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Murphy, Glynis H. and Sinclair, Neil and Hays, Sarah-Jane and Heaton, Kathryn M. and Powell, Simon and Langdon, Peter E. and Stagg, John and Williams, John and Scott, Jenny and Mercer, Kim and Lippold, Tessa and Tufnell, Janina and Langheit, Geetha and Goodman, Wendy and Leggett, Janice and Craig, Leam A. (2010) Effectiveness of group cognitive behavioural treatment

DOI

<https://doi.org/10.1111/j.1468-3148.2010.00560.x>

Link to record in KAR

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Published in JARID 2010

Manuscript No. 08/99 Revised

**Effectiveness of Group Cognitive-Behavioural Treatment
for Men with Intellectual Disabilities at Risk of Sexual
Offending**

**Sex Offender Treatment Services Collaborative – Intellectual
Disabilities (SOTSEC-ID)¹**

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ABSTRACT

Background For non-disabled men, group cognitive-behaviour therapy is a successful form of treatment when men have committed sexual offences. However, men with intellectual disabilities and sexually abusive behaviour are rarely offered treatment for their sexual behaviour and little research data on the effectiveness of such treatment has been collected.

Method 9 collaborating sites ran 13 one-year long cognitive-behavioural treatment groups for men with intellectual disabilities and sexually abusive behaviour. The men came from both community and secure provision and were assessed for sexual knowledge, victim empathy and cognitive distortions before and after the group treatment. Treatment was guided by a common treatment manual.

Results 46 men consented to take part in the research. Most men (83%) had engaged in more than one incident of sexually abusive behaviour but only 57% of the men who came for treatment were required by law to attend. Almost all the men (92%) who began treatment (and consented to take part in the research) completed treatment one year later, indicating considerable motivation amongst the men to get treatment for their difficulties. Over the period of treatment, the men showed statistically significant increases in sexual knowledge and victim empathy, as well as reductions in cognitive distortions. These changes were still significant at six month follow-up for sexual knowledge and cognitive distortions. Few men showed further sexually abusive behaviour during the one year period when they were attending treatment (3 men) or during the six month follow-up period (4 men). Only the presence of autistic spectrum disorders appeared to be related to re-offending (though this result should be treated with caution, given the small numbers who re-offended).

Conclusions This large treatment trial provides some evidence of the effectiveness of such treatment for men with intellectual disabilities but there remains a need for a longer follow-up period and a randomised controlled trial.

INTRODUCTION

Remarkably little is known about sexually abusive behaviour by men with intellectual disabilities (Murphy, 2007; Keeling, Rose and Beech, 2008), even though a very large literature exists concerning sex offenders without disabilities.

Reports that people with intellectual disabilities were sometimes victims of sexually abusive behaviour began to emerge from the 1980s onwards (Chamberlain et al., 1984; Hard & Plumb, 1987, quoted in Turk & Brown, 1993; Sobsey & Doe 1991; Buchanen & Wilkins, 1991; Turk & Brown, 1993; Brown et al., 1995; McCarthy & Thompson, 1997; Brown & Stein, 1998). It transpired that around 40-50% of this abuse was perpetrated by people who themselves had intellectual disabilities (Sobsey & Doe, 1991; Turk & Brown, 1993; Brown et al., 1995), and they were mostly men (Buchanen & Wilkins, 1991; Turk & Brown, 1993; Brown et al., 1995; McCarthy & Thompson, 1997). In addition, it seemed that men with intellectual disabilities sometimes engaged in sexually abusive behaviour with victims who were non-disabled children and /or adults (eg McCarthy & Thompson, 1997).

Most men with intellectual disabilities are not sexually abusive, of course, but research on the few men with ID who do engage in such behaviour has suggested that family backgrounds of marital disharmony, separation, violence and neglect are common (Day, 1994), as is also the case for non-disabled sex offenders. Mental health needs and other problems (such as anxiety, aggression, alcohol abuse) are also frequent amongst identified men with intellectual disabilities and sexually abusive behaviour (Lindsay et al., 2002). However, just as with non-disabled perpetrators, large numbers of incidents of sexually abusive behaviour by men with intellectual disabilities are not reported to the authorities (Brown & Thompson, 1997; McCarthy & Thompson, 1997; Thompson & Brown, 1997a; Thompson, 1997) and, even where they are reported, for many men no action is taken (Brown, Stein & Turk, 1995; McCarthy & Thompson, 1997). It may be that men with intellectual disabilities and sexually abusive behaviour are actually less 'successful' in keeping their behaviour hidden, than other men, since they have more supervision, fewer private spaces, less freedom to go out alone and have less advanced planning skills than other men. This

may result in a greater level of detection of sexually abusive behaviours in the intellectual disabled population, than would be possible in the mainstream population (Hayes & Craddock, 1992).

There are very few estimates of the prevalence of sexually abusive behaviour amongst men with intellectual disabilities, though Swanson & Garwick (1990) estimated that 3% of people with an intellectual disability showed sexually aggressive behaviour and Hayes (1991) estimated that 4% of the men with intellectual disabilities in prison had been convicted of a sexual offence (from a prison survey in Australia). Meanwhile, McBrien, Hodgetts, & Gregory (2003) surveyed one local authority in England and reported that almost 11% of people with intellectual disabilities, known to services, had engaged in 'sex related' challenging behaviours, though fewer than a third of these had been convicted of sexual offences.

A number of explanations have been proposed as to why men with intellectual disabilities sexually abuse others. Thompson & Brown, 1997, suggested that it may be because:

- they themselves have been sexually abused
- they lack opportunities for appropriate sexual expression
- they lack an understanding that such behaviour is illegal
- they over-identify with children, as a result of their own developmental immaturity.

