathy or the group nature of treatment.

Interviews lasted approximately thirty minutes (M=26:09, SD =09:06) and took place in Community Learning Disability Team offices, residential homes, secure wards and service users’ homes (with carers in adjacent rooms).

Interviews were recorded on a Dictaphone and transcribed by the first author using DSS Player Standard Transcription Module (v2) software. Following the interview, the men received a £10 voucher in payment for their time.

*ADOS-2*

The ADOS-2 (Rutter et al., 2012) is a standardised structured assessment which is one of two tools considered ‘the gold standard’ in the assessment of autism spectrum conditions (Kamp-Beck et al., 2001). It provides the opportunity for an individual to display social interaction and communication behaviours and for the observer to note any difficulties or idiosyncrasies associated with a diagnosis of ASD, including restricted and repetitive patterns of behaviour and sensory issues.

## Procedure:

A favourable ethical opinion was given by the Bromley NHS Research Ethics Committee (REC) and the Health Research Authority (HRA) for NHS sites (n=5). Participating independent healthcare services followed the organisation’s local research and ethics policy (n=1).

### Recruitment

Community learning disability teams, and secure mental health and/or learning disability services were invited to take part in the study. Potential participants were initially identified and approached by staff within their service to ensure participation would not impact upon mental state or recovery. This was also done to lessen any potential anxieties from being contacted by a stranger. It was emphasised in the accessible information sheets and consent forms that the study was being conducted independently of all service providers, that the information would be confidential, and the decision to participate would have no impact upon care or treatment provided.

## Analysis:

A qualitative, constructivist, interpretive method was selected for data analysis as the study aimed not only to record the experiences of service users with ASD, but also to understand how the men constructed their views of treatment effectiveness and perceptions of risk. These constructions were then explored in the context of existing propositions about ASD and sexual offending treatment from the literature.

Grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998, 2014; Charmaz, 2006), particularly the approach of Charmaz (2006, 2014) and Corbin & Strauss (2014), was applied to develop the data from descriptive codes into theoretical concepts.

The analysis and procedure were reviewed by the second author on multiple occasions to ensure sufficient codes for saturation, and agreement was reached for all categories, concepts and the resulting model.

The transcripts were read on multiple occasions by the primary author and coded in a line-by-line system to extract the descriptive-level content of the men’s narratives. One hundred and nine codes resulted from this initial process which were then refined and ordered into higher level categories. This stage involved exploring the codes in relation to each other, and when pieced together (examining larger chunks of text), led to the identification of a number of themes and processes involved in the men’s experiences and views of the treatment group, including their perceptions of their offence and risk of re-offending. The categories and themes were then elevated, moving away from the data, to abstract concepts that had explanatory power and subsequently developed into a model of how men with ASD experience sex offending treatment groups and perceive their effectiveness (Figure 1).

## Results:

All thirteen service user interviews were included in the analysis and used to develop the resulting model (Figure 1).

[Insert Figure 1 here]

The men’s **identity** formed the overarching theme in the data (Figure 1). Their sense of self was constructed through themes of (i) *who I am* and (ii) *my needs*, which were influenced by internal motivators and experience (including the group), immediate relationships (family, peers, professionals) and wider social and cultural factors.

The men acknowledged assimilation of some aspects of the treatment into their identity, such as development of new social roles and skills. However, opinions and experiences of the group were enmeshed with how the men viewed their offending behaviour specifically, if they considered themselves at risk of re-offending or if this was a concept inconsistent with their identity. They formulated beliefs about ‘Am I a risk?’ through the subthemes of (i) *beliefs and perceptions about the group and therapy*; (ii) *attitudes and beliefs about offending behaviour*, and (iii) *notions of change/difference* (Figure 1). Attitudes towards offending behaviours were mediated through views of blame and culpability.

Beliefs regarding treatment effect were also conveyed through accounts of change in the men’s lives following the group, particularly within the theme of *my needs.* As would be expected, those whose lives had changed very little since attending the group, frequently those who denied their offence, faced more restrictions and losses of freedom and thus experienced the group as unhelpful or believed it to be ‘not worth doing’. There was however little difference between those detained in secure services under the mental health act and those in the community regarding views of group helpfulness. For example, five out of seven men in the community described the group as helpful, as did four out of six who resided in secure services. Only one individual in the community stated the group did not help whereas two in secure services felt it was unhelpful. The majority of participants who saw improvements to their life, regardless of how they accounted for those improvements (refer to pages 13-14), believed the group to be “worth doing”:

*“If you didn’t have those groups something could have happened along the line that you could’ve ended up in prison if you hadn’t have come”.*

**My Identity:**

In constructing **identity**, the theme of *who I am* included statements regarding ‘how I see myself’, ‘what I like’, ‘what I deserve’, ‘how I behave’, ‘what I need help with’, ‘what I am good at’, etc. Whereas *my needs*were conveyed through narratives about whether the men felt their *needs* were met, what *social goods* they had, and their level of *social inclusivity.*

The role of others was a significant factor in constructing identity and the impact of different relationships spanned both themes of *who I am* and *my needs*, in addition to feeding into perceptions of risk. ‘Others’ were categorised into relationships in the ‘personal’ or ‘professional’sphere, with some having a direct influence or contact with the individual e.g. family, spouse, clinical team etc., and others being *indirect* e.g. the police, media, identified social groups. Many relationships were constructed as a protective factor e.g. staff, wives, family, employer etc. (e.g. Q1,3,4 &8), or a risk factor e.g. victims, potential victims. Professional relationships tended to be characterised as those ‘*providing help’* and those ‘*hindering progress*’ (as illustrated in Q20,29 & 31).

*Met needs, social goods* and *inclusivity* wereframed in terms of ‘freedoms vs restrictions’, and ‘gains vs. losses’ (post-group)*,* and included what the men believed they deserved or expected, as well as what they had. *Needs, goods* and *inclusivity* varied in precedence across the data, but each combination constituted ‘*what I have/what I want’* and formulated hopes/plans for the future.

Q1: “*[I] just want to start again and a job, a girlfriend and a house and start building something up … so I can buy a house, when I get a job somewhere and maybe a girlfriend might come into my life*”.

Individual desires/wants were shaped by cultural norms and comparisons to others. Employment and relationships, particularly romantic or sexual relationships, were key social goods, with employment mentioned in ten of the thirteen interviews, and romantic/sexual relationships mentioned in eight. Both jobs and relationships were used to symbolise met or unmet needs and contributed towards feeling part of society. Employment created monetary benefits and a sense of worth and self-esteem e.g. Q2: “*And my boss was very pleased with my work, gave me a pay rise once*”. It also provided opportunities to be part of a team and included in shared experiences:

Q3: “*This morning we had a bit of fun and games, I got there [to work] and the shutter had broken … So they had to call out somebody to come down to fix it, [it was] a nightmare and you know, and I’ve been put on the till [laughs].”*

Identities were formulated and supported by propositions of how the men are alike or dissimilar to others, with justifications of behaviour made through statements of ‘*what I say’* and statements of ‘*what others say’* (including in relation to offending behaviours, e.g. Q24-6). Membership of social groups and recognised roles, such as employee, husband, son, musician etc., contributed to identity, as well as individual factors and relationships, i.e. likes/dislikes, skills and abilities, childhood/life experiences, health or disability, people/relationships in their lives, and wishes, hopes, expectations and failures. A framework of similarities and differences was used, and comments fell into one of four statement types: ‘how I am like others’, ‘how I am different to others’, ‘me compared to others’ and ‘others compared to me’*,* depending on where or how the men placed themselves in relation to others. The men used these strategies to construct aspects of their identity in which they were just like ‘other men’, either simply by being a man or by identifying with a particular social group or subculture as mentioned previously e.g. the established roles/identities of ‘husband’, ‘employee’ gender norms/expectations, e.g. Q4: *“[get back to] being a decent chap … and be more gentleman[ly]*”.

**Notions of change/difference:**

In portraying their sense of self and identity, contrasts of ‘me before the group vs. me after the group’ and ‘different life, different me’, illustrated notions of change and difference.These contrasts were presented throughout the narratives, with the former being loosely based on references to internal motivations and behaviours (‘me before vs. me after’ representing changes to self), and the latter on external changes and situations (‘different life, different me’ indicating changes to circumstances) e.g. staffing/support levels and service provision, employment, marriage, etc. Changes to both self and circumstanceswere used to support the men’s propositions about their risk of re-offending.

 For some, their circumstances were similar to, or worse than, before their offence or attending the group e.g. unmet needs, lack of social goods and feeling socially excluded. For those whose lives had improved, the desire to retain these improvements and achieve more acted as protective factor, potentially reducing riskof re-offending**.**

*Fear of the consequences* was a primary motivator against re-offending, particularly the risk of social exclusion. Consequences were frequently framed as ‘punishments’, indicating an immature level of moral development, characterised by an emphasis on concrete aspects and ‘rules’ of behaviour (Gibbs et al., 1992). Morality is seen as dictated by physicality or authority (e.g. being older or ‘bigger’, or a parent, God, the police, etc.) or defined by ‘quid pro quo’ arrangements and calculating the advantages/disadvantages of demonstrating pro-social behaviours e.g. obeying the law to avoid going to jail. At the immature stages morality is not viewed as something that transcends contexts and situations or is malleable e.g. morality as governed by societies’ laws and principles which can change/be adapted where needed or deemed appropriate e.g. stealing food to feed a starving child.