There is circumstantial evidence for some of these hypotheses. For example, men with intellectual disabilities do have limited numbers of sexual partners compared to other people (see Murphy & O'Callaghan, 2004) and those men with intellectual disabilities who later become perpetrators of sexual abuse, have more often been sexually abused as victims, compared to men with intellectual disabilities who later engage in different crimes (Lindsay et al., 2001). However, Thompson & Brown (1997) have pointed out that none of the explanations alone (see above) can account for why some men with intellectual disabilities display sexually abusive behaviour, whilst the majority do not. It is possible that other factors are more important, such as those which are thought to be important in men without disabilities who commit

sexual offences, e.g. attachment problems, lack of empathy and cognitive distortions (see Marshall et al. 1999, for a review in relation to mainstream sex offenders; and Lindsay 2005 in relation to sexual offending amongst people with intellectual disability).

Treatment of sexually abusive men

Existing sex offender treatment programmes in UK prisons (e.g. the Sex Offender Treatment Programme, SOTP) and in the community (e.g. probation-run programmes) have increasingly been based on the group cognitive-behavioural treatment model (see, for example, Marshall et al, 1999), and this model does appear to be effective (Beckett et al., 1994; Hanson et al, 2002; Friendship, Mann & Beech, 2003; Kenworthy et al, 2003; Aos et al., 2006; Brooks-Gordon et al., 2006). However, these programmes have often been restricted to offenders whose IQ is 80 or over (Grubin & Thornton, 1994) and thus many sex offenders with an IQ below 80, are not offered such treatment

Nevertheless, some treatment programmes designed for men with mild or borderline intellectual disabilities do exist. There are some UK prisons which are running Adapted SOTP programmes (ASOTP), designed for men with lower ability, including intellectual disabilities (Rogers & Fairbanks, 2003). In the research literature, there have also been sporadic reports of programmes or elements of programmes adapted for men with intellectual disabilities, but most studies have evaluated small samples of men either in the UK (Charman & Clare, 1992; Lindsay et al, 1998a, b, c; Lindsay and Smith 1998; Rose et al. 2002; Garrett, 2006; Craig et al., 2006) or elsewhere (Griffiths et al., 1989; Swanson & Garwick, 1990; Haaven et al., 1990; O'Connor, 1996; Keeling et al., 2006; Nezu et al. 1998). Only a few studies had relatively larger samples:

- Lindsay et al (2006) showed a 70% reduction in harm amongst a group of 29 sexual offenders with intellectual disabilities who had a history of repeated offending, following community-based cognitive-behavioural treatment
- Williams et al (2007) showed significant pre-post treatment change on measures of attitudes, cognitive distortions, self-esteem and empathy in a

group of over 150 men with cognitive deficits (by no means all of whom had intellectual disabilities), treated in prison using the ASOTP programme.

In the research reported in this paper, the treatment model adopted was developed from the group cognitive-behavioural approach for the treatment of mainstream sexual offending (Marshall et al., 1999). The aim was to provide such treatment for men with intellectual disabilities who had shown sexually abusive behaviours and to evaluate the effect of such treatment in terms of changes to the men's knowledge, attitudes, beliefs and re-offending rates.

HYPOTHESES

It was predicted that:

1. There would be improvements in scores for sexual knowledge and attitudes for treated men between pre-group and post-group, and between pre-group and follow-up;
2. There would be improvements in scores for victim empathy for treated men between pre-group and post-group, and between pre-group and follow-up;
3. There would be improvements in scores for cognitive distortions for treated men between pre-group and post-group, and between pre-group and follow-up;
4. Treated men would show no further sexually abusive behaviour.

METHOD

Design

This research project involved a collaboration between 9 participating sites, each offering cognitive-behavioural treatment to men with intellectual disabilities who were at risk of sexual offending (some sites ran more than one group so 13 such groups were run altogether by the 9 sites). The collaborative group which coordinated the treatment and research was known as SOTSEC-ID (Sex Offender Treatment Services Collaborative – Intellectual Disability) – see www.kent.ac.uk/tizard/sotsec and Murphy & Sinclair (2009).

The participating sites were spread across the UK and each one consisted of a clinical team, based in an NHS Trust, usually as part of Community Learning Disability

Teams (CLDTs), or a clinical team based in secure services (often run by the independent sector). The only exception was one participating site which consisted of an independent group of psychologists providing treatment to men with intellectual disabilities on probation.

Typically, the teams running the treatment consisted of two male and two female clinicians, who would rotate to facilitate treatment sessions (such that there was always one man and one woman clinician facilitating each session). The teams were normally led by a clinical psychologist and the remaining team members would often include other clinical psychologists, behaviourally trained nurses, behaviour therapists, cognitive therapists, social workers and/or probation officers. All teams were required to undertake the SOTSEC-ID training.

The study was designed as a trial of treatment, with waiting list controls (it was not an RCT). The treatment lasted for one year and follow-up was at six months. This paper reports data from treated men only.

Participants

The participants in the research were all men with intellectual disabilities and a history of sexually abusive behaviour, who attended treatment groups and consented to take part in the research. Not all of the participants had convictions for sexual offences, although they had all engaged in sexually abusive behaviour (in many areas, police are reluctant to charge and the Crown Prosecution Service is reluctant to prosecute men with intellectual disabilities, even where it seems likely that sexually abusive behaviour has taken place, especially if the victim is another person with an intellectual disability, see Green et al., 2002).

The definition of sexually abusive behaviour used in this study was as follows:

Sexually abusive behaviour refers to any sexually related behaviour for which:

- the other person was not consenting (or was unable to consent), and
- the behaviour would be defined as illegal within the jurisdiction in which it occurred

This definition excluded sexual behaviours that may be considered unusual, but which are not illegal in the jurisdiction in question (for example, cross-dressing).