The men repeatedly referred to removal or ‘loss’ of freedoms/activities as a consequence of their behaviours, as illustrated in the quotes that follow. For example, all narratives indicated a level of social exclusion as a consequence of offending and anxieties of future exclusion were often expressed in terms of physicality i.e. being sent/locked away.

Q5: *I mean I know alright, they gave me a fine as well, but when they recommended [the group] … I thought at least … it’s better than sitting in some … prison cell… where you can’t on with your life … once you’re there, you can’t really speak to people … you’re kind of shut off there and it’s difficult … I’d rather be going to a programme and get to talk about these things than be sitting in prison … I think everyone’s said all along, prison is not a place for me, you know? Cos’ I am you know, a vulnerable person”.*

Impact on family, and loss of other freedoms or gains also contributed to *a fear of the consequences* of re-offending e.g. Q6: “*If [I] re-offend in the future and go back to prison [my] family [will] get upset*” and, Q7: “*(if I re-offended) I’d have to start from the bottom and get that trust again that I built up to be able to use the internet*”.

As mentioned, employment was viewed as a key social good and key motivator against re-offending, Q8: “*It’s what I lost my job for and that, one of the last things was, [I’m] never ever making a phone call [like that] again and losing my job over it*”

Other differences in circumstances and changes in self referred to romantic/sexual relationships. These were described in terms of ‘having’ or ‘wanting’ a wife/girlfriend. Some men identified these unmet needs in the context of their offending, for example:

Q9: “*I was in a pretty bad state, couldn’t get a partner at the time.*”, and “*I split with my girlfriend and [I made] a sexual type of phone call to her family … they told me I was not to see her again*”.

Within the theme of *how I’ve changed,* changes to romantic or sexual relationships were conveyed as of great relevance to risk and a sense of being different post-group (also see Q13 ). For some, having their sexual needs met was a priority (see quote below), whereas for others the esteem/status of being a husband or partner was dominant. References to love, companionship, finding ‘the right person’ or consideration of the others’ feelings were minimal or absent.

Q10: “Since that [sex] stopped I see prostitutes now … [I’m] quite happy with going to the brothel and having [wife] as a partner still.”

Poor mental health and other stressors such as family relationships or substance abuse were also identified as potential triggers or risk factors for offending and indicated to have since improved and thus reduced risk e.g. Q11: “*I don’t know what was going through my mind, it was a lot of things. There was a little bit of aggravation with my sister*”.

Men who denied any risk or offending behaviour (and subsequent need to be at the group), presented themselves as compliant and/or obedient i.e. they attended the group and did what was asked, but indicated any change in their belief/attitudes or behaviour was unnecessary.

Q12: *“The psychiatrist has still told me to carrying on [attending the group] for the time being … So I’m doing what they say, they’re the champions …”*

New roles as well *coping strategies* acquired from the group (such as ‘Stop and Think’ cards and reminding oneself of the consequences) were readily incorporated into the men’s identities and used to indicate change and reduced risk. For some, completion of the group and continued adherence to therapeutic principles or risk management strategies became an integral part of the ‘changed’ life and self, as seen below:

Q13: *but I learnt if I don’t do much and I think about re-offending … [if] you [are] having a lazy day, you do something creative like on the computer, brush the cat … and then [the] brain [is] occupied and then I don’t think about … ‘what could I do’ or ‘let’s go re-offend’. So now I’ve got everything in my life that I need, I’ve got a good cat, I’ve got a flat, I’ve got my wife and I’ve got jobs to do … and so I have completely changed my routine from what I was doing before when I was re-offending and thinking about what could I do to stop myself from re-offending … I knew I needed to get more volunteering, [then it] was a case of getting my bottom in gear … and [now] I don’t have to think about going to find more volunteering or going to work I … do that automatically.*

Other men denied or omitted any potential effect from the group and assigned changes to the result of others causes e.g. Q14: “*I just don’t think of hurting people any more … I just woke up one day and said ‘won’t do it anymore*” and, Q15: “(*Interviewer:) Is there one thing that has been helpful in keeping you safe and making sure that whatever happened before doesn’t happen again? (Interviewee:) I’m on the 1:1 [staffing level]”.*

**Attitudes and beliefs about offending behaviour:**

These were founded upon *experiences of going to group* and *existing perceptions of self and others,* and were shaped by notions of blame and responsibility.

*Experiences of the group* were described as: (i) those that affected the men on a personal level and centred on them as an individual, (ii) those that impacted upon their social sphere, including their immediate friends and family but also the wider community and their place in society, and (iii) those that were related to the group as a form of treatment. These themes were not mutually exclusive and fed into each other e.g. going to the group impacted them both socially and individually.

Opinions regarding the group were sometimes expressed directly e.g. it being ‘*boring*’ or inconvenient e.g. interfering with college, relationships, etc., Q:16 “s*o it was a little bit hard [going to the group] because I wanted it to concentrate on getting married”;* whilst others were implied or conveyed through their relationships with other group members and staff.