Normally the proof of whether a sexual offence has occurred should be established through the criminal justice process. However, if the alleged perpetrator was diverted out of the criminal justice system due to having an intellectual disability or other mental disorder, or the sexually abusive behaviour was not reported to the usual authorities, then eye-witness accounts of the sexually abusive behaviour (e.g. by the victims or other witnesses), would suffice to establish the probability that the behaviour occurred. (Sinclair, Booth and Murphy, 2002, p.4).

This definition was deliberately broad and acknowledged that a large number of incidents of sexually abusive behaviour by men with intellectual disabilities are not reported to the authorities (Brown & Thompson, 1997; McCarthy & Thompson, 1997; Thompson & Brown, 1997; Thompson, 1997) or are reported but not prosecuted (Brown, Stein & Turk, 1995; McCarthy & Thompson, 1997), and are therefore not technically ‘offences’ (since this requires a conviction).

The inclusion criteria for men entering treatment were:

- i. Participants must be aged between 18 and 60 years, have committed at least one act of sexually abusive behaviour, and have been associated with intellectual disability services, at some stage in their lives.
- ii. They must be deemed suitable for cognitive therapy, able to work in a group, and must have a Full Scale IQ in the mild or borderline range
- iii. Clients could be drawn from a number of places including community intellectual disability services, health or social services, or probation services, or secure settings.

Measures

All men were assessed on baseline or ‘initial’ measures at the start of the group, which were intended to reflect the men’s basic skills and adaptive behaviours (see

Table 1). In addition, men were assessed on dependent 'process' measures at the start of the group, at the end of the group and at six month follow-up – see Table 1.

Information was also collected on childhood history, previous offending, previous sexually abusive behaviour, sexually abusive behaviour during the group and for 6 months following the group. The rationale for selecting measures and details of the measures themselves are given elsewhere (Murphy, Powell, Guzman & Hays, 2007, and in Murphy & Sinclair, 2009).

Table 1 about here

Procedure

Ethical review

Ethical permission for the study was sought through the NHS Multi-Site Research Ethics Committee procedures. This process was extremely prolonged, required applications (and revisions) to three successive MREC committees but eventually a favourable ethical opinion was received (Hays, Murphy and Sinclair, 2003).

The research information sheets and consent forms made it clear that participation in the research was voluntary and that the men could withdraw their consent at any time. It was also emphasised that men could consent to the treatment without consenting to the research (research consent was sought some weeks after the treatment had begun, so as to ensure there was a clear separation between consent to treatment and consent to research).

Confidentiality of information during the assessment and/or treatment was dealt with by making it clear to the men that information they provided was confidential, provided it did not indicate that they themselves or someone else was in danger/liable to harm; any information signifying that they or others were in imminent danger/liable to harm, would be shared with named people; if disclosures of new offences were made and if the victim could be identified, then a (named) person would need to be contacted.

Procedure for joining research

Clinical teams wishing to participate in the research usually contacted SOTSEC-ID because they had referrals of men who needed treatment for sexually abusive behaviour. Once teams decided to participate, they joined SOTSEC-ID, attended the training, and then invited men who met the inclusion criteria to participate in the treatment groups. Provided men consented to treatment, they were included in the treatment group. Research consent was sought at a later point (see above).

Once men had consented to treatment the initial measures, process measures and background information schedules were completed (see **Measures** above and Table 1) and they entered the treatment groups. Process measures and information schedules were also completed at the end of the group and at six month follow-up (see under **Measures** above). No assessment measures or information about the men in treatment were passed to the research team until men had consented to participate in the research. Of the men in treatment groups, 70% consented to be involved in the research; this paper presents the data from that 70%.

Treatment procedure

The treatment procedure is fully described in the SOTSEC-ID treatment manual (Sinclair et al, 2002, and see Murphy & Sinclair, 2009). A summary of the treatment components is given in Table 2. The treatment groups each ran for one year; during that year each group had one treatment session of 2 hours duration, once per week.

Table 2 about here

Analysis

Data were checked for normality before analysis. The distribution of total scores for victim empathy, the SOSAS and the QACSO were not significantly different from normal on any of the occasions (pre-group, post-group, follow-up). However, the SAKS did not conform to normality. The victim empathy, SOSAS and QACSO data were therefore analysed by parametric methods; the SAKS data were analysed by non-parametric methods. There was some missing data, particularly in the follow-up phase, as not all sites were able to collect follow-up data. Therefore the pre-post group analyses were calculated first, as these have the most complete data. Then the pre, post, follow-up changes were examined.

Changes to victim empathy and cognitive distortions (on the victim empathy scale, the SOSAS and the QACSO) between the start and the end of the treatment group were analysed by t-tests (for repeated measures). Changes to sexual knowledge and attitudes (on the SAKS) between the start and the end of the treatment group were analysed by Wilcoxon matched pairs signed ranks test. Likewise the overall changes between pre-group and follow-up at 6 months for the victim empathy and cognitive distortions measures were tested by t-tests, while changes in sexual knowledge between pre-group and follow-up at 6 months were tested by Wilcoxon matched pairs signed ranks test.

RESULTS

The participants' characteristics

Thirteen treatment groups were run across 9 sites. Seventy percent of the men in treatment groups, i.e. 46 men, consented to take part in the research. Five of these men later participated in further treatment groups, as clinicians judged that they would benefit from this. However, for the purposes of clarity, the results reported here only refer to the 46 men who completed their first group. Those 5 men who repeated the treatment groups have not been included.

Table 3 shows the mean age of the men, their living situations at the time the groups started, the level of security of the venue where the group was held, and the men's legal status when the treatment groups started. In terms of ethnicity, 86% of men were reported to be 'white British' with fewer than 5% from each of the following groups: 'white Irish', 'white other', Indian and Afro-Caribbean origins. Almost all the men (91%) were receiving no treatment at all for their sexually abusive behaviour at the start of the group. Most (73%) were not on medications of any kind at the start of the group.