Group treatment was described as a positive and negative experience. Some men had received individual therapy at some point in their life (n=10), (not necessarily related to offending) and there was little preference between the two with only two men stating they preferred 1:1 and most saying they enjoyed both.

Q17: *“I did feel in one [way] it’s better working one-to-one but you don’t get the … other people … because what you might … think about, I might not think about.”*

Difficulties identified from the presence of otherswere those common to most social interactions e.g. personality clashes, shyness, social anxiety, fear of bullying, etc., with some specific to sex offender treatment i.e. disclosure of offence and hearing other members’ offences was sometimes identified as distressing. However, for many men the group provided a space of common ground, with numerous references to all “*being in the same boat*” (Q18) and members were seen as sources of support and encouragement, “*We just help each other*” (Q19).

Q20: “*I suppose you get over the initial thing of why you’re there … You just meet on a regular basis, like coming here, I’ll say, Rich the facilitator, you treat [him] as your mates (sic.) … whoever you’re with in groups, you do similar things and you have laugh and you talk about things*.”

How the men *perceived themselves and others* impacted on their engagement with the group and its members. These perceptions included the sense of identity and needs/expectations, as referred to previously i.e. ‘*who I am*’ and ‘*what I want*’, but in relation to their offence e.g. Q21: “*nobody would go out with me so I was panicking … I wanted a nice girlfriend in life but I couldn’t get hold of one”.*  This subtheme also includes perceptions of the men’s place within the group and their relationship to the other members.

**Beliefs and perceptions about therapy/the group:**

For some, the group created a sense of belonging, identity and opportunities for shared experiences as shown in the quote above. Additionally, it provided the chance to develop pro-social roles and relationships. For instance, in supporting other members of the group some men became role models or advocates for the less abled or experienced. Members established specific roles and played their own part in the group such as reading the group minutes each week or helping to provide refreshments. Some roles and benefits stretched beyond the group leading to employment or involvement with charities/organisations to advocate or represent men with IDD who have offended. One man regularly travels to events and discusses his experiences “*I explained why I was there, a little bit the problems and the autism that I have and explained to a whole a group of people*” (Q22). These positive experiences and new roles/skills were strongly emphasised during the interviews and appear an important integration into the men’s identities.

A handful of men (n=4) rejected the group and its members by isolating themselves e.g. Q23: “*I don't bother with them [other group members], I just stick to mysel*f”. Other members were not part of their experiences, only being referred to if asked directly. These types of ‘group’ experiences were described mostly by men who denied any offending behaviour and perceived themselves as “*not like the other men*” (Q24), distancing themselves from any sense of sexual risk “*It’s mainly the staff, maybe it’s one or two people who had said stuff, [like] ‘I’m [the participant] not a rapist’, ‘there’s no way I’m a rapist’ that sort of thing*” (Q25).

Whilst the group did create a shared identity and recognition of similarities between self and others, this did not always extend to perceptions of offending behaviours. Differences were often emphasised between the men’s own behaviours and other’s offences. For example, in the below quote, one member illustrates his perception of his non-contact (online) offence in comparison to members who had committed contact offences:

Q26: “*Often somebody else saw them [other group members] doing it, but it was like (inaudible) sexual, sexualised [acts] with other people … so I just thought [why] on earth [do I need to] come to the men’s group … if no one who got hurt by it*”.

Throughout the narratives, cognitive distortions were prominent in maintaining an identity which minimises or does not acknowledge sexual risk. This was particularly evident in statements relating to the victim, typically in terms of it being ‘their fault’ e.g. Q26: “*I’ve not done a sexual offence on anybody, … she was taking drugs, sometime in the day, she was different*” and, Q27: “*I was saying she probably wouldn’t understand because of, she was, the person what I did it [the victim] wasn’t English*”.

The consequences for the men were also important, particularly whether they considered them to be justified or unnecessary in relation to their ‘risk’. Any impact on their family relationships or loss of employment, imprisonment or sectioning under the Mental Health Act (1983), etc., influenced whether they believed themselves the victim rather than a threat to others, or treated unfairly as opposed to being punished for their crimes:

Q28: “*I’ve been in hospital for over fourteen years, actually I should have only done six years and I done fourteen. They should have let me out by now*”.

Group facilitators were important in the men’s experiences of the group, not only in terms of providing support and guidance *at* the group but group ‘membership’ was also seen as providing an additional route to staff and support. For example, men in the community and secure services asserted with confidence that they could contact staff, outside of their designated therapy sessions and express that they were experiencing ‘risky thoughts’ or ‘needed to talk’ and the staff would respond/provide support.

Q29: *“I just think I am doing so well and if [there’s] anything to be concerned of, I know she’s [facilitator] at the end of the telephone”*

Q30: *“it’s not like no one cares and no one worries about you, you know, the door is open”*

In this sense, the group is not seen a method of lessening support from services but is viewed as something that enables the men to be visible and get the help they need.

Opposing experiences of group facilitators were reported when they were seen as ‘hindering progress’ - *“… the ones who [are] meant to help me to move on … they didn’t listen to anyone”* (Q31) *-* or were unavailable e.g. not being able to work with the facilitator of their choice*.*

All men indicated a lack of choice in the decision to undergo treatment for sexual offending behaviours.

Q32:

*Interviewer: “And do you have to go [to the group], are you told to go?”*

*Interviewee: “No no, if we don’t go, it will hinder us moving on”*

*Interviewer: “Is that what some told you?”*

*Interviewee: “No, that’s what I know*”

In addition to feeling little choice over attending the group, the men typically recounted long histories of involvement with services, many having been in institutional care from a young age and undergoing multiple transitions. These accounts frequently depicted a life (and identity) lacking autonomy or control, with choice of care pathway being determined by finance and the judgements of others regarding risk, health, mental state and wellbeing.

Q33: *“[I moved here] because my funding was costing them too much money, to fund me … So they want[ed] to try and find somewhere, what [cost] less”* and, Q34: “*[you] try not to break any of their laws or try and keep rightness and [do] … what the doctors want*”*.*

How the men approached the group was influenced by how they believed it was going to help them, if at all. For example, those who saw it as a forum for personal development or change, perhaps related to ‘keeping safe’ or staying out of trouble (risk), indicated an openness to, and potential for internalisation of, therapy i.e. acknowledging the potential need for behaving differently. For others, the practice of attending the group and use of external management strategies (e.g. staffing levels) were understood as a method of ‘keeping safe’ (reducing risk) with little reference or insight to the need for self-directed behaviour and motivation.

Attending a group was commonly seen as a way of remaining in, or returning to society e.g. being diverted from prison to a facility offering a treatment group or agreeing to treatment as part of licence conditions:

Q35: “*Learnt my lesson, don’t want to get sectioned again. It took nearly nine years for me to get back into society*”.

Perceptions of the group and therapy were influenced by the men’s beliefs about why *they* were required to undergo treatment and attitudes towards their offending behaviour, including whether they acknowledged it or not. Narratives which included the aforementioned views of the group being a forum for change or method of keeping safe tended to admit that an incident or behaviour had indeed preceded the group. This was regardless of whether they felt they *needed* therapy or not. Whereas those who denied their offence or any risk often stated they couldn’t remember, or didn’t know why they were asked to go to the group, that it was “*probably just the newest thing they [psychology] started*”.

##  Discussion:

This study aimed explore the experiences of men with ASD who have completed an adapted CBT sex offender treatment programme and ascertain their views about whether treatment was helpful in reducing risk of re-offending.

Positive experiences from the group related to social benefits, professional support and the prospect of increasing social inclusion. These benefits were emphasised by many of the men and frequently portrayed as the ‘treatment objectives’ or primary goals of the group, more so than reductions in sexual risk or offending behaviours.

Despite an initial lack of choice in attending the group, for some it became a forum for empowerment and self-development, providing the opportunity for pro-social roles and skills to be integrated into their identity. For other men, particularly those who denied any offending behaviours, the group was a negative experience and seen as another occurrence in which they suffered a lack of choice, control or autonomy, doing little to change their circumstances, sense of self, or identity.

The social goods identified by the men in constructing their identities are universally recognised, appearing across genders, ages, ethnicities, in those with and without IDD, and those with and without convictions. They included: loving relationships, employment, a social life, meaningful activities, belonging and acceptance, choice, independence, self-esteem/sense of worth and control. These provide support for the use of strength-based models (e.g. the Good Lives Model) and attainment goals (e.g. Ward & Maruna, 2007) in treating offenders with ASD.

The indicated immature levels of moral reasoning amongst the men interviewed are consistent with research exploring offenders with IDD and moral development (e.g. Langdon et al., 2011; Langdon et al., 2013), and suggests the use of avoidance goals may also be of utility in treatment, particularly in considering the subtheme ‘fear of the consequences’. The men alluded to the ‘punishment’ quality of ‘losses’ for themselves as a consequence of breaking the law, more so than internal feelings of guilt or shame about harming another. Therefore, treatment focusing on social rules and risks to the offender’s quality of life associated with violating such rules may be a stronger motivator than impact on the victim or deviance of the offending behaviour.

The findings from this study regarding the group nature of treatment are inconsistent with some literature on men with ASD who sexually offend where offenders with ASD have been removed or considered potentially unsuitable group treatment (e.g. Higgs & Cater, 2015; Murphy, D., 2010b). Not all participants in this study had participated in both group and individual therapy, however, of those who had, only one preferred individual therapy, while two preferred or enjoyed the group more and the remainder claimed no preference or that they enjoyed both.