Table 3 about here

Childhood circumstances

The amount of information available on the men's childhood circumstances was limited for many men. Where information was available, most men (76%) were known to have lived mainly with one or more biological parent during their

childhood; 4% lived mainly with step-parents or close relatives; 4% were adopted or fostered; 6.5% lived largely in residential facilities as children; 6.5% lived in multiple settings. In 17 cases (37%), the men had spent at least some time in care as children. By the start of the group, one of the men's parents was known to have had died in 33% of cases (in just over half of these men (53%), this had occurred during the participants' childhood).

Where information on the childhood years was available, most men (84%) were known to have been diagnosed as having intellectual disabilities during childhood, a few were diagnosed as having autistic spectrum disorders (n=4) and/or ADHD (n=6) in childhood and 76% had had contact with psychiatry or psychology or intellectual disability services as children. In very few men (n=3) were the causes of the men's intellectual disabilities known (one man had Down syndrome, one man had Fragile X syndrome, one man had Klinefelter's syndrome). However, it was known that most men (65%) attended special schools during their primary school years, and 82% attended special secondary schools. Some men (n=8) were known to have already had convictions for offences during childhood (32 offences altogether: 1 or 2 convictions in 3 men; 4 or 5 convictions in 3 men; more than 5 convictions in 2 men). Most of these convictions were for burglary/robbery/theft, criminal damage or for violent behaviour. Three men had been convicted for sexual behaviour during childhood (they had 2, 3, and 4 convictions each).

Contact with services and convictions during adulthood

The majority of men (93%) had also had contact with intellectual disability services during adulthood. Most (91%) had a formal diagnosis of intellectual disabilities in adulthood; 31% had a diagnosis of personality disorder; 21% had an autistic spectrum disorder diagnosis; 16.7% had had a diagnosis of a mood disorder; 12% had had a diagnosis of anxiety disorder and 9.5% a diagnosis of schizophrenia or other psychotic disorder (these figures add to more than 100% as some men had dual diagnoses)

Quite a number of men (31%) had had convictions for non-sexual offences during adulthood, mostly burglary/robbery or theft, criminal damage or violent behaviour. None had been convicted of drug offences.

Relationships and abuse (as victims)

Most men (91%) reported having had consensual social relationships with ‘girlfriends’ or ‘boyfriends’ during their lives, but 9% said they had never had either a girlfriend or boyfriend. Most men had only had a few relationships of this kind: 28% had only ever had one girlfriend or boyfriend and a further 44% had only had 2 or 3.

The majority of men (78%) said they had also had a consensual sexual relationship in the past; conversely 22% said they had never had a consensual sexual relationship. It may be that some referred to relationships as ‘consensual’ where the other partner would not have termed it consensual. In 93% of men, the men’s sexual interests included adult women; in 31% their interests included adult men; in 71% female children; in 27% male children (these figures add to more than 100% as many men had sexual interests in more than one group)

It was not uncommon for men to have been a victim of sexual abuse themselves: 18 (55% of those for whom the information was known) had been victims of abuse themselves, mostly when they were children. Only 3 men said they knew their perpetrators had been convicted, even though abuse had often gone on for years. It is possible that the men did not always know when their perpetrators had been convicted, as many were abused while still young children.

Offences and abusive sexual behaviour by the men

Table 4 gives details of the ‘index’ sexually abusive behaviours (i.e. the sexually abusive behaviour that was most recent, whatever its severity, and regardless of the legal outcome, for each man, at the time of initial assessment). In most cases (63%) there was considerable documentation of the sexually abusive behaviour. However, in 37% of cases the amount of documentation was rated as relatively poor (e.g. accounts in the case notes were extremely brief).

Table 4 about here

Most men, 74%, were single (ie not in a relationship) at the time of the index sexually abusive behaviour. Many (38%) were living with their families (usually parents) at the time; 33% were living in group homes; 10% were living in their own homes with

support; 10% were living in their own homes without support; 3% were in adult 'foster' placements and 8% were living in secure provision at the time.

In terms of day activities, many men (26%) were enrolled in day services for people with intellectual disabilities during the period when the index sexually abusive behaviour occurred while 7% attended college during that period and 16% had supported employment, 13% were in full-time or part-time employment, and 39% were not involved in any formal day activities.

In 71% of men, the victim of the index offence was female, and in over 60% of men, the victim of the index offence was a child/children. Most of the men (69%) were interviewed by the police in relation to the index sexually abusive behaviour and 62% went to court. Three men were found unfit to plead and the legal outcome for the remaining convicted men was as follows: 12 received a community order of one kind or another, 5 received hospital orders; 3 were given custodial sentences; 1 was cautioned; 1 was fined.

Many men (35) were known to have engaged in previous sexually abusive behaviour, prior to their index abusive behaviour. Men were often quite young when they first engaged in such behaviour: 3 were under 12 years of age and a further 9 were under 18 years of age. Six of these 35 men were thought to have engaged in prior sexually abusive behaviour against one previous victim, but 13 men had between 2 and 4 previous victims and 16 men had 5 or more previous victims. Most men (69%) were considered contact abusers, 31% were considered non-contact abusers, taking all their sexually abusive behaviour into account. Table 4 shows the types of prior sexually abusive behaviour for the 42 men where this was known.

Of the 42 men who were known to have engaged in previous sexually abusive behaviour, 29 were known to have been interviewed by the police on at least one occasion, 5 were known never to have been interviewed for their previous sexually abusive behaviour (and for the remainder this information was not known). Of the 29 men known to have been interviewed, 22 had appeared in court on at least one occasion. Sentences were similar to those for the index sexually abusive behaviour.