Other, non-offending group therapies have illustrated benefits for individuals with ASD (Reaven et al., 2011; Sofronoff, Attwood & Hinton, 2005). A meta-analysis of CBT for people with ASD (including group treatment) by Weston et al. (2016), found small to moderate effect sizes depending on the type of outcome measures used e.g. self-report, carer/parent or clinician, suggesting that a diagnosis of ASD should not automatically mean group-based approached are contraindicated. As highlighted, for many men in this study the other group members were key in their positive experiences and provided the opportunity to develop pro-social roles and relationships as well as offering support, encouragement, acceptance and belonging, and different viewpoints/opinions.

The degree to which these positive experiences increased social opportunities and improvements in wellbeing, and thus reduced risk was unclear. As illustrated in Table 2, ten of the thirteen men continued to display offending or risky behaviours post-treatment e.g. inappropriate sexual behaviour whilst using the telephone. The behaviours are similar to those displayed pre-treatment, however, it is unknown whether these would occur at a higher frequency or have elevated in severity without the attending the treatment group.

Protection of others was not a dominant feature in the men’s narratives nor did it appear prominent in their perceptions of risk or treatment objectives. The notion of themselves as a threat to others was not constructed as part of their identities, concern for victims or potential future victims was strikingly absent from their accounts. This was perhaps to be expected as a lack of victim empathy, or perspective-taking is frequently referred to in offenders with ASD (Griffin-Shelley, 2010; Murphy, 2010a); however it is difficult to know if this may be the result of difficulties in emotion recognition or alexithymia, or egocentricity, each of which can be seen on the autistic spectrum.

It is unclear from this study, and other research, whether an absence of regard for the victim is due to problems with understanding other’s emotional states and theory of mind or, understanding but disregarding the feelings of others (Jones, Happe, Gilbert, Burnett & Viding, 2010). Furthermore, it remains to be seen if this absence of regard holds any function in neutralising shame and/or psychological distress caused by offending behaviours (Bumby, 2000), and what, if any, potential impact this may have on risk of re-offending (Mann & Barnett, 2012).

Reductions of risk were primarily conveyed through notions of change and difference and were implied treatment outcomes. These assertions of change and subsequent reductions in risk, were frequently justified by references to differences in circumstances and external controls e.g. access to staff or being married, rather than indications of internal change or shift in attitudes. Many of the men’s ‘post-group’ identities still displayed cognitive distortions consistent with their ‘pre-group’ identities. These included a sense of grievance or entitlement, self as victim, super-optimism and victim blaming which are commonly reported in the sexual offending literature (Mann & Beech, 2003; Mann and Hollin, 2001; Ward, Keoen & Gannon, 2007). The persistence of these thought patterns could be indicative of the cognitive inflexibility or rigidity, characteristic of ASD, but it is not possible from the current data set to identify if this rigidity is any different to that displayed in persistent offenders without ASD. Research has highlighted the difficulty of ascertaining if pro-criminal beliefs and attitudes are causative of offending behaviours or a method of defence, shielding against subsequent feelings of shame from acknowledging actions which are ego dystonic (Ward, Keown & Gannon, 2007; Lindsay et al., 2010). This challenge is present in non-IDD populations and further complexities are likely to arise with additional cognitive complexities such as those associated with ASD.

### **Strengths and Limitations:**

Whilst it was emphasised that all data from the study would be kept confidential and anonymous, additional findings replicated wider research interviewing vulnerable populations e.g. non-offending IDD populations and mental health service users, in that the men were reluctant to criticise their service or suggest improvements to the group (Hare, 2004; Goodley, 2000). Despite highlighting the independence of the study from service providers, it is possible that fear of reprisal or withdrawal of service remained a concern. Furthermore, the men may have been reticent to suggest improvements as it could imply that the therapy was unsuccessful and subsequently hinder their progress, and reassurance regarding confidentiality may not have been sufficient to allay the participants’ anxieties. As such, suggestions for improvements or further adaptations to treatment for sexual offenders with ASD were missing from this service user dataset. Practice recommendations and clinical opinion of treatment for autistic sex offenders are discussed in a sister study (Melvin et al,. in preparation).

Despite the study sample being small, it was fairly heterogeneous and included roughly equal numbers from the community and those detained under the MHA. The study also included those with long histories of offending as well as younger men who had committed a first offence. The similarity of the sample to other studies of offenders with ASD (which have not focused on treatment), including sexual offenders (e.g. Lindsay et al., 2004, 2013), indicates the participants to be representative of the target population.

The sample did not include men currently in prison or those not in receipt of some form of mental health or intellectual disability service. As such autistic sexual offenders without a co-morbid ID are not represented and extrapolation of any findings to this group should be made with caution.