Psychometric measures at baseline

Before the treatment group began, a number of psychometric measures were taken (see under **Measures**). The mean full scale IQ was 68, range 52-83 (s.d. 7.6); the mean verbal IQ was 68, range 53-85 (s.d. 7.6) and mean performance IQ was 73, range 58-99 (s.d. 8.2). Altogether 15 men had a full scale IQ of over 70, 3 had a full scale IQ of exactly 70. Thus 18 men did not technically have an intellectual disability (the definition of intellectual disability in the UK requires significant impairment in intellectual functioning, i.e. an IQ below 70, and significant impairments in adaptive behaviour, from the developmental period - see BPS, 2001). Yet all of the men in this research had been involved in intellectual disability services and 91% had had a formal diagnosis of intellectual disabilities. Often the more able men were those diagnosed with autistic spectrum disorder (which, it was hypothesised, had made them seem more disabled than their IQ score suggested).

The mean BPVS score for the men was 10.9 yrs (age equivalent), s.d. 3.2 yrs. The mean Vineland adaptive behaviour composite age equivalent was similar, at 10.1 yrs, with poorer mean Vineland communication skills (8.1 yrs) and Vineland socialisation skills (9.69 yrs) than Vineland daily living skills (12.8 yrs). Nine men had been previously formally diagnosed as on the autistic spectrum.

Process measures pre-group, post-group and at follow-up

Almost all the men (92%) who entered treatment and consented to the research completed the groups (i.e. they had only very occasional weeks of absence due to minor illness or other planned absence). Of those who did not complete the year's treatment, two left because of their deteriorating mental health and one committed a further offence (post group and follow-up data is patchy therefore for these three men).

There were four psychometric measures taken pre-group, post group and at follow-up to examine progress (see under **Measures**): the sexual knowledge assessment (SAKS), victim empathy scale - adapted (VESA), and two measures of cognitive distortions (the SOSAS and the QACSO). Progress in the SAKS is indicated by higher scores; progress in all other measures is indicated by lower scores. Table 5

shows the mean scores on all these measures pre-group, post group and at follow-up for all men for whom they were completed.

Table 5 about here

Table 6 shows the analysis of changes in the process measures between pre-group and post-group, and between pre-group and follow-up (see **Method** for details of the rationale for the statistical methods used). The changes between pre and post group were significant for the SAKS, victim empathy scale, QACSO and the SOSAS. The changes between pre-group and follow-up were significant for the SAKS and QACSO only (but inspection of Table 5 suggests that victim empathy changes may not have reached significance partly due to the smaller number of men for whom these were available at follow-up, since the mean scores and standard deviations were little changed from post-group levels). Hypothesis 1 was therefore supported; hypotheses 2 and 3 were partially supported.

Table 6 about here

Behaviour during the year of the treatment group

None of the men committed further **non-sexual offences** during the year of the treatment group. However, 3 men engaged in **further sexually abusive behaviours** during the year of the treatment group. In all men, these were non-contact behaviours, including public masturbation, indecent exposure, stalking and other non-contact offences (such as verbal sexual harassment). The victims were almost entirely unknown to the men: in all but one case they were groups of general public (possibly including children) or individual adult women from the general public (i.e. acquaintances/strangers to the men); in only one case was the victim a familiar female service user. Table 7 gives details of these behaviours, the victims and the legal outcome.

Table 7 about here

Behaviour during the six month follow-up period

None of the men committed further **non-sexual offences** in the 6 month follow-up period after the treatment group finished. However, four men engaged in **further sexually abusive behaviours** and details of these, the victims and the legal outcomes are shown in Table 8 (three of these four men had been diagnosed as on the autistic spectrum). Two of these men had also re-offended during the treatment groups (see Table 7).

Table 8 about here

Almost all of the sexually abusive behaviour during the 6 month follow-up period consisted of non-contact abusive behaviour but in two cases the men touched people's genitals through their clothing (see Table 8 for details). Details of legal outcome are given in the Table.

Predicting future sexually abusive behaviour

Variables that were thought likely to affect outcome (i.e. the appearance of further sexually abusive behaviour) were examined, although these analyses need to be treated with caution given the very small number of men re-offending. Variables which were examined and proved not to be significantly related to outcome included: IQ (full scale, verbal or performance), comprehension of language, pre-group SAKS, victim empathy, SOSAS, QACSO scores. Nor were there significant differences between 're-offending' men and the other men in their post-group scores or follow-up scores on the process measures. None of the following were significantly related to later sexually abusive behaviour either: the presence of a personality disorder, the presence of mental health problems, living in a secure setting, the previous experience of sexual abuse as a victim, a childhood history of any offending, a previous history as an adult of non-sexual offending, a previous history as an adult of sexually abusive behaviour (as the perpetrator). However, men who had been diagnosed as being on the autistic spectrum by the time they were adults were significantly more likely to have re-offended during the follow-up period than others (Fisher's exact test, $p=0.02$). Men diagnosed with autism also had significantly poorer QACSO scores pre-group, post-group and at follow-up than did other (non-autistic) men ($p<0.05$, $p<0.01$, $p<0.05$ respectively), though no other measures (SAKS, victim empathy, SOSAS) showed such differences, apart from poorer SAKS scores at pre-group ($p<0.05$) for the autistic men.

DISCUSSION

The men with sexually abusive behaviour who consented to treatment and also consented to the research were very similar to men with sexually abusive behaviour and intellectual disabilities described in previous studies (for example, Day, 1994; Hayes, 1991; Briggs & Hawkins 1996; Thompson & Brown, 1997; Lindsay et al, 2001). They were almost always identified as having intellectual disabilities in childhood, had often had contact with psychiatry or psychology services in childhood, had often attended special schools (especially in the secondary years), and had frequent dual diagnoses. They had often suffered disturbed childhoods, including not living with at least one biological parent, having more than two changes to parenting arrangements, having one or more parents die during their childhood or having at least some time in care as a child. Surprisingly though, despite the men having to have contact with intellectual disability services in order to enter the project, only 25 technically had an IQ below 70 (ie. had the intellectual component for a diagnosis of intellectual disabilities), while 18 had an IQ of 70 or above (and for 3 men there were no IQ data). Nevertheless, 91% of the men had had a formal diagnosis of intellectual disabilities. Thompson & Brown (1997) have also noted that many men described as having intellectual disabilities and sexually abusive behaviour did not really have intellectual disabilities, even though they were receiving intellectual disability services.