By interviewing numerous men from each site the study was able to gather different opinions on the same treatment group, however the sites were few in number and the majority were NHS (5 out of 6); therefore men receiving treatment from independent healthcare services or charities were underrepresented.

Difficulties in attaining details of the men’s treatment such as which programme they completed, the number of sessions attended and the facilitator’s fidelity to the treatment, meant it was not possible to examine effect in any systematic way or compare different programmes, bearing in mind that this was not the purpose of this study. Additionally, as the men had often completed more than one group comparisons of particular approaches or content were not possible.

Lastly, the views of men who withdrew from group treatment are not represented in this study and further research should investigate potential differences between men with ASD who partake in group treatment and those who do not.

## Conclusion

The findings contribute to the existing literature on ASD and sexual offending, gathering men’s experiences of adapted sex offender treatment group and how they perceive its effectiveness. These findings, coupled with data from group facilitator perspectives on adapted sex offender treatment programmes for offenders with ASD (Melvin et al,. in preparation), illustrate that such programmes can provide benefits and positive outcomes for autistic sex offenders, such as the opportunity to develop pro-social skills and relationships within the group itself and increased support and monitoring of risk behaviours. Future research should continue to investigate the views and experiences of men with ASD who sexually offend and the clinicians who treat them in order to expand the evidence-base for determining appropriate treatment. Whilst group treatment will not be suitable for all individuals with ASD (as it is not suitable for all individuals without ASD), the findings from this study suggest that adapted group sexual offending treatment groups can be beneficial to men with ASD despite potential social or communication difficulties and challenges regarding theory of mind and empathy.

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Table 1: Service User Demographics

| **Participant**  | **Age****(Yrs/mths)** | **ASD Diagnosis** | **Co-morbid Mental Health Conditions** | **Reported IQ**  | **Intellectual Disability** | **Residential Status** | **Marital Status** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| P1 | 36.6 |  Autism spectrum disorder | Not Known | 57 | Mild | Living in community under probation order and community treatment order. | Single |
| P2 | 29.5 | Atypical Autism  |  None reported | 65 | Mild | Living in own flat in community. | Married |
| P3 | 47.2 | Autism spectrum disorder | None reported | 69 | Mild to borderline | Living in community. | Single |
| P4 | 57.11 | Autism spectrum disorder | Eating disorders | 65  | Mild  | Living in community in supported group home. Has 24hr 1:1 staffing levels. | Married |
| P5 | 51.8 | Social Communication Disorder | Paranoid Schizophrenia  | 62-70 | Borderline to mild  | Detained under Section 37 of the MHA.Resides on locked ward. | Single |
| P6 | 39.1 | Meets threshold for Autism on ADOS | None | 85 | None reported | Detained under Section 37 of MHA. Resides on locked ward.  | Single |
| P7 | 52.8 | Atypical Autism  | Mixed and other personality disorder; Dissocial personality disorder  | 75 | Mild | Detained under Section 47/49 of MHA Resides in medium secure hospital. | Single (is thought to have had previous sexual relationships) |
| P8 | 37.2 | Autism | Features of personality disorder  | 61 | Mild | Detained under Section 3 of MHA. Resides on locked rehab ward.  |  Not stated |
| P10 | 26.1 | Autism/Asperger's Syndrome | None reported | - | Possible mild  | Living in community (submits to monitoring and restrictions from care staff on a voluntary basis). | Single (previous relationships with younger girls - see next section). |
| P11 | 21.2 | Meets threshold for Autism on ADOS  | None reported | - |  Mild  | Living in community (own flat), supported living. | Single (previously had a girlfriend) |
| P12 | 47.10 | Classical autism reported (plus meets threshold for autism on ADOS) | Anxiety and depression | 59-67 | Mild  | Living in community. Supported living in private flat.  | In relationship (previously married/engaged) |
| P13 | 35.5 | Atypical Autism | Klinefelter's syndrome | 79 | Mild | Detained under Section 37 of MHA. Resides in low secure hospital. | Not stated  |
| P14 | 36.6 | Classic Autism | Personality disorder | 80 | Borderline/low average IQ | Detained under Section 37 of MHA. Resides in locked rehab ward. | Not stated |