In this study, only a few men had a history of any kind of convictions for offences during childhood and even fewer had convictions for sexual offences in childhood. A relatively high proportion of men, however, had been sexually abused as children, often in a prolonged manner, much as Lindsay also found (Lindsay et al., 2001).

By the time they joined the group as adults, of course, all the men had engaged in sexually abusive behaviour and the vast majority had engaged in sexually abusive behaviour on more than one occasion in the past. About a third of the men engaged largely in non-contact sexually abusive behaviours but, amongst the other two thirds,

their previous sexually abusive behaviour was often serious, including attempted penetration, for example. Often these prior sexually abusive behaviours began before the age of 18 years (as is often the case for non-disabled sex offenders, Rich, 2009), even though very few were convicted in childhood.

The victims of these past sexually abusive behaviours included people of all ages (including children) and the majority of the victims were acquaintances/ strangers (i.e. they were people who were not known to the men beforehand), though other service users and staff were the second and third most common victim groups. Many men had been interviewed by the police at least once in the past and most of these men had appeared in court (the vast majority were convicted). The index sexually abusive behaviours (i.e. the one that had occurred most closely to the start of the treatment group) usually had a similar profile, in terms of form and victims to the prior sexually abusive behaviour. For these index behaviours, again, most men were interviewed by the police and appeared in court, with the majority receiving a conviction of some kind. This contrasts with studies which maintain that few men with intellectual disabilities are convicted (eg. Brown et al, 1995; McCarthy & Thompson, 1997) but of course it may have been that only the most severe offenders and/or mainly those with convictions were referred for treatment.

Once the men had started in the treatment group, the vast majority stayed until the end, one year later. This was impressive considering many of the men (around 40%) were not required by law to attend. The men's feedback at the end of the group (described in Hays et al, 2007) suggested that many had found the support of the group helpful, even though they acknowledged that facing up to talking about their offences had been difficult.

According to the SAKS measure taken before the group and repeated at the end of the group and at follow-up, the men's sexual knowledge and attitudes had improved significantly over the period of the group and this change was maintained at follow-up. Cognitive distortions measured on the QACSO had also improved significantly during the group and were maintained at follow-up, but those measured on the SOSAS tended to show less significant changes (perhaps because the men found the double negatives in the SOSAS difficult to understand). Victim empathy appeared to

have improved during the period of the treatment group and the improved scores were maintained at follow-up (though this change, from pre-group to follow-up, fell just short of significance). Previous studies of the effectiveness of group cognitive-behavioural treatment for men with intellectual disabilities and sexually abusive behaviour have tended to show similar findings, though many included fewer types of measures and often very small numbers of participants so that statistical testing of results was often not possible (Lindsay et al, 1998a, Lindsay et al, 1998b, Lindsay et al, 1998c, Lindsay et al, 1999, Rose et al., 2002, all with between 2 and 6 men).

Nevertheless, some men in this study did show further sexually abusive behaviour during the year of the treatment group and/or in the six months following the end of the treatment group. Mostly these behaviours were non-contact sexually abusive behaviours and many of the men engaging in them were on the autistic spectrum. Analysis of the variables which seem to be related to a poorer outcome demonstrated that, so far, only one variable was associated with a worse outcome: whether the man had been diagnosed as having autistic spectrum disorder. Those on the autistic spectrum were statistically more likely to show further sexually abusive behaviour and also had statistically poorer pre-group, post-group and follow-up scores on the main measure of cognitive distortions (the QACSO), compared to other men not diagnosed as autistic. Only two previous studies of re-offending amongst men with intellectual disabilities and sexually abusive behaviour could be located that identified other relevant variables for predicting outcome, including length of treatment (Lindsay and Smith, 1998), as well as poor relationship with mother, anti-social attitude, denial of crime, sexual abuse in childhood, erratic attendance and poor response to treatment (these were from a retrospective study of re-offending by Lindsay et al, 2004). In the current study, so few men re-offended in the period of follow-up that it is very unlikely that all the variables relevant to future re-offending have been detected. Clearly risk factors for re-offending is an important issue and needs further investigation.

This research had some major advantages over previous research of this kind. It was multi-site and therefore could acquire a dataset of almost 50 men who had participated in treatment. All facilitators had training in the treatment model and the treatment was guided by a treatment manual to ensure that the treatment model was

the same across all sites. A variety of measures of sexual knowledge, victim empathy and cognitive distortions were used, unlike in many previous studies and all known sexually abusive behaviours were logged, rather than just convictions (for men with intellectual disabilities this is particularly important as it sometimes seems rather arbitrary whether or not police interview them and whether or not they proceed to court).

Nevertheless, the research also had some serious limitations. The involvement of a large number of sites with limited resources has meant it has been difficult and time-consuming to ensure that the treatment provided was faithful to the manual (treatment fidelity could not be measured because of resource constraints) and it has also meant that the datasets were not always complete for each man, especially for follow-up data, so that there were some men with no process measures data at follow-up (i.e. no SAKS, VESA, SOSAS and/or QACSO). The vast majority of clinicians were collecting such data as part of their clinical duties and did not have extra allocated resources for data collection. Most clinicians were still in touch with the men in question at follow-up, so they did know whether they had re-offended or not, but they sometimes allocated a low priority to collecting follow-up SAKS, VES-A, SOSAS and QACSO data.