Table 2: Service User Offending and Risk Behaviours

| **Participant**  | **Harmful/risky sexual behaviours displayed** | **Convictions** | **Other offending/risky behaviours** | **Adapted SOTP completed** | **No. times completed group** | **Maintenance Group Attendance?** | **Received other/ additional therapy?** | **Re-offending behaviours displayed? [[2]](#footnote-3)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| P1 | * Public Masturbation,
* Defecating in public
* Staring/talking to young adolescents
* Voyeurism
 | * Probation order for Public Indecency
* Community Treatment Order
 | * Physical and verbal aggression
 | SOTSEC (currently undertaking BNM)[[3]](#footnote-4) | 3 | Y | Y | Y(Public indecency behaviours) |
| P2 | * Making indecent images of children.
* Possessing indecent images of children with intent to distribute.
* Sexual touching of peers.
 | * Community order and placement on sex offenders’ register (5yrs)
* Caution and registration on sex offenders’ register (2yrs)
 | * Previous aggression towards partner. No recent incidents.
 | SOTSEC-ID | 1 (but has previously completed similar work on 1:1) | N | N | N |
| P3 | * Obscene telephone calls.
* Previous behaviours include obscene letters and suggestions, exhibitionism.
 | * Probation order and requirement to complete SOTP.
 | * Shoplifting women's underwear (fetish behaviour)
* Gambling
 | SOTSEC-ID | 2 | Y | Y | N (not since second group but displays some risky behaviours e.g. sexually inappropriate behaviour when using the telephone) |
| P4 | * Stalking
* Inappropriate touching
* Rape
* Approaching/ displaying interest in teenage girls.
 | * None reported
 | * Physical and verbal aggression,
* Damage to property
* Unlawful entry to property
* Attends brothel
 | SOTSEC-ID | 3 | Y |  Unclear | N (continues to show interest in and approaches young girls) |
| P5 | * Rape and assault of adult female
* Reports touching women in clubs.
 | * Convicted of rape of adult female.
 | * Multiple drunk and disorderly convictions
 |  Unclear if prison, probation or community programme | 2 | Y | Y  | N (continues to display attitudes consistent with sexual offending) |
| P6 | * Exhibited sexualised behaviours from puberty.
* Indecent assault of young girls and female staff.
* Expressions of abusive sexual fantasies
* Displays interest in young girls in the community and expresses inappropriate thoughts.
 | * Caution (5 year) following assault of young girl.
* Convicted of sexual assault following assault of child.
 | * Historic accounts of violence and aggression towards other children when younger.
* Reported alcohol and cannabis during adolescence.
 | SOTSEC-ID | 6 | N | N | Y(sexual assaultand continues to display interest in young girls and expresses inappropriate thoughts) |
| P7 | * Necrophilic behaviour.
* Reports of 'stalking' - watching females.
 | * Convictions of wounding and murder (with sexual intent)
 | * None
 | SOTSEC-ID uncomplete (but has completed SOTP previously) | 2 | N/A | Y | N (continues to display 'stalking' behaviours) |
| P8 | * Long history of sexually abusive acts against vulnerable adults and children.
 | * No convictions relating to sexual behaviours
 | * History of physical aggression, destruction to property (has convictions for these offences).
* Also displays racially abusive behaviours.
 | SOTSEC-ID  | 2 | Y |  Y | Y(sexual assault) |
| P10 | * Reports of abuse against peers and siblings during childhood.
* Concerns over behaviour towards younger/ adolescent girls and vulnerable peers.
 | * None
 | * None reported
 | SOTSEC-ID | 1 | Y |  Y | N  |
| P11 | * Stalking behaviours followed by sexual assault of adult female.
* History of sexually inappropriate behaviour beginning in childhood, including disinhibited behaviours and assaults of females.
 | * Prosecuted and received referral order.
 | * Previous history of aggression as child, adolescent and adult.
 | SOTSEC-ID | 1 | Y | N |  N (displays ‘watching’ behaviours and taking photographs) |
| P12 | * Multiple incidents of rape and indecent assault of females under 16yrs.
 | * Convicted of sexual assault.
 | * No
 | SOTSEC-ID | 2 | Y | Y |  N |
| P13 | * Sexual assault of females (adults and children)
* Reports of touching fellow peers.
* Possession of indecent images of children (include level 5).
 | * Conviction for possession of indecent images of children.
* Conditional discharge and entry into sex offenders’ register (5 years).
 | * Convictions for arson, burglary, possession of drugs and theft.
* Use of social media to contact young females.
 |  Unclear which programme completed | 2 | Y | Y  | Y(possession of child sexual abuse images) |
| P14 | * Sexual/sadistic fetishist interest
* Grievous physical assaults related to fetish.
* Continues to express abusive thoughts and fantasies in relation to fetish.
 | * None related to sexual behaviours.
 | * Long history of physical violence (received convictions for these behaviours)
 | Unclear which programme completed | 1 | Possibly 2 but unclear if a previous group was relapse prevention or another adapted SOTP |  Y | N (continues to display sadistic interests and express abusive fantasies)  |

Figure 1: Men’s Construction of Risk within their Identity



1. Completed by the first author who is trained to research reliability level, when ASD diagnosis was otherwise uncertain. [↑](#footnote-ref-2)
2. Acts constituting offending, regardless of police involvement, since completion of first sex offender treatment programme. [↑](#footnote-ref-3)
3. Becoming New Me (Williams & Mann, 2010) [↑](#footnote-ref-4)