Furthermore, it had originally been intended that data should be collected for 'waiting list' controls but, even when clinicians received such referrals (of men with sexually abusive behaviour, after the SOTSEC-ID group had started), they did not prioritise collection of baseline data or one-year-on data, and so far too few data sets have been collected to be useful (hence none are included here). Without a control group it is difficult to be certain how effective the treatment is. In future, especially given the failure of the 'waiting list control' strategy, a stricter experimental design should be considered and a randomised controlled trial is one possibility. This would be extremely difficult to achieve, however, partly because the number of men referred to any one area is relatively small (so that randomly allocating them to treatment vs no treatment would result in unviably small treatment groups), and partly because service managers are extremely nervous about providing no treatment for men with sexually abusive behaviour, even when the treatment available is unproven. One possibility might be to randomise sites (rather than men) to treatment or no treatment, but while

this would take care of the first difficulty (group size), the second (service manager nervousness) would still remain.

Finally, the limited period of research grant support in this project meant that only 6 months follow-up was possible and clearly a longer follow-up would have been very desirable. Nevertheless, for lengthy treatment programmes (eg. those lasting one year), it is difficult to achieve longer follow-ups with the typical three year research grant, given the amount of time that ethical approval and recruitment takes. However, despite this, the current research has provided further evidence that cognitive-behavioural treatment for men with mild or borderline learning disabilities and sexually abusive behaviour is showing considerable promise and deserves further multi-site research. Certainly this form of treatment should be on offer to more men with intellectual disabilities and sexually abusive behaviour, so that the men can choose active treatment, rather than just long periods of tight risk management and close supervision, as in the past.

ACKNOWLEDGEMENTS

We owe all the men who participated in the research a debt of gratitude. It is not easy to admit to having sexually abusive behaviour, nor is it easy to accept treatment for such behaviour, nor to join research projects.

We are also very grateful to all the facilitators, both those named as authors and others who have also participated (for example, in helping lead facilitators to run treatment groups and in collecting data for treated men).

Finally we would like to express our thanks to the Dept of Health for funding the main part of this research and to Care Principles for funding the research worker during a gap in funding.

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Table 1: Measures

Variable	Measure
Baseline measures (once only)	
Intelligence	Wechsler Adult Intelligence Scale-Third Edition (WAIS-III; Wechsler, 1997).
Adaptive Behaviour	Vineland Scales of Adaptive Behavior (Vineland; Sparrow, Balla & Cicchetti, 1984).
Receptive Language	British Picture Vocabulary Scale-II (BPVS-II; Dunn, Dunn, Whetton & Burley, 1997).
Mental Health	Psychiatric Assessment for Adults with a Developmental Disability (mini PAS-ADD; Prosser, H., Moss, S., Costello, H., Simpson, N., & Patel, P. 1997). Hester Adrian Research Centre and the Institute of Psychiatry.
Autism	The Diagnostic Criteria Checklist (Operationalises DSM IV criteria for autism) (Howlin, 1997).
Process measures (pre, post and at follow-up)	
Sexual Knowledge	Sexual Attitudes and Knowledge (SAK) (Heighway & Webster, 2007).
Distorted Cognitions	Questionnaire on Attitudes Consistent with Sex Offences (QACSO; Lindsay, Carson & Whitefield, 2000). Sexual Offenders Self Appraisal Scale (SOSAS; Bray & Forshaw, 1996a).
Victim Empathy	Victim Empathy Scale (Beckett & Fisher, 1994) – Adapted.
Repeated sexually abusive behaviour (pre, post and follow-up)	
Sexually abusive behaviour	<ul style="list-style-type: none"> ▪ Sexually abusive behaviour not reported to the police ▪ Sexually abusive behaviour reported to the Police ▪ Convictions for sexual offending behaviour

Table 2: Treatment procedure

Summary The aim of the treatment is to reduce men's sexually abusive behaviour. It is also expected that there will be positive change in men's sexual attitudes and knowledge, their victim empathy, and their cognitive distortions in relation to sexual offending (e.g. degree of minimisation, denial for the offence (s) and blame for the victim). These issues form the main focus of the treatment programme. The curriculum is as follows:

Social and therapeutic framework The first part of the treatment seeks to establish the social and therapeutic framework within which the group treatment will proceed. Components include: establishing group rules, addressing initial denial, and developing group social skills.

Human relations and sex education: The purpose of sex education for the men with intellectual disabilities and sexually abusive behaviour is to provide: A common knowledge base and understanding for human sexuality and relationships, including consent and legal issues; 'permission' to talk about sexuality and sexually abusive behaviour; and opportunities to challenge any myths/beliefs/attitudes/cognitive distortions regarding relationships, behaviour or gender roles, which may contribute to sexually abusive behaviour

The Cognitive Model The treatment takes a cognitive approach to changing sexually abusive behaviour, through changing the men's cognitive distortions, and this phase of the treatment introduces men to the cognitive model, i.e. to the idea that there are emotional and cognitive aspects to behaviour. This begins with non-offending examples (e.g. someone being upset because a promised visit did not take place) and gradually moves on to challenging behaviour/offending (e.g. wanting items in a shop, not having the money but shop-lifting) and finally to sexual offending (including the men's own offences).

Victim Empathy Empathy has long been considered important for regulating and/ or mediating pro-social behaviour, motivating altruism and inhibiting aggression. It appears that low victim empathy may be related to some of the cognitive distortions that sex offenders hold, in that both minimisation of harm and victim blaming may be the result of low victim empathy.

Various methods are used in the treatment to try to increase victim empathy. Initially the men are supported to talk about times when they were victims of bullying or abuse. They consider how they felt. The group then works towards getting the men to think about how victims of sexual abuse, generally, might feel. Finally they are helped to face up to how their own victims felt, something which most men find very hard.

Sexual Offending Model Finklehor's 4 step model of sex offending and subsequent variations by HM Prison Service and Janet Shaw Clinic and SOTSEC-ID (see Murphy and Sinclair, in press) provides the framework within which facilitators and participants discuss the men's sexually abusive behaviour and help them to understand it better, especially the various steps involved in the offending process. This part of the programme is intended to help the men see that their previous abusive sexual behaviour did not occur in a random or unexplained fashion but that they planned to offend (and therefore that they can plan not to offend). The model provides a relatively simple framework for understanding sexual offending and forms a basis for relapse prevention. It proposes 4 steps to sexually abusive behaviour: thinking about sexually abusive behaviour (having 'not OK' sexy thoughts); making excuses about why this is OK; planning how to get access to a victim; engaging in sexually abusive behaviour

Each man is required to consider these steps in relation to his own past behaviour. In the process of discussion with the men, it usually transpires that they hold a variety of cognitive distortions (e.g. the belief that they didn't plan their offences, they just 'happened'). These cognitive distortions are then challenged, with the help of other men in the group, and each man is helped to develop a more honest account of how his sexually abusive behaviour occurred.

Relapse Prevention Relapse prevention is designed to address the difficulty encountered in most sex offender treatment programmes, that of recidivism or failure of maintenance. The purpose of relapse prevention strategies is to provide the client with a range of strategies and tactics that will reduce the probability of encountering situations in which a lapse is likely, and reduce the likelihood of lapses becoming relapses. Such strategies are needed because regardless of how powerful the initial treatment effect is, maintenance relies on self-administration of strategies and tactics to avoid relapse, and if such strategies are not explicitly addressed in treatment, the client is less likely to have the appropriate skills and knowledge to apply them.

Towards the end of the treatment, a number of sessions are spent developing detailed relapse prevention plans for each client. These serve as a summary of relevant points of the group treatment programme and are designed to be portable relapse prevention plans that the man can use at any time and that can also be shown to relevant parties such as the residential service and Care Manager.

Table 3: Men’s ages, living situations, legal status and the group venues

Variable	Mean/percentage
Mean age (& s.d.)	35.3 yrs (s.d. 12.0)
<u>Living situation</u>	
Living at home alone	6.57%
Living at home alone, with part-time support	6.5%
Living in adult placement	2.2%
Living with family members (usually parents)	10.9%
Living in group homes for people with intellectual disabilities	30.4%
Living in a low secure service	8.7%
Living in a medium secure service	30.4%
<u>Level of security of treatment group:</u>	
Community-based venue	67.4%
Low secure venue	4.3%
Medium secure venue	28.3%
<u>Legal status at start of group</u>	
Informal	40.9%
Detained under Mental Health Act	34.1%
Community Rehabilitation Order (CRO)	20.5%
On bail	2.3%
Other (eg on licence)	2.3%

Table 4 The index sexually abusive behaviour and prior sexually abusive behaviour for the 46 men

Sexually abusive behaviour	Number of men (index behaviour)	Number of men (prior behaviour)
Contact abuse:		
Perpetrator touching victim's genitals (unclothed)	9	11
Perpetrator touching victim's genitals (clothed)	8	13
Victim made to touch perpetrator's genitals (unclothed)	1	0
Victim made to touch perpetrator's genitals (clothed)	2	1
Perpetrator masturbates victim	3	2
Victim made to masturbate perpetrator	0	1
Performs oral sex on victim	1	1
Victim forced to perform oral sex	1	1
Anal/vaginal penetration of victim	10	11
Sadomasochistic sex	0	1
Other (frotteurism, fetishism, child kissing, child abduction)	10	15
Non-contact abuse		
Verbal sexual harassment	1	8
Stalking	3	5
Indecent exposure	4	10
Victim shown pornography	0	1
Perpetrator masturbates in public	7	8

Table 5: Pre-group, Post group and Follow-up mean scores (and standard deviations) for all process measures

Measure	Pre-group Mean (& s.d.)	Post-group Mean (& s.d.)	Follow-up Mean (& s.d.)
Sexual Knowledge and Attitude Scale (SAKS) Total score	42.0 (6.8) N=45	45.1 (7.1) N=42	47.3 (4.8) N=22
Victim empathy	34.5 (18.4) N=38	27.1 (17.9) N=35	21.9 (16.7) N=24
SOSAS Total	55.2 (9.1) N=42	51.2 (10.8) N=42	49.4 (12.4) N=20
QACSO Total	51.4 (20.7) N=40	28.0 (20.6) N=38	28.5 (27.6) N=23

Table 6: Analyses of changes on process measures

Pre-group to post-group changes on the process measures			
Measures	N	Test statistic	Significance
Victim empathy	34	t = 3.30	p = 0.002
SOSAS	39	t = 2.25	p = 0.030
QACSO	37	t = 8.39	p < 0.001
SAKS	42	Z= 3.81	p < 0.001

Pre-group to follow-up changes on the process measures			
Measures	N	Test statistic	Significance
Victim empathy	18	t = 1.77	p = 0.09
SOSAS	18	t = 1.95	P = 0.07
QACSO	22	t = 4.18	p < 0.001
SAKS	22	Z= 3.60	p < 0.001

Table 7: Sexually abusive behaviour during the year of the treatment group

Participant number	No. of sets of sexually abusive behaviour	Victims	No. of time interviewed by police	Legal outcome
1	6 (public masturbation X 5, 1 other)	Mostly general public	0	Nil
15	1 (public masturbation & stalking)	Adult female, acqu/stranger	1	Appeared in court; CRO & fine
31	1 (public masturbation)	Adult female service user	0	Nil

Table 8 Sexually abusive behaviour during the follow-up period

Participant number	No. of sets of sexually abusive behaviour	Victims	No. of times interviewed by police	Legal outcome
1	8 (public masturbation X 7; stalking X 1)	General public; 1 adult female	0	Nil
3	1 (touched victims genitals through clothing X 1)	Female staff member	0	Nil
7	1 (touched victims genitals through clothing X 1; other X 1)	Adult male service user	0	Nil
15	1 (public masturbation X 1)	Female, 12-18yrs old; acq/stranger	1	CRO